Colorado Health Partnerships
Fiscal Year 2013
Quality Management and Utilization Management Program
Annual Evaluation

Executive Summary

The 2013 annual evaluation was reviewed and approved by the Colorado Health Partnerships' Quality Improvement Steering Committee and Clinical Advisory/Utilization Management Committee (QISC/CAUMC) on September 6, 2013. The Class B Board members will complete their review of the annual evaluation in September, with final approval of the evaluation of quality activities and goals for FY2014 scheduled for the October 25, 2013 Class B Board meeting. *ValueOptions*® policy and procedure requires the Quality Management and Clinical Directors to complete an evaluation of CHP's Quality Improvement and Utilization Management Programs on an annual basis. Colorado Health Partnerships' governing body requires that the QISC/CAUMC evaluate the annual QM/UM Work Plan and establish new or revised goals on an annual basis. Following approval by the QISC/CAUMC, the annual evaluation is submitted to the *ValueOptions*® Company Quality Council for review.

The QISC/CAUMC made substantial progress toward achievement of the quality and utilization management goals identified in the FY13 QM/UM Work Plan, which are summarized throughout this document. Advancement on our work plan goals included new efforts toward reduction of emergency room visits, including the initiation of a focused study aimed at gathering additional data on the use of emergency rooms, especially by members who are not in behavioral health treatment. Data was gathered via survey, and is being evaluated with the ultimate goal of enhancing or revising current interventions. Evaluation of care for ER users with multiple visits was also initiated. The quality improvement project focused on improving accuracy and timeliness of EBP data has been very successful. Increased focus on monitoring coordination of care efforts as well as documentation was also initiated based on the Coordination of Care Performance Improvement Project (PIP) results, and EQRO recommendations. Through the barrier analysis conducted on the PIP results some challenging issues were identified related to increasingly integrated systems of care and the specificity of documentation required for the PIP; the PIP task group is considering potential solutions. Committee reviews of quarterly performance measures resulted in increased monitoring of hospital stays over 14 days, which achieves the goal of identifying system as well as care gaps. Decreasing readmission rates appear to reflect work done by providers to engage members in care, and other efforts, thus the Committee determined a quality improvement project in this are wasn't warranted; monitoring of readmission rates by the Committee will continue. This year's EQRO compliance review yielded very positive results. In addition, a full three-year URAC re-accreditation was achieved based on the results of an on-site visit conducted in February. The accomplishments described above are a direct reflection of the dedication of the QISC/CAUMC members, and our commitment to working together as a partnership to accomplish our goals.

The Colorado Health Partnerships QISC/CAUMC met 9 times during FY2013. Committee member participation in meetings has been consistent, averaging 85% during FY13, exceeding our standard of 75%. The Committee includes representation from all key areas: service center staff, providers, members and/or family members.

The QISC/CAUMC employs a variety of techniques to evaluate and improve performance and outcomes. When available, the Committee compares performance to national benchmarks, performance of other BHOs or like organizations, and to previous year's performance. Statistical testing may be applied, when appropriate, to determine whether an increase or decrease in performance is truly (significantly) different, or whether the difference is due to random variation. Trending over time is also useful in showing where performance may be

declining (or improving) even if testing doesn't show a significant difference from one time period to the next. When differences are detected, further analysis will occur. This may include analysis of more detailed or updated data, input from members or providers closely involved in the specific activity being evaluated to better understand what is occurring, or evaluation of circumstances or barriers that may be impacting performance. Once this process is completed, changes or interventions are often developed and implemented, and re-measurement occurs to determine whether the changes made have improved performance. The re-measurement is typically evaluated to determine whether the changes were effective, or whether more time, revision or additional change is necessary for improvement.

Two recent examples of the impact of this process are noted below; others are described throughout this document.

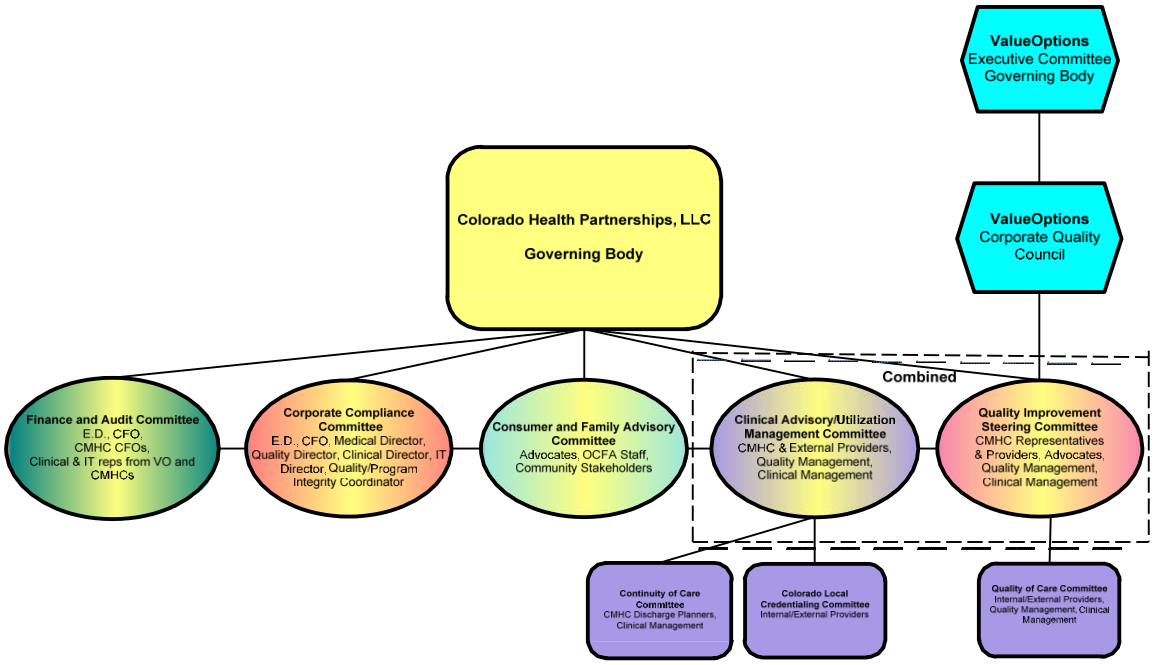
Emergency Room (ER) Visits: An analysis of ER visit data last year showed that nearly 60% of ER visits were attributed to members who have not accessed behavioral health services and that most often there was only one visit for the majority of members. To address this issue, the Committee initiated the mailing of outreach materials to try to prevent the occurrence of an emergency room visit, and potentially re-direct the member to contact behavioral health crisis services. Over the course of one year, VO sent letters to Medicaid members who had visited an ER at least twice and had not sought services from a behavioral health agency within six months prior to their latest ER visits. VO assessed the effectiveness of the outreach and found that 33% of the Medicaid members who received a letter from VO visited a behavioral health agency after their ER visit. The Committee has begun focusing on the 67% of people who had not visited a behavioral health agency after their latest ER visits at the time of the study. The Committee is considering different modes of outreach in addition to the mailed letters. Furthermore, ER utilization surveys were sent to Medicaid members who had visited an ER for behavioral health reasons since July 2012. The purpose of the survey was to determine the most common reasons why people obtain behavioral health services at an ER instead of at a behavioral health agency. The Committee will review the data analysis and make recommendations for subsequent actions.

Evidence based Practice (EBP) Data Reliability: VO gathers EBP data from Community Mental Health Centers (CMHCs) and uses this data to assess the effectiveness of the EBPs. To ensure good data quality, VO analyzed the EBP data to identify and quantify validity issues. In addition, VO assembled provider meetings (including IT and quality management staff) to talk through the process, explain the errors in the data submitted and identify barriers or confusion the providers were experiencing. VO also created an EBP data report card to provide additional feedback to the CMHCs regarding the types and quantities of errors. This led to revisions in the process for data submission. The number of errors has decreased drastically with CMHCs submitting virtually error-free EBP data every month.

An organizational chart of the CHP's Committee and Subcommittee structure is included below.

ATTACHMENT C

Colorado Health Partnerships
Committee and Subcommittee Structure



Committee Descriptions

Quality Improvement Steering Committee/Clinical Advisory/Utilization Management Committee (QISC/CAUMC)

The QISC/CAUMC is comprised of community agency providers, members and/or member representatives, and *ValueOptions*® Colorado staff that represent a variety of cultural/ethnic groups, geographic regions, and the full range of disciplines, subspecialties, and areas of practice within CHP's catchment area. The QISC/CAUMC committee meets at a minimum on a quarterly basis in order to monitor and evaluate the quality and appropriateness of care, pursue opportunities to improve patient care, and resolve potential issues. At any given meeting, trends are analyzed, deficiencies and barriers for improvement are identified, and solutions are recommended. Additionally, interventions are monitored for effectiveness and applicability. The QISC/CAUMC committee addresses a diversity of clinical and administrative issues including but not limited to; clinical treatment guidelines, utilization management guidelines, performance measurement and improvement activities, cross agency integration, and access issues. The QISC/CAUMC committee also reviews utilization management issues and indicators including monitoring and evaluating implementation of clinical guidelines, clinical criteria, and protocols. Furthermore, under and over-utilization issues are also monitored through the committee. CHP's Quality and Utilization Management Programs have a sound and sturdy history of process improvement and continue to advance due to the proactive involvement of stakeholders.
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and *ValueOptions*® Colorado staff that represent a variety of cultural/ethnic groups, geographic regions, and the full range of disciplines, subspecialties, and areas of practice within CHP's catchment area. QISC/CAUMC meets at least quarterly to monitor and evaluate the quality and appropriateness of care, pursue opportunities to improve patient care, and resolve problems. In the course of these meetings, trends are analyzed, deficiencies and barriers to improvement are identified, and solutions are proposed. Interventions are monitored for effectiveness. QISC/CAUMC addresses a variety of clinical and administrative issues including clinical treatment guidelines, utilization management guidelines, performance measurement and improvement activities, cross agency integration, and access issues. QISC/CAUMC reviews utilization management issues and indicators including monitoring and evaluating implementation of clinical guidelines, clinical criteria, and protocols. Under and over-utilization issues are also monitored through the committee. CHP's Quality and Utilization Management Programs have a strong history of process improvement because of the proactive involvement of stakeholders.

Colorado Local Credentialing Committee

The Colorado Local Credentialing Committee is chaired by the Medical Director and is comprised of providers representing the full range of disciplines, subspecialties, and areas of practice within the state. The Colorado Local Credentialing Committee meets monthly and provides input to *ValueOptions*® National Credentialing Committee regarding statewide practitioners' credentialing and re-credentialing decisions. Colorado Local Credentialing Committee minutes are distributed to the QISC/CAUMC for review.

Quality of Care Committee

The Quality of Care Committee (QOCC) is a sub-committee of the QISC/CAUMC Committee that meets monthly. The QOCC is chaired by the CHP Medical Director and is comprised of the Vice President of Quality Management, Provider Relations Director, Clinical Peer Advisor, and other appropriate staff. The purpose of this committee is to identify, investigate, monitor, resolve, and trend quality of care and patient safety issues, as well as patterns of poor quality within our system. Activities include a review of care issues related to adverse incidents, over- and under-utilization, repeated non-compliance with access standards, deviations from standards of care, and treatment/discharge planning and medication management, along with other identified quality of care issues. Identified trends in care issues may result in corrective actions, education, or other activities designed to improve care.

Access and Continuity of Care Committee

The CHP Access and Continuity of Care Committee is comprised of BHO and regional provider representatives involved in assuring continuity of care for Medicaid members, including evaluation and admission to inpatient care and discharge planning/oversight of the transition from inpatient to outpatient services. The Committee reviews issues and concerns that occur in the continuity of care process, problem-solves, shares ideas and current information, and proposes and enacts solutions.

Performance Improvement Projects (PIP)/Focused Studies

In addition to review and discussion at the QISC/CAUMC meeting, CHP has also established a PIP Task Group that meets monthly. The purpose of the PIP Task Group is to achieve more focused, in-depth analysis of opportunities, barriers, ideas, and feedback related to performance improvement initiatives. The group's tasks consist of analyzing PIP related data, identifying opportunities and barriers to improvement, examining the successes and challenges of interventions, working toward the development of new PIPs or other quality improvement projects. Current PIPs are summarized below.

Coordination of Care between Behavioral and Physical Health Providers

CHP continued efforts toward maintaining or improving the rate of documented care coordination this past year. The intent of this project is to evaluate and improve coordination of care between Medicaid physical and behavioral health providers for consumers who are receiving BHO services, and are diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder. This population represents a high-risk group who frequently has co-occurring medical conditions, and is at higher risk of early death due to their medical conditions being undiagnosed or untreated, complications from medications associated with their conditions, and behaviors associated with their mental health conditions. The first study indicator is the percentage of consumers with an outpatient mental health visit with one or more preventive or ambulatory medical office visits. The percentage has increased statistically significantly from the baseline measure of the indicator in 2008 (80%) to remeasurement 4 in 2012 (85%). The second indicator is the percentage of the study population consumers with documentation of coordination of care in the behavioral health record. The measurement of this percentage is accomplished through a treatment record audit. The percentage has increased from the baseline measure of the indicator in 2008 (46%) to remeasurement 4 in 2012 (49%). Considerations for the minimal 4-year improvement in percentage rate for documentation of coordination of care efforts focused on three mental health centers. Areas addressed included major changes to electronic record systems that significantly disrupted established internal processes for coordinating care or otherwise impacted internal operations beyond the scope of the established coordination of care policy; the increased incidences of leadership and staff turnover in key areas impacting previously implemented procedures developed for coordination of care; and unspecified coordination of care documentation practices for co-located facilities where behavioral and physical health providers are located in the same facility. We consider the latter a barrier regarding the documentation of coordination of care, because oftentimes there have not been specified processes to document when behavioral health records have been viewed by physical health providers since physical health providers generally cannot make notes in, or alter the behavioral health electronic health records; or some type of shared record exists where documentation may be viewed by another party, but no formal note or other evidence of that viewing is readily available. We believe that there may have been undocumented coordination of care because of this lack of specified documentation processes. As a solution to this documentation challenge, CHP devised detailed processes that will facilitate coordination of care documentation or to identify when information is viewed for co-located staff and/or facilities. CHP elected to continue this PIP for a fifth year, as both CHP and providers recognize the value of focusing in this area, and are motivated to continue working toward improving this measure.

Emergency Room Utilization Focused Study

The proposed study is prompted, in part, by the observation that CHP's hospital emergency room utilization rates are gradually increasing and existing interventions to influence hospital emergency room utilization for a mental health crisis, though initially effective, may need enhancement, or other interventions may need to be explored. General interest in quantitative measurement of the factors that adult Medicaid beneficiaries consider when ultimately deciding to seek mental health crisis services at the hospital emergency room, and the healthcare industry's focus on non-urgent utilization of hospital emergency rooms, are additional motivations for the study. The purpose of the study is to increase understanding of the factors that contribute to emergency department use by members.

The primary objectives of the ER Utilization focused study project are to survey adult Medicaid members who frequent the emergency room during FY 2013 (July 1, 2012 through March 31, 2013) to identify the factors/barriers that contribute to adult Medicaid members choosing the emergency room for mental health crisis services as opposed to other mental health service providers. Members surveyed will have a covered, primary mental health emergency room diagnosis with no subsequent inpatient admission. Frequencies will be calculated for all survey responses. As the study was recently completed, follow-up related to the study results

have not yet been completed. The results of the exploratory analyses have been distributed to the Committee and discussions are currently taking place regarding meaningful outcomes and plans of action.

Quality Improvement Project: Implementing Evidence Based Practices (EBP) in CHP and Obtaining Valid, Reliable and Comparable EBP Program Measurement Data. The goal of this quality improvement project is to improve the validity of data so that VO can effectively evaluate the positive health outcomes of the adults enrolled in the Evidence Based Practices (EBP) Programs. The quality management committee recognized that an initial EBP outcomes report did not accurately reflect the data submitted by the community mental health centers (CMHCs). The committee reviewed the submitted data and noted concerns with its validity. The committee agreed to prioritize the submission of valid data through this quality improvement project. From the baseline measure in Jan 2012 to the final remeasurement in July 2013), the valid data records in VO's EBP participation database increased from 71.8% to 93.6%. Though this quality improvement project ended in July 2013, the quality management committee will continue to monitor the validity of the data using an "EBP Data Report Card." This report card is distributed to each community mental health center and specifies the rates and descriptions of invalid data records submitted each month and over time so that the CMHCs can track the accuracy of their data submissions and take corrective action, if needed.

Measures of Performance

CHP's QISC/CAUMC Committee completed a review of the FY13 performance measures that are submitted to HCPF annually. The Committee review includes a comparison to the previous year's performance, as well as a comparison to the performance of other BHOs and national standards, where applicable. Core performance measures, as well as other indicators of performance designated by Committee or Committee Chairs, are presented to the Committee via a quarterly dashboard, using rolling annual data that is updated each quarter. This allows improved tracking and comparison of performance, and facilitates more timely interventions and Committee evaluation of the success of those interventions, furthering the goals of the Quality Management Program. The summary of performance measures below includes information on some of the more recent trends seen in the updated quarterly report.

In addition, current reports on performance measures are presented each quarter in the Access and Continuity of Care meetings. CHP leadership in the areas of discharge planning and crisis team evaluations attends this meeting on a regular basis. Providing regular feedback gives opportunity for these measures to inform practice and allows the leadership at the mental health centers to support performance improvement and to be aware of and address any problem areas in a timely manner. Performance measure highlights are noted below.

Discharges per Thousand Members: Both state and non-state hospital discharges per 1,000 members for FY13 (3rd Quarter measurement) were higher than the FY12 discharge rates. Discharge rates also were higher than the average rate across BHOs for FY12. When this metric is looked at more closely, there are continued opportunities for improvement, especially with the adolescent age group. In response to this finding, several mental health centers are developing intensive community-based programs that can serve as effective diversions from hospitalization or residential treatment.

Average Length of Stay: The overall average length of stay (ALOS) for both state and non-state hospitals during FY12 (3rd Quarter measurement) was slightly increased when compared with the ALOS for the prior fiscal year. The length of stay for non-state hospitals and state hospital admissions was below the state average across all age groups. There is some variation across age groups, with the 65 years and older age group recording the longest average length of stay. This trend is most apparent when looking at the group that includes both state and non-state hospitals. A relatively small number of lengthy state hospital stays have influenced this metric. Clinical analyses of these longer stays indicate that they most often occur when there is a co-morbid physical condition that complicates discharge planning or when discharge back to a nursing home

or assisted living facility is needed.

Seven-day Follow-up Post Inpatient Discharge: The overall follow-up rate within seven days of hospital discharge for both state and non-state hospitals midway through the fiscal year (3rd Quarter measurement) was slightly below the BHO average and generally consistent with CHP's performance during FY12. Committee discussions regarding CHP performance and associated barriers occurred, including the provision of services not included in the measure, such as case management. Work continues regarding flexible appointment scheduling, potential involvement of peers in the hospital transition process, and other efforts to strengthen performance. However, the impact of those efforts is not evident in the follow up rates at this point in the measurement cycle. The value of this measure is recognized, and will be closely monitored.

Thirty-day Follow-up Post Inpatient Discharge: The overall follow-up rate within 30 days of hospital discharge during the most recent 12 month measurement period (through December 2012) was slightly below CHP's FY12 performance as well as the FY12 state-wide average. The rates are significantly higher within 30 days (62.6% for non-state hospitals; 64.6% for all hospitals) than within seven days. Additional efforts to engage members during the hospital transition process are currently being evaluated. The discussions described above for the seven-day follow-up measure also apply to this measure.

Hospital Recidivism: For the last 12 month measurement period (through December 2012), CHP's overall readmission rate within seven days of hospital discharge is 2.6%. This figure is consistent with the FY12 CHP rate for both state and non-state hospitals and is below the BHO average (3%). Improvement in CHP's overall readmission rate is evident over the past year. CHP's overall 30-day readmission rate for the most recent 12 month measurement period is 9%. This is slightly below the statewide average for FY12 (9.11 at the mid-year point, CHP's 90-day readmission rate is slightly higher than the statewide FY12 BHO average for all hospitals across all age groups.) Overall, we have seen some improvement in readmission rates over the past year, which may be associated with some of the additional clinical efforts targeted toward this group.

Emergency Room Visits per Thousand: CHP's emergency room visit rate remained fairly consistent through calendar year 2012. Efforts to reduce emergency room visits continue, and CHP is hopeful that survey information gathered from ER users will be helpful in refining the activities currently to reduce this rate. CHP compares favorably with the FY12 statewide average; increased use of emergency rooms has been seen in other areas of the state.

Additional Quality Management Activities and Accomplishments: Over the past year, CHP's Quality Program accomplished some objectives and also targeted areas to initiate measurement and improvement. CHP's project to improve the accuracy and timeliness of EBP data was success, and clearly allows improved measurement of outcomes and participation in those programs, as well as overall measurement of outcomes based on SF-12 data. The final measure will be calculated in the first quarter of FY14 and if the positive trend is maintained, the Committee will consider the project completed. Attaining a full three-year URAC re-accreditation in spring of 2013 was also a highlight, validating the quality improvement efforts the Committee and staff engage in on a daily basis.

Additional accomplishments and activities include:

- Implementation of a new focused study designed to gather more information on ER users not participating in behavioral health services, an important endeavor as we continue toward the goal of ER visit reduction,
- A successful and informative EQRO compliance site review,
- Provider investigation and reporting of hospital stays over 14 days to identify system as well as care needs, monitored through the QISC/CAUMC Committee,
- Increased focus on coordination of care for members and associated documentation audits

- Improved inpatient readmission rates, and
- Revising the annual QISC/CAUMC Work Plan to reflect more performance-based measures, as recommended by the Committee members.

Colorado Health Partnerships (CHP) Evidence-based Practices (EBP)

During FY12, CHP implemented a quality improvement project designed to address the variations in measurement, reporting and data collection for evidence-based practice member participation and outcomes. As previously noted in this document, the results of this project have been quite good, and demonstrate significant improvement in the accuracy and consistency of the EBP data submitted to the BHO. In turn, CHP has much more confidence in the reports that are produced, as well as the results of analyses.

Some of the EBPs have been very successful; one of those is the Chronic Disease Management EBP. The newly added chronic pain management program has been gaining new participants every month, and the diabetes program demonstrates very good outcomes. CHP continues to struggle with low-volume EBPs due to inconsistent member participation. Maintaining a minimum number of members in some group-based EBPs has been a challenge; often more so in rural and frontier areas. Lower participation rates impact CHP's ability to fully evaluate member outcomes, although providers have tried various methods to enlist member attendance.

CHP Adult EBPs by type, with EBP Subset Programs

Listed below are EBPs by overall category type (bolded), with the individual EBP subset programs listed after the title. Summary information is included to highlight successes or issues specific to the EBP; no summary information was provided for EBPs that have not had occurrences out of the ordinary to highlight. Adult outcomes are assessed using the Short Form 12 Survey v.2 (SF-12), administered quarterly, and the CCAR.

Population Health Management/Chronic Disease Management

Summary: As of June 2013, 185 members are currently participating in or have completed the TeleCare Chronic Disease Management Program. This program provides disease management services to members diagnosed with asthma, diabetes, chronic pain, or heart disease. TeleCare does extensive outreach to contact and engage members who are appropriate for this program, and also accepts referrals from mental health centers for members who are currently in treatment and could benefit from disease management services.

Reports describing outcomes for members with diabetes and those with asthma (the two highest volume diagnoses) are produced every six months. A summary from the most recent report (July 2013) is provided below.

Diabetes Care Clients: The report provides information on members who have been enrolled in the program for approximately 6 months. The average age of participants is 50 years; 77% are female and 23% are male. For members with tenure of six months, the Summary of Diabetes Self-Care Activities Measure showed statistically significant improvement in self-care activities for four of the five areas measured. These areas are healthful diet, quality of diet, blood glucose testing, and foot care. The area of exercise showed improvement, but the increases of scores from pre-intervention to 6 months later were not statistically significantly different. SF-12 scores for this group indicate improvement in both physical and mental health summary scores; however, the score increases were not statistically significantly different.

Asthma Care Clients: After approximately six months in the program, participants experienced statistically significant improvement in physical limitation due to asthma, as assessed by scores from the Asthma Control Test. Three other areas measured showed improvement, but the differences between pre-intervention scores and 6

month scores were not statistically significantly different. Those areas are shortness of breath, sleep disrupted by asthma symptoms, and use of rescue inhaler or nebulizer medication. The self-rating of asthma control score declined very slightly after 6 months of intervention, but this result was not statistically significantly different. SF-12 scores indicated improvement in physical and mental health summary scores, with the mental health scores having a statistically significant improvement, overall.

Chronic Pain Clients: The Chronic Pain Management Program is the newest Population Health Management program. In its first year of implementation, the outcomes are already showing promise. Participants were assessed using the PEG Scale before entering the program and approximately 6 months later. The scores showed statistically significant improvement for all of the items on the scale. The items are pain intensity during past week, degree pain interfered with life enjoyment during past week, and degree pain interfered with general activity during past week. Over half of the participants had scores that improved more than 20% compared to the pre-intervention scores. The participants were also assessed using the Dallas Pain Questionnaire (DPQ) that evaluates a client's perception of the degree chronic pain affects four aspects of life. Again, all areas showed improvement in scores from pre-intervention to approximately 6 months later. Scores for two areas, interferes with daily activities and hampers social activities, improved statistically significantly.

Overall, the Medicaid population has responded favorably to the Disease Management Program, and CHP is satisfied with the positive outcomes from the recently implemented disease management services for chronic pain.

Illness Management & Healthcare Integration: Psychotherapy for those with Cancer and Depression, Psycho-education Group for those with Bipolar Disorder, Care management for those with Depression

Summary: This EBP category is based on outreach to individuals not currently receiving behavioral health services; members selected for outreach are based on pharmacy claims for drugs typically used to treat the diagnoses listed above. Responses to member outreach efforts (typically a letter and flyer about the groups or services offered and contact information) have been minimal. In addition, incorrect or outdated addresses have resulted in a high number of returned letters. Enrolment has increased, however, by 67% from fiscal year 2012 to fiscal year 2013. Outreach efforts continue to both members and high volume physical health providers.

Co-Occurring Substance Abuse & Mental Health: Seeking Safety, Integrated Dual Disorder Treatment (IDDT), Dialectical Behavioral Therapy (DBT)

Summary: Based on SF-12 pre to follow-up scores, the participants engaged in the Co-Occurring Substance Abuse and Mental Health programs reported increased improvement in the mental and physical composite scores, 2.23 and 1.25, respectively. The mental composite score is an aggregate of Vitality, Social Functioning, Role Emotional and Mental Health and the physical composite score is an aggregate of Physical Functioning, Role-Physical, Bodily Pain, and General Health Though there was an improvement from pre to follow-up SF-12 scores, the increase was not statistically significant.

Assertive Community Treatment (ACT)

Summary: Participation in this EBP has been consistent and continues to grow, with a total of 143 participants across providers during the fiscal year 2013.

Client-Run Peer Services: Peer Services

Summary: An outcomes instrument was administered last year to explore different aspects regarding the

types of services Peer Specialists provide across the expanse the three BHOs (i.e. CHP, NBHP, and FBHP) cover. Researchers were able to capture information regarding types and frequencies of services offered as well as conduct an analysis of variability across BHOs. Information obtained in this study has provided a starting place for BHOs to consider points of intervention. The information obtained in this study has prompted CHP to explore opportunities where expanded peer specialist involvement can positively impact members' recover.

Supported Employment: Vocational Services

Summary: This EBP had 16 participants during fiscal year 2013. Participation in this program continues to remain generally stable.

Overall Adult EBP Outcome Summary

The SF-12 (Health Satisfaction Survey) is a widely used clinical assessment tool that measures several health-related domain scores and two composite (global) scores. The adult EBP outcomes have benefited from focused training and protocols on standardizing data elements and assessment and submission intervals. Initial analysis of available outcomes data focused on the two composite (global) scores of the SF-12.

SF-12 data collected over the last three years from CHP's eight mental health centers were analyzed using a repeated measures analysis. Mean SF-12 scores for evidence-based practice program (EBP) participants were compared from the initial administration (pre-test) to an administration that took place approximately 6 months after the first SF-12 measurement. The pre/post score differences of the four EBPs with at least 20 participant composite scores for both measurement times were examined individually. All four EBPs had positive increases in mental health composite scores; however, none of these differences were statistically significant.

CHP Youth EBPs, with EBP Subset Programs listed below

Psychotherapy for Youth: Cognitive Behavioral Therapy (CBT)**,** Dialectical Behavioral Therapy (DBT)**,** Eye Movement Desensitization and Reprocessing (EMDR)**,** PCIT (Parent-Child Interaction Therapy)**,** HeartMath**,** Co-occurring Substance Use Disorder and Mental Health

Summary: This group of EBP programs has been successfully implemented; several have consistent participation, and continue to grow. Efforts to engage members continuously in these programs continue. Participants in this group of EBPs with pre- and follow-up parent/guardian assessments (n=59), reported statistically significant improvements for two items: Understood Child Needs (p=.012) and Parents Involved in Treatment (p=.013).

Family-Based Cognitive Behavioral Therapy: Eco-Systemic Structural Family Therapy

Summary: Thus far, this EBP continues to be slightly impacted by a low-volume of participants, though participation increased by 30% from FY12 to FY13. For the 19 participants with a pre and follow-up assessment, statistically significant increases were assessed for several of the indicators: Child Doing Well with Family (p<.000), Child Doing Well with Friends (p=.005), Child Making Good Choices (p=.001), and Parents Understanding Child's Needs (p<.000).

Multimodal Treatment: Multimodal Treatment

Summary: Thus far, this has been a low-volume EBP. There are too few participants with two SF-12

observations to conduct proper analyses.

Home-based Services: Wraparound**,** Family Preservation

Summary: Implementation of these EBPs has been very successful, with a high number of participants; clearly a member need for these programs has been addressed. Preliminary results indicate that scores from pre- to subsequent follow-up measures are inconsistent which makes inferential determinations challenging. Scores for some of the items became more positive from pre- to follow-up administrations, while others became more negative; though, none of the changes were statistically significantly different. These inconsistencies could be influenced by the unique treatment needs of members and their families and the involvement of multiple system supports.

Behavioral Health Promotions Strategies: Incredible Years**,** Incredible Years- Parenting**,** The Optimistic Child

Summary: Implementation of the Incredible Years – Parenting program has been very successful. For the participants with pre-and follow-up results on the parent/guardian survey, statistically significant increases ($p<.01$) were observed for Child Doing Well with Family, and Parents Able to Help with Child's Problems. In addition, slight increases, not statistically significant, from pre to follow-up were noted for Child Doing Well with Friends and Parents Understanding Child's Needs.

Brief Hospitalization: Inpatient

Intensive Case Management: Intensive Case Management

Psychoeducation for Families: Nurturing Parenting**,** Love and Logic

Summary: Love and Logic has been fairly successful, with a with a 15% increase in participation from FY12 to FY13. Nurturing Parenting participation, however, has dropped off from FY12 to FY13. Initial analysis observed positive increases for Child Doing Well with Friends, Child Doing Well in School (for those in school at the time), and Child Made Good Choices, and Parents Understanding Child's Needs; and the scores for the item Child Doing Well in School had a positive statistically significant change from pre to follow-up administration ($p=.008$)

School-based Services: School-based CBT Program**,** Coping CAT**,** Coping with Depression of Adolescents

Summary: Implemented with varied success in participation, with participation declining somewhat from FY12 to FY13. Pre to follow-up scores increased overall for the School-based Services EBPs for all of the survey items, though none of the score increases were statistically significant ($p<.01$).

Overall Youth EBP Outcomes Summary

Youth outcomes are assessed using the parent/guardian survey, administered quarterly, and the CCAR. By focusing on standardizing data elements and assessment and submission intervals CHP has identified several youth EBPs which maintain a higher volume of participants and associated outcomes for analysis based on parent/guardian survey results. Preliminary findings are noted in the summary above. Efforts to engage members in participation and assess the impact on treatment outcomes continue.

EBP Fidelity: EBP fidelity is evaluated during the annual mental health center contract compliance audits, where there are established fidelity measures. For many of the CHP EBPs, there are currently no recognized or

consistent fidelity measures to use for evaluation. The BHO does gather information on how fidelity is evaluated where there are no recognized fidelity measures.

SF-12 Outcomes

An outcome measure for adults, the Short Form Survey-12 v.2 (SF-12), was implemented across CHP during FY11, as directed by the CHP Class B Board. The SF-12 is to be administered quarterly for all adult Medicaid members in treatment; for new members during their initial visit, and for members currently in treatment the administration is to occur during the member's treatment plan update. Data is being compiled for the initial outcomes report, due to QISC/CAUMC in October. Preliminary results indicate the following:

1. While there were many initial administrations of the SF-12 to this population, the number of second administrations is much lower. We believe this is due to two factors: one is the staggered implementation for existing members, which may result in a second administration not yet being completed, and second is that members may participate in treatment for less than six months and not available for a second administration.

2. For those members who have two administrations, the aggregate mental composite score (Aggregate of Mental Health, Role Emotional, Social functioning, and Vitality items) shows an increase from the first to the second administration that took place at approximately six months later (average change 2.86), which is statistically significant ($p<.00$).

3. For those members who have two SF-12 administrations, the aggregate physical composite score (Aggregate of Physical Functioning, Role Physical, Bodily Pain, and General Health items) was almost identical for the first and second administrations , which is not a statistically significant change ($p=.993$).

4. When examining results of the SF-12 composite scores with EBP participation serving as a predictor of SF-12 score, EBP participation was found to be a statistically significant predictor of mental health composite score change from the first administration to the six-month administration ($p = .047$). When looking at EBP participant scores only, change in mental health composite score was positive for the EBP participants, but the change was not significant. In addition, for the physical composite score, the EBP participant group reported a small increase, which was not statistically significant. EBP participation was not a statistically significant predictor ($p=.262$) of physical health composite score change.

The individual survey items generally reflect the composite results noted above. CHP will continue analysis on the survey results, and intends to have a more robust report once further data is collected. In addition, CHP is exploring opportunities to utilize the SF-12 outcomes collected for all adults thus far with the population of members identified as having mental health services and at least one physical health office visit. Data for this specific population is made available to CHP as part of the Coordination of Care Performance Improvement Project.

The CCAR is also used as an outcomes measure. The committee chose to use the CCAR performance measures for evaluation rather than an additional outcomes report.

CHP also monitors results from the Fact Finders survey, addressed later in this document, to assist in evaluating member outcomes. Generally, outcome-related results to survey questions are positive and remain consistent over time.

Member Engagement in Treatment

QISC/CAUMC continues to review the data report produced by the Quality Management Department which is designed to assist in determining whether members were engaged in treatment within the recommended timeframe after the members' initial intake appointment. The standard for initial engagement is between zero to seven days. As variation continues to exist amongst providers, the summary information on the efficacy and timeframes was provided at QISC/CAUMC. Providers continue to strive to improve the initial engagement processes. Efforts from the previous year show that the numbers taken from the CHP engagement report have shown that these efforts have a positive impact on many of the CHMC's. , In addition, efforts to address areas of repeated non-compliance with the access standards were completed and monitoring continues; improvement continues to be shown and is evident. Providers continue to strive for member engagement in order to prevent members from disengaging in treatment.

Audits and Accreditation

The annual FY12 – 13 EQRO site review, evaluating compliance with contract requirements, was completed in November 2012. CHP earned an overall compliance score of 98% in the four standards reviewed. CHP earned 100% in three of the four standards (Coordination and Continuity of Care, member Rights and Protections, and Quality Assessment and Performance Improvement. CHP's 96% score for the Credentialing and Recredentialing standard related to a missing provision in the delegation agreement between VO and CHP which did not impact compliance with NCQA required processes. Corrective actions were identified for Credentialing and Recredentialing were made and found to be acceptable. CHP continues to monitor compliance for internal operations as well as requirements applicable to our network providers to ensure CHP is meeting the requirements specified in the BHO contract.

The Service Center continues to evaluate compliance with all requirements established by the Utilization Review Accreditation Commission (URAC) as part of our URAC accreditation. In FY12-13 the Service Center also underwent an onsite monitoring visit from URAC. With all of the mandatory standards fully met, the Service Center received a Certificate of Full Accreditation which is valid through March 2016.

Quality of Care

CHP undertakes a variety of activities aimed at evaluating and improving the quality of care for members. Provider treatment record documentation audits continue quarterly, along with provider education in areas where scores indicate problems are evident. If improvement is not seen, the corrective action process is initiated. Audits include a review of encounters/claims against the chart documentation.
Overall, documentation scores have improved, and an educational webinar for providers was offered again in fall of 2012. There were a large number of attendees, who asked many clarifying questions and feedback on the training indicated providers found it very helpful.

Investigations of potential quality of care issues are conducted through the Quality Management Department, and findings are evaluated for appropriate follow-up, corrective action, and monitoring through the Quality of Care Committee. All quality of care issues are documented, as are results of investigations, and corrective actions are tracked and monitored. Reporting, investigation and tracking of adverse incidents through the CHP Quality Management Department continued during the past fiscal year. An adverse incident may feed into the quality of care process based on investigation results. All providers are required to report adverse incidents; CHP received 172 adverse incident reports during FY2013. Both of these care monitoring initiatives, along with treatment record reviews and training, are conducted with the goal of assuring members receive the best care possible.

The Clinical Department sets high standards for our telephone performance, with goals that include keeping the average speed of answer (ASA) for all calls under 30 seconds and to maintain an abandonment

rate of less than 3 percent. For FY13, the department showed consistently excellent performance. Our performance consistently resulted in an excellent result, far exceeding our goal of less than a 3% abandon rate with outcomes that are under 1% for the entire year. Average speed of answer for daytime calls received during business hours was 2 seconds, and for all calls combined, including nights and weekends, with the support of our Texas Service Center, the average speed of answer overall was 5 seconds.

We continue to work closely with our after-hours team in the Texas Service center to insure the quality of service our providers and members receive. The Clinical Director continues to serve as a liaison to keep the team updated and apprised on local issues that our partners face, and oversees the adherence to workflows and processes to insure consistency of service provided by the team.

Systems Integration

The Service Systems Integration (SSI) Team advanced coordination and integration of services through multiple vehicles this past year. The Child Psychiatry Consultation Service continued to provide the valuable service of real-time "curbside" consultation for pediatricians with a child psychiatrist within twenty minutes of their call for six primary care practices in Colorado. In partnership with the Colorado Behavioral Healthcare Council, the Colorado Health Foundation is planning to fund expansion of the project to two pilot areas, including the Denver area and southeastern part of the state. The SSI team continued to provide project support and development through the year.
The team intensified its involvement in HB 1451 and SB 94 coordination of care initiatives in multiple areas. These programs foster various agencies working together to keep young people out of institutional settings and bring funding into the community for coordination of services. They reduce duplication of services and cost by linking consumers with the right services at the right time from the right agencies. Participants include juvenile court systems, probation departments, school systems, departments of human services, domestic violence prevention agencies, mental health agencies, court appointed special advocates, county health departments, division of youth corrections, substance abuse agencies, and many state agencies and departments. The team and *ValueOptions*® were also involved in the formation of the case management entity and system of care projects in the Colorado Springs area.

The statewide group therapy training was presented in October of 2012. Principal trainer was the team lead for the SSI team. The team lead co-chairs the Training and Development Subcommittee of the Colorado Behavioral Healthcare Council (CBHC). This group is working to pool resources of all member agencies, including all Behavioral Health Organizations and mental health centers (MHCs), in the state to reduce costs. Another project of this group is a statewide training calendar on the CBHC website. This will allow mental health centers to access information on trainings available to their staff so that the center doesn't have to recreate trainings thereby avoiding duplicative efforts. Other trainings presented by the SSI team include multiple trainings on accessing Medicaid mental health services, motivational interviewing, suicide assessment and intervention, understanding the Regional Care Collaboratives (RCCOs) to foster better integration with BHO services, and innovative trainings on peer health coaching. This is a training directed towards peer specialists but also valuable for clinicians that teaches people to educate and work with consumers on physical health issues, especially chronic health conditions. The team also has a representative on the CBHC conference committee planning four days of training available to all MHCs in the state this fall which includes nationally recognized speakers. Trauma informed care will be emphasized. Team members have attended several trauma informed care conferences, summits and trainings over the past year.

The team continues its efforts to promote Mental Health First Aid training. In order to facilitate providing this training to as many groups as possible the team lead has become certified as a Mental Health First Aid trainer. The team has educated community groups about the availability and usefulness of this training in many public speaking opportunities throughout the year. These have included outreach to long term services and supports providers such as single entry point agencies and alternative care facilities. Mental Health First Aid has been mentioned both nationally and by the state of Colorado in the past year as a useful intervention and prevention tool and a way to combat stigma. Team members have also worked with the School Safety Resource Center to coordinate efforts to reduce school violence. Other prevention activities in which the team has been actively involved include obesity reduction workgroups and teen and unintended pregnancy work groups. In addition, team members participate in the Substance Use Disorder Committee of the Colorado Behavioral Healthcare Council and the Drug Endangered Children workgroup.

The team is heavily involved in a new intensive case management program being piloted in certain areas. This program identifies "hot spotters", high utilizers of more intensive levels of care, and coordinates resources to better deliver services to prevent unnecessary overuse of inappropriate levels of care. This program also promotes compliance with federally mandated Olmstead requirements to treat consumers in the most community like setting possible. This fosters independence and integration into society to combat stigma. In areas not being piloted for intensive case management, the team provides complex case consultation and service coordination. This includes collaboration with local RCCOs on complex cases and members recently discharged from higher levels of care.

The department of human services (DHS) has been a focus of integration efforts in the past year. Participation in the statewide core services director's meetings as well as DHS service integration groups is leading to a better understanding of the department's needs. Likewise this has led to a better understanding on their part of how we can help them within the bounds of our contract requirements. The team is assisting in innovative projects such as computerized data sharing between a local department of human services and the BHO to streamline staffings on shared cases. This would allow immediate web access to treatment history, eligibility for services from multiple sources, and other information that could speed up the process of implementing a comprehensive, shared treatment plan. Other examples of forward thinking integration projects include exploration of braided funding models. The team has done a great deal of outreach to DHS to offer training and collaboration and problem solve areas of concern. Presentations regarding the RCCO system have helped local departments understand the overall Medicaid healthcare system and how their services can be interwoven within that wider system.

The importance of the long term services and supports (LTSS) system in Colorado has been recognized by the SSI team, which has become even more actively involved. The governor signed an executive order this past year creating the Community Living Advisory Group (CLAG) to redesign this system. The team has a member that is co-chairing the Care Coordination subcommittee of the CLAG and another that was appointed a member of the Entry Point/Eligibility Subcommittee. These committees worked diligently throughout the year and have presented specific recommendations to the CLAG to be included in their report to the governor this fall. LTSS redesign may require legislative and regulatory changes affecting BHOs and MHCs. Having a voice at the front end of this process enhances the possibility of changes that may be beneficial to the care and treatment of our members. Streamlined eligibility for programs like Medicaid and home and community based services may extend our reach to additional populations and

services. The team is also involved in other efforts such as the Colorado Coalition for Senior Behavioral Health and Wellness to address the needs of our fastest growing demographic group.

Evaluation of Overall Effectiveness of the Quality Management Program

The QISC/CAUMC Committee is comprised of both clinical and quality leaders/providers, as well as members and/or family members through the Office of Member and Family Affairs (OMFA). OMFA input on clinical and quality performance, projects, issues, and outcomes as well as updates of OMFA Committee activities continue to be valuable in defining the Quality Management Program and ensuring the member/family perspective is a tenet of the Quality Management Program. The diversity of membership is a great benefit and moreover continues to enhance CHP's ability to address all aspects of concerns and issues, as well as facilitating an understanding of the provider and BHO roles, operations and requirements. CHP believes that this structure is not only vital to developing projects, but is also valid in developing improvement initiatives, and developing interventions that will have a greater chance of success; this process will also lend itself to allowing CHP to fully evaluate the impact of these efforts. For CHP, this multi-faceted approach to quality management enhances the strength of our treatment, performance and outcomes system.

The QISC/CAUMC Committee meets on an established monthly schedule. The Committee's broad membership brings extensive knowledge and experience to our meetings. This diversity provides strength in managing the quality of care and service provided to CHP Medicaid members.

CHP continues to demonstrate success and completed many of the planned quality management activities over the past year. While all goals may have not been fully achieved, CHP remains steadfast, consistent and diligent in maintaining all efforts which are necessary in certain areas before improvement becomes evident. This is especially prevalent in relation to some annual performance measures. Even though rates of emergency room visits and the average length of hospital stay appeared to stay consistent within the BHO, the committee will remain focused on identifying trends and attempting to offer solutions to improve overall quality within the measures. Furthermore, various efforts to assure quality of care were completed, including assessing readmission rates through chart audits and other means, investigating reported quality of care issues, evaluating adverse incidents, completing treatment record documentation audits, and providing education both individually to providers as well as through webinars as well as evaluating network adequacy and accessibility. Member outcomes associated with evidence based practices, as well as treatment progress through CCAR and SF-12 analysis, and member survey results were also discussed and reviewed. Continued improvements in the reliability of outcomes data submission also helped to gain a better understanding of member outcomes. When considering the numerous quality management and improvement activities completed throughout the year, the Committee agrees that the Quality Management Program has been effective. Through the evaluation process, however; the Committee also identifies areas of focus for continued effort to bolster care, and the potential for new improvement opportunities. Education of newly added Quality Management Program staff continues in the area of program requirements, and analytical and reporting techniques. This experience results in more sophisticated and accurate reporting, fresh, new ideas, cross-training of staff; and ultimately, improved decision making capabilities within the Quality Management Program.

Although achievements for this past year were significant, there were areas where the QM Program strived to make a stronger impact as well. Following a year of decreased documentation in care coordination as presented in the Coordination of Care PIP measures, CHP saw a decline in the rate of documented coordination of care. Great concern was expressed by the Committee, and analysis was conducted to identify the reasons for the decrease. The analysis assisted in developing improved interventions at the provider level. CHP also

continues to work toward improving the rate of ER visits as well as to continually seek knowledge as to why members utilize the ER, and to better understand the complexities associated with ambulatory follow-up, and hospital readmissions. While steps toward improving performance in these areas continue, at this point the data reflects a slight improvement. Readmission rates continue trending downward, and ER visit rates continue to show small changes. To support ongoing improvement, the Committee will continue to analyze the performance measures to determine the best practices for positive change along with intervention planning.

Evaluation of Overall Effectiveness of the Utilization Management Program

Overall, the CHP UM program has been successful and effective. The committee structure described in the QM sections above has also been working well for the ongoing operations of the utilization management program. The Clinical Advisory/Utilization Management Committee (CAUMC) and the Quality of Care Committee (QOCC) have practitioner involvement and input that guarantees practical utilization management solutions for the BHO.

The UM program enjoys active leadership from the Medical Director and Service Center Vice President. Because the committee structure is set up as it is, leadership is also found through our Class B Board input, as this Board is comprised of Community Mental Health Center C.E.O.'s. In addition, the Director Of Service and System Integration, Clinical Peer Advisor and Clinical Director complement the leadership team, ensuring that both internal and external management issues are addressed efficiently and effectively.

The experienced Clinical team is another strength of the UM program. The increased specialization of roles within the team has led to improved performance. This year, the CHP Service Center created two new positions to increase oversight of clinical services and improve the team's functioning. First, we promoted our Clinical Team Lead, an experienced care manager, to the Clinical Service Supervisor position, whose focus is now on supervision of the Clinical Service Assistants, Clinical Care Manager training, problem resolution and process improvement. Next, we also added a Clinical Support Team Lead position and promoted an experienced Clinical Service Assistant to focus on Clinical Service Assistant training, problem resolution and performance improvement. The Clinical Service Assistants continue to be a vital part of the UM program, allowing the Clinical Care Managers to focus less on administrative details and more on the UM decision making which requires their clinical expertise and skills. The Clinical team consists of 1 Clinical Director, 1 Clinical Team Lead, 1 Clinical Support Team Lead, of 5 FTE clinicians and 2.5 Clinical Service Assistants. The success of the UM program is largely attributed to this well-seasoned staff. Stability of the team, a focus on continuous process improvement as well as, stable relationships with providers insured productive and efficient UM services. In Colorado, we have covered approximately 420,000 members (supporting three BHOs). The Care Management staff is directly supervised by a Clinical Director who monitors the productivity and quality of care provided by the team.

The performance of the clinical department is further reflected in the various measures completed throughout the year. The following is a summary of the key measures.

2012-2013	Q1July-Sep	Q2Oct-Dec	Q3 Jan-Mar	Q4 Apr-June
Initial Authorization Content audits	96%	96%	96%	100%
Initial Authorization Timeliness audits	95%	95%	100%	94%
Concurrent Review Authorization Content audits	100%	100%	100%	100%

Concurrent Review Timeliness audits	100%	100%	100%	96%
Average Speed of Answer	5 seconds	5.6 seconds	5 seconds	5.3 seconds
Abandonment rate (over 30 seconds)	0.75	0.95%	0.63%	0.84%
Annual inter-rater reliability survey	NA	85%	NA	NA

Evaluation of FY2013 Goals and Objectives

The QISC/CAUMC's effort over the past year resulted in continued progress toward achieving the work plan objectives and other quality and clinical issues that were presented during FY13.

The goals and objectives for FY13, which were determined by the QISC/CAUMC Committee, are listed below. Included below each goal/objective is a brief summary of the progress, the status and the committee's recommendation to continue, revise or discontinue the goal/objective for FY14. Following the review of goals are summaries and graphic information regarding some of our quality activities and satisfaction survey results over the past year.

Goal 1: Integrate member and family member involvement with CAUMC/ QISC efforts.

1. A. Collaborate with OMFA to complete Peer Services Focused study.

Results: The Peer Services focused study was completed, therefore; the Committee determined that the goal has been met. The results and data were presented to the OMFA group and it was found that Peer Specialists do have a positive impact upon recovery of the members which with they work with. In regards to target two, a recovery tool has been determined. The CROS was determined to be the best tool to use to access recovery outcomes.

Committee Recommendation; Revise the activity to, "OMFA will collaborate with the Quality Department to validate the value of Peer Services." The first targeted activity will read, "QISC will work with OMFA to identify the best practices when it comes to Peer Services utilization." Follow up can be conducted on impressions that staff may have towards Peer Services, issues arising surrounding the use of Peer Services and how to potentially use Peer Service Specialists more effectively. The second targeted activity will be reworded to state, "OMFA will plan the implementation of the CROS tool in order to access recovery outcomes."

Goal 2: Ensure clinical practice standards and contract requirements, as applicable, are met by providers.

2. A. A representative sample of IPN providers will be consistently evaluated against CHP clinical standards, guidelines, and contract requirements in the areas of treatment and discharge planning.

Results: Non-CMHC Providers: Regularly scheduled Non-CMHC Provider audits will continue to occur in order to continue to gain improvement in the audit scores, especially surrounding the revised audit elements. These audits are now being conducted using the new audit tool which encompasses the new standards. The first audit using the new standards was conducted in FY12 with a follow up audit which was conducted in FY13. The results of the FY13 audit demonstrated an increase in Non-CMHC Provider compliance. Continued education is also planned for the upcoming fiscal year. Mood disorder NOS will be monitored through the, "Top 5 Diagnosis Report" at QISC/CAUMC. If needed, providers will be given training on this particular diagnosis if it is seen to become a persistent diagnosis.

Committee Recommendations: Significant progress towards this goal has been made and the committee recommends maintaining the overall goal but changing the target for FY14. As the target for FY13 has been met, the committee also recommended revising the first target to state, "continue to conduct IPN audits and conduct training annually." The second target will now state, "Develop an audit tool in order to begin to initiate technical assistance audits of the new E&M and CPT codes." Finally, the third target states that QISC will, "continue to monitor the use of the diagnosis of Mood Disorder NOS through the Top 5 Diagnosis report."

2. B. A representative sample of providers will be consistently evaluated against CHP clinical standards, guidelines and contract requirements.

Results: Community Mental Health Centers (CMHCs) Provider monitoring efforts for the CMHCs in the area of clinical record documentation and enhanced clinical management are similar, and efforts continue in these areas. The Committee expressed interest in developing enhanced coordination of care audits.

This past fiscal year, CHP again conducted on-site contract compliance audits at each of the CMHCs. The purpose of the audit is to evaluate compliance with contract requirements, such as access to care, member rights, provision of services, documentation, etc. The CMHCs were found to be generally in compliance. Audit scores were good on most elements and no corrective actions required. The results of the contract compliance audits are presented to the CHP Class A Board for review.

Committee Recommendation:
The committee recommended continuing goal 2.B. through the next fiscal year, revising the target will be written as follows, "CHMC's will continue to focus on COC by adopting elements of the BHO's Coordination of Care audit tool and submit quarterly audit results."

Goal 3: Systematically analyze and evaluate outcomes data.

3. A. QISC will systematically evaluate relevant outcome data, and implement interventions as appropriate.

Results: The Committee recognizes the link between physical and behavioral health and believes that the coordination between physical and behavioral health providers is critical to providing the best care for all patients. Recently acquired physical health data has allowed behavioral health providers to understand their patients' health backgrounds more comprehensively. In addition,

Results from the MHSIP/YSS-F, and Fact Finders' survey (summary included elsewhere in this

document) relative to outcomes were reviewed by the Committee; results continue to be generally consistent over time.

The Committee also reviewed a report on the SF-12 outcome measures for adults. The improved validity in the recent data submissions, as evidenced through quality improvement project tracking, increased the Committee's confidence in the report's accuracy. QISC/CAUMC focused on the physical health scores of the SF-12 during the past year. Initial analysis revealed a slight increase in mental health summary scores from first recorded SF-12 administration to approximately six months later, though this result was not statistically significantly different. QISC/CAUMC plans to more comprehensively analyze the SF-12 physical and behavioral health scores.

Committee Recommendations: The Committee recommends continuing this goal into FY2014. A revision to the first target was recommended: "QISC will explore options to improve outcomes through education and outreach of members with chronic conditions, as well as outreach to PCP's." The target will be revised to read, "QISC will develop a new Quality Improvement Project (QIP)." The third target was also revised as follows, "Provide updated SF-12 outcome report semi-annually. A fourth target was added to read, "Complete ER focused study and the COC PIP."

Goal 4: Evaluate Clinical/Quality Compliance and Performance

4. A. To support the clinical quality improvement process, the QISC, or its designee, will review, evaluate, and/or monitor applicable standards and policies.

Results: On an annual basis, QISC/CAUMC reviews and approves policies and procedures relative to Quality and Clinical Management. Once approved, these policies are submitted to the Class B Board for approval and posted to the website.

As an accredited site, compliance with URAC standards are continually monitored; training was provided to all new staff. Annual training on identifying and reporting fraud and abuse, URAC standards and other key areas were completed by staff. Areas related to patient safety, including adverse incidents and the annual report on attempted and completed suicides are reviewed and evaluated annually.

Committee Recommendation: This goal was met and the committee recommends continuing goal 4.A for FY2014.

4. B. Review and update CHP Level of Care Guidelines.

Results: An annual review of all existing Guidelines occurred in FY13. The Clinical Peer Advisor and member of the QISC/CAUMC team reviewed, modified and made recommendations for all guidelines throughout the year. QISC/CAUMC approved all guidelines and recommended them to the Class B Board for approval and adoption. The revised guidelines were then posted to the CHP website and disseminated to the mental health centers.

Committee Recommendation: This goal was met in FY2013. The committee recommends continuing this goal for FY2014.

Goal 5: Assure Care Management Department Compliance with Established UM Standards

5. A. Ensure consistent application of Clinical LOC guidelines by Care Managers as well as Clinical and Medical leadership.

Results: 85% of all clinicians who took the 2012 test Individual scores above 75% were considered passing. The test was also analyzed by discipline and years of experience. No Care Managers fell below the 75% score. Two Integration Specialists, in support positions did fall just below the 75% score. The Clinical Director and Medical Director met with the two individuals who did not pass and both individuals completed their Corrective Action Plans. The Clinical Director, Clinical Peer Advisor, Integration Specialists, and the Medical Director of the BHO were among the staff taking the test.

Committee recommendation: This will continue to be monitored in FY14

5. B. Calls are processed efficiently.

Results: *ValueOptions*® standards for speed of answer and abandonment rates include ASA to be less than 30 seconds and abandonment rates to be less than 3%. The Colorado contract does not specify requirements for answer speed or abandonment. Current data for the year indicate that the average speed of answer was 5 seconds increased from the prior year) and the average abandonment rate was 0.79 %(which was an improvement from the prior year's results). The increase in call answer time had to do with the after-hours team, which had significant turnover this year and the Clinical Director continued to work with them. Results for next year are expected to show improvement. Of note, the answer speed during business hours remained stable at 2 seconds. Supervision and close management of department work schedules led to a continuation of excellent performance.

Committee Recommendation: This will continue to be monitored in FY14

5. C. Authorizations are made in timely sequence.

Results: Timeliness of initial authorizations consistently met our high standards. The initial authorization timeliness standard average for the year was 96%. Concurrent review authorizations averaged 100%. All cases audited resulted on 100 % compliance for both measures. Some scores below 100% reflected confusion in documentation, but authorizations were given in a timely manner. The team achieved excellence in their focus on serving our members and providers in a timely and efficient manner when making authorization decisions.

Committee Recommendation: This will continue to be monitored in FY14

5. D. Callers with urgent and emergent needs receive timely services.

Results: Reports were refined throughout the year as data consistently showed no urgent referrals. Referral calls are very rare and staff members are documenting all referrals in the Care Connect system as per their training and protocols. With the number of referral calls being very low, the

number of urgent/emergent referral calls has continued to be zero, despite improved documentation. With the retraining complete, the extremely low number of urgent/emergent calls appears to be accurate. Due to the wide array of services available to members at the Mental Health Center level, and the implementation of "warm lines" at multiple centers, it appears that members don't tend to call during urgent/emergent situations, but are instead going to the crisis centers at the local mental health centers and or accessing services through an emergency room. With the increased focus of staff and creation of new positions in the Clinical Department, we will continue to monitor urgent/emergent calls. Despite the very low numbers of referral calls received, the Clinical team remains available and focused on making these calls a priority. We will continue to monitor these calls on a quarterly basis.

Committee Recommendation: This will continue to be monitored in FY14, with quarterly reports in place.

5. E. CHP Clinical Policies and Procedures reflect current Corporate and contract standards.

Results: CHP Clinical Policies and Procedures were reviewed/revised in FY2011. The CAUMC committee approved all revised policies, and the Class B Board gave final approval on all policies brought before them in FY2011.

Committee Recommendation: This will continue to be monitored in FY14

5. F. Clinical training plan is complete as defined in the program description.

Results: We continue to monitor and improve our training plan. Our Clinical Team Lead has done well this year, and duties were expanded to include the supervision of the Clinical Service Assistants. With the addition of duties, the Team Lead was promoted to Clinical Services Supervisor. The team did experience significant turnover during the year, and is in the process of re-stabilizing. 40% of Care Managers have been with us five years or longer at this time. The Clinical Services Supervisor and our experienced Care Managers work closely with our newer team members to support and oversee the work.

With the balance of newer Care Managers, training is a major focus, both initial training and ongoing training on a variety of topics. Documentation of new hire and annual training of all staff is retained in employee HR files. A formal tracking system is in place to insure that documentation is turned in within a reasonable timeframe. This measure was completed.

Committee recommendation: This will continue to be monitored in FY14

5. G. Compliance with URAC standards is maintained.

Results: The Colorado Service Center did receive a URAC site visit in the summer of 2012, and helped lead *ValueOptions*® to an achievement of full accreditation, maintaining our high standards to achieve this accomplishment.

Committee Recommendation: Continue to monitor for URAC standard compliance. This will continue to be monitored in FY14.

Goal 6: Continue progress on current Performance Improvement Projects

6. A. Evaluate the effectiveness of interventions developed for the Coordination of Care PIP.

Results:
The goal for the fourth re-measurement period was to increase coordination of care documentation and maintain or increase the number of members in treatment who also completed a physical health appointment. While the latter was significantly improved, the documentation rate decreased significantly (to 49% from 71%) compared to the previous year's rate. Plausible considerations for the decrease include significant electronic record system changes that impacted internal operations and established processes for coordinating care; increased incidences of leadership and staff turnover in key areas impacting previously implemented procedures developed for coordination of care; lack of time to impact COC rates from the time the mental health agencies were aware of the low COC rates (March 2012) to the end of the fiscal year (June 2012); and lack of specified processes for documenting coordination of care in co-located behavioral and physical health facilities.

Most of the mental health centers increased or maintained their coordination of care documentation rates from remeasurement 3 to remeasurement 4 and had documentation rates greater than 80%. For the three mental health centers with rates of coordination of care documentation less than 80%, the Executive Director of Colorado Health Partnerships requested written plans of efforts to address their specific areas for improvement and the anticipated times of implementation. The Committee decided to continue this PIP and is hopeful that the interventions outlined in the plans of efforts will lead to increased coordination of care documentation.

Committee Recommendation: This goal was not fully achieved, and the Committee recommended continuing this goal, revising the target to "Continue to work towards gaining improvement in COC documentation and adding in a second target to state, "MHC's will increase over all documented COC for FY14."

6. B. Complete follow-up related to findings of peer services focus study.

Results: The Peer Services focused study was initiated and completed in October 2012, with results summarized in the section listed above in Goal 1A. As the study was recently completed, follow-up related to the study results have been completed and the study did show that there was a value to Peer Services as related to recovery. The Committee recommended follow-up with relation to staff viewpoints towards Peer Services and issues surrounding how to use Peer Services in a more effective manner.

Committee Recommendation: This goal was achieved, and was revised to, "Complete follow up related to the findings of the peer services focused study." The target has been changed to**, '**Work with QISC/CAUMC and OMFA to review and develop initiatives related to the value of Peer Specialists."

6. C. Continue quality improvement project (QIP) directed toward improvement accuracy and timeliness of EBP data

Results: A quality improvement project focused on improving the reliability of EBP participation and

outcomes data was initiated this past year. CHP worked with providers submitting EBP data to identify barriers to following the data format, gathering data, inconsistencies seen, etc., and changes were made in the data submission format, as well as processing of the data received. Preliminary results show a significant improvement in the reliability of the data submitted.

Committee Recommendation: The Committee elected that when this QIP is ended in FY14 that the Committee will work to develop a new QIP.

Goal 7: Implement new BHO Performance Indicators.

7. A. Monitor overall BHO performance measures quarterly (swf file).

Results: Monitoring of the core performance measures occurs quarterly. A report is presented at QISC/CAUMC using a rolling annual measure (updated quarterly) to allow for better comparison with fiscal year results. QISC/CAUMC has seen some downward performance trends in these measures, which has led to the data being analyzed in more detail. The group continues to have regular discussions regarding the data which is presented in this dashboard.

Committee Recommendation: This goal was achieved for FY13; the committee determined that the best course of action would be to continue to monitor the performance measures through the swf file on a quarterly basis. The committee also recommended including more performance-based metrics in the upcoming year's Work Plan.

7. B. Monitor Emergency Room utilization and evaluate strategies offered by HCPF work group.

Results: CHP continues to focus on improving the rate of emergency room visits. Initially the HCPF work group ideas were presented, although; some of the ideas were more applicable to physical health than behavioral health and group has since disbanded. CHP continued discussions on how to address this rate and developed some new strategies, presented elsewhere in this document. The Committee anticipates a downward trend in the coming year as new strategies are implemented. The results of the Emergency Room Utilization focused study were summarized in the Performance Improvement Project/Focused study section, above. As the study was recently completed, follow-up related to the study results have not yet been carried out. The committee recommended that follow up be completed, with distribution of results to include all survey response statistics, data interpretations, and a plan of action.

Committee Recommendation: The Committee decided to continue this activity. The committee recommended that the goal, **"**Monitor Emergency Room utilization and revise intervention strategies as needed**"** should be continued through the evaluation of the ER focused study survey results and action should be taken to conduct any additional follow up as needed.

7. C. Monitor 7, 30 and 90 day readmissions and associated interventions.

Results: Over FY13 readmission rates have decreased. At this point in time due to the rate decrease this goal will be discontinued

Committee Recommendations: At this point in time due to the rate decrease this goal will be discontinued.

Goal 8: QISC/CAUMC will evaluate the FY 2012 work plan progress and review Quality/Utilization Management Program Plans.

8. A. QISC/CAUMC will 1) conduct an annual review of work plan goals, 2) conduct annual review, update and approval of Program Description, and 3) QISC and CAUMC will complete an annual evaluation."

Results: This goal has been achieved.

Committee Recommendation: This goal was achieved, and will be continued for FY14.

*The committee recommended the creation of a new goal for FY14. This new goal will be goal number 6. Consequently, the old goal six will now become goal 7 and so on. The goal will read: "GOAL #6: Incorporate data based performance measures into the QISC/CAUMC Committee."

SUMMARY OF MONITORING AND SATISFACTION SURVEY MEASURES

Fact Finders Satisfaction Survey Information & Member Satisfaction

The Fact Finders Survey is a telephone survey completed by a vendor (Fact Finders, Inc.) contracted by *ValueOptions*®. Fact Finders' conducts telephone calls quarterly to a sample of clients who utilized services in the prior three-month period. The sample of clients number approximately 400 each year. CHP receives semi-annual reports from Fact Finders that consist of aggregate CHP data for calls conducted during the six-month timeframe. CHP also receives an annual (calendar year) report from Fact Finders the mental health center and aggregate results for the contracted provider network. Specific Fact Finders Survey results by CMHC and independent provider (IPN) networks for calendar year 2012 begin on page 29. The first set of questions routinely monitored by QISC is represented graphically beginning on page 35.

Comparing survey results from calendar year 2011 to 2012 for CHP, member satisfaction remained consistent. The *ValueOptions*® performance standard for this indicator is 90% and based on the calendar year 2012 data, CHP's satisfaction survey results indicated that 94.5% of respondents were satisfied with the services they received. This this is an increase from the 2011 calendar year satisfaction rate of 90.4%. The performance standard for this survey question continues to meet or exceed the established benchmark.

Member satisfaction with overall quality of services received from their therapist averaged 91.7% for CHP in calendar year 2012. This represents a statistically significant increase ($p<.05$) when comparing the ratings given in CY2011 when the overall satisfaction survey response rate was 85.1%. In CY2011 the Committee was concerned about the decrease which occurred between CY2011 and CY2010 responses. There had been a change in the wording of one of the questions related to access and the responses were significantly lower. Fact Finders was contacted about this they stated there had been a decrease in satisfaction in all contracts for this question and they were evaluating the way the question was being asked of members as they, too, were concerned.

The response to the question, "Thinking back to your first appointment, did you get an appointment as soon as you wanted," shows members remain satisfied with receiving appointments as soon as they

wanted. Although there remains no way to tell when a respondent's first appointment occurred, it is thought-provoking to know whether the request for an appointment was for a specialized service (prescriber, special program, etc.), or how long ago the initial appointment was requested. Also, it is difficult to ascertain whether or not the appointment offered within seven business days did not meet expectations for "as soon as you wanted."

A slight increase occurred from 2011 to 2012 for the survey question measuring improvement in general condition. In CY2012 67.8% indicated they are feeling "better" than a year ago. This again shows is a slight increase from the survey results in 2011 of 66.0% and results for 2012 remain higher than the *ValueOptions*® performance goal of 50%. The CHP overall results for 2012 are Better 67.6%, same 25.4% and Worse 6.9%.

When comparing survey responses from clients seen in the Community Mental Health Centers (CMHC) and by the independent provider network (IPN), the results are consistent with previous years. It is important to note that the number of CMHC clients responding is higher (approximately 395) than IPN clients (approximately 40). Clients receiving services from the CMHC were more satisfied with the quality of services from the CMHC, progress toward treatment goals and received their appointment as soon as they desired. For those respondents receiving services from the IPN, clients indicated they were slightly more involved in decisions about their care and also felt they were able to get an appointment as soon as desired. Additionally, members receiving services from the CMHC and IPN felt strongly that providers protected their confidential information. Some of the differences between the CMHC and IPN responses may be attributed to the fact that clients receiving services at the CMHCs are more seriously ill and may be involved in a variety of services at the CMHC not provided by the IPN such as the type and frequency of services available in (e.g., individual therapy, medication management, group therapy and support groups).

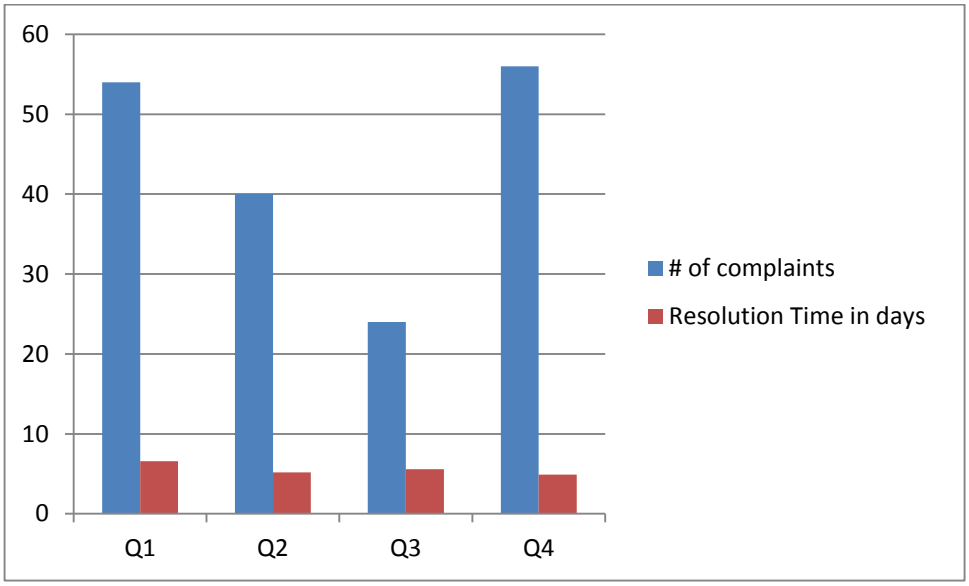
Complaints and Grievances

The total number of complaints received in FY13 was 174. This is a slight decrease compared to the 214 complaints reported in FY2012. In FY12 the average complaint resolution time was 6.3 days. This time decreased in FY13 to 5.6 days. The current standard for complaint resolution is 15 business days.

Complaint data is trended by categories and resolution times quarterly throughout the year. In FY10, the OMFA identified an increased number of complaints involving prescribers and developed a brochure to assist members being better prepared for office visits with prescribing providers. The result of this brochure seemingly addressed the concerns, as complaints in this category have decreased. The brochure continues to be used at some of the CMHC's and the decrease in complaints in this category reached a plateau in 2012, however we have not seen the high numbers of complaints in this category that we did in 2010. We continue to monitor the customer service complaints, and when the number trends upwards, it reminds us that it is time to conduct customer service training at the CMHC's. This continues to be monitored.

The volume of complaints by category and resolution times is reviewed by QISC/CAUMC and the Office of Member and Family affairs every quarter. An annual report is also produced and presents a more in-depth review.

Complaints by Quarter FY 2013



Colorado Health Partnerships Satisfaction Survey

Annual Report by CMHC, Contracted Provider and CHP Overall

Calendar Year 2012

Questions monitored by QISC:

Overall, how satisfied are you with the mental health services of CHP?

	CMHC	Non-CMHC	Total
N=	**345**	**38**	**383**
Completely Satisfied	26.7%	31.6%	27.2%
Very Satisfied	47.2%	36.8%	46.2%
Somewhat Satisfied	20.6%	26.3%	21.1%
Somewhat Dissatisfied	4.1%	2.6%	3.9%
Very Dissatisfied	1.4%	2.6%	1.6%

Overall, how would you rate the quality of services you have received from your counselor?

	CMHC	Non-CMHC	Total
N=	**356**	**40**	**396**
Excellent	44.1%	45.0%	43.6%
Very Good	29.5%	27.5%	26.3%
Good	17.4%	25.0%	20.1%
Fair	6.2%	0.0%	6.3%
Poor	2.8%	2.5%	3.8%

Have you and your therapist set goals for your treatment?

	CMHC	Non-CMHC	Total
N=	**354**	**40**	**393**
Member and Counselor Set Goals	83.6%	76.9%	84.0%
Member and Counselor Did Not Set Goals	16.4%	23.1%	16.0%

If yes, how satisfied are you with the progress you've made toward reaching these goals?

	CMHC	Non-CMHC	Total
N=	**290**	**30**	**320**
Very Satisfied	57.9%	46.7%	56.9%
Somewhat Satisfied	36.6%	53.3%	38.1%
Not Satisfied	5.5%	0.0%	5.0%

Is the office location convenient for you?

	CMHC	Non-CMHC	Total
N=	**355**	**39**	**394**
Not a Problem	87.6%	79.5%	86.8%
A Problem	12.4%	20.5%	13.2%

Compared to a year ago, in general are you feeling better, about the same, or worse?

	CMHC	Non-CMHC	Total
N=	**355**	**39**	**394**
Better	67.9%	66.7%	67.8%
About the Same	25.1%	28.2%	25.4%
Worse	7.0%	5.1%	6.9%

<u>Other Fact Finders Survey Results:</u>

When you go for mental health services, who is the person you usually see? A counselor, a doctor, a case manager, or someone else?

	CMHC	Non-CMHC	Total
N=	**360**	**40**	**400**
Counselor	59.4%	30.0%	59.5%
Doctor	33.6%	35.0%	33.8%
Case Manager	5.0%	2.5%	4.8%
Someone Else	0.6%	0.0%	0.5%
No Opinion	1.4%	2.5%	1.5%

Do you feel your counselor has shown respect for your cultural or religious needs?

	CMHC	Non-CMHC	Total
N=	**342**	**37**	**379**
Counselor Was Respectful	94.2%	100.0%	98.2%
Counselor Was Not Respectful	5.8%	0.0%	1.8%

Do you feel your counselor protects your confidentiality?

	CMHC	Non-CMHC	Total
N=	**348**	**40**	**388**
Counselor Protects Confidentiality	99.1%	100.0%	99.2%
Counselor Does Not Protect Confidentiality	0.9%	0.0%	0.8%

Does your counselor help you learn coping skills to deal with your mental health problems?

	CMHC	Non-CMHC	Total
N=	**304**	**37**	**341**
Counselor Helps with Coping Skills	89.1%	86.8%	88.9%
Counselor Does Not Help	10.9%	13.2%	11.1%

Has your counselor involved you in decisions about your care?

	CMHC	Non-CMHC	Total
N=	**351**	**40**	**391**
Member Involved in Care Decisions	90.3%	90.0%	90.3%
Member Not Involved in Care Decisions	9.7%	10.0%	9.7%

Has your counselor helped you make needed changes in your life?

	CMHC	Non-CMHC	Total
N=	**360**	**40**	**400**
Counselor Helped With Needed Changes	82.8%	77.5%	82.2%
Counselor Did Not Help With Needed Changes	13.9%	20.0%	14.5%
No Opinion	3.3%	2.5%	3.2%

Thinking back to your first appointment, did you get an appointment as soon as you wanted?

	CMHC	Non-CMHC	Total
N=	**348**	**39**	**387**
Got First Appointment As Soon As Desired	84.8%	84.6%	84.8%
Did Not Get Desired First Appointment	15.2%	15.4%	15.2%

When you were offered an appointment, did you choose the first available date or one more convenient for you? Dropped

	CMHC	Non-CMHC	Total
N=	**360**	**40**	**400**
Chose First Available Appointment	59.7%	70.0%	60.8%
Chose a More Convenient Appointment	31.9%	15.0%	30.3%
No Opinion	8.3%	15.0%	9.0%

Were you offered your first appointment within a week of your call?*

	CMHC	Non-CMHC	Total
N=	**323**	**34**	**357**
Able To Get Appointment Within 7 Days	72.8%	76.5%	73.1%
Not Able To Get Appointment Within 7 Days	27.2%	23.5%	26.9%

Can you get to the counselor's office in less than 30 minutes

	CMHC	Non-CMHC	Total
N=	**356**	**40**	**396**
30 Minutes or Less	82.6%	77.5%	82.1%
More Than 30 Minutes	17.4%	22.5%	17.9%

Is the office location convenient for you?

	CMHC	Non-CMHC	Total
N=	**355**	**39**	**394**
No Problem Getting to Appointments	87.6%	79.5%	86.8%
Problem Getting to Appointments	12.4%	20.5%	13.2%

Compared to a year ago, are you more confident in your ability to handle day-to-day activities? Question only asked of adults.

	CMHC	Non-CMHC	Total
N=	**201**	**21**	**222**
More Confident Than a Year Ago	81.6%	76.2%	81.1%
Not More Confident	18.4%	23.8%	18.9%

In addition to your mental health treatment, do you go to any activities such as drop-in center, Self-help group, workshop or class?
Question only asked of adults.

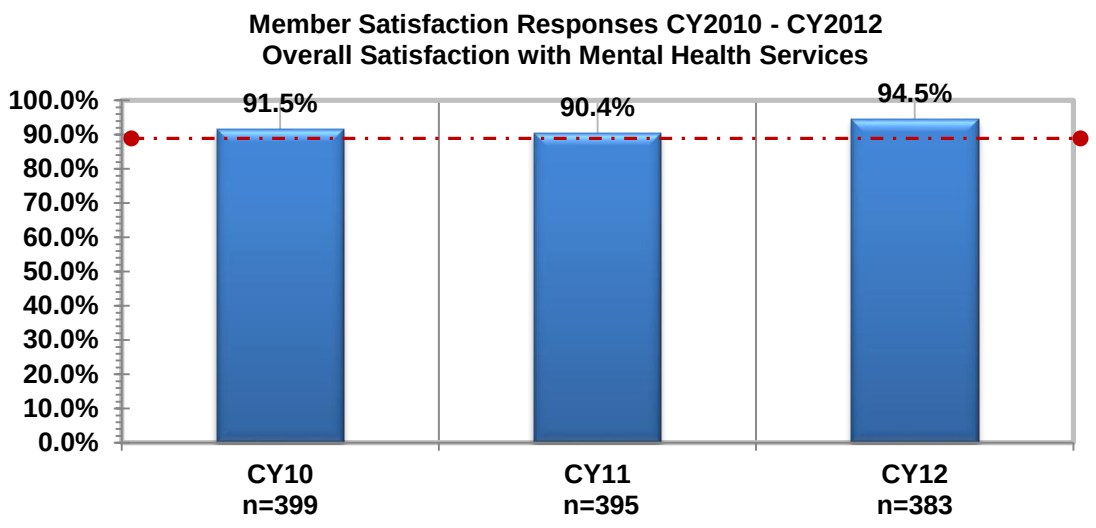
	CMHC	Non-CMHC	Total
N=	**213**	**24**	**237**
Participates in Activities	24.9%	20.8%	24.5%
Do Not Participate in Activities	75.1%	79.2%	75.5%

In the last year, have you stayed overnight in a hospital for any counseling or mental health services?

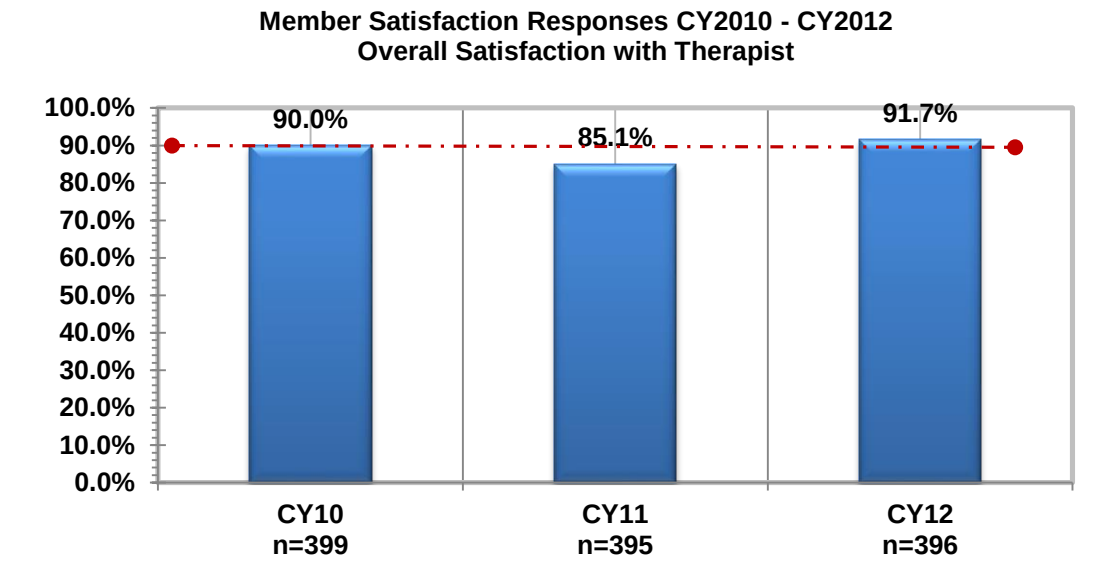
	CMHC	Non-CMHC	Total
N=	**360**	**40**	**400**
Have Received Services in Hospital	9.4%	7.5%	7.3%
Have Not Received Services in Hospital	90.6%	92.5%	92.8%

Are you satisfied or dissatisfied with the number of days approved for treatment in the hospital?

	CMHC	Non-CMHC	Total
N=	**31**	**3**	**34**
Satisfied	83.9%	100.0%	85.3%
Dissatisfied	16.1%	0.0%	14.7%

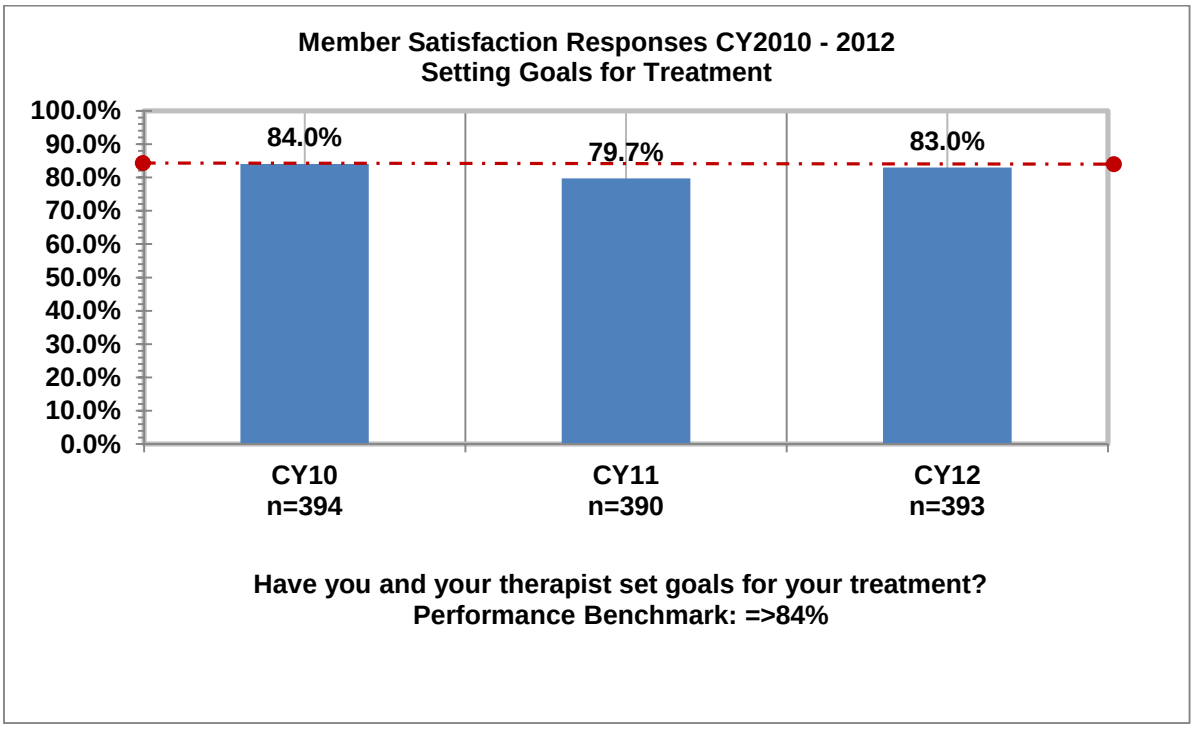


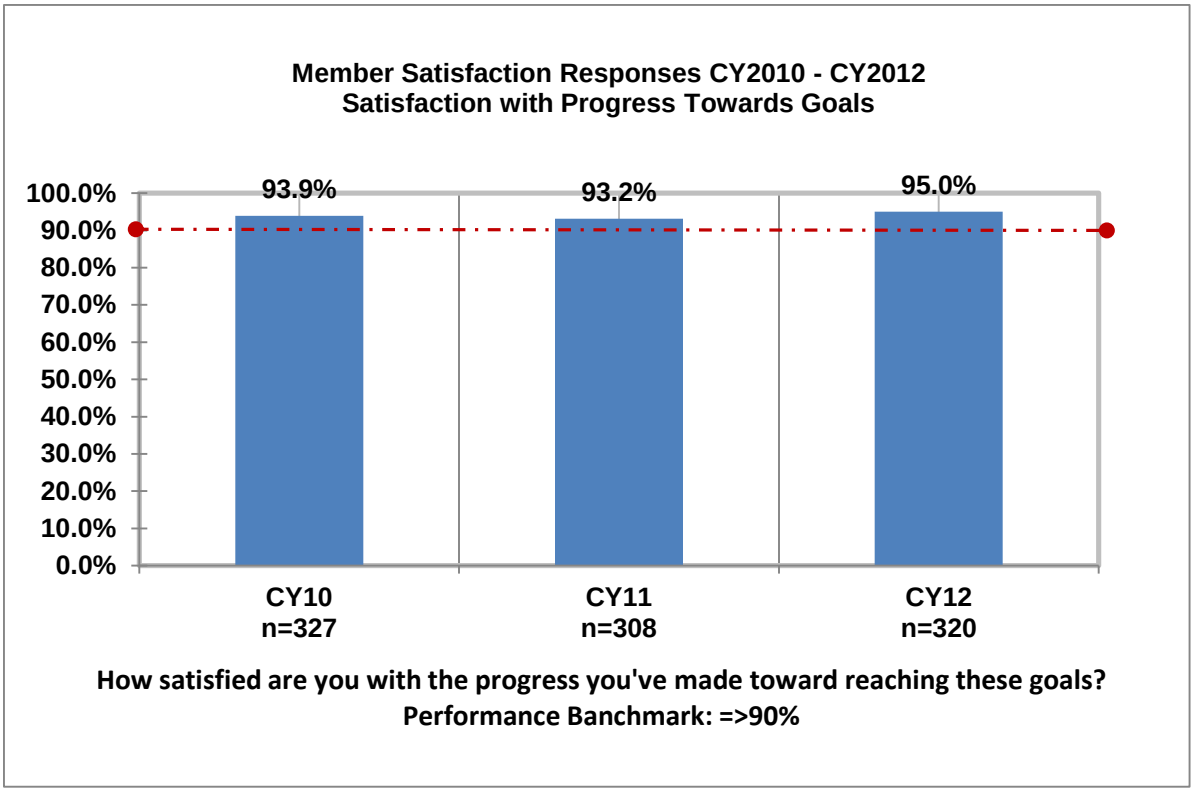
Overall, how satisfied are you with the mental health services of CHP?
NOTE: Completely satisfied, very satisfied, and somewhat satisfied are combined to create the positive response.
Performance Benchmark =>90%

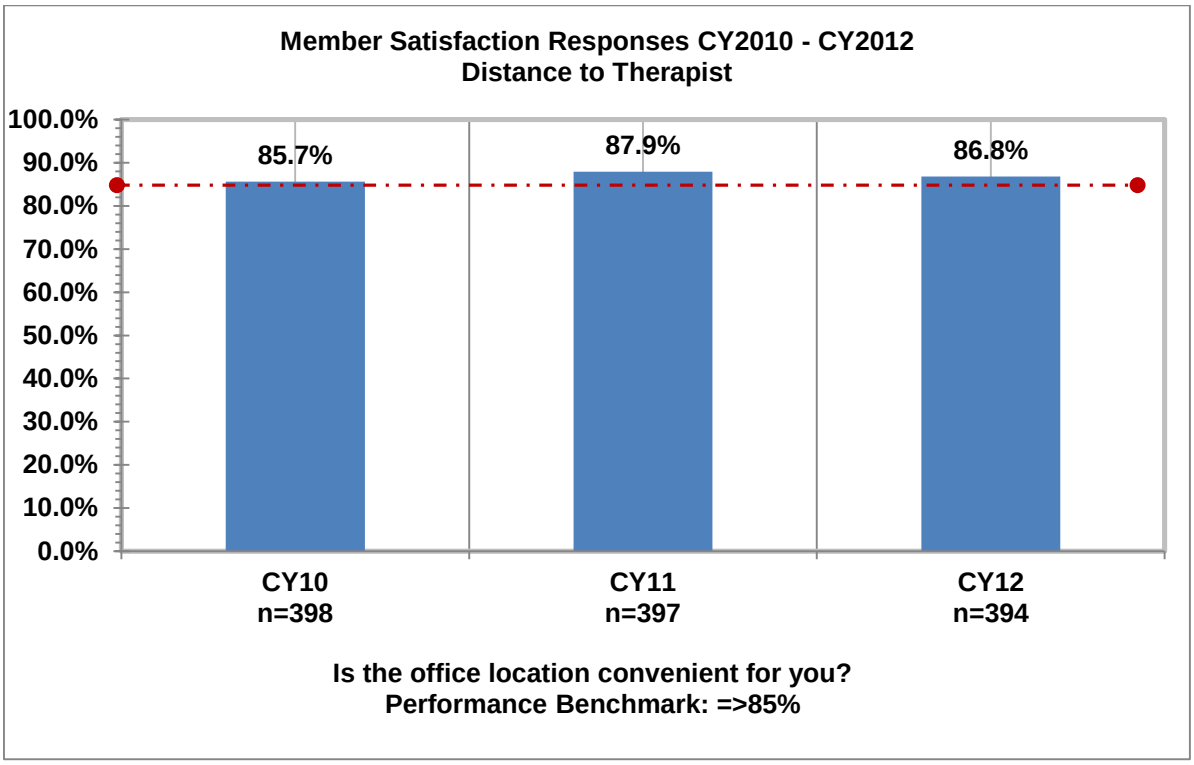


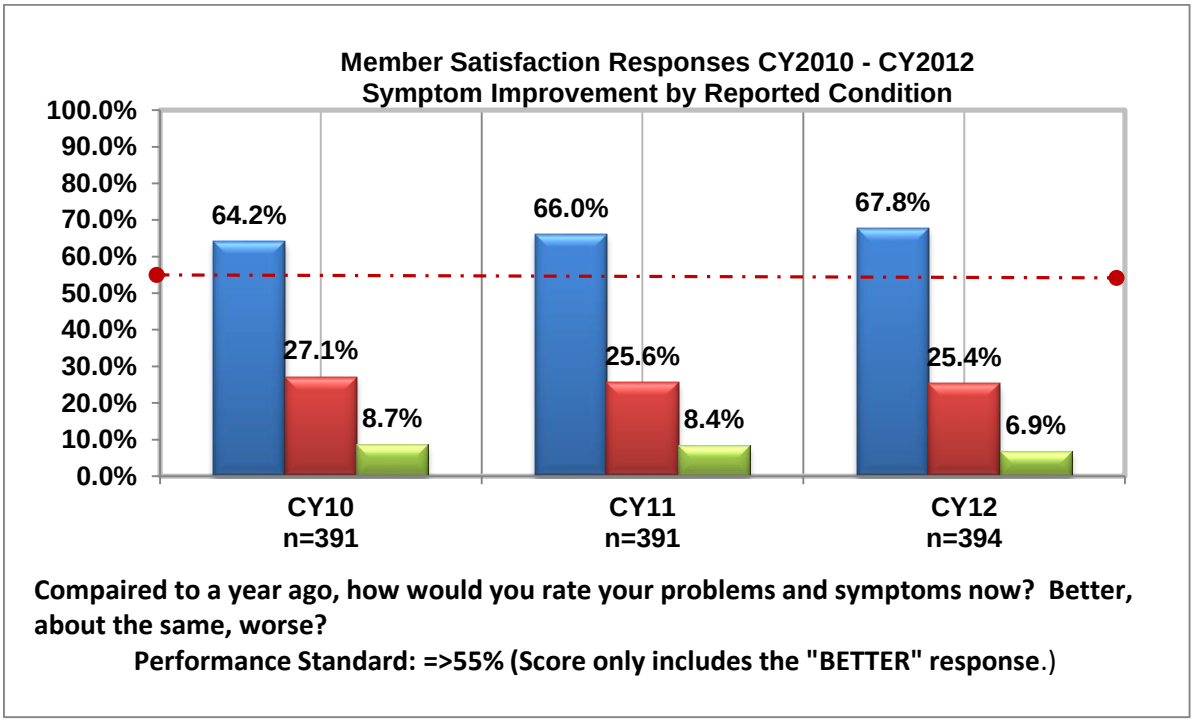
Overall, how would you rate the quality of services you have received from your therapist? Excellent, good, and very good are combined to create a positive response

Performance Benchmark =>90%


Member Satisfaction Responses CY2010 - 2012
Setting Goals for Treatment
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
84.0%
79.7%
83.0%
CY10
n=394
CY11
n=390
CY12
n=393
Have you and your therapist set goals for your treatment?
Performance Benchmark: =>84%


Member Satisfaction Responses CY2010 - CY2012
Satisfaction with Progress Towards Goals
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
93.9%
93.2%
95.0%
CY10
n=327
CY11
n=308
CY12
n=320
How satisfied are you with the progress you've made toward reaching these goals?
Performance Banchmark: =>90%


Member Satisfaction Responses CY2010 - CY2012
Distance to Therapist
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
85.7%
87.9%
86.8%
CY10
n=398
CY11
n=397
CY12
n=394
Is the office location convenient for you?
Performance Benchmark: =>85%


Member Satisfaction Responses CY2010 - CY2012
Symptom Improvement by Reported Condition
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
64.2%
27.1%
8.7%
66.0%
25.6%
8.4%
67.8%
25.4%
6.9%
CY10
n=391
CY11
n=391
CY12
n=394
Compaired to a year ago, how would you rate your problems and symptoms now? Better, about the same, worse?
Performance Standard: =>55% (Score only includes the "BETTER" response.)