Colorado Health Partnerships
Fiscal Year 2014
Quality Management and Utilization Management Program
Annual Evaluation

Executive Summary

The 2014 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 5, 2014. 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 FY2015 scheduled for the October 24, 2014 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 FY14 QM/UM Work Plan, which are summarized throughout this document. Advancement on our work plan goals included new efforts towards the implementation of the Substance Use Disorder benefit and the incorporation of data based performance targets. The ER utilization survey focused study was completed and submitted in October of 2013. The goal of the study was to identify the factors/barriers that contribute to adult Medicaid members choosing an emergency room for mental health crisis services instead of other mental health service providers. CHP considers this study to be mostly successful. The response rate was low (11.4%), which increases the potential for response bias. However, 89 surveys were completed and returned, which provided information regarding reasons Medicaid members use an emergency room for mental health crisis services instead of other mental health service providers. Information from this survey has provided a beginning point for CHP to develop follow-up activities and interventions. The quality improvement project focused on improving accuracy and timeliness of EBP data continued to be very successful. Increased focus on monitoring coordination of care efforts as well as documentation was also initiated through quarterly coordination of care audits as well as the Coordination of Care Performance Improvement Project (PIP). Through 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 investigated potential solutions; however, with the initiation of the statewide transition of care PIP the Coordination of Care PIP will be retired. The Committee continues to review quarterly performance measures. This continued review encompassed the monitoring of readmission rates. The committee also monitored the Top Five Diagnosis report for the use of the diagnosis Mood Disorder NOS. The detailed review of performance measures resulted in continued monitoring of ambulatory follow up. Decreasing ambulatory follow up rates for seven-day follow up post discharge is a concern for the committee; thus, the Committee determined a potential quality improvement project in this area may be warranted;. This year's EQRO compliance review yielded excellent results. The accomplishments described above are a direct reflection of the active particpation 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 11 times during FY2014. Committee member participation in meetings has been consistent, averaging 82% during FY14, 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 of CHP's latest examples demonstrating the impact of this process are noted below; others are described throughout this document.

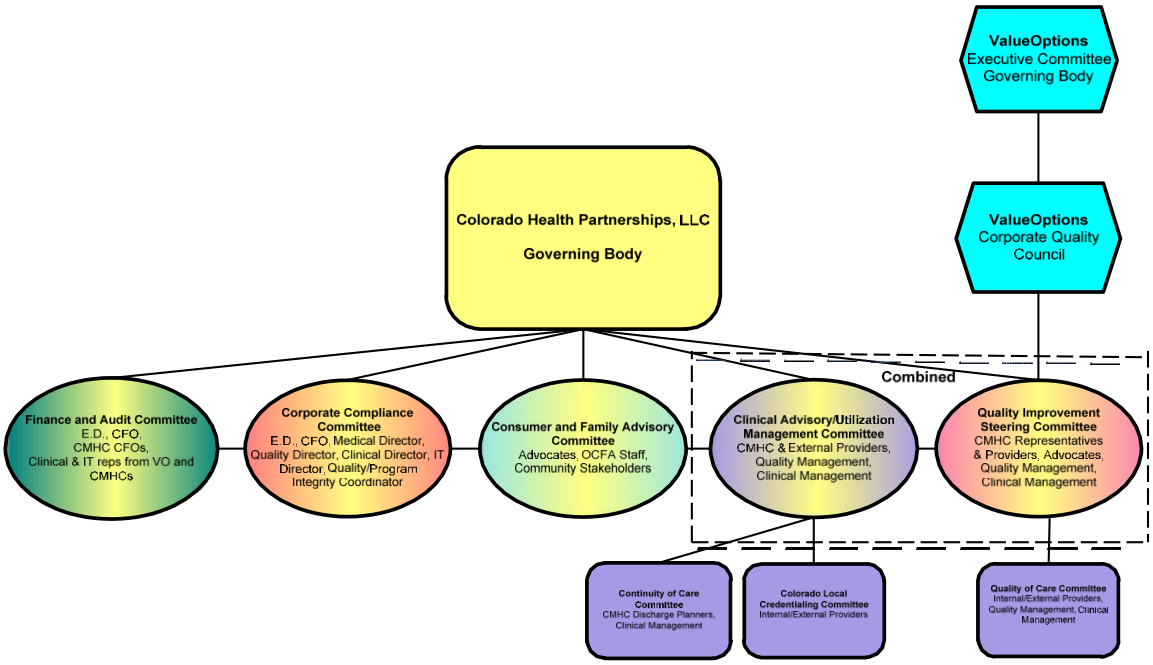
Emergency Room (ER) Visits: An analysis of ER visit data showed that nearly 60% of ER visits were attributed to members who have not accessed behavioral health services and that most often there was only one visit for the majority of members. To address this issue, the Committee initiated the mailing 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, The Quality Management Department (QM Department) 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. QM Department 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 been 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. During FY 2014, the Committee added a different mode of outreach in addition to the outreach letters: personal contact by CMHC staff. CMHC staff received monthly lists of Medicaid Members who had received the letters referenced above so that they could contact and inform the Members about services their CMHCs offer. In addition, the CMHCs began notifying clinicians and case managers about Medicaid members who are in treatment and have at least one emergency room visit that resulted in a primary DSM-IV diagnosis during the previous year. The clinicians or case managers discuss alternative services with the Medicaid members who are seeking care for non-life threatening concerns. Both of these ER visit interventions are ongoing

Evidence-based Practice (EBP) Data Reliability: the QM Department gathers EBP data from CHP 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. This effort in data cleanup was so successful, that the Committee decided to retire this project in order to focus more on integration projects. , Lessons learned from this EBP data reliability project will be used as CHP moves forward with new EBP implementation and data collection beginning July 1, 2014.

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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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.

Quality of Care Committee

The Quality of Care Committee (QOCC) is a sub-committee of the QISC/CAUMC. This committee 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 5 in 2013 (90%). 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 decreased from the baseline measure of the indicator in 2008 (46%) to remeasurement 5 in 2013 (49%). Considerations for the minimal 5-year decrease in percentage rate for documentation of coordination of care efforts focused on three mental health agencies that continued to have low coordination of care documentation rates for remeasurement 5 after having low rates for remeasurement 4. These three mental health agencies submitted corrective action plans after the results of remeasurement 4 were known in March 2013. The three-month time period where the mental health agencies implemented their new coordination of care policies may have been too short to allow for an impact of the coordination of care rates for the entire study period. We were pleased, however, that four of the eight mental health agencies had PIP coordination of care documentation rates above 88%, with one at 100%.

Plausible considerations for the decrease in coordination of care include significant problems with electronic record systems where fields necessary for coordinating care were not updating as expected; increased incidences of leadership and staff turnover in key areas impacting previously implemented procedures developed for coordination of care; lack of time to impact coordination of care rates from the time the mental health agencies were aware of ineffective coordination of care processes and corrective actions plans were implemented (March/April 2013) to the end of the fiscal year (June 2013). Annual compliance audit monitoring will continue for all providers to ensure that the mental health agencies are addressing coordination of care satisfactorily. In addition, in June 2013 we began conducting and discussing the results of quarterly coordination of care chart audits, and we have already seen promising results. Coordination of care quarterly monitoring for FY 2014, though not restricted to the same high-risk population as this PIP, has shown that CHP's documented coordination of care rate is 77% for the first half of fiscal year 2014. In addition, we feel that the methodology of this PIP – examining chart documentation of coordination of care – has become obsolete with the increased integration of care, chart sharing, and co-location. We anticipate that barriers associated with coordination of care will be addressed as CHP begins to implement the integration models, associated contract requirements and oversight monitoring for the new contract term. CHP, with HCPF's approval, elected to discontinue this PIP, though coordination of care monitoring will continue..

Emergency Room Utilization Focused Study

This study was prompted, in part, by the observation that CHP's hospital emergency room utilization rates were gradually increasing and existing interventions to influence hospital emergency room utilization for a mental health crisis, though initially effective, may have needed enhancement. 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, were additional motivations for the study. The purpose of the study was to increase understanding of the factors that contribute to emergency department use by members.

The primary objective of the ER Utilization focused study project was to survey adult Medicaid members who frequented 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 had a covered, primary mental health emergency room diagnosis with no subsequent inpatient admission. Frequencies were calculated for all survey responses. The study was completed at the end of FY2013, and, follow-up related to the study results commenced in FY2014. Follow-up included VO providing CMHCs with lists of Medicaid Members who had emergency room visits that resulted in primary DSM-IV diagnoses during the previous year. CMHCs were encouraged to contact Medicaid Members who were not current CMHC clients to alert

them of available services at the CMHC. Clinicians and case managers of Medicaid Members who were active clients of the CMHCs were encouraged to speak to the Medicaid Members at their appointments about alternative services available for non-life threatening concerns.

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 was 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 fourth remeasurement in January 2014), the valid data records in VO's EBP participation database increased from 71.8% to 93.3%. A second measure looked at validity of records in the SF-12 outcomes database. From the baseline measurement in January 2012 to the fourth remeasurement in January 2014), the valid data records in VO's outcomes database increased from 97.2% to 98.9%. A third measure was added for the fourth remeasurement period to examine the percentage of SF12 outcomes records submitted by CMHCs that contain valid domain and composite scores. The rate of valid records increased from 90.0% at the baseline measure to 91.3% for remeasurement 1. Though CHP voted to retire this quality improvement project in February 2014, the quality management committee continued 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. CHP plans to continue the EBP Data Report Card with EBPs beginning in the new contact year.

Measures of Performance

CHP's QISC/CAUMC Committee completed a review of the FY14 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: All hospital discharge rate per 1,000 members for FY14 (3rd Quarter measurement was 5.28 discharges per 1,000 members) was higher than the FY13 discharge rates. Discharge rates also were higher than the average rate across BHOs for FY12 (weighted average, all hospitals was 4.51). 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 FY14 (3rd Quarter measurement) was similar 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 above (i.e., better than) the statewide BHO average for the prior fiscal year and generally consistent with CHP's performance during FY13. 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.

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 2013) was slightly better than CHP's FY13 performance as well as the prior year's state-wide BHO average. The rates are significantly higher within 30 days (68.6% for non-state hospitals; 69.0% for all hospitals) than within seven days (50.0% for non-state; 49.4% for all hospitals). 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 2013), CHP's overall readmission rate within seven days of hospital discharge is 3.6%. This figure is somewhat greater (i.e., worse) than the previous year's rate for both state and non-state hospitals, yet it is below the statewide BHO average (4.61%). CHP's overall 30-day readmission rate for the most recent 12 month measurement period is 11.2%. This is above the statewide average for FY12 (8.78%). CHP's 90-day readmission rate (19.0%; Q3 measurement) for this fiscal year is slightly higher than the statewide FY12 BHO average for all hospitals across all age groups (14.91%). Readmission rates will continue to be an important focus during the next fiscal year.

Emergency Room Visits per Thousand: CHP's emergency room visit rate trended upward slightly in the last two quarters of calendar year 2013. Despite this trend, CHP's performance on this measure was still better (i.e., lower) than the statewide weighted BHO average for the prior year. Efforts to reduce emergency room visits continue, and CHP is hopeful that increased integration of behavioral health and medical services will positively impact this utilization.

Additional Quality Management Activities and Accomplishments: Over the past year, CHP's Quality Program accomplished many objectives and also targeted some areas to initiate measurement and improvement. CHP's project to improve the accuracy and timeliness of EBP data was a success, and clearly allowed for improved measurement of outcomes and participation in those programs, as well as overall measurement of outcomes based on SF-12 data. The final measure was calculated in the third quarter of FY14 the positive trend maintained; thus, the Committee considers the project completed. Attaining a perfect score for the 2013-2014 EQRO was also a highlight. This score validated the quality improvement efforts the Committee and staff engage in on a daily basis. Furthermore, CHP worked with RCCO 4 to establish a

work group comprised of representatives from CHP and representatives from RCCO 4, including behavioral and physical providers.. The purpose of the work group was to develop a BHO/RCCO integration effort whose focus was to reduce the overall cost of diabetic care in adults. The group provided several resources to those with diabetes and to the providers who treat them. The resources included educational resources within specific geographic regions, tip sheets for diabetic care, tracking logs, and signs and symptom check sheets. The integration group also held an educational dinner for providers to come and learn about the latest developments in diabetes care, and working with patient for whom treatment compliance is an issue.. The group continues to explore avenues of overall diabetes cost of care reduction as well as how to best educate members and providers in the area of diabetic care, as well as identifying and addressing barriers. While the group did see a slight increase in the overall cost of care for members with diabetes, we attribute this to the increased focus on member education and outreach. The group postulates that more educational opportunities, along with treatment, and provider information and general outreach on the availability of RCCO and BHO services led members to seek out care.. The group is currently exploring additional avenues for continued efforts to reduce the cost of care.

Additional accomplishments and activities include:

- Implementation of a Peer Services survey designed to gather more information on the use of Peer Services
- Continued focus and outreach efforts to reduce ER use,
- A successful and informative EQRO compliance site review netting a score of 100%,
- Development of provider performance target structure for a core set of performance measures,
- Continued participation in the BHO/RCCO Adult Diabetes work group,
- Continued focus on coordination of care for members and associated documentation audits
- Implementation of the Substance Use Disorder benefit,
- Initial development of an improvement activity focused on improving follow-up after hospitalization,
- The initial development of a new State wide Performance Improvement Project focused on transitions of care, 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)

Beginning in 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, this project has been successful, demonstrating 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, and these efforts will carry over into implementation of new EBPs.

Some of the EBPs have been very successful; one of those is the Chronic Disease Management EBP. The 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.

Population Health Management/Chronic Disease Management
Summary: As of July 2014, 253 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 2014) is provided below.

Diabetes Care Clients: The report provides information on members who have been enrolled in the program for approximately 6 months. Seventy-three percent of the participants are female and 27% 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; and, the score increases were statistically significantly different for physical health.

Asthma Care Clients: After approximately six months in the program, participants experienced improvement in physical limitation due to asthma, sleep disrupted by Asthma symptoms, and use of rescue inhaler as assessed by scores from the Asthma Control Test, but the differences between pre-intervention scores and 6 month scores were not statistically significantly different. The shortness of breath and asthma control self-rated score declined very slightly after 6 months of intervention, but this result was not statistically significantly different. SF-12 scores indicated statistically significant improvement in physical health summary scores. Though a statistically significant increase in mental health summary scores was seen for the previous measurement period, a statistically significant decline in mental health summary scores was seen during this measurement period. This area will be monitored closely to determine if the decline is a trend, or if this result is a measure-to-measure variation that could be explained by something unrelated to the program participation that might affect asthma – like wildfire smoke in the air, for example.

Chronic Pain Clients: The Chronic Pain Management Program is the newest Population Health Management program. 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. Almost 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 three of the four areas, interferes with daily activities, interferes with work and leisure activities, and hampers social activities, showed statistically significant improvement.

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. With the new Medicaid contract beginning July 2014, outcomes for these EBP will no longer be monitored. CHP will begin to monitor outcomes for other integration-focused EBPs.

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. This EBP category had a fiscal year 2014 enrollment of 441 – an increase of 11% from fiscal year 2013.

Assertive Community Treatment (ACT)

Summary: Participation in this EBP has been consistent, with a total of 140 participants across providers during the fiscal year 2014.

Client-Run Peer Services: Peer Services

Summary: Enrollment in this EBP has nearly doubled in the past two years. Based on SF-12 pre to follow-up scores, the participants engaged in the Peer Services program reported increased improvement in the mental and physical composite scores, 4.00 and 2.00, respectively. Though there was an improvement from pre to follow-up SF-12 scores, the increase was not statistically significant.

Supported Employment: Vocational Services

Summary: This EBP had 13 participants, with 9 of those being new to the EBP during fiscal year 2014. Participation in this program remains 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 a three-year period 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. Results were presented at the October 2013 QISC meeting.

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: This EBP continues to be slightly impacted by a low-volume of participants, though participation held steady in FY14 after an increase of 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<.001), Child Doing Well with Friends (p=.005), Child Making Good Choices (p=.001), and Parents Understanding Child's Needs (p<.001).

Multimodal Treatment: Multimodal Treatment

Summary: This continues to be a low-volume EBP, though enrollment has held steady for the past three years. 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. Participation increased by 80% from an already high enrollment in FY13 to FY14. 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. Enrollment for this group of EBPs increased 15% from FY13 to FY14.

Brief Hospitalization: Enrollment in this EBP has remained low, yet steady for the past three years. Enrollment numbers are too small to perform reliable outcomes analyses.

Intensive Case Management: Enrollment in this EBP has remained low, yet it has grown slightly over the past 3 years. Enrollment numbers are too small to perform reliable outcomes analyses.

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

Summary: Love and Logic has been fairly successful, with steady participation for the past three years. Nurturing Parenting participation, however, has dropped off from FY12 to FY14. 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: This group of EBPs has been implemented with varied success in participation, with participation declining somewhat from FY12 to FY13, then holding steady from FY13 to FY14. 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. Findings from an outcomes study presented to the Committee in FY 2014 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.. 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. Where available, fidelity measures will be incorporated in the annual evaluation for EBPs specified in the Medicaid contract beginning July 2014.

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. The SF-12 outcomes report was presented to QISC/CAUMC in October 2013. 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 ($p<.01$).

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. When the new Medicaid contract begins in July 2014, the SF-12 will continue to be used to monitor some of the EBPs; though, CHP will begin to collect data using various tools that are believed to be more sensitive to the outcomes of the EBPs

The CCAR is also used as an outcomes measure. The committee continues 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.

Audits and Accreditation

The annual FY13 –14 EQRO site review, evaluating compliance with contract requirements, was completed in March 2014. CHP earned an overall compliance score of 100% in the two standards reviewed. CHP's 100% score for the audit demonstrates CHP's dedication to striving for excellence. Health Services Advisory Group commented that, "Due to CHP's long-standing presence as the BHO in the region, CHP has secured contracts with the majority of qualified providers in the service area. Therefore, CHP has engaged in several initiatives related to expanding the availability of mental health services to members through nontraditional means such as provision of home-based services, telemedicine, and primary care provider (PCP) training programs for medication management of depression."

The Service Center continues to regularly evaluate compliance with all requirements established by the Utilization Review Accreditation Commission (URAC) as part of our URAC accreditation.

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.
An educational webinar on the topic of documentation was offered to providers in Fall of 2013. There were a large number of attendees, who asked many clarifying questions. Feedback on the training indicated that 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 FY2014. 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 a call abandonment rate of less than 3 percent. For FY14, the department showed consistently excellent performance. Our abandonment rate was under 1% for the entire year. Average speed of answer for all calls combined, including nights and weekends, was less than 7 seconds; averaging 6.55 seconds per call.

We continue to work closely with our after-hours team in the Texas Service center to ensure 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 services provided by the team.

Systems Integration

The Service Systems Integration Team strives to improve the quality of life for our members, partners and providers by innovatively bringing together resources, systems and strategies for better health care. Over the past year the team has continued some of our focused efforts, started new efforts and brought some projects to fruition.

Last year the team strengthened the Child Psychiatric Consultation Service program. This past year that program was grant funded and passed on to the Colorado Behavioral Health Care Council. The program is now called Child Psychiatric Access and Consultation for Kids. One of the team's former members, Mary Shatzer, is still heavily involved with that program. This program provides "curbside" psychiatric consultations to pediatricians dealing with behavioral disturbances in their patients. This is a valuable service in Colorado that attempts to bridge the gap between child psychiatric needs and the severe shortage of child psychiatrists.

The team has intensified its involvement with state and local departments of human service. A new team member, Lynne Bakalyan, has been recruited in this effort. Team Lead Paul Baranek has been elected as chairperson of the Finance Committee for El Paso counties HB 1451 effort, the REACH Program. The team is also involved in the Operations Committee and Executive Committee of that program. The state Department of Human Services is looking at this program closely as a model for the rest of the state. The team continues its involvement in the SB 94 programs as well as other HB 1451 programs in the southeast area of the state. Many presentations have been done for local DHS and foster care groups regarding our services. At a statewide level the team participates in the state DHS Core Services Director's quarterly meetings, where BHO issues can be addressed immediately as they are brought up, as well as other statewide DHS meetings.

Integration with physical health care services has been a major focus of the team this past year. Team member Vicki Linden's participation in efforts such as the Teen and Unintended Pregnancy Prevention workgroup and Chaffee County Health Coalition illustrate this effort. Other examples include integration and joint training

efforts with RCCOs that the team has conducted and participation in the Worksite Wellness Work Team and Preventing Long Term illness Due to Obesity workgroup. The Team Lead is also point person for a new project on integrating physical and behavioral health data called Spectrum.

The team has increased its presence at statewide meetings to enhance our image as a leader in the field throughout Colorado. We participate in the Behavioral Health Transformation Council and the Systems of Care subcommittee. Team members work on the duals demonstration project involving payment reform and blended payment options. We are on the ICD10/DSM5 Conversion workgroup at the request of the Office of Behavioral Health. We were asked to provide feedback to the governor's 27-65 reform group on handling Dementia and Alzheimer's issues and participate in that workgroup.

Long Term Services and Supports and aging services remain a priority. Team member Lisa Keenan co-chairs the Care Coordination subcommittee to advise the governor and Paul Baranek is on the Entry Point/Eligibility subcommittee. The team is also involved in a workgroup addressing training issues for assisted living facilities and has recommended Mental Health First Aid training. We also participate in the Senior Behavioral Health and Wellness Coalition which has allowed us to forge valuable relationships with the community serving this population. Team member Vicki Linden is on the ADRC (Aging and Disability Resource Center- formerly ARCH) Council and the Senior Services Networking group.

Training and education has remained a priority. Over the past year the team has provided multiple trainings to community groups and providers on topics such as; Motivational Interviewing, the DSM5, Trauma Informed Care, Medicaid Behavioral Health Services, Suicide Assessment and Intervention, Integration of Behavioral and Physical Health Care Services, and Mental Health First Aid. In addition, team members have composed an LMS (learning management system) course on the six levels of integrated care and a glossary of integrated care terms that is now being made available on the CBHC website.

Perhaps one of the most important, though most difficult to quantify, functions of the team has been the multiple meetings with state and local agencies and community partners when issues arise. Most often, these issues can be resolved with information about what we can and cannot do. Sometimes these have involved creative solutions for individual problems. These often involve coordinating with our own internal departments as well as partner and community providers to fashion individual plans addressing the member's unique needs. Brokering cross system collaboration is frequently required such as in the treatment of eating disorders, co-occurring intellectual and developmental disabilities, services provided to DHS clients and other more complicated situations.

More recently the team has been involved in implementation activities. The new BHO contracts start on July 1, 2014, and there are some new and exciting requirements that very much involve integration functions. Here are a few highlights: The team has been working with several local criminal justice agencies to advance continuity of behavioral health services for Medicaid members involved in the criminal justice system. This may involve some data sharing arrangements which have the potential to automate much of the process of identifying these members. The team has been involved in long term and aging services and supports on a statewide level for some time. Some new requirements regarding PASRRs and nursing home services have involved us in this arena as well. Integration with physical health care is an important component of the new contracts and the team has been involved in identifying partners, resources and processes by which this might be accomplished.

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 clinical and operational knowledge and experience to our meetings. This diversity provides strength in managing the quality of care and service provided to CHP Medicaid members. In addition, the continued dedication shown through the annual committee participation percentage allows not only for consistency in committee participation but also supports continued committee stability.

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, in maintaining all efforts which are necessary in certain areas before improvement becomes evident. This is especially prevalent in relation to the Coordination of Care PIP. Even though CHP experienced a decrease in the rate of coordination of care, CHP continues to evaluate quarterly mental health center audit results. These audits include checks for documented coordination of care by co-located providers and shared charts as well as other care coordination efforts. 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. For FY15, the SF-12 has been discontinued and there will be different tools introduced to evaluate outcomes. Continued improvements in the reliability of outcomes data submission also helped to gain a better understanding of member outcomes.
When reviewing the numerous quality management and improvement activities in progress and completed throughout the year, the Committee agrees that the Quality Management Program has been effective. Through the evaluation process; the Committee also identifies areas of focus for bolstering performance, and the potential for new improvement opportunities. The Quality Management Program staff continues to build expertise 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 improved capability for data-based decision making within the Quality Management Program.

Although achievements for this past year were significant, there were areas where the QM Department 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 another slight decline in the rate of

documented coordination of care. However, the results were based on a definition for measuring coordination of care that in our opinion was outdated and would benefit from revision to allow more precise measurement of care coordination. CHP also has begun preliminary research into the Statewide PIP transition of care initiative. While this PIP is still in the development stages, CHP hopes to make a positive impact upon transitions of care for the population who are released from jails. Furthermore CHP is taking steps toward improving performance in ambulatory follow-up. CHP noticed that seven day ambulatory follow-up rates began to trend downward. To support ongoing improvement in this area, the Committee will continue to analyze the performance measures to determine the best practices for positive change along with intervention planning. This will include the development of a performance improvement initiative targeting ambulatory follow up. In addition, CHP will be exploring the development of a new performance improvement project which is focused on increasing the number of members who have not received an A1C test in the past year and are currently prescribed atypicalanti-psychotic medications.

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 several members of the senior management team. 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 Team Lead for 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 a strength of the UM program, and increased specialization of roles within the team has led to improved performance. For example, our Clinical Services Supervisor focuses on supervision of the Clinical Service Assistants, Clinical Care Manager training and problem-resolution and process 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 presently consists of 1.0 FTE Clinical Director, 1.O FTE Clinical Services Supervisor, 5.0 FTE Clinical Care Managers, 2.5 Intensive Case Managers and 5.0 Clinical Service Assistants. The success of the UM program is largely attributed to this diverse and well-seasoned staff. Stability of the team, a focus on continuous process improvement and stable relationships with providers ensured productive and efficient UM services.

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.

2013-2014	Q1 July-Sep	Q2 Oct-Dec	Q3 Jan-Mar	Q4 Apr-Jun
Initial Authorization Content Audits	100%	100%	100%	100%
Initial Authorization	100%	100%	100%	100%

Timeliness Audits				
Concurrent Review Authorization Content Audits	100%	92%	100%	100%
Concurrent Review Timeliness Audits	90.3%	96%	100%	100%
Average Speed of Answer	7.6 seconds	6 seconds	7.3 seconds	5.33 seconds
Abandonment Rate (over 30 seconds)	0.52%	0.30%	0.46%	0.63%
Annual Inter-rater reliability survey	NA	77%	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 FY14.

The goals and objectives for FY14, 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 FY15. 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 consumer and family member involvement with CAUMC/ QISC efforts.

1. A. OMFA will collaborate with Quality to validate the value of peer services.

Results: OMFA and the Quality Department collaborated in order to develop a survey/study to address the validity and value of Peer Services. The survey was distributed and results continue to be returned. Once the results are evaluated, follow-up activities will be developed. Additionally, over the past year the CROS tool was examined in order to ascertain if the tool was a viable rescore to be used to collect and access recovery outcomes. It was decided that the tool would not be used to access recovery outcomes.

Committee Recommendation: Goal 1A will be continued for fiscal year 2015. The study was finalized in May 2014 and distributed in May as well. Once all data is received OMFA and Quality will work to evaluate the responses and generate a report for use in the upcoming year. The goal will be revised to state, "OMFA will continue to collaborate with Quality to validate the value of peer services." Furthermore, goal 1A , 2 will also be modified for the next fiscal year. The goal will now read, "OMFA will plan the implementation of a new tool in order to access recovery outcomes."

1. B. The QISC/CAUMC Committee will evaluate data related to cultural competency measures.

Results: This is a new goal for FY15

Committee Recommendation; The QISC/CAUMC Committee recommends that The question, "Do you feel your counselor is able to meet your cultural, religious and language needs?" will be taken from the Fact Finders survey and will be added to the Trending Report. The results will be evaluated no less than on an annual basis.

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. The results of the FY14 audit demonstrated an increase in Non-CMHC Provider compliance. Continued education is also planned for the upcoming fiscal year. Mood disorder NOS will continue to 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: The committee deemed this goal complete and recommended that the goal be continued through the next fiscal year. Providers will continue to receive annual training An audit tool has been created for use to audit the IPN providers against the new CPT and E&M codes. There is a potential that this audit tool could be put to use for the Mental Health Centers. 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 CMHC providers will be consistently evaluated against CHP clinical standards, guidelines and contract requirements.

Results: In order to enhance coordination of care efforts monitoring for the CMHCs in the area of coordination of care began in August of 2013 and continued quarterly.. A maximum of 15 audit results were submitted quarterly by each CHP mental health center.

Committee Recommendation:
The committee recommended continuing goal 2.B. through the next fiscal year. The committee also recommended that an inter-rater reliability audit be set up to confirm the validity of the coordination of care documentation submitted by the CMHC's.

2.C. **Audits** will be conducted on a regular ongoing basis. New audits will be scheduled and implemented and a schedule will be determined.

Results: This is a new goal for FY15

Committee Recommendation: This is a new goal for FY15. The aim of the goal is to broaden provider monitoring efforts.

Goal 3: Systematically analyze and evaluate outcomes data.

3. A. QISC will explore options to improve outcomes through education and outreach to members as well as outreach to PCP's who provide services to members with high cost/high risk diagnosis.

Results: The committee continues to receive the high cost/high risk diagnosis data from ValueOptions®. This data is used to populate EHR's. 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. 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, once again, focused on the physical health scores of the SF-12 during the past year as the Committee did the year before. 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.

Committee Recommendations: The Committee recommends continuing goal 3A and discontinuing all others goals in this section. The goal will focus on Members of the QISC/ CAUMC committee continuing to receive the high cost/ high risk diagnosis report for the next year.

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. Policies and procedures were reviewed and evaluated throughout the year

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 FY2015.

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

Results: An annual review of all existing Guidelines occurred in FY14. The Clinical Peer Advisor and members 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 FY2014. The committee recommends continuing this goal for FY2015.

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: 77% of all clinicians who took the 2013 annual Utilization Management inter-rater reliability test received Individual scores above 80% and were considered passing. The test was also analyzed by discipline and years of clinical experience. One Care Manager and the Clinical Services Supervisor fell just below the 80% score, scoring 77.8%. The average score of the team was 87%. The Clinical Director and Medical Director met with the entire team in August 2014 to review the test as a Corrective Action. The Clinical Director, Clinical Peer Advisor, Clinical Service Supervisor, Care Managers, 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 FY15

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 under 7 seconds and the average abandonment rate was less than 1%. The call abandonment rate was similar to the prior year's rate; the average speed of answer was slightly increased, yet still better than the BHO-defined performance standard. Supervision and close management of department work schedules led to continued excellent performance.

Committee Recommendation: This will continue to be monitored in FY15

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 100%. Concurrent review authorizations averaged 96.6% for timeliness. Content audits for initial authorization averaged 100% for the year; content audits for concurrent authorizations averaged 98%. The minor variances for both timeliness and content for concurrent authorizations were rectified through staff retraining and coaching. 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 FY15

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 response to urgent/emergent calls. Despite the very low numbers of emergency 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 FY15, 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 FY2014. The CAUMC committee approved all revised policies, and the Class B Board gave final approval on all policies brought before them in FY2014.

Committee Recommendation: This will continue to be monitored in FY15.

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

Results: 100% of newly hired clinical staff completed their defined training plan and achieved acceptable scores on monitoring audits. When deficiencies were observed, staff was provided with additional coaching or training until consistently accurate performance could be documented.

Committee recommendation: This will continue to be monitored in FY15

5. G. Compliance with URAC standards is maintained.

Results: The Colorado Service Center did receive a URAC site visit in February of 2013, and helped lead *ValueOptions*® to an achievement of full accreditation through 2016, maintaining our high standards to achieve this accomplishment.

Committee Recommendation: Continue to monitor for URAC standard compliance. This will continue to be monitored in FY15.

Goal 6: Incorporate data based performance targets into the QISC/CAUMC Committee

6.A Implement data based performance targets and monitor the implemented change.

Results: This was a new goal for FY2014. The .swf file was reviewed quarterly during the QISC/CAUMC committee meetings. Targets were established for the measures which relate to the overall 5 BHO weighted average.

Committee Recommendation: The committee recommends continuing this goal. Performance issues should continue to be identified. The performance measures will continue to be reviewed at the QISC/CAUMC committee quarterly. As needed, interventions will be discussed if targets are not met for a span of two quarters in a row.

Goal 7: Continue progress on current Performance Improvement Projects

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

Results:

The goal for the fifth 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 (to 90% from 85%), the documentation rate decreased significantly (to 40% from 49%) compared to the previous year's rate. We were pleased, however, that four of the eight mental health agencies had PIP COC documentation rates above 88%, with one at 100%.

Plausible considerations for the overall decrease include significant problems with electronic record systems where fields necessary for coordinating care were not updating as expected; 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 ineffective COC processes and corrective actions plans were implemented (March/April 2013) to the end of the fiscal year (June 2013). Annual compliance audit monitoring will be continued for all providers to ensure that the mental health agencies are addressing coordination of care satisfactorily. In addition, coordination of care quarterly monitoring for fiscal year 2014, though not restricted to the same high-risk population as this PIP, has shown that CHP's documented coordination of care rate is 77% for the first half of fiscal year 2014. We will continue to monitor COC rates quarterly for improvement. Finally, provider PIP results were presented to CHP's Board to determine recommendations for additional interventions and/or corrective actions. We feel that the methodology of this PIP – examining chart documentation of coordination of care – has become obsolete with the increased integration of care, chart sharing, and co-location. We anticipate that barriers associated with COC will be addressed as CHP begins to implement the integration models, associated contract requirements and oversight monitoring for the new contract term. CHP has approval from HCPF to retire this PIP.

Committee Recommendation: This goal was achieved, and the Committee recommended discontinuing this goal. The committee also recommended that goal 7 now read, "**Implement new Performance/Quality Improvement Projects."** Goal 7A will now read, "Develop a new Quality Improvement Project." The intention of this goal is to continue CHP's focus on performance improvement. The QIP will focus on increasing the 7 day ambulatory follow up rate.

Committee Recommendation: This goal was achieved, and the Committee recommended discontinuing this goal and replacing with a new goal which reads, "Develop a new Performance Improvement Project." This goal will focus on the creation of a new PIP addressing transitions of care for

the criminal justice population. In addition, goal 7B 2 will be added. This goal will read, "QISC and the PIP Task group will develop a second Quality Improvement Project (QIP)." This QIP will focus on increasing the, "diabetes testing for members currently prescribed atypical antipsychotics medication."

7. C. Develop a new QIP

Results: The Committee approved a new QIP topic - increasing the rate of seven-day ambulatory follow-up after inpatient hospitalization. Since CMHCs in CHP's service area can have greatly different barriers for providing ambulatory follow-up, the CMHCs determined intervention plans that are specific to their needs related to ambulatory follow-up. Many intervention plans are focused on addressing member-specific barriers, such as a Member's lack of transportation to the CMHC site or members failing to show up to their scheduled appointments. Some interventions are focused on communication with the hospitals. Interventions will begin in FY 2014.

Committee Recommendation: The Committee elected that since the QIP has ended that the Committee will work to develop a new QIP as referenced in goal 7A above.

Goal 8: Monitor and evaluate BHO Performance Indicators

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

Results: Monitoring of the core performance measures occurs quarterly during the QISC/CAUMC committee. A report is presented at QISC/CAUMC using a rolling annual measure (updated quarterly) to allow for better comparison with fiscal year results. In the past, QISC/CAUMC have 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 FY14; 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 and the committee will initiate barrier analysis or a CAP as deemed necessary, based on the identified performance targets

8. B. Monitor Emergency Room utilization and revise intervention strategies as needed.

Results: In FY14 CHP focused on improving the rate of emergency room visits. CHP discussed how to address this rate and developed some new strategies, presented elsewhere in this document. In October of 2013 the Emergency Room Utilization Focused Study was distributed to HSAG. The Focused Study procedures were summarized in the Performance Improvement Project/Focused study section, above. As a result of the study, CMHCs have been encouraged to reach out to Medicaid Members who have been to the Emergency Room for behavioral health reasons.

Committee Recommendation: The Committee decided that this goal was complete and thus should be discontinued for FY15. ER utilization will continue to be mon**itored** quarterly through QISC's performance measure monitoring.

Goal 9: Begin to work towards implementation of the SUD benefit

9.A. Work towards implementing the SUD benefit

Results: The QICS/CAUMC committee was able to make strides in the implementation of the SUD benefit and achieve the implementation date of January 2014.

Committee Recommendation This goal was new for FY15. The committee has decided that this goal should be continued into FY15. However, to be continuing the goal must be modified. The overall goal will change from, "Begin to work towards implementation of the SUD benefit" to, "Monitor and evaluate provider and BHO performance in the delivery of SUD services." Goal 9A will now read, "Continue implementing the SUD audits for the Independent Provider Network." The committees will identify a standard for the monitoring of the Independent Provider network.

9.B. **QISC/CAUMC or another work group will explore options to implement substance use disorder performance measures**

Results: This goal was met. In January of FY2014, CHP implemented the new Substance Use Disorder (SUD) benefit for all of its members. We recruited and credentialed providers for the independent provider network, and we implemented several training opportunities for both IPN providers and our partner mental health centers to inform them of the new benefit and the related processes for authorization and claims submission. The new SUD benefit currently includes only outpatient services, medication assisted treatment and social detoxification programs. It does not include residential or inpatient services. CHP developed utilization management and financial reporting to track this new benefit. It produced and disseminated weekly reports to monitor authorized services and paid claims data. Additional information, such as the number of members served and the penetration rate has been helpful in understanding how this new benefit is being utilized. Our QI and UM teams are also developing protocols for auditing SUD services and will use audit results to help define provider education efforts in the coming year.

Committee Recommendation: The QISC/CAUMC committee recommended that the committee Explore potential measures that can be qualified and quantified for the SUD benefit. A dashboard type tool will be developed and will include units' approved, specific categories by providers and centers as well as paid claims and social detox. The engagement measure will be added after the methodology has been decided upon. SUD engagement will be added to the .swf file. In FY2015, we will continue to refine reporting to include dashboard-type tools for reporting and monitoring authorized units, paid claims and other UM indicators. We also will integrate any SUD-specific quality metrics required by the Department of Health Care Policy and Financing. For these services, we will also implement an auditing process that includes service verification and quality components.

Goal 10: QISC/CAUMC will evaluate the FY 2015 work plan progress and review Quality/Utilization Management Program Plans.

10. 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 FY15.

Goal 11: *New for FY15* QISC/CAUMC will work towards the implementation of the integration program into committee efforts.

11. A The QICS/CAUMC Committee will work towards implementing the monitoring of the integration program

Results: This is a new goal for fiscal year 2015; consequently, there will be no results available until fiscal year 2016**.**

Committee Recommendation: The QISC/CAUMC Committee recommends beginning a goal to support the monitoring of the integration program. The Committee feels that a good area to begin will be to monitor the use of the screening tools. Another potential area could be exploring adding a question to the Fact Finders survey which will look for feedback surrounding member feedback on integration.

11. B The QISC/CAUMC committee will look at developing a question for Fact Finders

Results: This is a new goal for fiscal year 2015; consequently, there will be no results available until fiscal year 2016**.**

Committee Recommendation: The QISC/CAUMC committee will formulate a new question for the Fact Finders survey which focuses on member feedback on integration efforts. *The committee recommended the creation of a new goal for FY15. This new goal will be goal number 11.

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 2013 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 2012 to 2013 for CHP, member satisfaction remained consistent. The *ValueOptions*® performance standard for this indicator is 90% and based on the calendar year 2013 data, CHP's satisfaction survey results indicated that 93.3% of respondents were satisfied with the services they received. This this is a slight decrease from the previous calendar year satisfaction rate of 94.5%. However 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 87.3% for CHP in calendar year 2013. This represents a statistically significant decrease ($p<.05$) - comparing the ratings given in CY2012 when the overall satisfaction survey response rate was 91.7%. In CY2011 the Committee was concerned about a similar decrease which occurred between CY2011 and CY2010 responses. - Fact Finders had been - contacted about this they stated there had been a change in the wording of one of the questions related to access which showed a decrease in satisfaction in all contracts for this question. The QM Department reviewed the findings of the past four years related to this question to attempt to determine if there were any correlating factors which could be impacting the results. The evaluation revealed no striking reasons for the near mirrored increase and decreases.

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. Also it is difficult to establish whether or not the appointment offered within seven business days did not meet the members' expectations for getting an appointment "as soon as you wanted." Although there remains no way to tell when a respondent's first appointment occurred, it is challenging to know whether the request for an appointment was for a specialized service such as for a prescriber, special program, etc., or how long before the survey was taken the initial appointment was requested. -

A slight decrease occurred from 2012 to 2013 for the survey question measuring improvement in general condition. In -CY2013 63% indicated they are feeling "better" than a year ago. - Results for CY2013 remain higher than the *ValueOptions*® performance goal of 55%. The CHP overall results for 2013are Better 63%, About the Same-29% and Worse 8%.

When comparing survey responses from clients seen in the Community Mental Health Centers (CMHC) and by the independent provider network (IPN) –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 –indicate they were more satisfied with the quality of services from the CMHC, felt the office location was convenient for them, their problems and symptoms had improved, counselors involved them more in decisions about their care, are better able to handle day to day activities as a result of counseling received, and received an appointment as soon as they wanted.- For those respondents receiving services from the IPN, clients indicated they were slightly more -satisfied with the quality of services received from the counselor, the counselor was just right for their needs, helped more by the counseling they received, also felt the office location was convenient. Additionally, members receiving services from the CMHC and IPN felt strongly that providers met their cultural needs and 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 engaged in a variety of services at the CMHC that may not be 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

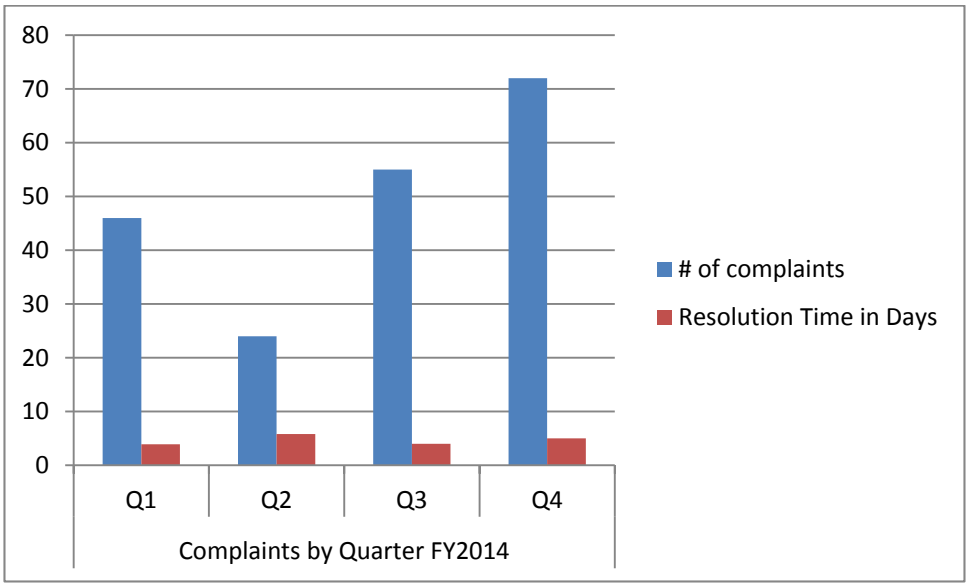
The total number of complaints received in FY14 was 197. This is a slight increase compared to the 174 complaints reported in FY2013. In FY13 the average complaint resolution time was 5.6

days. This time decreased in FY14 to 4.6 days. The current standard for complaint resolution is 15 business days.

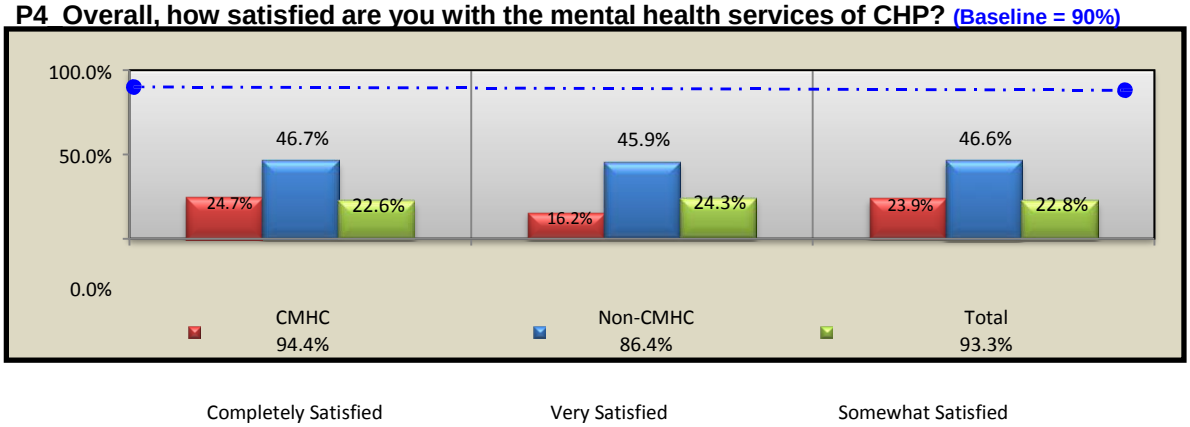
Complaint data is trended by categories and resolution times quarterly throughout the year. In FY10, the OMFA identified an increased number of complaints involving prescribers and developed a brochure to assist members being better prepared for office visits with prescribing providers. The result of 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.

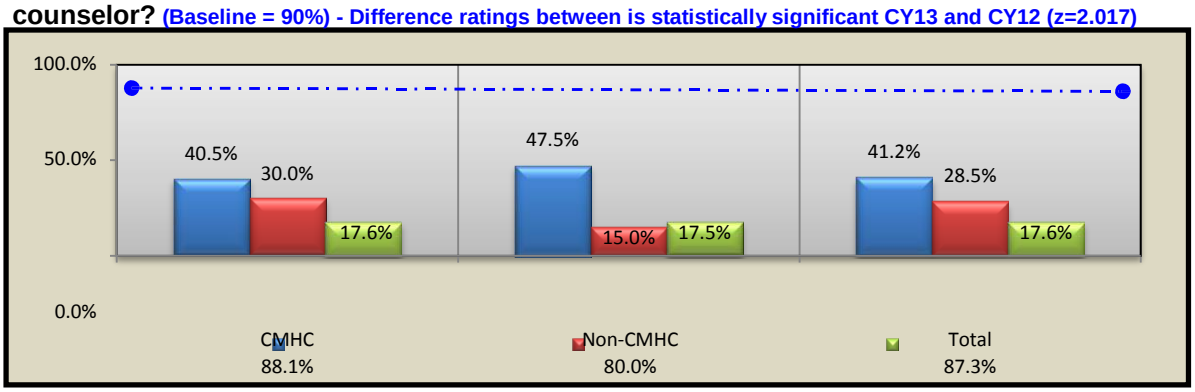
Complaints by Quarter FY 2014



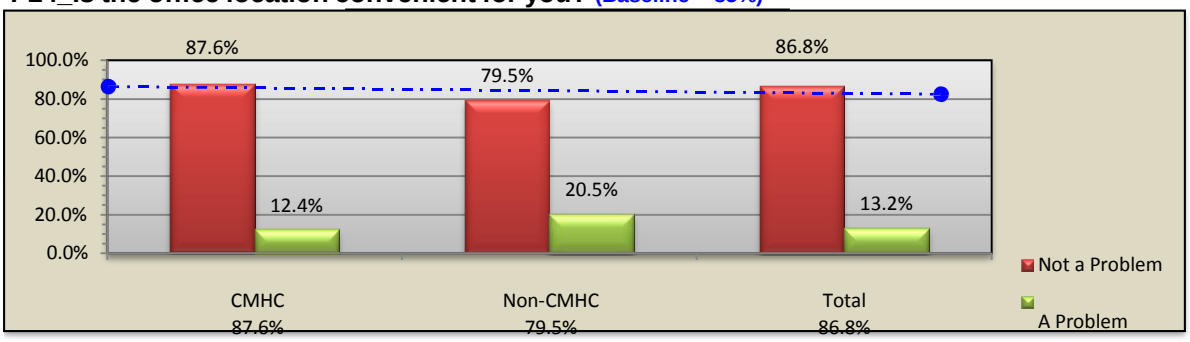
P4_Overall, how satisfied are you with the mental health services of CHP? (Baseline = 90%)



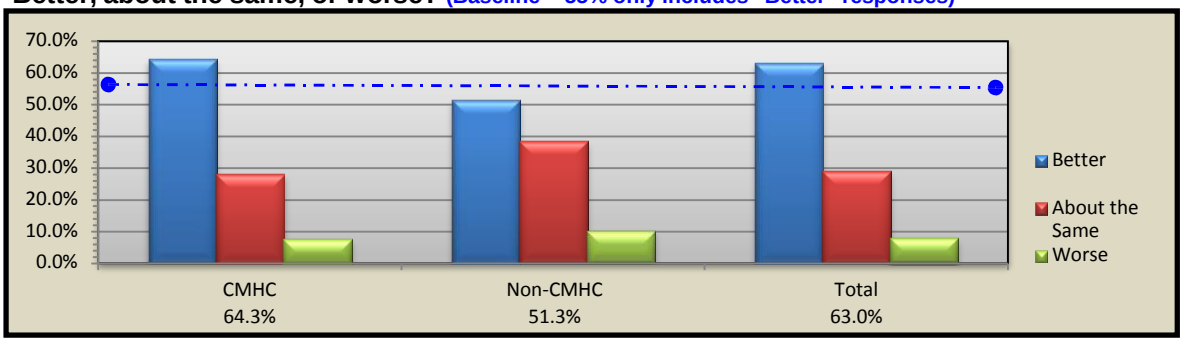
P6_Overall, how would you rate the quality of services you have received from your counselor? (Baseline = 90%) - Difference ratings between is statistically significant CY13 and CY12 (z=2.017)



P24_Is the office location convenient for you? (Baseline = 85%)



P16_Compared to a year ago, how would you rate your problems and symptoms now? Better, about the same, or worse? (Baseline = 55% only includes "Better" responses)



QUESTIONS REGARDING COUNSELOR RATING

P7_Do you feel your counselor is able to meet your cultural, religious and language needs?

	CMHC	Non-CMHC	Total
N=	354	40	394
Counselor Able to Meet Needs	90.4%	92.5%	90.6%
Counselor Was Not Able to Meet	6.5%	5.0%	6.3%
No Opinion	3.1%	2.5%	3.0%

P8_Do you feel your counselor protects your confidentiality?

	CMHC	Non-CMHC	Total
N=	354	40	394
Counselor Protects Confidentiality	94.6%	90.0%	94.2%
Counselor Does Not Protect Confidentiality	2.3%	10.0%	3.0%
No Opinion	3.1%	0.0%	2.8%

P9_Has your counselor involved you in decisions about your care?

	CMHC	Non-CMHC	Total
N=	349	40	389
Member Involved in Care Decisions	90.0%	85.0%	89.5%
Member Not Involved in Care Decisions	10.0%	15.0%	10.5%

P10_Has your counselor helped you make needed changes in your life?

	CMHC	Non-CMHC	Total
N=	394	40	354
Counselor Helped With Needed Changes	78.8%	77.5%	78.7%
Counselor Did Not Help With Needed Changes	15.5%	15.0%	15.5%
No Opinion	5.6%	7.5%	5.8%

P11_Do you feel your counselor is just right for your needs?

	CMHC	Non-CMHC	Total
N=	340	38	378
Counselor is Right	85.3%	86.8%	85.4%
Counselor Not Just Right	14.7%	13.2%	14.6%

QUESTIONS RELATED TO OUTCOMES OF SERVICES

P7_How much were you helped by the counseling you got?
A great deal, somewhat, not much

	CMHC	Non-CMHC	Total
N=	346	40	386
A Great Deal	51.7%	60.0%	52.6%
Somewhat	37.0%	27.5%	36.0%
Not Much at All	11.3%	12.5%	1.4%

P8_ compared to a year ago are you more confident in your ability to handle day-to-day activities?

(only asked of adults

	CMHC	Non-CMHC	Total
N=	219	29	248
More Confident	74.0%	62.1%	72.6%
Not More Confident	18.7%	34.5%	20.6%
No Opinion	7.3%	3.4%	6.9%

P9_Have to talked to a peer specialist?

	CMHC	Non-CMHC	Total
N=	219	29	248
Talked to Peer Specialist	13.2%	27.6%	14.9%
Have Not Talked	69.4%	51.7%	67.3%
No Opinion	17.4%	20.7%	17.7%

P10_In addition to your mental health treatment, do you go to any activities, i.e., drop-in center, self-help group, workshop or class. Only asked of adults

	CMHC	Non-CMHC	Total
N=	244	29	215
Participates in Activities	23.3%	31.0%	24.2%
Does Not Participate	76.7%	69.0%	75.8%

QUESTIONS RELATED TO COORDINATION OF CARE

P21_As far as you know has your counselor sent any information or discussed your care with your medical doctor?

	CMHC	Non-CMHC	Total
N=	354	40	394
Counselor Communicated	36.4%	37.5%	36.5%
Did Not Communicate	42.9%	45.0%	43.1%
No Opinion	20.6%	17.5%	20.3%

P22_Is Your Medical Doctor Aware that you have received mental health services?

	CMHC	Non-CMHC	Total
N=	354	40	394
MD is aware	87.0%	77.5%	86.0%
MD not aware	6.8%	10.0%	7.1%
No Opinion	6.2%	12.5%	6.9%

Questions Related to Access

P24_Can you get to the counselors office in less than 30 minutes?

	CMHC	Non-CMHC	Total
N=	352	39	391
Can get to office	83.5%	89.7%	81.4%
Cannot get to office	16.5%	10.3%	15.9%

P25_Thinking back to your first appointment with the counselor, Was this first appointment within the last year?

	CMHC	Non-CMHC	Total
N=	343	39	382
Within last yr.	62.4%	43.6%	60.5%
Longer than 1 year ago	37.6%	56.4%	39.5%

P26_Did you get an appointment as soon as you wanted? (References question above)

	CMHC	Non-CMHC	Total
N=	341	39	380
As soon as desired	85.9%	69.2%	84.2%
Did not get as soon as desired	14.1%	30.8%	15.8%

P27_Were you offered your first appointment within a week of your call?

	CMHC	Non-CMHC	Total
N=	307	35	342
Offered within 1 week	73.3%	82.9%	74.3%
Longer than 1 week	26.7%	17.1%	25.7%

P28_Were you offered your first appointment within 10 days of your call?

	CMHC	Non-CMHC	Total
N=	319	36	355
Offered within 10 days	82.4%	86.1%	82.8%
Longer than 10 days	17.6%	13.9%	17.2%

P29_In the last year, have you stayed overnight in a hospital for any counseling or mental health services?

	CMHC	Non-CMHC	Total
N=	354	40	394
Have Received Services in Hospital	9.0%	25.0%	10.7%
Have Not Received Services in Hospital	91.0%	75.0%	89.3%

QUESTIONS RELATED TO HOSPITAL SERVICES (SATISFACTION WITH CARE)

P30_Are you satisfied or dissatisfied with the number of days approved for treatment in the hospital? New question in 2013

	CMHC	Non-CMHC	Total
N=	32	10	42
Satisfied	65.6%	70.0%	66.7%
Dissatisfied	28.1%	20.0%	26.2%
No Opinion	6.2%	10.0%	7.1%

P5_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=	354	40	394
Counselor	59.0%	60.0%	59.1%
Doctor	28.8%	27.5%	28.7%
Case Manager	7.6%	10.0%	7.9%
Someone Else	1.1%	2.5%	1.3%
No Opinion	3.4%	0.0%	3.0%