

**Foothills Behavioral Health Partners (FBHPartners)
Quality Assessment, Performance Improvement Program Plan FY '14**

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FOOTHILLS BEHAVIORAL HEALTH PARTNERS (FBHPartners)

QUALITY IMPROVEMENT WORK PLAN FY '14

FBHP develops an annual Quality Improvement Plan (QI Plan) to guide its performance improvement activities. The QI Plan describes in detail the QAPI program activities of performance indicator development and refinement, ongoing and time-limited performance improvement projects or focused studies and other monitors to ensure quality care. QI Plan activities derive from a number of sources of information about quality of care and service issues. These include client and family feedback, Department and Federal requirements, national public behavioral health agendas and initiatives, for example, the Institute of Medicine's Quality Chasm Series, FBHP-specific utilization information, such as hospital recidivism and issues identified through performance evaluation. New for this year's plan is the addition of Substance Use Disorder (SUD) benefits and providers, beginning 1/1/14. Development measures are added for each Quality of Care dimension as FBHP implements this new Member benefit.

Structure of the Plan

The QI Plan includes five essential Quality of Care dimensions:

- *Access to Care: Ensuring that members have ready access to all necessary services within the comprehensive FBHP network;*
- *Member and Family Service and Satisfaction: Enhancing member and family satisfaction with FBHP service quality and care outcomes;*
- *Care Quality and Appropriateness: Analyzing and supporting continual improvement of FBHP clinical and administrative processes in order to achieve the highest standard of care, with care processes that are recovery oriented, evidence-based and culturally sensitive;*
- *Outcomes and Effectiveness of Care: Developing a well-designed system of outcome measurement to ensure that FBHP provider services are linked to positive outcomes and objective progress toward client resilience and recovery; and*
- *Care Coordination and Integration: Ensuring provider procedures support effective behavioral health and physical health coordination and support, though evaluation and innovative models of integration.*

Responsibility for the Plan

The Chief Quality Officer (CQO), with oversight from the QI/UM Committee, has overall responsibility for the QI Plan, its development, implementation and evaluation. Annually, the CQO established a QI Plan based on an evaluation of the previous year's QI Plan; input from clients, families and providers; results from the Department's External Quality Review and changes to the Department's performance requirements. The QI Plan is submitted to the QI/UM Committee for review and approval and to the Department for final approval. Performance through monthly updates and quarterly reports.

Quality Dimension #1: ACCESS TO CARE

Access to Care Issues	Indicator/Benchmark/Goal	Plan	Timetable
Monitoring Status			
1a. Timeliness of response to Emergency and Urgent Requests	1a. 1. Hours to emergency contact Standard: By phone within 15 minutes of initial contact; 100% in person within 1 hour of request in urban/suburban areas. Goal: Maintain standard 100% of the time 1a. 2. Hours to urgent face to face contact Standard: Within 24 hours of contact Goal: Maintain standard 100% of the time	1a. 1 & 2. Monitor quarterly indicator results compared to goal. Implement improvement project and/or provider corrective action if below standard for two quarters.	1a. 1 & 2 Review quarterly with QI/UM committee
1b. Timeliness of response to first routine offered appt	1b. Days to first routine offered appointment date Standard: 100% within 7 business days. Goal: Maintain standard 100% of the time	1b. Monitor quarterly indicator results compared to goal. Implement improvement project and/or provider corrective action if below standard for two quarters	1b. Review quarterly with QI/UM committee
1c. Overall Member access	1c. Overall Access: Proportion of Medicaid eligible Members who receive a FBHPartners provider service (rolling 12-month) overall, by age group, and population category. Benchmark: Overall BHO penetration rates, total, by age group and eligibility category, FY '13 Goal: Above the previous fiscal year BHO penetration rates overall and for all age groups and eligibility categories.	1c. Monitor indicator results Quarterly (12 month period) compared to goal. Consider improvement project if two quarterly reports indicate below BHO percent.	1c. Review quarterly with QI/UM committee
1d. Phone response	1d. Member call abandonment rates Benchmark: <3% Goal: Below the benchmark percent call abandonment rate	1d. Monitor indicator results quarterly compared to goal. Consider improvement project if goal not met for two quarters.	1d. Review quarterly with QI/UM committee

Access to Care Issues	Indicator/Benchmark/Goal	Plan	Timetable
1e. Access for Members with a HCBS waiver for Community Mental Health Supports	1e. Percent members with a Community Mental Health Supports Waiver, both living in an ACF or overall, with one or more behavioral health service in previous 12 months Goal: Maintain percent at 90% or above of members with a Community Mental Health Supports Waiver, with one or more behavioral health service in previous 12 months.	1e. Monitor indicator results quarterly compared to goal. Consider improvement project if goal not met for two quarters.	1e. Review quarterly with QI/UM committee
1f. Access to outpatient care after initial assessment	1f. Average days to the next face-to-face attended contact after the initial intake and assessment. Goal: At or below an average of 9 business days	1f. Monitor indicator results quarterly compared to goal and continue to assess appropriateness of goal	1f. Review quarterly with QI/UM committee
Development Status			
1g. Access to prescriber	1g. For members with an attended prescriber visit, the average number of days from initial intake to initial prescriber visit. Goal: Determine criteria for appropriate goal	1g. Begin collecting data quarterly. Develop appropriate criteria for goal	1g. Review quarterly with QI team
1h. Access for Members with SUD	1h. Goal: Establish with HCPF and QI team appropriate measures for access for Members with SUD including inclusion in present access measures	1h. Meet goal by 6/30/14	1h. Begin discussion QI team 1/1/14

Quality Dimension #2: MEMBER AND FAMILY SERVICE AND SATISFACTION (Grievance monitoring in Appendix A)

Client/Family Service/Satisfaction Issue	Indicator/Standard/Benchmark/Goal	QI Initiative/Plan	Timeline for QI Initiative/Plan
Monitoring Status			
<p>2a. Member/family/Youth Perception of Access</p>	<p>2a 1. Percent adult respondents agreeing with the MHSIP six Access domain items, family respondent with the two YSS-F, and youth with the two YSS Access domain items. Benchmark: Percent overall agreement, BHO Access domain items, for the fiscal year on the MHSIP, YSS-F, and YSS survey Goal: FBHPartners' survey results will, at a minimum, be above the lower confidence interval for the BHO's overall percent agreement</p> <p>2a 2. Percent adult and family respondents strongly agreeing and agreeing with access items #1, 4 and 6. Goal: FBHPartners' internal survey item 1, 4, and 6 results will, at a minimum, be at or above 80%</p>	<p>2a 1. Monitor performance on the three access indicators annually and consider improvement project if significantly below the overall BHO percent agreement.</p> <p>2a 2. Monitor performance on items #1, 4, & 6 quarterly. If below 80% for 2 quarters consider improvement project.</p>	<p>2a 1 Monitor annually in QI/UM committee</p> <p>2a 2. Monitor quarterly in QI/UM committee</p>
<p>2b. Member Perception of Overall Satisfaction with Service</p>	<p>2b. Percent Adult respondents agreeing With the three MHSIP overall satisfaction domain items. Benchmark: Percent overall agreement for all BHOs for Overall Satisfaction Domain for the fiscal year Goal: FBHPartners' results will, at a minimum, be above the lower confidence interval for BHOs overall percent agreement</p>	<p>2b. As indicated in 2a 1.</p>	<p>2b. As indicated in 2a 1</p>
<p>2c. Client/family/youth Perception of Outcomes</p>	<p>2c 1. Percent adult respondents agreeing with the eight Outcome domain items of the MHSIP survey, family respondents agreeing with the six YSS-F, and youth</p>	<p>2c 1 As indicated in 2a 1</p>	<p>2c. 1 As indicated in 2a 1.</p>

Client/Family Service/Satisfaction Issue	Indicator/Standard/Benchmark/Goal	QI Initiative/Plan	Timeline for QI Initiative/Plan
	<p>respondents with the six YSS Outcome domain items</p> <p>Benchmark: Percent overall agreement, BHO Outcome domain items, for the fiscal year on the MHSIP, YSS-F, and YSS survey</p> <p>Goal: FBHPartners' survey percent agreement will be above the lower confidence interval for the BHOs overall percent agreement</p> <p>2c 2. Percent adult and family respondents strongly agreeing and agreeing with outcome items #8, 10, and 12</p> <p>Goal: FBHPartners' internal survey item 8 and 10 results will, at a minimum, be at or above 80%.</p>	<p>2c 2. As indicated in 2a 1.</p>	<p>2c 2. As indicated in 2a 2.</p>
<p>2d. Client/family/youth perception of care quality and appropriateness</p>	<p>2d. 1. Percent adult respondents' agreement with the nine Quality and Appropriateness of Service domain items on the MHSIP and percent family and youth agreement with the four Cultural Sensitivity and six appropriateness Domain items on the YSS-F and YSS.</p> <p>Benchmark: Percent overall agreement, BHO Cultural and Appropriateness domain items, for the fiscal year on the MHSIP, YSS-F, and YSS survey</p> <p>Goal: FBHPartners' percent agreement, at a minimum, will be above the lower confidence interval for the BHO overall percent agreement</p> <p>2d. 2. Percent adult and family respondents strongly agreeing and agreeing with Cultural and Quality of Care items #3, 5, 9, 12 and 13</p> <p>Goal: FBHPartners' internal survey item 3, 5,</p>	<p>2d. 1 As indicated in 2a 1</p> <p>2d 2 As indicated in 2a 2</p>	<p>2d. 1 & 2 As indicated in 2a. 1</p> <p>2d 2 As indicated in 2a 2</p>

Client/Family Service/Satisfaction Issue	Indicator/Standard/Benchmark/Goal	QI Initiative/Plan	Timeline for QI Initiative/Plan
	9, 12 and 13 results will, at a minimum, be at or above 80%.		
2e. Client/family/youth participation in treatment	<p>2e. 1. Percent adult respondents' agreement with the two Participation domain items on the MHSIP and percent family and youth agreement with the three Participation Domain items on the YSS-F and YSS. Benchmark: Percent overall agreement, BHO Participation domain items, for the fiscal year on the MHSIP, YSS-F, and YSS survey Goal: FBHPartners' percent agreement, at a minimum, will be above the lower confidence interval for the BHO overall percent agreement</p> <p>2e 2. Percent adult and family respondents strongly agreeing and agreeing with Participation items #2, 7, and 11 Goal: FBHPartners' internal survey item #2, 7 and 11 results will, at a minimum, be at or above 80%.</p>	<p>2e. 1 As indicated in 2a 1</p> <p>2e 2 As indicated in 2a 2</p>	<p>2e. 1 As indicated in 2a.1</p> <p>2e 2 As indicated in 2a 2</p>
Development Status			
2f. Service Satisfaction for Members with SUD	2f. Goal: Establish with HCPF and QI team appropriate measures for service satisfaction for Members with SUD including inclusion in present service satisfaction measures	2f. Meet goal by 6/30/14	2f. Begin discussion QI team 1/1/14

Quality Dimension #3: CARE QUALITY and APPROPRIATENESS (EBP Implementation monitoring Appendix B)

Quality/Appropriateness of Care Issue	Indicator/Standard or Benchmark/Goal	QI Initiative Plan	Timetable for QI Initiative/Plan
Monitoring Status			
3a. Coordination/timeliness of hospital follow-up	3a. 7 and 30 day rates of follow-up visit post-hospital discharge all hospital Benchmark: 7 and 30 day rates - Overall BHOs prior fiscal year Goal: At or above benchmark for Overall BHO's 7 and 30 day follow-up rates	3a. Monitor indicator results quarterly compared to goal. Consider improvement project if goal not met for two quarters	3a. Review quarterly in QI/UM committee
3b. Follow-up after residential treatment	3b. Percent members discharged from residential treatment with an offered outpatient appointment within 7 days. Goal: At least 80% of members, discharged from a residential facility, will have an offered 7 day follow-up appt.	3b. Monitor indicator results quarterly compared to goal. Consider improvement project if goal not met for two quarters; continue to investigate errors in data source	3b. Review quarterly in QI/UM committee
3c. Percent members taking duplicative antipsychotic medication	3c. Percent of members prescribed an atypical antipsychotic that are prescribed two or more atypical antipsychotic medications for 120 days or more Benchmark: Percent of Overall BHOs prior fiscal year Goal: At or below the overall FY '13 BHO percent	3c. Monitor indicator results quarterly compared to goal. Consider improvement project if goal not met for two quarters.	3c. Review quarterly in QI/UM committee

Quality/Appropriateness of Care Issue	Indicator/Standard or Benchmark/Goal	QI Initiative Plan	Timetable for QI Initiative/Plan
3d. Effective Acute Phase antidepressant medication management	3d. 1. The percent of newly diagnosed and treated members with major depression who remained on an antidepressant medication for at least 84 days (12 weeks) Goal: At or above the overall BHO percent 2. The percent of newly diagnosed members with major depression who are prescribed an antidepressant and who had 3 follow-up contacts, one of which with a prescriber, within a 12 week period. Goal: At or above the overall BHO percent	3d. 1&2 Monitor quarterly and investigate outliers	3d. Review quarterly in QI/UM committee
3e. Engagement in Behavioral Services	3e. The percent of members with 4 outpatient services, including intake, within 45 days Goal: Above the overall BHO percent	3e. Monitor Quarterly and investigate outliers	3e. Review quarterly in QI/UM committee
3f. Behavioral Health Focal Point of Care	3f. Percent adult members with bipolar or schizophrenic illness with three or more treatment services or two or more medication management services in the study period Goal: Percent at or above BHO overall for FY '12	3f. Monitor indicator results quarterly compared to goal. Consider improvement Project if goal not met for Two quarters.	3f. Review annually in QI/UM committee
Development Status			
3g. Post-residential 7 day follow up	3g. Percent members discharged from residential treatment, who are not readmitted within 7 days, with outpatient appointment attended within 7 days. Goal: Determine criteria	3g. Begin collecting data quarterly and determine appropriate criteria for goal	3g. Review quarterly with QI team
3h. Care Quality and Appropriateness for Members with SUD	3h. Goal: Establish with HCPF and QI team appropriate measures for care quality and appropriateness for Members with SUD including inclusion in present measures	3h. Meet goal by 6/30/14	3h. Begin discussion QI team 1/1/14

Quality Dimension #4: CARE COORDINATION AND INTEGRATION:

Coordination & Integration Concern	Indicator/Standard/Goal	QI Initiative/Plan	Timetable QI Initiative/Plan
Monitoring Status			
4a. Member access to PCP	4a. Percent members (by youth and adults) who received outpatient mental health treatment during the fiscal year with a qualifying physical healthcare visit Goal: At or above the BHO overall percent	4a. Monitor annually.	4a. Review with QI/UM Committee annually
4b. Care Coordination with PCP	4b. Percent members with a prescriber visit, with a care coordination letter sent to the PCP annually Goal: A minimum of 90% of members with a prescriber visit that have a care coordination letter sent to their PCP annually	4b. Monitor Quarterly and consider improvement project if goal not met for 2 quarters	4b. Review with Q
Development Status			
4c. Identified PCP in the member medical record	4c. Percent members, by youth and adults, with an identified PCP in the medical record. The “identified PCP” should be updated annually but doesn’t require a release of information to count in the numerator. Goal: Develop consistency in how data is collected for this measure, and increase capabilities for pulling PCP information from medical record.	4c. Develop consistency in how measure is defined and data collection procedure	4c. Review with QI team quarterly
4d. Improve Access to Care Coordination with Healthcare	4d. Percent of adults with severe mental illness diagnosis, with two or more behavioral health prescriber services, enrolled in CCHA Goal: Determine goal and usefulness of the measure	4d. Begin collecting data quarterly	4c. Review with QI team quarterly
4e. Body Mass Index screening in behavioral health setting	4e. Percent of adults with severe mental illness diagnosis, with two or more behavioral health prescriber services, with BMI documented in the medical record Goal: Clarify criteria for measure as well as method for collection	4e. Meet goal end of 2 nd qtr	4d. Review with QI Team quarterly
4f. Care Coordination and Integration for Members with SUD	4f. Goal: Establish with HCPF and QI team appropriate measures for access for Members with SUD including inclusion in present access measures	4f. Meet goal by 6/30/14	4f. Review with QI Team quarterly

Quality Dimension #5: OUTCOMES AND EFFECTIVENESS OF CARE

Outcome of Care Concern	Indicator/Standard/Goal	QI Initiative/Plan	Timetable QI Initiative/Plan
Monitoring Status			
5a. Hospital readmissions, 7, 30, and 90 days after discharge	5a. 7, 30 and 90-day hospital recidivism rates Benchmark: Annual overall BHO 7, 30, and 90-day recidivism rates, prior fiscal year. Goal: At or below benchmark, overall BHO 7, 30, and 90 day recidivism rates	5a. Monitor rates quarterly (12-month periods) comparing with overall BHO rates previous fiscal year Performance improvement project implemented FY '12 (see Appendix A)	5a. Review quarterly with QI/UM committee Report project status quarterly with QI/UM committee
5b. Outpatient crisis care effectiveness	5b. Number of ED visits/1,000 Members that do not result in hospitalization (rolling 12-month) Benchmark: Annual overall BHO ED visits/1,000 Members, prior fiscal year Goal: Below the BHO ED visits/1,000 rate	5b. Monitor indicator quarterly (12-month periods) compared with overall BHO rates previous fiscal year. Informal improvement project implemented in FY '13. Continue project (See Appendix A)	5b. Review quarterly with QI/UM committee
5c. Maintenance and improvement in independent living status	5c. 1. Percent members maintaining independent living status in 12 month period Goal: At or above 95% 2. Percent members progressing toward independent living Goal: Above the BHO percent previous fiscal year	5c. Monitor quarterly. Consider improvement project if goal isn't met	5c. Review with QI/UM committee quarterly
Development Status			
5d. 30 and 90 Day ATU Recidivism	5d. Percent members by youth (through age 18) and adults (age 19+) with a ATU readmit 30 and 90 days after ATU (ATU-like for youth) discharge Goal: Determine appropriate goal or baseline for monitoring	5d. Achieve goal by 1/1/14	5d. Review
5e. Lack of BH symptom improvement	5e. Goal: Work with Mental Health Centers, BHO QI Directors, and HCPF to identify appropriate outcome measures for	5e. Complete goal end of FY '14	5e. Review in QI/UM as needed to

outcome measures for Members in treatment	improvement in member self-reported symptoms		achieve goal
4f. Outcomes and Effectiveness for Members with SUD	4f. Goal: Establish with HCPF and QI team appropriate measures for outcomes and effectiveness for Members with SUD including inclusion in present access measures	4f. Meet goal by 6/30/14	4f. Review with QI Team quarterly

Appendix A
Performance Improvement Plan, FY '14

I. Performance Improvement Projects (PIP)/Focused Studies:

- 1. Focus Study:** Improving Care Coordination/Care Management for Members with Severe Mental Illness

Timeline: 10/1/2012 through 9/30/2013

Description of Problem: The intent of this focus study is to complete efforts, begun in a FY '12 focus study "Design of a Healthcare Management Program" to establish a best practice for care coordination/care management for individuals with severe mental illness, specifically those with schizophrenia, schizoaffective, or bipolar disorder. FBHPartners, through the FY '12 focus study, met two key objectives toward this best practice design goal:

1. Developed and tested an audit tool to assess fidelity to the Healthcare Management Program. Through a baseline audit of 411 medical records, sampled from the study population, FBHPartners was able to identify gaps in adherence to the best practice guideline.
2. Developed a self-report health behavior survey. Through its administration, to a sample of 127 members from the study population, FBHPartners identified self-reported health behaviors that may affect members' prevention and management of cardiovascular disease and/or diabetes.

Results of the medical record audit indicated significant gaps in documenting basic screening, health risk assessment, care coordination, and health education, with only 6.3% of the 411 audited medical records receiving "met" status on 80% of the audit items (see Table 1.) Documentation of annual screening of key medical indices, such as blood pressure, BMI, glucose, and lipids, was at 2.2% and only 25% documented coordination with the primary care provider, including obtaining physical health records. In addition, less than half of the records had documentation as to the clients "risk status" for cardiovascular disease or diabetes. Last, indication of health education provided, was found in only about 20% of audited records, which falls short of meeting members' needs, with health behavior survey results suggested that more than half of respondents continue to smoke, more than one fourth were inactive, and many had poor nutrition habits, including two-thirds eating fast food weekly and about half lacking daily consumption of fruit and vegetables.

These FY '12 focus study results highlight the importance of implementing and supporting a best practice care coordination/care management guideline for this at risk study population. In addition, further refinement of the guideline may be needed, as findings indicated a larger than expected gap in care coordination activities, including limited documentation of key physical health information. FBHPartners, based on recent data indicating that only 23.2% of the at risk study population are enrolled in the Regional Colorado Care Organization (RCCO), has begun collaborative efforts with the RCCO to increase this percent in order to expand access to RCCO care coordination (see Table 1). Along with this strategy, additional collaborative efforts, with

the RCCO, are needed, including improved access to physical health and utilization information, to focus care coordination efforts.

Table 1: Baseline to re-measurement

Measure	FY '12 (baseline)	FY '13
HCM audit (80% with met status)	6.3%	
CCHA enrollment	23.2%	

Study Questions:

1. Do focused interventions, including the pilot of the Healthcare Management Program and enhanced care coordination efforts with the Regional Colorado Care Organization (RCCO) significantly improve adherence to the Healthcare Management best practice guideline?
2. Does improved information and education, provided to members diagnosed with schizophrenia, schizoaffective and bipolar disorder, about the benefits of contacting and self-attributing their physical health care, with the RCCO, significantly improve the percent of this population enrolled in the RCCO?
3. What are the chronic physical health issues and overall healthcare utilization for the study population, identified through a collaborative process of information sharing with the RCCO?

Interventions:

1. Implementation of the Healthcare Management Program
2. Develop efficient procedures and processes for routine sharing and tracking of physical health and behavioral health information between behavioral health and physical health providers
3. Implement procedures to increase percent of the study population enrolled in the RCCO

Measures:

1. The percent of the study population with documentation of key components of the Healthcare Management Program, defined as $\geq 80\%$ of items on the Healthcare Management Audit Tool receiving a “met” or “partially met” status
2. Significant increase in the percent of the study population enrolled in the RCCO and with an attributed PCMP
3. Descriptive health information (chronic physical health issues, physical health “at risk” factors, and healthcare utilization data) for the study population

2. Performance Improvement Project: Reducing Overall 90 Day Hospital Recidivism

Timeline: 7/1/2012 through 6/30/2014 (baseline FY'12)

Description of Problem: The intent of this project is to significantly reduce the percent of discharges with a 90 day hospital readmission, for a covered behavioral health diagnosis, from the percent reported in FY'12. FBHPartners noted a steady increase in all hospital 90 day recidivism rates from FY '10 through FY '12. FBHPartners' 90 day recidivism rate went from 12.9%, three standard deviations below the Overall BHO recidivism percent, in FY '10, to 19.5%, more than three standard deviations above the BHO weighted average percent in FY '12 (Table 1).

Table 1. FBHPartners 30 and 90 Day Recidivism FY'10 and FY'12

Days to Readmit	FY '10 (n=349)	FY '12 (n=379)
30 days	7.7%	10.8%
90 days	12.9%	19.5%

A comparison of recidivism percent between FY '10 and FY '12 by adolescent and adult age groups, which comprise more than 90% of readmissions, is provided in Table 2. For all hospital recidivism the adolescent age group 90 day percent went from, in FY'10, three standard deviations below the BHO percent, to, in FY '12, three standard deviations above the BHO recidivism percent. For the adult age group FBHPartners 90 day recidivism percent, went from three standard deviations below, in FY '10, to more than three standard deviations above the BHO weighted average in FY '12.

Table 2. FBHPartners 30 and 90 Day Recidivism FY '10 and FY '12 by Adolescent and Adult Age Group

Days to Readmit	Adolescent FY '10 (n=86)	Adolescent FY '12 (n=69)	Adults FY '10 (n=226)	Adults FY '12 (n=278)
30 days	5.8%	4.4%	8.9%	13.0%
90 days	12.8%	14.5%	12.8%	21.9%

Study Question: Do focused interventions, to provide timely and effective behavioral health follow-up care, after hospital discharge, for members with an all hospital discharge, for treatment of a covered mental health disorder, significantly reduce the percent of hospital readmissions, 90 days after discharge for another treatment episode of a covered mental health disorder?

Interventions: An initial cause analysis resulted in the following interventions in FY '13

1. Implementation of same day or next day prescriber appointments for clients discharged from the hospital (Urgent care model at MHP and Real Time clinic at Jefferson Center)
2. Development of Hospital Discharge Follow Up Guidelines to standardize follow up procedures at Jefferson Center, Mental Health Partners and IPN:
 - a. All members with a psychiatric hospitalization, for a covered mental health diagnosis, will have a hospital liaison who will work with the hospital treatment team, the member, and family to plan hospital follow-up. The liaison will see the

- client/family face-to-face in the hospital, and at discharge, clients should have a crisis/self-care plan in place that is communicated with the follow-up provider.
- b. At discharge the hospital liaison will ensure the member, at a minimum, has a 7-day (calendar day) face-to-face follow-up appointment and a prescriber follow-up appointment within 10 calendar days (unless discharged to residential treatment facility or determined by Medical Director as not needed). A follow-up contact with the provider will be initiated to ensure the client attended the 7-day and 10-day prescriber appointment. If the client no-shows, an outreach call is made and another appointment is scheduled as soon as possible.
 - c. FBHPartners expects that, within 30 days of hospital discharge, that the client receives at least 3 clinical visits and 1 prescriber visit. If the client no-shows for any clinical visits within 30 days of hospital discharge a follow-up with the client will be initiated to ensure another appointment is scheduled as soon as possible.
 - d. The hospital liaison/care coordinator checks in with the client weekly, throughout the first 30 days, to assess effectiveness of the discharge plan and that follow-up appointments are in place.
 - e. If the client is discharged from a hospital to residential there should be a follow-up appointment scheduled within 7 days of the residential discharge. If the residential discharge is within 30 days of the hospital discharge then all follow-up requirements described above are relevant.
3. FBHP worked with Value Options to hire care coordinators to provide transition care or intensive care management (ICM) for IPN clients and clients in out of area hospitals.

Measures

The percent of all hospital Member discharges, for treatment of a covered mental health diagnosis, which does not result in a re-hospitalization within 24 hours, with a readmission for another hospital episode for treatment of a covered mental health diagnosis, within 90 days after the date of discharge.

Re-measurement Status: The first re-measurement will occur in FY'13. Data will be available in December, 2013 to assess progress towards improving recidivism rates. The 2nd re-measurement will occur in FY'14 (see Table 3).

Table 3: Baseline to 1st and 2nd Re-measurement

Days to Readmit	FY '12 (n=379)	FY '13	FY '14
90 days	19.5%		

3. Collaborative Performance Improvement Project

FBHPartners will collaborate with HCPF to develop and implement one Performance Improvement Project that combines efforts of BHOs, MCOs and RCCOs for improving quality of care for Medicaid members.

II. Other Quality Improvement Activities, FY '13

1. Improvement in FBHPartners Internal Survey Return Rates

Results of the FBHPartners' Client Survey and Family Survey, have continued to demonstrate low return rates, approximately 16.1% and 12.4% respectively, for FY'13. FBHPartners will continue efforts to collaborate with the Mental Health Centers in order to revise the internal survey and/or survey administration procedure.

2. Monitoring Provider Quality of Care Concerns

Continue to monitor trends in provider quality of care concerns, reporting to QI/UM committee annually, including improvements implemented as a result of this monitoring effort.

3. Practice Guideline Development FY '14

FBHPartners, and its two partner mental health centers, Jefferson Center and Mental Health Partners, in collaboration with NBHP and its three partner mental health centers, Centennial, Touchstone Health Partners, and Northrange MHC, and ValueOptions will be completing the following new or revised guidelines in FY '14, as part of this committee's one year plan:

FY '14:

- Revise: Panic Disorder
- New: Generalized Anxiety Disorder
- Revise: Obsessive Compulsive Disorder
- New: Borderline Personality Disorder

4. Monitor Grievances for any unusual trends in type or QOC concerns biannually.

5. Reduce Emergency Department Utilization

Emergency department utilization has been steadily rising over the past few years, increasing from 5.7 per 1000 members in FY'11 to 9.7 in FY'12. ED utilization in FY '13 is currently slightly higher than FY'12 at 10.9/1000 for the 3rd Quarter. However rates dropped slightly in the last quarter. FBHPartners will monitor final FY'13 results and consider a causal analysis and strategy implementation to decrease ED utilization in FY'14 if appropriate. Additional strategies planned for Fall 2013, including implementation of crisis stabilization units, may have a positive effect on reducing ED utilization.

6. Care Coordination with Colorado Community Health Alliance (CCHA)

FBHPartners will continue collaborative efforts with the area RCCO, Colorado Community Health Alliance (CCHA), to provide effective care coordination for Medicaid members. Collaborative efforts, for FY '14, include establishing consistent procedures for efficient data exchange, developing collaborative care coordination projects and clarifying roles and responsibilities for effective care coordination.

7. Depression Screening and Referrals in Primary Care

FBHPartners, for FY '14, will continue collaboration with CCHA, in the completion of the Adult Medicaid Quality Grant tasks outlined in the Grant awarded to CCHA in FY'13 (See Appendix C for project description).

8. Increase Collaboration with Pediatric Medical Care

FBHPartners will work with Partner Mental Health Centers, area pediatric primary care offices, and HCPF to expand the behavioral health referral project that began in FY'13 in collaboration between HCPF and the BHO Quality Improvement Directors. The purpose of this project is to increase access to behavioral health services for children and families by implementing standardized procedures for referrals to behavioral health services and to increase collaboration and communication between behavioral health and physical health providers (See Appendix D for project description).

9. ACF/NCF Survey

FBHPartners, in FY '14, will follow up with ACF/NCF facilities surveyed in FY'13, to reassess facilities' satisfaction with behavioral health services and follow up on any areas of previous concern and identify any progress in these areas. FBHPartners will coordinate with Partner Mental Health Centers to communicate progress and ensure that any concerns are addressed and facilities are appropriately outreached to increase care coordination for these Medicaid members.

Appendix B
FBHPartners Evidence-Based Practices
Implementation and Reporting Plan FY'14

FBHPartners continues reporting on the 17 evidence based practices or promising practices that have been implemented since FY '10. Data reporting will include descriptive and clinical information regarding members treated in the program, including program outcomes and fidelity. A final report will be completed in FY '14 providing on overall evaluation of program utilization, outcomes, and effectiveness for all EBP's/Best Practices. Summary recommendations will be provided for future EBP implementation and tracking.

EBPs/Best Practices Implemented since FY '10:

- **Integrated Dual Diagnosis Treatment (IDDT):** Jefferson Center; Adults
- **Supported Employment:** Jefferson Center; Adults
- **Functional Family Therapy (FFT):** Jefferson Center and MHP (youth)
- **Families Together:** Jefferson Center (youth)
- **Multi-systemic Therapy (MST):** Jefferson Center (youth)
- **Senior Reach:** Jefferson Center and MHP (senior adults)
- **Assertive Community Treatment (ACT):** MHP (adults)
- **Wellness Management & Recovery (WMR):** MHP (adults)
- **Dialectical Behavior Therapy (DBT):** Jefferson Center and MHP (adults)
- **Trauma-based Cognitive Based Therapy:** Jefferson Center (youth)
- **CrossRoads:** Jefferson Center (youth)
- **Psychosocial Rehabilitation:** MHP (adults)
- **Peer Services:** Jefferson Center and MHP (adult)
- **Early Intervention Services:** Jefferson Center (children)
- **Not on Tobacco (N-O-T):** Jefferson Center (youth)
- **Home-based Community Infant Program (CIP):** MHP (children)
- **Family-to-Family:** Jefferson and Boulder Counties (adults)

Appendix C
Adult Quality Grant
Depression Screening in Primary Care

Purpose:

An Adult Medicaid Quality Grant was awarded to Colorado Community Health Alliance (CCHA) with intent to increase the incidence of depression screening for adult Medicaid clients.

Summary:

CCHA, in collaboration with FBHP, developed and implemented a standardized depression screening tool and referral process within regional primary care practices. Creating standardized referral processes between PCMPs and the area Mental Health Centers (MHC's) is intended to strengthen collaboration and ease access to services once depression is identified.

The first phase of the project, beginning in early FY '14, involved the implementation of the screening and referral program at one PCMP offices in Jefferson County and Boulder/Broomfield County. Implementation involve providing practices with standardized depression screening tools, instructions for administration, best practices in depression care referral and treatment, educational materials for providers and patients about depression and treatment options, and design of a referral process. CCHA will provide IT and coaching assistance to create standard practices for screening and referrals. Phase two expands efforts to a total of 6 PCMPs with the regional counties, with an emphasis on embedding the screening tool into the medical record.

FBHP's key tasks:**Completed:**

- Researched and developed materials related to best practices in depression screening, referral, and treatment recommendations
- Developed educational materials for medical providers and PCMP staff on depression screening, how to assess for and talk with patients about depression and suicide, depression treatment options and follow up care recommendations
- Developed educational materials for patients on depression, treatment options and self-management tips

In progress:

- Work with the mental health centers to develop a referral process, including a system for tracking and follow up on referrals
- Assist in providing training to the PCMPs related to depression care

Appendix D

Pediatric Referral Process Project

Purpose: To implement standardized procedure for referring children and families to behavioral health services based on identified need by pediatric primary care offices and to increase collaboration and communication between behavioral health and physical health providers.

Identified barriers to Present Referral Process: Through communication with pediatric offices, Jefferson Center for Mental Health, and HCPF, the primary barriers, to the present referral process, identified included:

- Pediatric offices unfamiliar with referral form and process and rarely, if ever, use the form when making a referral
- Pediatric offices lack of familiarity with the mental health centers or services provided, and/or lack of specific contact person at the mental health centers
- Pediatric offices report that they don't hear back after a referral has been made
- Lack of clear feedback loop to let providers know that the family has engaged with services
- Long wait time for access to psychiatry
- Mental health center noted that the referral form does not include a place for family's phone number
- Mental health center doesn't have a specific contact at most of the pediatric offices, and often difficult to get in touch with someone directly

FBHP Steps to address barriers (began in Summer 2013):

- Workgroup established at Jefferson Center, along with FBHP QI team, includes the Family Services Manager, who serves as the primary contact for pediatric referrals, Pediatric Care Coordinator, and Director of Family Services
- FBHP contacted pediatric practices identified by HCPF to inquire about barriers
- Requested/received assistance from CCHAP to facilitate contact with pediatric offices
- Provided pediatric offices with: updated referral form (with family phone # included), education about referral process, importance of using referral form in order to ensure feedback loop, and names and phone numbers of specific contacts at the mental health center and FBHP who will follow up on referrals
- Face to face meeting with Arvada Pediatrics, Jefferson Center and FBHP staff, to assess current barriers and effective strategies, increase collaboration, and educate about behavioral health service options
- Additional meetings have been set with Rocky Mountain Pediatrics, Kids First Pediatrics, and Peak Pediatrics, during the month of July, to continue outreach and collaboration with pediatric offices with intent of increasing: face to face contact, awareness of standardized referral form and process, education of behavioral health services available through Jefferson Center and FBHP independent provider network
- FBHP working with mental health centers and Value Options to ensure standard tracking of referrals received and follow up procedures

Evaluation of Referral Process. FBHP intends to track by month all referrals through this procedure and implement a Pediatric Office satisfaction survey January 2014.