June 7, 2021

William Elsass, MD
Chief Medical Officer
Mind Springs Health
136 Windward Cir
Breckenridge, CO 80424

Dear Dr. Elsass,

On April 9, 2021, Rocky Mountain Health Plans (RMHP) temporarily suspended payment authorizations to Mind Springs Health and West Springs Hospital after identifying quality of care issues that could present a risk of severe or immediate harm to our Members.

RMHP's Quality Team has since completed a focused review of the medical records of 112 RMHP Members who have received inpatient or outpatient services from Mind Springs Health or West Springs Hospital. Pharmacy information collected from a claims data review identified outpatient Members who were prescribed high doses of benzodiazepine equivalents (80 mg of diazepam per day or greater) between February 1, 2020, and February 28, 2021. The diazepam equivalent conversion was based on the Ashton Manual: https://benzo.org.uk/manual/. The same date parameters were used to review a report of the inpatient Members identified as having a readmission within 30 to 60 days. Known member deaths, overdoses, and attempted suicides were also included in this report.

RMHP requested that Mind Springs Health and West Springs Hospital provide medical record documentation for the 112 Members. The medical records we received were divided into two groups: the records for Members who received outpatient services, and the records for Members who received inpatient services.

A Quality Auditor reviewed the medical records for quality of care concerns and submitted all files to a RMHP Behavioral Health Associate Medical Director for a second review. All OUTPATIENT medical records were also sent to a second Behavioral Health Associate Medical Director for a third independent review. Any INPATIENT medical record that has a Severity Index Rating (SIR) level of 2 or greater from the first Medical Director were sent for a third independent review as well.

The following Severity Index Rating (SIR) scale was used to score each case.

SIR Rating Levels:

0 No Quality of Care Concern Identified
1 No Detrimental Effect
2 Minor Short-term Impact
3 Moderate Impact
4 Quality of Care Concern- Severe Life- Threatening Impact

Additionally, the RMHP Quality Team reviewed the Mind Springs Health and West Springs Hospital Policies and Procedures. The documentation reviewed included policies related to Peer Review; Appeals and Grievances; Member Rights and Responsibilities; EMTALA Transfers; and Admissions, Discharge, and Suicide Precautions.

Outpatient Review: The Quality Team reviewed the medical records of 58 RMHP Members who received outpatient services at Mind Springs Health. These records were reviewed for quality of care issues.

The following levels were identified:

- 1.7% (1/58) of the medical records reviewed were determined to have a SIR of 2.
- 39.7% (23/58) of the medical records reviewed were determined to have a SIR of 3.
- 48.3% (28/58) of the medical records reviewed were determined to have a SIR of 4.

Of the 52 medical records reviewed for outpatient services and identified as having a quality of care concern (SIR 2, 3 or 4), one physician was involved in the care of 18 of the Members (34.6%).

Inpatient Reviews: RMHP reviewed medical records for 54 Members, which resulted in a review of 208 actual episode for those who received inpatient services at West Springs Hospital. These records were reviewed for quality of care issues.

The following levels were identified:

- 22.2% (12/54) of the medical records reviewed were determined to have a SIR of 2.
- 22.2% (12/54) of the medical records reviewed were determined to have a SIR of 3.
- 3.7% (2/54) of the medical records reviewed were determined to have a SIR of 4.

Of the 26 medical records reviewed for inpatient services and identified as having a quality of care concern (SIR 2, 3 or 4), one physician was involved in the care of one of the Members (3.8%).

The RMHP review of Members' medical records reveals the following areas of concern:

Outpatient:

- Mind Springs Health Policies and Procedures were deficient in describing quality processes specific to the oversight and implementation of quality programs.
- The peer review oversight process was inconsistent. Some reviews met peer review standards, while others did not meet standards. There was no indication that deficient findings were reviewed or acted upon.
- The review identified inconsistent transition processes, including post discharge follow-up after an inpatient stay.

- In reviewing prescribing practices, the quality review identified:
    - A pattern of prescribing benzodiazepines and other controlled substances with a 30-day supply for high-risk patients, including at least one patient experiencing suicidal ideation.
    - Early and multiple refills dispensed without a corresponding visit for individuals at risk for, or known to have, an opioid use disorder or other addictions.
    - A pattern of prescribing sedative hypnotics for patients undergoing treatment for opioid use disorder.
    - Members were prescribed simultaneous controlled substances, such as stimulants and benzodiazepines at high doses, increasing potential for overdose and addiction.
    - There was a lack of communication, or other coordination with outside providers prescribing other sedatives, such as Suboxone or muscle relaxants.
    - There was no documentation of monitoring for members being prescribed controlled substances, such as monitoring the Prescription Drug Monitoring Program (PDMP) controlled substance database or performing drug screens.
    - There was a lack of documentation in the chart of the specific rationale for prescribing controlled substances or justifying the prescribing by documenting diagnoses or symptoms that are FDA approved for those controlled substances.
    - There was a practice of prescribing sedatives at high doses with other meds that are highly sedating at high doses, such as Seroquel or Gabapentin and not monitoring or documenting levels of sedation.

Inpatient:

- West Springs Hospital Policies and Procedures were deficient in describing quality processes specific to the oversight and implementation of quality programs.
- The peer review oversight process was inconsistent. Some reviews met peer review standards, while others did not meet standards. There was no indication that deficient findings were reviewed or acted upon.
- Inconsistent transition processes, including post discharge follow-up after an inpatient stay.
- In reviewing prescribing practices, the quality review identified:
    - Members were prescribed simultaneous controlled substances, such as stimulants and benzodiazepines at high doses, increasing potential for overdose and addiction.
    - There was a lack of documentation in the chart of the specific rationale for prescribing controlled substances or justifying the prescribing by documenting diagnoses or symptoms that are FDA approved for those controlled substances.
    - A pattern of prescribing benzodiazepines and other controlled substances with a 30-day supply for high-risk patients, including at least one patient experiencing suicidal ideation.

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RMHP is requesting a written response to each of the areas of concern identified above which includes:

- A written Corrective Action Plan that articulates Mind Springs Health and West Spring Hospitals current and intended efforts to address the deficiencies identified above.
- Identification of methods for improvement, implementation and evaluation of policies and procedures specific to the oversight of prescribing practitioners.

Please send the requested responses to RMHP at the address below **no later than June 18, 2021**.

Rocky Mountain Health Plans
QI Department
Attn: Dr. Lisa Latts
Chief Medical Officer, RMHP
PO Box 10600
Grand Junction, CO 81502

Please feel free to call should you have any questions regarding this letter at 303-888-6002.

Sincerely,

Lisa Latts, MD, MSPH, MBA, FACP
Chief Medical Officer

Cc: Patrick Gordon, CEO