BHI Annual Quality Report

Fiscal Year 2014

Quality Improvement Department
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Section 1: Executive Summary

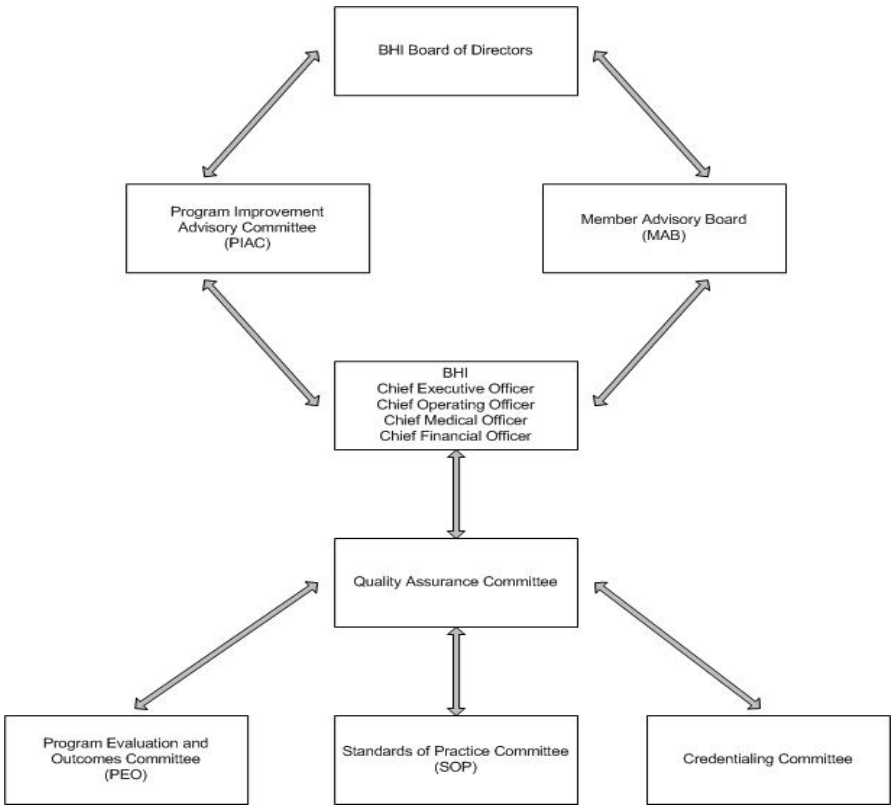
Behavioral Healthcare, Inc.'s (BHI) Quality Improvement (QI) Program is modeled after the Total Quality Management (TQM) System. This model allows BHI departments the sharing of knowledge to provide multidimensional health care management and incorporate business intelligence into programmatic decision-making. BHI departments work collaboratively to implement and maintain a continuous process of quality assessment, measurement, intervention, and re-measurement of service and outcome related measures.

The QI program at BHI has demonstrated a great deal of progress in FY14. The QI program is committed to continued growth and development of additional measurement, metrics, and data-driven quality improvement projects. The committee structure of the QI program was re-designed with the creation of the Quality Assurance Committee and the need for a dedicated Compliance Monitoring Specialist was identified. This re-structure of the Quality Improvement program will allow the QI program to grow and develop in various projects and better monitor the effectiveness of interventions implemented. Overall, resources and structure of the QI program continue to meet the quality improvement needs of BHI to monitor its progress in meeting safe clinical practice goals.

QI Structure and Committees

The structure of the BHI Quality Improvement Program, illustrating reporting relationships and the chain of supervisory authority, is displayed below.

Figure 1: QI Reporting Structure



The ultimate authority for the Quality Improvement Program rests with the Board of Directors. The Board delegates this authority to the Chief Executive Officer (CEO), the Chief Operating Officer (COO), and the Chief Medical Officer (CMO). The Director of Quality Improvement and Utilization Management is accountable to the CEO/COO/CMO for all operations of the Quality Improvement Program.

Quality Assurance Committee

The Director of Quality Improvement and Utilization Management created the Quality Assurance Committee (QAC) in FY14 to monitor, oversee, and design interventions for BHI daily operations. QAC monitors activities from BHI's quality improvement, utilization management, provider relations, and member and family affairs departments, including (but not limited to): access to care, audits, quality of care concerns, critical incidents, over and under-utilization, UM decision timeframes, and provider network adequacy. Trends are analyzed and interventions are developed and implemented as necessary. Effectiveness of interventions and follow-up activities are also reviewed. QAC oversees any significant change in policies and operational procedures from each department. QAC meets monthly and membership includes the following:

Table 1: FY14 QAC Membership

Quality Assurance Committee			
Name	**Credentials**	**Title**	**Affiliation**
Brian Hemmert	**MA**	**Director of QI and UM (chair)**	**BHI**
Ron Morley	MD	Chief Medical Officer	BHI
Lindsay Cowee	LPC, CACII	Manager of QI	BHI
Jessie Wood	LPC	QI Project Manager	BHI
Emily Schrader	LPC, CACIII	Substance Use Disorder Coordinator	BHI
Jane Moore	LCSW	UM Care Manager	BHI
Candace Workman	RN	UM Care Manager	BHI
Teresa Summers	BA	Director of Provider Relations	BHI
Laura Hill	RN	Director of Integrated Care	BHI
Cara Mason	MPA	Manager of Member Services and Outreach	BHI
Travis Rosen	MPH	QI Project Manager	BHI

QAC has three subcommittees, each of which includes providers from the BHI network. Each subcommittee chair reports activities and progress to QAC:

- Program Evaluation and Outcomes Committee
- Standards of Practice Committee
- Credentialing Committee

Program Evaluation and Outcomes Committee:
The Performance Evaluation and Outcomes (PEO) Committee focuses on the improvement of service provision and membership includes several BHI network providers. Each participating member of PEO submits quarterly data to BHI for monitoring and oversight. The PEO committee develops standards for performance on a variety of clinical and service indictors, analyzes trends in performance at both the provider and network levels, and develops interventions accordingly. The PEO Committee meets monthly and membership includes:

Table 2: FY14 PEO Membership

Performance Evaluation and Outcomes Committee			
Name	**Credentials**	**Title**	**Affiliation**
Lindsay Cowee	**LPC, CACII**	**Manager of QI (chair)**	**BHI**
Jessie Wood	LPC	QI Project Manager	BHI
Travis Rosen	MPH	QI Project Manager	BHI
Brian Hemmert	MA	Director of QI and UM	BHI
Lisa Traudt	LMFT	Director of Managed Care and QI	Arapahoe Douglas Mental Health Network
Cynthia Grant	PhD, LCSW	Clinical Program Evaluator	Arapahoe Douglas Mental Health Network
Karen Levine	LPC	Manager of Quality and Training	Aurora Mental Health Center
Clay Cunningham	LPC	Director of Quality Assurance	Community Reach Center
Matt Louzon	LPC	Director of Community Based Services	Excelsior Youth Center
Angela Bournemann	LPC, CACIII	Co-Director of Services	Arapahoe House
Lara Dicus	LCSW	Clinical Services Administrator	CO Coalition for the Homeless
Janet Rassmusen	MSW	Director of Accountable Care and Behavioral Health	Clinica Family Health Services

The Standards of Practice Committee:
The Standard of Practice Committee (SOP) oversees the development, implementation, monitoring, and evaluation of BHI Clinical Practice Guidelines. Membership includes several psychiatrists and clinicians from the BHI provider network. The SOP committee develops and reviews BHI practice guidelines, reviews requests for new technology. The SOP committee reviews the results of guideline compliance evaluations, identifies education opportunities, and makes recommendations for performance improvement. The SOP Committee meets as needed and membership includes:

Table 3: FY14 SOP Membership

Standards of Practice Committee			
Name	**Credentials**	**Title**	**Affiliation**
Ron Morley	**MD**	**Chief Medical Officer – Psychiatry (chair)**	**BHI**
Lindsay Cowee	LPC, CACII	Manager of QI	BHI
Drew Sylvester	MD	Medical Director – Child Psychiatry	ADMHN
Terri Banks	LCSW	Clinical Supervisor – Child and Family	ADMHN
Leslie Winters	MD	Medical Director – Psychiatry	AUMHC
Karen Levine	LPC	Manager of Quality and Training	AUMHC
Roderick O'Brien	MD	Medical Director – Psychiatry	CRC

Credentialing Committee

BHI utilizes a multidisciplinary Credentialing Committee that includes both BHI personnel and network providers with experience in all levels of care and behavioral health specialties, including substance use disorders. The Credentialing Committee reviews and discusses complete credentialing files and then approves or declines the credentialing request. The Credentialing Committee reviews the credentials of all providers who do not meet BHI's established criteria. BHI's Chief Medical Officer is a member of the Credentialing Committee and as such, participates in all credentialing decisions. Only the Chief Medical Officer has the authority to determine if the files meets the BHI credentialing criteria and sign off on it as complete, clean, and approved by the Credentialing Committee and sign off on the credentialing decision. The Credentialing Committee meets monthly and membership includes:

Table 4: FY14 Credentialing Committee Membership

Credentialing Committee			
Name	**Credentials**	**Title**	**Affiliation**
Teresa Summers	**BA**	**Director of Provider Relations (chair)**	**BHI**
Brian Hemmert	MA	Director of QI and UM	BHI
Ron Morley	MD	Chief Medical Officer	BHI
Lindsay Cowee	LPC, CACII	Manager of QI	BHI
Jessie Wood	LPC	QI Project Manager	BHI
Emily Schrader	LPC, CACIII	SUD Coordinator	BHI
Jane Moore	LCSW	UM Care Manager	BHI
Laura Hill	RN	Director of Integrated Care	BHI
Travis Rosen	MPH	QI Project Manager	BHI
Rebecca Hea	PsyD	Executive Director	Denver Children's Home
Bryan Standley	BS	Operations and Technology Director	Creative Treatment Options

Key Metric Trends

Table 5: Key Metric Trends

Measure	Goal	FY11	FY12	FY13	FY14
Access to Care					
• Routine Care within 7 days	100.00%	99.73%	99.83%	99.84%	96.55%
• Urgent Care within 24 hours	100.00%	100.00%	100.00%	100.00%	100.00%
• Emergent Care within 1 hour	100.00%	99.46%	100.00%	100.00%	100.00%
• Emergency Phone Calls	100.00%	100.00%	100.00%	100.00%	100.00%
Access to Medication Evaluations					
• Adult	90.00%	Data	88.44%	91.15%	80.21%
• Children	90.00%	Unavailable	87.61%	85.82%	83.77%
Penetration Rates					
• Total Rate	>13%	10.46%	11.28%	11.42%	*
Utilization Monitoring					
• Inpatient: Admits per 1000 members		3.26	2.87	2.81	*
• Inpatient: Average length of stay		7.80	7.13	7.76	*
• Emergency room visits per 1000 members		6.64	9.95	9.94	*
Follow-up After Hospital Discharge					
• 7 Days	90.00%	51.01%	59.31%	61.19%	*
• 30 Days	95.00%	67.45%	72.70%	75.20%	
Inpatient Readmits					
• 7 Days		4.13%	2.95%	2.75%	*
• 30 Days		12.56%	8.84%	9.11%	*
• 90 Days		19.45%	15.08%	14.19%	*

*Data will be available upon validation of FY14 Performance Measures

Key Accomplishments from FY14

Table 6: Key Accomplishments from FY14

Project	Accomplishment
Encounter Data Validation Audit	Achieved near-perfect inter-rater reliability with HSAG
Provider audits	Developed clinical documentation training to support audit process
Utilization Management data analysis	Implemented new mechanisms for tracking and analyzing authorization and census data
Critical Incident reporting	Implemented new process for provider reporting of critical incidents
Practice Guidelines	Re-designed the practice guideline program to include practice guidelines for most common behavioral health disorders, including member information about practice guidelines
Access to Care	Implemented new Secret Shopper process to monitor provider appointment availability
Member Satisfaction	Improved survey scores from previous year; had some of the highest survey scores amongst all BHOs
Quarterly Performance Report Card	Redesigned format of Report Card for ease of trend analysis and corrective action

Key Initiatives for FY15

Table 7: Key Initiatives for FY15

Project	Initiative
Report Card data integrity	Develop data specifications for report card data to ensure that providers are collecting, reporting, and analyzing data in a consistent manner
Follow up after hospital discharge	Execute new oversight process for discharge planning and follow up for members receiving inpatient services
Practice Guidelines	Finalize remaining practice guidelines and distribute member information about practice guidelines
Cultural needs and preferences	Develop mechanism to collect cultural and linguistic information about facility providers in the BHI network
Improve provider documentation training	Create and promote a quarterly clinical documentation training for providers
Performance Measures	Create more in-depth monitoring and interventions for various performance measures

Barrier Analysis and Planned Interventions

The primary barriers to a more effective QI program for BHI are all data related: data quality, data timeliness, and data consistency. The table below shows the specific data barriers encountered and the interventions planned to address these barriers.

Table 8: Barrier Analysis

Barrier	Planned Intervention(s)
Inconsistent data definitions	Create data specifications documents for various reports
Data entry errors	Train BHI staff on Excel and Access to improve data entry
Need for better understanding of QI initiatives	Educate members and providers about QI program
Need to expand provider audit program	Recruit and retain a full-time Compliance Monitoring Specialist to audit and train providers on billing and documentation

Section 2: NCQA Accreditation

In September 2013, BHI received a full, 3-year accreditation with the National Committee for Quality Assurance (NCQA) as a Managed Behavioral Health Organization (MBHO) accreditation. Accreditation required compliance in several categories: Quality Improvement, Utilization Management, Credentialing, Member Rights and Responsibilities, and Preventive Health.

The NCQA re-accreditation process continues to be project managed by the Quality Improvement team. The 2014 standards have been reorganized to also include standards for Care Coordination. BHI continues to oversee compliance with existing standards and implement new programs, policies, and procedures in order to meet compliance with newly developed standards.

Goal for FY15

Project Title	Goal(s)	Action(s)	Target Date
NCQA Accreditation	Achieve re-accreditation in 2016	Continue to project manage implementation and oversight of NCQA standards	6/1/2016

Section 3: BHI Population Characteristics and Penetration Rates

Aid Categories and Demographic Characteristics

The BHI member population varies slightly from month to month. By the end of FY14, BHI was responsible for a total of 242,551 members. This is a drastic increase from FY13, in which BHI served an average of 169,406 members. Table 9 shows the breakdown of the BHI member population by aid category.

Table 9: Member Aid Categories

Aid Category Description	# of members	Percentage of Member Population
Categorically Eligible Low-Income Adults (AFDC-A): includes low income adults who receive Medicaid, families who receive Temporary Aid to Needy Families, and adults receiving Transitional Medicaid (adults in families who have received Medicaid in three of the past six months and become ineligible due to an increase in earned income)	44,760	48.0%
Categorically Eligible Low-Income Children (AFDC-C): includes children of low-income families and children on Transitional Medicaid.	117,430	48.0%
Disabled Individuals to 59 (AND-AB): these individuals are blind, have a physical or mental impairment that keeps them from performing substantial work, or are children who have a marked and severe functional limitation	12,862	5.0%
Baby Care-Adults, Breast, and Cervical Cancer Program (BC-W, BCCP): includes women with incomes up to 133% of the federal poverty level. Coverage includes prenatal care and delivery services, plus 60 days of postpartum care. Also covers women who were screened using national breast and cervical cancer early detection and prevention guidelines, and found to have breast or cervical cancer. These women are between the ages of 40 and 64, uninsured, and otherwise not eligible for Medicaid.	45	< 1.0%
Baby Care Children (BC-C): Children who are born to women enrolled in the Baby and Kid Care program (described above)	7,701	3.0%
Foster Care (Foster): Title IV-E provides federal reimbursement to states for the room and board costs of children placed in foster homes and other out-of-home placements. Eligibility is determined on family circumstances at the time when the child was removed from the home.	4,488	2.0%
Adults 65 and Older (OAP-A): Colorado automatically provides Medicaid coverage to individuals who receive Supplemental Security Income. Supplemental An individual must have income below the federal monthly maximum Supplemental Security Income limit and limited resources.	7,987	3.0%
Disabled Adults 60 to 64, Working Adults with Disabilities (OAP-B, WAWD): Colorado automatically provides Medicaid coverage to individuals who receive Supplemental Security Income. An individual must have income below the federal monthly maximum Supplemental Security Income limit and limited resources. Disabled adults aged 60 to 64 who are eligible for Supplemental Security Income are included in this category.	1,597	1.0%
Non-categorical Refugee Assistance (NCRA): mandatory full coverage for refugees for the first seven years after entry into the United States regardless of whether the individual is an optional or mandatory immigrant	48	< 1.0%
Adults without Dependent Children (AWDC): adults between the ages of 19-64, who earn approximately $95 or less a month for a single adult ($129 for a married couple).	41,177	17.0%
Total	242,551	100%

Table 10 shows the breakdown of the BHI member population by age, race/ethnicity, and gender.

Table 10: Member Demographic Characteristics

	Number of members	% of Population
Age		
Under 5 years	38,775	16%
5-13 years	67,580	28%
14-17 years	21,313	9%
18-64 years	106,849	44%
65+ years	8,802	3%
Race/Ethnicity		
African American	24,949	11%
Native American	2,921	1%
Asian	8,905	4%
Asian/Pacific Islander	772	< 1%
Caucasian	63,474	27%
Hispanic	77,047	33%
Native Hawaiian/other Pacific Islander	1,060	< 1%
Other	24,516	11%
Unknown	28,977	12%
Gender		
Female	133,255	55%
Male	107,171	45%

Penetration Rates

Summary of project

Penetration rates refer to the percent of members with at least one behavioral health contact during the fiscal year. Throughout this document are interventions designed to increase performance on several different aspects of member care. The calculation of penetration rates (broken down by age, race, eligibility type, and overall) helps BHI to better target interventions to improve member's access to timely, and appropriate services that meet their needs.

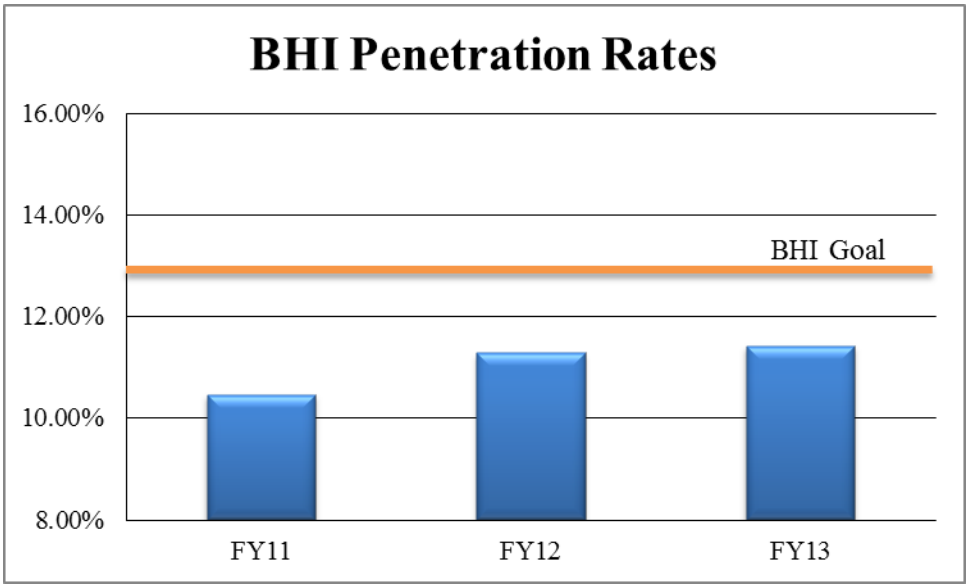
Goals from FY14

Project Title	Goal(s)	Action(s)	Target Date
Penetration Rates	Increase overall penetration rate by 2% from 11.28%.	Continue to assess penetration rates by age, race, and eligibility type to better target interventions	6/30/14
		Use Geo-Coding project to better target interventions	

Results and analysis

BHI was able to utilize the geo-coding project to assist our community mental health centers in identifying a specific geographic areas as each of their respective catchment areas. BHI also developed a monthly report to assess member engagement in CMHCs, particularly for members receiving inpatient services. This report has helped each CMHC identify opportunities for outreach and early intervention for members in the BHI catchment area. BHI increased overall penetration rates by 1.23% (11.28% to 11.42%) in FY13 performance measures, as shown in Figure 2. This is just shy of BHI's goal of a 2% improvement.

Figure 2: BHI penetration rates



Barrier analysis and planned interventions
BHI and the CMHC providers will continue to utilize the Geo-Coding information to assess specific geographic areas in the BHI catchment area. BHI also plans to implement a process by which each individual CMHC penetration rates will be calculated for monitoring and targeted improvements. This information will be calculated annually, at minimum.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Penetration Rates	Increase overall penetration rate by 2% to 11.64%	Calculate penetration rates for each CMHC in the BHI catchment area on an annual basis	6/30/15

Section 4: Network Adequacy and Availability

Ensuring Availability

Summary of project – Quality of Services
BHI continuously builds its provider network to meet the needs of members in Adams, Arapahoe and Douglas counties, and throughout Colorado. BHI members can receive services through three different service delivery systems:

- Prescribers: BHI defines a prescriber as one of the following:
  - Psychiatrist (either a Doctor of Medicine or a Doctor of Osteopathy) who is licensed by the Colorado Board of Medical Examiners
  - Physician's Assistant who is licensed by the Colorado Board of Medical Examiners
  - Advanced Practice Nurse with Prescriptive Authority (RxN) who is licensed who has been granted prescriptive authority by the Colorado Board of Nursing
- Practitioners: BHI and NCQA define a practitioner as any professional who provides behavioral health care services. This includes licensed practitioners in private practice and practitioners in the community mental health centers (CMHCs). It is noteworthy that the CMHCs also have many non-licensed mental health clinicians providing certain services. For the purposes of this report, "practitioners" includes only licensed clinicians.
- Providers/Facilities: BHI and NCQA define a provider as an organization that provides services to members, including hospitals, residential facilities, or group practices.

The US Department of Health and Human Services designates a psychiatric health professional shortage area (HPSA) when the prescriber to member ratio reaches 1:20,000 and the licensed mental health professional (MHP) ratio reaches 1:6,000. In December 2012, the BHI Leadership team set a standard for the provider-to-member ratio in the BHI catchment area. Because BHI strives to build a robust network, The BHI standard was set at 25% of the HPSA benchmark – for prescribers, a ratio of one prescriber per 5,000 members and for practitioners, a ratio of one practitioner per 1,500 members. As there is no state or national standard for facility ratios, BHI adapted the CMS guidelines for Medicare Advantage and state penetration rates to develop our own network standard. For providers/facilities, BHI's standard is set as one facility per 15,000 members.

Goal from FY14

Project Title	Goal(s)	Action(s)	Target Date
Network Adequacy – Ensuring Availability	Meet the geographical needs of members by assuring provider availability	Continue to assess provider network availability against BHI standards and respond to the needs of the ever-growing Medicaid population.	6/30/14

Results and analysis

The FY14 network performance and BHI standards are listed in Table 11 below, demonstrating BHI compliance with the standards for availability of services.

Table 11: Provider availability in BHI catchment area

	Total Number	Total BHI Members	BHI Members living in catchment area	Ratio	BHI Standard
Prescribers	84	213,458	202,809	1:2,414	1:5,000
Practitioners	528	213,458	202,809	1:384	1:1,500
Providers/Facilities	36	213,458	202,809	1:5,634	1:12,000

BHI monitors the number of prescribers, practitioners, and providers/facilities in each county of our catchment area to assure that our provider network is not only adequate but also robust to meet the needs of our members. BHI uses the same ratio standards as outlined above to assess the availability in each county of the catchment area. Tables 12-14 reflect the different types of service delivery systems in the different counties of the catchment area and demonstrates BHI compliance with the standards of availability of services.

Table 12: Prescriber availability in BHI catchment area by county

Prescribers	Total Number	Members in Catchment area	Ratio	BHI Standard
Adams County	17	97,336	1:5,726	1:5,000
Arapahoe County	52	90,214	1:1,735	1:5,000
Douglas County	4	15,259	1:3,814	1:5,000

Table 13: Practitioner availability in BHI catchment area by county

Practitioners	Total Number	Members in Catchment area	Ratio	BHI Standard
Adams County	196	97,336	1:497	1:1,500
Arapahoe County	289	90,214	1:312	1:1,500
Douglas County	43	15,259	1:355	1:1,500

Table 14: Providers/Facility availability in BHI catchment area by county

Providers/Facilities	Total Number	Members in Catchment area	Ratio	BHI Standard
Adams County	12	97,336	1:8,111	1:15,000
Arapahoe County	22	90,214	1:4,101	1:15,000
Douglas County	1	15,259	1:15,251	1:15,000

While the prescriber/member ratio in Adams County currently exceeds BHI standard, the percentage of compliance with the Access to Medication Evaluation standard has remained consistent. However, BHI will continue to work with the community mental health center in Adams County, and continue to recruit prescribers in Adams County to assure that members can access medication services in a timely manner. While BHI continues to work to expand the provider network, BHI is confident that the network is adequately meeting the needs of our ever-growing population. For more information, please reference the Access to Services section of this report.

Barrier analysis and interventions

Due to the diverse geographical locations of BHI members, BHI contracts with multiple providers and other community mental health centers outside of our catchment area to provide easier access to quality mental health services. BHI frequently examines adequacy of the provider network and how it relates to the changing Medicaid population.

Provider recruitment efforts are geared toward filling any provider gaps based on the distribution and demographics of Medicaid members. BHI also works collaboratively with the Director of Member and Family Affairs to identify any increasing trends or patterns identified through client assistance calls and grievances. If a member calls because they are having problems locating a provider in their area, BHI gives hands-on assistance to finding the member an appropriately qualified provider within reasonable traveling distance and/or helps them with transportation arrangements.

BHI and the CMHC providers have experienced the effects of the national physician shortage in the efforts to recruit and retain qualified prescribers for our members. To mitigate the impact of the shortage, BHI has adjusted the fee schedule for contracted prescribers to make rates more attractive. BHI also offers single-case agreements as an option for a provider to see a specific member. BHI is working with current single-case agreement prescribers to get them fully contracted to better meet the needs of our members. The CMHCs have recently expanded their telemedicine programs to fill gaps while new prescribers can be recruited.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Network Adequacy – Ensuring Availability	Meet the geographical needs of members by assuring provider availability	Continue to assess provider network availability against BHI standards and respond to the needs of the ever-growing Medicaid population.	6/30/15

Cultural Needs and Preferences

Summary of project – Quality of Services
Behavioral Healthcare, Inc. (BHI) believes that our mental health system must continuously evolve to reduce mental health disparities. Our primary goal is to meet the needs and expectations of the all members and families we serve with a robust network of culturally competent providers. Our providers excel at embracing divergent norms, beliefs, expectations, and resources and how these factors are related to cultural background and identity. BHI has recognized that quality care for all diverse communities depends on inclusion and accessibility of services. Staff members at BHI are trained to be conscious of and sensitive to, the cultural needs of our members.

BHI conducts ongoing assessment of demographic profiles of members who utilize services through monthly clinical reports and the assessment of census and eligibility data. Utilization rates by diverse member categories are calculated annually. BHI uses these assessments and other surveillance data to determine where and how to allocate cultural and linguistic resources to best serve the variety of individuals and communities we serve.

Goal from FY14

Project Title	Goal(s)	Action(s)	Target Date
Network Adequacy – Cultural Needs and Preferences	Meet the cultural, ethnic, and linguistic needs of members by assuring diverse provider network	Develop a mechanism to identify cultural makeup of provider network to assess whether they meet members' language needs and cultural preferences.	1/1/14
		Take action if network does not meet members' language needs and cultural preferences.	

Results and analysis
Table 15 shows the demographics of the member population in BHI's catchment area – Adams County, Arapahoe County, Douglas County, and the city of Aurora (based on eligibility information provided by member at application). Table 16 shows languages other than English spoken in households throughout Colorado, based on US Census Data from 2010 (most recent available data). BHI has also recently begun requesting race/ethnicity of the individual providers in the Contracted Provider Network. Please note that the data in Table 15 does not include the providers working at each of the 100+ facilities statewide with which BHI has contracted.

Table 15: Population demographics in BHI's catchment areas

	% of member Population	% of provider network*
Race/Ethnicity		
African American	11%	3%
Native American	1%	1%
Asian	4%	< 1%
Caucasian	27%	76%
Hispanic	33%	4%
Native Hawaiian/other Pacific Islander	< 1%	< 1%
Other	11%	< 1%
Unknown	12%	17%

Table 16: Languages Spoken in Colorado

Languages Spoken in Colorado			
Spoke only English at home			83%
Spoke a language other than English at home			17%
Breakdown of non-English speaking homes			
Spanish	71%	Other Indo European Languages	1%
French	2%	Chinese	2%
Italian	1%	Japanese	1%
German	4%	Korean	2%
Russian	2%	Vietnamese	2%
Polish	1%	Other Asian Languages	1%
Other Slavic Languages	1%	Tagalog	1%
Hindi	1%	All Other Languages	4%
Source: US census 2010			

BHI believes that linguistically appropriate services are crucial to service delivery. All members who access the network will be evaluated at intake to assess linguistic needs. If a member is in need of interpretation services, BHI will contact one of the resources available through a CMHC or the CPN (see Table 17 below). In cases where the language needed is not available within the network, BHI will access telephonic interpretation though Cyracom language services. A family member of the member will not be used to provide interpretation unless requested by the member.

Table 17: Providers offering services in languages other than English

	ADMHN	AUMHC	CRC	CPN	Total		ADMHN	AUMHC	CRC	CPN	Total
Arabic	0	2	0	0	**2**	Marshallese	0	0	0	1	**1**
ASL	2	2	0	5	**9**	Mina	0	0	0	1	**1**
Amharic	0	1	0	0	**1**	Navajo	0	2	0	0	**2**
Burmese	0	1	0	0	**1**	Nepali	0	4	1	0	**5**
Cambodian	0	0	0	1	**1**	Nigerian	0	1	0	0	**1**
Cantonese	0	1	0	0	**1**	Norwegian	0	1	0	0	**1**
Chinese	2	1	0	0	**3**	Oromo	0	1	0	0	**1**
Dutch	0	0	1	0	**1**	Pashto	0	1	0	0	**1**
Ewe	0	0	0	1	**1**	Pidgin	0	1	0	0	**1**
Farsi	0	2	0	0	**2**	Portuguese	0	1	0	0	**1**
French	3	2	0	4	**9**	Punjabi	0	0	0	1	**1**
Fuzhounese	0	1	0	0	**1**	Russian	5	0	0	1	**6**
German	4	3	0	0	**7**	Serbo-Croa	0	1	0	0	**1**
Hebrew	0	0	0	1	**1**	Sinhala	0	1	0	0	**1**
Hindi	0	3	0	0	**3**	Spanish	18	76	20	19	**133**
Igbo	0	1	0	0	**1**	Swahili	0	1	0	0	**1**
Indonesian	0	1	0	0	**1**	Tagalong	0	1	0	0	**1**
Italian	3	3	0	0	**6**	Thai	0	2	0	0	**2**
Japanese	1	3	0	0	**4**	Taiwanese	0	2	0	0	**2**
Khmer	0	1	0	0	**1**	Tigrinya	0	1	0	0	**1**
Korean	0	3	0	0	**3**	Ukrainian	0	0	0	1	**1**
Lakota	0	0	0	1	**1**	Urdu	0	1	0	0	**1**
Laotian	0	1	0	0	**1**	Vietnamese	0	1	0	0	**1**
Mandarin	0	3	0	0	**3**	Yoruba	0	1	0	0	**1**

BHI began collecting cultural demographic information from our individual providers in FY14. BHI has not yet begun collecting the same information from our contracted facilities. For this reason, the cultural identification of the BHI providers (listed above) is skewed and incomplete. Several facilities in the BHI network employ a wide range of provider cultural backgrounds. For example, BHI contracts with Asian Pacific Development Center and Denver Indian Health and Family Services. The providers from these facilities are not included in the analysis above.

BHI strives to meet our member's linguistic and cultural needs by printing the Member and Family Handbook in both English and Spanish. The handbook is also available upon request in large print and in audio (English and Spanish) versions. Educational brochures and informational brochures are also available in other languages (including Braille) upon request. Informational flyers (such as the grievance procedure and member rights and responsibilities) are posted in each CMHC in both English and Spanish.

Since 2005, BHI has only received one compliant from a member regarding accessing providers that meet his/her linguistic needs (a Spanish speaking provider). BHI staff was able to link the member to a Spanish-speaking provider at one of the CMHCs. The member was satisfied with the resolution and the complaint was resolved within 14 days.

In FY13, BHI began a UM satisfaction survey to accompany the annual member satisfaction surveys each year. As a part of the UM satisfaction surveys, BHI asked three additional questions to determine if member's cultural, linguistic and special needs were being met. For more information on the survey methodology, please see Section 9 (page 70). Below are the results of those three questions from FY13 and FY14.

Table 18: Member Satisfaction with Cultural, Linguistic, and Special Needs

Member Satisfaction Questions	FY13 Percent Satisfied	FY14 Percent Satisfied
How satisfied are you with the way your cultural needs or preferences were met	91.26%	94.93%
How satisfied are you with the way your linguistic needs or preferences were met	90.97%	95.57%
How satisfied are you with the way your special needs or preferences were met (such as disability, living situation, multiple diagnosis, medical condition, or substance use)	89.31%	91.91%

Barrier analysis and planned interventions
BHI scored between 2.5% and 4.6% better on the member satisfactions between FY13 and FY14. Since scores remain above 90% for each category, BHI believes that our provider network is adequately meeting the needs of our membership.

BHI is still in the process of implementing a facility update form that captures the demographic information of the facilities in our network. The provider database will be updated to include the collection of this new data so that BHI can effective analyze the cultural makeup of the provider network. Once BHI has more complete data, disparities between the member and provider cultural makeup can be more accurately assessed.

Based on the results of the member satisfaction survey, BHI does not believe that any interventions are necessary at this time. While BHI believes that our provider network adequately meets the needs of our member population, it is understood that our population is ever growing and ever changing. BHI is committed to continued assessment of the provider network and increasing the level of cultural competence and proficiency of our provider network.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Network Adequacy – Cultural Needs and Preferences	Meet the cultural, ethnic, and linguistic needs of members by assuring diverse provider network	Implement facility update form to capture cultural information from facility providers	1/1/15

Section 5: Access to Services

Access to Care

Summary of project – Quality of Services
Access to care refers to the ease in which a member can obtain behavioral health services. Providing access to quality behavioral health services for members and families is central to the mission of BHI and its providers. Providers can be both facilities and individual practitioners. BHI assesses compliance with Access to Care standards in the following manners:

- BHI's three CMHCs are required to submit an access to care report quarterly
- Other providers are assessed for access to care through the secret shopper program
- BHI conducts an annual survey of members to assess specific access to care standards

The four access to care indicators required by the Colorado Department of Health Care Policy and Financing (HCPF) include: Initial requests for routine services, urgent service requests, emergency face-to-face requests, and emergency phone calls.

- Initial requests for routine services include the non-urgent and non-emergent requests for services. The performance standard for this indicator is offering an appointment within seven business days.
- Urgent service requests include those situations in which acute mental health symptoms are present, have potential for an emergency health condition, or any other condition that would place the health or safety of a member or other individual in jeopardy in the absence of treatment. Urgent services require offering an appointment with 24 hours of the urgent request.
- Emergency face-to-face requests occur when a member presents with a condition manifesting itself with acute symptoms that require immediate medical attention/mental health services. Emergency Services (ES) shall be available in-person within one hour of contact (in urban and suburban areas).
- Emergency phone calls consist of calls that require immediate interventions. Calls can be received at any time during and/or after business hours and are responded to by a qualified mental health practitioner within 15 minutes. BHI does not have a centralized triage and referral center for members.

Goals from FY14

Project Title	Goal(s)	Action(s)	Target Date
Access to routine, urgent, and emergency services	Provide access to covered services as indicated in the Medicaid standards for access to care Improve member satisfaction with Access to Care by 5%	Increase provider education about access to care standards	1/1/14
		Increase frequency of secret shopper calls to CPN providers	
		Educate members about definitions of routine, urgent, and emergent appointments and the associated standards	

In FY14, BHI implemented the following interventions to help improve access to care standards:

1. Educate CPN providers about how to properly refer clients and manage staff shortages during the holiday season
2. Educate providers through the quarterly provider bulletin about access to care standards
3. Conduct the "secret shopper" calls on a quarterly basis
4. Complete an inter-rater reliability session with the individual staff members who are making the secret shopper calls to the CPN to help improve the accuracy of scoring

BHI educated providers through the provider bulletin and clinical documentation trainings about access to care, and how to refer members back to BHI, if a provider could not offer an appointment within the standard timeframe. Instead of conducting secret shopper calls internally, BHI contracted with Market Power to conduct secret shopper calls to providers to measure access to care standards. Providers were called as often as monthly to quarterly during this fiscal year. Because BHI contracted with Market Power for secret shopper calls, the inter-rater reliability session was not conducted. BHI believes, based on the results presented on the following pages, that interventions implemented were effective and successful.

Results and Analysis – CMHC Access to Care

BHI's CMHCs are contractually required to report on access to care standards once a quarter. BHI's CMHCs have seen 22,364 unique members since July 1, 2013 (the start of Fiscal Year 2014), and have provided 325,183 services. The CMHCs continue to see the majority of BHI members (76% of members receiving services).

To monitor performance and meet contractual requirements, each CMHC pulls access to care data from their Electronic Medical Record (EMR) and submits quarterly reports of the four access to care indicators to BHI (as seen on page 22). BHI reviews and aggregates these reports and submits them to HCPF. HCPF has established performance standards for each indicator, typically at least 95%. Failure to meet the 95% performance standard requires a formal Corrective Action Plan (CAP).

While BHI has consistently met access to care performance standards in recent years, instances of non-compliance are of concern to HCPF, BHI, and CMHCs. The quarterly reports submitted to HCPF include a narrative explanation of patterns of non-compliance. Other serious concerns may result in a formal CAP. In addition, BHI routinely reviews compliance concerns with CMHCs in the Program Evaluation and Outcomes Committee (PEO) to identify opportunities for improvement.

As seen in Table 19, in FY14 Q4 several routine services took place outside the seven-day requirement. The non-compliance is from one CMHC and BHI is closely monitoring a corrective action plan to determine if this is going to be continuing trend. The CMHC, as part of the corrective action plan, is required to refer members who cannot be seen within the seven-day requirement back to BHI, so BHI can assist those members with finding another provider within the standard timeframe. It is important to note that NCQA's standard for routine access to care is to offer an appointment with 10 days; however, BHI's contract with the Department of Healthcare Policy and Finance dictates a stricter seven-business day requirement. The results presented in the table below are based on a 7-calendar day routine access to care standard.

BHI has continued to see an increase in the number of enrollees and the number of members accessing services, which could have contributed to a portion of the non-compliance. BHI will also be working with the CMHCs and other providers on developing an access to care reporting data specifications documentation to ensure each provider is reporting information in the same way and correctly identifying business days versus calendar days.

Table 19: CMHC Access to Care Results for FY14

Initial Requests for Routine Services				
	Q1	**Q2**	**Q3**	**Q4**
Offered within 7 days	1,792	2,002	2,680	2,494
Offered between 8-14 days	0	0	0	300
Offered in 15 day or more days	0	0	0	20
Percent Compliance	100.0%	100.0%	100.0%	88.6%
Percent Non-Compliance	0.0%	0.0%	0.0%	11.4%
Request for Urgent Services				
	Q1	**Q2**	**Q3**	**Q4**
Offered within 24 hours	117	103	123	79
Offered in greater than 24 hours	0	0	0	0
Percent Compliance	100.0%	100.0%	100.0%	100.0%
Percent Non-Compliance	0.0%	0.0%	0.0%	0.0%
Emergency Face to Face				
	Q1	**Q2**	**Q3**	**Q4**
Offered within 1 hour	523	564	744	895
Greater than 1 hour but less than 2 hours	0	0	0	0
Greater than 2 hours	0	0	0	0
Percent Compliance	100.0%	100.0%	100.0%	100.0%
Percent Non-Compliance	0.0%	0.0%	0.0%	0.0%
Emergency Phone Calls				
	Q1	**Q2**	**Q3**	**Q4**
Offered within 1 hour	4,272	3,341	3,531	7,527
Greater than 1 hour but less than 2 hours	0	0	0	0
Greater than 2 hours	0	0	0	0
Percent Compliance	100.0%	100.0	100.0	100.0%
Percent Non-Compliance	0.0%	0.0%	0.0%	0.0%

Results and Analysis – Secret Shopper

BHI contracted with Market Power to conduct 187 calls within the year to various providers/practitioners within the network. The purpose of the calls was to monitor knowledge related to access to care standards, available services for members, and availability of appointments. The results guided BHI in developing specific training to ensure that providers are providing information based on BHI's contract with HCPF and related Medicaid regulations.

BHI listened to the audio recording of each phone call and determined if access to care (ATC) standards were met when a live person answered the call. BHI also determined if emergency instructions (such as calling 911 in an emergency) were on the provider's voicemails. Table 20 shows the analysis of the calls to providers conducted by Market Power.

BHI will continue to work with all providers regarding secret shopper call results and training on access to care standards. BHI does not believe that any formal corrective action is necessary for providers at this time related to secret shopper calls, as there is a very small sample size of answered calls completed to date and emergency instructions on clinician's voicemails is not a required element of access to care. BHI is also considering returning to conducting secret shopper calls internally to better capture how access to care standards are being met.

Table 20: Secret Shopper Call Results

Community Mental Health Centers			
	Yes	**No**	**Percentage Yes**
ATC Standard Met with Live Call	25	6	81%
Emergency Instructions on Voicemail	11	9	55%
Individual Providers			
	Yes	**No**	**Percentage Yes**
ATC Standard Met with Live Call	5	0	100%
Emergency Instructions on Voicemail	16	13	55%

Results and Analysis – Member Satisfaction with Access to Care
Satisfaction surveys provide BHI with knowledge on member perceptions of well-being, independence, and functional status as well as perceptions on the scope of services offered, accessibility to obtain services when needed, availability of appropriate practitioners and services, and acceptability or "fit" of the practitioner, program, and services in meeting the members' unique needs and preferences. This feedback helps to modify the service system for actual utilization patterns and enables member choice. If a pattern is detected or there is a statistically significant level of concern, BHI requires and/or develops a corrective action plan.

For 2014, BHI conducted an additional survey of 15 questions to assess Utilization Management services and Access to Care as well as to assess more thoroughly acceptability or "fit" of the practitioner, program, and services in meeting the members' unique needs and preferences. The Access to Care questions specified "In the past 12 months:"

- If you had a mental health emergency and you contacted your mental health provider, were you contacted by someone within 1 hour or told to go to the emergency room/dial 911 for help (this includes clinician voicemails)?
- If you had an urgent need to speak with someone about your mental health, called your clinician, were you contacted by someone within 24 hours of your initial call?
- If you needed to schedule a routine office visit, were you scheduled and seen within 7 business days of your request (this includes walk-in and "open access")?
- The answer choices available were yes, no, and N/A.

These questions are worded somewhat differently than last year's member satisfaction questions as part of our interventions for the FY13 surveys. The results of this year's survey are listed below in Table 21. For information regarding sampling methodology, scoring, and response rates, please reference the section in this report titled: Member and Family Input into the Quality Improvement Section on page 68.

Table 21: Member satisfaction with access to care

	Percent that answered "Yes"	
	FY13	FY14
Emergency	70.72%	79.13%
Urgent	82.69%	85.07%
Routine	82.42%	86.47%

FY13 was the first time BHI has assessed member satisfaction with member's ability to receive timely service appointments. BHI did not set a specific goal for this measure in FY14; however believed that a five-percentage point increase from FY13 to FY14 would be a marked improvement for each category. As shown in Table 21, BHI increased member satisfaction with each of the access to care categories and does not believe that any formal interventions are necessary for FY15. BHI will continue to monitor and improve access to care in a variety of ways.

BHI still believes member perception of emergent and urgent care could vary greatly from BHI's definition, so it would be important for BHI to continue to educate members on not only definitions, but also access to care standards. BHI may continue to revise the access to care questions for next year's survey and give the specific definition of each appointment type within the survey.

Results and Analysis – Overall
Based on the results of the monitoring activities in FY14, BHI has determined that overall, BHI members are able to access needed services within the timeliness standards:

- CMHC access to care reports remain in compliance with standards
- Preliminary reports from Market Power indicate compliance with identified standards
- Surveys indicate improvement of 3-12% in member satisfaction with the ability to access services within identified timeframes

Barrier analysis and planned interventions
BHI will continue to monitor access to care standards via the quarterly access to care report, secret shopper calls, and member satisfaction and grievances. BHI will consider implementing the following interventions for FY15 to continue to improve member access to care:

1. Continue to educate providers on access to care standards via quarterly trainings and the Provider Bulletin
2. Educate providers on how to refer members back to BHI if access to care standards cannot be met by the provider
3. Continue to conduct secret shopper calls. It has not been determined if BHI will terminate the contract with Market Power and conduct calls internally.
4. Continue to educate members about definitions of routine, urgent, and emergent appointments and the associated standards.
5. Develop data specifications for report card data to ensure that providers are collecting and reporting data in a consistent manner.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Access to routine, urgent, and emergency services	Provide access to covered services as indicated in the Medicaid standards for access to care	Increase provider education about access to care standards and referrals to BHI	1/1/15
		Continue to conduct secret shopper calls of all providers.	
	Improve member satisfaction with Access to Care by 5%	Educate members about definitions of routine, urgent, and emergent appointments and the associated standards	

Access to Medication Evaluations

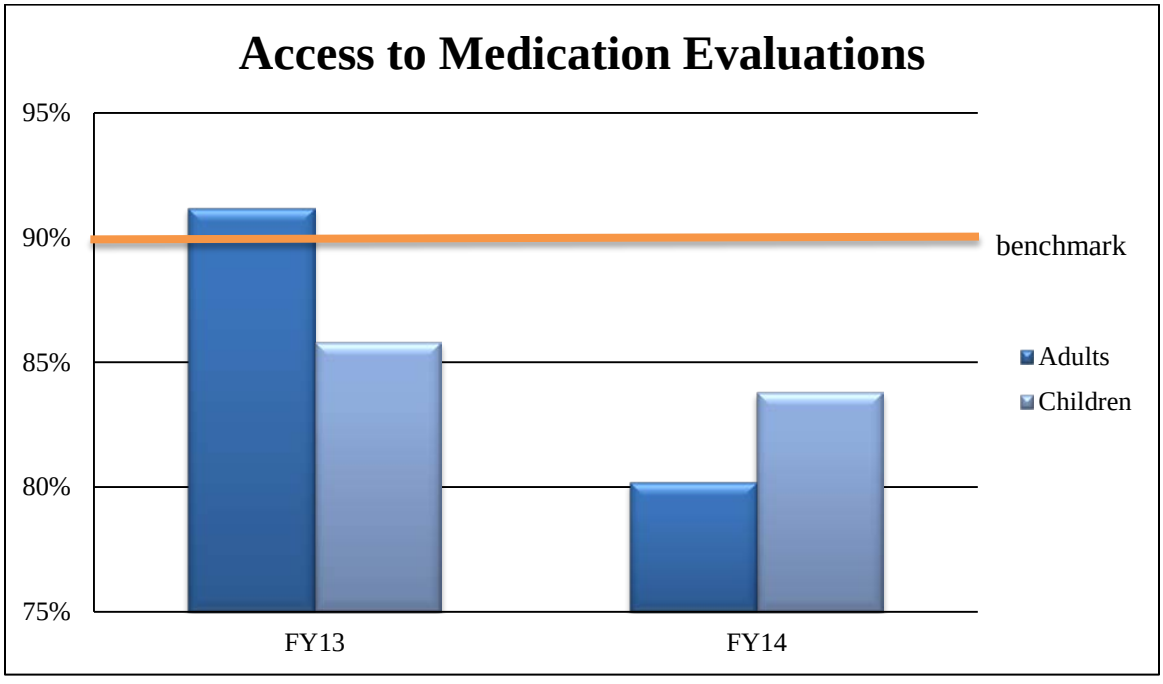
Summary of project – Quality of Services
Medication evaluations are comprehensive assessments completed by psychiatric prescribers in order to assist in diagnosis development and begin any necessary medication regimens that complement the other therapeutic services the member may be receiving. It is crucial to offer members medication evaluations in a timely manner in order to facilitate effective treatment. Many members cannot fully benefit from other therapeutic services until their symptoms (particularly acute) are addressed.

Goal from FY14

Project Title	Goal(s)	Action(s)	Target Date
Access to medication evaluations	Provide access to medication evaluations within 30 days of client request for service	Assist providers in barrier analyses to identify opportunities to improve access to medication evaluations.	6/30/14

Results and analysis
Figure 3 shows the percent of members offered a medication evaluation within 30 days of the request for a medication evaluation. BHI set a performance standard of 90% compliance on this measure based on a pervious focused study. Any performance under the 90% standard requires a CAP from the CMHC. Figure 3 demonstrates overall BHI performance with this standard.

Figure 3: Overall performance on access to medication evaluations indicator



Barrier analysis and planned interventions
BHI saw an overall performance decrease for access to medication evaluations for both children and adults during FY14; however, BHI's also saw a 43% increase for requested medication evaluations for adults and 4% for children. Therefore, BHI's goals for this project were not met.

BHI is continuing to work closely with the CMHCs to identify issues with data collection procedures and identify needed areas of improvement. The CMHCs are currently sending medication evaluation data to BHI on a monthly basis for monitoring. The CMHCs identified that hiring and retaining prescribers remains an issue; however, each of the centers have created a telemedicine program within the past fiscal year to address access to medication evaluations and staffing issues. BHI continues to contract with psychiatrists to provide medication services outside of the CMHCs.

Goal(s) for FY15
Continue to monitor access to medication evaluations and require corrective action for any provider who falls below the 90% benchmark.

Project Title	Goal(s)	Action(s)	Target Date
Access to medication evaluations	Improve compliance with 30-day standard by 90%	Assist providers in barrier analyses to identify opportunities to improve access to medication evaluations.	6/30/15

Focal Point of Behavioral Health for SMI Population

Summary of project – Quality of Services
BHI monitors the BHO-HCPF Annual Performance Measure data to identify opportunities for improvement. One such indicator measures the percent of adult members with SMI (Diagnosis of Schizophrenia, Bipolar Disorder, or Schizoaffective Disorder) who have a focal point of behavioral health care identified (three or more behavioral health services or 2 or more prescriber services in a 12 month period). Note that FY13 performance measures are included in this report as the FY14 measures are not calculated until fall of 2014.

Goal from FY14

Project Title	Goal(s)	Action(s)	Target Date
Focal point of behavioral health services	Continue to perform at or above the statewide average for this performance indicator.	Continue to monitor clients' accessibility to services	6/30/14

Results
In FY13, 90.49% of BHI members with SMI had a focal point of behavioral health. The weighted average of all Colorado BHOs was 90.79%. While BHI performed slightly lower than the state average, this difference is not statistically significant. BHI considers this objective met.

Goal for FY15

Project Title	Goal(s)	Action(s)	Target Date
Focal point of behavioral health services	Continue to perform at or above the statewide average for this performance indicator.	Continue to monitor clients' accessibility to services	6/30/15

Section 6: Compliance Monitoring

External Quality Review Organization Audit (EQRO Audit)

Summary of Project
BHI underwent the tenth EQRO audit and site visit in FY14. HCPF focused review on four standards: Coverage and Authorization of Services and Access and Availability. Compliance with federal regulations and contract requirements was evaluated through review of these two standards.

Goals from FY14

Project Title	Goal(s)	Action(s)	Target Date
External Quality Review Organization (EQRO) audit	Continue to score at or above the previous year's performance	Participate in annual, external independent reviews of the quality of services covered under the Medicaid contract	6/30/14
		Coordinate with HSAG (Health Services Advisory Group) to comply with review activities conducted in accordance with federal EQR regulations 42 C.F.R. Part 438 and the CMS mandatory activity protocols	

Results and analysis
Table 22 below represents the score in each category for BHI.

Table 22: FY14 EQRO audit results

Standard	Number of Elements	Number of Applicable Elements	Number Met	Number Partially Met	Number Not Met	Score
Coverage and Authorization of Services	31	31	25	5	1	81%
Access and Availability	15	15	15	0	0	100%
Totals	**46**	**46**	**40**	**5**	**1**	**87%**

BHI's strongest performance was in Access and Availability, which earned a compliance score of 100%. HSAG identified six required actions in Coverage and Authorization of Services. However, these six required actions were all related to the un-delegation of utilization management (UM) functions from the CMHC's, which occurred in October 2013. At the time of the desktop tool submission and site review, BHI had not yet updated all policies and materials to reflect this change. With an FY13 score of 96%, BHI did not meet the goal of performing at or better than the previous year's score.

Barrier analysis and planned interventions

The review of UM policies and procedures prompted BHI to thoroughly review all UM policies, program descriptions, sections of the provider manual and member and family handbook for consistency even before required to do so for the EQRO Corrective Action Plan. BHI is confident that with new, clarified policies and procedures that performance on these standards will be fully compliant in future reviews. BHI conducted similar reviews of the policies and materials for other departments and revised these documents for added clarity.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
External Quality Review Organization (EQRO) audit	Continue to score at or above the previous year's performance	Coordinate with HSAG (Health Services Advisory Group) to comply with review activities conducted in accordance with federal EQR regulations 42 C.F.R. Part 438 and the CMS mandatory activity protocols	6/30/15

Delegation Oversight

Summary of project
BHI conducts annual evaluations of each of its delegates and the various functions for which each delegate is responsible. These evaluations require the delegates to submit evidence of compliance for each delegated function, including policies, reports, trainings, etc.

Goal from FY14

Project Title	Goal(s)	Action(s)	Target Date
Delegation Oversight	Re-design Utilization Management department in order to manage all service authorizations 24 hours per day, 7 days per week	Transition the remaining delegated authorizations from the CMHCs back to BHI without interrupting client care	1/1/14
		Train all relevant service providers on authorization changes	
	Oversee the quality of activities delegated to any subcontractor	Continue to monitor the activities delegated to Colorado Access as our Administrative Service Organization through Delegation Oversight Audits	6/30/14

Results
In October 2013, BHI transitioned all remaining delegated functions from the CMHCs. BHI now manages all services authorizations 24 hours per day, 7 days a week. Therefore, no delegation oversight review of the CMHCs was necessary. For more information about this transition, please reference the Utilization Management Program Evaluation.

BHI conducted the delegation audit of Colorado Access (COA) beginning in January 2014. The results of the delegation audit, including a credentialing file review, are listed below. Colorado Access completed a Corrective Action Plan to address any areas scoring less than full compliance, including policy and procedure revisions, training, and additional reporting requirements. BHI considers both goals related to delegation oversight to be met.

Table 23: COA Credentialing delegation oversight results

Standard #	Standard Name	Possible Points	Points Scored by Delegate	% of Pts Scored
CR 1	Credentialing Policies	9	9	100%
CR 2	Credentialing Committee	9	9	100%
CR 3	Initial Credentialing Verification	25	25	100%
CR 4	Application and Attestation	10	10	100%
CR 5	Initial Sanction Information	10	10	100%
CR 6	Practitioner Office Site Quality	8	8	100%
CR 7	Recredentialing Verification	38	38	100%
CR 8	Recredentialing Cycle Length	10	10	100%
CR 9	Ongoing Monitoring	10	10	100%
CR 10	Notification to Authorities and Practitioner Appeal Rights	12	12	100%

Table 24: COA Administrative Service Agreement delegation oversight results

Function	Possible Points	COA Score
Administrative Duties		
A. Establish and Maintain a system of data integrity processes	2	2
B. Maintain the integrity and security of all data	2	2
C. Maintain back up files of all BHI data	2	1
D. Establish and maintain and system of quality assurance	2	2
I. Claims and Encounter Processing and Adjudication		
1A. Processing all claims and encounter data	2	2
1B. Necessary system configuration /modifications	2	1
1C. Processing of all claims adjustments	2	1
1D. Preparation of encounter and claims data for submission to HCPF	2	2
1E. Preparation of any additional or modified reports	2	1
II. Decision Support and Required Reporting		
2A. Submission of monthly, quarterly and annual reports	2	2
2B. All reports shall be submitted to BHI for review and approval	2	1
2C. The list of reports is subject to revision	2	2
III. Tactical Reports		
3A. Preparation of various operational, financial, and quality reports	2	2
IV. Network Development and Provider Relations		
4A. Claims Support	2	2
4B. Credentialing and Provider Database Management Services	2	2
V. Clinical/Care Management Services		
5A. Three FTE Care Managers	2	2
VI. Eligibility and Database Services		
6A. Loading of eligibility data	2	2
6B. Preparation of mailing labels for new client mailing	2	2
6C. Preparation of mailing labels for annual member mailing	2	2
Totals (38 points total)		
Total Points Scored	38	33
Overall Percentage		86.8%

Barrier analysis and planned interventions

During delegation oversight process in the past two years, BHI has identified several opportunities for improvement in the administrative service and delegation agreements. BHI has collaborated with Colorado Access to revise and clarify this document in order to improve the delegation oversight process and to meet NCQA standards.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Delegation Oversight	Oversee the quality of activities delegated to any subcontractor	Continue to monitor the activities delegated to Colorado Access as our Administrative Service Organization through Delegation Oversight Audits	6/30/15

Encounter Data Validation Audit (411 Audit)

Summary of project
Three service program categories were selected by the Department of Health Care Policy and Financing (HCPF) for review in this year's audit. The categories are outlined as follows:

- 137 encounters from prevention/early intervention services (Service Category "HT")
- 137 encounters from club house or drop-in center services (Service Category "HB")
- 137 encounters from school-based services (Service Category "TJ" or "HE" with POS 03)

BHI used the 411 sample to identify lists of encounters/claims by provider. This year, largely due to the format of this year's audit, most of the claims in BHI's 411 sample consisted of CMHCs. Once the 411 sample was developed, BHI communicated with the QI Directors for the CMHCs during meetings as well as via phone and email about the records being requested. Providers in the CPN were mailed a letter requesting the appropriate records.

Each CMHC provided remote access to their electronic health records for the review. The remaining provider submitted records via fax.

To create the audit tool, BHI modified the Excel spreadsheet containing the 411 sample to include columns for auditor comments next to each required field for the audit. BHI used numbers to code the results of each audit field, per Appendix II of the Annual BHO Encounter Data Quality Review Guidelines (1 = compliance, 0 = non-compliance). If a field was found to be non-compliant, the auditor indicated the reason for non-compliance in the adjoining comment box. The audit tool was tested and validated during the inter-rater reliability session with all auditors. The auditors were instructed to make sure that all assigned fields were completed for each encounter they audited before they closed the medical record. Each auditor found the tool both simple and efficient to use during the audit process.

Two auditors conducted the audit of the 411 sample. All three auditors had extensive experience in behavioral health, maintaining, and reviewing clinical records. The lead auditor has prior experience with the Encounter Data Validation audit. Prior to any records being reviewed, training was conducted by the lead auditor and covered the following topics:

- The Annual BHO Encounter Data Quality Review Guidelines
- Scoring criteria for the various audit fields
- Review of the Uniform Service Coding Standards Manual (including the transition from the 2012 manual to the 2013 manual); both the 2012 and 2013 versions of the USCS manual were used depending on the date of service
- Navigating each of the CMHC EMR systems and where to locate the necessary information

The two auditors included:

- Lindsay Cowee, LPC, CACII (Manager of Quality Improvement, lead auditor)
- Jessie Nelson, LPC, (QI Project Manager)

BHI provided three-hour training for the auditors. Five records were used as practice records. Auditors were given specific instructions for each EMR, including where to locate the necessary information within the EMR. Both hands-on training and hardcopies of instructions for EMR access were provided. During the practice session, auditors rated the records and had an open discussion on any issues with abstraction. Following the practice session, an inter-rater reliability study was conducted on 10 records. The records were projected on a screen and all auditors abstracted data individually with no discussion. An inter-rater reliability analysis summarized the results and provided kappa scores for each of the auditors. An inter-rater reliability analysis yielded a 97.3% agreement (with kappa = 0.842), which is considered "almost perfect agreement."

BHI conducted most of the audits in a group format. Any problematic records were reviewed by more than one person. The teams arrived at audit results after discussion and reference to the Uniform Service Coding Standards (USCS) manual and the Diagnostic and Statistical Manual (DSM-IV). Several checks were conducted in the data analysis process that also acted as internal over read.

The audit tool was used to verify the accuracy and completeness of auditor abstraction. Pivot tables were created to analyze the results for the required fields and overall audit performance. QI auditors verified all required fields based on auditor comments. Any missing information was gathered from the medical records and consultation with clinicians and administrators. Data analysis was conducted using the complete and accurate file. Pivot tables were created to calculate scores for each required field.

Goals from FY14

Project Title	Goal(s)	Action(s)	Target Date
Encounter Data Validation (411) Audit	Improve provider claims review to a compliance score of 80% or higher (increase from 74%)	Continuing to train providers on proper billing and documentation practices	6/30/14
	Maintain or improve inter-rater reliability with HSAG	Continuing to train audit team on the USCS Manual	

Results and analysis

The tables below list the elements that were scored for each encounter and a breakdown of audit score by program service category. Because the review period included dates of service from before the corrective actions from the CY12 review was completed, BHI felt it essential to calculate compliance rates for CY13 overall, and for CY13 dates that occurred after corrective action was implemented (titled CY13 post-CAP). The results for CY13 overall and CY13 Post-CAP are listed below.

Table 25: Audit scores by program service category

Program Service Category Comparison	CY12	CY13	CY13 (post-CAP)
Overall - all categories	74%	79%	90%
Prevention/Early Intervention Services	77%	84%	89%
School-Based Services	88%	93%	95%
Drop-In Center Services	56%	58%	NA

Table 26: Audit scores across all providers and program service categories

	All Dates of Service				Post-CAP Dates of Service			
Field Descriptor	# of Claims / Records Accurate	# of Claims / Records Audited	% Records Accurate	Weighted Score	# of Claims / Records Accurate	# of Claims / Records Audited	% Records Accurate	Weighted Score
Diagnosis Code	390	411	95%	5%	47	50	94%	5%
Start Date	403	411	98%	5%	49	50	98%	5%
End Date	403	411	98%	5%	49	50	98%	5%
Procedure Code	348	411	85%	13%	40	50	80%	12%
Place of Service	392	411	95%	10%	47	50	94%	9%
Program Category	386	411	94%	9%	41	50	82%	8%
Duration	266	411	65%	10%	49	50	98%	15%
Units	211	411	51%	8%	40	50	80%	12%
Population	406	411	99%	5%	49	50	98%	5%
Mode	405	411	99%	5%	49	50	98%	5%
Staff Requirement	212	411	52%	5%	45	50	90%	9%
Overall Compliance	3822	4521	85%	**79%**	505	550	92%	**90%**

Each year, HSAG pulls a random sample of the 411 claims to perform an over-read audit in order to check the accuracy of audit methodology of the behavioral health organizations. This provides BHI with inter-rater reliability scores between our internal audit team and the state's external quality review organization. The below table reflects the combined scores for all BHOs on the over-read audit and the individual scores for BHI. BHI scored a 100% in the majority of categories. These scores reflect a commitment by BHI to provide thorough and comprehensive audits on a continuous basis. The quality improvement department strives to be consistent in their audits and the scores below reflect a very high inter-rater reliability between the BHI audit team and HSAG, an accomplishment that has been found to be very helpful to our individual providers during the audit feedback and corrective action process. Table 27 below shows BHI performance on the over-read audit results as compared to the statewide BHO average.

Table 27: BHI 411 over-read audit results

	All Claims		PEI		Drop In		School	
	All BHOs	BHI	All BHOs	BHI	All BHOs	BHI	All BHOs	BHI
Overall	**86.0%**	--	**90.0%**	--	**94.0%**	--	**74.0%**	--
Procedure Code	96.7%	93.3%	98.0%	100%	100%	100%	92.0%	80%
Service Category	99.3%	96.7%	98.0%	90%	100%	100%	100%	100%
Diagnosis	90.7%	100%	92.0%	100%	100%	100%	80.0%	100%
POS	99.3%	100%	100%	100%	100%	100%	98.0%	100%
Units	97.3%	100%	100%	100%	94.0%	100%	98.0%	100%
Start Date	100%	100%	100%	100%	100%	100%	100%	100%
End Date	100%	100%	100%	100%	100%	100%	100%	100%
Population	100%	100%	100%	100%	100%	100%	100%	100%
Duration	97.3%	100%	98.0%	100%	96.0%	100%	98.0%	100%
Mode of Delivery	98.0%	100%	96.0%	100%	100%	100%	98.0%	100%
Minimum Staff Req.	83.3%	100%	78.0%	100%	72.0%	100%	100.0%	100%

Based on the results of both the claims review and the HSAG over-read audit, BHI considers all of the goals from FY14 to be met.

Barrier analysis and interventions
As previously mentioned, true progress on this audit was difficult to assess, as over 80% of the encounters selected for review by HCPF occurred prior to the implementation of corrective action from the previous year's audit.

Similarly, as a response to the CY11 audit, BHI implemented a new system for tracking member encounters at each of our drop in centers, Patient Tools. This program was not fully implemented until the summer of 2013, and therefore 100% of the encounters reviewed for the BHI drop in centers were from the previous system – a system that was known to be inadequate. Therefore, the audit performance of the BHI drop in centers is not reflective of the diligent work to improve the encounter submission process.

Providers with an overall score below 95% were required to submit a Corrective Action Plan (CAP) addressing any deficiencies discovered during the audit. Each provider was given specific feedback on resolving issues such as system errors, clinical errors, or errors related to the USCS Manual. To address areas of deficiency, providers implemented corrective actions such as:

- Training with staff regarding proper definition and billing of various Prevention/Early Intervention codes
- Configuring EMRs to correctly calculate units for encounter codes
- Including staff credentials on all service templates in the EMR

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Encounter Data Validation (411) Audit	Improve provider claims review to a compliance score of 90% or higher	Continuing to train providers on proper billing and documentation practices	6/30/15
	Maintain or improve inter-rater reliability with HSAG	Continuing to train audit team on the USCS Manual	

Provider Audits

Summary of project
In FY13, BHI streamlined the provider audit process. BHI created an audit tool that combined several different elements, including claims and billing validation (with elements similar to the 411 audit), treatment plan requirements, and requirements for the full clinical records (such as releases of information, disclosure forms, components of an intake, etc.).

An audit is conducted to examine the quality and appropriateness of medically necessary services delivered to members, whether the services were billed accurately and supported through documentation in the medical records. The audit process is designed to identify a provider's compliance with applicable BHI, state and/or federal regulations governing the healthcare program and payment to the provider.

Providers are typically selected for audit using one or more of the following criteria: high volume of services provided, high cost services provided, new providers, as required for state and/or federal regulations, member inquiry or complaint, internal staff inquiry, and random selection.

In FY14, BHI continued to refine the audit process and completed audits with ten providers (3 follow up audits, 7 initial audits). Upon completion of the audit, BHI schedules a face-to-face meeting with the provider to discuss results, including areas of strength, suggestions for improvement and required actions (for providers who score less than 90%). The required actions can include completing a corrective action plan (CAP), completing specific trainings on the deficit's identified through the audit, and possibly repayment of claims previously paid. Each provider is offered a training that is facilitated by BHI staff. Providers who score between 80-90% are given tools to self-monitor their clinical records and encounter submissions. Providers who score less than 80% complete a re-audit with BHI between 3-6 months after CAP implementation in order to formally monitor the effectiveness of their corrective action.

Goal from FY14

Project Title	Goal(s)	Action(s)	Target Date
Provider claim/record audits	Improve provider documentation and reduce incidence of waste and abuse in billing practices	Continue to develop the audit process and educate providers about compliance requirements	6/30/14
		Initiate a minimum of 10 provider audits	

Results and analysis
BHI providers have been very responsive to the audit process. Providers appreciate the training being provided by BHI as a part of the corrective action process (often requiring entire clinical staff to attend), and having a QI contact within BHI for questions about coding and documentation. Several providers have revamped various templates, including progress note templates and treatment plan templates in order to meet compliance and prompt clinicians to meet all documentation standards. Due to the success of the audit process, BHI considers this objective to be met.

Several patterns have emerged across provider compliance with these audits, particularly around minimum documentation. Clinicians most often struggle with citing the therapeutic interventions being utilized in the session, directly linking the service to the treatment plan, and specifically documenting process (or lack thereof) towards the specific treatment goals.

Table 28 demonstrates the various scores from provider audits as well as the primary deficiencies identified during the audit.

Table 28: BHI provider audit results

Provider	Initial Audit Score	Follow up Audit Score
A	17%	79%
B	46%	83%
C	52%	78%
D	78%	*
E	47%	*
F	68%	*
G	89%	n/a
H	51%	*
I	74%	*
J	83%	n/a

* Follow up audit not yet conducted

Barrier analysis and planned interventions

As the provider audit program continues to grow, the time constraints have become cumbersome. In response, BHI is in the process of hiring a Compliance Monitoring Specialist whose primary job responsibilities will include conducting provider audits, meeting with providers about results, monitoring corrective action and conducting provider trainings around billing and clinical documentation. BHI hopes to have the position filled by October 2014.

In addition, BHI plans to schedule regular, quarterly documentation trainings for providers. BHI has been providing these trainings individually to providers as the result of an audit or upon provider request. Provider has responded positively to these trainings, and other providers are beginning to request trainings for their agencies. Therefore, BHI plans to offer regular clinical documentation trainings to meet this demand.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Provider claim/record audits	Improve provider documentation and reduce incidence of waste and abuse in billing practices	Implement quarterly clinical documentation trainings	6/30/15
		Initiate a minimum of 10 provider audits	

Section 7: Performance Measures

BHI believes that to provide truly excellent mental health services, programs should go beyond basic quality assurance. BHI strives to use data continually, to improve services, and develop innovative solutions where traditional methods have failed. Note that all performance measures are being reported for FY13, as FY14 Performance Measures will not be calculated until fall of 2014.

Reducing Over- and Under-Utilization of Services

Summary of project – Quality and Safety of Clinical Care
BHI utilizes a very skilled Utilization Management (UM) department whose focal point is to authorize the medical necessary appropriate level of care, in the least restrictive environment. BHI is able to achieve these outcomes by utilizing a UM department that actively manages the members admitted to inpatient hospitals. The UM Department also has a close relationship with the CMHC and CPN providers. This relationship allows the UM team to identify an outpatient service provider that will be the best fit for our members' unique mental health needs. The UM team also keeps records on frequent ED utilizers. Becoming familiar with our members who are high utilizers in the ED allows BHI to connect that member with the most appropriate outpatient provider.

The Office of Member and Family Affairs (OMFA) also provides programming to reduce member's ED utilization and inpatient hospital stays. Through initiatives like the peer specialist program and the Drop-in centers, OMFA is able to provide members with support, education, outreach, advocacy, and basic needs. These services help members reduce their need for hospitalization or the utilization of an ED. Drop-in centers provide a safe place where members can get their daily needs met, which reduces stress that can often times exacerbate a mental illness. The peer support program provided is crucial to many members living with a severe mental illness. Peer specialists understand the experience of being admitted to the hospital or utilizing an ED to cope with severe mental illness symptoms. With those experiences in mind, the peer specialists can empathize with the member and relate with real life solutions that can help the member avoid over utilization of EDs and/or inpatient hospital stays. Peer specialists are crucial in addressing concerns of our members that are the impetus for ED use and hospital stays.

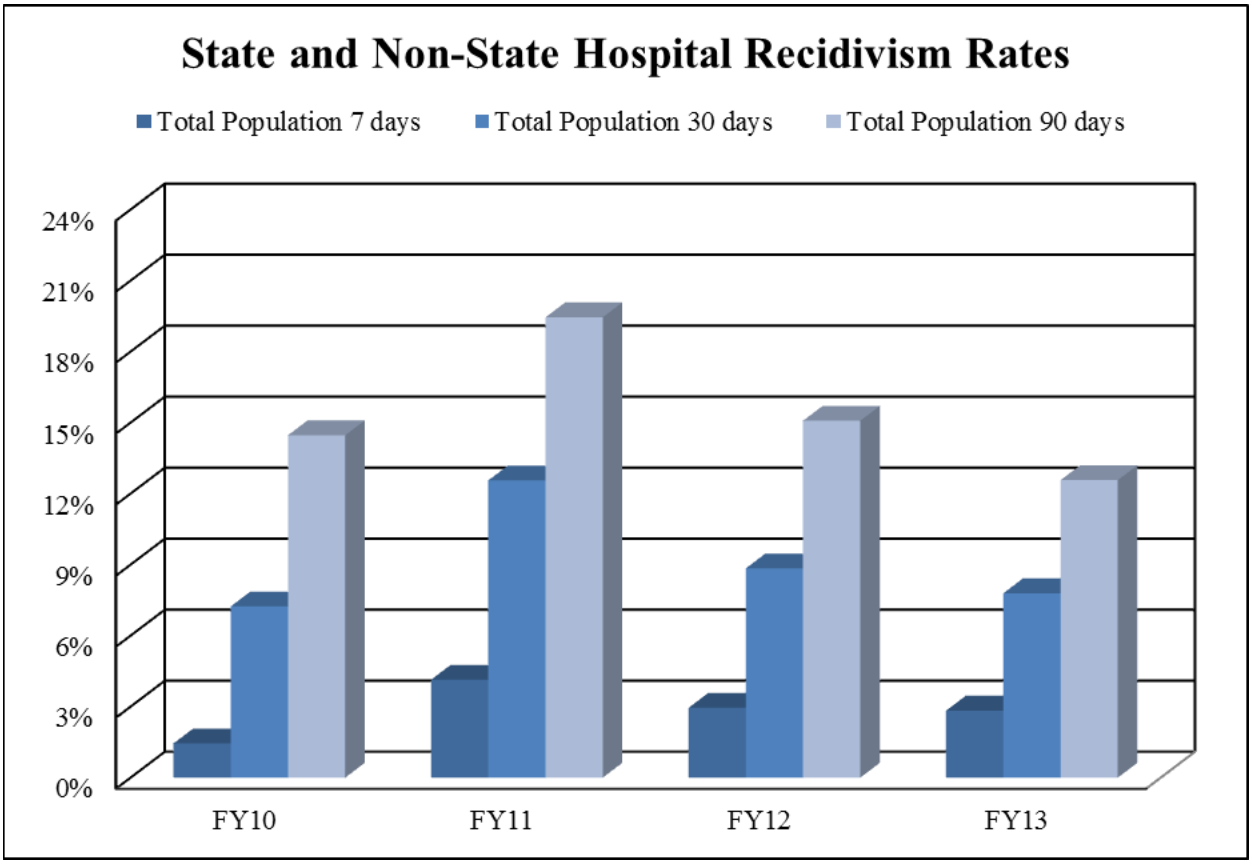
Goals from FY14

Project Title	Goal(s)	Action(s)	Target Date
Reducing Cost of Care	Continue to perform at or above the statewide BHO average for cost-of-care performance measures.	Continue to measure performance indicators quarterly to monitor for patterns and trends across services	6/30/14
		Continue to monitor specific member utilization for targeted interventions	
		Continue to develop peer specialist program to assist in interventions	

Results and analysis – Hospital Readmissions

BHI calculates the proportion of member discharges from a hospital episode and those members who are readmitted for another hospital episode within 7, 30, 90 days. This measure is calculated by HEDIS age group and by hospital type (non-state hospital and all hospital). Figure 4 shows the percentage of members who were readmitted to a hospital within 7, 30, and 90 days of discharge from another hospital stay. In FY13, BHI reduced recidivism in each of the three timeframes. Therefore, BHI considers this objective met.

Figure 4: Hospital recidivism

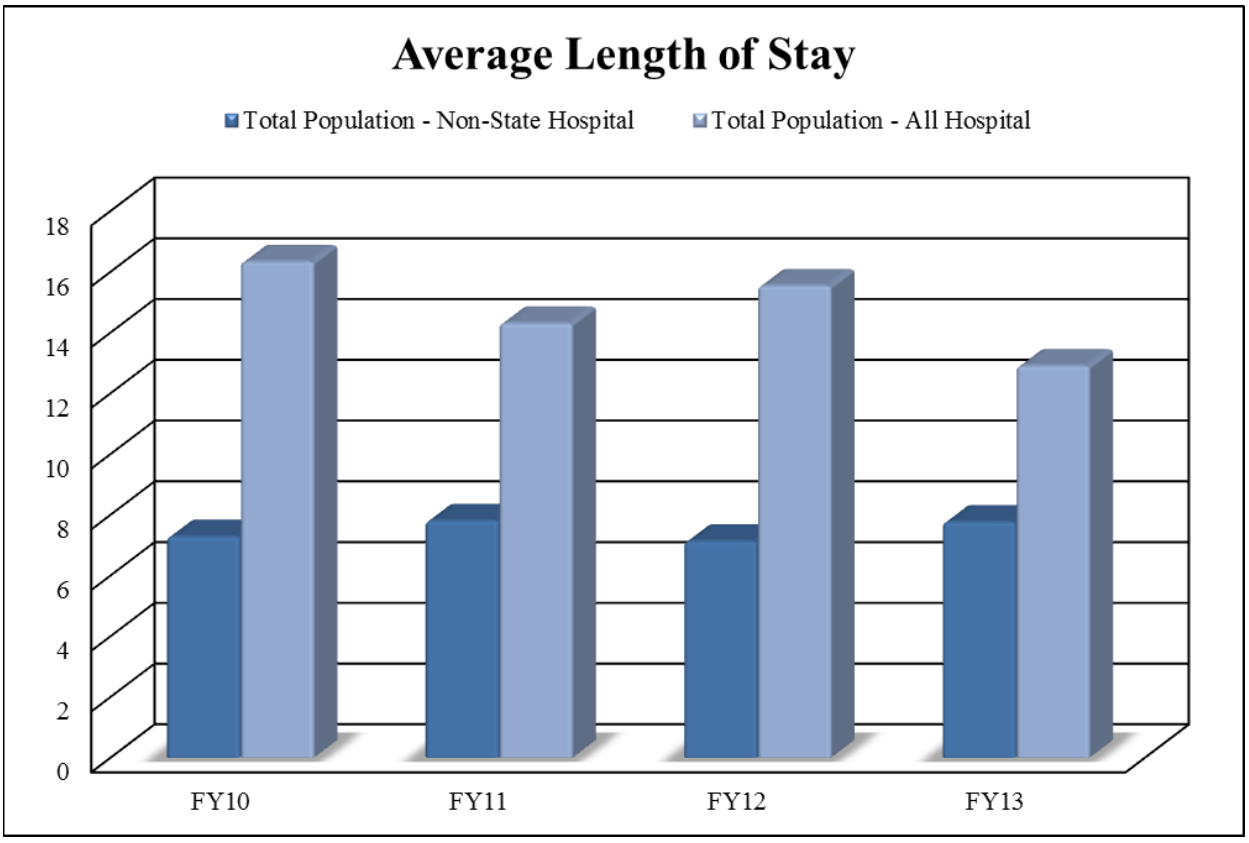


Results and analysis – Length of Stay

This indicator measures the average length of stay (ALOS, in days) for BHO members discharged from a hospital (non-state and state hospital) episode by age group and total population. For members transferred from one hospital to another within 24 hours, total length of stay for both hospitals is attributed to the hospital with the final discharge. For final discharges from a State hospital, all days in the hospital episode will be included if the member was Medicaid eligible at the time of admission. Because inpatient stays in state hospitals tend to be disproportionately longer than those of non-state hospitals, Figure 5 shows the average length of stay for all hospitals (both state and non-state) as well as the average length of stay for non-state hospitals alone.

Although BHI demonstrated a slight increase in ALOS for non-state hospitals, the ALOS is consistent with the national ALOS of 7.2 days (according to the Center for Disease Controls). Therefore, BHI still considers this objective to be met.

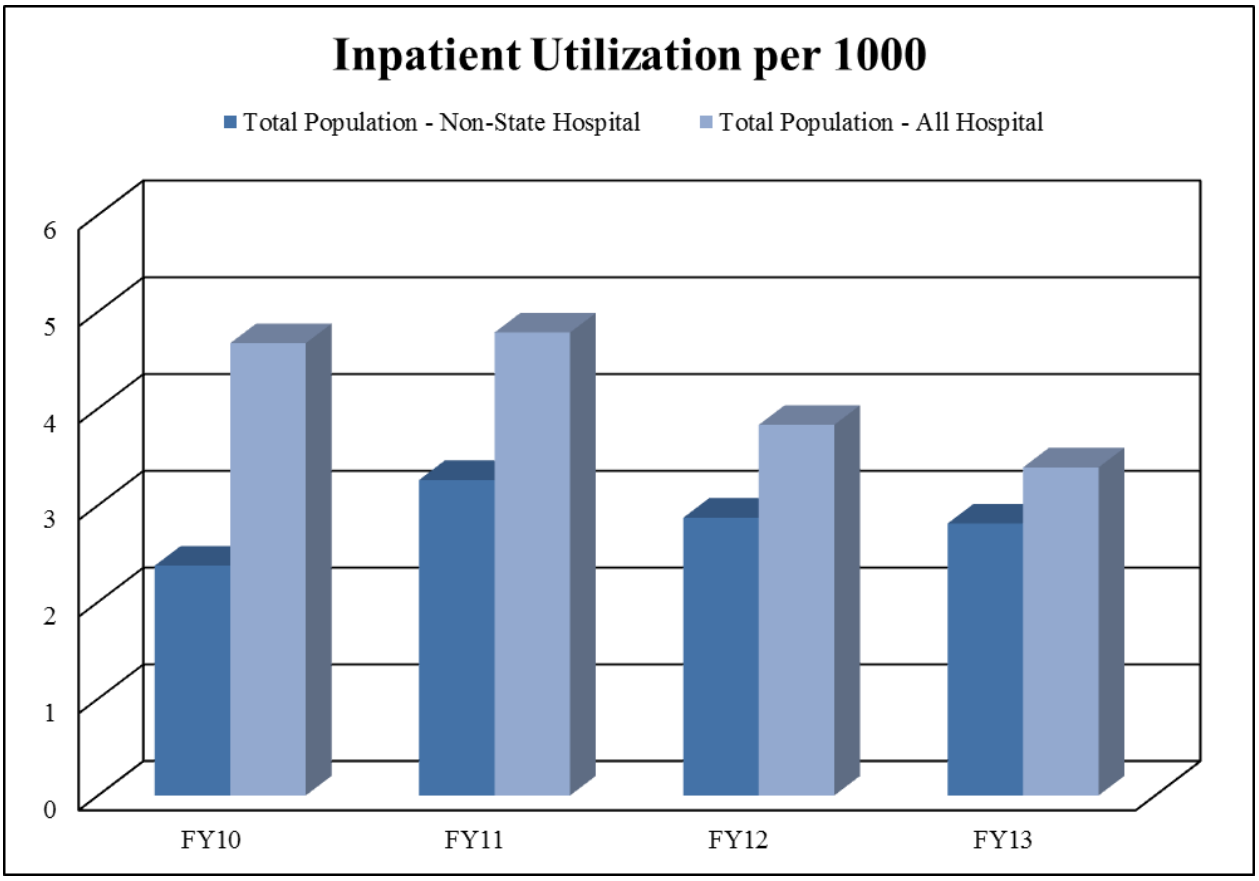
Figure 5: Average length of stay



Results and analysis - Inpatient Utilization

This indicator measures the total number of BHI member discharges from a hospital episode for treatment of a covered mental health disorder per 1000 members. Again, because the UM department continues to build relationships with providers at all levels of care, BHI has increased the utilization of other sub-acute levels of care, thereby decreasing inpatient utilization, as demonstrated in Figure 6. Therefore, BHI considers this objective to be met.

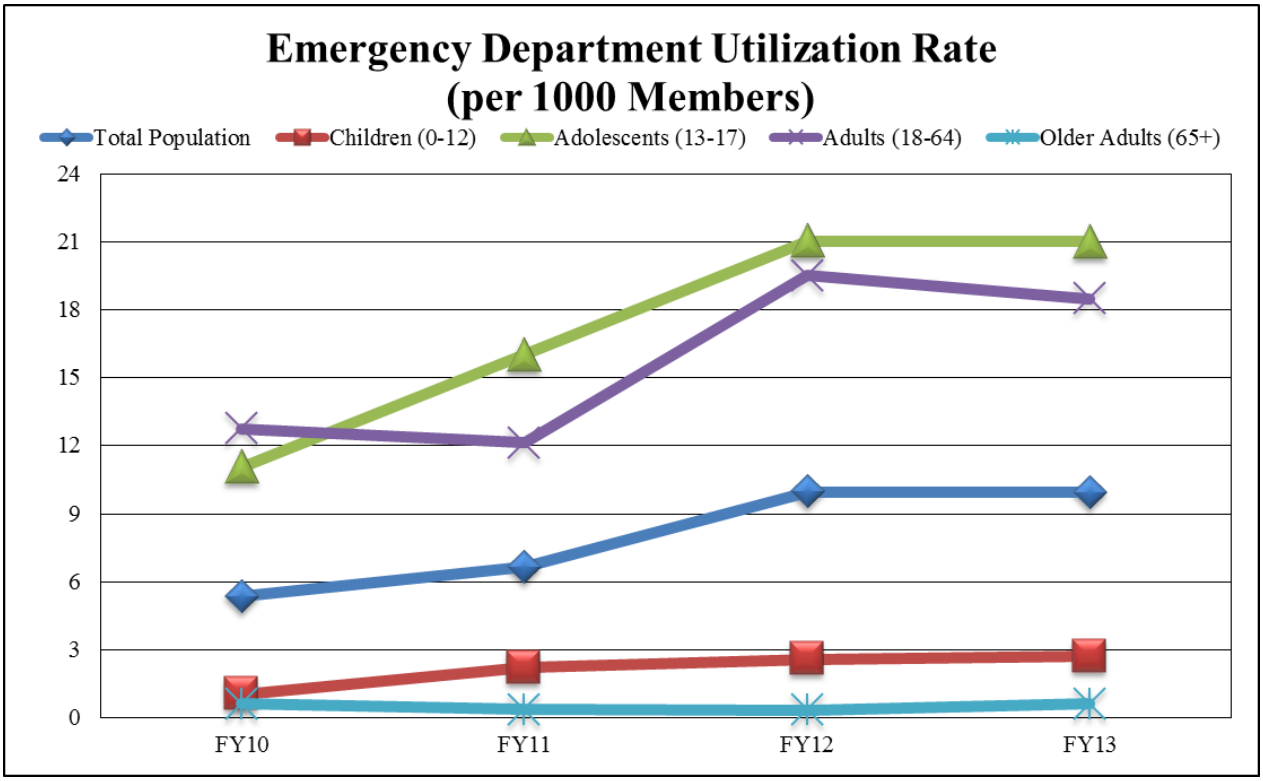
Figure 6: Inpatient utilization



Results and analysis – ED Utilization

This indicator measures the number of BHO member emergency room visits for a covered mental health disorder per 1,000 Members by age group and overall for the specified fiscal year 12-month period. In FY13, BHI experienced results very consistent with performance in FY12. Therefore, BHI considers this objective met.

Figure 7: ED utilization rates by age category



Barrier analysis and planned interventions

In an effort to obtain more timely data and see more timely effects of interventions, BHI has begun measuring each of these indicators on a quarterly basis for reporting in the Quarterly Performance Report Card. The BHI UM Department will continue to monitor all those admitted to an inpatient or ED level of care. The BHI QI Department will continue to measure these indicators on a quarterly basis to determine the short and long-term effects of the various interventions from the UM Department.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Monitoring over- and under-utilization	Continue to perform at or above the statewide BHO average for cost-of-care performance measures.	Continue to measure performance indicators quarterly to monitor for patterns and trends across services	6/30/15
		Continue to monitor specific member utilization for targeted interventions	

Improving Member Health and Safety

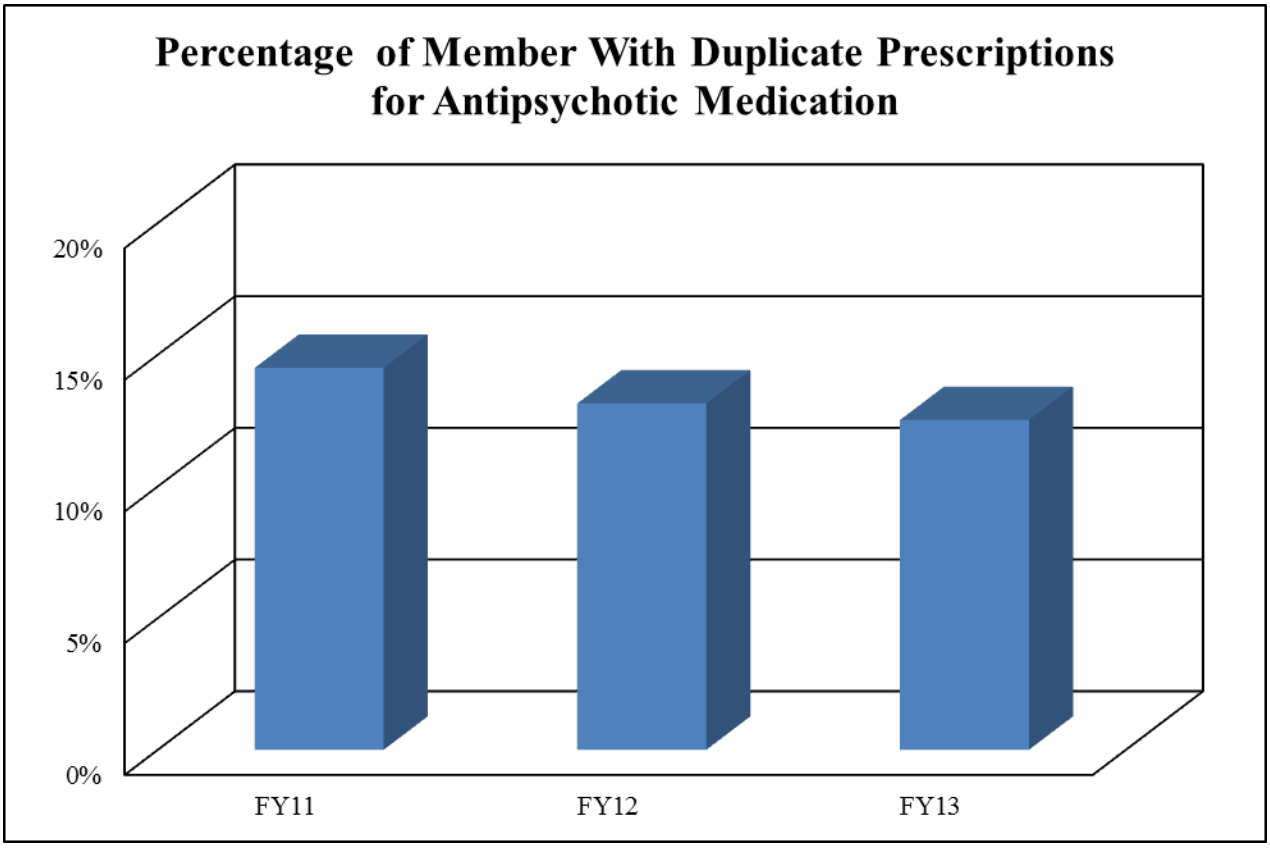
Summary of project – Quality and Safety of Clinical Care
There are several statewide performance measures designed to monitor member health and safety, particularly regarding psychotropic medications. BHI furthered this study in the recent selection and design of the Performance Improvement Project (PIP). For more information, see page 61.

Goals from FY14:

Project Title	Goal(s)	Action(s)	Target Date
Member Health and Safety	Perform at or above the statewide BHO average for the member health and safety performance measures.	Assess need for quarterly calculation of performance measures to better target interventions.	1/1/14

Results and analysis – Percentage with duplicate antipsychotic
Certain clinical circumstances allow members occasionally to be prescribed two or more atypical antipsychotic medications at the same time. This indicator measures those members prescribed multiple atypical antipsychotic medications (for 120 days or more) in proportion to members who are prescribed only one atypical antipsychotic. BHI demonstrated a slight decrease from FY12 to FY13 in this measure, as demonstrated in Figure 8.

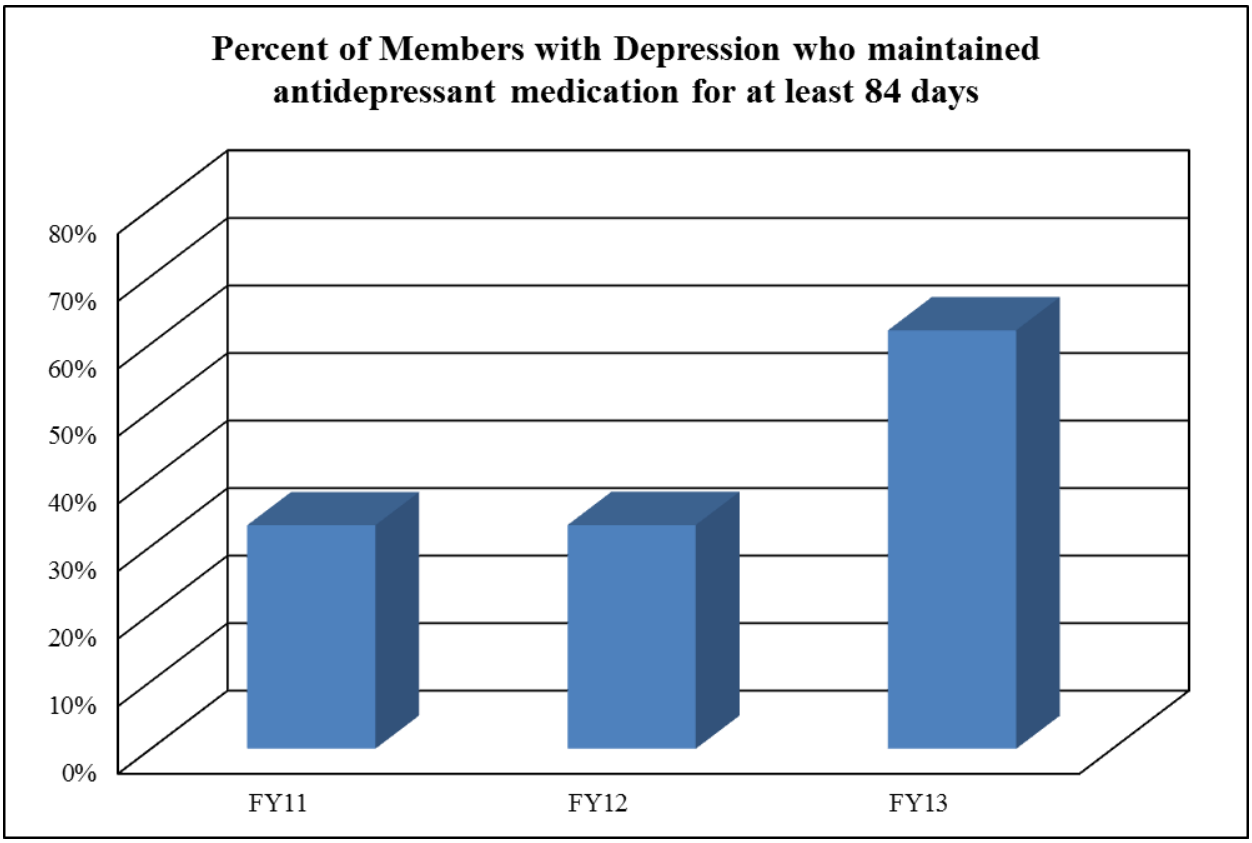
Figure 8: Of all members on antipsychotics, percent on two or more



Results and analysis – Adherence to atypical antipsychotics
This indicator measures the percentage of members 19-64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. Overall, Colorado Medicaid performed at 75.85% compliance (this measure was not calculated by BHO in FY13, but will be in FY14). BHI will continue to monitor and trend this indicator to identify opportunity for improvement.

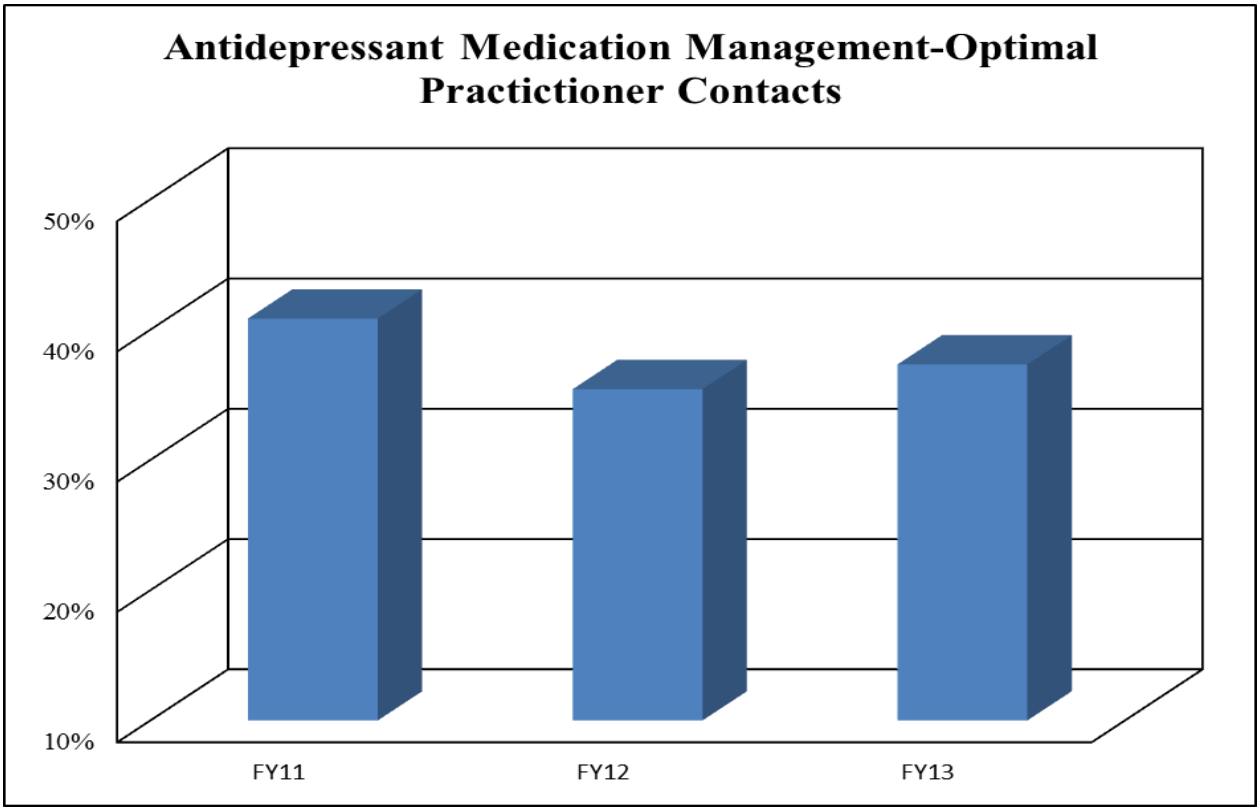
Results and analysis - Depression and Medication
This indicator measures the percent of members who have been: 1) diagnosed with a new episode of major depression, 2) treated with antidepressant medication, and 3) maintained on antidepressants for at least 84 days (12 weeks). As demonstrated in Figure 9, BHI showed significant improvement from FY12 to FY13. This can be attributed not only to clinical improvement, but also clarification in the calculation of this measure. BHI considers objectives for this measure to be met.

Figure 9: Depression and medication monitoring



Results and analysis - Anti-depression Medication Management and optimal practitioner contacts
This indicator measures the percent of members diagnosed with a new episode of major depression, treated with antidepressant medication, and who had at least three follow up contacts with a practitioner during the acute treatment phase (84 days or 12 weeks). As shown in Figure 10, BHI demonstrated a slight increase in performance from FY12, and continued to perform well above the statewide average for this measure (22.70%). Therefore, BHI considers the objective for this measure to be met.

Figure 10: Anti-depression medication management



Barrier analysis and planned interventions
Because these measures are calculated on an annual basis and often several months following the end of the fiscal year, targeted and timely interventions are difficult. BHI has an in-depth quality improvement project planned for FY15 that addresses both polypharmacy and standard dosages of psychotropic medications. This project has the potential to affect several of these member safety-related measures, particularly the polypharmacy of antipsychotics.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Member Health and Safety	Perform at or above the statewide BHO average for the member health and safety performance measures.	Implement polypharmacy medication project	1/1/15

Coordination of Care – Follow-up after Hospital Discharge

Summary of project – Quality and Safety of Clinical Care
It is important to provide regular follow-up treatment to members after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner after discharge is recommended to make sure that the member's transition to the home or work environment is supported and that gains made during hospitalization are not lost. It also helps health care providers detect early post-hospitalization reactions or medication problems and provide continuing care. Research has found that member access to follow-up care within 7 days of hospital discharge from hospitalization for mental illness to be a strong predictor of a reduction in hospital readmission. Facility treatment may stabilize individuals with acute behavioral conditions, but timely and appropriate continued care is needed to maintain and extend improvement outside of the hospital. The period immediately following discharge from inpatient care is recognized as a time of increased vulnerability. Ensuring continuity of care by increasing compliance to outpatient follow up care helps detect early post-hospitalization medication problems and provides continuing support that improves treatment outcomes and reduces health care costs.

Follow up after hospital discharge is a yearly performance measure that is calculated by BHI. The measure is the percentage of member discharges from an inpatient hospital episode for treatment of a covered mental health disorder to the community or a non-24-hour treatment facility and were seen on an outpatient basis (excludes case management) with a mental health provider within 7 or 30 days after discharge. Readmissions within that timeframe are excluded.

Goal from FY14

Project Title	Goal(s)	Action(s)	Target Date
Coordination of Care – Follow-up after hospital discharge	Provide 90% of outpatient appointments within 7 days after hospital discharge Provide 95% of outpatient appointments within 30 days of hospital discharge	BHI will continue to monitor this measure quarterly and implement targeted interventions	6/30/14

Results and analysis
BHI continued efforts from FY13 to provide high-volume providers with education about the services included and excluded from this performance indicator. Because this measure is calculated on an annual basis as part of the Performance Measure process, FY14 data is not yet available. While BHI continues to perform well above the statewide BHO average for this measure, performance continues to fall short of the new internal benchmarks set by the QI and UM departments.

Table 29: 7-day follow-up after hospital discharge (non-state hospitals)

Measurement Period	Measurement	Numerator	Denominator	Compliance	Benchmark
FY11	Baseline	139	278	50.00%	90.00%
FY12	Re-measurement 1	180	312	57.69%	90.00%
FY13	Re-measurement 2	182	313	58.15%	90.00%

Table 30: 30-day follow-up after hospital discharge (non-state hospitals)

Measurement Period	Measurement	Numerator	Denominator	Compliance	Benchmark
FY11	Baseline	188	278	67.63%	95.00%
FY12	Re-measurement 1	221	312	70.83%	95.00%
FY13	Re-measurement 2	229	313	73.16%	95.00%

Barrier analysis and interventions

In FY13, BHI attempted to measure this data on a quarterly basis. However, BHI encountered several barriers and issues with the integrity of the data being collected and analyzed, including incomplete data due to claims lag. To address this issue and to facilitate both timely and accurate data, BHI will be implementing a new process in September 2014 to utilize information from the CMHC hospital liaisons about members' discharge planning and confirmation of follow-up appointment attendance to calculate this measure on a quarterly basis. This data will be validated with claims data upon completion.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Coordination of Care – Follow-up after hospital discharge	Provide 90% of outpatient appointments within 7 days after hospital discharge Provide 95% of outpatient appointments within 30 days of hospital discharge	BHI will continue to monitor this measure quarterly and implement targeted interventions	6/30/15

Coordination of Care - Improving Physical Healthcare Access

Summary of project – Quality of Services
Physical healthcare access is defined by the total number of Members who received outpatient mental health treatment during the measurement period and had a qualifying physical healthcare visit during the measurement period.

In an effort to provide effective preventive behavioral health programs, BHI recognizes the need to integrate medical and psychosocial health. The solution was to create a Care Management program that promotes behavioral wellness by addressing, stabilizing, and preventing decline in its members' physical health. A majority of the population BHI serves has co-occurring chronic mental and physical illness such as diabetes, bipolar disorder, asthma, heart disease, COPD, and schizophrenia. The goal of the Care Management program is to eliminate barriers members face when navigating the healthcare system and, thus, enabling them to better care for themselves - both mind and body. BHI acknowledges the connection between the quality of one's physical health and their ability to maintain mental stability. The BHI Care Management program seeks to ensure the mental health of its members by improving their overall health; therefore, reducing costs for both behavioral and physical healthcare.

There are many ways BHI Health Coordinators work to connect members to appropriate medical care. BHI Health Coordinators provide members with referrals to PCPs and specialists in their catchment area. If a member is unable to do so themselves, the coordinator will also schedule appointments and make transportation arrangements. Linking each member to a PCP allows him or her to establish a Medical Home with access to ongoing and preventative care reducing the need for ED visits and inpatient hospital stays. The Health Coordinator receives referrals from therapists, case managers, and prescribers within the CMHCs. The Health Coordinator also reviews claims data and contacts members who are considered high utilizers of hospital resources. In these cases, if the member is not already connected to their local CMHC, the Health Coordinator will make a psychiatric referral, if appropriate.

Once a member is connected to a PCP or specialist, the Health Coordinator continues a documented process. Upon written permission from the member, the Health Coordinator seeks to ensure that all parties involved in the member's medical care are aware of all interventions. This includes facilitating the release of records, making sure all providers have access to lab results, current medication lists, and most importantly, increasing communication between physical and mental health care providers. Communication between physical and behavioral health care providers is paramount to maintaining a member's psychiatric stability and preventing future decline.

Goal from FY14

Project Title	Goal(s)	Action(s)	Target Date
Coordination of Care – Improving physical healthcare access	Continue to improve coordination of care	Continue to develop the Care Management Program	6/30/14
	Improve measurement of coordination of care	Develop Quarterly Performance Measure to identify the percentage of members receiving services who are linked with a PCP	1/1/14

Results and analysis
This performance measure is calculated by HCPF. BHI will continue to monitor this measure and implement interventions to increase performance. Table 31 below shows BHI performance in FY12 and FY13. While BHI showed significant increase from FY12, performance was below the state average.

Table 31: Percentage of BHI members with a physical healthcare visit

	FY12	FY13
Total number of unduplicated members who had at least one BHI outpatient service claim/encounter during the measurement period. Members must be Medicaid eligible and enrolled at least ten months with the same BHO during the 12-month measurement period (denominator).	12,124	13,262
Total number of members from the denominator with at least one preventive or ambulatory medical visit (numerator)	8,828	11,552
BHI Performance	72.81%	87.11%
Statewide BHO average	72.80%	89.31%

In FY14, BHI also began working with providers to collect information about the number and percentage of members receiving behavioral health services who had a primary care physician (PCP). This information will be collected and reported in our Quarterly Report Card. Therefore, BHI considers the objectives for this measure to be met.

Barrier analysis and planned interventions
The CMHC's in the BHI's catchment area have built the necessary information into their electronic health records for the measurement of the PCP indicator. However, collecting this information on all existing Medicaid members has been daunting; therefore, BHI has taken a phased approach to implementing this indicator. BHI hopes that the measure will be fully implemented by fall 2014.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Coordination of Care – Improving physical healthcare access	Continue to improve coordination of care	Continue to develop the Care Management Program	6/30/15
	Improve measurement of coordination of care	Fully implement PCP measure for Quarterly Report Card	1/1/15

Improving Member Functioning

Summary of Project – Quality and Safety of Clinical Care
The Recovery Model focuses on empowering members not only in relation to their illness, but also for members to take charge of their entire lives. Two performance measures focus on improving overall member functioning, as measured by their living status.

Goals from FY14

Project Title	Goal(s)	Action(s)	Target Date
Improving Member Functioning	Continue to measure and monitor performance	Cooperate with HCPF on the calculation of performance measures	6/30/14

Results and analysis
The Independent Living Status indicator measures the percent of clients, age 18 years and older, living independently, that maintain this status during the measurement period. The progress towards Independent Living Status indicator measures the percent of clients, age 18 years and older, who move to a less restricted place of residence, including independent living, during the measurement period. BHI performance on these measures is reflected in Figure 11 and Figure 12.

While BHI performance decreased slightly, it remains consistent with the statewide average for this measure. Therefore, BHI considers objectives for this measure to be met.

Figure 11: Members maintaining independent living status

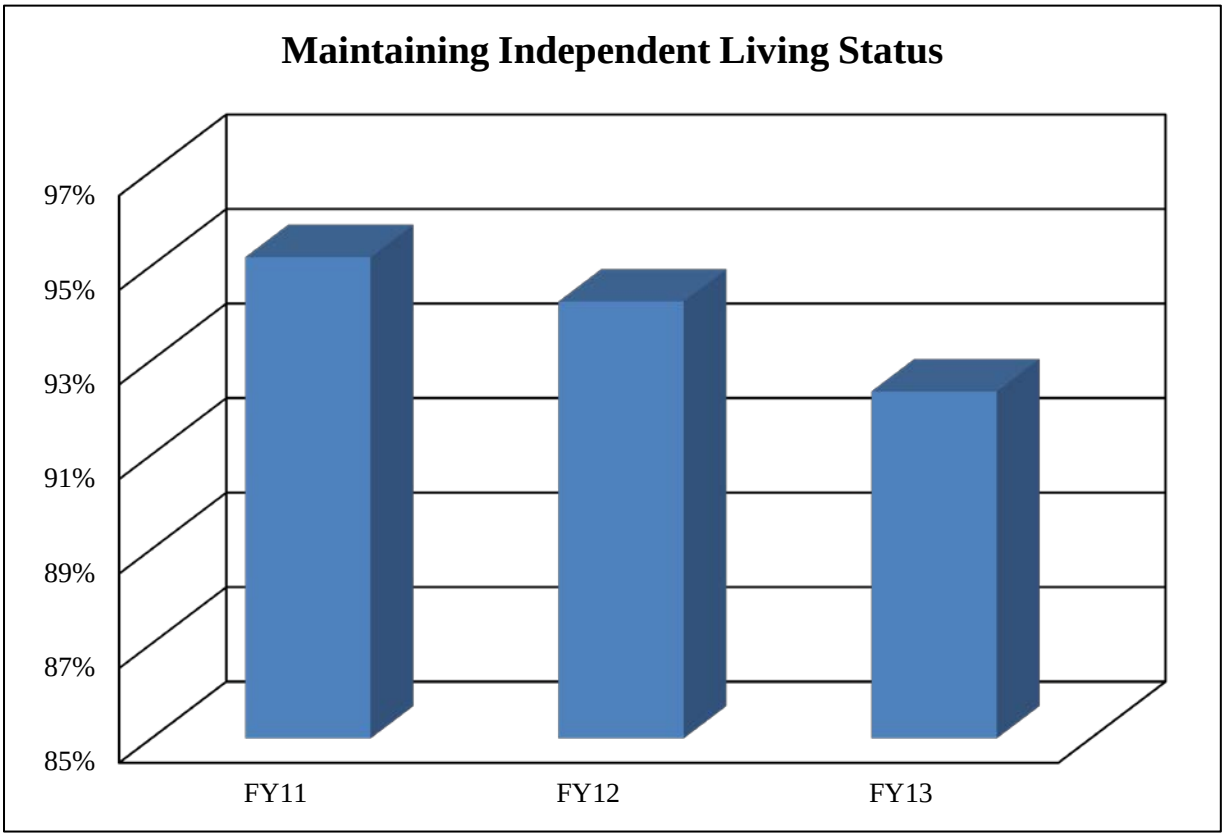
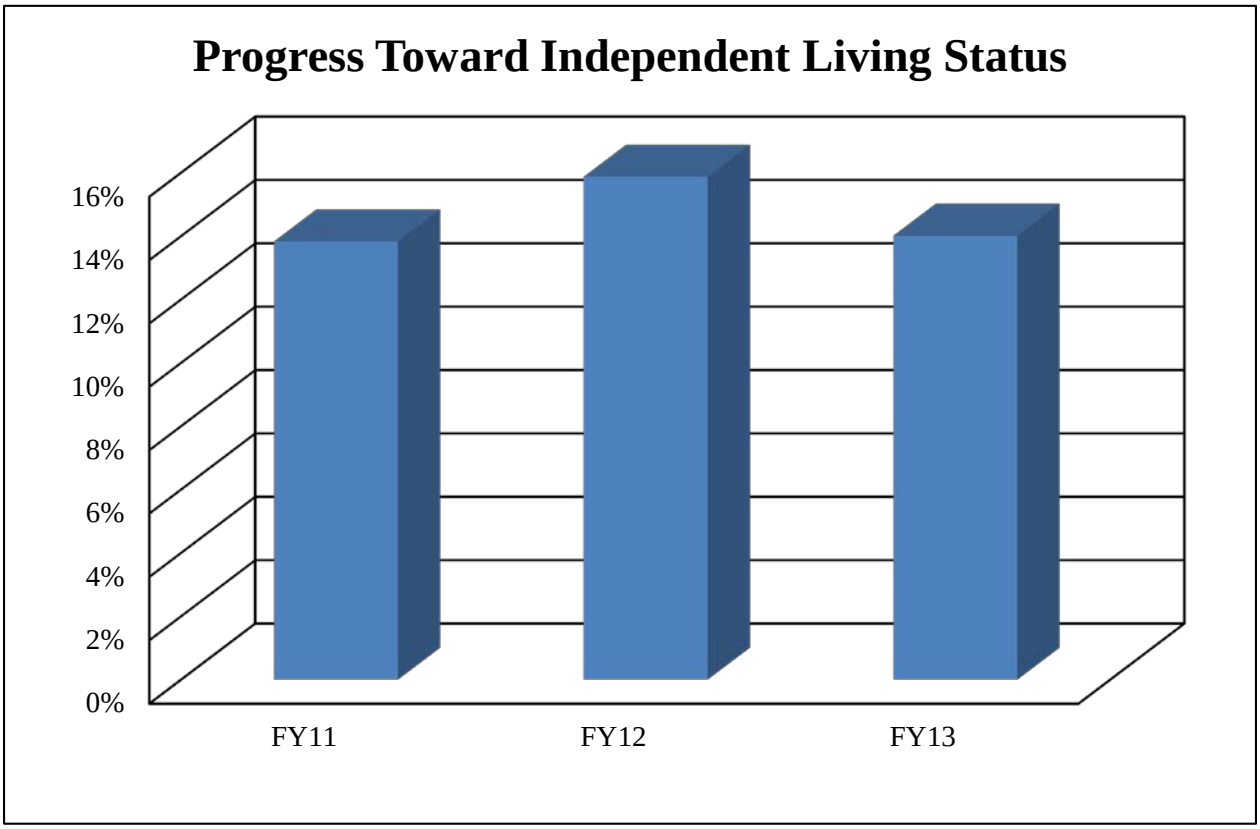


Figure 12: Members making progress towards independent living status



Barrier analysis and planned interventions

Performance measures such as these are difficult to assess for proper benchmarks and goals. While optimistic to believe that 100% of members receiving services could be living independently, this goal would be unrealistic. It is therefore difficult to distinguish an appropriate percentage of members who "should" be living independently and/or making progress towards independent living. Therefore, BHI will continue to monitor these measures over time and assess the need for intervention on a case-by-case basis if negative trends emerge.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Improving Member Functioning	Continue to measure and monitor performance	Cooperate with HCPF on the calculation of performance measures	6/30/15

Information Systems Capabilities Assessment Tool (ISCAT) Audit

Summary of project
Each of the performance measures that are calculated for BHI is subject to validation by HSAG. Some of these measures were calculated by HCPF using data submitted by the BHOs; other measures were calculated by the BHOs. The measures came from a number of sources, including claims/encounter and enrollment/eligibility data.

The CMS Performance Measure Validation Protocol identifies key types of data that should be reviewed as part of the validation process. Below is a list of the types of data collected and how HSAG conducted an analysis of this data:

- Information Systems Capabilities Assessment Tools (ISCATs) were requested and received from each BHO and the Department. Upon receipt by HSAG, the ISCATs were reviewed to ensure that all sections were completed. The ISCATs were then forwarded to the validation team for review. The review identified issues or items that needed further follow-up.
- Source code (programming language) for performance measures was requested and was submitted by the Department and the BHOs. The validation team completed query review and observation of program logic flow to ensure compliance with performance measure definitions during the site visit. Areas of deviation were identified and shared with the lead auditor to evaluate the impact of the deviation on the measure and assess the degree of bias (if any).
- Performance measure reports for FY 2012–2013 were reviewed by the validation team. The team also reviewed previous reports for trends and rate reasonability.
- Supportive documentation included any documentation that provided reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. All supportive documentation was reviewed by the validation team, with issues or clarifications flagged for further follow-up.

Performance measures that were selected for validation for FY13 were:

- Hospital Recidivism
- Overall Penetration Rates (by service category, age category, eligibility category)
- Follow-up After Hospitalizations for Mental Illness (7- and 30-day follow-up)
- Percent of Members with SMI with a Focal Point of Behavioral Health Care
- Improving Physical Healthcare Access
- Inpatient Utilization
- Hospital Average Length of Stay
- Emergency Department Utilization

Goal from FY14

Project Title	Goal(s)	Action(s)	Target Date
Information Systems Capabilities Assessment Tool (ISCAT) audit	Continue to achieve 100% compliance on the audit by	Continue to monitor and assess each aspect of the performance measure calculation process and adjusting accordingly	6/30/14

Results and analysis
BHI achieved "met" status for all elements reviewed, resulting in a 100% compliance score. The strengths and suggested areas of improvement include:

- Strengths:
  - BHI continued to have a very collaborative relationship with Colorado Access, its administrative service organization (ASO).
  - BHI collaborated with the BHOs and the Department in acting on the recommendations from the previous year's audit to revise the scope document.
  - BHI maintained a team of experienced professionals who work together to ensure robust and accurate performance measure reporting.
- Suggested areas of improvement:
  - BHI should continue to work with the Department and other BHOs to address and resolve issues identified in the scope document, such as clarifying the type of mental health practitioners required and required diagnoses for select measures.
  - BHI should implement a rate validation process to ensure accurate rates. This process should include checking the source data using various data sorts to ensure that proper date ranges and codes are used, as well as ensuring all data for the review period have been included.
  - It was identified during the site visit that one individual was responsible for the performance measure rate calculation process. BHI should implement a process to provide additional staff as backup for this process.
  - As Colorado Access begins the transition of its claims processing to a new transactional system, BHI should make sure that this process is thoroughly documented, including any issues encountered along the way and how those issues were resolved.

Barrier analysis and planned interventions
HSAG reported that BHI acted on the recommendations made from the previous year, collaborating with the Department and the other BHOs regarding the scope document, addressing the challenges that were associated with continuous enrollment and concerns related to proper numbering of the indicators. The formatting of the scope document was addressed and corrected by a joint effort between BHI, the other BHOs, and the Department.

BHI has not encountered any barriers in implementing the areas of improvement suggested by HSAG. Therefore, each of the interventions above has been implemented effectively.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Information Systems Capabilities Assessment Tool (ISCAT) audit	Continue to achieve 100% compliance on the audit.	Continue to monitor and assess each aspect of the performance measure calculation process and adjusting accordingly	6/30/15

Section 8: Clinical Practice Guidelines and Evidence-Based Practices

Practice Guideline Review and Development

Summary of project – Quality and Safety of Clinical Care
BHI adopts practice guidelines that meet the following criteria as required by the Medicaid contract and federal managed care regulation:

- The guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field
- The guidelines take into consideration the particular needs of BHI members
- The guidelines have only been adopted after consultation with appropriate contracted health care and mental health professionals
- The guidelines are reviewed and updated periodically as appropriate

BHI reviews, updates, and implements practice guidelines through our Standards of Practice Committee (SOP). Upon approval from the SOP Committee, BHI distributes the new or updated practice guidelines to providers in the following manners:

- To any providers on the SOP and PEO committees
- To the CPN providers through the provider bulletin or individual mailings/emails
- Posting on the BHI website

Goals from FY14

Project Title	Goal(s)	Action(s)	Target Date
Clinical Practice Guidelines	Develop and implement practice guidelines to meet the clinical needs of members and improve consistency across providers	Develop or adopt practice guidelines based on valid and reliable clinical evidence or a consensus of health care professionals	6/30/14
		Review all current practice guidelines every 2 years (or as necessary)	

Results and analysis
Table 32 below indicates the current BHI practice guidelines, including which guidelines have been newly implemented, recently reviewed, or remain ongoing. Because NCQA requires that practice guidelines are updated every two years (rather than the HCPF requirement of updating "as appropriate,") BHI has been working to review existing practice guidelines to remain in compliance with NCQA standards.

BHI also re-designed the practice guideline program. All specific medication algorithms were discontinued, and relevant medication guidelines are now included as an aspect of treatment in each practice guideline. Each practice guideline also includes a member information handout which explains the parameters set forth in the practice guideline in a member-friendly format (6^{th} grade language where possible) rather than clinical and medical terms. The member handouts are posted on the BHI website and promoted in the quarterly Member and Family Newsletter. BHI considers FY14 objectives for the practice guideline program to be met.

Table 32: Current BHI practice guidelines

Practice Guideline	Reviewed in FY14	Remain ongoing	Planned for FY15
Atypical Antipsychotics: Monitoring for Metabolic Side Effects		X	
Bipolar Disorder		X	
Schizophrenia			X
Risk Assessment		X	
Eye Movement Reprocessing and Desensitization (EMDR)	X		
Developmental Disabilities and Mental Illness		X	
Reactive Attachment Disorder		X	
Obsessive Compulsive Disorder		X	
Major Depressive Disorder			X
Attention Deficit Disorder			X
Anxiety Disorders			X

Barrier analysis and planned interventions

BHI spent much of the fiscal year strategically planning the re-design of the practice guideline program and reviewing previous procedures. While this re-design was necessary, it proved to be time consuming and left little time for the creation and review of the current guidelines. However, BHI has a project plan for all guidelines identified above to be created and/or reviewed by December 2014. This new process will ensure success with related NCQA standards for the creation and monitoring of practice guidelines.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Clinical Practice Guidelines	Develop and implement practice guidelines to meet the clinical needs of members and improve consistency across providers	Create and review all identified practice guidelines per NCQA standards.	1/1/2015
		Create and distribute member informational materials about practice guidelines	

Practice Guideline Compliance – Reactive Attachment Disorder

Summary of project – Quality and Safety of Clinical Care
BHI developed the Reactive Attachment Disorder (RAD) practice guideline in March 2013. The practice guideline includes specifications for the assessment and treatment of RAD, including a "focus on creating positive interactions with caregivers" and an avoidance of polypharmacy. In order to measure compliance with these aspects of the practice guideline, BHI analyzed encounter and pharmacy claims data in the following manner:

- Indicator 1: Percentage of members with primary diagnosis of RAD (313.89) who received family therapy during fiscal year 2014 (encounter data)
- Indicator 2: Percentage of members with primary diagnosis of RAD (313.89) who were prescribed three or fewer psychotropic medications (pharmacy data)

Goal from FY14

Project Title	Goal(s)	Action(s)	Target Date
Compliance with Clinical Practice Guidelines	Increase oversight of providers' compliance with BHI clinical practice guidelines	Continue to monitor compliance with at least two important aspects of at least two clinical practice guidelines	6/30/14

Results and analysis
While compliance with Indicator 2 (avoidance of polypharmacy) was very high, the compliance with Indicator 1 was rather low (inclusion of family therapy). BHI only included one family therapy code in this analysis – 90847 is family therapy with the client present. The code for family therapy *without* the client present (90846) was excluded.

Table 33: Compliance with RAD Practice Guideline

Indicator 1: Percentage of members with primary diagnosis of RAD (313.89) who received family therapy during FY14	
Denominator: number of members with primary diagnosis of RAD (313.89)	137
Numerator: number of members with primary diagnosis of RAD (313.89) who also received a family therapy service (90847)	43
Percent compliance	**31.39%**
Indicator 2: Percentage of members with primary diagnosis of RAD (313.89) who were prescribed three or fewer psychotropic medications	
Denominator: number of members with primary diagnosis of RAD (313.89)	137
Numerator: number of members with primary diagnosis of RAD (313.89) who were prescribed three or fewer psychotropic medications	134
Percent compliance	**97.8%**

Barrier analysis and planned interventions
BHI has planned some further analysis for this project, including investigating if members who did not have a 90847 service may have had a 90846 service. Clinical services with the child's caregiver(s) without the client present can be an integral part of building a healthy environment for the child and teaching techniques to the caregivers.

In addition, BHI will continue to educate providers through the provider bulletin about all practice guidelines, including the RAD guideline. The RAD guideline will also be revised for clarity.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Compliance with Clinical Practice Guidelines	Monitor providers' compliance with BHI clinical practice guidelines	Monitor compliance with RAD guideline via encounter and pharmacy claims	6/30/15

Practice Guideline Compliance – Risk Assessment

Summary of project – Quality and Safety of Clinical Care
BHI reviewed and updated the Risk Assessment practice guideline in 2013. The practice guideline includes specifications for both suicide and violence assessments and includes a tool (based on the SAFE-T assessment) that can be utilized by clinicians.

The BHI provider audit process (please reference page 38) includes a review of two full clinical records. In order to monitor compliance with the BHI Risk Assessment practice guideline, BHI includes the following elements in the clinical record review:

- Suicide risk assessment
- Violence risk assessment
- Crisis Plan (or documentation that crisis plan is not needed)

Goal from FY14

Project Title	Goal(s)	Action(s)	Target Date
Compliance with Clinical Practice Guidelines	Increase oversight of providers' compliance with BHI clinical practice guidelines	Continue to monitor compliance with at least two important aspects of at least two clinical practice guidelines	6/30/14

Results and analysis
BHI completed full clinical record audits on six providers (two records per provider). The results of the Risk Assessment practice guideline compliance review are listed in Table 34 below.

Table 34: Risk Assessment Practice Guideline Compliance Review

	Suicide Assessment	Violence Assessment	Crisis Plan
Provider A	100%	100%	100%
Provider B	100%	100%	100%
Provider C	100%	100%	100%
Provider D	100%	100%	0%
Provider E	100%	100%	0%
Provider F	100%	100%	50%

Each of the non-compliance scores for Crisis Plan (providers D, E, and F) were due to a lack of documentation that a Crisis Plan was not needed at the time of assessment. Each of the assessments was thorough and the members were low risk, and therefore a crisis plan was not necessary. BHI provided education to each provider about documenting this in the members' assessments. BHI considers objectives related to this project to be met.

Barrier analysis and planned interventions
When providing education to providers about the results of this review, providers admit to being unaware of BHI's practice guidelines. Therefore, BHI plans to highlight one practice guideline in each provider bulletin during FY15. BHI will provide a link to the full guideline and include a narrative of the main points of each guideline.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Compliance with Clinical Practice Guidelines	Monitor providers' compliance with BHI clinical practice guidelines	Monitor compliance with Risk Assessment guideline via clinical record review	6/30/15

Practice Guideline Compliance – Atypical Antipsychotics and Monitoring of Metabolic Side Effects

Summary of project – Quality and Safety of Clinical Care
The intent of this Performance Improvement Project (PIP) is to improve processes such as timely metabolic lab documentation, review, and appropriate follow-up for clients prescribed atypical antipsychotics. BHI chose this topic as a PIP for several reasons. Primarily, the prevalence of metabolic side effects for atypical antipsychotics is getting national recognition as a problem that needs addressing. Secondly, BHI and its centers have been focusing on improving coordination and integration of care between physical and mental health through several initiatives over the past few years and addressing this current topic is a logical next step in continuing those efforts.

In FY10, BHI conducted a Focused Study exploring current provider practices in monitoring metabolic side effects. Through the process of conducting the Focused Study, BHI and its committees developed and adopted a practice guideline based on national standards for monitoring side effects for clients taking atypical antipsychotics. BHI believes that focusing on this topic across its service-region will improve awareness as well as encourage the drastic changes in both primary and mental health practices needed to improve conformance with our guideline.

This PIP is designed to improve processes such as timely metabolic lab documentation, review and appropriate follow-up for clients prescribed new atypical antipsychotics. BHI will develop resources and tools to assist our providers in implementing process changes. These process changes will help medication management teams refer clients in a timely manner for initial or ongoing labs based on BHI guidelines. As a result, clinicians will be able to catch and address changes in metabolic functioning earlier to minimize the effects on the client in order to prevent new onset or exacerbation of diabetes, dyslipidemia, and cardiovascular disease, and slowing or reversing weight gain. Discussing and addressing side effects collaboratively with the client will encourage better medication adherence and, ultimately, lead to better mental health outcomes. The ultimate goal of these interventions is improved client health.

Quantifiable Measure #1: Fasting plasma glucose lab documentation within 30 days prior to or up to 30 days after initiating a new atypical antipsychotic
Quantifiable Measure #1a: Follow-up within 30 days of lab documentation for clients with abnormal fasting plasma glucose results

Quantifiable Measure #2: Fasting lipid panel documentation within 30 days prior to or up to 30 days after initiating a new atypical antipsychotic
Quantifiable Measure #2a: Follow-up within 30 days of lab documentation for clients with abnormal fasting lipid panel results

Goal from FY14

Project Title	Goal(s)	Action(s)	Target Date
Atypical Antipsychotics and Monitoring for Metabolic Side Effects	Meet all HCPF/HSAG requirements and deadlines for Performance Improvement Projects	Coordinate with HSAG to ensure that projects are designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care and services while showing confidence in the reported improvements	6/30/14
	Increase performance on Measures 1 and 2 by 5% in Re-Measurement period 1	Educate prescribers and members about the importance of lab testing and monitoring of metabolic side effects	
	Increase performance on Measures 1a and 2a by 10% in Re-Measurement period 1	Work with IT and medical support staff to improve communication and documentation of lab results and follow up	

Results and analysis
FY12 served as the baseline measurement period for this PIP, and data was analyzed during FY13. FY13 data was analyzed in fall 2013. Table 35 reflects the baseline results from FY12 and Remeasurement 1 results from FY13.

Table 35: Baseline and Remeasurement data for all quantifiable measures

Quantifiable Measure	Baseline Measurement Rate	Remeasurement 1 Rate
Measure 1 (Fasting plasma glucose lab documentation)	6.71%	9.97%
Measure 1a (Follow-up for abnormal fasting plasma glucose results)	NA	100%
Measure 2 (Fasting lipid panel documentation)	4.69%	7.72%
Measure 2a (Follow-up for abnormal fasting lipid panel results)	57.14%	45.83%

The data collection process for the Re-measurement 1 period was collected in the same way as Baseline data to preserve the integrity of the study. BHI still believes this study is generalizable to a larger population of individuals who receive atypical antipsychotic medications.

Baseline measurement for Indicator 1a was 6.71% and for Indicator 2a is 4.69% and the goal for Re-measurement 1 was to increase that percentage by 5% for 1a and 2% for 2a. Indicator 1b measured at 0% (because no labs recorded were abnormal) and Indicator 2b measured at 57.14%, and the goal for Re-measurement 1 was to increase those percentages by 10% each.

The Re-measurement 1 result for Indicator 1a was 9.97%, which is an increase of 3.26 percentage points. This is equal to a 48.6% ((9.97-6.71)/6.71) over the baseline rate; therefore BHI met its goal of a 5% improvement. The Re-measurement 1 result for Indicator 1b was 100%; however only one lab was found to be abnormal. An assessment of the improvement rate for Indicator 1b cannot be completed because the baseline results were not applicable, as none of the initial labs had abnormal values. The Re-measurement 1 result for Indicator 2b was 7.72%, which is an increase of 3.03 percentage points. This is equal to a 64.6% increase over the baseline rate; therefore BHI met its goal of a 2% improvement for this indicator. Indicator 2b Re-measurement 1 result was 45.83%, which is a decrease of 11.31 percentage points over the baseline value. This is equal to a decrease of 19.8% over the baseline value, which shows that BHI did not meet its goal of a 10% increase.

BHI believes this PIP was moderately successful. In the process of the PIP, BHI was able to update the practice guideline with feedback from providers, distribute it to relevant providers, and educate members about the importance of getting labs completed. Overall, BHI was able to improve lab documentation results. There was a decrease in the follow-up lab documentation for abnormal labs from baseline to Re-measurement 1, but often members would miss/reschedule/cancel appointments within the 30-day timeframe leading to follow-up happening between 31-90 days after documentation was completed. BHI will educate providers about the importance of following-up with members about their lab results in a timely manner either via telephone if an appointment has to be missed/cancelled/rescheduled or in person when the member comes in for another appointment. BHI plans to continue to update the practice guideline at least every two years or sooner, if appropriate and continue to distribute to providers on an on-going basis to help improve lab documentation. BHI will also continue to provide education to members about the importance of getting labs completed. BHI has considered posting a flyer at its drop-in centers and provider's offices that informs members about the necessity of labs.

BHI does not believe that there was any random variation in the sample population between Baseline and Re-measurement 1. Further analysis of Re-measurement 1 results, revealed that several labs were documented between 31 and 45 days after initiation of the antipsychotic medications and led BHI to continue to be concerned with the stringent timeframes identified in the indicators. The same was true for follow-up if the lab was abnormal. In addition, several lipid panel lab values were close to "normal" as defined in the study; however, the BHI practice guideline does not specifically state what an abnormal value for glucose or lipid panel labs would be and what the procedure is for follow-up.

BHI also believes that since the PIP measures fiscal year data that interventions cannot be completed in time to make a significant difference in the results. For instance, Re-measurement 1 period covered initiation of atypical antipsychotics for FY12; however, interventions from the Baseline measurement period did not start until halfway through FY12. This could contribute to the lack of improvement in results of this PIP, along with the lack of clarification in the practice guideline about the expectation of lab documentation.

Barrier analysis and planned interventions

The BHI QI team met with executive leadership (including CEO, COO, and CMO) to discuss barriers and determined that the same barriers exist from baseline line to Re-measurement 1. Since BHI is too far into the Re-measurement 2 period, it is unlikely that the interventions will affect the results in the ways that BHI hoped. However, it was also decided that the PIP design might need to be modified to more accurately reflect lab documentation and follow-up procedures and the BHI practice guideline. One possible redesign is to check to make sure the CMHCs are capturing true initiation by analyzing the data sent in by the CMHCs against pharmacy files to determine if the member has not taken the medication within the prior year. The other possible redesign is to broaden the date range for lab documentation to 45-60 days to allow for a more inclusive sample.

The only exception is the barrier of logistics and losing the lab referral. BHI did not find this to be a crucial problem as the member can lose the lab referral and still complete the lab. The lab facility can call the provider (or the Community Mental Health Center) to find out what type of lab was ordered, etc. so the member can complete the required labs.

One of the barriers identified in this study was that labs were not being ordered when a client started a new atypical antipsychotic medication. FY13 documentation still indicated that the need for medication outweighed the possible metabolic side effects. Other notes continued to indicate that previous labs were within normal limits. A large percentage of providers were still not ordering labs at the time the client started a new atypical antipsychotic medication. In addition, as mentioned before, the guideline does not spell out the 30-day documentation requirements, so providers could be following the guideline but not documenting the lab within 30 days, which in this PIP, would count against the results. BHI believes the 30-day documentation requirements are too stringent and BHI would like to consider changing the requirements of the PIP in the future. BHI believes that the updating of the practice guideline and distribution of it to providers in FY13 was helpful in improving the lab documentation from Baseline to Remeasurement 1. BHI would like to continue this intervention to help continue to improve lab documentation results. As an intervention for FY14, BHI's Chief Medical Officer will review the guideline with the SOP Committee in July of 2014 and discuss this PIP project so providers are knowledgeable about what BHI is assessing and how improvement is defined. The practice guideline will be updated at least every two years, or as needed. Providers will continue to be informed of the revisions to the practice guideline via the Provider Bulletin, the BHI website, and through the SOP Committee.

BHI is in the process of developing a new practice guideline program, in which a member information sheet about the practice guideline is created (with member input/feedback) and given out to members at various provider locations, the BHI website, and as requested. BHI will create this member information sheet for the Atypical Antipsychotic Monitoring guideline and ensure it is discussed via the Member Advisory Board (MAB) and sent out in the Member Newsletter. This intervention is new and will address member education about the importance of labs. This intervention is also targeted at providers because BHI feels the more members that are educated about the need for labs, they can advocate for themselves with providers to have labs ordered. As seen in the results, informing providers of the need to order labs helps improve the documentation of those labs results.

BHI did not provide training on the practice guideline, since there were very little changes during the revision process last year. BHI believed that provider education about the practice guideline was not necessary and the providers would be able to understand the guideline without education. This intervention was discontinued. BHI also determined that losing the lab referral slip was not a factor in why members would not complete lab work, so the intervention has been discontinued and replaced with the education of BHI Care Managers about the practice guideline. BHI is in the process of refining its Care Management Program. Care Managers will be educated on the practice guideline so they can encourage and help members to schedule and complete labs. The Care Managers can act as a bridge to help coordinate care between lab facilities and providers. This is a new intervention this year and is designed to help improve member's ability to complete labs.

BHI did send a mailer out about the importance of having labs completed via the Member and Family Newsletter and the BHI QI Department also attended a MAB meeting to further educate members. BHI believes that ongoing education of members about labs is important and will again attend a MAB meeting to discuss the results of the PIP and the importance of getting labs completed, as a current intervention. BHI will also share the "member information sheet" via the MAB meeting and the Member and Family Newsletter when it is completed.

For NCQA requirements, BHI has to monitor compliance with practice guidelines. BHI plans to monitor the Atypical Antipsychotic – Monitoring for Metabolic Side Effects through the NCQA process, instead of through the PIP process. BHI is aware that the guidelines for this PIP are more stringent than the requirements of the practice guideline. BHI would like the opportunity to monitor compliance with the practice guideline in a more effective and efficient way. BHI is considering providing more member education about the importance of labs through focus groups and finding out why members may not be completing labs. BHI believes that prescribers are ordering labs more often at the initiation of an atypical antipsychotic medication, but members are not having the labs completed, or the results are not forwarded to the prescriber for review.

Secondly, BHI believes that a more effective way to measure initiation is by using pharmacy files. A simple query of pharmacy files, should allow BHI to identify true initiation of an atypical antipsychotic medication better than using the CMHC data provided to us. This would allow for more member inclusion in the overall population, as we would be looking at all members who initiated an atypical antipsychotic instead of just those being seen by the CMHCs. For the NCQA process, BHI is considering a heavier focus on member interventions and the importance of care coordination.

BHI requested formal end to this PIP project, as it appears there can be some re-design and different ways to measure lab documentation and compliance with the practice guideline that does not include chart reviews. BHI recently decided to send out a member survey to monitor compliance with this practice guideline. The CMHCs were asked to hand out the two-question survey to members as they are checking in for a medication appointment. Results will be available in the FY15 Annual Quality Report.

Goal for FY15

Project Title	Goal(s)	Action(s)	Target Date
Compliance with Clinical Practice Guidelines	Monitor providers' compliance with BHI clinical practice guidelines	Monitor compliance with Atypical Antipsychotic guideline via member survey	6/30/15

Evidence-Based and Promising Practices

Summary of Project – Quality and Safety of Clinical Care
Evidence-based practices (EBPs) typically refer to programs or practices that are proven to be successful through research methodology and have produced consistently positive patterns of results. The implementation of proven, well-researched programs is standard practice and required by most funding sources. Promising practices are those that may have demonstrated efficacy through qualitative evaluation protocols but have not yet been supported by quantitative, peer-reviewed scientific publication.

Goal from FY14

Project Title	Goal(s)	Action(s)	Target Date
Evidence-based and Promising Practices	Provide optimal care for members using well-researched clinical practice	Implement several additional measurements/metrics associated with the above evidence-based practices, to both measure outcomes of these practices and increase fidelity to the various models of treatment.	6/30/14

Results and analysis
Table 36 indicates the evidence-based and promising practices utilized by providers in the BHI network.

Table 36: Evidence-Based Practices

For Adults	For Children
Adult Behavioral Health Promotions	Brief Hospitalization for suicidal children/adolescents
Assertive Community Treatment (ACT)	Child Parent Psychotherapy
Brief Dynamic Therapy	Child Behavioral Health Promotion Strategies
Cognitive Behavioral Therapy	Cognitive Behavioral Therapy
Crisis Services	Collaborative Problem Solving
Dialectical Behavioral Therapy	Crisis Services
Eye Movement Desensitization Reprocessing	Dialectical Behavioral Therapy
Illness Management and Recovery	Eye Movement Desensitization Reprocessing
Integrated Dual Diagnosis Treatment	Family-Based Cognitive Behavioral Therapy
Interpersonal Therapy	Functional Family Therapy
Member-run/Peer Services	Home-Based Services
Motivational Enhancement Therapy	Intensive Case Management
Motivational Interviewing	Love and Logic Parenting
Psychiatric Rehabilitation	Multimodal Treatment for ADHD
Psychoeducation for Families	Multi-Systemic Therapy
SAFE-T: SAMHSA model for crisis assessments	Nurturing Parenting Program
Solution Focused Therapy	Parent Child Interaction Therapy
Supported Employment	Psychoeducation for Families
Supported Housing	School-Based Services
Trauma Recovery and Empowerment Therapy	Trauma-Focused Cognitive Behavioral Therapy

BHI's PEO Committee is working on refining a process by which providers using the various evidence-based practices above can report the results of both fidelity assessments and/or outcome measures related to each EBP. BHI hopes to have this process implemented fully by January 1, 2015. BHI did not meet the goal of implementing this process by the end of FY14, but BHI is confident that the attention to detail and thorough planning for this process will result in a more effective implementation in FY15.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Evidence-based and Promising Practices	Provide optimal care for members using well-researched clinical practice	Refine and implement EBP reporting process	6/30/15

Section 9: Member & Family Input in QI Program

Member and family involvement and input into the quality improvement program are vital to true service improvement. The QI program involves members and their families in a bi-directional manner, assuring that not only is member input driving improvement activities, but also that information about those quality improvement activities are being given back to members, increasing member education about the quality improvement process.

For example, a member of the BHI QI Department attends the Member Advisory Board meeting on a monthly basis in order to educate members about the activities of the QI department (including member satisfaction surveys, education about practice guidelines, etc.) and receive feedback about the barriers they may experience (including accessing services, the quality of care received, etc.)

Additional mechanisms for incorporating the member experience into the quality improvement department are outlined in the following sections:

- Member Satisfaction (MHCA Survey)
- Member Satisfaction (MHSIP, YSS, YSS-F Surveys)
- Grievances and Appeals
- Quality of Care Concerns
- Critical Incident Reporting

Member Satisfaction (MHCA Survey)

Summary of project – Quality of Services
Member evaluation of health plan services offered through Behavioral Healthcare Inc. (BHI) is critical to the identification of opportunities to improve all aspects of care provided to our members. BHI has conducted its member surveys since 1996. Satisfaction surveys provide BHI with knowledge on member perceptions of well-being, independence, and functional status as well as perceptions on the scope of services offered, accessibility to obtain services when needed, availability of appropriate practitioners and services, and acceptability or "fit" of the practitioner, ensuring program changes and services redesign in meeting the members' unique needs and preferences. This feedback helps to modify the service system for actual utilization patterns and enables member choice. If a pattern is detected or there is a statistically significant level of concern, BHI requires and/or develops a corrective action plan.

As stated in its contract with HCPF, BHI conducts an annual internal satisfaction survey of both adult and youth members receiving services at its CMHCs, in BHI's CPN, and in member-run Drop-in Centers using the Mental Health Corporation of America (MHCA) satisfaction survey. This data is then compared to a matched group of Medicaid members and other behavioral health agencies across the nation. This tool has been validated for use across a variety of service delivery modalities and can be utilized for analysis of youth and adult populations. BHI submits the results of this internal survey as well as its comparison data to HCPF annually.

For 2014, BHI conducted an additional survey of 15 questions to assess Utilization Management services and Access to Care as well as to assess more thoroughly, acceptability or "fit" of the practitioner, program design, and services in meeting the members' unique needs and preferences.

From February 12 through April 11, 2014, the surveys were administered at BHI's CMHC sites and Drop-in Centers, and they were mailed to a random sample of CPN members.

The total population size used for determining the needed number of completed surveys was 12,220 members. This was the total number of members who received services from the start of FY13 (July 1, 2013) through January 24, 2014 when the sample was obtained. Using the sample size calculator, it was determined that 387 members was a sufficient overall sample size. The sample size calculator prepares a random sample where n = N/(1+(N*0.0025)) where sample error & confidence level = 0.05 & 95% from study population, with a 5% oversample.

Based on previous years return rates, BHI provided the three MHC's with three times the number of surveys needed to obtain the stratified sample for each site plus 50 Spanish surveys. The Drop-In Centers each received 15 surveys and 10 Spanish surveys. A total of 1,411 surveys were distributed and 666 completed surveys were returned, which indicates a 42.20% response rate.

Table 37: Sample Methodology

Sample Methodology						
Group	**Population Size**	**Percent of Total**	**Desired Sample Size**	**Number of Distributed Surveys**	**Returned Surveys**	**Response Rate**
ADMHN	2,442	19.98%	77	281	129	45.90%
AuMHC	4,161	34.05%	132	446	262	58.74%
CRC	2,646	21.65%	84	302	222	73.50%
CPN	2,821	23.09%	89	317	34	10.73%
Drop-In Centers	150	1.23%	5	50	19	38.00%
Total	12,220	100.0%	387	1,411	666	47.20%

The MHCA survey consists of four dimensions: *Personal Therapy, Physical Environment, Client/Staff Interaction, and Overall Outcome & Reputation*; however, BHI matched the MHCA questions and the additional survey questions to the NCQA categories of: *Services, Accessibility, Availability, and Acceptability*. Members responded to the questions by answering Poor, Fair, Good, Very Good, or Excellent on the MHCA survey questions as well as on "A" through "L" as well as AA, BB, CC on the additional questions survey. The measurement of "satisfaction" was determined by dividing the number of members who responded with Good, Very Good, or Excellent by the total number of members who answered that question anything except Not Applicable or not answered.

The *Services* category refers to the scope of services offered by the organization. It includes the following questions:
From MHCA

- 1a How would you evaluate the quality of service you received?
- 2a Helpfulness of staff
- 2b Courtesy shown to you by staff
- 2c Concern of staff
- 2d Attention to privacy
- 2e Degree of confidentiality
- 2f Professionalism of staff
- 3c Organization of weekday program schedule

- 3d Organization of weekend/holiday program schedule
- 3e Appropriate therapies & interventions offered
- 3h Ease of completing paperwork
- 7d Overall quality of care and services

From Additional Questions

- D The help you received when you called the BHI office
- E The quality of services you received from providers within the BHI network
- F If you filed a grievance, how it was handled
- G The BHI/Medicaid appeal process
- H If you requested a change of provider, how it was handled
- I How you were treated by BHI staff

The *Acceptability* category refers to the "fit" of the practitioner, program and services with the member receiving care, representing an organization's "cultural competence," or its capability to assess and meet the special, cultural, ethnic, communication and linguistic needs and preferences expressed by its members. It includes the following questions:

From MHCA

- 3a Opportunity to participate in decisions about your treatment
- 3b Extent to which your individual needs were addressed
- 3f Ability of services to meet your needs
- 7a Degree to which treatment helped deal with problem/complaint.

From Additional Questions

- J The way your cultural needs or preferences were met
- K The way your linguistic needs or preferences were met
- L The way your special needs or preferences were met (such as disability, living situation, multiple diagnosis, medical condition, or substance use)

Accessibility is the ability of the organization to obtain, readily and easily, services when needed. It includes the following questions:

From MHCA

- 4c Ability to reach desired department or person by phone
- 4d Hours appointments are available
- 4e Length of time between making appointment & seeing the psychiatrist
- 4f Length of time between making appointment & seeing the therapist/counselor
- 4g Time spent in waiting area for your scheduled apt
- 6a Arrangements for you to pay bill without unnecessary hardship
- 6b Reasonableness of fees

From Additional Questions

- A Receiving the services you needed
- B The process of getting services approved
- C The time it took to approve your services
- AA If you had a mental health emergency and you contacted your mental health provider, were you contacted by someone within 1 hour or told to go to the emergency room for help?

- BB If you had an urgent need to speak with someone about your mental health, and called someone, were you contacted within 24 hours of your initial call?
- CC If you needed to schedule a routine office visit, were you scheduled and seen within 7 business days of your request?

Availability is the presence of the appropriate types of practitioners, providers, and services in locations convenient for members. It includes the following questions:
From MHCA

- 3g Availability of staff to talk with you
- 4a Convenience of location of facility
- 4b Signs and directions to treatment areas

Goal from FY14

Project Title	Goal(s)	Action(s)	Target Date
Member Satisfaction Surveys	Continue to monitor and improve member satisfaction with services	Conduct MHCA satisfaction survey on active members	6/30/14
		Increase return rate of MCHA surveys by 10%	
		Meet or exceed satisfaction results from FY13	

Results and Analysis
Table 38 shows the percentage of satisfaction for each of the four NCQA categories. For the mean and standard deviation the Poor, Fair, Good, Very Good, or Excellent possible responses were converted to a 1-5, with 1 being poor and 5 being excellent.

Table 38: BHI performance on MHCA

	Percentage Satisfied*	
	FY14	**FY13**
Services	93%	91%
Accessibility	90%	82%
Availability	91%	91%
Acceptability	92%	91%
Overall	92%	86%

*Percent of Good, Very Good, and Excellent responses in the survey questions for that category

Of the four member satisfaction categories, three (Services, Accessibility, Acceptability) improved from last year's results. The availability category stayed the same at 91% satisfaction. Since the accessibility category continued to show the lowest level of satisfaction, BHI will continue to monitor that area in following years. Because each category of satisfaction surveys demonstrated an increase from FY13, BHI considers objectives related to this project to be met.

Barrier analysis and planned interventions
BHI did meet all its target goals for FY14. BHI increased the response rate of surveys from 25% to 42% for the MHCA and supplemental surveys. BHI also saw an improvement in three of the four categories of satisfaction, with one category staying the same. Because BHI achieved 90% satisfaction on all four categories of member satisfaction, BHI sees no need for formal intervention to improve satisfaction scores.

BHI recognizes that while the overall sample size was adequate to meet NCQA sample size needs, the number of returned surveys from the CPN were low. BHI will consider allowing high-volume CPN providers to hand out the survey in following years to ensure a better response rate.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Member Satisfaction Surveys	Meet or exceed satisfaction results from FY14	Support OBH and the Department on implementation with the ECHO survey	6/30/15

Member Satisfaction (MHSIP, YSS, YSS-F Surveys)

Summary of project – Quality of Services
The Colorado Office of Behavioral Health (OBH) conducted its annual Mental Health Statistics Improvement Program (MHSIP) Consumer Survey with a focus on services provided in State Fiscal Year 2013 (July 1, 2012-June 30, 2013). OBH administers the MHSIP Consumer Survey to assess perceptions of behavioral health services provided in Colorado.

The MHSIP Consumer Survey consists of 36 items, each answered using a Likert scale ranging from one (strongly agree) to five (strongly disagree). Standardized at a national level, the survey comprises of the following domains:

- Access (six items that assess perceptions about service accessibility)
- Quality/Appropriateness (nine items that asses perceptions of quality and appropriateness)
- Outcomes (eight items that asses perceptions of outcomes as a result of service)
- Participation (two items that asses perceptions of member involvement in treatment)
- General Satisfaction (three items that assess satisfaction with services received)

The Youth Services Survey for Families (YSS-F) was modeled after the MHSIP. A modification of the MHSIP survey for adults, the YSS-F assesses caregivers' perceptions of behavioral health services for their children (aged 14 and under). Caregivers complete items pertaining to demographic (e.g. age, gender) and other pertinent information (e.g. medication, police encounters) about their child. Caregivers then use a Likert scale, ranging from strongly agree to strongly disagree to answer 21 items that include the following five domains:

- Access (two items)
- Appropriateness (six items)
- Outcomes (six items)
- Participation (three items)
- Cultural sensitivity (four items)

This year, the Youth Services Survey was also offered, allowing young adult consumers to complete their own survey on their perceptions of behavioral health services.

Goal from FY14

Project Title	Goal(s)	Action(s)	Target Date
Member Satisfaction Surveys	Continue to monitor and improve member satisfaction with services	Support OBH in the MHSIP survey process and incorporate survey data into any interventions designed to improve member satisfaction.	6/30/14

Results and analysis
Table 39 below displays BHI's results from FY13 as compared to the statewide BHO average performance.

Table 39: BHI performance on the MHSIP, YSS, and YSS-F

MHSIP	Total	Not Satisfied	Satisfied	Percent Satisfied	BHO Average
Perception of Access	296	36	260	87.84%	84.78%
Perception of Appropriateness and Quality	294	26	268	91.16%	90.00%
Perception of Outcomes	284	73	211	74.30%	65.76%
Perception of Participation in Treatment	289	46	243	84.08%	81.07%
Perception of Satisfaction	293	31	266	90.78%	90.21%
YSS	**Total**	**Not Satisfied**	**Satisfied**	**Percent Satisfied**	**BHO Average**
Perception of Access	111	17	94	84.68%	76.78%
Perception of Appropriateness and Quality	114	13	101	88.60%	87.21%
Perception of Outcomes	110	38	72	65.45%	66.28%
Perception of Participation in Treatment	106	11	95	89.62%	86.41%
Perception of Cultural Sensitivity	109	4	105	96.33%	95.32%
YSS-F	**Total**	**Not Satisfied**	**Satisfied**	**Percent Satisfied**	**BHO Average**
Perception of Access	216	38	178	82.41%	74.45%
Perception of Appropriateness and Quality	219	19	200	91.32%	85.59%
Perception of Outcomes	219	72	147	67.12%	56.87%
Perception of Participation in Treatment	206	8	198	96.12%	91.43%
Perception of Cultural Sensitivity	201	5	196	97.51%	94.66%

BHI performed above the BHO average in all categories on each survey, with the exception of "Perception of Outcomes" on the YSS survey. In addition, in each category on the MHSIP, YSS, and YSS-F, BHI improved member satisfaction with the exception of the "Perception of Outcomes" on the YSS and the "Perception of Access" on the YSS-F. Therefore, BHI considers objectives related to this project to be met.

Barrier analysis and planned interventions

BHI member response rate for the MHSIP, YSS, and YSS-F is low compared to other member satisfaction surveys. Because BHI completes two member satisfaction surveys each year, survey burnout could be an issue for members. BHI and the Department, along with the Office of Behavioral Health and other Colorado BHO's are working together to implement the ECHO survey for FY15. If the ECHO survey is used in the future, member burnout could decrease resulting in an improved response rate and possible improvement in satisfaction.

BHI does not have any planned interventions for member satisfaction for FY15, other than to support OBH and the Department in efforts to implement the ECHO member satisfaction survey.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Member Satisfaction Surveys	Continue to monitor and improve member satisfaction with services	Support OBH and the Department on implementation of the ECHO survey.	6/30/15

Grievances and Appeals

Summary of project – Quality of Services
It is the policy of Behavioral Healthcare Inc. (BHI) to support the rights of clients, family members and interested others to register concerns and/or file grievances related to any issue regarding the care received through BHI and provide reasonable assistance in completing any forms requested. The purpose of this policy is to ensure that clients and interested others have a means of providing ongoing feedback to the BHI system which results in prompt resolution of individual problems, the tracking or problematic trends within the system, an overall improvement in the quality of services, and the prevention of retaliation.

Goal from FY14

Project Title	Goal(s)	Action(s)	Target Date
Grievances and Appeals	Ensure that clients and interested others have a means of providing ongoing feedback to the BHI system	Continue to collect and analyze grievance and appeal data through the quarterly Performance Report Card and implement interventions if patterns or trends emerge.	6/30/14

Results and analysis
In an effort to monitor member and family concerns about quality of care issue, BHI operates a comprehensive grievance tracking and resolution process. Figure 13 shows the trend in number of grievances for the past four quarters.

Figure 13: Grievance data by quarter

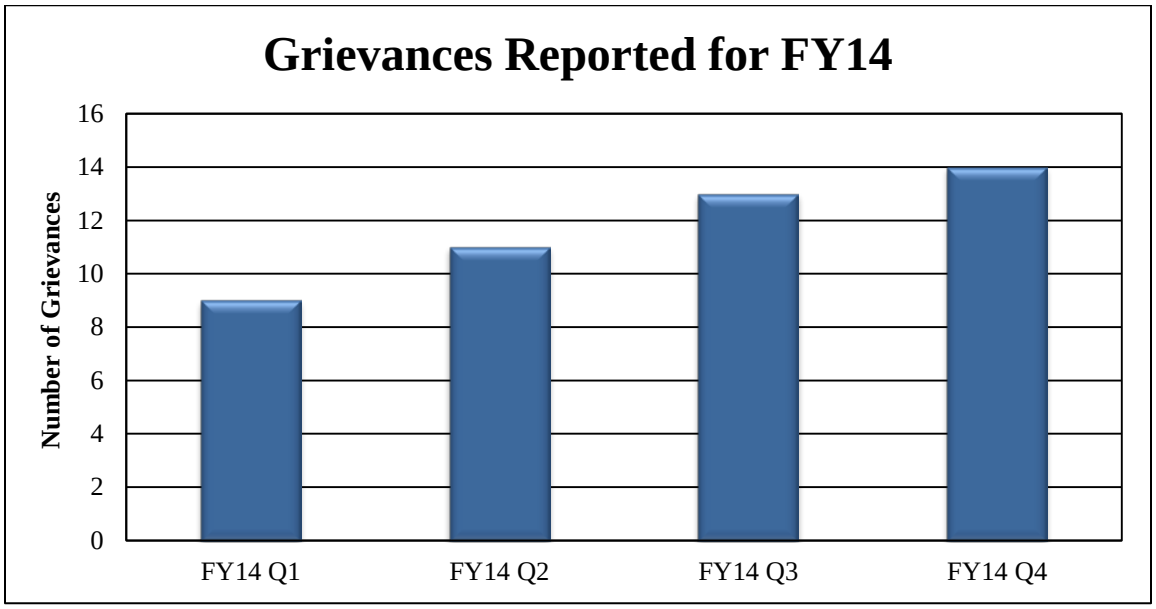


Table 40 shows the number of complaints and appeals by NCQA category for the past year, by quarter. Note: BHI defines a "grievance" as a member complaint.

Table 40: Grievances by Category, by quarter

2013 - 2014 Grievances by Category						
Category	**FY14 Q1**	**FY14 Q2**	**FY14 Q3**	**FY14 Q4**	**Total by Category**	**Percentage of Total**
Quality of Care	3	6	7	7	23	48.94%
Access	0	0	0	1	1	2.13%
Attitude and Service	3	3	5	4	15	31.91%
Billing and Financial Issues	3	2	0	1	6	12.77%
Quality of Practitioner Office Site	0	0	0	1	1	2.13%
Rights/Legal	0	0	1	0	1	2.13%
Total Number of Grievances	9	11	13	14	47	100.00%

While BHI has had eight (8) appeals during this same period, none pertained to the categories listed above. BHI understands that the majority of the grievances are going to be in the quality of care, access, and attitude and service categories. BHI has seen a decrease in the number of access related grievances in the past four quarters as compared to last year's results. BHI staff reviewed the grievances for the quality of care issues to determine if patterns could be identified with a particular staff person and/or CMHC team, but determined that no patterns existed.

Upon review of a request for mental health services, if BHI determines that the request for service does not meet medical necessity a notice of action is given. If the member is dissatisfied with the Notice of Action, they have a right to appeal this action locally and/or through a State Fair Hearing. Table 41 shows the types of action appealed in FY14 and the results of the local appeal and/or State Fair Hearing.

Table 41: Appeals

Type of Action Appealed	**FY14 Q1**	**FY14 Q2**	**FY14 Q3**	**FY14 Q4**
Denial or limited authorization of a requested service, including the type or level of service	0	2	2	4
Reduction, suspension or termination of a previously authorized service	0	0	0	0
Appeal Outcome				
Local Level – Appeal Upheld (Action Overturned)	0	0	2	2
Local Level – Appeal Denied (Action Upheld)	0	1	0	2
State Fair Hearing – Appeal Upheld (Action Overturned)	0	0	0	0
State Fair Hearing – Appeal Denied (Action Upheld)	0	1	0	0

Both grievances and appeals are analyzed by quarter and addressed by the Office of Member and Family Affairs and the Utilization Management Department. BHI does not set "goals" for the number of appeals or grievances filed as members are encouraged to file for both as often as needed and necessary.

Barrier analysis and interventions

As seen in Table 40, almost 50% of the grievances within the past fiscal year were related to quality of care issues. Quality of Care grievances also has the largest subcategory groups and therefore it is expected that a majority of the grievances will fall here. Upon further analysis of the grievances, a majority was filed because a member wanted to switch providers (includes: case manager, psychiatrist, and therapist). These grievances were resolved within required timeframes and the member was satisfied with the outcome of the grievance, as each member was able to switch to a new provider. Other aspects of quality of care grievances are medication issues and coordination of care. Upon review of the grievances related to both of these categories, the medication issues were resolved and the care coordination issues were related to members wanting to switch to a new provider not associated with the community mental health centers.

At this time, BHI does not believe that interventions are necessary for any of the grievance categories or appeals. BHI will continue to monitor grievance and appeal patterns through the quarterly Performance Report Card and the Annual Quality Report.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Grievances and Appeals	Improve the process by which members and family members have a means of providing ongoing feedback to BHI	Continue to collect and analyze grievance and appeal data through the quarterly Performance Report Card	6/30/15

Quality of Care Concerns

Summary of project – Quality and Safety of Clinical Care
BHI's Quality of Care Concerns (QOCC) system identifies, investigates, and addresses potential quality of care concerns, including those involving physician providers. QOCC detection is permanently built into BHI's standard operating procedures and requirements. QOCCs include all potential problems, concerns, or complaints concerning access to urgent or emergent care, delay or denial of care or services, after-hours services, professional conduct or competence, coordination of care, medication issues, diagnosis issues, service plan or delivery issues, or concerns with legal or member rights. QOCCs are also triggered by care resulting in unexpected death, suicide attempts requiring medical attention, medication errors, or adverse medication effects requiring medical attention, preventable complication requiring medical attention, assault or accident related injuries requiring medical attention, or an at-risk client missing from a 24-hour facility.

A potential quality of care concern regarding one or more BHI members can be reported to BHI by any of the following entities: the Colorado Department of Health Care Policy and Financing (HCPF), an employee of BHI, a Client Representative, a clinician, or an external agency. Any concerns raised by a member will be forwarded to the Office of Member and Family Affairs to be handled as a grievance.

Goal from FY14

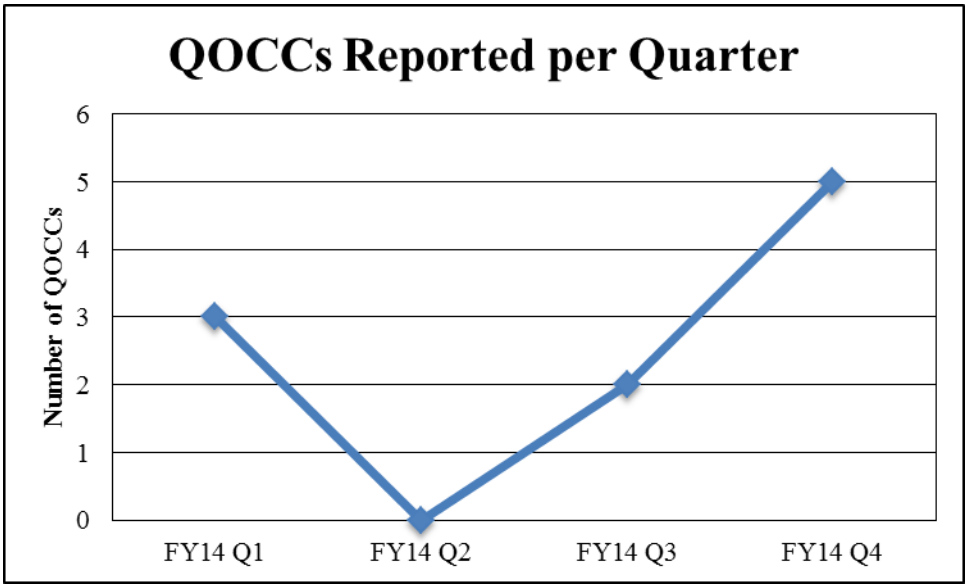
Project Title	Goal(s)	Action(s)	Target Date
Quality of Care Concerns	Address any potential member safety issue	Continue to trend QOCCs by provider and by category and address any patterns	6/30/14
		Continue to work with individual providers on corrective actions if a QOCC is substantiated	
		Educate providers about the QOCC process	

Results and analysis
In FY14, BHI has investigated 10 QOCCs, seven of which were substantiated. For these issues, corrective action plans were completed and implemented by the facility involved and resulted in changes to the applicable programs to assure a better quality of care. Table 42 below indicates the categories of the QOCCs reported in FY14, whereas Figure 14 indicates the number of QOCCs reported in each quarter of FY14. BHI continues to improve the process by which QOCCs are reported and investigated. Therefore, BHI considers objectives related to this project to be met.

Table 42: Categories of FY14 QOCCs

QOCC Category	Unsubstantiated	Substantiated
Professional Conduct or Competence	0	1
Medication Issues	1	0
Coordination of Care	0	2
Delay of Care/Services	2	4

Figure 14: QOCCs reported by quarter in FY14



Barrier analysis and interventions
During a QOCC investigation in FY14, BHI became concerned that there was no formal process for providers and facilities to report critical incidents to BHI. Therefore, in fall 2013, BHI began developing such a process, which was finalized in February 2014 (please reference next section for more information).

In addition, BHI received four QOCC notifications for a facility that provides post-stabilization services. While each of the four QOCCs was substantiated, the provider was not contracted with BHI – which made requiring corrective action rather difficult. BHI worked collaboratively with the executive team of the facility to arrive at agreements around future procedures for BHI members.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Quality of Care Concerns	Address any potential member safety issue	Continue to trend QOCCs by provider and by category and address any patterns	6/30/15
		Continue to work with individual providers on corrective actions if a QOCC is substantiated	

Critical Incident Reporting

Summary of project – Quality and Safety of Clinical Care
In order to more closely monitor the safety of clinical care our members were receiving, BHI developed a Critical Incident reporting policy and procedure during FY14. BHI now requires any provider/agency/facility it credentials, contracts with, or approves to provide services ("Providers") to report Critical Incidents involving BHI members to the BHI Quality Improvement Department. Reporting and investigation of Critical Incidents recognizes the importance of health, safety, and well-being of members. BHI believes a standard system of reporting Critical Incidents will enhance the quality of service provided and minimize the risk of harm to members.

Critical Incidents include the following:

- Breach of Confidentiality
- Suspected Neglect
- Suspected Sexual Abuse
- Sexual Contact
- Restraint
- Seclusion
- Arrest
- Medication Error
- Attempted Suicide
- Death
- Suspected Physical Abuse
- Missing Person
- Assaultive Behavior
- Diverted Drugs
- Medical condition/injury requiring physician attention

BHI began the Critical Incident reporting process in February and March of 2014 with its CMHCs and the full policy and procedure were implemented with all providers in April of 2014.

Goal from FY14
New initiative, no previous goals

Results and analysis
BHI receives Critical Incident reports from providers, documents information related to the Critical Incident in a database, and will investigate further, as needed. BHI generates a report of critical incidents similar to Table 43 below and reports results to the Quality Assurance Committee monthly. Table 43 highlights several data points related to Critical Incident reports. Overall, BHI has seen an increase in the number of Critical Incidents reported from month to month, as providers are still learning the process. Restraint and Seclusion are the highest categories of Critical Incidents reported, which is expected, as providers are required to report every instance of restraint and seclusion of a BHI member.

Table 43: Critical Incident Reporting

Critical Incident Information Year to Date (YTD)	
Number of Critical Incidents YTD	141
Number of Unique Members YTD	58
Number of Members 2 or more CIs YTD	17
Most CIs on one member YTD	38
Highest Frequency YTD: Critical Incident Categories	
Restraint/Seclusion	83
Death	16
Medical Condition requiring Physician	10
Assaultive Behavior	6

Barrier analysis and planned interventions

BHI recognizes that the Critical Incident reporting process is new and therefore is using this first year of implementation as a guide to revise the policy and procedure in the future, if necessary. During the development of this policy and procedure, BHI conducted research about provider reporting requirements for other entities, such as the Office of Behavioral Health and the Colorado Department of Public Health and Environment. BHI outreached providers to determine what policies and procedures were already in place within organizations to report critical incidents. BHI attempted to align its Critical Incident form with other entity forms. Providers have indicated that all entities forms are different and most providers have their own internal forms as well, so BHI continues to work with providers around this issue.

BHI has noticed that not all providers are reporting critical incidents. The Utilization Management Department comes into contact with providers more frequently than the QI Department so the two departments are working internally on a strategy to education providers about Critical Incident reporting requirements. BHI will continue to educate and work with providers on the process and update the policy/procedure as needed in the coming fiscal year.

Goal(s) for FY15

Project Title	Goal(s)	Action(s)	Target Date
Critical Incident Reporting	Address any potential member safety issue	Continue to trend critical incidents by provider and by category and address any patterns	6/30/15
	Increase compliance with critical incident reporting	Outreach providers and provide education about the critical incident reporting process	

Section 10: Cultural Competency

Summary of project – Quality of Services

BHI recognizes that high quality care for all diverse communities depends on inclusion and accessibility of services. Staff members and providers are trained to be conscious of and sensitive to the cultural differences of our members. In order to ensure that BHI is continually addressing the needs of our members, BHI maintains a comprehensive Cultural Competency Plan. Each of the FY14 goals from the Cultural Competency Plan are listed below, with information about BHI's progress towards each goal.

Results and analysis

Goal #1: Provide health care services that respect individual health care attitudes, beliefs, customs, and practices of members related to cultural affiliation
Targeted Actions
1. Create and improve policies and procedures to accommodate cultural affiliations such as: race, preferred language, gender, disability, age, religion, deaf and hard of hearing, sexual orientation, homelessness, and geographic location. Incorporate information from other projects into policy revisions. Make sure employee handbook/provider handbook/member handbook is consistent with policies. Review annually.
2. Re-structure Cultural Competency Committee to include membership from each CMHC, CPN providers, community agencies and members
3. Re-define purpose of Cultural Competency Committee

Targeted Action #1 Status: In progress

- BHI has revised several policies, procedures, and member letter templates to better accommodate the language needs of our members.
- Corresponding updates to the Provider Manual and Member and Family Handbook are scheduled for fall 2014.

Targeted Actions #2-3 Status:

- BHI has made the decision to transfer the oversight responsibility for cultural competency matters to the Program Improvement Advisory Committee (PIAC), effective 7/1/2014.
- The existing members of the Cultural Competency Committee will transition to become members of (PIAC). The PIAC charter will include specific responsibilities for overseeing the cultural competency activities and initiatives of BHI.
- The Cultural Competency Committee met for the last time on 6/6/2014.

Goal #2: Develop and maintain a provider network that meets the cultural, racial, and linguistic needs of BHI members
Targeted Actions
1. Identify language needs and cultural background of members (both eligible and those receiving services), including prevalent languages and cultural groups using US census and enrollment data. Review annually.
2. Correlate data from Action #1 with members' expressed preferences based on feedback or grievance data. Review annually.
3. Identify languages and cultural background of providers in the BHI network to assess whether they meet members' language needs and cultural preferences. Review annually.
4. Create annual survey for providers to keep up to date information about provider cultural and linguistic backgrounds; improve provider database to track this information
5. Take action to adjust the provider network if member needs and preferences are not being adequately met.

Targeted Actions #1-5 Status: Please reference the Cultural Needs and Preferences section of this report (pages 18).

Goal #3: Increase staff and provider knowledge of cultural competency
Targeted Actions
1. Create basic training program for all BHI staff (including drop in center staff) and credentialed providers to be renewed annually, available on the BHI website
2. Ensure that all BHI staff are trained in the use of Cyracom services, TTY, etc.

Targeted Action #1 Status: partially completed

- BHI will roll out the new training requirements for staff through its electronic training system (Relias) October 1, 2014. BHI is currently working on obtaining the necessary technology to make this training available to its credentialed providers.

Targeted Action #2 Status: In progress

- BHI is in the process of clarifying the above mentioned procedures in order to train staff as effectively as possible.

Goal #4: Ensure that services for those with limited English proficiency meet BHI quality standards
Targeted Actions
1. Post all BHI flyers and informational materials in English and Spanish, at minimum

Targeted Action #1 Status: Completed and ongoing

- BHI posts information about the Ombudsman program, grievances, and appeals in both English and Spanish. Each BHI provider is instructed to do the same.

Goal #5: Develop procedures through the Quality Improvement program to assess gaps in cultural and linguistic competency and implement interventions as necessary
Targeted Actions
1. Create additional survey questions for member satisfaction surveys related to member perception of provider cultural competency
2. Assess performance against Cultural Competency Plan annually in Annual Quality Report

Targeted Action #1 Status: Tabled

- With upcoming changes to the member satisfaction survey process (i.e., changing to the ECHO), BHI will re-assess the need for additional survey questions once the ECHO has been implemented.

Targeted Action #2 Status: Completed and ongoing

Goals for FY15

Goal #1: Provide health care services that respect individual health care attitudes, beliefs, customs, and practices of members related to cultural affiliation
Targeted Actions
1. Create and improve policies and procedures to accommodate cultural affiliations such as: race, preferred language, gender, disability, age, religion, deaf and hard of hearing, sexual orientation, homelessness, and geographic location. Incorporate information from other projects into policy revisions. Make sure employee handbook/provider handbook/member handbook is consistent with policies. Review annually.
2. Conduct initial organizational self-assessment of cultural competency activities. Review bi-annually.
Goal #2: Develop and maintain a provider network that meets the cultural, racial, and linguistic needs of BHI members
Targeted Actions
1. Identify language needs and cultural background of members (both eligible and those receiving services), including prevalent languages and cultural groups using US census and enrollment data. Review annually.
2. Correlate data from Action #1 with members' expressed preferences based on feedback or grievance data. Review annually.
3. Identify languages and cultural background of providers in the BHI network to assess whether they meet members' language needs and cultural preferences. Review annually.
4. Create annual survey for providers to keep up to date information about provider cultural and linguistic backgrounds; improve provider database to track this information
5. Take action to adjust the provider network if member needs and preferences are not being adequately met.
Goal #3: Increase staff and provider knowledge of cultural competency
Targeted Actions
1. Create basic training program for all BHI staff (including drop in center staff) and credentialed providers to be renewed annually
2. Create annual basic training program for all credentialed providers, available on the BHI website or via webinar
3. Ensure that all BHI staff are trained in the use of Cyracom services, TTY, etc.
Goal #4: Ensure that services for those with limited English proficiency meet BHI quality standards
Targeted Actions
1. Post all BHI flyers and informational materials in English and Spanish, at minimum
Goal #5: Develop procedures through the Quality Improvement program to assess gaps in cultural and linguistic competency and implement interventions as necessary
Targeted Actions
1. Create additional survey questions for member satisfaction surveys related to member perception of provider cultural competency
2. Assess performance against Cultural Competency Plan annually in Annual Quality Report

Section 11: BHI Quality Improvement Work Plan for FY15

Project Title	Goal(s)	Action(s)	Target Date
Member Population			
Penetration Rates	Increase overall penetration rate by 2% from 11.64%.	Calculate penetration rates for each CMHC in the BHI catchment area on an annual basis	6/30/15
Network Adequacy			
Network Adequacy – Ensuring Availability	Meet the geographical needs of members by assuring provider availability	Continue to assess provider network availability against BHI standards and respond to the needs of the ever-growing Medicaid population.	6/30/15
Network Adequacy – Cultural Needs and Preferences	Meet the cultural, ethnic, and linguistic needs of members by assuring diverse provider network	Implement facility update form to capture cultural information from facility providers	1/1/15
Access to Services			
Access to routine, urgent, and emergency services	Provide access to covered services as required by the Medicaid contract	Increase provider education efforts about access to care standards and referrals to BHI	6/30/15
	Improve member satisfaction with Access to Care by 5%	Continue to conduct secret shopper calls for all providers	
		Educate members about definitions of routine, urgent, and emergent appointments and the associated standards	
Access to medication evaluations	Improve compliance with 30-day standard to 90%	Assist providers in barrier analyses to identify opportunities to improve access to medication evaluations.	6/30/15
Focal point of behavioral health services	Continue to perform at or above the statewide BHO average	Continue to monitor clients' accessibility to services	6/30/15
Compliance Monitoring			
External Quality Review Organization (EQRO) audit	Continue to score at or above the previous year's performance	Coordinate with HSAG to comply with review activities conducted in accordance with federal EQR regulations 42 C.F.R. Part 438 and the CMS mandatory activity protocols	6/30/15
State-wide Performance Improvement Project	Coordinate with ABC and RCCO partners to improve transitions in care	Participate in the HCPF statewide Performance Improvement Project (PIP) and meet all requirements.	6/30/15
Encounter Data Validation (411) Audit	Improve provider claims review to a compliance score of 90% or higher	Continuing to train providers on proper billing and documentation practices	6/30/15
	Maintain or improve inter-rater reliability with HSAG	Continuing to train audit team on the USCS Manual	
Delegation Oversight	Oversee the quality of activities delegated to any subcontractor	Continue to monitor the activities delegated to Colorado Access as our Administrative Service Organization through Delegation Oversight Audits	6/30/15
Provider claim/record audits	Improve provider documentation and reduce waste and abuse in billing practices	Implement quarterly clinical documentation trainings	6/30/15
		Initiate a minimum of 10 provider audits	

Project Title	Goal(s)	Action(s)	Target Date
Performance Measures			
Monitoring over- and under-utilization	Continue to perform at or above the statewide BHO average for performance measures	Continue to measure performance indicators quarterly to monitor for patterns and trends across services	6/30/15
		Continue to monitor specific member utilization for targeted member interventions	
Member Health and Safety	Perform at or above the statewide BHO average for performance measures	Implement polypharmacy medication project	10/1/15
Coordination of Care – Follow-up after hospital discharge	Increase performance to meet internal benchmarks (90% and 95%)	BHI will continue to monitor this measure quarterly and implement targeted interventions	6/30/15
Coordination of Care – Improving physical healthcare access	Continue to improve coordination of care	Continue to develop the Care Management Program	6/30/15
	Improve measurement of coordination of care	Fully implement PCP measure for Quarterly Performance Report Card	1/1/15
Improving Member Functioning	Continue to measure and monitor performance	Cooperate with HCPF on the calculation of performance measures	6/30/15
Information Systems Capabilities Assessment Tool (ISCAT) audit	Continue to achieve 100% compliance on the audit	Continue to monitor and assess each aspect of the performance measure calculation process and adjusting accordingly	6/30/15
Clinical Practice Guidelines and Evidence-Based Practices			
Clinical Practice Guidelines	Develop and implement practice guidelines to meet the clinical needs of members	Create and review all identified practice guidelines per NCQA standards	1/1/15
		Create and distribute member information materials about practice guidelines	
Compliance with Clinical Practice Guidelines	Monitor providers' compliance with BHI clinical practice guidelines	Monitor compliance with RAD guideline via encounter and pharmacy claims	6/30/15
		Monitor compliance with Risk Assessment guideline via clinical record review	6/30/15
		Monitor compliance with Atypical Antipsychotic guideline via member survey	6/30/15
	Increase provider education about guidelines	Provide education about each clinical practice guideline through the Provider Bulletin	6/30/15
Evidence-based and Promising Practices	Provide optimal care for members using well-researched clinical practice	Refine and implement EBP reporting process	1/1/15
Member and Family Input into the QI Program			
Member Satisfaction Surveys	Meet or exceed satisfaction results from FY14	Support OBH and the Department on implementation of the ECHO survey	6/30/15
Grievances and Appeals	Improve process by which members and family have a means of providing feedback	Continue to collect and analyze grievance and appeal data through the quarterly Performance Report Card	6/30/15
Quality of Care Concerns	Address any potential member safety issue	Continue to trend QOCCs by provider and by category and address any patterns	6/30/15
		Continue to work with individual providers on corrective actions if a QOCC is substantiated	
Critical Incident Reporting	Address any potential member safety issue	Continue to trend critical incidents by provider and by category and address any patterns	6/30/15
	Increase compliance with critical incident reporting	Outreach providers and provide education about the critical incident reporting process	