BHI Annual Quality Report

Fiscal Year 2015

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.

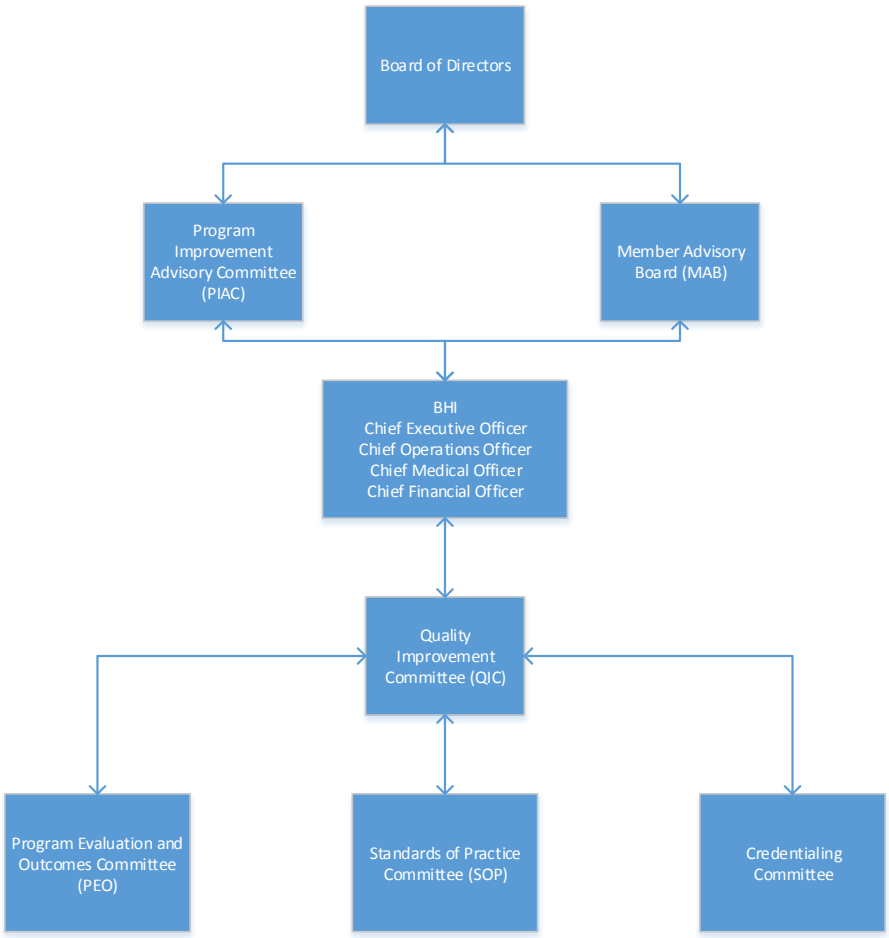
At the beginning of FY14, BHI decided to combine the Quality Improvement and Utilization Management Departments under one Director. With the dual-director role, BHI found it difficult to concentrate efforts and ensure the needs of each department were being met. Furthermore, due to the increased demands on both departments, BHI determined that each department needed its own Director to achieve on-going goals successfully.

The QI Department accomplished many of the work plan goals established for FY15 and is committed to continuously enhancing the quality of services received by our members. A Compliance Monitoring Specialist as well as an additional .25 FTE was hired to assist the department in achieving its goals. Quarterly clinical documentation trainings were implemented and providers have been receptive to the feedback received during the trainings. The QI Department completed an in depth analysis of network adequacy and determined that our network of providers can meet the needs of our ever-growing membership. Through the critical incident procedure and collaboration with a provider, the number of restraints was reduced by 72% over three months. The QI Department was able to refine and implement a more comprehensive evidenced-based reporting process with providers. All of the on-going and newly developed QI Program activities, including the accomplishments described above allowed the QI program to continue to be effective during FY15.

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 Operations Officer (COO), and the Chief Medical Officer (CMO). The Director of Quality Improvement is accountable to the CEO/COO/CMO for all operations of the Quality Improvement Program.

Quality Improvement Committee

The Quality Improvement Committee (QIC) was created in FY14 to monitor, oversee, and design interventions for BHI daily operations. QIC monitors activities from BHI's quality improvement, utilization management (UM), 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, grievance and appeal data, 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. QIC oversees

any significant change in policies and operational procedures from each department. QIC meets monthly and membership includes the following:

Table 1: FY15 QIC Membership

Quality Improvement Committee			
Name	**Credentials**	**Title**	**Affiliation**
Lisa Brody	**MS**	**Chief Operations Officer (Chair)**	**BHI**
Ann Winters	BA	Compliance Monitoring Specialist	BHI
Cara Mason	MPA	Director of Member Services and Outreach	BHI
Clara Cabanis	MHA	Director of Quality Improvement	BHI
Emily Schrader	LPC, CACIII	Substance Use Disorder Coordinator	BHI
Jane Moore	LCSW	UM Care Manager	BHI
Jessie Nelson	LPC	Quality Improvement Team Lead	BHI
Laura Hill	RN	Director of Integrated Care	BHI
Mandy Jamieson	LPC	UM Care Manager	BHI
Ron Morley	MD	Chief Medical Officer	BHI
Sam Madden	BS	Quality Improvement Coordinator	BHI
Teresa Summers	BA	Director of Provider Relations	BHI

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

- Program Evaluation and Outcomes Committee (PEO)
- Standards of Practice Committee (SOP)
- Credentialing Committee

Program Evaluation and Outcomes Committee:
The Program 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 indicators, 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: FY15 PEO Membership

Performance Evaluation and Outcomes Committee			
Name	**Credentials**	**Title**	**Affiliation**
Clara Cabanis	**MHA**	**Director of QI (Chair)**	**BHI**
Ann Winters	BA	Compliance Monitoring Specialist	BHI
Jessie Nelson	LPC	Quality Improvement Team Leader	BHI
Sam Madden	BS	Quality Improvement Coordinator	BHI
Cynthia Grant	PhD, LCSW	QI Clinical Manager	ADMHN
Lisa Traudt	LMFT	Director of Managed Care and QI	ADMHN
Karen Levine	LPC	Director of Quality Development	AuMHC
John Mahalik	LPC	Clinical Services Administrator	CCC
Lara Dicus	LCSW	Clinical Services Administrator	CCH
Janet Rassmusen	MSW	Director of Accountable Care and Behavioral Health	Clinica Family Health Services
Clay Cunningham	LPC	Director of Quality Assurance	CRC
Brian Stanley	BS	Director of QI & UM	Creative Treatment Options
Matt Louzon	LPC	Director of Community Based Services	Excelsior Youth Center

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 and 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: FY15 SOP Membership

Standards of Practice Committee			
Name	**Credentials**	**Title**	**Affiliation**
Ron Morley	**MD**	**Chief Medical Officer – Psychiatry (chair)**	**BHI**
Sam Madden	BS	Quality Improvement Coordinator	BHI
Lisa Traudt	LMFT	Director of Managed Care and QI	ADMHN
Resul Ozbayrak	MD	Medical Director	ADMHN
Karen Levine	LPC	Manager of Quality and Training	AUMHC
Leslie Winters	MD	Medical Director – Psychiatry	AUMHC
Clay Cunningham	LPC	Director of Quality Assurance	CRC
Jeanette Valdivieso	MD	Medical Director	CRC

Credentialing Committee
BHI utilizes a multidisciplinary Credentialing Committee that includes both BHI personnel and network providers with experience in a variety level 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 CMO is a member of the Credentialing Committee and as such, participates in all credentialing decisions. Only the CMO 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. The Credentialing Committee meets monthly and membership includes:

Table 4: FY15 Credentialing Committee Membership

Credentialing Committee			
Name	**Credentials**	**Title**	**Affiliation**
Teresa Summers	**BA**	**Director of Provider Relations (chair)**	**BHI**
Ann Winters	BA	Compliance Monitoring Specialist	BHI
Ashley Murphy	LPC	Utilization Reviewer	BHI
Cara Mason	MPA	Director of Member and Family Affairs	BHI
Clara Cabanis	MHA	Director of Quality Improvement	BHI
Emily Schrader	LPC, CACIII	SUD Coordinator	BHI
Heather Piernik	LCSW	Director of UM	BHI
Jessie Nelson	LPC	Quality Improvement Team Leader	BHI
Laura Hill	RN	Director of Integrated Care	BHI
Lisa Brody	MS	Chief Operations Officer	BHI
Mandy Jamieson	LPC	UM Care Manager	BHI
Ron Morley	MD	Chief Medical Officer	BHI
Sam Madden	BS	Quality Improvement Coordinator	BHI
Bryan Stanley	BS	Director of QI and UM	Creative Treatment Options
Rebecca Hea	PsyD	Executive Director	Denver Children's Home

Key Metric Trends

Table 5: Key Metric Trends

Access to Care Measures					
Measure	**Goal**	**FY12**	**FY13**	**FY14**	**FY15**
Access to Care					
• Routine Care within 7 days	100.00%	99.83%	99.84%	96.55%	98.8%
• Urgent Care within 24 hours	100.00%	100.00%	100.00%	100.00%	100%
• Emergent Care within 1 hour	100.00%	100.00%	100.00%	100.00%	94.8%
• Emergency Phone Calls	100.00%	100.00%	100.00%	100.00%	100%
Access to Medication Evaluations					
• Adult	90.00%	88.44%	91.15%	80.21%	66.9%
• Children	90.00%	87.61%	85.82%	83.77%	82.8%
Penetration Rates					
• Total Rate	>13.00%	11.28%	11.42%	12.04%	*
Utilization Monitoring					
• Emergency room visits per 1000 members	-	9.95	9.94	12.46	*
Hospital Measures: All Hospital Data					
Measure	**Goal**	**FY12**	**FY13**	**FY14**	**FY15**
Utilization Monitoring					
• Inpatient: Admits per 1000 members	-	3.83	3.39	3.84	*
• Inpatient: Average length of stay	-	15.54	12.90	13.17	*
Follow-up After Hospital Discharge					
• 7 Days	90.00%	59.31%	61.19%	54.55%	*
• 30 Days	95.00%	72.70%	75.20%	71.34%	*
Inpatient Readmits					
• 7 Days	-	2.95%	2.83%	3.50%	*
• 30 Days	-	8.84%	7.79%	8.11%	*
• 90 Days	-	15.08%	12.57%	13.48%	*
Hospital Measures: Non-State Hospital Data					
Measure	**Goal**	**FY12**	**FY13**	**FY14**	**FY15**
Utilization Monitoring					
• Inpatient: Admits per 1000 members	-	2.87	2.81	3.29	*
• Inpatient: Average length of stay	-	7.13	7.76	7.11	*
Follow-up After Hospital Discharge					
• 7 Days	90.00%	57.69%	58.15%	52.43%	*
• 30 Days	95.00%	70.83%	73.16%	70.58%	*
Inpatient Readmits					
• 7 Days	-	2.78%	2.99%	3.20%	*
• 30 Days	-	8.33%	7.91%	7.71%	*
• 90 Days	-	14.58%	12.39%	18.35%	*

*Data will be available upon validation of FY15 Performance Measures

Key Accomplishments from FY15

Table 6: Key Accomplishments from FY15

Project	Accomplishment
Encounter Data Validation Audit	Achieved near-perfect inter-rater reliability with HSAG
Provider audits	Continued Clinical Documentation Training initiative and trained over 100 providers. BHI also completed training with four facilities.
Utilization Management data analysis	Continued to refine process for tracking authorization and census data and reporting. BHI expanded tracking and reporting to additional levels of care requiring authorization.
Evidenced Based Practices	Developed a reporting process for 12 evidenced based practices across the Community Mental Health Centers (CMHCs) and other community based providers. BHI identified fidelity scores for nine of the practices and reported a total of 23 outcome measures.
Performance Improvement Project (PIP)	Adolescent Depression Screening and Transition to a Behavioral Health Provider PIP was reviewed and scored 100% by HSAG.
Critical Incident reporting	Through the critical incident reporting process, BHI was able to collaborate with a provider to successfully reduce the number of restraints by 72% in 90 days.
Follow up after hospital discharge	Implemented new oversight process for discharge planning and follow up for members receiving inpatient services. Preliminary reports indicate a significant improvement in follow-up after hospital discharge for FY15.
Access to Care	Developed access to care and other reporting requirements specifications document that details definitions, numerator and denominator values for each measure included in the report card.

Key Initiatives for FY16

Table 7: Key Initiatives for FY16

Project	Initiative
Report Card data integrity	Develop systematic way to audit data that providers are submitting to ensure data integrity.
Provider Monitoring	Develop a new process to monitor providers' contractual requirements, quality of care, and data validation in a better systematic manner; through scheduled periodic audits covering a larger number of contracted providers.
Performance Improvement Project (PIP)	Continue working with providers and facilities to increase the rate of adolescent follow-up with a behavioral health provider after screening positive for depression in a primary care setting.
Data Reporting system	Implement, test, and train BHI Quality Improvement staff on new electronic systems that will expedite data analysis and reporting needs.
Performance Measures	Create more in-depth monitoring and interventions for various performance measures.
NCQA Accreditation	BHI will apply for NCQA reaccreditation in June 2016.
Access to Care	Enhance the current monitoring of access to care measures with all contracted providers, including the Colorado Crisis Connection data collection process
Member Satisfaction	Develop and implement effective process to assess member experience with BHI processes and customer service, including Utilization Management procedures.

Barrier Analysis and Planned Interventions

The current staffing and historical staffing of the Quality Improvement Department remains a challenge that limits the amount of progress and projects the department can effectively work on at a time. The QI Department continues to need more resources in order to effectively monitor progress and implement timely interventions for on-going/new projects.

At the same time the data quality and quantity is another barrier. There are three sources of data the QI department relies on: claims, internal systems, and external sources. Claims data is often delayed due to provider submission requirements, which is expected. Internal tracking mechanisms rely heavily on manual input and reporting which can lead to incomplete and inaccurate data. In addition, the QI Department does not have the resources to track, validate, and monitor data from all external sources.

A third barrier is related to the lack of understanding of the QI initiatives by all Stakeholders. As the QI Department continues working on a wide variety of initiatives, stakeholders are not always aware of the new and on-going initiatives. This lack of engagement could create delays and conflict during the execution of the different initiatives.

The table on the next page shows the specific barriers encountered and the interventions planned to address these barriers.

Table 8: Barrier Analysis

Barrier	Planned Intervention(s)
Adequate Quality Improvement Department Staffing	Hire a Quality Provider Monitoring Specialist by the end of October 2015. Hire an additional Quality Improvement Coordinator by January 2016.
Data accuracy and timeliness	Continue to coordinate data requirements to providers and Colorado Access, as BHI's Administrative Service Organization and implement a better internal data tracking system.
Lack of understanding of QI initiatives by Stakeholders.	Continue educating and engaging stakeholders, members, providers, and other community partners about BHI's QI program and activities through communication in different committees, the provider bulletin, and the Member and Family Newsletter.

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 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. BHI continues to oversee compliance and implement new programs, policies, and procedures in order to meet the standards.

Goal for FY16

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	6/30/2016

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 2015 BHI was responsible for a total of 296,998 active members. This is an increase of 22% from FY14, in which BHI served 242,551 members by the end of the FY14 fiscal year. Table 9 shows the breakdown of the BHI member population by aid category, as of June 30, 2015.

Table 9: Member Aid Categories

Aid Category Description	# of members	% 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)	42,331	14.25%
Categorically Eligible Low-Income Children (AFDC-C): includes children of low-income families and children on Transitional Medicaid.	133,505	44.95%
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	15,279	5.14%
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).	78,924	26.57%
Baby Care-Adults, Breast, and Cervical Cancer Program (BCKC-A, 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.	7,626	2.57%
Baby Care Children (BCKC-C): Children who are born to women enrolled in the Baby and Kid Care program (described above)	3,288	1.11%
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.	4,852	1.63%
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	42	< 1.0%
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.	8,457	2.85%
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.	2,652	<1.0%
Total	296,998	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	41,013	13.81%
5-13 years	76,728	25.84%
14-17 years	26,167	8.81%
18-64 years	144,124	48.53%
65+ years	8,945	3.01%
Race/Ethnicity		
Hispanic	91,207	30.71%
Caucasian	79,288	26.70%
Unknown / Not Stated	44,371	14.94%
Other	34,636	11.66%
African American	30,122	10.14%
Asian	11,903	4.01%
Native American	4,023	1.35%
Native Hawaiian/other Pacific Islander	1,205	0.41%
Asian/Pacific Islander	222	0.07%
Gender		
Female	162,540	54.73%
Male	134,437	45.27%

Results and analysis

The member aid categories and demographic characteristics remained relatively stable from FY14 to FY15. Within the aid categories the most significant change was that of Adults without Dependable Children (AWDC) that increased from 17% to 26%. The largest changes in the opposite direction were the categories for Categorically Eligible Low-Income Adults and Children (AFDC-A & AFDC-C), both of which reduced by four percentage points.

There was very little change in the demographic characteristics, the most significant being the increase in age of the member population. All three categories for members aged under-18 reduced in terms of the overall percentage, whereas members aged between 18 and 64 increased by four percentage points. The race and ethnicity figures are difficult to interpret as there is such a high number that are unknown or not stated. It is not a requirement that members identify a race/ethnicity; however there were still 85% of the population that did identify themselves as a certain race or ethnicity and BHI will therefore continue to use the above information to appropriately plan services for FY16.

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.

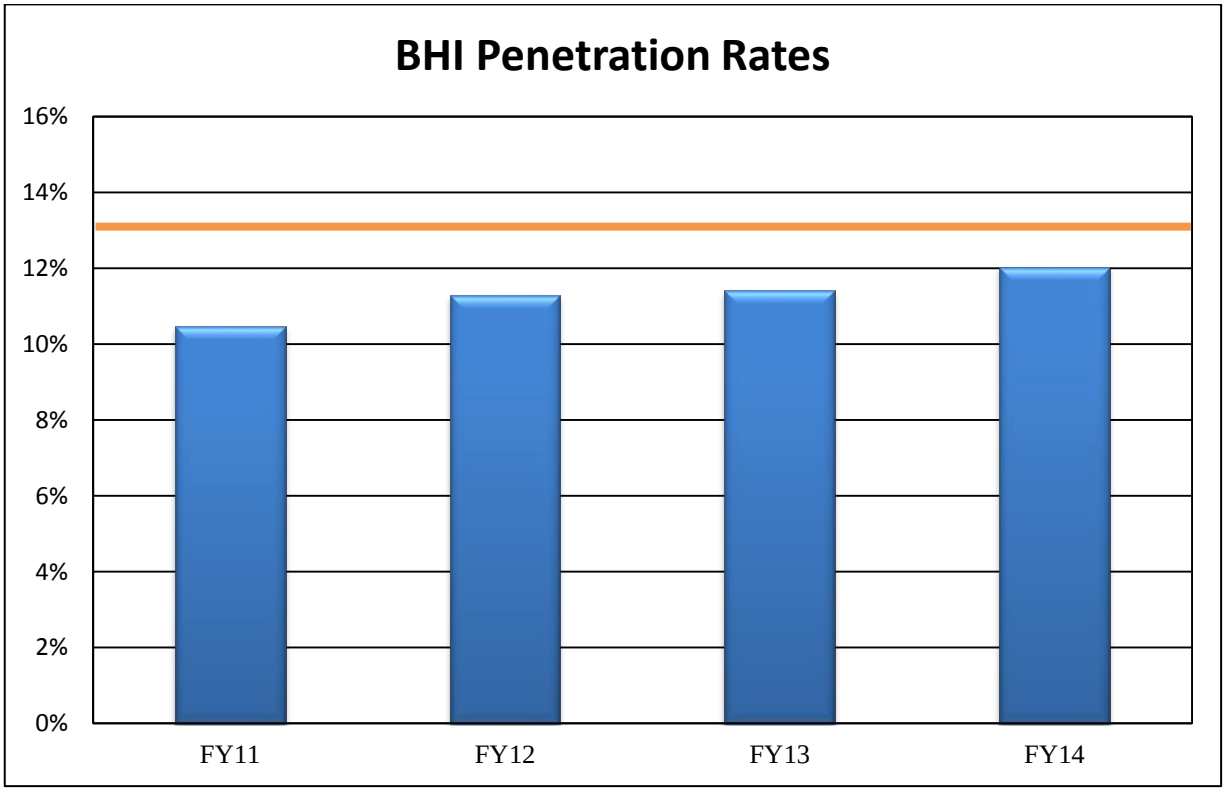
Goal from FY15

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

Results and analysis

BHI will continue to utilize the Geo-Coding information to assess specific geographic areas in the catchment area. BHI continues to work towards the benchmark of 13.00% and increased overall penetration rates by 5.43% (11.42% to 12.04%) in FY14 performance measures, as shown in Figure 2. This is more than double the target of 2% improvement and therefore BHI considers the objectives for this measure to be met.

Figure 2: BHI penetration rates



Barrier analysis and planned interventions
BHI will continue the process by which each individual CMHC penetration rates will be calculated for monitoring and targeted improvements. This information will be calculated annually, at minimum. BHI also plans to monitor the geo-coding information by zip code so that the more in depth analysis will be able to highlight the exact areas of the catchment area that have lower numbers of providers.

Goal(s) for FY16

Project Title	Goal(s)	Action(s)	Target Date
Penetration Rates	Increase overall penetration rate by 2% to 12.28%	Calculate penetration rates for each CMHC in the BHI catchment area on an annual basis	6/30/16

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.

In addition to the HPSA guidelines, the access standards for Medicaid Managed Care Organizations sets out requirements that the maximum distance within the state of Colorado that members should travel to receive services is 30 miles. To ensure that this standard is met BHI calculates the percent of members throughout the catchment area that live within 30 miles of a BHI-contracted prescriber, practitioner, and facility.

Goal from 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

Results and analysis

The FY15 provider to member ratio 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	Members in catchment area	Ratio	BHI Standard
Prescribers	94	286,680	263,745	1:2,803	1:5,000
Practitioners	641	286,680	263,745	1:411	1:1,500
Providers/Facilities	43	286,680	263,745	1:6,134	1:15,000

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	23	124,148	1:5,398	1:5,000
Arapahoe County	62	117,039	1:1,888	1:5,000
Douglas County	9	22,558	1:2,506	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	207	124,148	1:600	1:1,500
Arapahoe County	390	117,039	1:300	1:1,500
Douglas County	49	22,558	1:460	1:1,500

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

Providers / Facilities	Total Number	Members in Catchment area	Ratio	BHI Standard
Adams County	15	124,148	1:8,277	1:15,000
Arapahoe County	26	117,039	1:4,502	1:15,000
Douglas County	2	22,558	1:11,279	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 throughout FY15. However, BHI will continue to work with the CMHC in Adams County, and continue to recruit prescribers in Adams County to assure that members can access services in a timely manner.

As the geographic access standard is a newer measurement for BHI, both the FY14 and FY15 performance and BHI standards are listed in Table 15 and 16 below. BHI met the geographic access standards goals in FY14 and FY15 across all provider types and all three counties.

Table 15: FY14 Access standards in BHI catchment area

	BHI Members living in catchment area	BHI Members living within 30 miles of a provider	% of BHI Members living within 30 miles of a provider	BHI Standard
Prescribers	219,668	219,017	99.7%	95%
Practitioners	219,668	219,668	100.0%	95%
Providers/Facilities	219,668	219,017	99.7%	95%

Table 16: FY15 Access standards in BHI catchment area

	BHI Members living in catchment area	BHI Members living within 30 miles of a provider	% of BHI Members living within 30 miles of a provider	BHI Standard
Prescribers	263,745	262,963	99.7%	95%
Practitioners	263,745	263,745	100.0%	95%
Providers/Facilities	263,745	262,963	99.7%	95%

As with the number of providers, BHI monitors the access standards within each county of our catchment area using the same distance of 30 miles. Tables 17-19 reflect the members within 30 miles of each of the provider types for FY14 and FY15.

Table 17: FY14 & FY15 Prescriber access standards in BHI catchment area by county

Prescribers	BHI Members living in catchment area	BHI Members living within 30 miles of a provider	% of BHI Members living within 30 miles of a prescriber	BHI Standard
FY14				
Adams County	104,685	104,587	99.7%	95%
Arapahoe County	97,574	97,023	99.4%	95%
Douglas County	17,409	17,407	99.9%	95%
FY15				
Adams County	124,148	124,031	99.9%	95%
Arapahoe County	117,039	116,374	99.4%	95%
Douglas County	22,558	22,558	100.0%	95%

Table 18: FY14 & FY15 Practitioner access standards in BHI catchment area by county

Practitioners	BHI Members living in catchment area	BHI Members living within 30 miles of a provider	% of BHI Members living within 30 miles of a practitioner	BHI Standard
FY14				
Adams County	104,685	104,685	100.0%	95%
Arapahoe County	97,574	97,574	100.0%	95%
Douglas County	17,409	17,409	100.0%	95%
FY15				
Adams County	124,148	124,148	100.0%	95%
Arapahoe County	117,039	117,039	100.0%	95%
Douglas County	22,558	22,558	100.0%	95%

Table 19: FY14 & FY15 Providers/facilities access standards in BHI catchment area by county

Providers / Facilities	BHI Members living in catchment area	BHI Members living within 30 miles of a provider	% of BHI Members living within 30 miles of a provider	BHI Standard
FY14				
Adams County	104,685	104,587	99.7%	95%
Arapahoe County	97,574	97,023	99.4%	95%
Douglas County	17,409	17,407	99.9%	95%
FY15				
Adams County	124,148	124,031	99.9%	95%
Arapahoe County	117,039	116,374	99.4%	95%
Douglas County	22,558	22,558	100.0%	95%

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 CMHCs outside of our catchment area to provide easier access to quality services. BHI frequently examines adequacy of the provider network and how it relates to the changing Medicaid population. Where necessary single-case agreements are utilized with individual providers including prescribers to ensure adequate access for members in difficult to reach locations or for areas with very low member numbers.

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 member 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 the member 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 continues to adjust 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.

To improve the ratio of members to prescribers in Adams County and generally to maintain a high compliance with all network adequacy goals, BHI is planning the following interventions for FY16:

1) Recruit prescribers outside of CMHCs
2) Ongoing monitoring of the number of prescribers at CMHCs through quarterly reporting
3) Discuss network adequacy results in PEO and develop specific interventions as a result
4) Ongoing monitoring of access to medication evaluations
5) Develop a data collection process for monitoring follow up of medication appointments

Goal(s) for FY16

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.	6/30/16

Cultural Needs and Preferences

Summary of project – Quality of Services
BHI believes that our health system must continuously evolve to reduce behavioral 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 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

Results and analysis
Table 20 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 21 shows languages other than English spoken in households throughout Colorado. The information for Table 21 is based on US census data from 2010 as this remains the most recent census data available and is the most reliable data source. BHI has also begun requesting race/ethnicity of individual providers in the Contracted Provider Network (CPN). Please note that the data in Table 22 does not include the providers working at each of the 100+ facilities statewide with which BHI has contracted.

Table 20: Population demographics in BHI's catchment areas

Race/Ethnicity	% of member Population	% of provider network*
Hispanic	30.71%	7.06%
Caucasian	26.70%	73.43%
Unknown / Not Stated	14.94%	10.04%
Other	11.66%	1.97%
African American	10.14%	4.01%
Asian	4.01%	2.80%
Native American	1.35%	0.64%
Native Hawaiian/other Pacific Islander	0.41%	0.06%
Asian/Pacific Islander	0.07%	0.00%

*this does not include the providers working at each of the 100+ facilities statewide with which BHI has contracted

Table 21: 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 22 below). In cases where the language needed is not available within the network, BHI helps facilitate gaining access to language services. A family member of the member will not be used to provide interpretation unless requested by the member.

Table 22: Providers offering services in languages other than English

	ADMHN	AUMHC	CRC	CPN	Total		ADMHN	AUMHC	CRC	CPN	Total
ASL	1	0	0	9	**10**	Lugisa	0	1	0	0	**1**
Afrikaans	0	1	0	0	**1**	Mandarin	0	3	0	5	**8**
Amharic	0	2	0	0	**2**	Mandika	0	1	0	0	**1**
Arabic	0	2	0	1	**3**	Marshallese	0	0	0	1	**1**
Burmese	0	2	0	2	**4**	Navajo	0	1	0	0	**1**
Cambodian	0	1	0	3	**4**	Nepali	0	3	0	4	**7**
Cantonese	0	1	0	0	**1**	Nigerian	0	1	0	0	**1**
Ethiopian	0	1	0	0	**1**	Norwegian	0	2	0	0	**2**
Farsi	0	1	1	1	**3**	Polish	0	0	0	1	**1**
French	2	3	0	9	**14**	Portuguese	0	1	0	1	**2**
Fuzhounese	0	1	0	0	**1**	Punjabi	0	0	0	1	**1**
German	1	2	0	4	**7**	Russian	1	5	1	4	**11**
Greek	0	0	0	1	**1**	Sango	0	1	0	0	**1**
Hebrew	0	0	0	2	**2**	Sinhala	0	1	0	0	**1**
Hindi	0	0	0	1	**1**	Somali	0	1	0	0	**1**
Hmong	0	1	0	1	**2**	Spanish	19	74	33	37	**163**
Hungarian	0	1	0	0	**1**	Swahili	0	1	0	0	**1**
Italian	0	3	0	2	**5**	Swedish	0	1	0	0	**1**
Japanese	0	2	0	1	**3**	Tagalog	0	1	0	1	**2**
Karen	0	2	0	2	**4**	Thai	0	2	0	1	**3**
Khmer	0	1	0	0	**1**	Ukrainian	0	2	0	2	**4**
Korean	0	2	0	3	**5**	Urdu	0	0	0	1	**1**
Lakota	0	0	0	1	**1**	Vietnamese	0	2	0	3	**5**
Laotian	0	0	0	1	**1**	Yiddish	0	0	0	1	**1**
Lingala	0	1	0	0	**1**	Yoruba	0	1	0	0	**1**
Luganda	0	1	0	0	**1**	**TOTAL**	**24**	**136**	**35**	**107**	**302**

BHI began collecting cultural demographic information from our individual providers in FY14. BHI has not yet begun aggregating data from 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.

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 as well as other provider locations in both English and Spanish.

In FY15, BHI continued to expand the provider network in order to continue to meet member's cultural and linguistic needs and preferences. BHI also hired a Member Services Outreach team member who is Bilingual (English and Spanish). BHI continues to work with its Cultural Competency Consultant to ensure the best quality of care is being provided to members and member needs are being met. Additionally, BHI continues to contract with Cyracom for translation and interpreter services.

Since 2005, BHI has only received one complaint 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. Below are the results of those three questions from FY13, FY14, and FY15.

Table 23: Member Satisfaction with Cultural, Linguistic, and Special Needs

Member Satisfaction Questions	FY13 Percent Satisfied	FY14 Percent Satisfied	FY15 Percent Satisfied
How satisfied are you with the way your cultural needs or preferences were met	91.26%	94.93%	93.26%
How satisfied are you with the way your linguistic needs or preferences were met	90.97%	95.57%	92.53%
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%	92.66%

Last year, BHI implemented a facility update form and a new individual practitioner form that providers can use to update their language, cultural, and specialty areas so BHI can more accurately capture provider information. Providers also are required to fill out this new form upon recredentialing.

While there was a slight decrease in satisfaction from FY14 to FY15 for cultural and linguistic needs or preferences, scores remains above 90% for each category. BHI also saw an increase in

experience with special needs or preferences being met. Experience scores are still well above FY13. Since experience scores remain above 90% for each question above, BHI believes that, our provider network is adequately meeting the needs of our membership.

Barrier analysis and planned interventions
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.

BHI will continue to gather and update information from providers and practitioners related to cultural, linguistic and specialty areas of practice. BHI will update the provider and practitioner databases as new information becomes available.

Goal(s) for FY16

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	Aggregate data provided by facilities & incorporate into analysis	1/30/16
		Continue to monitor grievances via QIC committee related to cultural needs / preferences	6/30/2016

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
- Two other BHI organizations are submitting access to care reports 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 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	Continue educating providers 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 resources available	

In FY15, BHI implemented the following interventions to help improve access to care standards:

1. Educated providers through the provider bulletin and training about access to care standards
2. Conducted secret shopper calls
3. Educated members about the differences between routine, urgent and emergent access to care standards through the Member and Family Newsletter and Member Advisory Board meetings.

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. BHI conducted secret shopper calls internally, having members recruited from BHI's Drop-In Centers make calls to measure access to care standards with a random selection of providers. Providers were called as often as monthly to quarterly during this fiscal year. BHI educated both members and provides on the access to care standards. BHI also educated members about the differences between routine, urgent, and emergency care through the Member Advisory Board and the Member and Family Newsletter.

Results and Analysis –Access to Care Reporting

BHI's CMHCs are contractually required to report on access to care standards once a quarter. BHI's CMHCs have seen 24,275 unique members since July 1, 2014 (the start of Fiscal Year 2015), and have provided 276,369 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. 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). BHI's goal is to maintain at least 95% compliance with each measure for access to care.

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 24, in FY15 Q1 several routine services took place outside the seven-day requirement. The non-compliance appeared to carry over from FY14 Q4 and a corrective action plan was put into place to address the continued non-compliance. The CMHC, as part of the corrective action plan, was 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. The non-compliance with this access to care standard ended in FY15 Q2 and was seen as an anomaly rather than a continuing trend.

For the third and fourth quarter of FY15, BHI was out of compliance for the Emergency Face-to-Face within one hour measure by less than 1%. There are a variety of explanations for non-compliance with this measure that BHI has considered.

In December of 2014, Colorado Crisis Services expanded behavioral health resources to nearly three million Coloradans in nine counties throughout the Denver/Boulder region. Community Crisis Connection (CCC) is the partnership between six Community Mental Health Centers in the metro area including the three CMHCs within BHI's catchment area, as well as Jefferson Center for Mental Health, Mental Health Center of Denver, and Mental Health Partners. Community Crisis Connection offers walk-in crisis stabilization centers, mobile crisis, and crisis stabilization units. Services are available 24/7/365.

Since the implementation of the CCC, the CMHCs have expanded their coverage area of emergency evaluations to cover not only evaluations at the local emergency rooms, but evaluations completed at the walk-in centers and crisis stabilization units across the metro area. The increase in coverage area created increased travel time for evaluators. Secondly, BHI has seen an increase in the number of requests for emergency face to face requests of 108.55% from FY14 to FY15. The increase in covered metro area locations and increased requests for emergency face to face services contributed to BHI's non-compliance with this measure for the third and fourth quarters of FY15.

Since FY15 Q3, the CCC has provided data to BHI regarding emergency face-to-face requests, both for mobile crisis and walk-in center requests. Evaluations completed in the emergency room are included in the mobile crisis data submission from CCC. One issue of note with the CCC data submission for this indicator is that time of request to time being seen is not captured. BHI's CMHCs within the catchment area are still able to report the number of emergency face-to-face evaluations that are occurring in the emergency department as well as the time of request to the time being seen. Since BHI is receiving data on emergency face-to-face evaluations from both the CCC and the CMHCs, the data submitted has the potential to be duplicative. BHI continues to partner with the CCC to determine if data is being collected in a manner consistent with reporting requirements and de-duplicate data as much as possible to avoid over-reporting of the number of emergency face-to-face requests.

It was recently noted by one CMHC that evaluators were documenting the time of the request for an evaluation from the time of the call, rather than recording the time of request after the member has been medically cleared, when evaluators are contacted again to complete the evaluation. The time difference was noted as anywhere between three and twelve hours. This contributed to the increase in the number of requests that took greater than two hours to start the face to face service. The CMHC noted that new staff was not trained properly on how to document request times and since has been trained appropriately.

Table 24: Access to Care Results for FY15

Initial Requests for Routine Services				
	Q1	**Q2**	**Q3**	**Q4**
Offered within 7 days	2,070	2,667	3,181	2,742
Offered between 8-14 days	55	4	0	0
Offered in 15 day or more days	67	1	0	0
Percent Compliance	94.4%	99.8%	100.0%	100.0%
Percent Non-Compliance	5.6%	0.2%	0.0%	0.0%
Request for Urgent Services				
	Q1	**Q2**	**Q3**	**Q4**
Offered within 24 hours	64	60	171	266
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	806	929	1,523	2,134
Greater than 1 hour but less than 2 hours	25	30	54	76
Greater than 2 hours	4	4	42	58
Percent Compliance	96.5%	96.5%	94.1%	94.1%
Percent Non-Compliance	3.5%	3.5%	5.9%	5.9%
Emergency Phone Calls				
	Q1	**Q2**	**Q3**	**Q4**
Calls made within 15 minutes	5071	10,087	7,043	7,231
Calls made within 16-30 minutes	0	0	2	0
Calls made after 30 minutes	0	0	0	0
Percent Compliance	100.0%	100.0%	99.9%	100.0%
Percent Non-Compliance	0.0%	0.0%	0.1%	0.0%

Results and Analysis – Secret Shopper

From July 2014 to September 2014, BHI was contracted with Market Power to conduct secret shopper calls to various practitioners/providers within the network. BHI ended the contract with Market Power mid-September of 2014, as BHI was able to hire an additional full-time staff to analyze secret shopper calls as well as organize the project to allow member involvement in making the calls.

BHI enlisted the help of members, recruited from the Drop-in centers at Community Connections and the Rainbow Center. The purpose of the calls was to monitor knowledge related to access to care standards, available services for members, and availability of appointments.

One BHI staff 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 25 shows the analysis of the calls made during FY15.

During the past fiscal year, this project has not yielded great results. One potential barrier to conducting secret shopper calls, especially with facilities, is that BHI often requires a pre-authorization for services. Prior to scheduling an appointment for a member, the facility would need to obtain the authorization for services, and then be able to provide the member with an

appointment. Another barrier for the secret shopper calls is related to individual practitioners and availability of BHI members to participate in the calls. Often during the day and into evening hours, practitioners are providing services to members and often use their cell phone as a point of contact at their office location. Because of the nature of secret shopper, BHI members were unable to leave callback numbers on practitioner voicemails so access to care could not be assessed properly. In addition, BHI was not able to recruit enough members to participate and make a large amount of phone calls. BHI is working to redesign the process to be able to monitor access to care better.

BHI offers new provider orientation quarterly that covers the access to care measures. 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.

Table 25: Secret Shopper Call Results

Community Mental Health Centers			
	Yes	**No**	**Percentage Yes**
ATC Standard Met with Live Call	10	2	83%
Emergency Instructions on Voicemail	NA	NA	NA
Facilities			
	Yes	**No**	**Percentage Yes**
ATC Standard Met with Live Call	6	7	46%
Emergency Instructions on Voicemail	5	4	55%
Individual Providers			
ATC Standard Met with Live Call	3	2	60%
Emergency Instructions on Voicemail	11	6	65%

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 2015, BHI conducted a survey to assess member experience with access to care.
The Access to Care questions on the survey 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.

The results of this year's survey are listed below in Table 26. 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.

Table 26: Member experience with access to care

	Percent that answered "Yes"	
	FY14	FY15
Emergency	79.13%	71.67%
Urgent	85.07%	82.85%
Routine	86.47%	84.00%

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.

BHI saw an increase in membership (22%) over the last fiscal year; however, the amount of providers, including CMHCs, hospitals, and other acute care facilities remained relatively the same. BHI expected with the addition of the CCC mobile crisis units and walk-in centers that members could access emergency care more quickly; however the access to care data and member's perception indicate members may be waiting longer to receive emergency care. The longer wait times for care could be attributed specifically to the "mobile" crisis response teams. The mobile crisis response teams have expanded the coverage area where services are provided, including various schools, jails, and client homes across the metro area. Previous to the implementation of the CCC, CMHC staff only completed evaluations at the local emergency departments.

Results and Analysis – Overall
Based on the results of the monitoring activities in FY15, BHI has determined that members are able to access needed services within the timeliness standards. While BHI saw a decrease in access to emergency face-to-face appointments since the implementation of the CCC, the percent of non-compliance is less than 1%. BHI is continuing to work with the CCC as well as the CMHCs to ensure date is not duplicated and accurate data is being collected for the emergency face-to-face measure.

Due to the low amount of secret shopper calls that BHI was able to conduct in FY15, no conclusions can be made about the results. Knowing this, BHI is working to develop a robust process to revitalize the monitoring of access to care.

When comparing the number of grievances related to access to care from FY14 to FY15, BHI determined there was a significant increase. One possible explanation for the increase is the revision to the grievance process. Another possible explanation for the increase in the number of

grievances is related to how grievances are being filed by BHI. If a member files a grievance about two different categories, then BHI counts each category of grievance as a separate grievance, instead of choosing the first category.

Due to the significant increase in access-to-care related grievances from FY14 to FY15, BHI Quality Improvement staff reviewed each of the grievances related to access to care to determine if there were any patterns, trends, or significant issues that were not resolved. The grievances related to access varied from issues with scheduling a medication management appointment to not being able to reach the intake department at a facility. The Quality Improvement Department determined that there were no trends related to grievances involving access to care.

Barrier analysis and planned interventions
Barriers to all of the access to care initiatives are listed below:

1. Member engagement in secret shopper program
2. Number of successfully completed secret shopper calls
3. Potential duplicative data from the CCC and CMHCs related to the emergency face-to-face measure
4. Increase in locations and areas covered by the mobile crisis response teams
5. On-going staff turn-over and staffing issues

BHI will continue to monitor access to care standards via the quarterly access to care report, member experience, and grievances. BHI will implement the following interventions for FY16 to continue to improve member access to care:

1. Redesign the provider monitoring of access to care standards via phone calls. BHI will increase the number of providers who are contacted about appointment availability. Interventions may also be implemented with providers on an on-going basis.
2. BHI will continue to partner with the CCC and CMHCs to align data collection efforts to more accurately capture emergency face-to-face appointment wait times.
3. Educate providers on access to care standards. BHI will also educate providers on how to refer members back to BHI if access to care standards cannot be met.
4. Continue to educate members about definitions of routine, urgent, and emergent appointments and the associated standards.
5. BHI may re-design the member experience survey questions to better assess access to care
6. If a trend is identified with grievances related to access to care, the Quality Department will work with the Office of Member and Family Affairs to create interventions as needed.

Goal(s) for FY16

Project Title	Goal(s)	Action(s)	Target Date
Access to routine, urgent, and emergency services	Increase the number of providers assessed for meeting access to care standards by 25%	Redesign secret shopper program and align with new provider monitoring process	1/1/16
		Continue with BHI efforts to educate providers on access to care standards and referrals to BHI	6/30/16
	Improve current access to Emergency Face to Face care to 95%	Continue to collaborate with community partners to determine barriers to accurate reporting	1/1/16
	Increase member experience with access to care by 5%	Continue to educate members about access to care standards, member experience survey process, and definitions of emergent, urgent, and routine appointments	6/30/16
		Redesign member experience survey questions	
		Continue to educate providers about access to care standards and when to refer members back to BHI	
		Continue to monitor grievances related to access to care via the Quality Improvement Committee	

Access to Medication Evaluations

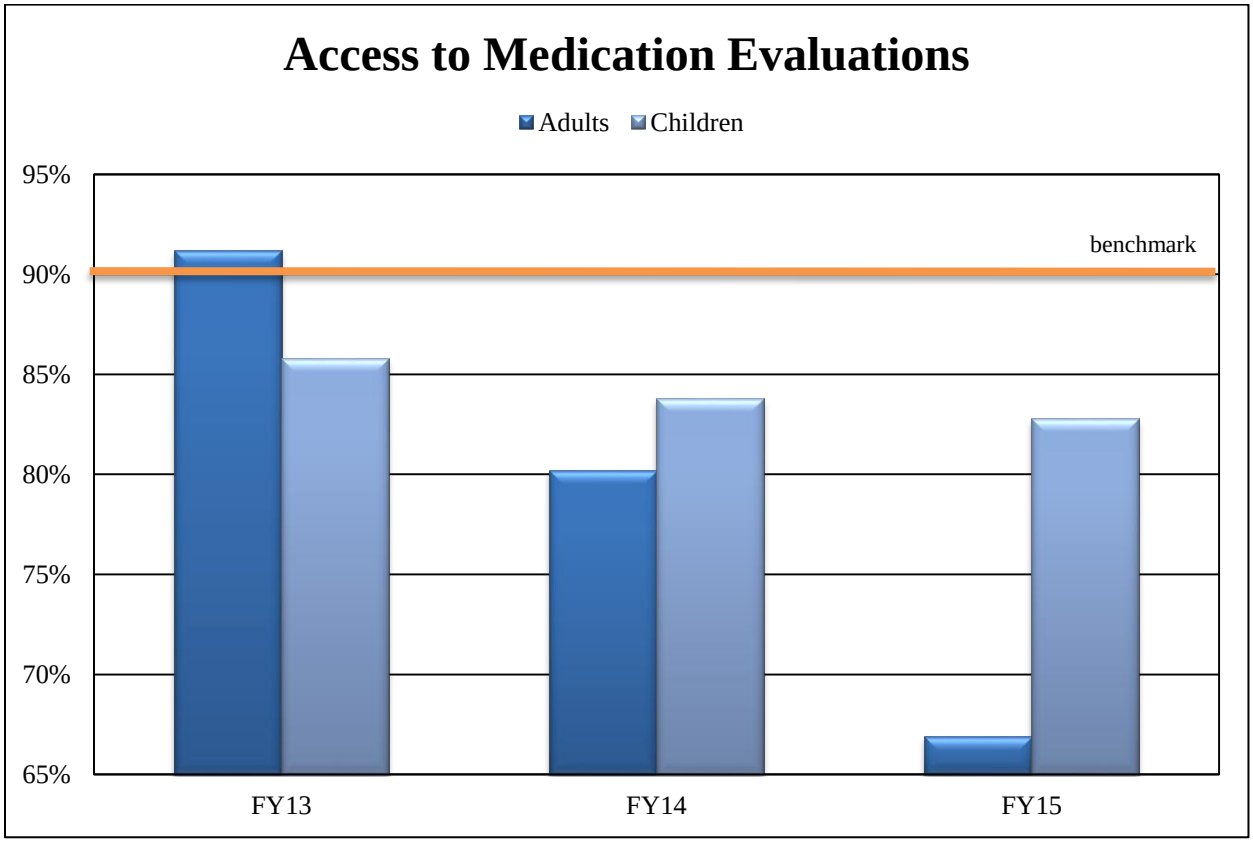
Summary of project – Quality of Services
Medication evaluations are comprehensive assessments completed by psychiatric prescribers in order to assist in diagnosis development and begin any necessary medication regimens that complement the other therapeutic services the member may be receiving. It is 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 FY15

Project Title	Goal(s)	Action(s)	Target Date
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

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 FY15; however, BHI's also saw a 60% increase for requested medication evaluations for adults and 1.5% for children. BHI's FY15 goals for this project were not met.

Some improvement in the measure was noted throughout the year and this has been accomplished through recruitment and hiring of additional prescribers at the CMHC level. Another barrier identified that training needs to be completed for some staff that are entering the data as well as scheduling the medication appointments.

One of BHI's CMHCs implemented an "Open Access" program on June 1, 2015 after researching best practice options to reduce appointment wait times and to maximize provider availability for medication appointments. To accommodate this new program, the CMHC hired eight new psychiatrists and already showed improvement to 100% compliance with the standard in June of 2015 and no-show rates have decreased as well.

Another CMHC has been meeting the goal of 90% for the last few quarters. They have new front desk staff that are organizing the medication evaluation appointments and the process is working much better. There is a process to offer the member medication evaluation at the location of his/her choice; however, other locations may have a sooner appointment time and that time is offered to the member as well.

BHI is expecting to see remarkable improvement in this measure in the next fiscal year due to the changes the CMHCs and other providers have implemented. BHI will continue to monitor this measure quarterly and discuss interventions through the PEO Committee. BHI will also continue to recruit prescribers outside of the CMHCs to provide medication evaluations to members in order to meet the increased demand.

Goal(s) for FY16
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 for children and adults to 90%	Continue to monitor access to medication evaluations on a quarterly basis and discuss results and potential interventions in the Program Evaluation and Outcomes Committee as needed.	6/30/16

Focal Point of Behavioral Health for SMI Population

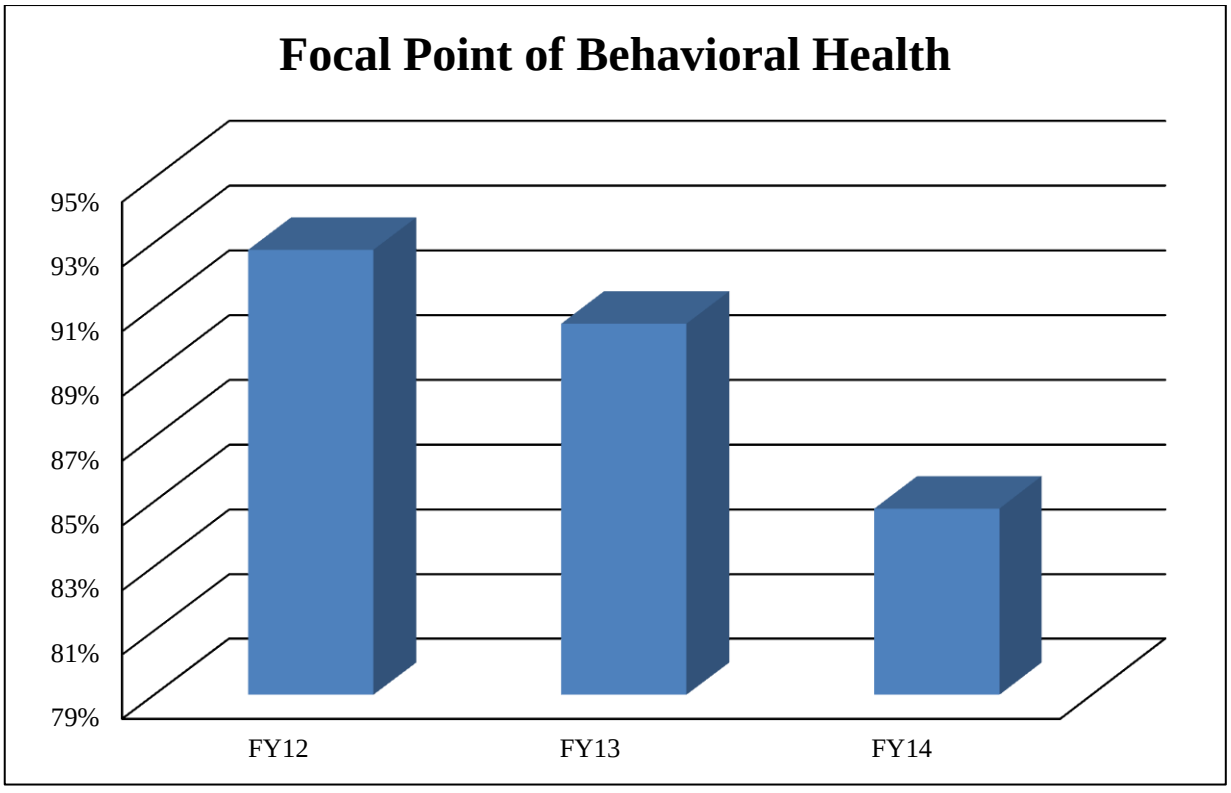
Summary of project – Quality of Services
BHI monitors the BHO-HCPF Annual Performance Measure data to identify opportunities for improvement. One such indicator measures the percent of adult members with severe mental illness (SMI) who have a focal point of behavioral health care identified (three or more behavioral health services or two or more prescriber services in a 12 month period). Note that FY14 performance measures are included in this report as they are calculated in November, after the previous annual quality report has been published.

Goal from 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

Results
In FY14, 84.78% of BHI members with SMI had a focal point of behavioral health. The weighted average of all Colorado BHOs was 87.61%. BHI performed lower than the state average for FY14, however, it was decided between HCPF and the Colorado BHOs that this measure would not be reported for FY15. BHI intends to measure focal point of behavioral health in line with the Colorado C-Stat measures for FY15, as BHI can collect data from the CMHCs.

Figure 4: Focal point of behavioral healthcare within SMI population



Section 6: Compliance Monitoring

External Quality Review Organization Audit (EQRO Audit)

Summary of Project
BHI underwent the eleventh EQRO audit and site visit in FY15. HSAG focused review on four standards: Member Information, Grievance System, Provider Participation and Program Integrity, and Subcontracts and Delegation. Compliance with federal regulations and contract requirements was evaluated through review of these four standards.

Goal from 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

Results and analysis
Table 27 below represents the score in each category for BHI.

Table 27: FY15 EQRO audit results

Standard	Number of Elements	Number of Applicable Elements	Number Met	Number Partially Met	Number Not Met	Score
Member Information	20	20	19	1	0	95%
Grievance System	26	26	19	7	0	73%
Provider Participation and Program Integrity	14	14	12	2	0	86%
Subcontracts and Delegation	6	6	6	0	0	100%
Totals	**66**	**66**	**56**	**10**	**0**	**85%**

BHI's strongest performance was in Subcontracts and Delegation and Member Information, which earned a compliance score of 100% and 95% respectively. HSAG identified ten required actions throughout the entire tool. The ten required actions focused on revision of policies and procedures for consistency, further development of provider monitoring, and enhancement of Fraud, Waste, and Abuse identification practices and tools. With an FY14 score of 87%, BHI did not meet the goal of performing at or better than the previous year's score.

BHI's strengths included:

- A well-organized Member and Family Handbook to assist members in understanding the behavioral health managed care program.
- Well defined policy and procedure for responding to grievances and appeals
- Robust oversight of delegated functions and improvement activities

Barrier analysis and planned interventions
The corrective action plan prompted BHI to thoroughly review and develop an ongoing provider monitoring plan as well as further develop the provider claims auditing process. BHI trained all staff on corporate compliance procedures and gave examples of how to identify upcoding, unbundling of services, and services that were never rendered. BHI is confident that with new, clarified policies and procedures that performance on these standards will be fully compliant in future reviews.

Goal(s) for FY16

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	6/30/16

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 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

Results
BHI conducted the delegation audit of Colorado Access (COA) in January 2015. 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 28: COA Credentialing delegation oversight results

Standard #	Standard Name	Possible Pts	Pts Scored by Delegate	% of Pts Scored	Weighted Pts	Weighted Pts Earned
CR 1	Credentialing Policies	9	9	100%	0.50	0.50
CR 2	Credentialing Committee	9	9	100%	0.30	0.30
CR 3	Initial Credentialing Verification	20	20	100%	1.10	1.10
CR 4	Application and Attestation	10	10	100%	0.35	0.35
CR 5	Initial Sanction Information	10	10	100%	0.75	0.75
CR 6	Practitioner Office Site Quality (NA)	8	8	100%	1.20	1.20
CR 7	Recredentialing Verification	38	38	100%	1.65	1.65
CR 8	Recredentialing Cycle Length	10	10	100%	0.35	0.35
CR 9	Ongoing Monitoring	10	10	100%	1.40	1.40
CR 10	Notification to Authorities and Practitioner Appeal Rights	8	8	100%	0.40	0.40
CR 12	Delegation of Credentialing	NA	NA	NA	NA	NA
Total		132	132	0%	8.00	8.00

Table 29: COA Administrative Service/Delegation Agreement oversight results

Function	Possible Points	COA Score
Administrative Duties		
A. Establish and Maintain a system of data integrity processes	2	1
B. Maintain the integrity and security of all data	2	2
C. Maintain back up files of all BHI data	2	2
D. Establish and maintain and system of quality assurance	2	1
I. Claims and Encounter Processing and Adjudication		
1A. Processing all claims and encounter data	2	0
1B. Necessary system configuration /modifications	2	2
1C. Processing of all claims adjustments	2	2
1D. Preparation of encounter and claims data for submission to HCPF	2	2
1E. Preparation of any additional or modified reports	2	2
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/approval	2	2
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. Contracting/Credentialing (see next page)	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**	**34**
Overall Percentage		**89.5%**

Barrier analysis and planned interventions

During delegation oversight process in the past three years, BHI has identified opportunities for improvement in the administrative service and delegation agreements. BHI continues collaborating 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 FY16

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	6/30/16

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 residential services (Service Category "SC" or "HE")

BHI used the 411 sample to identify lists of encounters/claims by provider. BHI communicated with the QI Directors for the various providers 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 providers submitted records via fax or delivery of paper records.

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.

Four auditors conducted the encounter validation. Two auditors had prior experience with the Encounter Data Validation audit and extensive experience in behavioral health, maintaining, and reviewing clinical records. 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 2013 manual to the 2014 manual); both the 2013 and 2014 versions of the USCS manual were used depending on the date of service
- Navigating each of the EMR systems and where to locate the necessary information

The four auditors included:

- Lindsay Cowee, LPC, CACII (Manager of Quality Improvement, lead auditor)
- Jessie Nelson, LPC, (QI Project Manager)
- Travis Rosen, MPH (QI Project Manager)
- Ann Winters, (Compliance Monitoring Specialist)

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 scored the various elements for each record 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 94.1% agreement (with kappa = 0.772), which is considered "substantial 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.

Goals from 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	

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 CY13 review was completed, BHI felt it essential to calculate compliance rates for CY14 overall, and for CY14 dates that occurred after corrective action was implemented (titled CY14 post-CAP). The results for CY14 overall and CY14 Post-CAP are listed below.

Table 30: Audit scores by program service category

Program Service Category Comparison						
	CY11	**CY12**	**CY13**	**CY13 post-CAP**	**CY14**	**CY14 post-CAP**
Overall - all categories	79%	74%	79%	90%	83%	86%
PEI Services	n/a	77%	84%	89%	87%	91%
Drop-In Center Services	n/a	56%	58%	n/a	78%	81%
Residential Services	n/a	n/a	n/a	n/a	84%	n/a

Table 31: Audit scores across all providers and program service categories

BHI Overall - All Services										
	All Dates of Service Claims paid 10/1/13-9/30/14					**Post-CAP Dates of Service** 5/1/14-9/30/14				
Field Descriptor	**Records Accurate**	**Records Audited**	**% Records Accurate**	**Weight**	**Weighted Score**	**Records Accurate**	**Records Audited**	**% Records Accurate**	**Weight**	**Weighted Score**
Diagnosis Code	381	411	93%	5%	5%	83	83	100%	5%	5%
Start Date	410	411	100%	5%	5%	83	83	100%	5%	5%
End Date	410	411	100%	5%	5%	83	83	100%	5%	5%
Procedure Code	363	411	88%	15%	13%	67	83	81%	15%	12%
Place of Service	253	411	62%	10%	6%	59	83	71%	10%	7%
Service Program Category	352	411	86%	10%	9%	81	83	98%	10%	10%
Duration	407	411	99%	15%	15%	83	83	100%	15%	15%
Units	269	411	65%	15%	10%	42	83	51%	15%	8%
Population	409	411	100%	5%	5%	83	83	100%	5%	5%
Mode	400	411	97%	5%	5%	78	83	94%	5%	5%
Staff Requirement	248	411	60%	10%	6%	47	83	57%	10%	6%
Overall Compliance	3902	411	86%	100%	**83%**	789	913	86%	100%	**86%**

BHI did not meet the goal of 90% compliance score for providers for the overall 411 audit results. Overall services categories, the compliance score was 83% for CY14 and post-CAP CY14 scores were at 86%. BHI saw an increase in compliance with PEI services as well as drop-in center services. It is likely that BHI's scores decreased overall post-CAP in CY14 because of the review of residential claims. These claims have not been previously included in the 411 Audit and resulted in an 84% compliance score.

Each year, HSAG pulls a random sample of 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 QI 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 32 below shows BHI performance on the over-read audit results as compared to the statewide BHO average.

Table 32: BHI 411 over-read results

	All Claims		PEI		Drop- In Center		Residential	
	All BHOs	BHI	All BHOs	BHI	All BHOs	BHI	All BHOs	BHI
Overall	**97.1%**	--	**98.0%**	--	**97.5%**	--	**96.0%**	--
Procedure Code	97.9%	96.7%	98.0%	100%	100%	100%	96.0%	90%
Service Category	99.3%	100%	100%	100%	100%	100%	98.0%	100%
Diagnosis	100%	100%	100%	100%	100%	100%	100%	100%
POS	100%	100%	100%	100%	100%	100%	100%	100%
Units	99.3%	100%	100%	100%	97.5%	100%	100%	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	100%	100%	100%	100%	100%	100%	100%	100%
Mode of Delivery	100%	100%	100%	100%	100%	100%	100%	100%
Minimum Staff Req.	96.4%	93.3%	98.0%	100%	95.0%	90%	96.0%	90%

BHI did maintain inter-rater reliability with HSAG from the CY13 over-read records to the CY14 over-read records.

Barrier analysis and interventions
As previously mentioned, the number of the claims selected for review by HCPF occurred prior to the implementation of corrective action from the previous year's audit as claims were selected by paid date and not date of service.

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 as encounters are selected by date claim was submitted, rather than date of service. However, the overall score did increase for the drop-in center services from CY13 (58%) to CY14 (78%). BHI continues to work with the drop-in centers on documentation guidelines and training new staff on requirements.

Three 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

One provider that scored deficiencies related to system programming submitted appropriate documentation to reflect corrections are in place. The remainder of provider claims was such a

small number that they did not give reasonable representation of their practices. A letter was sent to each provider with scores to address deficient elements.

Goal(s) for FY16

Project Title	Goal(s)	Action(s)	Target Date
Encounter Data Validation (411) Audit	Increase provider overall compliance score to 90% or higher	Continuing to train providers on proper billing and documentation practices no less than quarterly	6/30/16
	Maintain or improve inter-rater reliability with HSAG	Continuing to train audit team on the USCS Manual	

Provider Audits

Summary of project
BHI utilizes an audit tool that combines 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 November of FY15, BHI added one staff member to allow for additional auditing functions. The additional auditor continued to refine the audit process and completed audits with six providers (three follow up audits, two initial audits and one service specific audit). The volume of records for the two initial audits is a statistically valid sample. 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 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.

Goals from 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	

Results and analysis
BHI trained over 100 providers and completed the documentation training with four facilities within the past fiscal year. Due to the success of the audit process, BHI considers the objective of implementing quarterly trainings to be met. 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.

As staff was added later than October 2014, as originally planned, and training requirements, the goal for 10 provider audits was not 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 33 demonstrates the various scores from provider audits.

Table 33: BHI provider audit results

Provider	Initial Audit Score	Follow up Audit Score	Status
A	47%	89%	Provider upgraded EHR after re-audit, all CAP requirements met
B	44%	18%	Initial CAP requirements met. No indication corrections made with re-audit. Additional audit scheduled for Dec. 2015.
C	47%	52%	Pending CAP submittal based on follow-up audit results. Provider will be required to self-monitor and a follow-up audit will be completed in 3-6 months of original audit date.
D	44%	*	Pending CAP submittal for initial audit. Provider will be required to self-monitor and a follow-up audit will be completed in 3-6 months of original audit date.
E	85%	*	Pending CAP submittal for initial audit. Provider will be required to self-monitor and a follow-up audit will be completed in 3-6 months of original audit date.
F	64%	*	re-audit scheduled for Oct. 2015

* Follow up audit not yet conducted

Barrier analysis and planned interventions

One barrier to meeting the goal of auditing 10 providers between FY14 and FY15 is related to staffing issues. BHI planned to hire a Compliance Monitoring Specialist at the beginning of FY15; however, one was not hired until November. Shortly after the Compliance Monitoring Specialist hire date, BHI began preparing for the annual encounter validation audit (411 audit) that continues through the end of March. Provider audits were not conducted on a regular basis until after the annual audit was completed.

An audit plan was developed to help aid the process of provider auditing. In response to the EQRO audit, BHI continued to refine the provider monitoring process further. The plan was developed in order to have structured guidelines for selection of service category and provider for review. The FY16 audit plan used CY14 data to determine which service categories to review. A minimum of 10 providers will be randomly selected for auditing/monitoring. Under the circumstances where there are less than 10 providers per service category, all providers will be audited. The audits will include a sample of claims reviewed for validation, a sample of full chart audits reviewed for quality, and an office-site evaluation tool.

Since the provider-monitoring plan in more detailed and in-depth than previous years, BHI determined that two additional staff were needed. An additional Compliance Monitoring Specialist will be hired under the Compliance Department and a Provider Quality Monitoring Specialist will be hired under the Quality Improvement Department. Specifically, the Provider Quality Monitoring Specialist will conduct the quality of care reviews (based on the full chart

audits) and the office site evaluation form. Based on the results of the provider monitoring, a more in depth audit of full charts and/or claims validation auditing can occur.

The FY16 Provider Monitoring Plan includes the following service categories:

- Q1: In-home providers; Outpatient providers
- Q2: Inpatient services
- Q3: Annual Encounter Validation Audit (411)
- Q4: Substance Use Disorder (SUD) Organizations/Facilities

In addition, BHI continues to schedule at a minimum, quarterly documentation training that is open for all providers to attend. Documentation training currently available include, routine outpatient services, higher levels of care that comprise of day treatment, residential, and intensive in-home services and outpatient services. In addition, service specific training in SUD is available.

Providers can request supplementary trainings based on their needs. BHI has been conducting these trainings individually to providers as the result of an audit or upon provider request. Providers have responded positively to these trainings, and other providers are requesting trainings for their agencies. Therefore, BHI will continue to offer regular clinical documentation trainings to meet this demand.

Goal(s) for FY16

Project Title	Goal(s)	Action(s)	Target Date
Provider claim/record audits	Increase volume of provider audits completed to at least 30 per year	Initiate a minimum of 10 provider audits per service category according to the FY16 audit plan.	6/30/16
	Hire two additional staff	Hire additional compliance monitoring specialist and provider quality monitoring specialist.	
Documentation training	Provide training to meet provider needs	Develop additional service specific trainings to meet provider needs.	6/30/16
	Train at least 100 individual outpatient providers	Continue to provide quarterly routine outpatient documentation trainings	

Section 7: Performance Measures

BHI believes that to provide truly excellent behavioral 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 FY14, as FY15 performance measures will not be calculated until fall of 2015.

Reducing Over- and Under-Utilization of Services

Summary of project – Quality and Safety of Clinical Care
BHI utilizes a very skilled 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 behavioral 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 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.

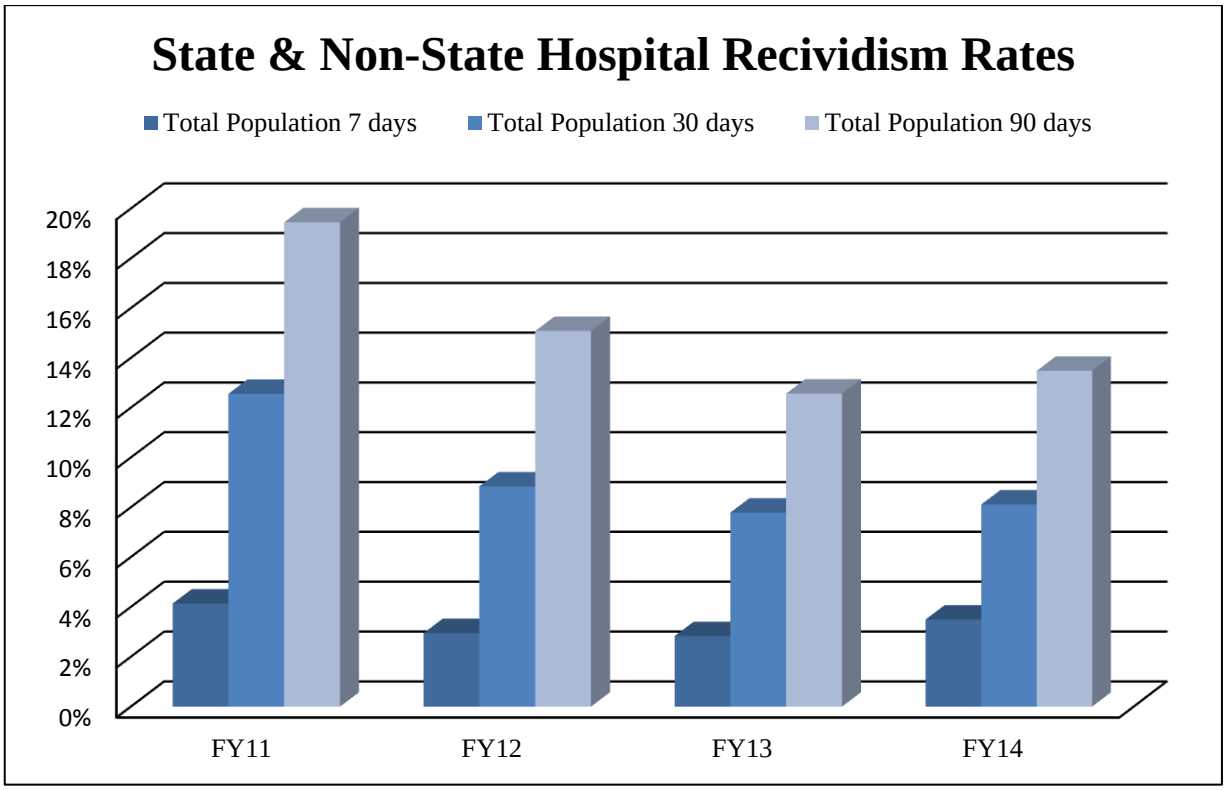
Goals from FY15

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	

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 FY14, BHI actually increased recidivism in each of the three timeframes; however BHI remained below the state average for both 30 days (9.61%) and 90 days (15.98%). Therefore, BHI considers this objective to be partly met.

Figure 5: Hospital recidivism rates

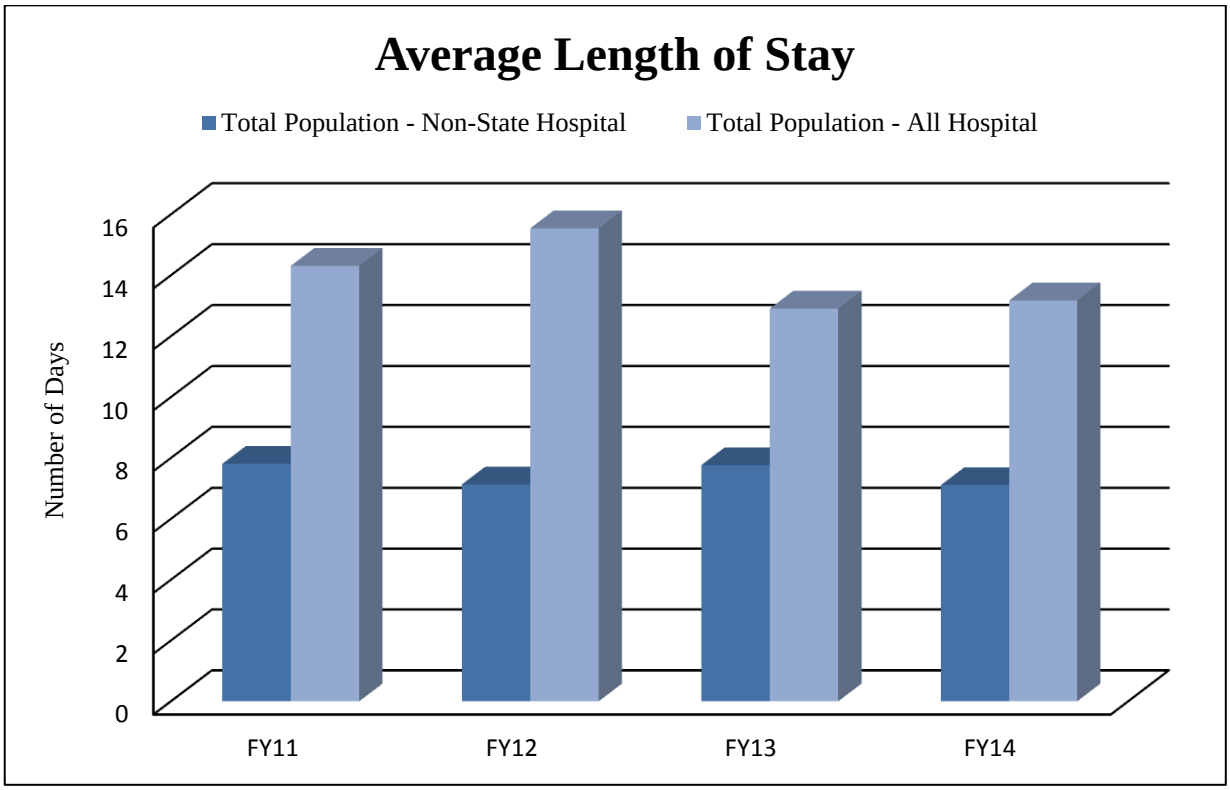


Results and analysis – Length of Stay

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.

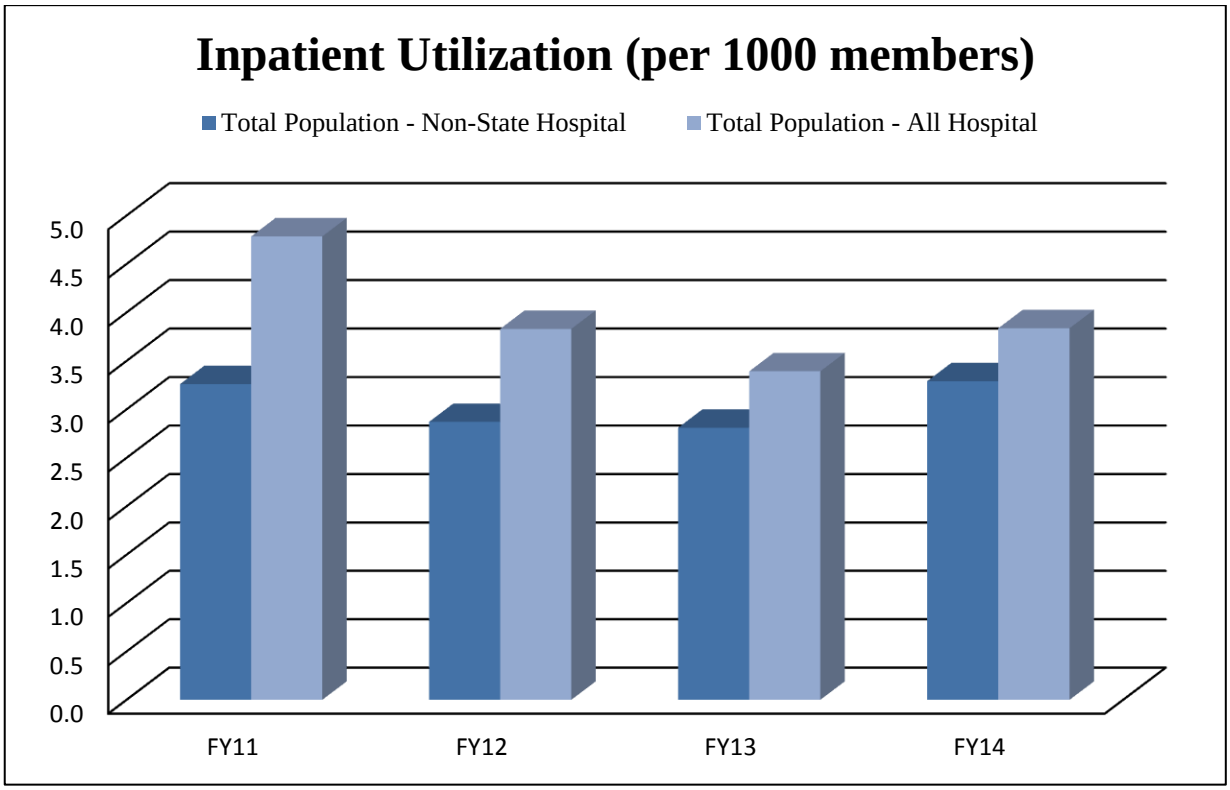
Although BHI demonstrated a slight increase in ALOS for all hospitals in FY14, the ALOS reduced for non-state hospitals and remained below the state average for both non-state hospitals (8.15) and all hospitals (14.24). Therefore, BHI considers this objective to be met.

Figure 6: 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 1,000 members. The UM department continues to build relationships with providers at all levels of care and BHI has increased the utilization of other sub-acute levels of care. As demonstrated in Figure 7, inpatient utilization increased for FY14, however, BHI remains below the state average for non-state hospitals (4.37) and for all hospitals (5.08). BHI also has the lowest utilization amongst all the Colorado behavioral health organizations; therefore, BHI considers this objective to be met.

Figure 7: Inpatient utilization

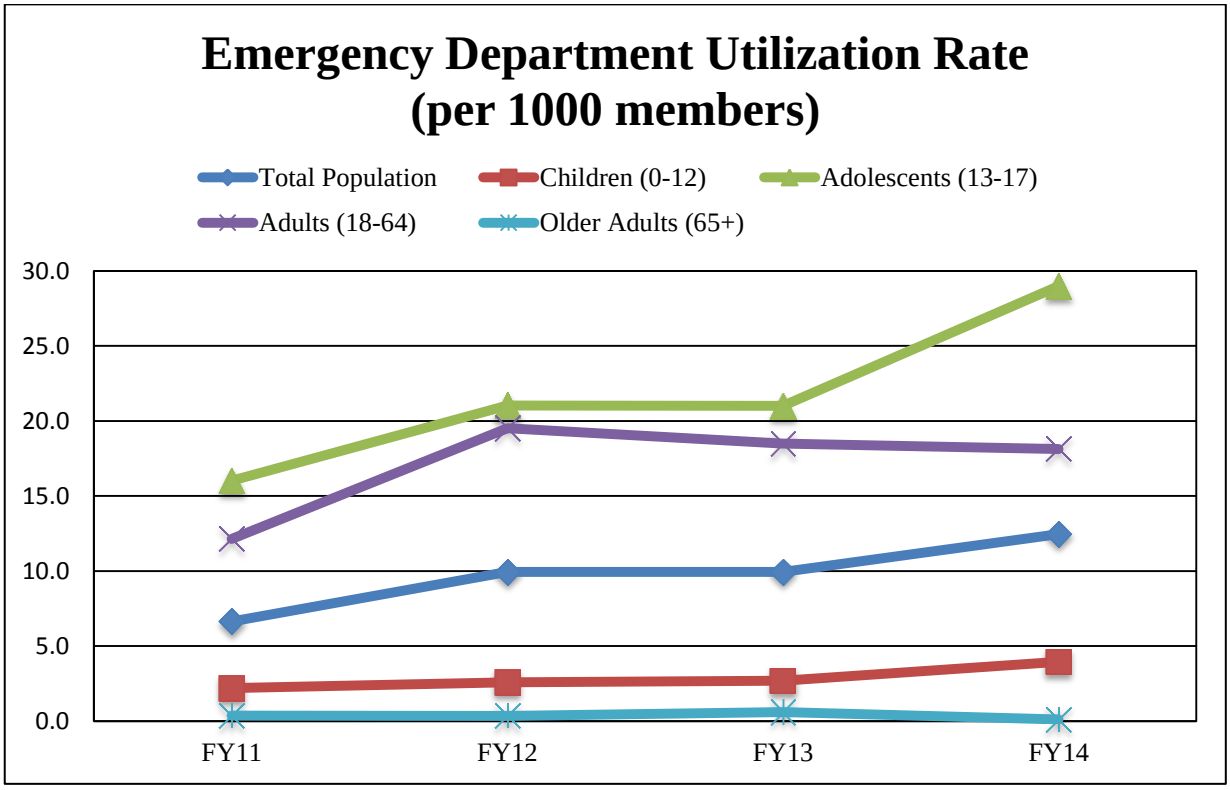


Results and analysis – ED Utilization
This indicator measures the number of BHO member emergency room visits for a covered mental health disorder per 1,000 members by age group and overall for the specified fiscal year. BHI's ED utilization rate was higher than the statewide BHO average rate (10.92) and therefore, BHI considers its goal not met.

BHI saw a decrease in the total population rate of ED utilization. The rate increased for children and adolescents and decreased for adults and older adults in FY14. BHI will consider interventions for these specific ages group if utilization continues to increase. BHI is monitoring ED use on a monthly basis in the QIC and sharing the analysis and interventions with the Performance Improvement Advisory Committee (PIAC). BHI is expecting that ED Utilization will decrease in the coming years due to the implementation of the CCC programs.

BHI understands that the ED utilization rate for adolescents has increased in the past three fiscal years. Many of the Colorado BHO's show an increase in adolescent utilization as well as total population ED utilization. One explanation for the increased utilization among adolescents this year is that the rate of adolescent eligible continued to increase. Many of these individuals new to the behavioral health system may be using the EDs for entry into mental health services, and now substance use services. Potential outreach and education services can be planned to target adolescents via school district to prevent and lower ED use among this age group.

Figure 8: ED utilization rates by age category



Barrier analysis and planned interventions – All measures
In an effort to obtain more timely data and see more timely effects of interventions, BHI measures each of these indicators on a quarterly basis for reporting in the Quarterly Performance Report Card. These measures are also included in the monthly UM Report, that is reviewed by senior leadership, Director and Manager of UM, and the QIC.

BHI has planned and implemented several interventions due to the increase in readmission rates, inpatient utilization, and ED utilization. Several of these interventions are also targeted to increase the rate of follow-up after hospital discharge within 7 and 30 days. The following are a list of implemented interventions:

1. If a member readmits to the hospital within 30 day of a previous discharge and the member is currently receiving services via the CMHCs within BHI's catchment area, the hospital liaison for that CMHC is contacted by the UM acute care team at BHI to plan some targeted wrap-around services for that member. If the member is not currently being

seen by the CMHC, the member is automatically referred to the Care Management team by the hospital liaison and the BHI UM acute care team.
2. If a BHI member presents at the ED for evaluation for admission to inpatient services, the UM acute care team notifies the member's Care Manager, if the member is currently enrolled in the Care Management program prior to authorizing an inpatient stay.
3. BHI has continued to develop and refine its hospital liaison program. This refining process has led to better communication, including monthly meetings at the BHI offices to discuss cases, interventions, and program planning.
4. BHI continues to address the 'big-picture' system issues that are direct result of increased need for behavioral health services. BHI continually discusses, via the Board of Directors and PIAC, the need for building specific programs to tailor to member needs.
5. BHI has previously had discussions with its PEO Committee about the annual performance measures and how they are calculated. BHI specifically discussed Follow-up after hospital discharge and what CPT/HCPCS codes count towards this measure. The Director of Utilization Management plans to have similar discussions with the hospital liaison teams at the CMHCs to ensure follow-up care is being coded correctly.
6. BHI monitors follow-up after hospital discharge anywhere from monthly to quarterly. The hospital liaisons send BHI information about follow-up appointments monthly and this is compared to claims data quarterly to determine any discrepancies in reporting.

It is likely, due to the timing of the annual performance measures, that the interventions implemented will not have a marked effect on the FY15 measures; however, the interventions are expected to influence the FY16 measures.

Goal(s) for FY16

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 some performance indicators quarterly to monitor for patterns and trends across services	6/30/16
		Continue to monitor specific member utilization ensure targeted interventions are working	

Improving Member Health and Safety

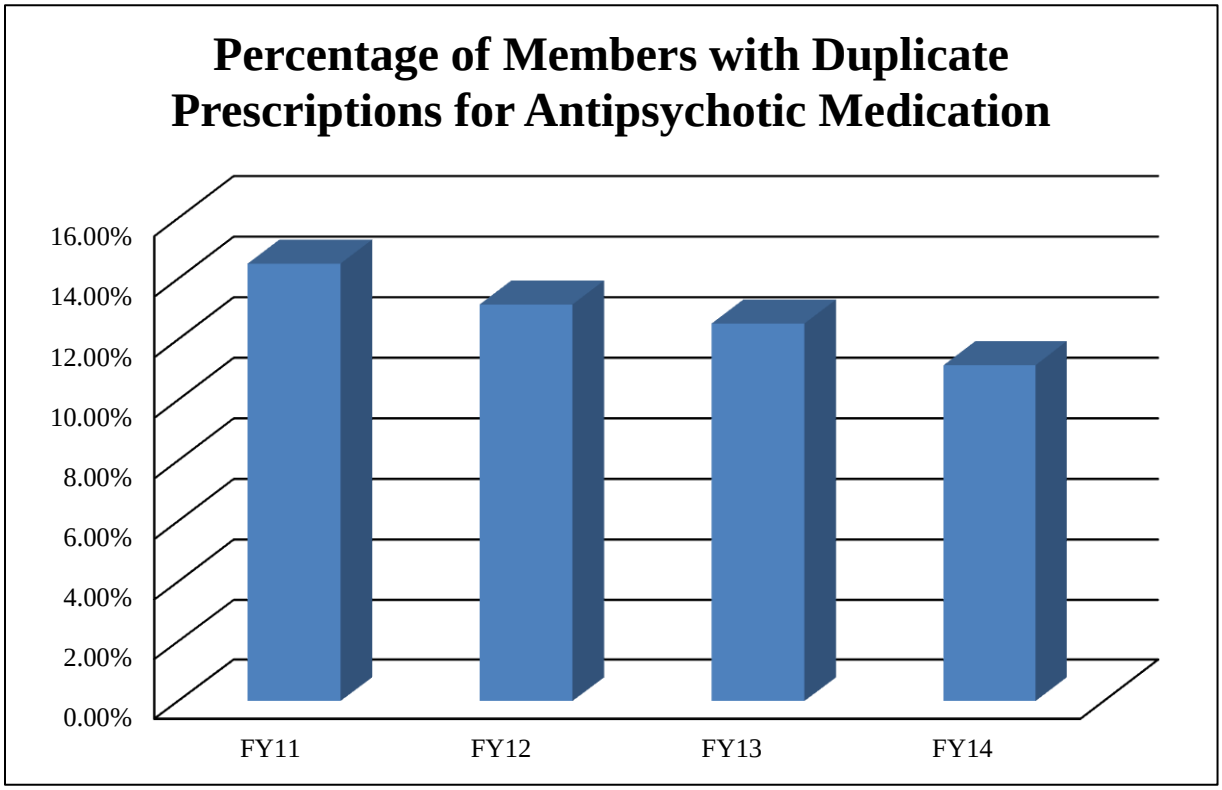
Summary of project – Quality and Safety of Clinical Care
There are several statewide performance measures designed to monitor member health and safety, particularly regarding psychotropic medications. BHI furthered this study in the recent development of a safety medication project. For more information, see the Coordination of Care Section of this report.

Goal from 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

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. Though BHI continues to be higher 11.14% than the statewide BHO average 7.07%, there has been continued decrease from FY13 to FY14 in this measure, as demonstrated in Figure 9. BHI considers objectives for this measure to be partly met.

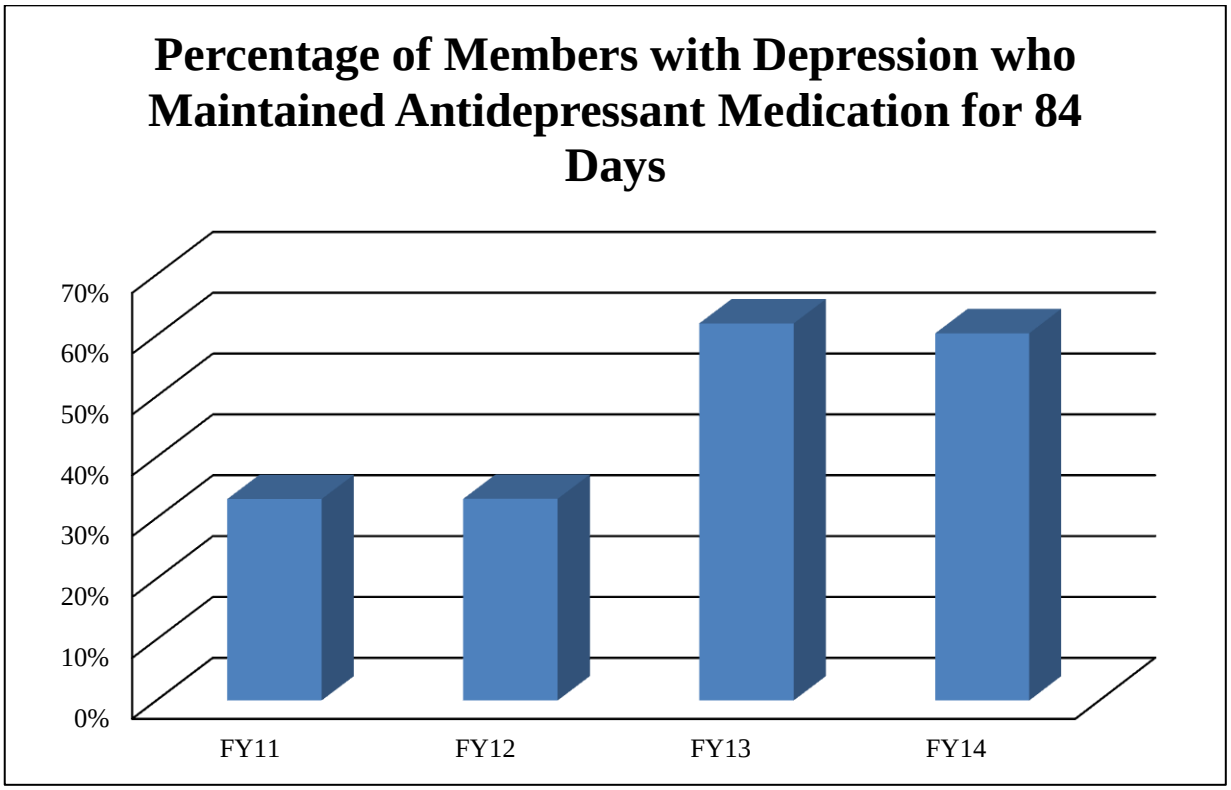
Figure 9: Of all members on antipsychotics, percent on two or more



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. This measure is calculated State-wide rather than split by BHO and in FY14 Colorado Medicaid performed at 70.37% compliance, a slight decrease from FY13. BHI will continue to monitor and trend this indicator to identify opportunity for improvement.

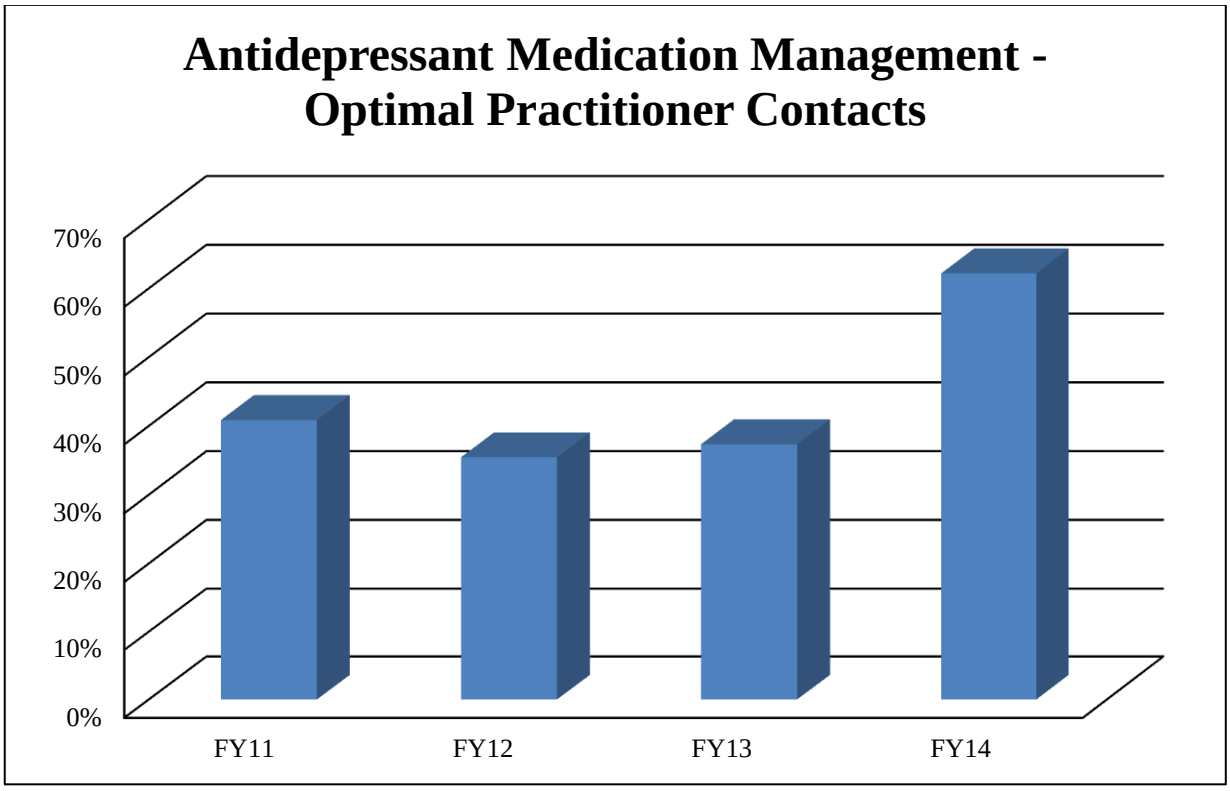
Results and analysis - Depression and Medication
This indicator measures the percent of members who have been: 1) diagnosed with a new episode of major depression, 2) treated with antidepressant medication, and 3) maintained on antidepressants for at least 84 days (12 weeks). As demonstrated in Figure 10, BHI showed a slight decrease from FY13 to FY14 but continued the significant increase from FY11-12. BHI remains higher than the state-wide average (58.91%) and therefore considers objectives for this measure to be met.

Figure 10: Depression and medication monitoring



Results and analysis - 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 11, BHI demonstrated a significant increase in performance from FY13, and continued to perform well above the statewide average for this measure (32.38%). Therefore, BHI considers the objective for this measure to be met.

Figure 11: 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. It was decided between HCPF and the Colorado BHOs that this measure would not be reported for FY15.

As an additional measure for member safety BHI decided to implement a child safety medication project similar to the one discussed in the next section of this report.

Goal(s) for FY16

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.	Continue to monitor member safety performance measures annually	6/30/16

Safety Standards in Medication Dosages Report

Summary of Project
BHI has historically monitored several performance measures related to medication safety, including:

- Members prescribed duplicate atypical antipsychotics
- Member adherence to atypical antipsychotics
- Members diagnosed with major depression and treated with antidepressant medication

While BHI's performance on these measures remains consistent with the other Colorado BHOs, BHI identified this area as an opportunity to improve the use and safety of psychotropic medications with our member population. Because BHI prioritizes member safety, this project seeks to identify whether physicians within BHI's network are prescribing within standard guidelines by using an accepted method of equivalency of one drug per medication class.

Sixteen different prescribers across BHI's three main CMHCs were evaluated for this project. Any prescriber who prescribed medication to at least 40 unique members in the allotted timeframe (calendar year 2014) was included in the sample. If any prescriber saw more than 100 unique members, a total sample of 100 members for that individual prescriber was used. This resulted in a total sample size of 1,365 child and adolescent members. The member clinical records for each member were extracted, and only the most recent medication management service was reviewed, in order to capture the most current data.

Each CMHC provided remote access to their EMR in order to perform the clinical record reviews. Data extracted from the clinical record included: the member's age, the specific medications prescribed, the overall total number of medications prescribed per member, the total number of medications per member in each class, the precise dosage for each medication prescribed, and the number of DSM-IV Axis I diagnoses per member. In order to measure dosages for the three main medication classes (Antidepressants, Antipsychotics, and Stimulants), an established method of conversion was developed by BHI's CMO by reviewing and incorporating peer-reviewed and established governmental guidelines for comparing and switching the most common medications in each class (see table below). Antidepressants were converted to Prozac; Antipsychotics were converted to Abilify, and stimulants were converted to Methylphenidate.

Table 34: Conversion Equivalents

Conversion to PROZAC	Conversion to ABILIFY	Conversion to METHYLPHENIDATE
ZOLOFT (Sertralne) = **3.75**	RISPERDAL (Risperidone) = **0.2**	ADDERALL (Dextroamphetamine) = **0.5**
CELEXA (Citalopram) = **1**	SEROQUEL (Quetiapine) = **25**	VYVANSE (Lisdexamfetamine) = **1.25**
LEXAPRO (Escitalopram) = **0.5**	HALDOL (Haloperidol) = **0.4**	
PAXIL (Paroxatine) = **1**	ZYPREXA (Olanzapine) = **1**	

For example, if a member had been prescribed Zoloft, the amount prescribed was converted into the equivalent of Prozac for each member. If a member was prescribed 100mg of Zoloft, that dosage would be converted to 26.67mg of Prozac for our analysis. A member who is taking 10mg of Zyprexa would convert to an even 10mg of Abilify, as that ratio is 1:1.

Results and Analysis
For these results, the average dosages per member for each major medication class was analyzed based on the conversions in Table 34.

In Figures 12-15, each prescriber was assigned a letter for the presentation of the results, in order to "blind" the results. Figures 12-14 include the dosage information for Antidepressants, Atypical Antipsychotics, and Stimulants. The vertical axes represent the converted average dosage in milligrams, broken into titrations of 10 mg for conversion to Prozac, 5 mg for conversion to Abilify, and 25 mg for conversion to Methylphenidate. Also included are the minimum and maximum dosages of each prescriber in each medication class. Figure 15 shows the average number of medications and the average number of diagnoses per member by prescriber.

Figure 12: Average dosage (in mg) of Antidepressants converted to Prozac per prescriber

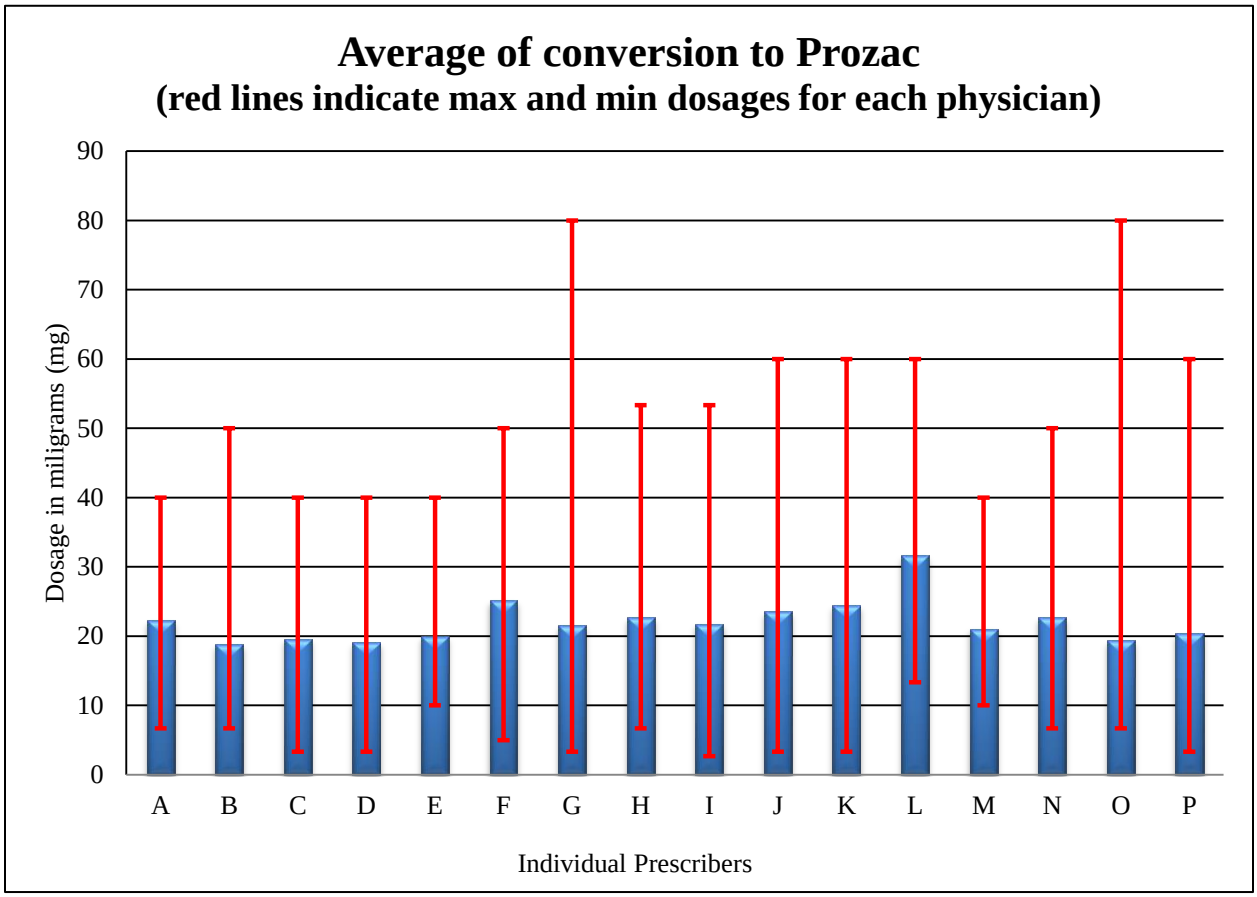


Figure 13: Average dosage of Abilify per prescriber

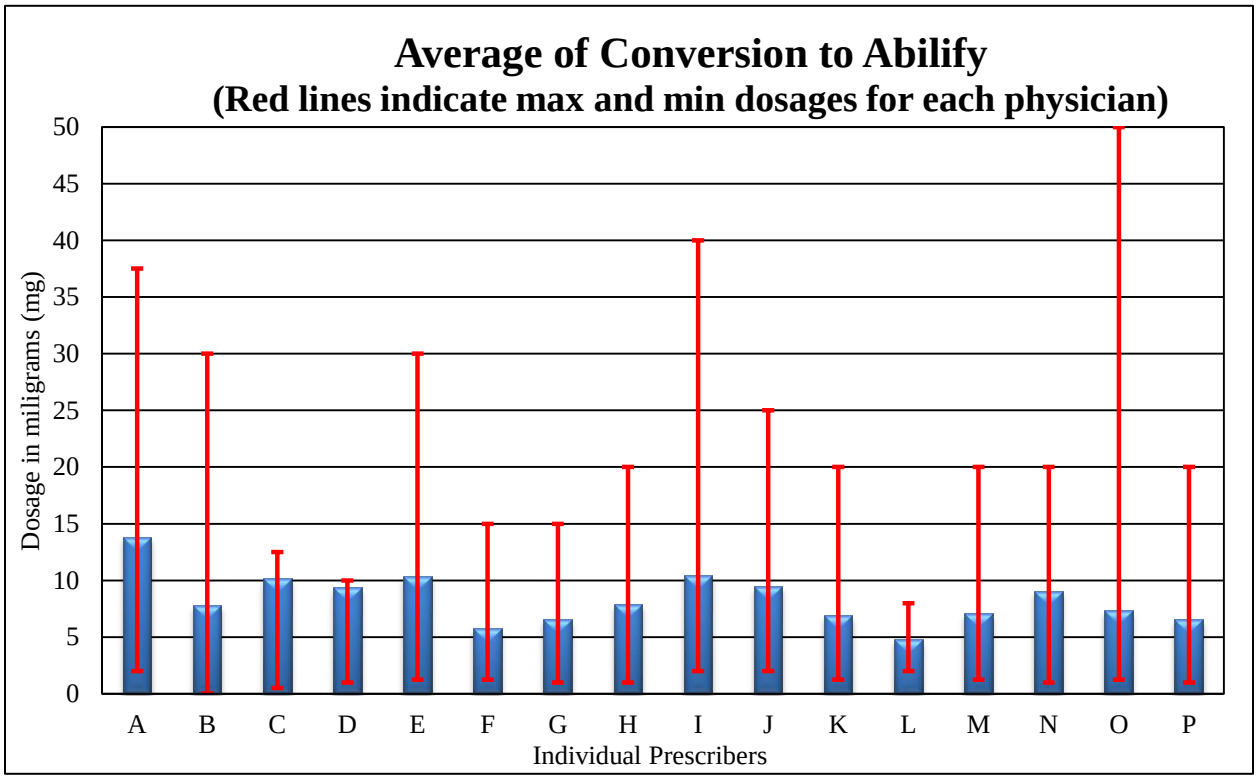
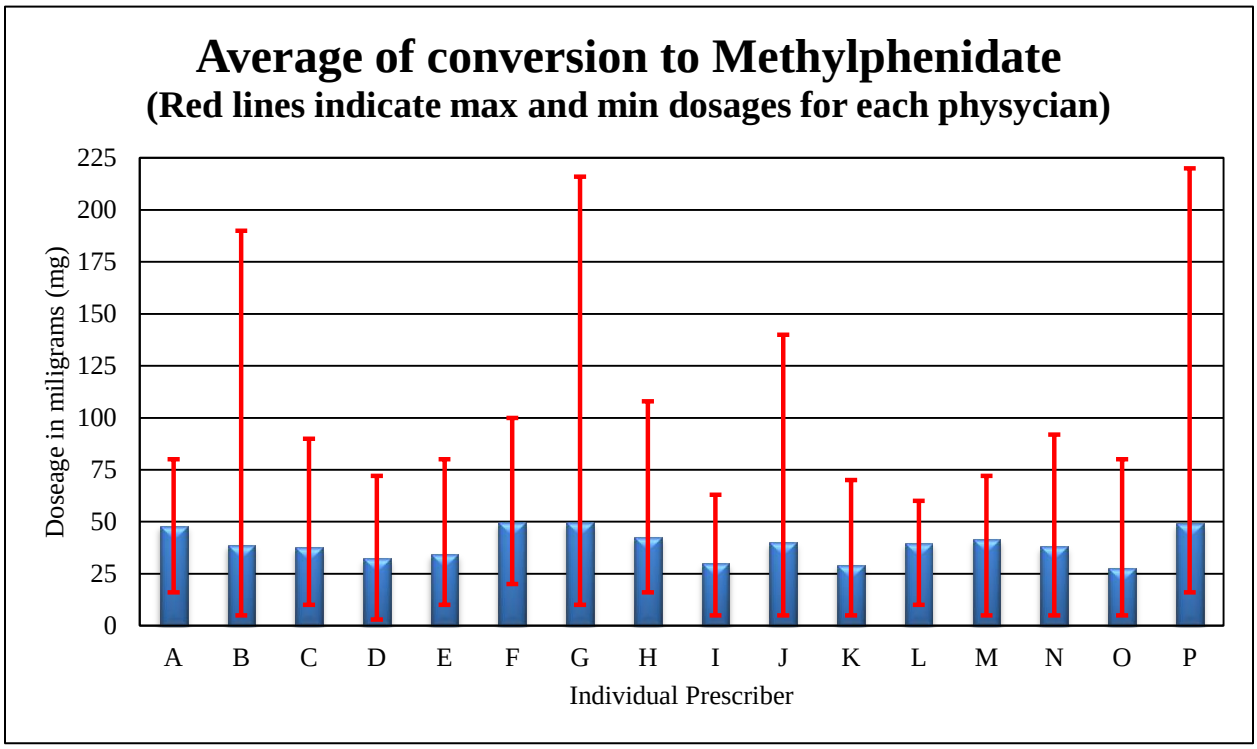
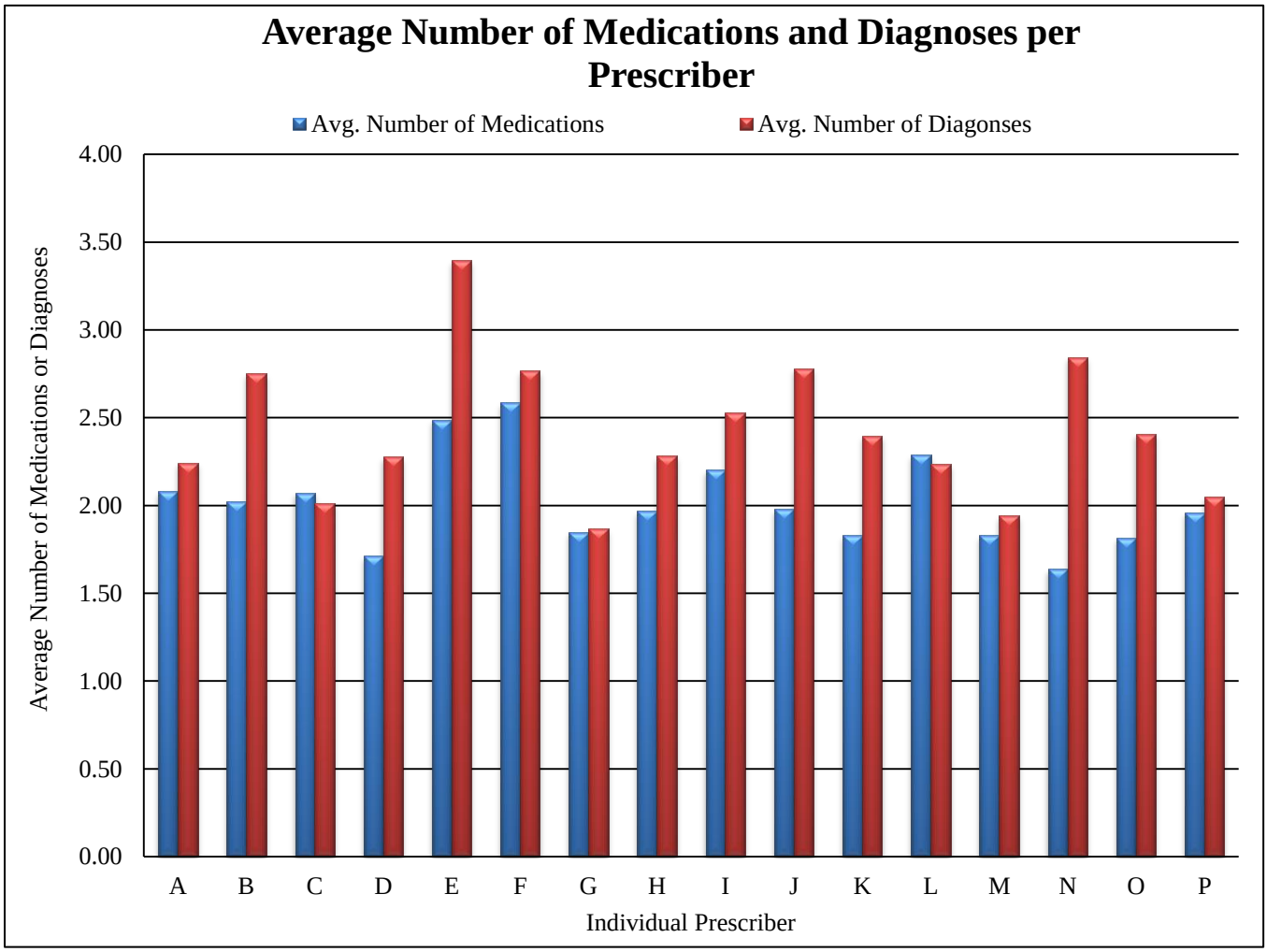


Figure 14: Average dosage of Methylphenidate per prescriber



In order to account for the medical complexities of the members being seen by each prescriber, the comparison between the average number of diagnoses each prescribers' members have in relation to the average number of medications prescribed. Figure 4 demonstrates these relationships.

Figure 15: Average number of medications and diagnoses per member per prescriber



Based on the result presented above, it can be concluded that most of the average dosages for each prescriber are in line with regularly accepted benchmarks for all the examined classes of medication. However, the maximum dosages for several medications were above the recommended guidelines.

Barrier Analysis and Planned Interventions

BHI did not identify any barriers to this project at this time. Based on the results of this quality improvement activity, BHI has planned several interventions.

1) Non-blinded findings will be presented to the CEOs and medical directors of each CMHC.
2) Blinded findings will be presented to each of the prescribers included in the project.
3) Outliers will be discussed at the organization level

With this information, the CMHCs will be able to implement the interventions as a team within their own organizations. This project is scheduled to occur annually in order to monitor improvement over time for each provider and to measure the efficacy of the planned interventions. This project will also be replicated with adult members.

Goal(s) for FY16

Project Title	Goal(s)	Action(s)	Target Date
Member Health and Safety	Complete the medication safety project with children annually	Implement annual medication safety project	6/30/16
	Implement adult medication safety project	Complete adult medication safety project	1/1/16

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 seven days of hospital discharge 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.

Goals from 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

Results and analysis
BHI continued efforts 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, full-year FY15 data is not yet available. As seen below the amount of members increased significantly and while BHI continues to perform above the statewide BHO average for both 7 days (50.51%) and for 30 days (69.53%), performance decreased compared to FY13 and continues to fall short of the new internal benchmarks set by the QI and UM departments.

Table 34: 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%
FY14	Re-measurement 3	237	452	52.43%	90.00%

Table 35: 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%
FY14	Re-measurement 3	319	452	70.58%	95.00%

Barrier analysis and interventions

In FY15, BHI started to measure the data on a quarterly basis; however the information was always three months behind when the analysis was conducted due to claims lag. To address this issue and to facilitate both timely and accurate data, BHI implemented a new process in April 2015 utilizing information from the CMHC hospital liaisons about members' discharge planning and confirmation of follow-up appointment attendance. This allowed the calculation of this measure within 15 days of the end of the quarter. This data will be validated with claims data upon completion. Also considering how far our current results are from the benchmark new goals are being set for FY16.

Goal(s) for FY16

Project Title	Goal(s)	Action(s)	Target Date
Coordination of Care – Follow-up after hospital discharge	Provide 62% of outpatient appointments within 7 days after hospital discharge Provide 80% of outpatient appointments within 30 days of hospital discharge	BHI will continue to monitor this measure quarterly and implement targeted interventions	6/30/16

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 Care Managers work to connect members to appropriate medical care. BHI Cara Managers provide members with referrals to PCPs and specialists in their catchment area. If a member is unable to do so themselves, the care manager 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 Cara Manager receives referrals from therapists, case managers, and prescribers within the CMHCs. The Cara Manager 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 Care Manager will make a psychiatric referral, if appropriate.

Once a member is connected to a PCP or specialist, the Care Manager continues a documented process. Upon written permission from the member, the Care Manager 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.

Goals from 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

Results and analysis
This performance measure is calculated by HCPF. BHI will continue to monitor this measure and implement interventions to increase performance. Table 36 below shows BHI performance increased from FY12- FY14. No improvement was achieved between FY13 and FY14 and our results continue to be lower than the statewide BHO average (89.24%).

Table 36: Percentage of BHI members with a physical healthcare visit

	FY12	FY13	FY14
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	15,226
Total number of members from the denominator with at least one preventive or ambulatory medical visit (numerator)	8,828	11,552	13,327
BHI Performance	72.81%	87.11%	87.30%
Statewide BHO average	72.80%	89.31%	89.24%

In FY15, BHI continued collecting information regarding the number and percentage of members receiving behavioral health services who had a primary care physician (PCP). This information is being collected and reported in our Quarterly Report Card. In addition, BHI also extended the Care Management service in FY15. The new Complex Case Management service commenced as a pilot on April 1st, 2015 to specifically work with members that have had high a high cost for both physical and behavioral health services over the previous 12 months.

Barrier analysis and planned interventions
The CMHC's in the BHI's catchment area have built the necessary information into their EMRs for the measurement of the PCP indicator. BHI will continue to monitor the reporting of the PCP indicator on a quarterly basis, as well as develop performance indicators for the new Complex Case Management service to determine key outcomes.

Goal(s) for FY16

Project Title	Goal(s)	Action(s)	Target Date
Coordination of Care – Improving physical healthcare access	Continue to improve coordination of care by 5%, (from 87.30% to 92%).	Continue the development of the new Complex Case Management service	6/30/16
	Develop performance indicators for complex case management.	Implement key performance indicators for the Complex Case Management service, in line with NCQA requirements	

Coordination of Care – Adolescent Depression Screening and Follow-up

Summary of Project

The goal for this performance improvement project is to increase the number of adolescents who are screened positive for depression within the medical setting and follow-up with a behavioral health provider. It is believed that youth who receive timely behavioral health treatment as soon as possible after a positive depression screening will fare better with their overall health outcomes and ultimately will be at lesser risk for the complications arising from depression mentioned previously.

This performance improvement project places an emphasis on the primary care setting because the "majority" of "depressed youth identified in primary care…seem to start treatment." By systematically assessing the adolescent population for depression it is likely that more individuals with depression would be identified, that those with depression would be diagnosed and treated earlier than they would have been otherwise. By increasing assessment, identification, and treatment of adolescents with depression, the ultimate goal is to improve their heath and level of functioning by improving symptoms, thus mitigating the negative downstream effects of untreated depression.

The proposed target population is shared BHI and RCCO Medicaid members between the ages of 12-17 who screen positive for depression by a medical provider. Members must be continuously enrolled for at least 90 days prior to and 30 days following the date of the positive depression screen. Members with a depression diagnosis within the past 90 days will be excluded from the project (unless the diagnosis was made in an Emergency Department). Members who are currently receiving treatment from a behavioral health provider prior to the screening are also excluded. CPT 99420 code with diagnosis code of V40.9 will be used to identify those members in the denominator. Diagnosis codes used to identify members with a previous diagnosis of depression within 90 days prior to the screening date will be DSM-IV diagnosis codes: 296.20-296.25; 296.30-296.35; 298.0; 311. Follow-up visits with a behavioral health provider can occur on the same day as the positive depression screening. Follow up visits include:

CPT Codes	HCPCS Codes
90791; 90792; 99201-99205; 90839; 90840	H0002, H0004, H0031; H0023; H0025; H2011; T1016; T1017

HSAG evaluated Activities I-VI and determined that there is a high confidence in the results. BHI is in the process of gathering baseline data (CY14) and implementing interventions with both primary care providers and behavioral health providers. A list of references for this project are available upon request.

Goal(s) for FY16

Project Title	Goal(s)	Action(s)	Target Date
Adolescent Depression Screening and Follow-up	To improve screening and follow-up by more than 5% by the end of CY15	Implement interventions as presented in the PIP write-up tool	6/30/16

Coordination of Care – E-Visits

Each county within BHI's catchment area has a CMHC that provides an array of services to BHI members. In order to accommodate the expansion of Medicaid, each CMHC has started a subgroup of availability of e-visits for their members. BHI began collecting data related to the number of unique members seen via e-visits as well as the total number of visits provided. E-visits, currently, only includes those services provided via HIPAA secure video conferencing. Each of the CMHCs within BHI's catchment area receives a capitated rate payment to help support/facilitate the telehealth program.

Arapahoe Douglas Mental Health Network (ADMHN)
ADMHN began an e-visit program in June 2013, in order to address retention of psychiatrists. Two of the agency's Child and Family psychiatrists were relocating to other states. The psychiatrists both expressed interest in retaining their clients for continuity of care. ADMHN was able to create a HIPAA and privacy secure mechanism for video and audio exchange between the psychiatrist and their clients. The service is offered at four of ADMHN's locations. The psychiatrists have retained their caseload and can also take new clients. There have been 247 unique BHI members seen since 2013 and over 985 e-visits.

Aurora Mental Health Center(AuMHC)
AuMHC began an e-visit program in Fiscal Year 2015, in order to retain a Child Psychiatrist who was relocating to another state. AuMHC was able to create a HIPAA and privacy secure mechanism for video and audio exchange between the psychiatrist and her clients. The psychiatrist has retained her caseload and also takes new clients. She visits clients in person one time per year who are on medications that require dosage and frequency monitoring. Since the program began, there have been 204 unique BHI members seen and over 601 e-visits.

Community Reach Center (CRC)
CRC began an e-visit program in Fiscal Year 2015, in order to address the growing number of members due to Medicaid expansion. CRC was able to create a HIPAA and privacy secure mechanism for video and audio exchange between the psychiatrist and her clients. CRC offers both behavioral health and medication management e-visits to their members. The services are offered at all Outpatient Offices and Residential Facilities. Services are available Monday through Friday 8:00am- 5:00pm, and are available after hours and weekends through the on-call services. CRC saw 1,304 members during FY15 and provided 3,129 telehealth visits.

Goal(s) for FY16

Project Title	Goal(s)	Action(s)	Target Date
Coordination of Care – E Visits	BHI will continue to support the telehealth programs at each of the CMHCs by developing policies and procedures for billing and data collection	Create policies and procedures related to telehealth programming and data collection	6/30/16

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.

Goal from 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

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 16 and Figure 17.

While BHI performance is still not as high as FY12, it remains consistent with the statewide average for maintaining independent living status (95.18%) and performed highest of all the Colorado BHOs for progress towards independent living status in FY14 (statewide average was 10.49%). Therefore, BHI considers objectives for this measure to be met.

Figure 17: Members maintaining independent living status

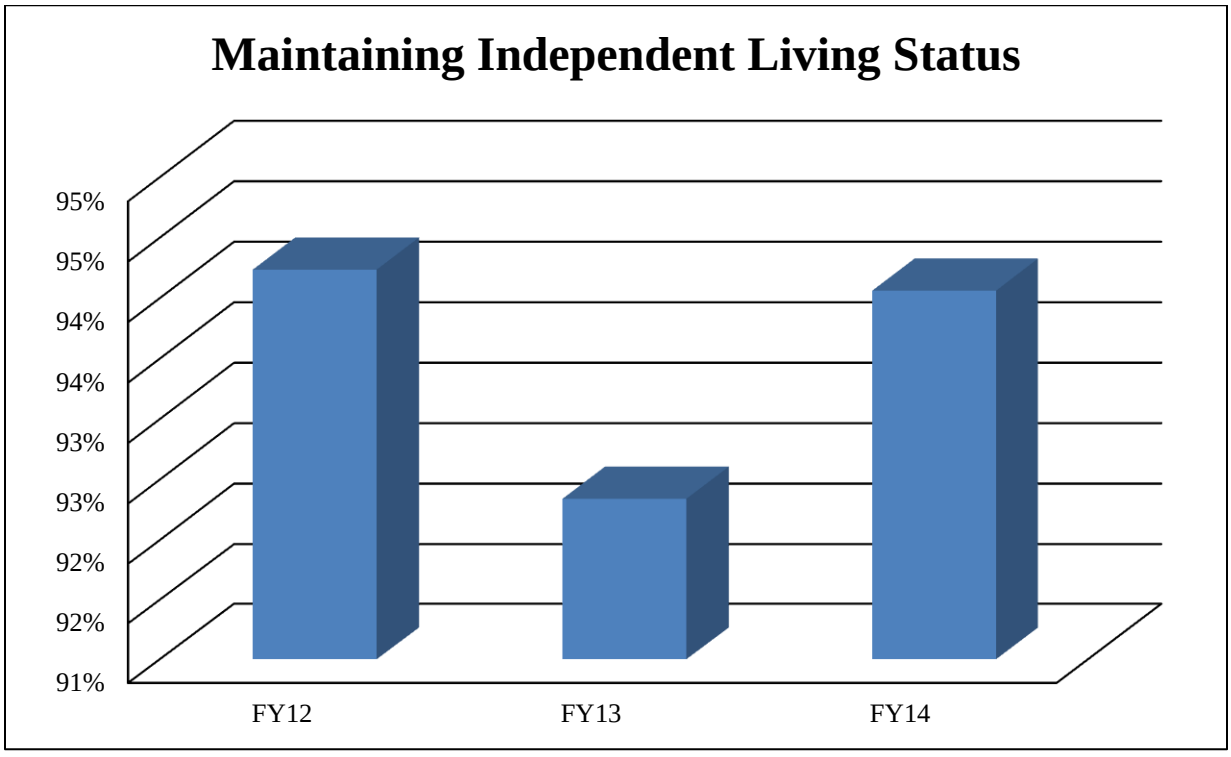
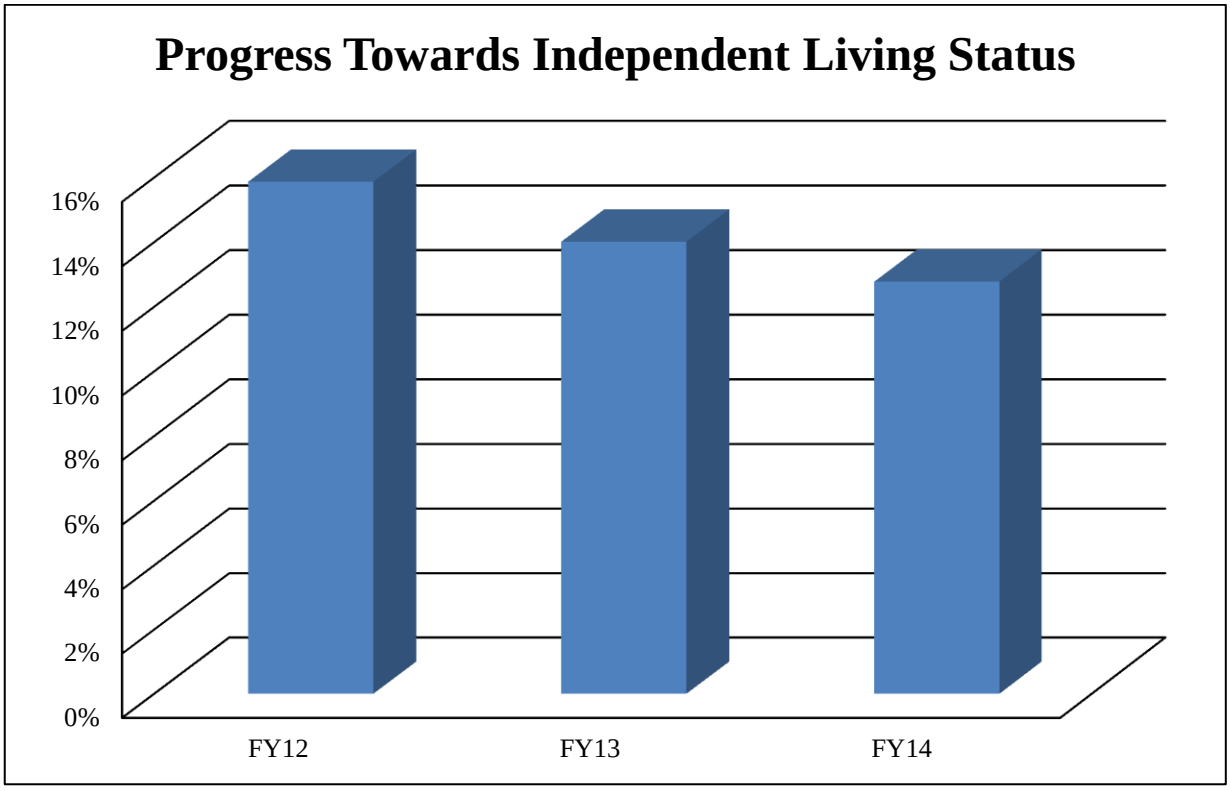


Figure 17: Members making progress towards independent living status



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. It was decided between HCPF and the Colorado BHOs that this measure would not be reported for FY15.

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 the BHOs and the Department. Upon receipt by HSAG, the ISCATs underwent a cursory review to ensure each section was complete and all applicable attachments were present. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- Source code (programming language) for performance measures was requested and was submitted by the Department and the BHOs. HSAG completed line-by-line review of the supplied source code to ensure compliance with the State-defined performance indicator specifications. HSAG identified areas of deviation from the specifications, evaluating the impact to the indicator and assessing the degree of bias (if any).
- Performance measure reports for FY 2014–2015 were reviewed by the validation team. The team also reviewed previous reports to assess trending patterns and rate reasonability.
- Supporting documentation included any documentation that provided additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, with issues or clarifications flagged for follow-up.

Performance measures that were selected for validation for FY14 were:
- Hospital Readmissions Within 7, 30, 90 Days Post-Discharge
- Behavioral Health Engagement (BHE)
- Overall Penetration Rates
- Penetration Rates by Age Category
- Penetration Rates by Eligibility Category
- Follow-up Appointments Within Seven (7) and Thirty (30) Days After Hospital Discharge
- Percent of Members with SMI with a Focal Point of Behavioral Health Care
- Improving Physical Healthcare Access
- Inpatient Utilization (per 1000 members)
- Hospital Average Length of Stay (LOS)
- Emergency Department Utilization (per 1000 members)

Goal from 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

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 collaborative relationship with Colorado Access, the BHO's administrative service organization (ASO).
    - As in prior years, the BHO had the same cohesive team (with a high degree of technical expertise), which was responsible for performance calculation and reporting.
    - In 2014, BHI experienced major system change along with assuming responsibility for an additional product line (substance use disorder [SUD]), which resulted in an increase in membership. However, even with these changes, the BHO was able to provide quality services to its members and maintain its performance level throughout the year.

- Suggested areas of improvement:
    - During the on-site visit, it was found that the incorrect data field was captured for the inpatient services. However, the BHO's analytical staff members were responsive and corrected these discrepancies prior to the generation of this report.
    - The corrected data files were resubmitted for review. After the file review, HSAG noted no further issues or concerns.
    - BHI should continue to work closely with the Department to resolve discrepancies with the flat files not matching the 837 files in the State's Medicaid Management Information System (MMIS).

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 to address and resolve any issues identified in the scope document. BHI will work with the department during the 2015 ISCAT to ensure that the flat files match the files in the State's Medicaid Management Information System.

Goal(s) for FY16

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	6/30/16

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 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	

Results and analysis
Table 37 indicates the current BHI practice guidelines, including which guidelines have been newly implemented and which have been recently reviewed. 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.

Medication guidelines are 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 (6th 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 FY15 objectives for the practice guideline program to be met.

Table 37: Current BHI practice guidelines

Practice Guideline	Reviewed in FY14	Newly Implemented in FY15	Reviewed in FY15
Schizophrenia		X	
Atypical Antipsychotics: Monitoring for Metabolic Side Effects			X
Bipolar Disorder			X
Risk Assessment			X
Eye Movement Reprocessing and Desensitization (EMDR)	X		
Reactive Attachment Disorder			X
Obsessive Compulsive Disorder			X
Attention Deficit Hyperactivity Disorder		X	
Major Depressive Disorder		X	
Generalized Anxiety Disorder		X	

Barrier analysis and planned interventions

After the redesign of the practice development program in FY14, BHI has now reviewed all practice guidelines within the last two years. This new process now ensures success with related NCQA standards for the creation and monitoring of guidelines and BHI will continue to aim towards meeting the standards for future years.

Goal(s) for FY16

Project Title	Goal(s)	Action(s)	Target Date
Clinical Practice Guidelines	Continue developing and implementing practice guidelines to meet the clinical needs of members and improve consistency across providers	Develop new guidelines as identified by the Standards of Practice Committee	6/30/2016
	Review/update 100% of practice guidelines every two years	Continue process of reviewing/updating all identified practice guidelines every 2 years	
	Continue with the distribution of informational material to members	Continue posting information in our website and disseminating this information to members	

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 and updated in October of 2014. 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 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

Results and analysis
While compliance with Indicator 1 (inclusion of family therapy) improved from FY14, the compliance with Indicator 2 (avoidance of polypharmacy) decreased. BHI included additional therapy codes for FY15 (90846) which represented family therapy *without* the child present and also in-home therapy codes (H2015, H2021 & H2022). It was recognized that it would still be of benefit to the child if the parents attended therapy without the child, and also the therapy did not have to be in a clinical setting and therefore the additional codes should be included in the practice guideline compliance. Table 38 highlights the results of both indicators, and for Indicator 1 shows compliance scores with and without the additional codes.

Table 38: Compliance with RAD Practice Guideline

Indicator 1: Percentage of members with primary diagnosis of RAD (313.89) who received family therapy during FY14		
	FY14	**FY15**
Denominator: number of members with primary diagnosis of RAD (313.89)	137	116
Numerator: number of members with primary diagnosis of RAD (313.89) who also received a family therapy service (90847)	43	54
Percent compliance	**31.39%**	**46.55%**
Numerator: number of members with primary diagnosis of RAD (313.89) who also received a family therapy service (90847, 90846, and in-home therapy codes H2015, H2021 & H2022)	N/A	63
Percent compliance	**N/A**	**54.31%**
Indicator 2: Percentage of members with primary diagnosis of RAD (313.89) who were prescribed three or fewer psychotropic medications		
	FY14	**FY15**
Denominator: number of members with primary diagnosis of RAD (313.89)	137	116
Numerator: number of members with primary diagnosis of RAD (313.89) who were prescribed three or fewer psychotropic medications	134	95
Percent compliance	**97.80%**	**81.89%**

Barrier analysis and planned interventions
BHI has planned some further analysis for this project to determine the increase in polypharmacy, including investigating the specific providers that prescribed the psychotropic medications. Though the inclusion of family therapy increased significantly from FY14 the numbers are still much lower than would be expected therefore BHI will continue to look into ways of increasing performance for FY16.

In addition, BHI will continue to educate providers through the provider bulletin about all practice guidelines, including the RAD guideline.

Goal(s) for FY16

Project Title	Goal(s)	Action(s)	Target Date
Compliance with Clinical Practice Guidelines	Maintain provider compliance with Indicator 1 and increase provider compliance with Indicator 2 to 90%	Monitor compliance with RAD guideline via encounter and pharmacy claims	6/30/16
		Identify areas to improve performance with the local CMHCs	
		Investigate prescriptions of multiple psychotropic medications to determine ways to avoid polypharmacy	

Practice Guideline Compliance – Risk Assessment

Summary of project – Quality and Safety of Clinical Care
BHI reviewed and updated the Risk Assessment practice guideline in March 2015. 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 includes a review of two full clinical records. In order to monitor compliance with the BHI Risk Assessment practice guideline, BHI requires that the following elements are included in the clinical record:

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

Goal from 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

Results and analysis
BHI completed full clinical record audits on eight providers across multiple levels of care; outpatient, inpatient and residential. The number of randomly sampled cases reviewed per provider and the overall results of the Risk Assessment practice guideline compliance review are listed in Table 39.

Table 39: Risk Assessment Practice Guideline Compliance Review

		Indicator 1	Indicator 2	Indicator 3
	Number of Cases	Suicide Assessment	Violence Assessment	Crisis Plan
Provider A	5	0%	100%	40%
Provider B	5	0%	0%	0%
Provider C	5	0%	0%	80%
Provider D	5	0%	0%	0%
Provider E	5	0%	0%	0%
Provider F	2	100%	100%	0%
Provider G	2	0%	0%	0%
Provider H	4	100%	100%	100%
TOTAL	**33**	**18%**	**33%**	**30%**

The non-compliance scores for suicide and violence assessments for provider E were due to no assessment being present, but non-compliance throughout the other providers was due to insufficient documentation. Most providers did include reference to violence or suicide ideation, however a thorough assessment was not documented and therefore the providers did not meet the standards as set out in the BHI practice guideline. Each of the non-compliance scores for Crisis Plan were due to either not having a crisis plan in place or due to a lack of documentation that a Crisis Plan was not needed at the time of assessment.

Barrier analysis and planned interventions

The scores for FY15 were very low and therefore it will be important to work with the providers in FY16 to ensure that risk assessment guidelines are adhered to. BHI will provide education about the results of the review, including specific details for each individual provider with regards to non-compliance, and continue discussion throughout the year to support changes to the risk assessment and documentation processes.

Goal(s) for FY16

Project Title	Goal(s)	Action(s)	Target Date
Compliance with Clinical Practice Guidelines	Increase providers compliance with all indicators by 10%	Monitor compliance with Risk Assessment guideline via new provider monitoring process	6/30/16
		Support providers to update risk assessment processes	
		Educate providers about the Risk Assessment Practice Guideline	

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

Summary of project – Quality and Safety of Clinical Care
BHI developed the Atypical Antipsychotics & Monitoring of Metabolic Side Effects practice guideline in August 2009 and the guidelines has since been reviewed every two years. The practice guideline includes recommendations and considerations when initially prescribing atypical antipsychotics, as well as the effect that this can have on different people and a detailed timeline of follow-up and monitoring.

BHI analyzes compliance with the guidelines through a member survey. This was first introduced after clinical research determined that the monitoring of fasting blood glucose and fasting lipid panels was not in line with the guidelines for members on atypical antipsychotic medication. Simply having the practice guideline in place was therefore not enough and instead adherence to the required practices needed to be monitored for improvement. The survey records members that have taken antipsychotic medication and had the following monitoring within the previous 3 months:

- *Indicator 1: Monitoring of fasting blood glucose and full lipid panel*
- *Indicator 2 : Monitoring of weight*

Goal from 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

Results and analysis
As shown in the tables below there was significant improvement from FY14 to FY15. The recording of weight increased to 91.27% and is now close to the benchmark goal of 95%, whereas glucose and lipid panels were reported to have been drawn in 71.18% of the clients that returned a survey, up from only 39.84% the previous year. This is above the 65% benchmark goal and therefore the overall objective is considered to have been met.

Table 40: Monitoring of weight

	2014			2015		
	Completed Surveys	Weight Recorded	Weight Recorded %	Completed Surveys	Weight Recorded	Weight Recorded %
ADMHN	54	49	**90.74%**	55	48	**87.27%**
AuMHC	37	30	**81.08%**	76	64	**84.21%**
CRC	36	32	**88.89%**	98	97	**98.98%**
TOTAL	127	111	**87.40%**	229	209	**91.27%**

Table 41: Monitoring of fasting blood glucose and full lipid panel

	2014			2015		
	Completed Surveys	**Labs Drawn**	**Labs Drawn %**	**Completed Surveys**	**Labs Drawn**	**Labs Drawn %**
ADMHN	55	28	**50.91%**	55	34	**61.82%**
AuMHC	37	5	**13.51%**	76	47	**61.84%**
CRC	36	18	**50.00%**	98	82	**83.67%**
TOTAL	128	51	**39.84%**	229	163	**71.18%**

Barrier analysis and planned interventions

It was acknowledged for FY15 that some pharmacies where the survey was distributed did not have a doctor on site that would be able to monitor fasting blood glucose and a full lipid panel, therefore the survey was altered to also include times that the client had been referred to a doctor to have the labs drawn. This may have accounted for some of the increase in performance from FY14 to FY15 but is likely to only be a small amount.

The survey is carried out annually and therefore only shows a snapshot in time of people who went to the pharmacy and filled out a survey in June of that year. For FY16 the QI department therefore plans on increasing the number of times the survey is run to be able to track performance and if needed implement interventions prior to the end of year survey in June 2016. Since the survey only captures member self-report, claims data will also be pulled from the RCCO system to cross-check labs.

Goal(s) for FY16

Project Title	Goal(s)	Action(s)	Target Date
Compliance with Clinical Practice Guidelines	Maintain provider compliance with Indicator 1 and increase provider compliance with Indicator 2 to 80%	Monitor compliance with Atypical Antipsychotic guideline via member survey and laboratories to every 6 months to improve measurement and track progress.	6/30/16

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 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

Results and analysis
In order to monitor BHI's contracted providers and how evidence-based practices are being performed, a new process was developed in FY15. This process included the tracking of 12 evidenced based practices and a report on fidelity and/or outcomes in each case. Six practices for both adults and children's services were agreed on, with co-occurring substance use disorders evident in four of them. Table 42 indicates the reporting for FY15.

Table 42: Evidence-Based Practices

ADULT SERVICES														
Evidenced Based Practices		Type of Reporting				Reporting								
#	Program / Curriculum	SUD / Co-occurring?	Fidelity Measure	Outcome Measure	Toolkit	Fidelity Score	Max Fidelity Score	Fidelity % Score	Outcome Measure 1	Outcome Measure 2	Outcome Measure 3	Outcome Measure 4	Outcome Measure 5	Outcome Measure 6
1	Assertive Community Treatment		✓	✓	CO-ACT Fidelity Scale	98	115	85%	11%	71%	-	-	-	-
2	Integrated Dual Diagnosis Treatment	✓	✓	-	SAMHSA toolkit	43	70	61%	-	-	-	-	-	-
3	Wellness Recovery Action Plan (WRAP)		✓	✓	WRAP Adherance Scale & Trait Hope	17.4	30	58%	↑ 11%	↑ 16%	-	-	-	-
4	Seeking Safety	✓	✓	✓	Seeking Safety Adherence Scale	50.28	57	88%	↑ 9%	-	-	-	-	-
5	Individualized Placement and Support (IPS)		✓	-	IPS Supported Employment Fidelity	85	105	81%	-	-	-	-	-	-
6	Supported Housing		✓	✓	SAMHSA toolkit	22.375	28	80%	100%	-	-	-	-	-
CHILD & ADOLESCENT SERVICES														
Evidenced Based Practices		Type of Reporting				Reporting								
#	Program / Curriculum	SUD / Co-occurring?	Fidelity Measure	Outcome Measure	Fidelity / Outcome Measure	Fidelity Score	Max Fidelity Score	Fidelity % Score	Outcome Measure 1	Outcome Measure 2	Outcome Measure 3	Outcome Measure 4	Outcome Measure 5	Outcome Measure 6
7	Parent-Child Interaction Therapy		✓	-	PCIT Training Competencies	30.5	52	59%	-	-	-	-	-	-
8	Adolescent Community Reinforcement Approach (A-CRA)	✓	-	✓	GAIN-SS	-	-	-	69%	↓ 8%	↓ 9%	-	-	-
9	Multi-Systemic Therapy (MST)		✓	✓	TAM-R & SAM-R	0.69	1.00	69%	90%	-	-	-	-	-
10	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	✓	✓	✓	RASAI	17	30	57%	80%	30%	-	-	-	-
11	Nurturing Parenting Program		-	✓	AAPI-2	-	-	-	↑ 23%	↑ 49%	↑ 18%	↑ 25%	↑ 23%	-
12	Healthy Environments & Response to Trauma in Schools (HEARTS)		-	✓	Training of Trainers Survey (TOT)	-	-	-	↑ 45%	↑ 29%	↑ 56%	↑ 28%	↑ 28%	↑ 70%

BHI's PEO Committee worked to finalize the EBP reporting process for FY15 and considers objectives related to this project to be met.

Goal(s) for FY16

Project Title	Goal(s)	Action(s)	Target Date
Evidence-based and Promising Practices	Continue monitoring EBP within contracted providers and develop a system to improve fidelity and outcomes	Develop ongoing and meaningful EBP reporting to track progress over time	6/30/16
		Collaborate with contracted providers to set goals and mechanisms to achieve those goals related to fidelity & outcome measures	

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 (BHI Member Experience Survey)
- Member Satisfaction (ECHO Survey)
- Grievances and Appeals
- Quality of Care Concerns
- Critical Incident Reporting

Member Satisfaction (BHI Member Satisfaction Survey)

Summary of project – Quality of Services
Member evaluation of health plan services offered through 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.

For 2015, BHI conducted a Member Experience Survey of 25 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. In April, the surveys were given to CMHC sites and Drop-in Centers, and mailed to a random sample of CPN members. Surveys had to be sent back to BHI to start the analysis by May 30, 2015 giving approximately six weeks to complete the survey.

The total population size used for determining the needed number of completed surveys was 21,685 members. This was the total number of members who received services from the start of FY14 (July 1, 2014) through January 24, 2015 when the sample was obtained. Using the sample size calculator, it was determined that 393 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.

For 2015, BHI provided each CMHC with an electronic version of the Member Survey, allowing them to produce as many copies as necessary for maximum distribution. This was also done as to enable them to add additional specific location codes to aid them in tracking responses by location. These codes were logged for each CMHC and analysis offered for their own internal use.

Table 43: Sample Methodology

Sample Methodology				
Group	**Population Size**	**Percent of Total**	**Desired Sample Size**	**Returned Surveys**
ADMHN	3,332	15.37%	60	258
AuMHC	6,237	28.76%	113	577
CRC	4,624	21.32%	84	434
CPN	7,165	33.04%	130	10
Drop-In Centers	3,27	1.51%	6	10
Total	21,685	100%	393	1289

BHI matched the Member Satisfaction Survey 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 questions regarding how well they rated different aspects of their treatment across categories, and Yes or No to three access-related questions, specifying whether they received services in a timely manner. The measurement of "satisfaction" was determined by dividing the number of members who responded with Good, Very Good, Excellent, or Yes 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:

- The services you received
- The help you received when you called the BHI office
- The grievance process (not the outcome)
- The BHI/Medicaid appeal process (not the outcome)
- If I requested a change of provider, how was it handled
- How were you treated by BHI staff when you called or stopped by
- The courtesy shown to you by staff
- The appropriateness of therapies and interventions offered
- The ability of services to meet your needs
- The availability of staff to talk with you

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

- The process of getting the services you needed approved
- The time it took to approve the services you received
- Signs and directions to treatment areas

- The ability to reach desired department or person by phone
- The hours appointments are available
- The time spent in the waiting area for your scheduled appointment
- If you had a mental health emergency and you contacted your provider, were you contacted by someone with 1 hour and/or told to go the ER or call 911 for help?
- If you had an urgent need to speak with someone about your mental health, and 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")?

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

- Convenience of travel between provider locations
- Length of time between making appointment and seeing the psychiatrist
- Length of time between making appointment and seeing the therapist/counselor

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:

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

Goal from 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

Results and Analysis

Table 44 shows the demographics of the members who completed the BHI Member Experience Survey. BHI continues to have the highest number of members who are between the ages of 18-64, as well as a predominantly white and female population.

Table 44: Member Experience Survey Demographics

Member Age		Member Race	
0-12	18.54%	White	66.17%
13-17	15.82%	Black	10.44%
18-64	63.18%	Asian	1.77%
65+	2.46%	Pacific Islander	<1%
Member Gender		American Indian	2.88%
Male	40.77%	Other	17.98%
Female	59.23%		
Hispanic/Latino Origin			
Yes	32.59%		

Table 45: BHI Member Experience Survey results

	Percentage Satisfied*		
	FY15	**FY14**	**FY13**
Services	92%	93%	91%
Accessibility	88%	90%	82%
Availability	89%	91%	91%
Acceptability	93%	92%	91%
Overall	91%	92%	86%

*Percent of Good, Very Good, Excellent, and "Yes" responses for the survey questions in each category

Overall, member's satisfaction scores remain higher than the baseline year (FY13) with the exception of the availability category. It is important to note that the decrease in satisfaction from FY13 to FY15 was minimal. Table 45 shows the results of the BHI Member Experience Survey based on NCQA categories. Of the four member satisfaction categories, three (Services, Accessibility, Availability) declined slightly from last year's results. BHI saw an improvement in the Acceptability category, while the other categories decreased slightly as well as the overall score. BHI established a goal of 90% in each category as well as 90% or greater overall for member experience.

BHI failed to meet the goal in two of the three categories this year. Scores were at 88% and 89% for the accessibility and availability categories, respectively. BHI believes that these scores are still well within normal range for member satisfaction. BHI expected the accessibility experience to fall this year because of the notable access to care issues, not only related to routine appointments but also emergency face to face wait time. Comments from the member satisfaction survey were analyzed due to the fall below 90%. Comments indicated members found it difficult to reach their therapist or psychiatrist via phone. BHI will address this issue in FY16 through interventions noted in this section.

The availability category decreased from FY14 to FY15 and was likely due to wait times in between appointments with psychiatrists and therapists. Due to the decline in wait times for medication evaluations, this is expected. While access to medication evaluations only assesses the percent of members who were offered a medication evaluation appointment within 30 days of their request for one, continued access to medication appointments has been a concern for BHI, CMHCs and other providers. In FY15, BHI added University Physician, Inc. as a provider to the network to provide psychiatry services. BHI is also actively recruiting independent prescribers outside of the CMHCS to provide services to members.

Barrier analysis and planned interventions

One barrier identified was that BHI members interact almost exclusively with staff from the CMHCs, where members are receiving services, and very rarely do members directly interact with BHI. This year, BHI created a separate section of the Member Experience Survey with instructions to answer questions related to the member experience with his/her current provider. Survey results analyzed questions from both parts of the surveys, which included member experience with BHI and with providers. The majority of members receive services through the CMHCs. It is still very likely that members answered all the questions from the perspective of their interactions with the CMHCs.

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. The criteria for the population of members seen by the CPN included currently being enrolled in BHI and receiving at least one service within the last year. If members saw more than one provider for more than one service, the primary provider was identified as where the members received the most services. Members selected from the CPN population and included in the sample could have only received one service and received a survey. It is unlikely that if a member only received one service during a year that he/she would send back a survey.

A final barrier to the CPN response rate is that BHI did not offer an incentive to participate in the survey this year. Last year, BHI had members who returned the survey also return an informational card so they could be contacted if they won the incentive. The incentive was a $20 gift card to Target.

Based on the results and the barrier analysis BHI will implement the following interventions for the FY16 member experience surveys.

1) When selecting a random sample of CPN members to mail the survey to, BHI will identify members who have received at least five services within the past five months to be selected for the sample. This will ensure members who are completing the survey can provide an appropriate assessment of BHI and the provider.
2) BHI will again offer the $20 gift card incentive for completing and returning the survey.
3) BHI will provide members with a short instructional page about the survey, explaining the purpose, intended outcomes, and gift-card incentive information.
4) BHI will continue to monitor access to care measures, including access to medication evaluations, quarterly to determine if interventions are needed on an on-going basis.
5) BHI will continue to monitor grievances/complaints quarterly to determine if services offered, accessibility, availability, and/or acceptability become an issue with a particular provider.
6) BHI will continue to monitor network adequacy on a quarterly basis to determine if an increase in providers is necessary.
7) In PEO, BHI will discuss how a member can reach his/her therapist/psychiatrist or other provider by phone and if any data is collected on the response time.

Goal(s) for FY16

Project Title	Goal(s)	Action(s)	Target Date
Member Satisfaction Surveys	Meet or exceed results from the FY15 BHI Member Survey	Develop new sample size methodology for members seen by CPN	6/30/16
		Offer incentive for completing survey	
		Develop instructional sheet for survey with information about BHI	
		Continue to monitor access to care measures	
		Continue to monitor grievances by category	
		Continue to monitor network adequacy	
		Discuss how members can contact provider outside of appointment times	

Member Satisfaction (ECHO)

Summary of project – Quality of Services
Beginning in 2014, the Department of Health Care Policy and Financing (HCPF) contracted with Health Services Advisory Group to initiate a member satisfaction survey to replace the previously used Mental Health Statistics Improvement Program (MHSIP), Youth Services Survey (YSS), and Youth Services Survey for Families (YSS-F). BHI supported the implementation of the survey and shared the results with key stakeholders through the Program Evaluation and Outcomes Committee.

Satisfaction surveys were given to clients identified as having received at least one behavioral health care service through one of the participating behavioral health organizations (BHOs) and/or BHO-contracted community mental health centers (CMHCs) and specialty clinics. The goal of the ECHO Survey is to provide performance feedback that is actionable and will aid in improving overall client satisfaction.

The survey instrument selected for adult clients was a modified version of the Adult ECHO Survey, Managed Behavioral Healthcare Organization (MBHO) Version 3.0, which incorporates items from the MHSIP survey. The survey instrument selected for child clients was a modified version of the Child/Parent ECHO Survey, MBHO Version 3.0, which incorporates items from the YSS-F and the YSS. Adult clients and parents/caretakers of the child client (or the child client) completed the surveys from July to October 2014.

Adult clients eligible for ECHO Survey sampling included clients who were identified as having received at least one behavioral health service or treatment from one of the five participating BHOs, as reflected in the encounter data, or corresponding BHO-contracted CMHCs and specialty clinics during the measurement year (i.e., January 1, 2013 to December 31, 2013). For the Medicaid population, clients eligible for sampling included those who were enrolled in Medicaid at the time the sample was created and who were continuously enrolled for at least 11 out of the last 12 months in 2013 (January through December 2013), with no more than one gap in enrollment of up to 45 days. Additionally, adult clients eligible for sampling included those who were 18 years of age or older as of December 31, 2013. The child clients eligible for the ECHO survey sampling were identified in the same way as the adults. Additionally, child clients eligible for sampling included those who were 17 years of age or younger as of December 31, 2013.

BHI matched some of the ECHO questions to the NCQA categories of *Services, Accessibility, and Acceptability*. There were no questions on the ECHO that correlated with the *Availability* category for NCQA.

The *Services* category refers to the scope of services offered by the organization. It includes the following questions from the ECHO survey:

- In the last 12 months, how often did anyone talk to you about whether to include your family or friends in your counseling or treatment?
- In the last 12 months, were you told about self-help or support groups, such as consumer-run groups or 12-step programs?
- In the last 12 months, how often were you given information about different kinds of counseling or treatment that are available?
- In the last 12 months, were you given information about your rights as a patient?
- In the last 12 months, did you feel you could refuse a specific type of medicine or treatment?
- In the past 12 months, how much were you helped by the counseling or treatment you got?
- In the last 12 months, how often did you /your family get the professional help you wanted for yourself/your child?
- In the last 12 months, how often did you feel you/your child had someone to talk to for counseling or treatment when you were/your child was troubled?
- In the last 12 months, were you given as much information as you wanted about what you could do to manage your/your child's condition?

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

- In the last 12 months, how often did the people you went to for counseling or treatment spend enough time with you/your child?
- In the last 12 months, how often did you get the professional counseling you/your child needed on the phone?
- In the last 12 months, when you/your child needed counseling or treatment right away, how often did you see someone as soon as you wanted?
- In the last 12 months, not counting times you/your child needed counseling or treatment right away, how often did you get an appointment for counseling or treatment as soon as you wanted?
- In the last 12 months, how often were you seen within 15 minutes of your/your child's appointment?

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 the ECHO survey:

- In the last 12 months, how often did the people you went to for counseling or treatment listen carefully to you?
- In the last 12 months, how often did the people you went to for counseling or treatment explain things in a way you/your child could understand?
- In the last 12 months, how often did the people you went to for counseling or treatment show respect for what you/your child had to say?
- In the last 12 months, how often did you feel safe when you were with the people you went to for counseling or treatment?

- In the last 12 months, how often were you involved as much as you wanted in your/your child's counseling or treatment?
- In the last 12 months, was the care you/your child received responsive to your needs (related to language, race, religion, ethnic background, culture)?

Goal from 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

Results and analysis

Table 46: Survey Response Rates

Sample Distribution and Response Rates for Adults				
	Total Sample	**Eligible Sample**	**Total Respondents**	**Response Rate**
Overall Colorado BHO Program	7,690	6,343	1,608	25.35%
Behavioral Healthcare, Inc.	1,538	1,278	339	26.53%
Sample Distribution and Response Rates for Children				
	Total Sample	**Eligible Sample**	**Total Respondents**	**Response Rate**
Overall Colorado BHO Program	7,690	5,965	1,120	18.78%
Behavioral Healthcare, Inc.	1,538	1,232	267	21.67%

Table 47: Age Demographics

Adult Age Demographics					
	18 -24	**25 - 34**	**35 - 44**	**45 - 64**	**65+**
Overall Colorado BHO Program	6.1%	15.7%	18.9%	51.9%	7.4%
Behavioral Healthcare, Inc.	8.0%	17.8%	22.5%	45.8%	5.8%
Child Age Demographics					
	1 - 3	**4 - 7**	**8 - 12**	**13 - 18**	
Overall Colorado BHO Program	0.9%	14.7%	38.0%	46.3%	
Behavioral Healthcare, Inc.	0.4%	15.1%	42.9%	41.7%	

Table 48: Race/Ethnicity Demographics

Adult Race/Ethnicity Demographics						
	Multi-Racial	**White**	**Black**	**Asian**	**Native American**	**Other**
Overall Colorado BHO Program	7.8%	72.6%	6.6%	1.3%	1.9%	9.8%
Behavioral Healthcare, Inc.	9.1%	70.7%	7.9%	3.8%	0.9%	7.6%
Child Race/Ethnicity Demographics						
	Multi-Racial	**White**	**Black**	**Asian**	**Native American**	**Other**
Overall Colorado BHO Program	12.9%	67.2%	6.3%	0.7%	1.2%	11.8%
Behavioral Healthcare, Inc.	10.3%	66.1%	7.3%	1.3%	0.4%	14.6%

Table 49: Gender Demographics

Adult Gender Demographics		
	Male	**Female**
Overall Colorado BHO Program	32.6%	67.4%
Behavioral Healthcare, Inc.	33.8%	66.2%
Child Gender Demographics		
	Male	**Female**
Overall Colorado BHO Program	58.2%	41.8%
Behavioral Healthcare, Inc.	59.8%	40.2%

Demographic information for BHI members appeared to be comparable to the overall Colorado BHO program demographic results. ECHO survey results were analyzed by NCQA category; however, the ECHO survey did not contain any questions related to availability. BHI chose not to combine the results of the BHI Member Experience survey with the results of the ECHO survey, as the timing of the surveys was different. Results for the ECHO survey by NCQA category are presented in Table 50. The percent satisfied was calculated by dividing the number of survey questions for each category with a "yes," "usually" or "always" answer by the total number of responses (not applicable and blank/missing responses were omitted from the percent satisfied calculation).

Table 50: Results of ECHO Survey (Adult and Child)

	Percentage Satisfied*
	FY14
Services	74%
Accessibility	71%
Acceptability	86%
Overall	77%

*Percent of "Usually," "Always," and "Yes" responses for the survey questions in each category

Since this is the first year of the ECHO survey, BHI does not have previous year results to compare. The ECHO survey results by category were lower than the BHI member experience survey. Of the three categories, accessibility was the lowest on the ECHO survey as well as on the BHI survey. This is likely due to the access to care issues experienced throughout the year. As mentioned in the access to care section of this report, providers struggled with meeting standards related to routine access to care at the end of FY14 and the beginning of FY15. Providers also struggled with providing emergency care within one hour of the request during FY15. BHI is continuing to monitor access to care issues through data sent in by providers, the grievance process, and assessment of member experience.

Barrier analysis and planned interventions

One barrier identified during the implementation of the ECHO was the timing of the survey. The survey was sent out to members who received at least one behavioral health service between January 1, 2013 and December 31, 2013 which was halfway through FY13 and into FY14. The survey period was from July-October of 2014, which depending on when the member was receiving services could have been up to a year and a half after the member received services.

BHI believes that the internal member experience survey conducted each year represents a more accurate picture of member experience with services, accessibility, availability, and acceptability. The BHI member experience survey allows members who are actively in treatment within the CMHCs to discuss their experience. BHI also includes a sample of members who are currently being seen within the Contracted Provider Network and at the BHI drop-in centers; therefore, a more comprehensive picture of member experience is collected and analyzed.

Another barrier to assessing member satisfaction via the ECHO survey is survey burnout. BHI completes the internal member experience survey every spring and the ECHO is completed in the late summer/early fall. Because of this, members are more likely to experience survey burnout when completing the ECHO, as it is potentially the second survey the member has had to fill out within a year period.

Finally, BHI identified that the length of the ECHO survey could also contribute to the low responses and low response rates. BHI's member experience survey is about 30 questions while the ECHO has 59 questions. In addition, the sample size for the ECHO survey was only 267 for children and 339 for adults. With the very small sample size, it is difficult to draw conclusions and implement appropriate interventions.

BHI does not have any planned interventions for the ECHO survey results, as BHI does not control the timing, sample size, or data collection for the ECHO nor are there results to compare. BHI will continue to support the Department in efforts to continue the survey process in the next fiscal year and provide feedback about the survey process to HCPF and HSAG. BHI will continue to analyze the ECHO survey results according to the NCQA categories and develop interventions as needed.

Goal(s) for FY16

Project Title	Goal(s)	Action(s)	Target Date
Member Satisfaction Surveys	Compare ECHO survey results from FY14 to FY15 when FY15 results are available.	Continue to analyze ECHO survey results according to NCQA categories and implement interventions if needed.	6/30/16

Grievances and Appeals

Summary of project – Quality of Services
It is the policy of BHI to support the rights of members, 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 of problematic trends within the system, an overall improvement in the quality of services, and the prevention of retaliation.

Goal from 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

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 18 shows the trend in number of grievances for the past four quarters.

Figure 18: Grievance data by quarter

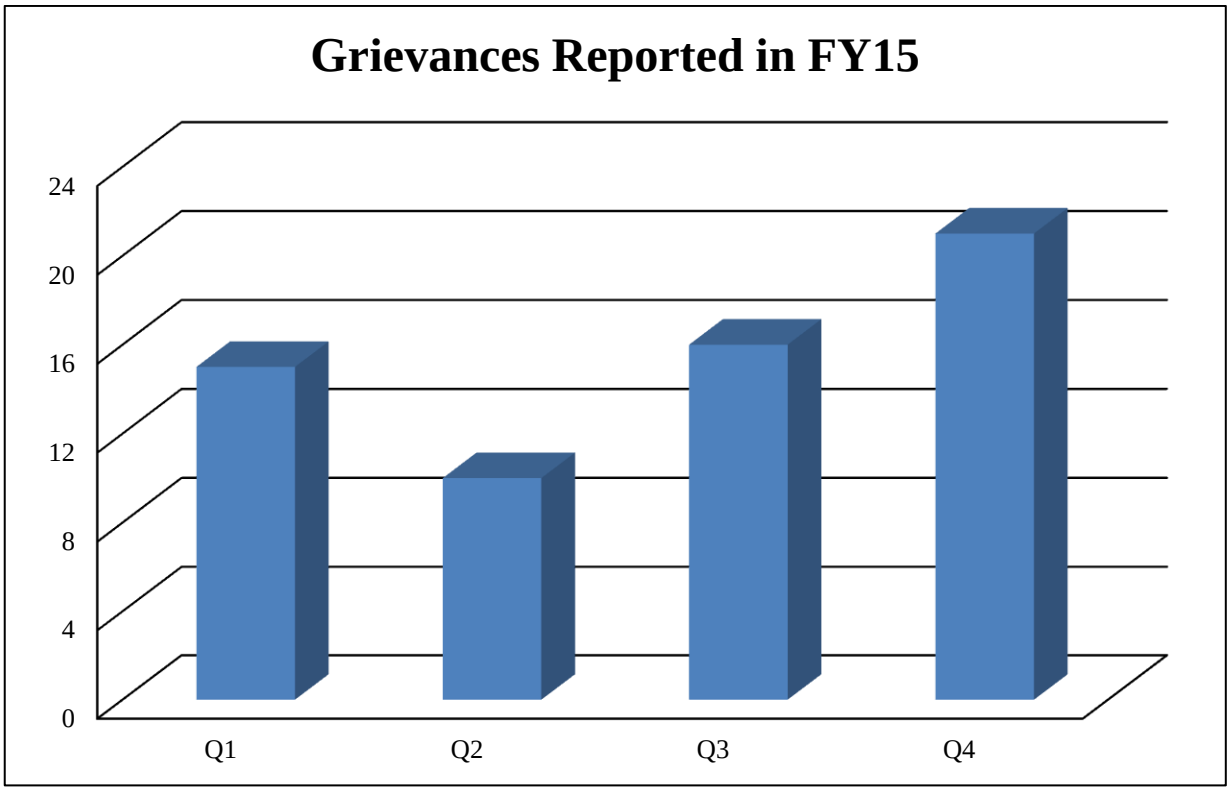


Table 51 shows the number of complaints and appeals by NCQA category for the past year, by quarter. Note: BHI defines a "grievance" as a member complaint.

Table 51: Grievances by Category, by quarter for FY15

2014 - 2015 Grievances by Category								
Category	**FY15 Q1**	**FY15 Q2**	**FY15 Q3**	**FY15 Q4**	**FY15 Total by Category**	**FY15 Percentage of Total**	**FY14 Total by Category**	**FY14 Percentage of Total**
Quality of Care	8	4	7	7	26	44.07%	23	48.94%
Access	3	3	3	5	14	23.73%	1	2.13%
Attitude and Service	2	1	4	6	13	22.03%	15	31.91%
Billing and Financial Issues	1	0	1	0	2	3.39%	6	12.77%
Quality of Practitioner Office Site	0	0	0	0	0	0.00%	1	2.13%
Rights/Legal	1	1	0	2	4	6.78%	1	2.13%
Total Number of Grievances	15	9	14	20	59	100.00%	47	100.00%

BHI understands that the majority of the grievances are going to be in the quality of care, access, and customer service categories. The quality of care category also has the biggest number of subcategories. The number of grievances filed increased by 26% from FY14 to FY15. One possible explanation for this is the revision to the grievance process. BHI is now handling the majority of grievances related to its members, instead of allowing providers to handle the grievances internally. Another possible explanation for the increase in the number of grievances is related to how grievances are being filed by BHI. If a member files a grievance about two different categories, then BHI counts each category of grievance as a separate grievance, instead of choosing the first category.

BHI also saw a significant increase in the number of grievances related to access. This is likely due to the aforementioned access to care issues experienced throughout the BHI network within the last year. Of the 14 access related grievances filed in FY15, four were related to appointment delays, four were related to call back issues, one was related to telephone accessibility, one was related to wait time for scheduled appointment, and four were categorized as "other." The BHI QI Department reviewed each of these grievances to determine if any trends occurred. Several of the grievances in the access category were related one of BHI's CMHCs. Since the CMHC implemented an "open access" system for medication evaluations and appointments, the number of grievances increased. Due to the new system, it was expected that this increase in grievances would occur and BHI is working with the CMHC to ensure members are receiving care in an appropriate amount of time. Three of the grievances related to access also required the provider and/or BHI to implement formal corrective action plans to ensure the issue did not continue to occur.

BHI also saw an increase in the number of grievances related to Rights/Legal issues from FY14 to FY15. Two of the five grievances in this category were related to HIPPA, one was related to member rights, and one grievance was filed as "other." Due to the increase in the number of grievances in this category, BHI QI staff reviewed the grievances, but found no significant trends.

The number and overall percentages of grievances related to quality of care, attitude and service, and billing and financial issues each decreased from FY14 to FY15. Since the number of grievances related to quality of care remained high, BHI QI Department also reviewed these grievances and found that a majority of the grievances (14) in this category were related to one CMHC. Two grievances were filed under the subcategory of coordination of care, three were filed under medication issues, five were under service delivery issue, and four were related to professional conduct/competence. Nine of the 14 grievances were substantiated and three required a formal corrective action plan. There were no trends identified in the grievances; however, QIC met to discuss the increase in grievances from the one CMHC. It was determined that a quarterly meeting with the CMHC to review grievances and other data would be set up through the COO of BHI and the COO of each of the CMHCs within BHI's catchment area. The meeting will focus on data collection and review of data with each CMHC individually to determine if corrective action is needed.

Upon review of a request for 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 52 shows the types of action appealed in FY15 and the results of the local appeal and/or State Fair Hearing.

Table 52: Appeals

Type of Action Appealed	FY15 Q1	FY15 Q2	FY15 Q3	FY15 Q4
Denial or limited authorization of a requested service, including the type or level of service	5	4	2	0
Reduction, suspension or termination of a previously authorized service	0	0	0	0
Failure to provide services in a timely manner	0	0	0	0
Failure to act within timeframes provided in rule 8.209	0	0	0	0
Appeal Outcome				
Local Level – Appeal Upheld (Action Overturned)	2	0	0	0
Local Level – Appeal Denied (Action Upheld)	3	4	2	0
State Fair Hearing – Appeal Upheld (Action Overturned)	0	0	0	0
State Fair Hearing – Appeal Denied (Action Upheld)	0	0	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 51, 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. Across FY15 there were seven grievances that resulted in a corrective action plan. These included a member not being involved in treatment planning, inadequate discharge planning, delays in providing medication reviews/outpatient services, and a member being discharged from the emergency department rather than being transferred to an inpatient facility.

All corrective action plans were developed and implemented to a satisfactory standard, with lessons learned from each of the grievances in place to prevent similar incidents from repeating. BHI will continue to monitor reported grievances into FY16 and look for any trends that may identify the necessity for corrective action.

Goal(s) for FY16

Project Title	Goal(s)	Action(s)	Target Date
Grievances and Appeals	Continue 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 and quarterly meetings with the CMHCs	6/30/16

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: 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(s) from FY15

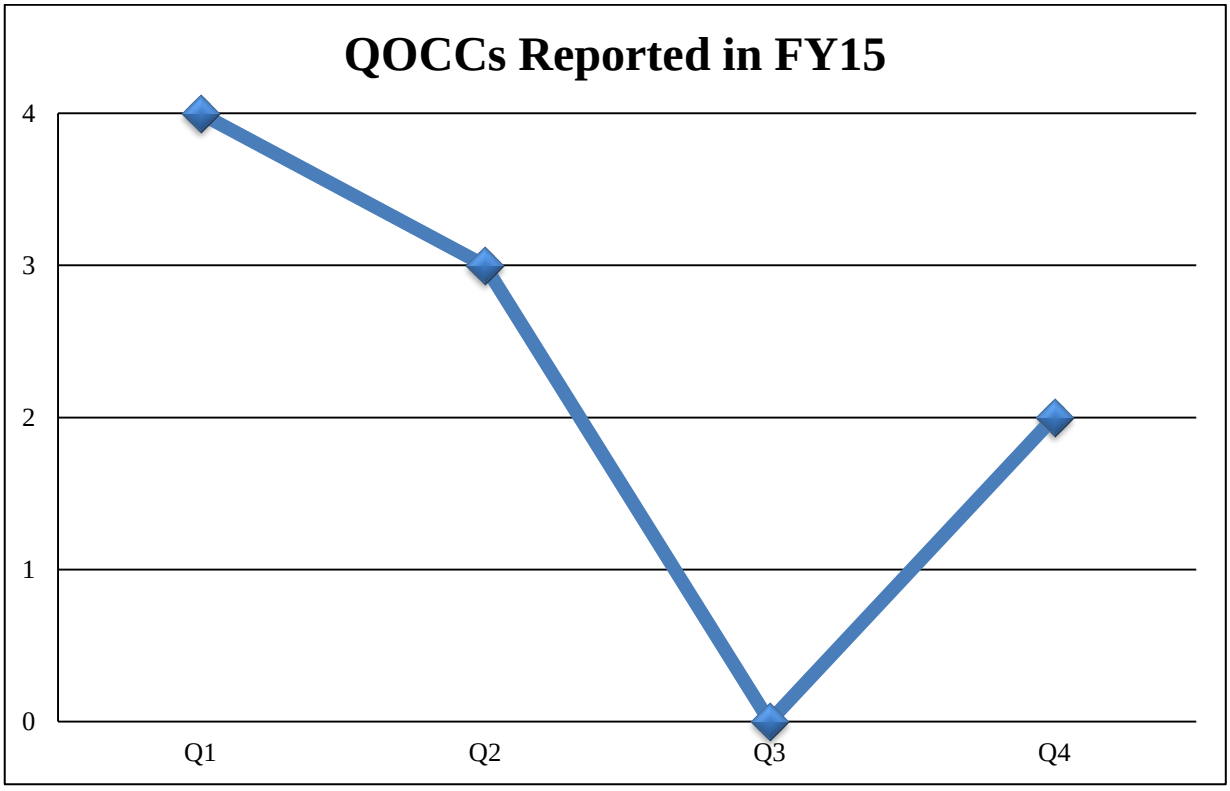
Project Title	Goal(s)	Action(s)	Target Date
Quality of Care Concerns	Address any potential member safety issue	Continue to trend QOCCs by provider and by category and address any patterns	6/30/15
		Continue to work with individual providers on corrective actions if a QOCC is substantiated	

Results and analysis
In FY15, BHI has investigated nine QOCCs, six 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 53 below indicates the categories of the QOCCs reported in FY15, whereas Figure 19 indicates the number of QOCCs reported in each quarter of FY15. 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 53: Categories of FY14 QOCCs

QOCC Category	Unsubstantiated	Substantiated
Professional conduct or competence	1	2
Medication issues	0	1
Coordination / continuity of care	1	1
Discharge planning	0	1
Suicide attempt requiring medical attention	1	1

Figure 19: QOCCs reported by quarter in FY15



Barrier analysis and interventions

BHI now discusses all QOCCs at QIC to be able to review the concerns and make suggestions for further actions. This also provides an opportunity to bring together any other feedback in relation to specific providers that are subject to QOCCs and discuss any recurring themes or incidents. In FY15 one provider in particular had three QOCCs, two of which were substantiated and therefore it was decided by the Committee that a further investigation into overall care would be carried out.

Goal(s) for FY16

Project Title	Goal(s)	Action(s)	Target Date
Quality of Care Concerns	Address any potential member safety issue	Continue to trend QOCCs by provider & category and address any patterns	6/30/16
		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 back in 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 report in FY15 included the following:

- Assaultive Behavior
- Breach of Confidentiality
- Diverted Drugs
- Medical Condition
- Member AWOL
- Restraint/Seclusion
- Serious Physical Injury
- Suicide
- Suspected Neglect
- Attempted Suicide
- Death
- Injury
- Medication Error
- Missing Person
- Seclusion
- Sexual Contact
- Suicide
- Suspected Physical/Sexual Abuse

Goals from 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	

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 and reports results to the Quality Improvement Committee monthly.

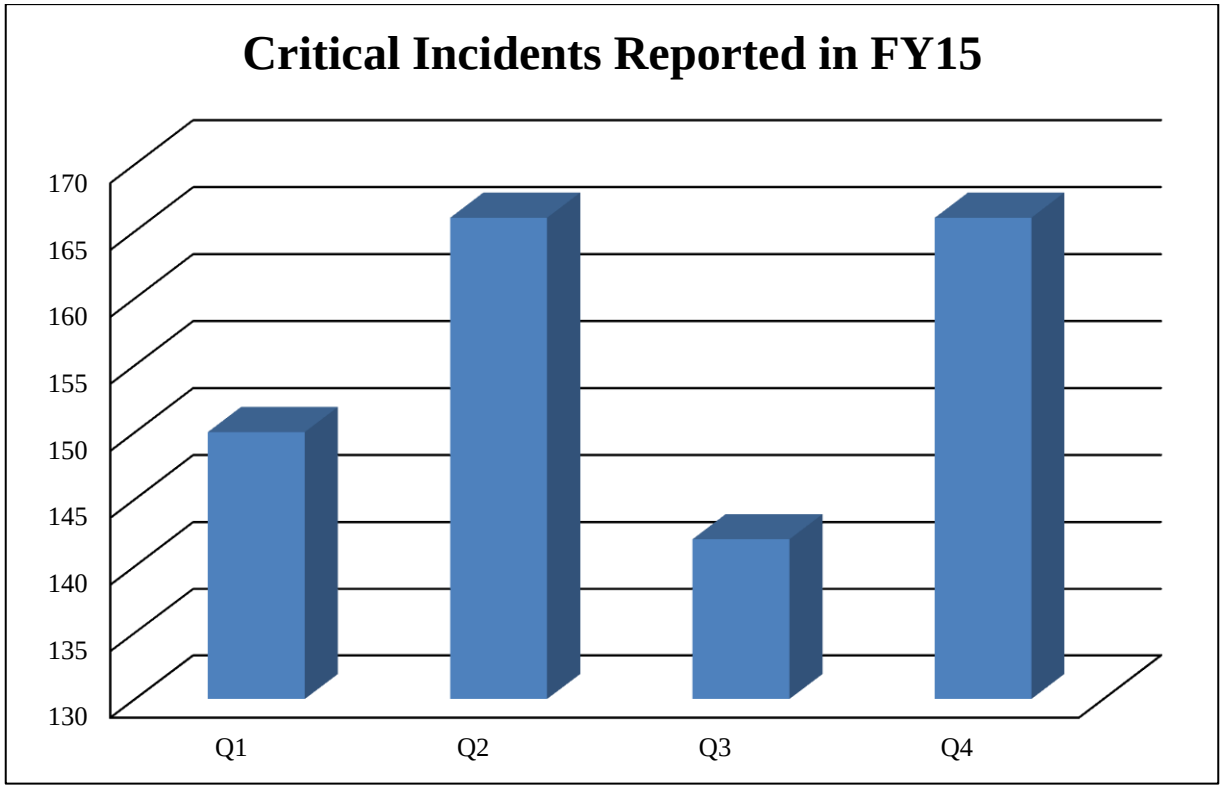
FY15 was the first full year that critical incidents were being reported to BHI and therefore the process is still being updated and improved. Table 54 below highlights the total number of incidents reported throughout the year, as well as the most commonly reported types of incident. Restraint & seclusion is the highest category of incidents reported, which is expected, as providers are required to report every instance of restraint and seclusion of a BHI member.

Table 54: Critical Incident Reporting FY15

Critical Incident Information FY15	
Number of Critical Incidents	624
Number of Unique Members	218
Number of Members 2 or more CIs	63
Most CIs on one member	44
Highest Frequency: Critical Incident Categories	
Restraint/Seclusion	359 (58%*)
Assaultive Behavior	50 (8%*)
Death	47 (8%*)
Medical Condition	37 (6%*)
Medication Error	37 (6%*)

** Percentage of the total critical incidents submitted*

Figure 20: Critical Incidents reported by quarter in FY15



Barrier analysis and planned interventions

BHI recognizes that the Critical Incident reporting process is still relatively new and therefore FY15 was used as a time to review the processes and update as 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 attempted to align its Critical Incident form with other entity forms; due to the fact that providers' own forms are very different BHI is looking to align with the Office of Behavioral Health form for FY16.

BHI has noticed that not all providers are reporting critical incidents. The UM Dept. comes into contact with providers more frequently than the QI Department so the two departments continue to work internally on a strategy to educate providers about Critical Incident reporting requirements.

Goal(s) for FY16

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	6/30/16
	Increase compliance with critical incident reporting	Continue to outreach providers and provide education about the critical incident reporting process. Facilitate reporting process to diminish the quantity of forms providers need to complete.	

Section 10: BHI Quality Improvement Work Plan for FY16

Project Title	Goal(s)	Action(s)	Target Date
Member Population			
Penetration Rates	Increase overall penetration rate by 2% from 12.28%.	Calculate penetration rates for each CMHC in the BHI catchment area on an annual basis	6/30/16
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.	6/30/16
Network Adequacy – Cultural Needs and Preferences	Meet the cultural, ethnic, and linguistic needs of members by assuring diverse provider network	Aggregate data provided by facilities & incorporate into analysis	1/1/16
		Continue to monitor grievances via QIC committee related to cultural needs / preferences	
Access to Services			
Access to routine, urgent, and emergency services	Increase the number of providers assessed for meeting access to care standards by 25%	Redesign secret shopper program to asses at and align with new provider monitoring process	1/1/16
		Continue with BHI efforts to educate providers on access to care standards and referrals to BHI	6/30/16
	Improve current access to Emergency Face to Face care to 95%	Continue to collaborate with community partners to determine barriers to accurate reporting	1/1/16
	Increase member experience with access to care by 5%	Continue to educate members about access to care standards, member experience survey process, and definitions of emergent, urgent, and routine appointments	6/30/16
		Redesign member experience survey questions	
		Continue to educate providers about access to care standards and when to refer members back to BHI	
		Continue to monitor grievances related to access to care via the Quality Improvement Committee	
Access to medication evaluations	Improve compliance with 30-day standard to 90%	Continue to monitor access to medication evaluations on a quarterly basis and discuss results and potential interventions in the Program Evaluation and Outcomes Committee as needed.	6/30/16
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	6/30/16
Delegation Oversight	Oversee the quality of activities delegated to any subcontractor	Continue to monitor the activities delegated to Colorado Access as BHI's	6/30/16

Project Title	Goal(s)	Action(s)	Target Date
		Administrative Service Organization through Delegation Oversight	
Encounter Data Validation (411) Audit	Increase provider overall compliance score to 90% or higher	Continuing to train providers on proper billing and documentation practices no less than quarterly	6/30/16
	Maintain or improve inter-rater reliability with HSAG	Continuing to train audit team on the USCS Manual	
Provider claim/record audits	Increase volume of provider audits completed to at least 30 per year	Initiate a minimum of 10 provider audits per service category according to the FY16 audit plan.	6/30/16
	Hire two additional staff	Hire additional compliance monitoring specialist and provider quality monitoring specialist.	
Documentation training	Provide training to meet provider needs	Develop additional service specific trainings to meet provider needs.	6/30/16
	Train at least 100 individual outpatient providers	Continue to provide quarterly routine outpatient documentation trainings and train at least 100 providers	
Performance Measures			
Monitoring over- and under-utilization	Continue to perform at or above the statewide BHO average for performance measures	Continue to measure some performance indicators quarterly to monitor for patterns and trends across services	6/30/16
		Continue to monitor specific utilization measures to determine if interventions are working.	
Member Health and Safety	Perform at or above the statewide BHO average for the member health and safety performance measures	Continue to monitor member safety performance measures annually	6/30/16
	Complete the medication safety project with children annually	Implement annual medication safety project	6/30/16
	Implement adult medication safety project	Complete adult medication safety project	1/1/16
Coordination of Care – Follow-up after hospital discharge	Provide 62% of outpatient appointments within 7 days after hospital discharge	BHI will continue to monitor this measure quarterly and implement targeted interventions	6/30/16
	Provide 80% of outpatient appointments within 30 days of hospital discharge		
Coordination of Care – Improving physical healthcare access	Continue to improve coordination of care by 5%, (from 87.30% to 92%).	Continue the development of the new Complex Case Management service	6/30/16
	Develop performance indicators for complex case management.	Implement key performance indicators for the Complex Case Management service, in line with NCQA requirements	
Adolescent Depression Screening and Follow-up	To improve screening and follow-up by more than 5% by the end of CY15	Implement interventions as presented in the PIP write-up tool	6/30/16

Project Title	Goal(s)	Action(s)	Target Date
Coordination of Care -E Visits	BHI will continue to support the telehealth programs at each of the CMHCs by developing policies and procedures for billing and data collection	Create policies and procedures related to telehealth programming and data collection	6/30/16
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	6/30/16
Clinical Practice Guidelines and Evidence-Based Practices			
Clinical Practice Guidelines	Continue developing and implementing practice guidelines to meet the clinical needs of members and improve consistency across providers	Develop new guidelines as identified by the Standards of Practice Committee	6/30/16
	Review/update 100% of practice guidelines every two years	Continue process of reviewing/updating all identified practice guidelines every 2 years	
	Continue with the distribution of informational material to members	Continue posting information in our website and disseminating this information to members	
Compliance with Clinical Practice Guidelines	Maintain provider compliance with Indicator 1 and increase provider compliance with Indicator 2 to 90%	Monitor compliance with RAD guideline via encounter and pharmacy claims	6/30/16
		Identify areas to improve performance with the local CMHCs	
		Investigate prescriptions of multiple psychotropic medications to determine ways to avoid polypharmacy	
Compliance with Clinical Practice Guidelines	Increase providers compliance with all indicators by 10%	Monitor compliance with Risk Assessment guideline via new provider monitoring process	6/30/16
		Support providers to update risk assessment processes	
		Educate providers about the Risk Assessment Practice Guideline	
	Maintain provider compliance with Indicator 1 and increase provider compliance with Indicator 2 to 80%	Monitor compliance with Atypical Antipsychotic guideline via member survey and laboratories to every 6 months to improve measurement and track progress.	6/30/16
Evidence-based and Promising Practices	Continue monitoring EBP within contracted providers and develop a system to improve fidelity and outcomes	Develop ongoing and meaningful EBP reporting to track progress over time	6/30/16
		Collaborate with contracted providers to set goals and mechanisms to achieve those goals related to fidelity & outcome measures	

Project Title	Goal(s)	Action(s)	Target Date
Member and Family Input into the QI Program			
Member Satisfaction Surveys	Meet or exceed results from the FY15 BHI Member Survey	Develop new sample size methodology for members seen by CPN	6/30/16
		Offer incentive for completing survey	
		Develop instructional sheet for survey with information about BHI	
		Continue to monitor access to care measures	
		Continue to monitor grievances by category	
		Continue to monitor network adequacy	
		Discuss how members can contact provider outside of appointment times	
Member Satisfaction Surveys	Compare ECHO survey results from FY14 to FY15 when FY15 results are available.	Continue to analyze ECHO survey results according to NCQA categories and implement interventions if needed.	6/30/16
Grievances and Appeals	Continue 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 and quarterly meetings with the CMHCs	6/30/16
Quality of Care Concerns	Address any potential member safety issue	Continue to trend QOCCs by provider & category and address any patterns	6/30/16
		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	6/30/16
	Increase compliance with critical incident reporting	Continue to outreach providers and provide education about the critical incident reporting process. Facilitate reporting process to diminish the quantity of forms providers need to complete.	