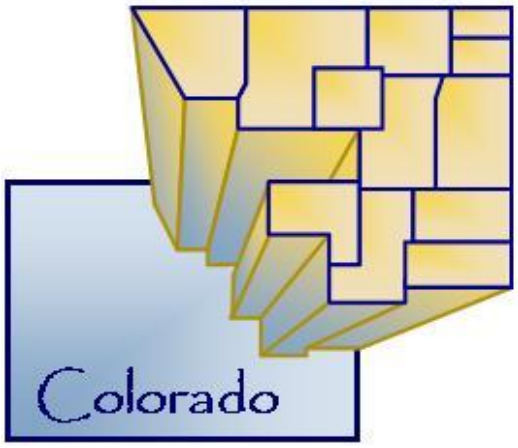
Northeast Behavioral Health Partnership, LLC



Annual Quality Report

Fiscal Year 2012-2013

Executive Summary

Northeast Behavioral Health Partnership (NBHP) has a comprehensive Quality Assessment and Performance Improvement (QAPI) program designed to ensure the highest quality services to its members and stakeholders. The NBHP QAPI program represents the integration of the activities of the Quality Improvement and Utilization Management departments. It also ensures that the behavioral health organization and its providers are in compliance with the required Federal and State of Colorado Medicaid standards.

The purpose of this annual quality report is to assess the effectiveness of services provided by NBHP and its providers. This report evaluates the activities conducted over fiscal year 2012-2013 and focuses on the extent to which indicators and other measures give evidence that quality services were provided to members. The report includes a summary of techniques used to improve performance as well as an analysis of their impact on overall quality. Outcomes are compared to previous years. Recommendations and strategies are developed for the upcoming measurement period. As such, this report includes the evaluation of nine domains that were instrumental in making determinations of the effectiveness of NBHP's service delivery. These domains are:

- Access to Services
- Performance Indicators
- Evidence Based Practices
- Quality of Care
- Cultural Competency
- Performance Improvement Projects
- Practice Guidelines
- Systems Integration
- Satisfaction Surveys

For each of these domains, areas of focus are identified and the means for assessing the outcomes are specified. When available, NBHP compares performance to national benchmarks, performance of other BHOs or like organizations, and to previous year's performance. Statistical testing may be applied, when appropriate, to determine whether an increase or decrease in performance is significant, or more easily attributed to random variation. When statistical testing is not significant or unwarranted NBHP may analyze trends over time in an effort to understand how performance may be improving or declining using input from various stakeholders (e.g., members, clinicians, families, subject matter experts).

Highlights for Quality Improvement and Utilization Managements Departments during Fiscal Year 2012-2013

Member Involvement: NBHP's Quality Improvement and Utilization Management Committee continues to have a strong member presence.

RCCO Collaboration Efforts: Implementation of a RCCO/BHO quarterly "Data Sharing" meeting aimed at increased collaboration and the development of a shared vision. NBHP has partnered with The Colorado Department of Healthcare Policy and Financing (HCPF) on its initiative to coordinate and integrate care between behavioral health and physical health Providers. NBHP has a Business Associate agreement with RCCO 2 to share data within the limits of confidentiality. This data will be used by NBHP's providers to outreach and engage members in care management. NBHP is in the process of finalizing Business Associate Agreements with RCCO 1 and RCCO 7. NBHP is involved in the State Innovation Model grant to improve data sharing processes between RCCOs and BHOs. In addition NBHP participates in RCCO stakeholder meetings and provides feedback to help RCCOs in program implementation.

Cultural Competency: The NBHP cultural competency committee continues to work alongside its provider centers. NBHP cultural competency committee has expanded their "Did You Know" email campaign into email blasts which provide specific tips for clinicians in working with a diverse population. Additionally, NBHP has partnered with its MHC's to create a single service cultural competency plan to ensure consistency of cultural competency activities. This plan has resulted in a variety of assessment activities following NCQA guidelines in this area. NBHP has very high rates of satisfaction regarding cultural competence on Colorado Office of Behavioral Health's Mental Health Statistics Improvement Program (MHSIP) satisfaction survey. The Appropriateness of Care Domain scored 90.76%. Staff being culturally sensitive is one of the 9 questions in that domain. The Fact Finders reports also show the same high level of satisfaction, 93.6% believe their counselor can meet cultural needs. NBHP counties have a large population of refugees from other countries. Providers seek necessary training to work with members who experience extreme trauma, and who have cultural and language difficulties.

Involvement in Community-based Forums: NBHP's quality improvement personnel continued work with the Director of Member and Family Affairs and its provider centers to present quality improvement data at community/public forums. During fiscal year 2012-2013, the NBHP Director of Quality Improvement presented at and obtained feedback from individuals attending the community/public forums throughout the NBHP service area. NBHP works closely with its National Alliance on Mental Illness (NAMI) chapter on peer run groups, advocacy, and support. In addition, NBHP and its providers have worked consistently over the years on several stakeholder forums with HCPF, OBH, RCCOs, etc.

Met Standards for Access to Care: NBHP's providers continue to meet the access to care standards at a very high rate.

Performance Indicators: NBHP's quality improvement personnel continue to participate in the statewide collaborative process to develop and refine performance indicators for behavioral health organizations. Additionally, NBHP's rates on performance indicators demonstrate strong performance in many areas.

Satisfaction Surveys: NBHP's quality improvement personnel reviewed and presented satisfaction survey results from several sources. The satisfaction surveys demonstrated high satisfaction and upward trends across multiple areas.

Completed Assisted Care Facility Focused Study: The focused study surveyed employees at the Assisted Care Facilities. The survey asked questions in two domains. The first domain was knowledge of the local mental health centers and the second domain assessed satisfaction with services provided by the mental health centers.

Performance Improvement Project: Initiated new performance improvement project to see if certain interventions would increase the penetration rate for Medicaid members 65 years or older.

Access to Services

Quarterly Monitoring of Access to Services

Routine Services: NBHP continued to monitor access to routine services as part of its reporting process to HCPF. During fiscal year 2012-2013, NBHP providers offered an initial appointment within seven business days in over **99.20%** of the **4577** requests for routine services. This rate is somewhat lower than FY12, where NBHP providers were in compliance over **99.80%** of the time for **3947** requests for routine services; however, NBHP provided 16% more initial requests for routine services than during FY12.

Urgent and Emergency Services: NBHP also monitored access to urgent and emergency services as part of its reporting to HCPF. NBHP was in compliance **100%** of the time for the **20** requests for urgent services. This is comparable to the previous fiscal year's results. NBHP was also in compliance **100%** of the time with the standards for the **1070** emergency phone contacts. The compliance rate matches the last fiscal year's rate, of 100% compliance; however there was an increase in the number of contacts, which went from 1044 in fiscal year 2011-2012 to 1070 in fiscal year 2012-2013. NBHP provided 908 Emergency Face-2-Face evaluations during FY13, which was an increase from FY12's 576 emergency evaluations. This increase is greatly due to the implementation of evaluators in the emergency department in Ft. Collins. NBHP was in **100%** compliance for the Emergency Face-2-Face evaluations category.

Quarterly Monitoring of BHO Telephone Access

The quarterly reporting of BHO telephone access data to HCPF is part of NBHP's contractual requirements. The data represents overall compliance to HCPF's 2006 Mercer Audit recommended standards of less than 5% call abandonment. Extensive training and support of the after-hours team was provided by the Clinical Director and senior Clinical Care Managers. The Clinical Director continues to serve as a liaison to the after-hours team to keep them appraised of contract changes and local issues our partners are facing, as well as to oversee the quality of service provided by this team.

In addition to Telephone Access, The Clinical team also monitors several key performance indicators described in the table below:

Colorado Health Partnerships/Foothills Behavioral Health Partners/Northeast Behavioral Health Partnership's Combined Telephone Performance by Quarter

2012-2013	Q1 July-Sep	Q2 Oct-Dec	Q3 Jan-Mar	Q4 Apr-June
Initial Authorization Content audits	96%	96%	96%	100%
Initial Authorization Timeliness audits	95%	95%	100%	94%
Concurrent Review Authorization Content audits	100%	100%	100%	100%
Concurrent Review Timeliness audits	100%	100%	100%	96%
Average Speed of Answer in seconds	5	5.6	5	5.3
Abandonment rate (over 30 seconds)	0.75%	0.95%	0.63%	0.84%
Annual inter-rater reliability survey	NA	85%	NA	NA

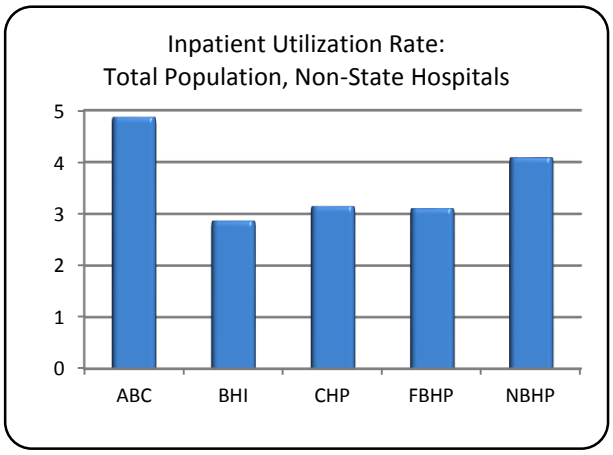
Performance Indicators

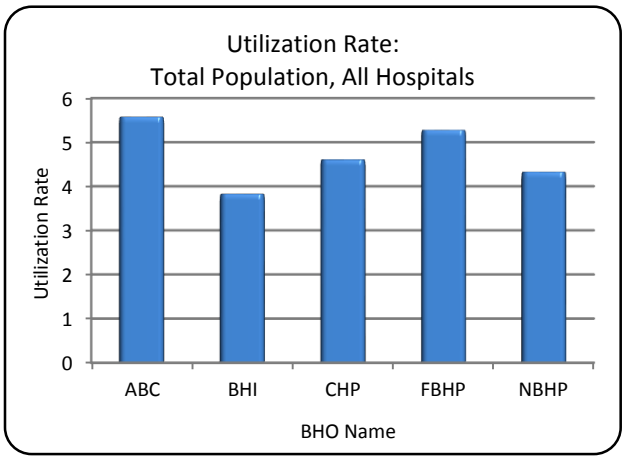
The data presented within this section represents a lens through which a managed care organization can view its overall performance. These "performance indicators" provide information to evaluate the effectiveness of NBHP's utilization management process. This process was piloted for fiscal year 2007-2008 by all the behavioral health organizations. NBHP quality improvement staff continues to work collaboratively with the other organizations and HCPF to develop and refine the statewide performance indicators.

The data collection and calculation processes for the set of performance measures listed below was validated by an external quality review organization (Health Services Advisory Group) as a part of its annual review of BHO information systems and data collection procedures. While the performance measures were calculated during the 2012-2013 fiscal year, the data represents activities conducted during fiscal year 2011-2012. The performance indicator data presented in this report include: hospital admissions, hospital length of stay, follow up after discharge, hospital recidivism rates, emergency room use, and penetration rates. The data presented are broken out by non-State hospital and all hospital data; all data for this section is provided through the annual performance measure report distributed by HCPF.

Hospital Admissions

The hospital admissions indicator examines the rate at which members within a behavioral health organization are admitted to an inpatient setting. Hospital admissions are measured by adding all of the hospital admissions and dividing it by the number of Medicaid eligible individuals. This number is then multiplied by 1000 to allow for comparisons between organizations of varying sizes. As a result, this indicator is presented as a "rate per 1000 individuals." Hospital admission rates can provide useful information regarding utilization management functions, such as the level and quality of outpatient care. Hospital admission rates may also be reflective of the number of intensive community resources and the degree of psychopathology that exists within the organization's member population. Hospitalizations are expensive to the managed care organization and restrictive for the member. While most inpatient hospitalizations represent an appropriate level of care, concerns regarding utilization management functions arise when the rates exceed industry benchmarks.



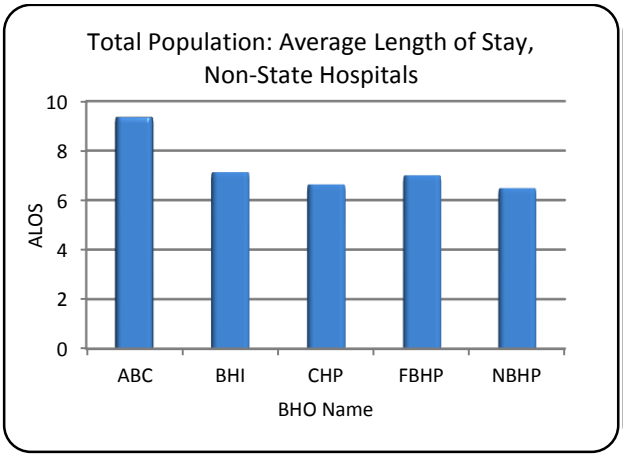


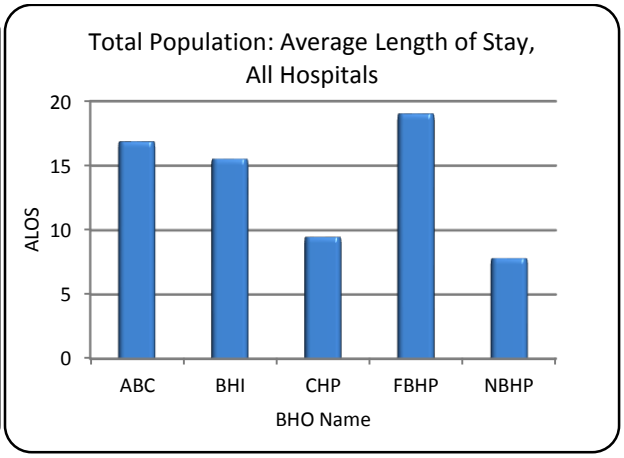
The graphs above present the overall rates for hospital admissions (all age groups) and provide comparisons between all behavioral health organizations. The statewide means for this indicator (as calculated by HCPF) for non-State hospitals is 3.49 and for all hospitals is 4.63. **For non-State hospitals NBHP's rate of 4.09 is above the respective statewide mean; however, for all hospitals NBHP's rate of 4.33 is below the statewide mean.** One reason the non-State hospital rate is higher than the statewide mean could be because the State institutions are located in South Denver and Pueblo, which are not convenient locations for NBHP members or their families. NBHP's has shown improvement in the inpatient utilization numbers over the past two fiscal years. In FY10, the rates were 5.38 (non-State hospital) and 6.16 (all hospitals). In both cases, NBHP's rates were above the respective statewide mean. Similar to last year, NBHP's higher rate for non-State hospitals is mainly due to the adolescent hospital utilization rates, which were 15.84 adolescents per 1000 (non-state hospitals) and 17.31 adolescents per 1000 (all hospitals). NBHP demonstrated improvements in adolescent utilization compared to FY11 rates, which were 18.8 (non-state hospitals) and 19.8 (all hospitals). This was greatly due to Touchstone Health Partners placing evaluators in Poudre Valley's emergency department. As this program has been a success in this area, Touchstone plans to continue its efforts in Poudre Valley's emergency department. There is some speculation that placing these

evaluators in the ED is one of the causes for the ED performance measure increase to be discussed at the end of this section.

Hospital Length of Stay

Hospital Length of Stay (LOS) is a performance indicator that looks at the average length of stay for members discharged from an inpatient setting. Hospital LOS is measured by adding all of the hospital days utilized by members discharged from an inpatient setting and dividing it by the total number of hospital discharges. When used in conjunction with other performance indicators, hospital LOS helps behavioral health organizations and mental health centers assess its utilization management functions. For instance, if the hospital LOS averages are higher or lower over time, it may suggest concerns with the management of inpatient episodes of care, inadequate discharge planning/services, or insufficient community resources.



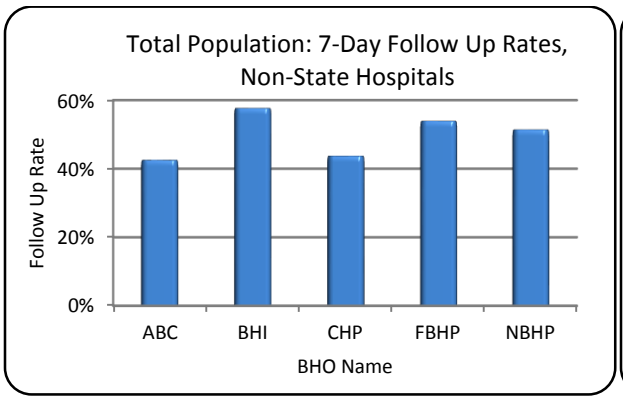


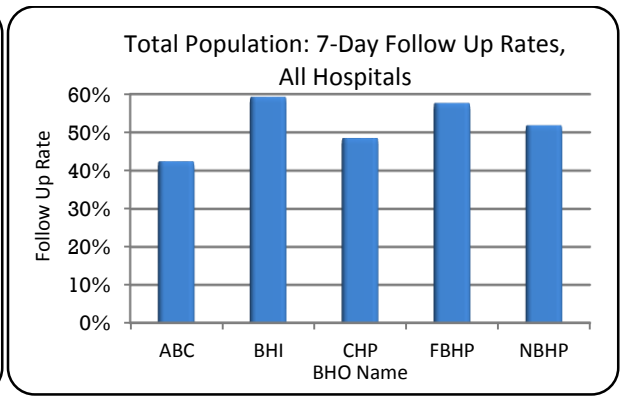
The data in graphs above presents the overall rates for hospital length of stay (all age groups) and provides comparisons between all behavioral health organizations. The statewide means for this indicator (as calculated by HCPF) for non-State hospitals is 7.39 and for all hospitals is 13.29. **NBHP's overall rates were below the statewide mean.** NBHP's overall means for this indicator were 6.48 days (non-State hospital) and 7.83(all hospitals). There was a slight increase in the average length of stay for patients in non-State hospitals and a decrease for patients in the all hospitals category. The age category 65+ realized a substantial increase with an average length of stay at 126 days. The State average for this measure was 25.87. The denominator for this measure was two members. NBHP will continue to monitor this measure through the quarterly performance measure report for the upcoming fiscal year.

Follow up Post Hospital Discharge

This indicator is a measure of the rate at which newly discharged individuals receive a face-to-face outpatient appointment within 7 or 30 days after leaving the hospital. It is measured by assessing the rate at which all individuals discharged from a mental health hospital attended a face-to-face outpatient appointment with a mental health care provider within 7 or 30 days post discharge. Because many individuals who are discharged from an inpatient setting are at high risk for hospital recidivism or illness relapse, face-to-face outpatient follow-up after an inpatient stay is an important continuity of care issue. High follow-up post discharge rates are indicative of a managed care organization or mental health center that provides a high level of care to its members.

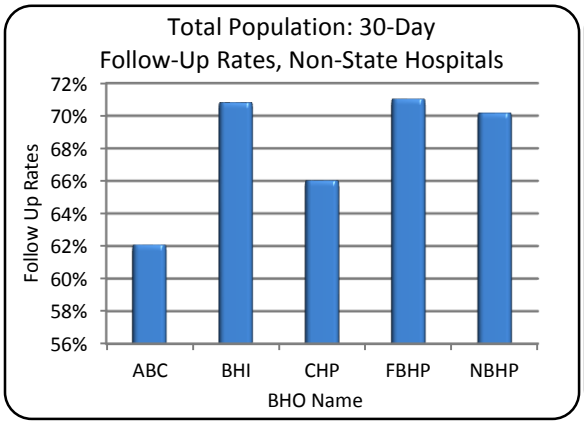
Data for 7-day post hospitalizations are displayed below.

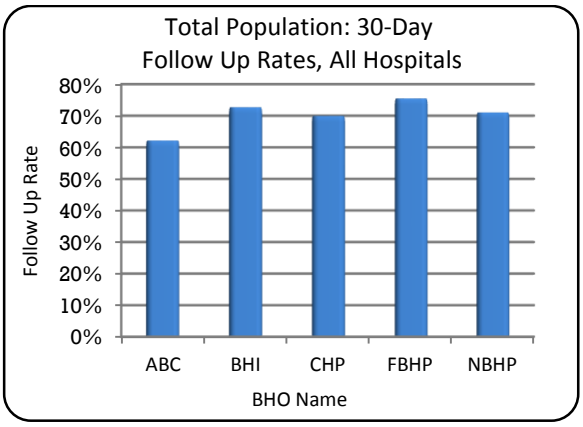




The data in graphs above presents the overall rates for 7-day follow up post hospital discharge and provides comparisons between all behavioral health organizations. The statewide means for this indicator (as calculated by HCPF) for non-State hospitals is 48.28% and for all hospitals is 50.86%. **In both cases, NBHP's rates of 51.44% (non-State hospitals) and 51.87% (all hospitals) were above the statewide average.** Although NBHP saw decreases in each category when compared to the previous year, they continue to be above the statewide average as demonstrated in previous years. NBHP will continue to monitor this measure through the quarterly performance measure report for the upcoming fiscal year. This measure will also be evaluated through the recidivism report that is currently under development.

Data for 30-day post hospitalizations are displayed below.





The data in graphs above presents the overall rates for 30-day follow up post hospital discharge and provides comparisons between all behavioral health organizations. The statewide means for this indicator (as calculated by HCPF) for non-State hospitals is 67.11% and for all hospitals is 69.66%. **In both instances, NBHP's mean rates for non-State hospitals (70.19%) and for all hospitals (71.03%) were above the statewide average.** These results are similar to the previous year, where NBHP's averages were 75.32% for non-State hospitals and 74.80% for all hospitals; whereas the statewide averages were 66.35% for non-State hospitals and 67.72% for all hospitals. These rates did drop when compared to the previous year. Although NBHP is among the highest in the State for this measure, NBHP will continue to monitor this measure through the quarterly performance measure report for the upcoming fiscal year. This measure will also be evaluated through the recidivism report that is currently under development.

Hospital Recidivism

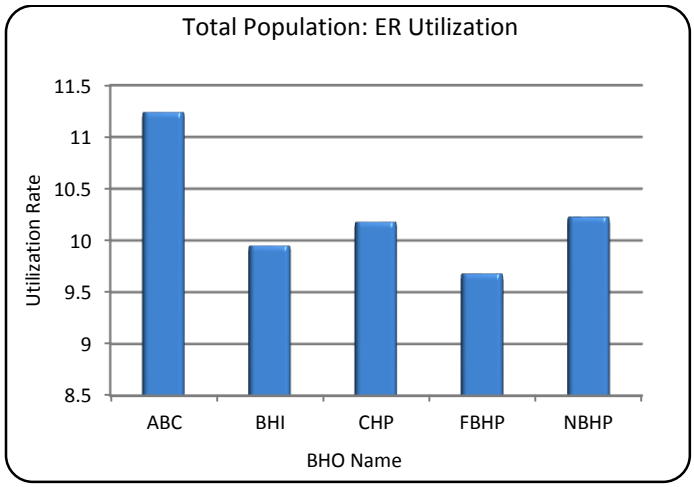
The hospital recidivism indicator measures the rate at which members within a managed care organization are re-admitted to a hospital within 7, 30, or 90 days after leaving the hospital. This indicator is measured by adding together the number of members readmitted to a hospital within a 7-, 30-, or 90-day period and dividing it by the total number of members discharged from a hospital. Recidivism rates can be due in part to the nature of severe and persistent mental illness; however, recidivism rates can also be due to factors related to the managed care organization and mental health center. For instance, low quality outpatient care, premature discharge from a previous hospitalization, or lack of community supports are issues that can drive high hospital recidivism rates. As such, monitoring recidivism rates can provide insight into both the organization's utilization management functions and overall quality of services. To conserve space, the hospital recidivism data will not be displayed in this report and will instead be detailed in the bulleted information below**. NBHP's overall recidivism rates were below the statewide mean.** These rates represent the lowest in the state. NBHP will continue to monitor this measure through the quarterly performance measure report.

- 7-day Recidivism Rates
  - Non-State Hospitals: NBHP's 7-day rates were 1.55%, which is below the statewide mean of 3.01%. Last year the NBHP's rate (0.32) was below the statewide average of 3.37%.
  - All Hospitals: NBHP's 7-day rates were 1.76%, which is below the statewide mean of 3.00%. Comparatively, NBHP's recidivism rate (0.30%) was below the statewide mean of 3.49% last year.
- 30-day Recidivism Rates
  - Non-State Hospitals: NBHP's 30-day rates were 5.90% and were below the statewide mean of 8.75%. In the previous year, the statewide average was 9.97%. NBHP was well below the state average with a rate of 2.26%.
  - All Hospitals: NBHP's 30-day rates were 5.87% and were below the statewide mean of 9.11%. The statewide average for the previous year was 10.44%, and NBHP's recidivism rate of 2.38% was below the statewide mean.
- 90-day Recidivism Rates
  - Non-State Hospitals: NBHP's 90-day rates were 10.87% and below the statewide mean of 15.56%. Last year, NBHP's 90-day rate was 7.1% and below the statewide mean of 18.42%.
  - All Hospitals: NBHP's 90-day rates were 11.73% and below the statewide mean of 16.34%. Last year, NBHP's 90-day rate was 11.73%, which was below the statewide mean of 19%.

NBHP is currently developing an inpatient report to analyze why there was over a 100% increase in 30 day recidivism rates and over a 50% increase in 90 day recidivism rate. In this report, NBHP will be looking at high level data for inpatient admissions and narrowing the report to look at those members who did have recidivism. For those member, such things as ambulatory follow-up, benefit packages, age categories, and types of services will be examined. Further areas will be evaluated as the report develops.

Emergency Room Utilization

The emergency room visit indicator measures the rate at which members within a managed care organization are admitted to an emergency room for a mental health issue. Emergency room visit rates are measured by adding all of the emergency room admissions and dividing by the number of Medicaid eligible individuals. This number is then multiplied by 1000 to allow for comparisons among organizations of varying sizes. As a result, this indicator is presented as a "rate per 1000 individuals." Excessive emergency room visits for treatment of a mental health issue can be a sign of inadequate outpatient care, lack of continuity of care, or lack of community supports. As with recidivism rates, emergency room visit rates can provide insight into both the organization's utilization management functions and overall quality of services.



The data in the graph above presents the overall rates for emergency room utilization (all age groups) and provides comparisons between all behavioral health organizations. The statewide means for this indicator (as calculated by HCPF) is 10.25. **NBHP's rate was below the statewide mean with a utilization rate of 10.23.** This is an 89.4% increase compared to the previous year where the rate was 5.40. An examination of NBHP's emergency room utilization rates by age reveals that there was an increase in every age category except the 65 years and older age group. The largest increases were seen in the 13-17 and the 18-64 age categories. NBHP completed a full ED analysis report that is attached at the end (Attachment C, pg. 51) of this document. The report goes into detail the number of distinct members for FY11 and FY12 that sought ED services and identifies the percentage increase between the years, a detail comparison of services for members who had 1, 2, and 3 ED services for all members and for AND-SSI members, examines high utilizers that are considered members with 3+ visits during the fiscal year, which hospitals members were using for ED services, billing changes from hospitals between FY11 and FY12, and a detailed analysis of members who were high utilizers and had the Medicaid benefit package AND-SSI.

NBHP has developed a new monthly report to be sent to Quality and Clinical staff at each mental health center. The report will be completed on a three month lag and will be

cumulative for each fiscal year. Each center will be given a full list of services provided to their capitated members at the ED during the fiscal year, who the services were provided to, where members received services, and members with multiple ED visits will be highlighted to help spot patterns. ED visits where an inpatient visit occurred within 24 hours will be excluded from the report – to follow the ED performance measure in the BHO Scope Document.

Last year, NBHP reported that Touchstone Health Partners began conducting crisis evaluations in the Poudre Valley ED. This year, North Range Behavioral Health has negotiated a contract with North Colorado Medical Center to place evaluators in the emergency department. North Range hopes to implement this program during FY14.

Penetration Rates

Penetration rates are the proportion of eligible individuals within a managed care organization that are utilizing the organization's services. They are measured by adding the number of individuals who actually received a service and dividing by total number of individuals eligible for services. Penetration rates are monitored to help managed care organizations determine how well they are reaching out to members eligible for services and also to provide some insight into the degree of accessibility of services. The penetration rates presented here were calculated by HCPF and are broken out by age, race/ethnicity, and eligibility category. NBHP's overall penetration rate for FY12 was 12.74% which is a .13% increase compared to FY11's rate of 12.61.

- Age. See chart below. NBHP's penetration rates by age continue to be **within +/- 5% of the statewide rates in all categories**.

Category	NBHP Rates	Statewide Rates
Child	6.93%	7.44%
Adolescent	20.24%	18.65%
Adult	19.25%	19.89%
Older Adult	5.93%	6.32%

  These results are similar to the previous year, were NBHP's rates were below the statewide means in every category except the adolescent category.

- Currently NBHP's PIP to increase penetration is in progress. FY12 was considered a baseline year for the PIP submission, but interventions are already being implemented. Details about the PIP can be found the PIP section of this report.

- Race/Ethnicity: See chart below. An examination of BHO numbers by race/ethnicity reveals that penetration rates are comparable to those of other organizations. However, these rates fall within the lower half of race/ethnicity penetration rates for all BHO's.

Category	NBHP Rates	ABC Rates	BHI Rates	CHP Rates	FBHP Rates
American Indian	17.98%	19.57%	13.77%	12.01%	23.38%
Asian	4.96%	5.48%	4.78%	7.61%	6.85%
Black	14.70%	14.44%	13.56%	15.29%	25.57%
Native Hawaiian/Other Pacific Islander	13.89%	15.39%	11.86%	11.43%	29.01%
Other	17.96%	19.54%	14.84%	17.79%	21.05%
Other-White	17.07%	22.49%	17.71%	17.13%	23.07%
Spanish American	9.39%	7.37%	7.68%	10.28%	14.16%
Unknown	7.20%	10.88%	9.54%	10.73%	14.96%

- Eligibility Category: See chart below. NBHP's rates by eligibility category were variable, as compared to the other organizations. No notable exceptions or patterns emerged.

Category	NBHP Rates	ABC Rates	BHI Rates	CHP Rates	FBHP Rates
AFDC/CWP Adults	13.90%	10.89%	12.91%	15.43%	17.43%
AFDC/CWP Children	8.67%	6.14%	7.00%	8.61%	14.78%
AND/AB-SSI	32.28%	33.73%	32.85%	28.87%	35.80%
BC Children	4.69%	6.16%	5.42%	6.13%	8.58%
BC Women	10.30%	13.43%	9.11%	14.42%	15.74%
BCCP	10.08%	16.43%	12.06%	16.70%	15.84%
Foster Care	35.14%	43.24%	36.71%	31.64%	38.81%
OAP-A	5.90%	6.58%	4.59%	6.82%	7.22%
OAP-B-SSI	22.75%	24.18%	21.32%	19.96%	26.82%
Overall:	12.53%	11.22%	11.13%	13.17%	17.75%

NBHP's overall rate this year saw a decrease by 2.13% when compared to the overall rate last year of 14.65%. NBHP saw a decrease in every Medicaid eligible category this year, except for OAP-A and AND/AB-SSI.

Evidence Based Practices

The NBHP quality improvement department, in conjunction with NBHP's provider centers, has implemented and continues to monitor a subset of Evidence Based Practices for children (ages 6-11 and 12-17) and adults (age 18 and older). Currently NBHP is monitoring two practices for children, two for adults, and two that encompass both children and adults. The results for fiscal year 2011-2012 show marked improvement over the previous year lending support to the theory that negative outcome CCAR's were overrepresented in the initial analysis. It is likely that working backwards from the most recent CCAR (regardless of position relative to intake CCAR) yields a more accurate reflection of the efficacy and impact of Evidence Based Practices. NBHP will continue to monitor this area closely. For fiscal year 2014 Evidence Based Practices will remain a standing agenda item for the Clinical Advisory Committee as they continue to explore efficient and accurate data collection as well as model fidelity.

Provision of Crisis Services – Adult/Youth

Timeliness of services

The data for timeliness of services was obtained from the FY 2013 Access to Care Report. The portion used for this report was the EMERGENCY FACE-TO-FACE CONTACTS data. The data used reflects a combined adult and child metric. During FY 2013 there were 908 requests for emergency face to face contacts. This is a 57.6% increase when compared to FY 2012 which had 576 requests for emergency face to face contacts. For these requests, 100% of the emergency services were delivered within the one (urban) to two (rural) hour time frame. The increase for this measure is greatly due to Touchstone Health Partners implementing a new program where evaluators have been placed in the Poudre Valley Emergency Department.

Recommendation: All providers were compliant. Continue to monitor this area.

Beneficiaries receiving greater than three crisis services

For FY 2013 data was collected for adult and youth age groups accessing greater than three mental health center based crisis services. There were a total of 535 beneficiaries who received crisis services (376 adults and 159 youths). Twenty-one of the 376 adults or 5.6% used greater than three services. This is a very slight decrease from FY 2012 in which 5.8% of adults used greater than three services. Ten of the 159 youths or 6.3% received greater than three services. This is a decrease from FY 2012 in which 7.0% of adolescents used greater than three services. Total crisis services accessed during FY 2013 were 833 (Adults used 585 services and Youth used 248 services).

Recommendation: Continue to monitor this area

Cognitive-Behavioral Therapy for Depression – Adult/Youth

Outcomes were collected on CCAR data for adults in the domains of Mental Functioning and Mood Disturbance. The adolescent group was assessed using the domains of Mental Functioning and Depression/Suicidality (mood disturbance)

Adults

There were 59 cases in this group and both of the CCAR measures showed **movement in the desired direction for improvement of symptoms**. The movement for Mood Disturbance **was statistically significant,** which is an improvement over CY11's results where neither measure was considered a statistically significant change. For CY12 a p value of 0.0004 was reported for Mood Disturbance, and a p value of 0.0926 was reported for Mental Functioning. Mental Functioning decreased by -0.387 points, and Mood Disturbance decreased by -0.169 points.

Adolescents

There were 19 adolescent cases in this group. Both the Mental Functioning and the Mood Disturbance domains **showed movement in the desired direction for improvement of symptoms. Both Measures also demonstrated statistical significance, which is an improvement over CY11.** During CY11 neither measure proved to have a statistically significant change and the Mental Functioning domain was the only measure to have movement in the desired direction. For CY12, a p value of 0.026 was reported for Mental Functioning and a p value of 0.016 was reported for Mood Disturbance. Mental Functioning decreased by -0.466 and -0.375 for the Mood Disturbance measure.

Children

There were 3 cases for children (6-11) receiving CBT for depression. For CY11, there was one child receiving CBT treatment for depression. There was one case for children (6-11) receiving CBT for depression. For the 2010 report there were no children found receiving CBT treatment for depression. No further information is provided for this section.

Recommendation: Continue to review the measurement and implementation of this measure quarterly in subcommittee. Explore options around fidelity testing.

Multimodal Treatment for ADHD – Youth

DBH CCAR Mental Functioning Scales (separate scales for children and adolescents)

Outcomes were collected from CCAR data measuring Mental Functioning. There were 100 cases in the 12-17 age group. This group demonstrated an average change of -0.3. **This change was found to be statistically significant with movement in the desired direction for improvement of symptoms** (p=0.0002). These results are similar to the previous calendar year. There were 196 cases in the 6-11 age group. This group demonstrated an average change of (-0.46) points. Although the change for this age group was **not significant** (p=3.64), the change was **in the desired direction**. These results are similar to the previous year.

Caregiver Involvement

During CY12 the measure for caregiver involvement was derived from a Caregiver Involvement Performance Improvement Project (PIP). This project has been retired for some time now. This report used the same criteria for caregiver involvement, but the sample was derived using encounter data as opposed to electronic record data. The following results are likely a more accurate reflection of actual caregiver involvement as barrier analysis on the FY 2010 PIP results indicated documentation issues within the electronic record system.

For CY12, there were a total of 609 beneficiaries under the age of 18 that had a primary diagnosis of ADHD. 53 of these patients did not meet the criteria for the sample because they only had one mental health service. The remaining 556 beneficiaries that did have 2 or more services **–402 had caregiver involvement.** This is a decrease when compared to CY11. For CY11, there were 581 beneficiaries that had 2 or more services and all had caregiver involvement.

Recommendation: Continue to monitor for sustained improvement.

School Based Services

Youth and Children age 6-11 (N = 40)

Outcomes were collected from CCAR data measuring Mental Functioning and Social Functioning using the sample time period CY12. The change that occurred **for both CCAR measures was in the desired direction**. Average change was -0.33 for Mental Functioning and -0.62 for Social Functioning. These results were an improvement over CY11 where the average change for both was in the undesired direction. The change for both CCAR domains was also statistically significant with Mental Functioning at 0.002 and Social Functioning at 0.0004.

Adolescents age 12-17 (N = 67)

Outcomes were collected from CCAR data measuring Mental Functioning and Social Functioning using the sample time period CY12. **The change that occurred for both CCAR measures was in the desired direction.** Average change was -0.2 for Mental Functioning and -0.57 for Social Functioning. This is an improvement over last year were change was in the desired direction only for Social Functioning. The change for the Social Functioning domain was statistically significant with a p value of 0.0002; however the p value for mental functioning was not statistically significant at 0.08.

Recommendation: Move school based services metrics to Clinical Advisory Subcommittee for review of metric and possible fidelity.

Peer-Specialists/Member-Run Services - Adult

Number of clients receiving services

There were a total of 221 beneficiaries who received peer services through NBHP. The data is described in the table below:

CMHC Name	Number of Members Per CMHC	Percentage of Beneficiaries
Centennial	3	1.4%
Touchstone	117	52.9%
North Range	101	45.7%
Total:	221	100.0%

This data has a much smaller N than the previous year where the total N was reported as 667. A change in methodology was made this year. Last year, all codes that allowed a peer to provide services according to the USCS Coding Manual were used; however, there was discussion that this most likely was not accurate due to the fact that others, as well as peers, could be providing these services. This year licensure plus the modifier code 'TS' was used when retrieving data. These counts are most likely a more accurate reflection of the number of members receiving peer services at the mental health centers.

Recommendation: This is baseline information. Continue to monitor in FY14.

Recovery Oriented Questionnaire

The below survey was developed as part of a three BHO focus study conducted during FY 2011, information was collected on types of Peer Services being offered across the BHO's. An extensive list of possible peer services offered at community health centers was compiled based on Peer Service/Recovery literature and qualitative interview with 2 Peer Services subject matter experts from each mental health center. This list organized into broad service categories and was disseminated to all employed Peer Specialists within the BHO. Respondents were asked to indicate which services they provided so that a quantified measure of each of the broad categories could be developed. NBHP demonstrated improvement in every services category when compared to the previous year. The percentage change reported was calculated by using the numerators from each year (FY _Yes Response). The improvement for each category could be due to the increased N of completed surveys. For CY11 there were 12 surveys completed and for CY12 there were 18 surveys completed.

	FY12 Results		FY11 Results		
Type of Service Provided	**FY12 Yes**	**Percentage Yes**	**FY11 Yes**	**Percentage Yes**	**Percentage Change**
Outreach to the Community	11	61.1%	7	63.6%	57.1%
Outreach to Engage Clients	16	88.9%	9	81.8%	77.8%
Advocating for Clients	11	61.1%	10	90.9%	10.0%
Political/Community Advocacy	8	44.4%	4	36.4%	100.0%
Peer Specialist Group Development	9	50.0%	5	45.5%	80.0%
Committee Membership	9	50.0%	8	72.7%	12.5%
Educating Services on Recovery	15	83.3%	11	100.0%	36.4%
Client Orientation to Mental Health Services	14	77.8%	9	81.8%	55.6%
Treatment Planning Support	16	88.9%	8	72.7%	100.0%
Medication Education &/or Appt. Prep	9	50.0%	4	57.7%	125.0%
Peer Led Groups	11	61.1%	8	72.7%	37.5%
Co-Facilitation of Clinical Groups	9	50.0%	8	72.7%	12.5%
Supporting Families	5	27.8%	4	36.4%	25.0%
Case Management	13	72.2%	7	63.6%	85.7%
Life Skills Training	14	77.8%	9	81.8%	55.6%
Counseling and Support	15	83.3%	9	81.8%	66.7%
Transitional Assistance at Tx Discharge	7	38.9%	6	54.5%	16.7%
Crisis/Emergency Support	10	55.6%	7	63.6%	42.9%
Transitional Assistance at Hosp. Discharge	6	33.3%	3	27.3%	100.0%
Finding Housing	10	55.6%	8	72.7%	25.0%
Vocational Rehabilitation & Support	8	44.4%	6	54.5%	33.3%
Transportation Support	11	61.1%	9	91.8%	22.2%
Accessing Healthcare	7	38.9%	5	45.5%	40.0%
Assistance with Other Community Agencies	10	55.6%	7	63.6%	42.9%
Interpersonal Support	15	83.3%	11	100.0%	36.4%
Telephone Support	16	88.9%	9	81.8%	77.8%
Recreation/Leisure Activit Coordination	11	61.1%	8	72.7%	37.5%

Percentage increase is based on the numerator or the number of peers who responded 'Yes'.

IDDT - Adult

Outcomes were collected on CCAR data measuring mental functioning and sociability/substance abuse. Data was collected on a total of 45 members enrolled in the program. The change for both measures was found to be statistically insignificant for both functioning (P= 0.40) and sociability/substance use (P= 0.46). Functioning (0.10) had an average change with movement in the undesired direction. Sociability/substance use (-0.10) had movement in the desired direction. This is different than CY11 were **there was significant change in both** mental functioning (p=.022) and sociability/substance abuse (p=.015), with movement in the desired direction for both CCAR domains demonstrating an average change of -0.2 for each.

Recommendation: Continue to monitor this area for sustained improvement.

Quality of Care

The NBHP quality improvement department, in conjunction with NBHP's provider centers, conducted a variety of clinically-based quality improvement activities.

Chart audits

NBHP regularly reviews its provider's charts utilizing a variety of mechanisms. Provider treatment record documentation audits continue regularly, along with provider education in areas where scores indicate problems are evident. If improvement is not seen, the corrective action process is initiated. Audits include a review of encounters/claims against the chart documentation. A revision of the treatment record audit tool was completed during FY12 based on an overall assessment of compliance and treatment elements; the new audit tool and associated training has been successfully implemented. Training was mandatory for providers; those providers who did not attend were contacted and are required to complete the online training and submit an attestation that training was completed. In addition to these ongoing audits conducts a "service plan" study that investigates the rate at which its provider centers ensure members have treatment plans that are signed and dated by the member, clinician, and the clinician's supervisor. Thirdly, NBHP performs an annual internal audit of 411 randomly sampled encounters and claims to examine the accuracy and completeness of data submitted to HCPF. **During fiscal year 2012-2013, NBHP and its providers successfully completed all required activities regarding the chart auditing process.**

Quality of Care Concerns and Critical Incidents

Investigations of potential quality of care issues are conducted through the Quality Management Department, and findings are evaluated for appropriate follow-up, corrective action, and monitoring through the Quality of Care Committee. All quality of care issues are documented, as are results of investigations, and corrective actions are tracked and monitored. Reporting, investigation and tracking of serious adverse incidents through the NBHP Quality Management Department continued during the past fiscal year. An adverse incident may feed into the quality of care process based on investigation results. All providers are required to report adverse incident. For fiscal year 2012-2013, NBHP recorded a total of 55 critical incidents, which was a decrease from the previous year. Each of these reports was reviewed by the NBHP Director of Quality Improvement, the NBHP Medical Director, and ValueOptions Quality Improvement staff. The 55 incidents are presented by severity type and treatment setting in the two charts below. No trends or overarching concerns were noted; however the mental health centers did demonstrate more accurate reporting during FY13.

Incident by Severity Level	Number
Not an Incident	0
Minimal Risk	33
Moderate	6
Major	16
Sentinel	0
Incident by Treatment Setting	**Number**
ATU	6
Not in Treatment	4
Group Home	2
Outpatient	43
Residential	0

Enhanced Clinical Management

Enhanced Clinical Management (ECM) is the clinical review of encounter/claims data and treatment information to achieve greater treatment effectiveness, improved quality of care, enhanced safety for beneficiaries, and prudent utilization of financial, and treatment resources. EMC indicators are developed in collaboration with the clinical and administrative leadership of NBHP's partner mental health centers and the QI-UM Committee. All providers, whether directly or indirectly contracted to deliver Medicaid services, are subject to the ECM review process.

An enhanced clinical management case involves a person, program/service of facility whose measured performance lies outside the normal range of similar persons, program, or facilities and for this reason is the object of further study. Current areas of focus for ECM include the following indicators:

- Client is less than five years old.
- Client has a secondary therapist using more than two sessions.
- Two or more family members simultaneously receiving individual therapy from the same therapist.
- Thirty-five individual therapy sessions within a fiscal year.

Cultural Competency

NBHP and Center Cultural Competence Plans

NBHP addresses the issue of cultural competence through the development of its own cultural competence plan and through the competency plans at each of the NBHP provider Centers. During the fall of 2009 NBHP and each provider Center developed a cultural competency plan that described activities that would take place to ensure the provision of culturally competent services. Updates of progress toward implementation of the 2011-2012 Cultural Competency Plans' activities were presented at the October 2012 NBHP Cultural Competency Committee meeting. For fiscal year 2012-2013 each of the NBHP MHC's have developed and implemented a combined BHO/MHC plan to increase efficiency and consistency across the service area. This plan is currently focused on the assessment phase of the NCQA guidelines in this area.

NBHP Cultural Competency Committee

The NBHP Cultural Competency Subcommittee is answerable to the Quality Improvement Department. During the fiscal year 2012-2013, NBHP's Cultural Competency committee met to undertake a variety of activities designed to increase culturally competent service delivery. Additionally, the NBHP cultural competency committee has expanded their "Did You Know" email campaign into email blasts which provide specific tips for clinicians in working with a diverse population.

Performance Improvement Projects

Performance Improvement Projects (PIPs) are an integral part of NBHP's quality improvement program. NBHP is committed to developing and conducting future PIPs that will improve client access, administrative efficiency, and demonstrably impact client satisfaction and outcomes. Each PIP or Focus study is developed and monitored by the Clinical Advisory Committee and approved by the QIUM Committee. The review process consists of a focused, in-depth analysis of opportunities, barriers, ideas, and feedback related to these performance improvement initiatives. Current projects are reviewed below:

ACF Focused Study

Topic and Goal: NBHP's topic for this focused study was: ACF Perceptions of MHC Services. The purpose of this Focused Study is to begin a process of addressing the complex needs of CMHS waiver beneficiaries through a better understanding of perceptions and barriers to MHC and ACF collaboration. The Focused Study aims to explore perceptions and knowledge of ACF staff regarding MHC services provided to CMHS waiver beneficiaries. The information obtained will be used to assess opportunities for improvement projects that focus on the MHC/ACF alliance and to inform the development of new systems for collaboration and coordinated care. The study questions were:

- Do differences exist in the frequencies of negative and positive responses as they relate to specific survey questions regarding ACF staff satisfaction with MHC services and relationship?
- Do differences exist in the frequencies of negative and positive responses as they relate to specific survey questions regarding ACF staff knowledge of MHC services offered?
- What proportions of the staff surveyed have no knowledge of the MHC in their area?

Methodology: Community Mental Health Support (CMHS) Medicaid Waiver Program beneficiaries were identified using the quarterly CMHS waiver data file from HCPF. The ACFs that provided services to these clients were identified. A survey asking 5 questions about ACF knowledge of MHC and 5 questions about ACF satisfaction with MHC was disseminated to identify respondents at the ACFs. Quantitative responses were tallied to identify areas for improvement. Qualitative responses were reviewed for more specific information and possible concerns.

Summary of Findings:

- Frequencies of negative vs. positive responses for specific survey questions are within the satisfaction domain.
- Frequencies of negative responses for 3 of 5 questions about satisfaction were higher than positive responses. These frequencies show a need to improve ACF satisfaction with MHC in the areas of: MHC responsiveness to requests for services, and MHC collaboration with the ACFs on residents' treatment or transition plan. ACFs are also generally dissatisfied with the MHCs.
- Frequencies of negative vs. positive responses for specific survey questions are within the knowledge domain.

- Frequencies of negative responses for 3 of 5 questions about knowledge were also higher than positive responses. These frequencies indicate need for improvement in providing information to the ACFs on the crisis phone number for the local MHC, possibly sharing the MHC training calendars with the ACFs, and disseminating information to the ACFs on MHC family support groups.
- The proportion of facilities surveyed reporting no knowledge of a local MHC.
- Of the five ACFs surveyed, some staff from only one ACF-Park Regency reported no knowledge of a local MHC. This result is misleading as some staff at Park Regency also reported knowledge of the local MHC.

Conclusion & Recommendations (Interventions): NBHP considers this study to be very successful. In spite of the survey return rate being 53.1%, the results were very detailed and included qualitative responses that supported the quantitative responses. The following areas were clearly identified as areas for improvement which will be addressed in future projects/intervention with ACFs:

- Improve MHC responsiveness to ACF request for services
- Increase MHC collaboration on resident treatment and transition plan
- Provide MHC crisis phone number to ACFs
- MHCs' training calendars will be shared with the ACFs
- MHC will make ACFs aware of family support programs

Increasing Penetration for Medicaid Members Aged 65+

The purpose of the PIP is to increase penetration into the community of older adults in the NBHP service area. A preliminary review of the literature indicates that older adults experience both elevated mental health treatment needs and lower participation in treatment. Depression and anxiety are among the most prominent disorders for older adults. Penetration rates for 60+ in NBHP have been identified as low, at 7.36% while overall penetration is 12.39%, as provided by HCPF data.

The intervention proposed in this submission will include:

(a) Creation of an educational mailer/packet for members to facilitate understanding of mental health issues for the older adult population by taking a self-assessment as an example, access to care by providing contact information for services, and reducing stigma by listing everyday life events that could cause distress. The informational packets include two self-administrable assessment tools designed to assist with the determination of treatment needs and encourage further evaluation. The mailer and tools will be disseminated by direct mail and also onsite at such locations as PCP offices, churches, or at mental health-related special events or fairs (depending on availability during the study periods). The mailers will be sent to adults 65+ identified from NBHP eligibility. All mailing projects will be set up on both an annual (bulk) mailing and monthly (new eligible) mailing. These mailings will be systematized and become part of the BHO ongoing procedural process. Specific providers who are likely to serve adults 65+ such as Nursing Homes, Alternative Living Facilities, and PCP offices will be targeted locations for mailer distribution.

(b) A PowerPoint training will be developed for providers that will refute stereotypes and identify tools for engaging, supporting, and treating older adults. The power point training will be posted to the NBHP website for all providers. Trainings will be provided to the NBHP's large providers such as the Community Mental Health Centers.

(c) Quarterly reports to NBHP management and large providers to understand the gaps in service provision and trends towards improvement.

Some interventions were already put in place for this year to include: the monthly mailing to members started in December 2012, brochures, and inserts were taken to one Greeley Senior Center, two Loveland Senior Centers, and one Ft. Collins Senior Center. At the end of the fiscal year, NBHP will conduct data analysis on members who received informational packets to see if the mailing encouraged members to obtain treatment. If the mailing does not appear effective, NBHP will evaluate whether or not to continue the mailing for the duration of the study.

HCPF supplied NBHP with a list of primary care physicians that had provided services to members that were 65 years or older. This data will be used to outreach primary care physicians. If deemed appropriate by a primary care physician practice, NBHP will send the brochure and inserts to that practice. If a medical practice would like on-site training, NBHP's Quality Director will be available for this service.

This was NBHP's first year and was considered the baseline year. The reported penetration rate as calculated by HCPF was 5.93% for members 65 years or older. This rate is the second lowest among the 5 Colorado BHOs. The goal for FY13 is to achieve a statistically significant increase in penetration as compared to FY12's penetration rate. This will be calculated using the Chi-Square test. The results from FY13 will be submitted to HCPF on April 1, 2014.

Practice Guidelines

NBHP participates in a two-BHO practice guideline workgroup that is tasked with reviewing and updating the existing practice guidelines. This workgroup consists of mental health professionals from each BHO who review recent evidence and best practice standards. Input is gathered from medical professionals as well as members and families before final guidelines are approved by the NBHP Clinical Advisory Subcommittee. Guidelines are updated at least every two years and are made available at no cost on the NBHP website.

Recovery and Resiliency Initiatives

During the fall of 2012, each of the three NBHP provider centers developed Recovery and Resiliency Initiative Plans that detailed the recovery activities that would take place during fiscal year 2012-2013. These plans will be reviewed at the November 2012 NBHP Quality Improvement and Utilization Management Committee. Additionally, each of the three provider centers will present summary updates at the previously mentioned meeting. For fiscal year 2012-2013, each of the NBHP Provider centers met 80% of the goals in their Recovery Initiative Plans.

Systems Integration

The Service Systems Integration (SSI) Team advanced coordination and integration of services through multiple vehicles this past year. The Child Psychiatry Consultation Service continued to provide the valuable service of real-time "curbside" consultation for pediatricians with a child psychiatrist within twenty minutes of their call for six primary care practices in Colorado. In partnership with the Colorado Behavioral Healthcare Council, the Colorado Health Foundation is planning to fund expansion of the project to two pilot areas, including the Denver area and southeastern part of the state. The SSI team continued to provide project support and development through the year.

The team intensified its involvement in HB 1451 and SB 94 coordination of care initiatives in multiple areas. These programs foster various agencies working together to keep young people out of institutional settings and bring funding into the community for coordination of services. They reduce duplication of services and cost by linking consumers with the right services at the right time from the right agencies. Participants include juvenile court systems, probation departments, school systems, departments of human services, domestic violence prevention agencies, mental health agencies, court appointed special advocates, county health departments, division of youth corrections, substance abuse agencies, and many state agencies and departments. The team and ValueOptions were also involved in the formation of the case management entity and system of care projects in the Colorado Springs area.

The statewide group therapy training was presented in October of 2012. Principal trainer was the team lead for the SSI team. The team lead co-chairs the Training and Development Subcommittee of the Colorado Behavioral Healthcare Council (CBHC). This group is working to

pool resources of all member agencies, including all Behavioral Health Organizations and mental health centers (MHCs), in the state to reduce costs. Another project of this group is a statewide training calendar on the CBHC website. This will allow mental health centers to access information on trainings available to their staff so that the center doesn't have to recreate trainings thereby avoiding duplicative efforts. Other trainings presented by the SSI team include multiple trainings on accessing Medicaid mental health services, motivational interviewing, suicide assessment, and intervention, understanding the Regional Care Collaboratives (RCCOs) to foster better integration with BHO services, and innovative trainings on peer health coaching. This is a training directed towards peer specialists but also valuable for clinicians that teaches people to educate and work with consumers on physical health issues, especially chronic health conditions. The team also has a representative on the CBHC conference committee planning four days of training available to all MHCs in the state this fall which includes nationally recognized speakers. Trauma informed care will be emphasized. Team members have attended several trauma informed care conferences, summits, and trainings over the past year.

The team continues its efforts to promote Mental Health First Aid training. In order to facilitate providing this training to as many groups as possible the team lead has become certified as a Mental Health First Aid trainer. The team has educated community groups about the availability and usefulness of this training in many public speaking opportunities throughout the year. These have included outreach to long term services and supports providers such as single entry point agencies and alternative care facilities. Mental Health First Aid has been mentioned both nationally and by the state of Colorado in the past year as a useful intervention and prevention tool and a way to combat stigma. Team members have also worked with the School Safety Resource Center to coordinate efforts to reduce school violence. Other prevention activities in which the team has been actively involved include obesity reduction workgroups and teen and unintended pregnancy work groups. In addition, team members participate in the Substance Use Disorder Committee of the Colorado Behavioral Healthcare Council and the Drug Endangered Children workgroup.

The team is heavily involved in a new intensive case management program being piloted in certain areas. This program identifies "hot spotters", high utilizers of more intensive levels of care, and coordinates resources to better deliver services to prevent unnecessary overuse of inappropriate levels of care. This program also promotes compliance with federally mandated Olmstead requirements to treat consumers in the most community like setting possible. This fosters independence and integration into society to combat stigma. In areas not being piloted for intensive case management the team provides complex case consultation and service coordination. This includes collaboration with local RCCOs on complex cases and members recently discharged from higher levels of care.

The department of human services (DHS) has been a focus of integration efforts in the past year. Participation in the statewide core services director's meetings as well as DHS service integration groups is leading to a better understanding of the department's needs. Likewise this has led to a better understanding on their part of how we can help them within the bounds of our contract requirements. The team is assisting in innovative projects such as computerized

data sharing between a local department of human services and the BHO to streamline staffings on shared cases. This would allow immediate web access to treatment history, eligibility for services from multiple sources, and other information that could speed up the process of implementing a comprehensive, shared treatment plan. Other examples of forward thinking integration projects include exploration of braided funding models. The team has done a great deal of outreach to DHS to offer training and collaboration and problem solve areas of concern. Presentations regarding the RCCO system have helped local departments understand the overall Medicaid healthcare system and how their services can be interwoven within that wider system.

The importance of the long term services and supports (LTSS) system in Colorado has been recognized by the SSI team which has become even more actively involved. The governor signed an executive order this past year creating the Community Living Advisory Group (CLAG) to redesign this system. The team has a member that is co-chairing the Care Coordination subcommittee of the CLAG and another that was appointed a member of the Entry Point/Eligibility Subcommittee. These committees worked diligently throughout the year and have presented specific recommendations to the CLAG to be included in their report to the governor this fall. LTSS redesign may require legislative and regulatory changes effecting BHOs and MHCs. Having a voice at the front end of this process enhances the possibility of changes that may be beneficial to the care and treatment of our members. Streamlined eligibility for programs like Medicaid and home and community based services may extend our reach to additional populations and services. The team is also involved in other efforts such as the Colorado Coalition for Senior Behavioral Health and Wellness to address the needs of our fastest growing demographic group.

Satisfaction Surveys

The NBHP Quality Improvement Department utilizes three member satisfaction surveys as partial indicators of the delivery of high quality services. The satisfaction survey results contained in this report are drawn from the 2012 Fact Finders' Member Satisfaction Survey (a telephonic survey conducted by a third-party vendor), the 2012 Mental Health Statistics Improvement Program survey (MHSIP), and the 2012 Youth Services Survey for Families (YSS-F), both of which are conducted by the OBH.

2012 Fact Finders' Member Satisfaction Survey
Annual Report by CMHC, Contracted Provider and NBHP Overall

The Fact Finders Survey is a telephone survey completed by a vendor (Fact Finders, Inc.) contracted by *ValueOptions®*. FactFinders' conducts telephone calls quarterly to a sample of members who utilized services in the prior three-month period. The sample of members number about 200 each year. NBHP receives semi-annual reports from Fact Finders that consist of aggregate NBHP data for calls conducted during the six-month timeframe. The results of the member feedback are bulleted below.

Questions monitored by QIUM:

Overall, how satisfied are you with the mental health services of NBHP?

	CMHC	Non-CMHC	Total
N=	142	49	191
Completely Satisfied	23.2%	30.6%	25.1%
Very Satisfied	48.6%	38.8%	46.1%
Somewhat Satisfied	24.6%	24.5%	24.6%
Somewhat Dissatisfied	1.4%	0.0%	1.0%
Very Dissatisfied	2.1%	6.1%	3.1%

Overall, how would you rate the quality of services you have received from your counselor?

	CMHC	Non-CMHC	Total
N=	149	51	200
Excellent	49.0%	60.8%	52.0%
Very Good	28.9%	21.6%	27.0%
Good	14.8%	7.8%	13.0%
Fair	3.4%	3.9%	3.5%
Poor	4.0%	5.9%	4.5%

Have you and your therapist set goals for your treatment?

	CMHC	Non-CMHC	Total
N=	145	50	195
Member and Counselor Set Goals	86.2%	84.0%	85.6%
Member and Counselor Did Not Set Goals	13.8%	16.0%	14.4%

If yes, how satisfied are you with the progress you've made toward reaching these goals?

	CMHC	Non-CMHC	Total
N=	123	41	164
Very Satisfied	61.8%	56.1%	60.4%
Somewhat Satisfied	35.0%	41.5%	36.6%
Not Satisfied	3.3%	2.4%	3.0%

Is the office location convenient for you?

	CMHC	Non-CMHC	Total
N=	148	51	199
Convenient	82.4%	84.3%	82.9%
Not Convenient	17.6%	15.7%	17.1%

Compared to a year ago, in general are you feeling better, about the same, or worse?

	CMHC	Non-CMHC	Total
N=	147	51	198
Better	66.0%	70.6%	67.2%
About the Same	27.9%	19.6%	25.8%
Worse	6.1%	9.8%	7.1%

Other Fact Finders Survey Results:

When you go for mental health services, who is the person you usually see? A counselor, a doctor, a case manager, or someone else?

	CMHC	Non-CMHC	Total
N=	149	51	200
Counselor	61.1%	82.4%	66.5%
Doctor	26.2%	13.7%	23.0%
Case Manager	12.1%	2.0%	9.5%
No Opinion	0.7%	2.0%	1.0%

Do you feel your counselor has shown respect for your cultural or religious needs?

	CMHC	Non-CMHC	Total
N=	145	49	194
Counselor Meets Needs	95.9%	95.9%	95.9%
Counselor does not Meet Needs	4.1%	4.1%	4.1%

Do you feel your counselor protects your confidentiality?

	CMHC	Non-CMHC	Total
N=	146	51	197
Counselor Protects Confidentiality	97.3%	96.1%	97.0%
Counselor Does Not Protect Confidentiality	2.7%	3.9%	3.0%

Does your counselor help you learn coping skills to deal with your mental health problems?

	CMHC	Non-CMHC	Total
N=	143	49	192
Counselor Helps with Coping Skills	86.7%	85.7%	86.5%
Counselor Does Not Help	13.3%	14.3%	13.5%

Has your counselor involved you in decisions about your care?

	CMHC	Non-CMHC	Total
N=	145	51	196
Member Involved in Care Decisions	91.7%	90.2%	91.3%
Member Not Involved in Care Decisions	8.3%	9.8%	8.7%

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

	CMHC	Non-CMHC	Total
N=	149	51	200
Counselor Helped With Needed Changes	84.6%	82.4%	84.0%
Counselor Did Not Help With Needed Changes	12.1%	13.7%	12.5%
No Opinion	3.4%	3.9%	3.5%

Thinking back to your first appointment, did you get an appointment as soon as you wanted?

	CMHC	Non-CMHC	Total
N=	146	50	196
Got First Appointment As Soon As Desired	87.7%	90.0%	88.3%
Did Not Get Desired First Appointment	12.3%	10.0%	11.7%

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

	CMHC	Non-CMHC	Total
N=	127	49	176
Able To Get Appointment Within 7 Days	76.4%	83.7%	78.4%
Not Able To Get Appointment Within 7 Days	23.6%	16.3%	21.6%

Can you get to the counselor's office in less than 30 minutes?

	CMHC	Non-CMHC	Total
N=	146	51	197
30 Minutes or Less	78.1%	90.2%	81.2%
More Than 30 Minutes	21.9%	9.8%	18.8%

Is the office location convenient for you?

	CMHC	Non-CMHC	Total
N=	148	51	199
Convenient	82.4%	84.3%	82.9%
Not Convenient	17.6%	15.7%	17.1%

Compared to a year ago, are you more confident in your ability to handle day-to-day activities? Question only asked of adults.

	CMHC	Non-CMHC	Total
N=	95	15	110
More Confident Than a Year Ago	87.4%	80.0%	86.4%
Not More Confident	12.6%	20.0%	13.6%

In addition to your mental health treatment, do you go to any activities such as drop-in center, self-help group, workshop or class? Asked of adults only.

	CMHC	Non-CMHC	Total
N=	102	15	117
Participates in Activities	32.4%	33.3%	32.5%
Do Not Participate in Activities	67.6%	66.7%	67.5%

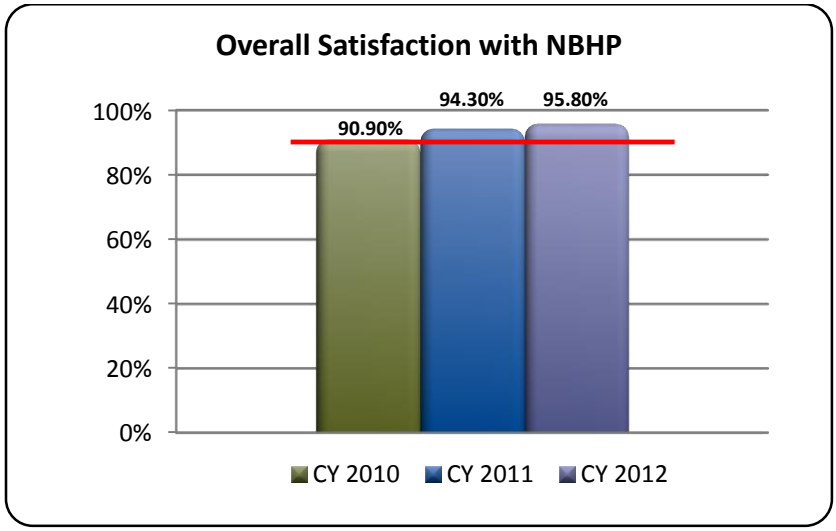
In the last year, have you stayed overnight in a hospital for any counseling or mental health services?

	CMHC	Non-CMHC	Total
N=	149	51	200
Have Received Services in Hospital	12.8%	5.9%	11.0%
Have Not Received Services in Hospital	87.2%	94.1%	89.0%

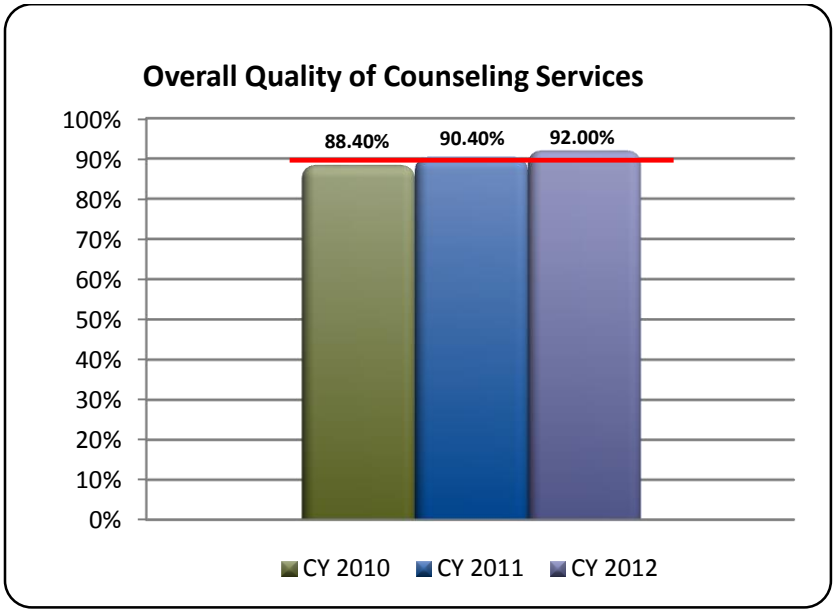
Are you satisfied or dissatisfied with the number of days approved for treatment in the hospital?

	CMHC	Non-CMHC	Total
N=	17	2	19
Satisfied	82.4%	100.0%	84.2%
Dissatisfied	17.6%	0.0%	15.8%

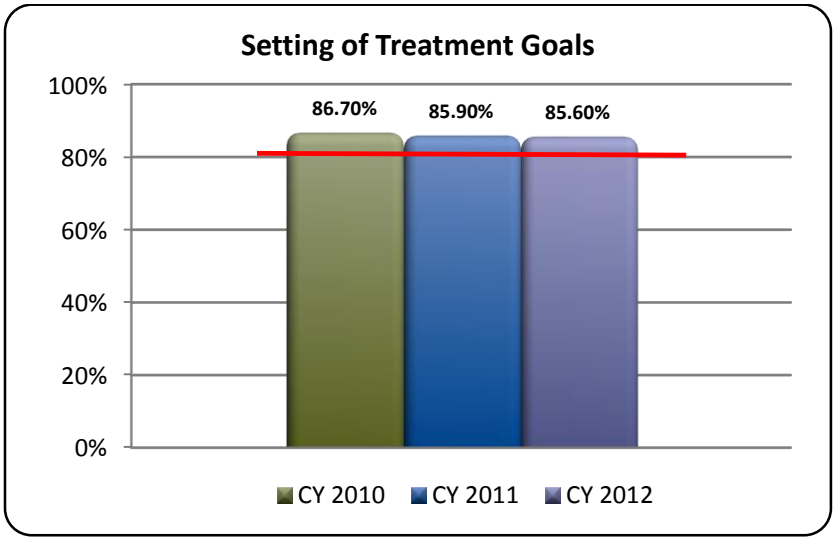
- Of the members asked about their satisfaction with the mental health services, 95.8% of members indicated they were satisfied. This is a 1.5% absolute increase in satisfaction with NBHP's services when compared to CY 2011. The rate of satisfaction continues to be above the benchmark of 90% and increasing annually.



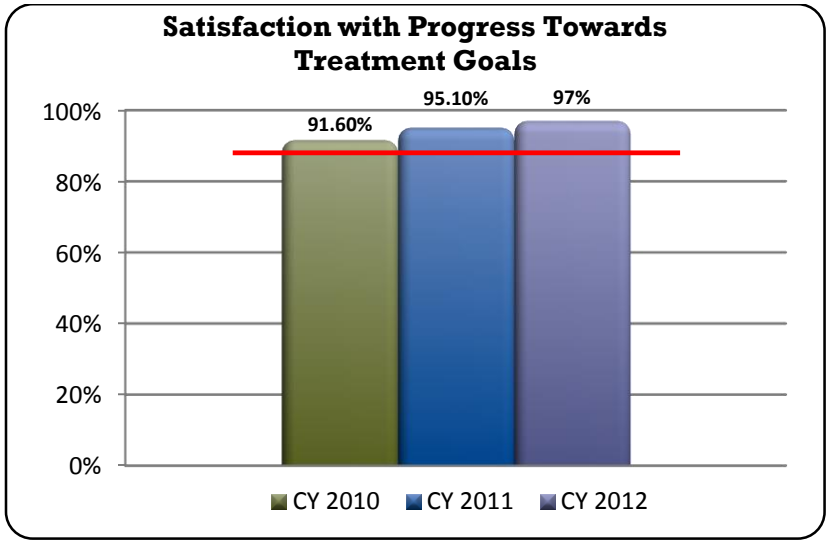
- 92% of members suggested they received quality services from their therapist. This is a 1.6% absolute increase in perception of quality when compared to CY 2011 data. The perception of quality from members continues to remain around the benchmark of 90%.



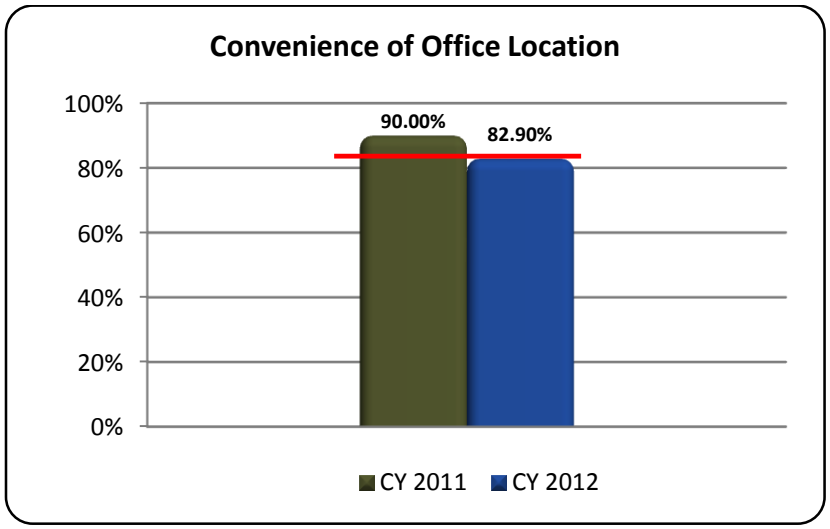
- 85.6% of members along with their therapist set treatment goals. This is a slight decrease when compared to CY 2011, but well above the benchmark of 83%.



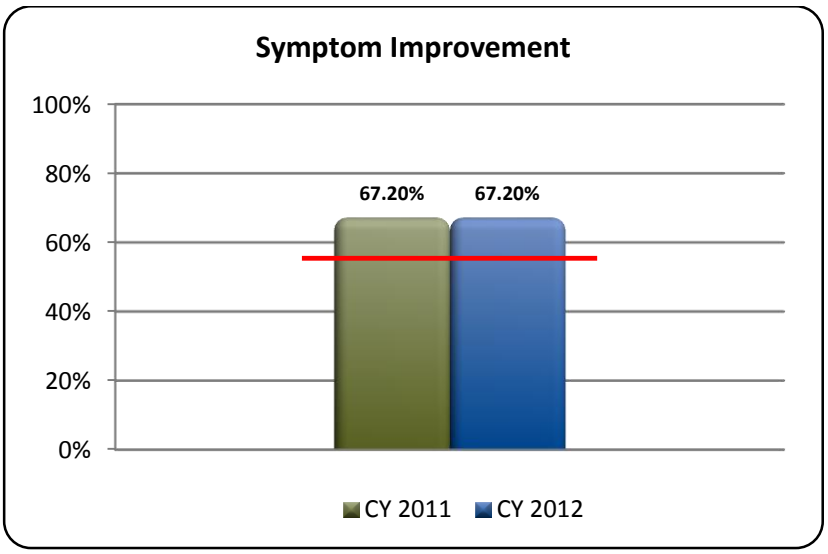
- Of those setting treatment goals, 97% were satisfied with the progress made toward reaching those goals. This is a 1.9% absolute increase in satisfaction when compared to CY 2011 and well above the performance standard of 90%.



- 82.9% of members indicated the distance travelled to meet with their therapist is not a problem. This is a 7.1% absolute decrease when compared to CY 2011. These results are below the performance standard of 85%. This item will continue to be monitored.



- When asked about how they were feeling compared to a year ago, 93% of members indicated they were better (67.2%) or about the same (25.8%). The better response is the element that is monitored for this survey question depicted in the graph below. The better response remained the same when compared to CY 2011. The results are above the performance standard of 55% for the "better" response. This item will continue to be monitored.



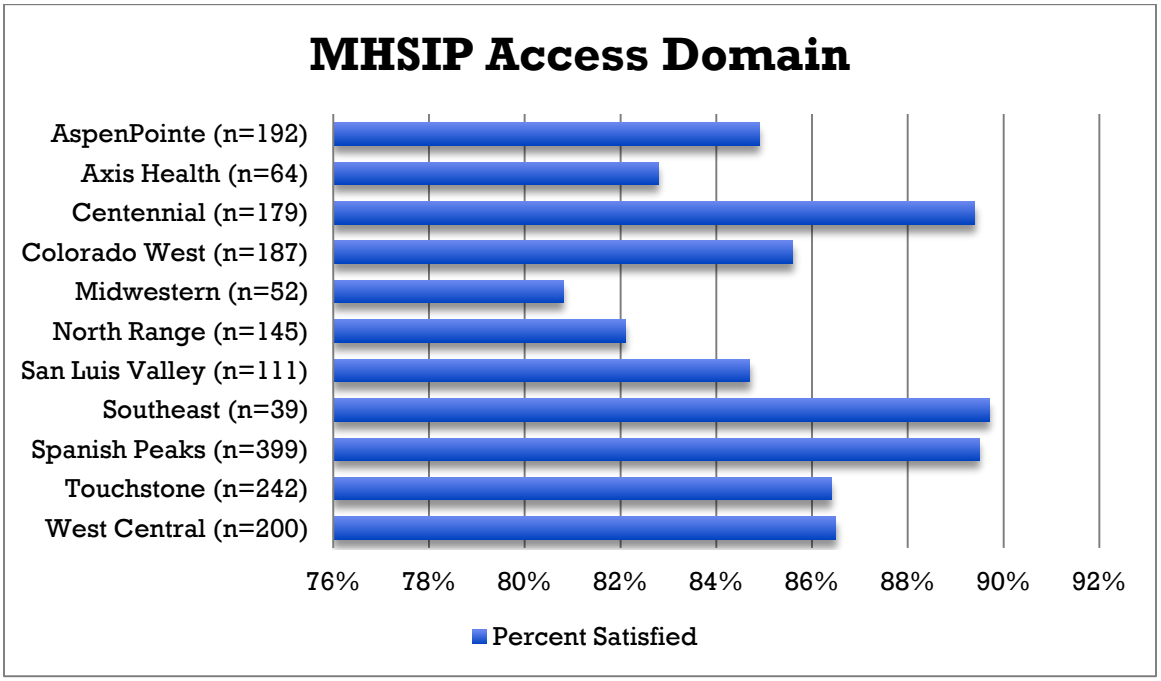
2012 MHSIP

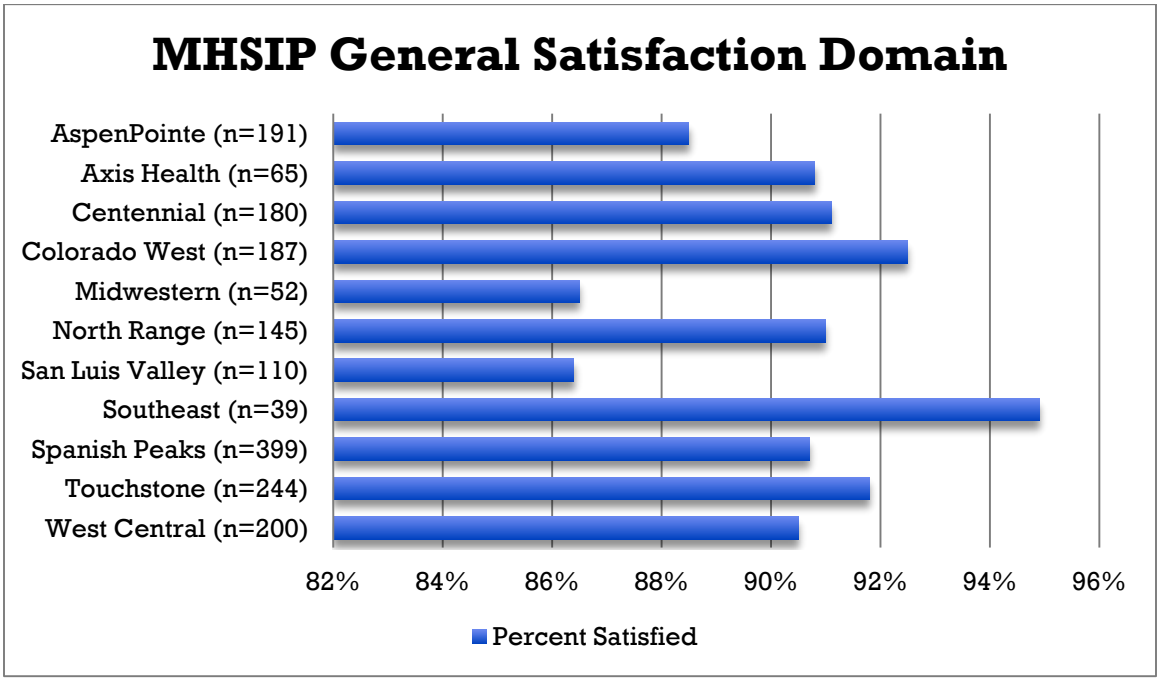
The Colorado Division of Behavioral Health (DBH) conducted the 2012 Mental Health Statistics Improvement Program (MHSIP) Member Survey. The survey was conducted in September 2012. NBHP coordinated efforts with another BHO (Colorado Health Partnerships-CHP) to collect overall MHSIP data for its respective mental health centers and report the results. The results reported reflect Medicaid and non-Medicaid respondents; there is no mechanism available to separate the sample.

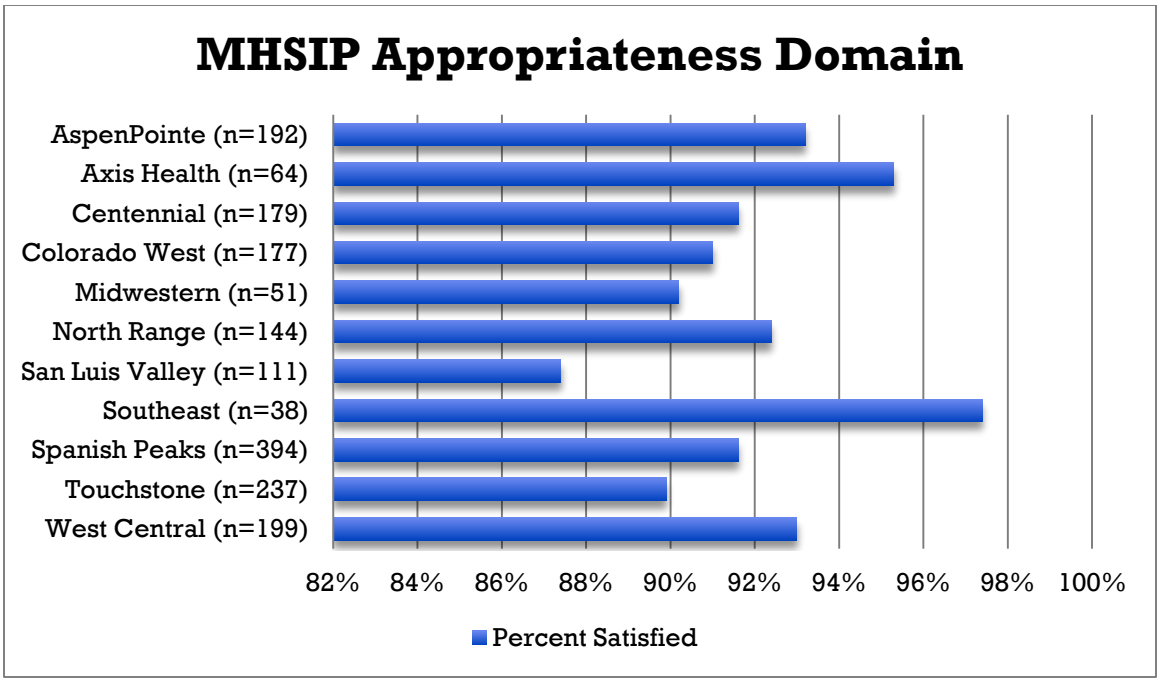
NBHP's satisfaction rates were higher than the statewide mean in every category. The highest scores were in the Perception of Satisfaction and Perception of Appropriateness Domains.. The lowest score was in the Perception of Outcomes Domain. The results for the 2012 survey are shown below:

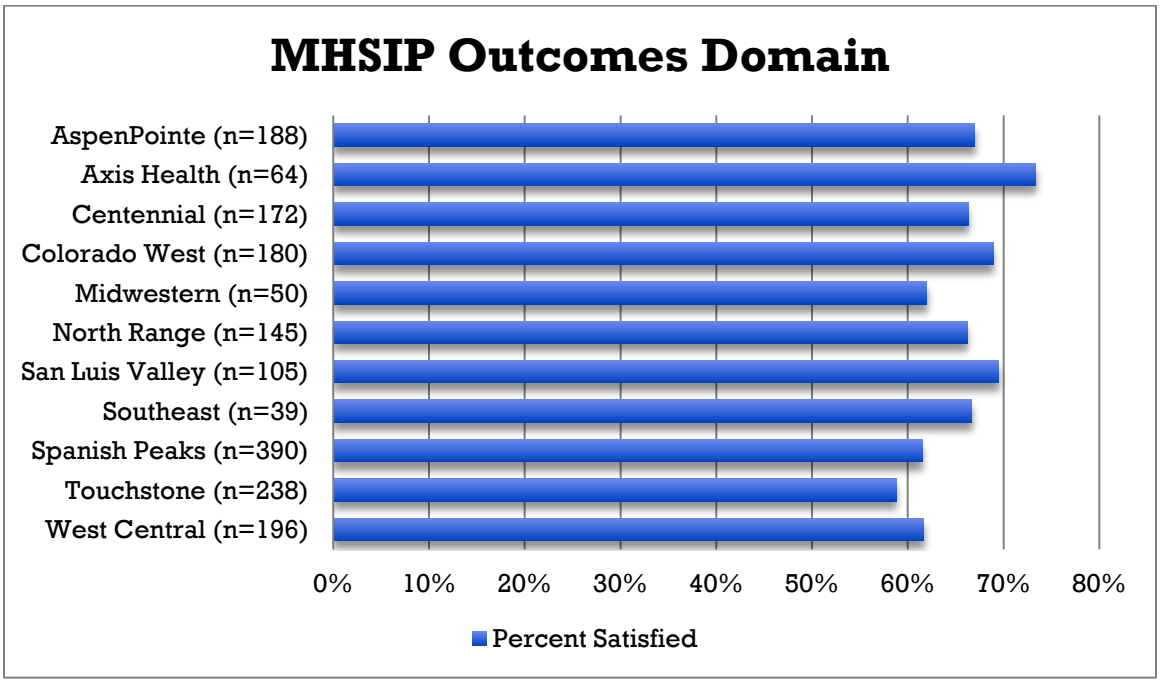
- Perception of Access 86%
- Perception of Appropriateness 91%
- Perception of Outcomes 63%
- Perception of Participation 83%
- Perception of Satisfaction 91%

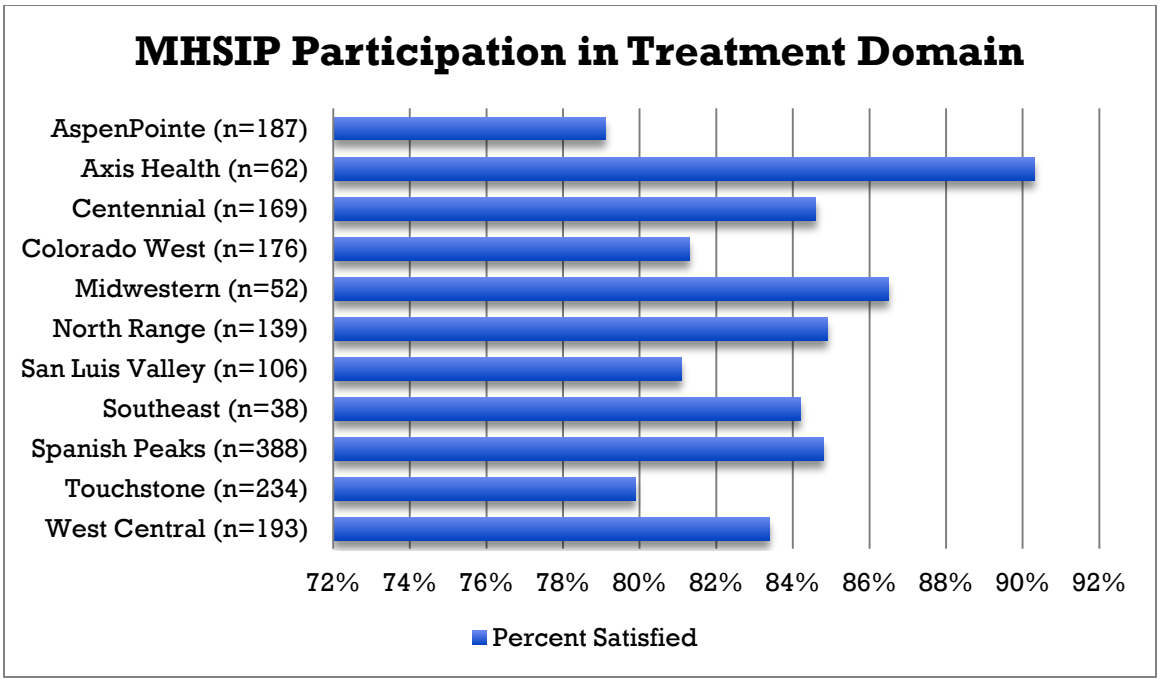
NBHP maintained or improved in all categories except for the Perception of Outcomes domain. There was a 8.8% decrease in the perception of outcomes domain compared to 2011. There was less than a percentage change in the appropriateness of care domain, less than a 1% increase in the participation in treatment domain, and less than a percentage change in the perception of Access domain.






MHSIP Appropriateness Domain
AspenPointe (n=192)
Axis Health (n=64)
Centennial (n=179)
Colorado West (n=177)
Midwestern (n=51)
North Range (n=144)
San Luis Valley (n=111)
Southeast (n=38)
Spanish Peaks (n=394)
Touchstone (n=237)
West Central (n=199)
82%
84%
86%
88%
90%
92%
94%
96%
98%
100%
Percent Satisfied


MHSIP Outcomes Domain
AspenPointe (n=188)
Axis Health (n=64)
Centennial (n=172)
Colorado West (n=180)
Midwestern (n=50)
North Range (n=145)
San Luis Valley (n=105)
Southeast (n=39)
Spanish Peaks (n=390)
Touchstone (n=238)
West Central (n=196)
0%
10%
20%
30%
40%
50%
60%
70%
80%
Percent Satisfied



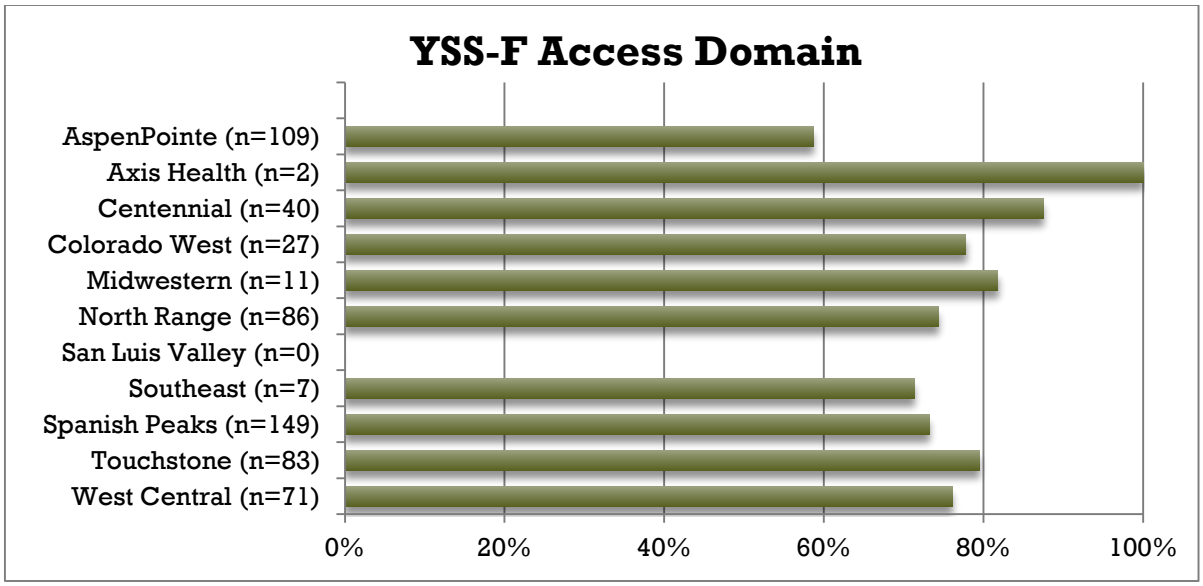
2012 YSS-F

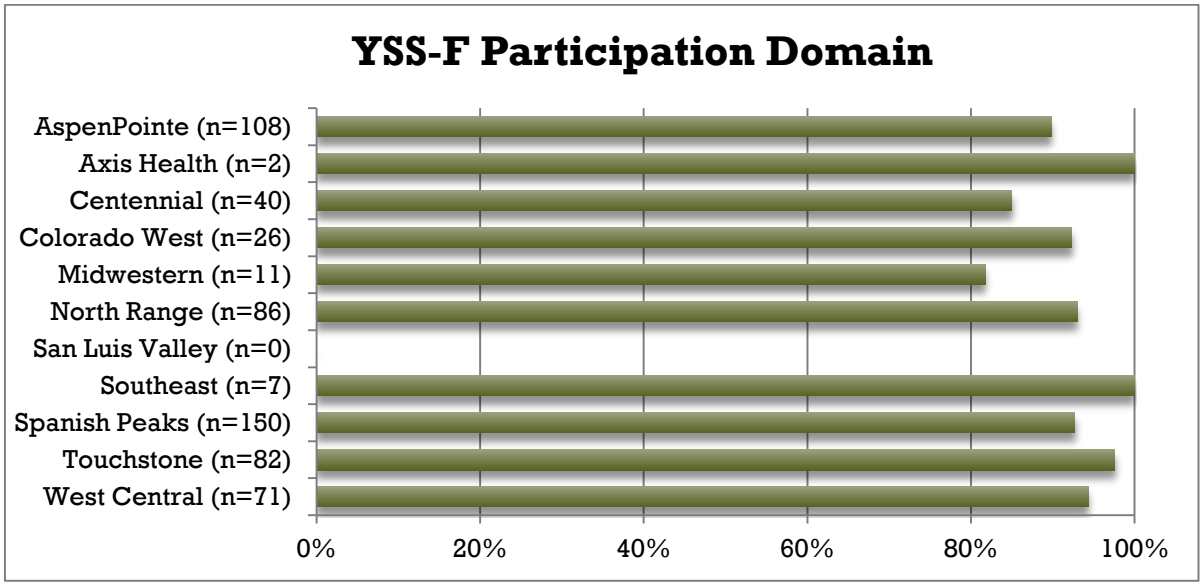
The Colorado Division of Behavioral Health (DBH) also conducted the 2012 Youth Satisfaction Survey for Families (YSS-F). The methodology and related issues are identical to the MHSIP survey. As with the MHSIP, NBHP coordinated efforts with another BHO (Colorado Health Partnerships-CHP) to collect overall YSS-F data for its respective mental health centers and report the results. The results reported reflect Medicaid and non-Medicaid respondents; there is no mechanism available to separate the sample.

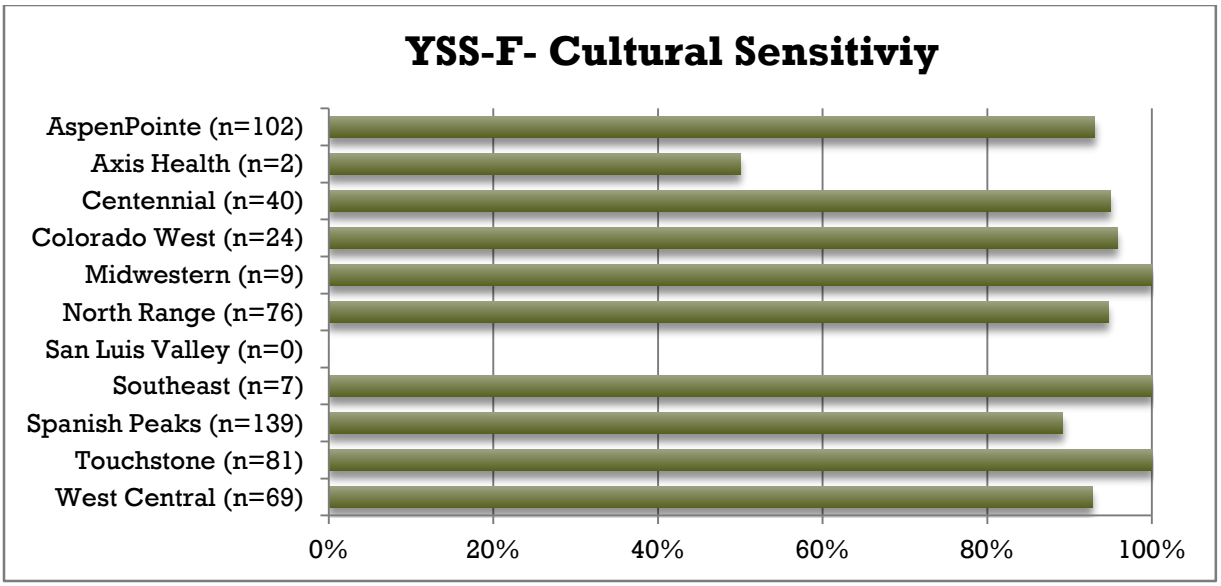
NBHP's satisfaction rates were higher than the statewide mean in every category. The highest score was in the Perception of Cultural Sensitivity. The lowest score was in the Perception of Outcomes Domain. The results for the 2011 survey are shown below:

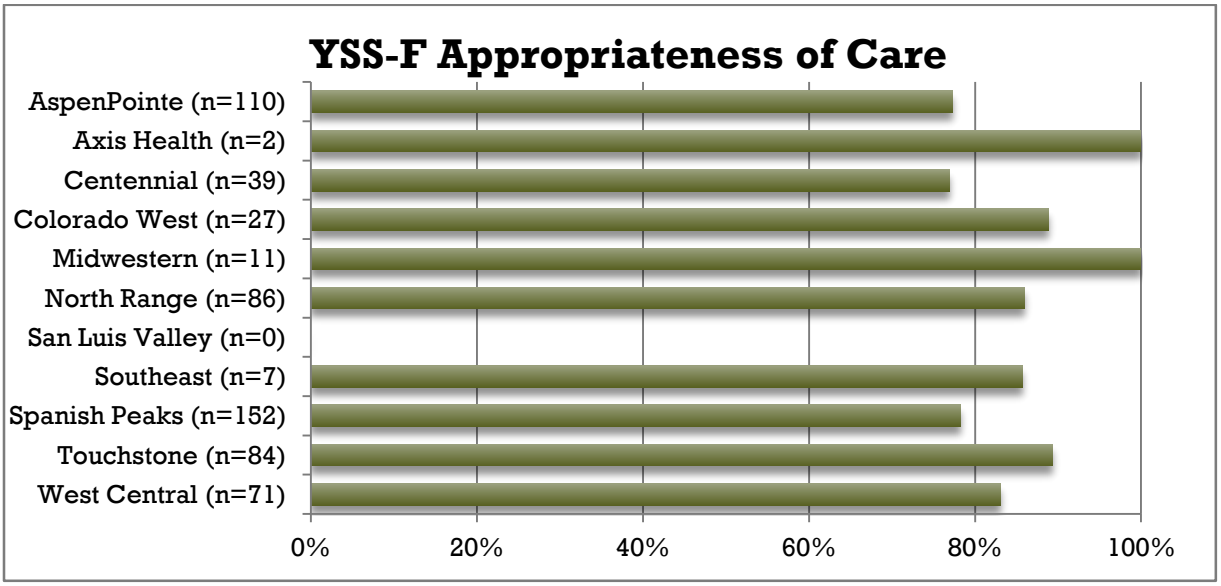
- Perception of Access 79%
- Perception of Appropriateness 86%
- Perception of Outcomes 55%
- Perception of Participation 93%
- Perception of Cultural Sensitivity 97%

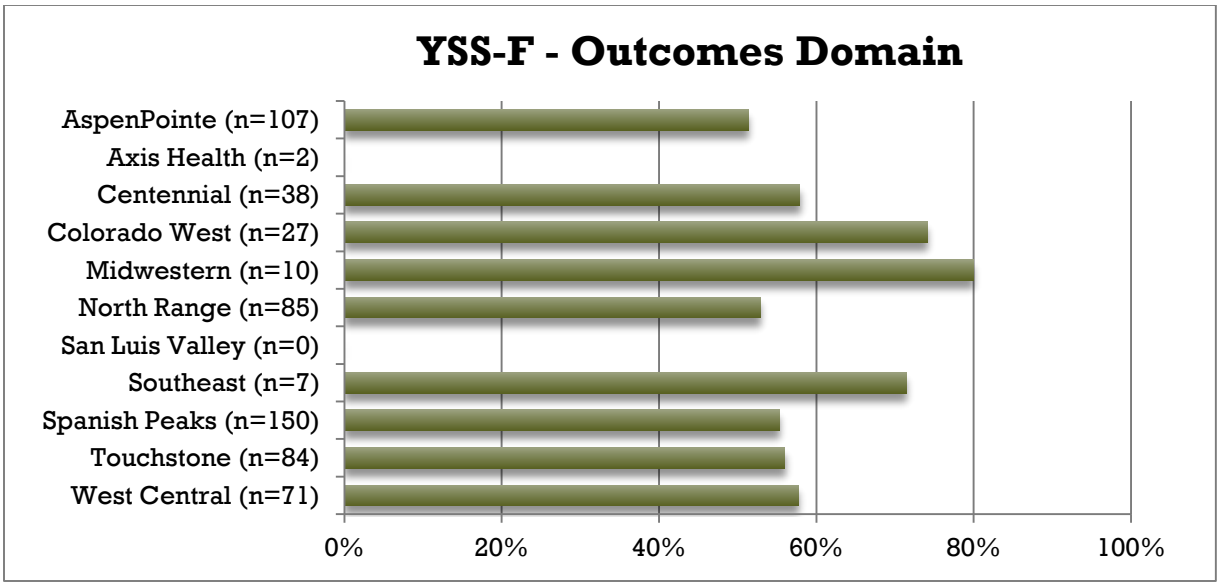
Compared to the 2011 YSS-F survey, there was less than a percentage change in the perception of cultural sensitivity and participation. There was an 14.9% decrease in the outcomes domain and no change in the access domain there was a 5.59% decrease in the appropriateness domain.


YSS-F Access Domain
AspenPointe (n=109)
Axis Health (n=2)
Centennial (n=40)
Colorado West (n=27)
Midwestern (n=11)
North Range (n=86)
San Luis Valley (n=0)
Southeast (n=7)
Spanish Peaks (n=149)
Touchstone (n=83)
West Central (n=71)
0%
20%
40%
60%
80%
100%


YSS-F Participation Domain
AspenPointe (n=108)
Axis Health (n=2)
Centennial (n=40)
Colorado West (n=26)
Midwestern (n=11)
North Range (n=86)
San Luis Valley (n=0)
Southeast (n=7)
Spanish Peaks (n=150)
Touchstone (n=82)
West Central (n=71)
0%
20%
40%
60%
80%
100%


YSS-F- Cultural Sensitiviy
AspenPointe (n=102)
Axis Health (n=2)
Centennial (n=40)
Colorado West (n=24)
Midwestern (n=9)
North Range (n=76)
San Luis Valley (n=0)
Southeast (n=7)
Spanish Peaks (n=139)
Touchstone (n=81)
West Central (n=69)
0%
20%
40%
60%
80%
100%


YSS-F Appropriateness of Care
AspenPointe (n=110)
Axis Health (n=2)
Centennial (n=39)
Colorado West (n=27)
Midwestern (n=11)
North Range (n=86)
San Luis Valley (n=0)
Southeast (n=7)
Spanish Peaks (n=152)
Touchstone (n=84)
West Central (n=71)
0%
20%
40%
60%
80%
100%


YSS-F - Outcomes Domain
AspenPointe (n=107)
Axis Health (n=2)
Centennial (n=38)
Colorado West (n=27)
Midwestern (n=10)
North Range (n=85)
San Luis Valley (n=0)
Southeast (n=7)
Spanish Peaks (n=150)
Touchstone (n=84)
West Central (n=71)
0%
20%
40%
60%
80%
100%

Overall Evaluation of the Quality Improvement Program

The QI program plan put forth the following 9 goals. A brief statement regarding progress is stated after each, although detailed results for each goal can be found within the body of this report.

1. Monitor all new aspects of the Medicaid contract, including evidence based practices and new core performance measures.

   Status: Met

   NBHP had implemented and continues to monitor a subset of Evidence Based Practices for children and adults. Outcomes on these practices indicate improvements over the previous year but continue to need close monitoring and require deeper inquiry into data collection techniques as well as model fidelity. NBHP continues to participate in the development and implementation of core performance measures for the state of Colorado. These measures are reported on annually as well as analyzed quarterly for trends and to identify areas of improvement.

2. Further integrate consumer and family member involvement with QIUMC efforts.

   Status: Met

   NBHP continues to work with the NBHP OMFA Director to increase participation and input by members and family in all quality initiatives. Additionally, the director of quality has continued to report on performance and outcome measures at member forums and events.

3. Ensure clinical practice standards and contract requirements, as applicable, are met by providers.

   Status Met:

   Clinical Practice Guidelines continue to be updated and available on the BHO website. The ongoing chart audit process is designed to evaluate practice standards as well as contract compliance. Training needs for providers were addressed through the development and implementation of multiple trainings conducted both live and via webinar.

4. Systematically analyze and evaluate outcomes data.

   Status: Met

   During FY 13 data was systematically analyzed from multiple sources including outcomes in Evidence Based Practices, Performance Measures, Satisfaction Surveys, and Performance Improvement Projects and Focused Studies.

5. Evaluate Clinical Performance.

   Status: Met

   NBHP monitors clinical performance through an ongoing chart audit process and its resisting corrective action mechanisms. Additional monitoring occurs though the monitoring of adverse incidents and quality of care concerns.

6. Assure Care Management Department Compliance with Established UM Standards.

   Status: Met

   The performance of the clinical department is reflected in its performance on measures of; initial authorization content audits, initial authorization timeliness audits, concurrent review authorization content audits, concurrent review timeliness audits, average speed of answer, abandonment rate, and an annual inter-rater reliability survey.

7. Continue progress on current Performance Improvement Projects and implement new PIP's/focus studies as needed.

   Status: Met

   NBHP successfully passed both the Focus Study and PIP in FY13. NBHP will participate in HCPF initiative for a Statewide PIP.

8. Ensure compliance with EQRO standards.

   Status: Met

   For the four standards reviewed by HSAG, NBHP earned an overall compliance score of 99 Percent. NBHP earned 100 percent in three of the four standards reviewed (Coordination and Continuity of Care, Member Rights and Protections, and Quality Assessment and Performance Improvement). NBHP's 98 percent score for the Credentialing and Recredentialing Standard related to a missing provision in the delegation agreement between VO and NBHP, which did not impact compliance with NCQA-required processes. NBHP demonstrated strong performance overall and a clear understanding of federal regulations and Medicaid contract requirements. For FY12, NBHP received an overall compliance score of 93% for the four areas surveyed. All corrective action requirements were met.

9. QIUMC will evaluate the FY 2013 work plan and review Quality and Care Management Program Plans.

   Status: Partially Met

   The QIUMC contributed to the FY 2013 work plan. The Quality Program will be provided to the NBHP Board of Directors and the QI/UM committee in October, 2013.

The results of this report indicate that NBHP's Quality Improvement and Utilization Management Departments are meeting the contractual Federal and State requirements and are assisting providers in providing quality services to Medicaid members. The QIUM committee structure is such that input on quality performance and initiatives, and clinical measures and outcomes is monitored and modified using input from a variety of stakeholders. Of particular importance in this process is the member and family perspective, blended with input from clinical, quality, and utilization experts as well as providers. Member and family input continue to be valuable in defining the Quality Management Program and ensuring the member/family perspective is the basis for the Program. NBHP believes that input from these diverse sources is vital to the development of projects, improvements initiatives, and interventions that have the highest level of impact and are most likely to succeed.

As outlined in the "highlights" section of this report, NBHP has continued success in several areas of performance. Among these areas is the continued blending of Quality and OMFA departments within NBHP. NBHP's quality improvement personnel continued work with the Director of Member and Family Affairs and its provider centers to present quality improvement data at community/public forums. During fiscal year 2012-2013, the NBHP Director of Quality Improvement presented at and obtained feedback from individuals attending the community/public forums throughout the NBHP service area. We continue to enjoy high levels of member involvement and our QIUM committee and during this fiscal year the process for recruiting and ensuring proper representation from this group has been streamlines.

Also of great importance in the NBHP quality efforts is the burgeoning relationship between the local RCCO and the BHO. There are several initiatives underway in this arena including the use of a new "hot spotter" model for high utilizers as well as the implementation of a monthly data sharing meeting. Additional important improvements include; the implementation of a unified MHC/BHO cultural competency plan, continued high ratings on measures of access, performance, and satisfaction, continued efforts toward training and monitoring our provider network to ensure high quality clinical care, and ongoing improvements in statewide coordination of care efforts through the ongoing Systems Integration initiatives.

Although NBHP performs well on most measures there continues to be areas that warrant improvement. Although outcome data on Evidence Based Practices is much improved over the last reporting period, there continues to be a need for close monitoring and continued efforts toward refining data collection and ensuring fidelity. Additionally, rates of inpatient utilization among adolescents continue to warrant scrutiny. Emergency Department (ED) use is also a focus for NBHP. FY 13 focused on an analysis of the data on ED. Please See Attachment A. All levels of NBHP and its provider organizations are involved in the initiative to reduce ED visits.

Overall Evaluation of the Utilization Management Program

The NBHP UM program is led by the Medical Director and Service Center Vice President. The Director of Service and System Integration, Clinical Peer Advisor and Clinical Director complement the leadership team, insuring that both internal and external management issues are addressed efficiently and effectively.

The most important asset in the NBHP UM program is the supporting clinical team. During FY13, the NBHP Service Center created two new positions to increase oversight of clinical services and improve the team's functioning. An experienced care manager was promoted to the Clinical Team Lead position, whose focus is now on Clinical Care Manager training, problem resolution and process improvement. Additionally, a Clinical Support Team Lead position was added and an experienced Clinical Service Assistant was promoted to focus on Clinical Service Assistant training, problem resolution and performance improvement. The Clinical Service Assistants continue to be a vital part of the UM program, allowing the Clinical Care Managers to focus less on administrative details and more on the UM decision making which requires their clinical expertise and skills. The Clinical team consists of 1 Clinical Director, 1 Clinical Team Lead, 1 Clinical Support Team Lead, of 5 FTE clinicians and 2.5 Clinical Service Assistants. The Care Management staff is directly supervised by a Clinical Director who monitors the productivity and quality care of the team. The success of the UM program is largely attribute to this well-seasoned staff who have been a stable team over the years. Stability of the team, a focus on continuous process improvement as well as stable relationships with providers insured productive and efficient UM services.

Highlights from FY 2013 include:

- Continuation of weekly clinical Rounds for discussion of complex cases;
- All UM staff passed the annual inter-rater reliability test;
- Successfully completed UM portion of the 2013 EQRO audit and URAC audit, earning a 3-year accreditation decision from URAC;
- Call responsiveness stats have been outstanding; less than 1% abandonment rate and average speed of answer is about 5 seconds;
- Care management staff have participated in a significant amount of continuing education related to DSM5, substance use issues, medication side effects, interpreting lab results, etc.
- Greater than 99% compliance on meeting Notice of Action standards for Medicaid and URAC
- Annual review of all clinical policies and procedures
- Annual review of all Clinical Guidelines
- 100% compliance with all state required UM reporting (e.g., CMHTA report)

Overall, the NBHP UM program has been successful and effective. The committee structure described in the QM sections above has also been working well for the ongoing operations of the utilization management program. The Clinical Advisory and QI/UM committees and the Quality of Care Committee (QOCC) have practitioner involvement and input that guarantees practical utilization management solutions for the BHO.

Appendix A

NBHP Quality/Utilization Management Committees

NBHP QM/UM Committee and Subcommittees

Ultimate authority for NBHP's Quality Management and Utilization Management Program rests with the Board of Members and Managers. The Quality Improvement-Utilization Management Committee (QIUMC) works on technical details and reports to the Board findings and recommendations. The Committee consists of the NBHP Director of Quality Improvement, the ValueOptions VP of Quality Management, the ValueOptions Director of Systems Integration, the ValueOptions Clinical Peer Advisor, the NBHP Director of Member and Family Affairs, the Deputy Directors of the three Provider Centers, and other NBHP and Provider Center staff as appropriate. In the course of these meetings, trends are analyzed, deficiencies and barriers to improvement are identified, and solutions are proposed. Interventions are monitored for effectiveness. The QIUMC reviews utilization management issues and indicators including monitoring and evaluating implementation of clinical guidelines, clinical criteria, and protocols. Under and over-utilization issues are also monitored through the committee. The QIUMC annually reviews and approves the Program Description and Work Plan to focus on areas in need of improvement and to ensure that there is continuous overall quality improvement. Lastly, the QIUMC addresses a variety of clinical and administrative issues including clinical treatment guidelines, utilization management guidelines, performance measurement and improvement activities, cross agency integration, and access issues.

QI/UM Subcommittees:

1. *Cultural Competency Committee- outlined*

   The Cultural Competency Committee has partnered with its MHC providers to:

   - Develop outreach and education programs targeting specific cultural groups.
   - Educate providers, staff, and other stakeholders about the unique challenges people face when trying to access services.
   - Help staff/providers identify their own cultural biases and addressing those biases.
   - Provide resources for staff, members, and professionals relevant to cultural competency.

2. *Clinical Advisory Committee*

   The Clinical Advisory Committee has partnered with its MHC providers to:

   - Review the methodology of Performance Improvement Projects and Focus Studies
   - Provide oversight of the measurement of Evidence Base Practices across MHC's.
   - Approve Clinical Practice Guidelines.
   - Approve Level of Care Guidelines.
   - Evaluate new clinical technologies and practices as needed.

NBHP's quality improvement program has a strong history of process improvement because of the proactive involvement of stakeholders. The NBHP QIMC (Quality Improvement Member Committee is comprised of all individuals in the QIUMC as well as Members/Family Members that represent a variety of cultural/ethnic groups, and geographic regions. QIMC meets monthly to monitor and evaluate the quality and appropriateness of care, pursue opportunities to improve care, and resolve problems. The following is the composition of the FY 2012-2013 QIUMC:

Representatives from the MHCs:

- Centennial Mental Health Center – Two (2)
- Touchstone Health Partners – Three (3)
- North Range Behavioral Health – Four (4)
- Consumer Representatives – Five (5)
    - Consumers meet with the entire QIUM committee bi-monthly. On opposite months they meet without the larger group in order to go over quality indicators in greater detail.

NBHP and ValueOptions Staff:

- VP of Quality Management
- NBHP Director of Quality Improvement
- Director of Systems Integration
- Director of Utilization Management
- NBHP Director of the Office of Member and Family Affairs
- Compliance Coordinator
- Medical Director

Following approval by the QIUMC and the NBHP Board, the QM/UM Program Description, Work Plan, and Annual Evaluation are submitted to *ValueOptions®'* National Quality Council for review and input. Following the National Quality Council review, *ValueOptions®'* Executive Quality Council reviews these documents.

To assist in the implementation of the goals of the QM/UM Program, NBHP has established other committees to work with the QIUMC and the NBHP Board. These committees were established to ensure that NBHP meets consumer, family member, clinical community, and provider relations needs. The collective input from these committees is shared through the quality structure by cross representation on the committees.

Consumer Advisory Council

The Consumer Advisory Council meets at least quarterly and is structured to develop, promote, and support consumer driven services. The primary purpose of the Consumer Advisory Council is to collaborate with the partnership to design a successful recovery program that incorporates the values that define the group's vision. The Consumer Advisory Council is chaired by the Director of Member and Family Affairs.

Local Credentialing Committee

The Local Credentialing Committee is chaired by Dr. Leslie Moldauer and is comprised of providers representing the full range of disciplines, subspecialties, and areas of practice within

the state. The Local Credentialing Committee meets monthly and provides input to the National Credentialing Committee regarding statewide practitioners' credentialing and recredentialing decisions. Local Credentialing Committee minutes are distributed to the NBHP Quality Committees for review.

Quality of Care Committee

The Quality of Care Committee (QOCC) is a sub-committee of the Local Credentialing Committee that meets at least quarterly. The QOCC is chaired by NBHP's Medical Director and is comprised of the VO Colorado VP of Quality Management, the VO Colorado Provider Relations Director, the VO Colorado Clinical Peer Advisor, the NBHP QM Director and representatives from other BHOs who are contracted with ValueOptions for management of the provider network. The purpose of this committee is to identify, investigate, monitor, and resolve quality of care issues and patterns of poor quality within our system. Activities include a review of quality of care issues reported, results of any investigations and recommendations for the disposition and follow-up of those issues.

Office of Member & Family Affairs

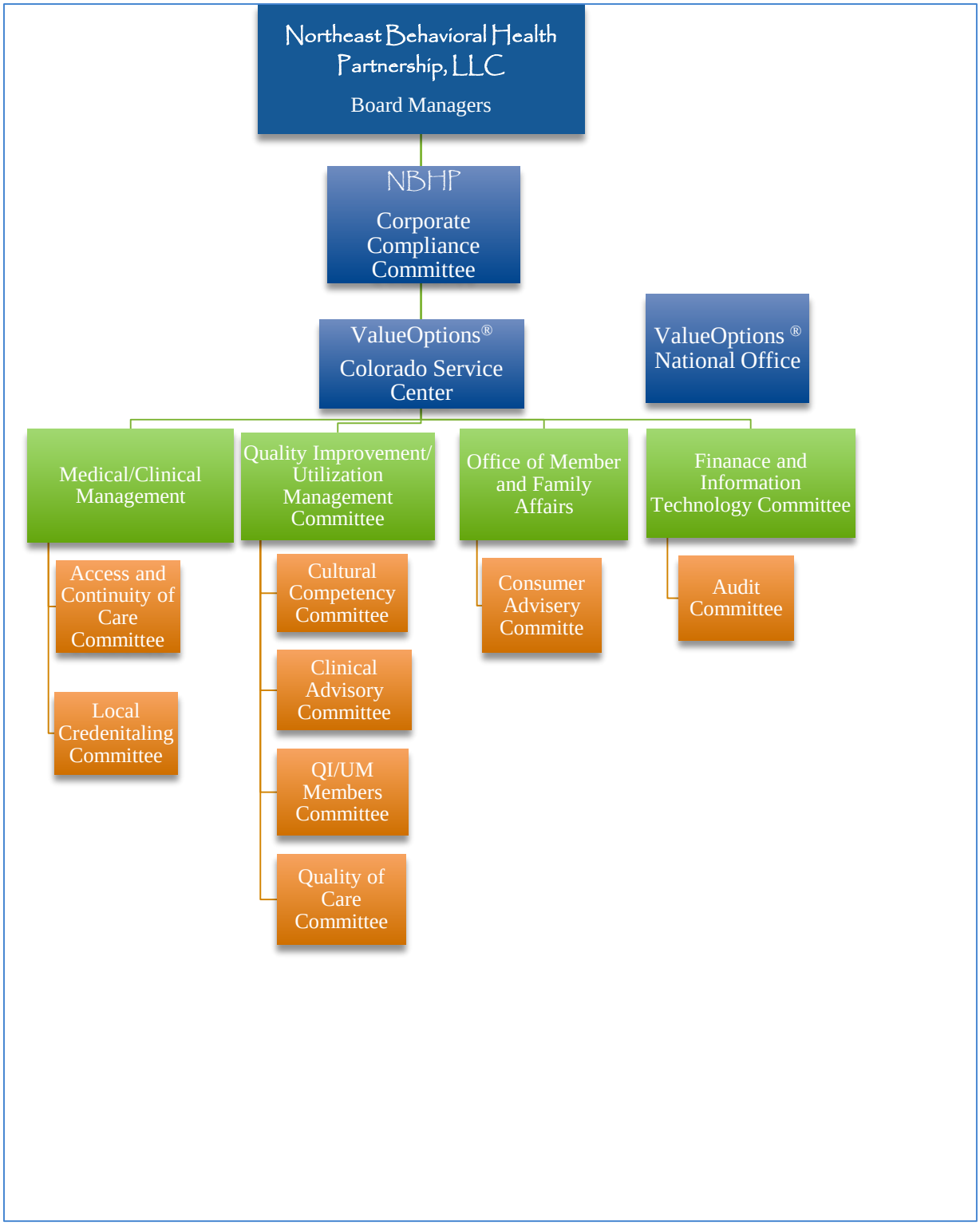
Office of Member and Family Affairs (OMFA) is made up of advocates, members, and family members in the NBHP service area who are committed to providing recovery- oriented services to our membership. The OMFA provides input into Quality Improvement committees, and where appropriate, clinical committees from a consumer/family perspective. The OMFA meets quarterly and is responsible for the following functions:

- Upholding consumer and family rights through advocacy; helping members and families understand their rights and access their benefits.
- Providing education and training to professionals about recovery-oriented practices and philosophies; reviewing clinical and level of care guidelines to ensure recovery and resiliency principles and language are incorporated.
- Providing input into the development of member handbooks, newsletters and other marketing materials.
- Reviewing the member complaints and grievances process.
- Reviewing member materials for content and readability.
- Reviewing policies and procedures which impact client care (e.g., members' rights policy and procedure).
- Providing input into issues raised in member, provider, and client satisfaction surveys.
- Suggesting topics for member and professional education and training on timely concerns pertinent to the member community (i.e., prevention and wellness).

An organizational chart describing the above mentioned committees follows this document in the appendices.

Appendix B

NBHP Quality/Utilization Management Organizational Chart



Area of focus: Reduce NBHP utilization rate for ED.

NBHP's utilization rate for emergency department had increased from 5.40 per 1,000 in FY11 to 10.23 per 1,000 in FY12, an 89.4% increase. In terms of actual ED visits, this increase in utilization rate accounted for 415 more visits to the ED between the two years.

	Total Population			
FY2011/2012	**BHO**	**Denominator**	**Numerator**	**Utilization Rate**
	BHI	150,753	1500	9.95
	FBHP	71,795	695	9.68
	NBHP	***78,712***	***805***	***10.23***
	ABC	105,206	1182	11.24
	CHN	212,776	2,165	10.18
	Weighted Ave	*619,242*	*6347*	10.25
FY2010/2011	**BHO**	**Denominator**	**Numerator**	**Utilization Rate**
	BHI	136,497	907	6.64
	FBHP	64,972	409	6.30
	NBHP	***72,262***	***390***	***5.40***
	ABC	97,978	779	7.95
	CHN	195,699	1,961	10.02
	Weighted Ave	*567,408*	*4446*	7.84

The following table shows detailed ED visit increases by age group between FY11 and FY12.

Age Group	FY 2011 Distinct Members	FY 2012 Distinct Members	% Increase
0-12	27	64	137%
13-17	71	163	130%
18-64	262	457	74%

The largest increases by age group were in the "0-12" and "13-17" age groups; however, the increase for the "18-64" age group was still a significant increase.

The next table details the number of members and the total count of ED visits for each FY 2011 and FY 2012. The table is categorized by members who had 1 ED visit, 2 ED visits, and 3+ ED visits. Percentage increases are included and highlighted in yellow. The AND-SSI Medicaid benefit package analysis is included in the table as well. There will be further discussion of the AND-SSI benefit package starting on page 6 of this document.

FY COMPARISON	FY 11 ALL MEMBERS	FY 12 ALL MEMBERS	ALL MEMBERS % INCREASE	FY 11 AND MEDICAID	FY 12 AND MEDICAID	BENEFIT M925 % INCREASE
Distinct count of members with an ED visit	360	684	90.0%	92	165	79.3%
Total number of services	418	869	107.9%	116	255	119.8%
Count of members with only 1 ED visit	319	571	79.0%	76	122	60.5%
Total number of services	319	571	79.0%	76	122	60.5%
Count of members with 2 ED visits	28	70	150.0%	12	19	58.3%
Total number of services	56	140	150.0%	24	38	58.3%
Count of members with 3+ ED visits	13	42	223.1%	4	25	525.0%
Total number of services	43	158	267.4%	16	95	493.8%

The next table demonstrates the above information broken out by CMHC.

	FY 2011	FY 2012		FY 2011	FY 2012	
CENTENNIAL	ALL MEMBERS	ALL MEMBERS	% Increase All	BENEFIT AND	BENEFIT AND	% Increase AND
Distinct count of members with an ED visit	47	86	83.0%	6	22	266.7%
Total number of services	49	101	106.1%	6	28	366.7%
Count of members with only 1 ED visit	46	78	69.6%	6	20	233.3%
Total number of services	46	78	69.6%	6	20	233.3%
Count of members with 2 ED visits	0	3	-	0	0	-
Total number of services	0	6	-	0	0	-
Count of members with 3+ ED visits	1	5	400.0%	0	2	-
Total number of services	3	17	466.7%	0	8	-
	FY 2011	FY 2012		FY 2011	FY 2012	
NORTH RANGE	ALL MEMBERS	ALL MEMBERS	% Increase All	BENEFIT AND	BENEFIT AND	% Increase AND
Distinct count of members with an ED visit	191	336	75.9%	50	54	8.0%
Total number of services	220	435	97.7%	61	80	31.1%
Count of members with only 1 ED visit	168	277	64.9%	41	38	-7.3%
Total number of services	168	277	64.9%	41	38	-7.3%
Count of members with 2 ED visits	17	40	135.3%	7	7	0.0%
Total number of services	34	80	135.3%	14	14	0.0%
Count of members with 3+ ED visits	6	19	216.7%	2	9	350.0%
Total number of services	18	78	333.3%	6	28	366.7%
	FY 2011	FY 2012		FY 2011	FY 2012	
TOUCHSTONE	ALL MEMBERS	ALL MEMBERS	% Increase All	BENEFIT AND	BENEFIT AND	% Increase AND
Distinct count of members with an ED visit	122	262	114.8%	36	89	147.2%
Total number of services	149	333	123.5%	49	147	200.0%
Count of members with only 1 ED visit	105	216	105.7%	29	64	120.7%
Total number of services	105	216	105.7%	29	64	120.7%
Count of members with 2 ED visits	11	27	145.5%	5	12	140.0%
Total number of services	22	54	145.5%	10	24	140.0%
Count of members with 3+ ED visits	6	19	216.7%	2	13	550.0%
Total number of services	22	63	186.4%	10	59	490.0%

Data Sources and Analysis: NBHP claims and encounter data; Colorado Department of Healthcare Policy and Financing (HCPF) report of ED utilizers with 3+ visits; Community Mental Health Centers (CMHC) review of medical records.

Findings:

Aggregate Data by Age Category

The following table represents the Medicaid members who met the criteria for a high utilizer of ED services. Each age group has detailed information regarding a specific Medicaid member. The table includes where the member is capitated, where the member receives services, member age, FY12 and FY13 ED visits, and physical health ED visits.

In the behavioral health ED visit section, there are columns for episode 1, episode 2, etc. An episode starts when a Medicaid member goes into the ED for any service within FY12. The original date of ED service counts as time one and that visit to the ED is counted, as well as any following visits within that 30 day time frame. Each episode is not necessarily consecutive such as 30, 60, 90 days. A second episode starts at the first date of service outside of the original 30 day time frame.

Table 1: High ED Utilizers

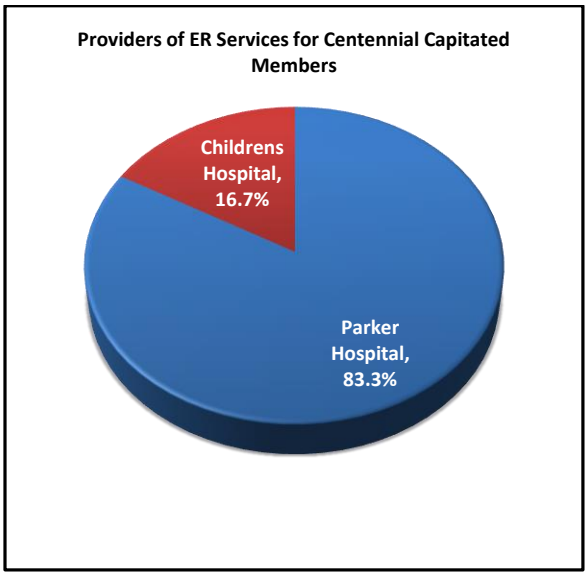
Members Ages 0-12													
Member Number	Capitation by CMHC	Served by CMHC	Member Age	3+ ER Visits	Behavioral Health ED Visits							Physical Health
					FY12	FY13	Episode 1	Episode 2	Episode 3	Episode 4	Episode 5	ED Visits
1	NRBH	**NRBH**	12	Yes	5	1	2	1	2	-	-	-
2	NRBH	**NRBH**	11	Yes	6	4	3	1	1	1	-	-
3	THP	**THP**	10	Yes	3	1	1	2	-	-	-	-
4	THP	**THP/NRBH**	10	Yes	3	1	1	2	-	-	-	-
5	THP	**THP**	9	Yes	3	-	1	2	-	-	-	-
6	THP	**THP/NRBH**	12	Yes	3	-	2	1	-	-	-	-
Members Ages 13-17												
Member Number	Capitation by CMHC	Served by CMHC	Member Age	3+ ER Visits	Behavioral Health ED Visits							Physical Health
					FY12	FY13	Episode 1	Episode 2	Episode 3	Episode 4	Episode 5	ED Visits
7	CMHC	**CMHC/NRBH**	15	Yes	3	-	1	1	1	-	-	-
8	CMHC	**CMHC**	14	Yes	3	-	1	2	-	-	-	-
9	NRBH	**NRBH**	17	Yes	3	-	2	1	-	-	-	-
10	NRBH	**NRBH**	17	Yes	3	1	1	2	-	-	-	-
11	NRBH	**NRBH**	15	Yes	4	-	3	1	-	-	-	-
12	NRBH	**NRBH**	15	Yes	3	-	1	1	1	-	-	-
13	NRBH	**NRBH**	16	Yes	6	3	2	1	2	1	-	-
14	NRBH	THP	17	Yes	3	-	1	1	1	-	-	-
15	THP	**THP**	15	Yes	3	2	1	1	1	-	-	-
16	THP	**THP**	16	Yes	3	2	1	1	1	-	-	-
17	THP	**THP**	13	Yes	3	-	3	-	-	-	-	-
Members Ages 18-64												
Member Number	Capitation by CMHC	Served by CMHC	Member Age	3+ ER Visits	Behavioral Health ED Visits							Physical Health
					FY12	FY13	Episode 1	Episode 2	Episode 3	Episode 4	Episode 5	ED Visits
18	CMHC	No	28	Yes	4	1	1	1	2	-	-	-
19	CMHC	NRBH	31	Yes	5	-	3	2	-	-	-	-
20	CMHC	**CMHC**	19	Yes	3	-	2	1	-	-	-	10
21	NRBH	**NRBH**	41	Yes	3	1	1	1	1	-	-	-
22	NRBH	**NRBH**	28	Yes	3	-	1	1	1	-	-	3
23	NRBH	**NRBH**	25	Yes	6	-	2	3	1	-	-	-
24	NRBH	**NRBH**	33	Yes	5	3	2	2	1	-	-	-
25	NRBH	**NRBH**	28	Yes	3	2	3	-	-	-	-	-
26	NRBH	**NRBH**	22	Yes	3	-	1	1	1	-	-	-
27	NRBH	**NRBH**	18	Yes	3	-	3	-	-	-	-	-
28	NRBH	**NRBH**	41	Yes	9	6	3	1	2	2	1	-
29	NRBH	**NRBH**	45	Yes	3	-	1	1	1	-	-	-
30	NRBH	**NRBH**	20	Yes	5	2	1	1	2	1	-	-
31	NRBH	**NRBH**	22	Yes	4	2	1	1	2	-	-	-
32	THP	**THP**	33	Yes	5	-	3	2	-	-	-	-
33	THP	**THP/NRBH**	28	Yes	3	2	2	1	-	-	-	-
34	THP	**THP**	53	Yes	3	-	1	2	-	-	-	-
35	THP	**THP/NRBH ATU**	38	Yes	4	-	3	1	-	-	-	-
36	THP	**THP/NRBH ATU**	31	Yes	3	-	2	1	-	-	-	-
37	THP	**THP**	48	Yes	6	12	3	2	1	-	-	-
38	THP	**THP**	20	Yes	3	2	3	-	-	-	-	-
39	THP	NRBH	29	Yes	3	-	2	1	-	-	-	-
40	THP	No	51	Yes	3	-	3	-	-	-	-	-
41	THP	**THP**	28	Yes	3	-	2	1	-	-	-	3
42	THP	**THP/NRBH**	46	Yes	3	-	1	2	-	-	-	58

Yellow shade = Members who have AND benefit package. Dark blue shade = Difference between capitation and rendering provider. Light green shade = Physical Health ED data.

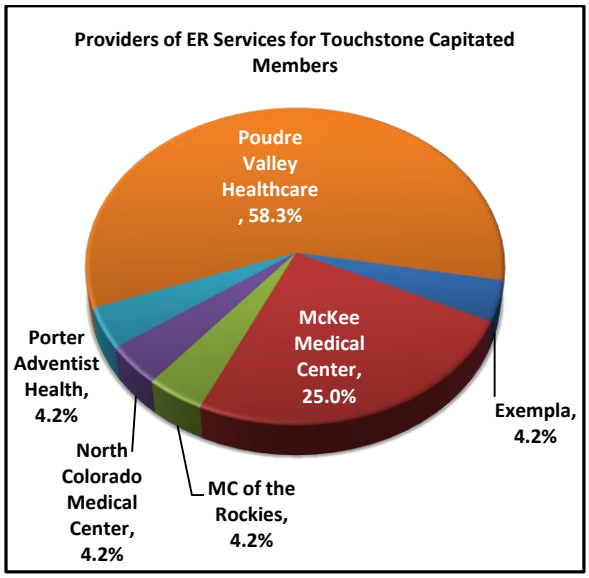
The following graphs demonstrate which hospitals high utilizers of ED services used during FY12. The HEDIS age groups 0-12 and 13-17 were combined for this report into member age

group 0-17. Each graph represents services by capitation, not unique members. Unique member information can be found below each graph. Some members were capitated to more than one mental health center throughout the fiscal year.

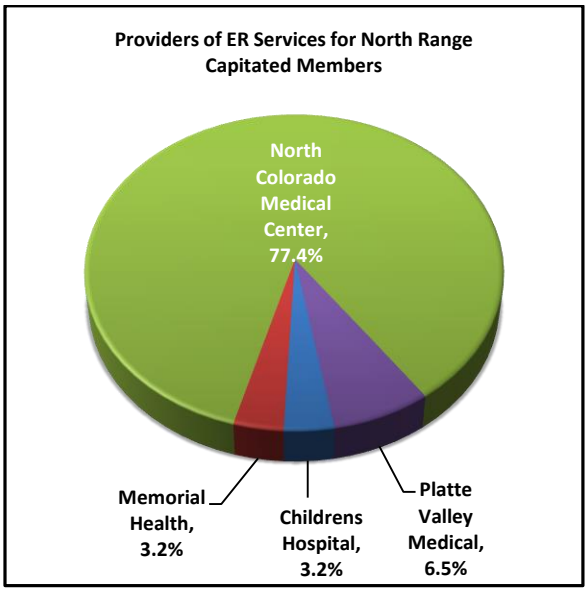
Member Age Group 0-17



Total members = 2; Total ED Services = 6

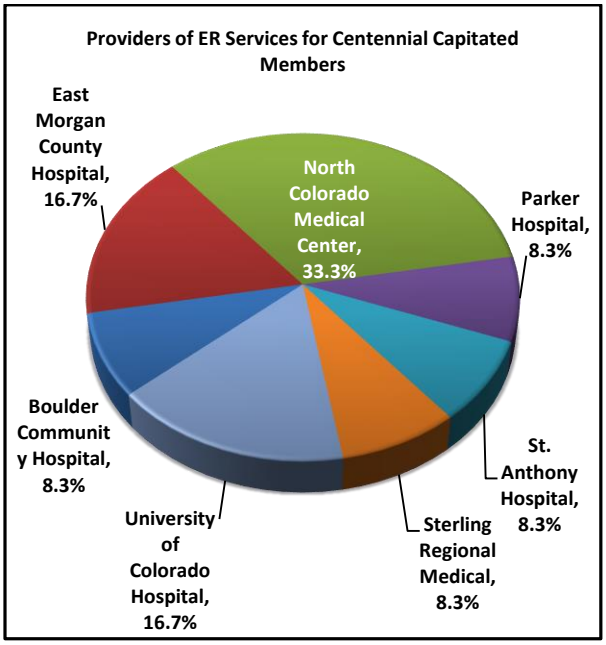


Total Members = 7; Total ED Services = 21

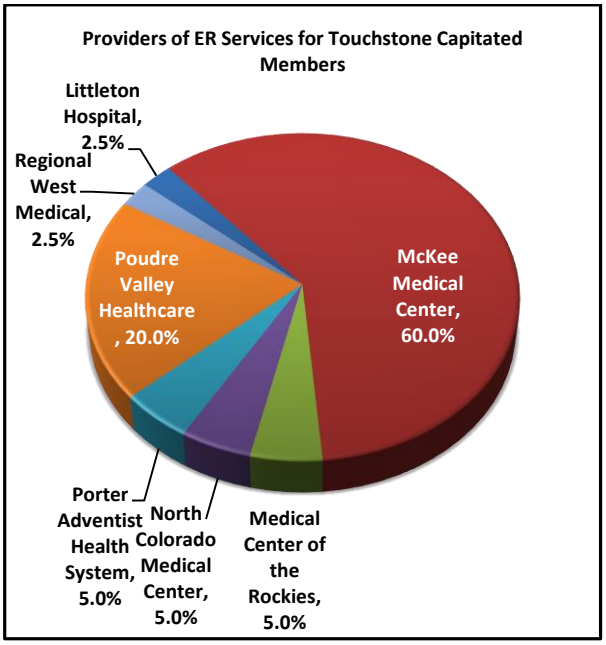


Total Members = 5; Total ED Services = 25

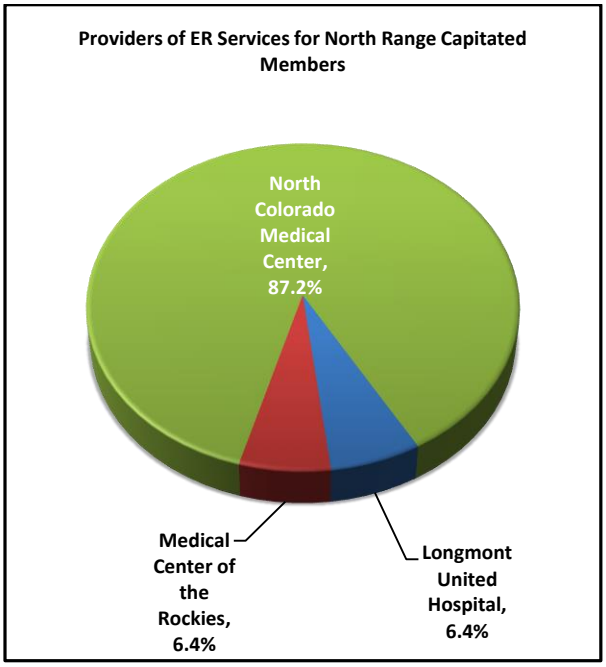
Member Age Group 18-64



Total Members = 3; Total ED Visits = 12



Total Members = 12; Total ED Visits = 43

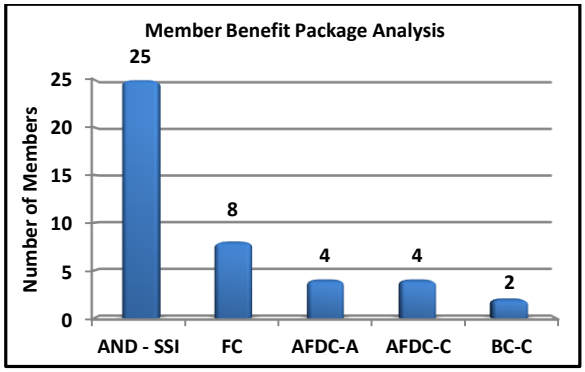


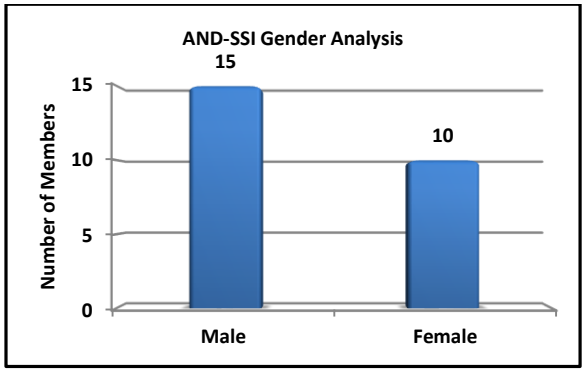
Total Members = 13; Total ED Services = 53

The next table demonstrates percentage increase from FY11 to FY12 for providers of ED services. The table includes paid claims data only. Any provider with greater than a 50% increase was highlighted in green.

Provider of ED Service	FY11 Count of ED Service	FY12 Count of ED Service	Percentage Increase
Avista Hospital	1	-	-
Billings Clinic	-	1	-
Boulder Community Hospital	3	3	0.0%
Centennial Healthcare Plaza	2	-	-
Cheyenne Regional Medical Center	-	1	-
Childrens Hospital Colorado	18	12	-33.3%
Colorado Plains	-	19	-
Denver Health and Hospital	4	3	-25.0%
East Morgan County Hospital	2	9	350.0%
Estes Park Medical Center	-	2	-
Exempla Behavioral Health	-	2	-
Exempla Good Samaritan	-	3	-
Exempla St. Joseph	-	1	-
Hays Medical Center	-	1	-
HCA Healthone	4	4	0.0%
Kit Carson County Health	1	6	500.0%
Las Colinas Medical	-	1	-
Littleton Hospital	2	3	50.0%
Longmont United Hospital	30	22	-26.7%
Lower Valley Hospital	1	-	-
McKee Medical Center	28	117	317.9%
Medical Center of the Rockies	27	52	92.6%
Melissa Memorial Hospital	8	-	-
Memorial Health System	2	8	300.0%
North Colorado Medical Center	171	367	114.6%
North Suburban MC - Columbia	6	8	33.3%
Parker Hospital	8	12	50.0%
Parkview Medical Center	3	-	-
Penrose St. Francis	2	1	-50.0%
Platte Valley Medical Center	2	4	100.0%
Porter Adventist Health System	-	4	-
Poudre Valley Healthcare Inc	82	172	109.8%
St. Lukes Medical Center	2	1	-50.0%
Regional West Medical Center	-	1	-
Rose Medical Center	1	-	-
San Juan Regional Center	-	1	-
Sedgwick County Hospital	1	2	100.0%
Southwest Memorial Hospital	-	1	-
St. Anthony Hospital	9	2	-77.8%
Sterling Regional Medical Center	13	16	23.1%
Swedish Medical Center	-	2	-
University of Colorado Hospital	1	6	500.0%
Valley View Hospital	1	-	-
Wray Community Hospital	-	1	-
Wythe County Community Hospital	1	-	-
Hospitals with > 50% increase were highlighted.			

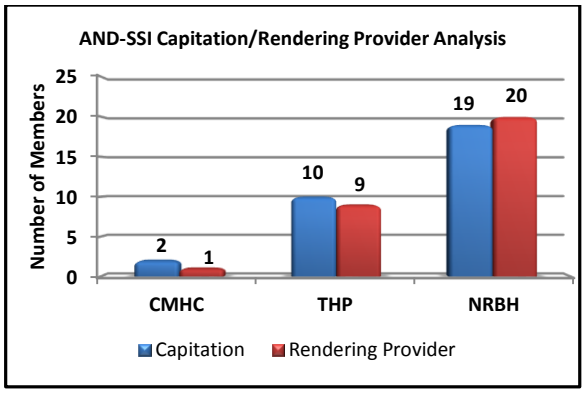
After analyzing Table 1 (located on page 58) Medicaid benefits packages for each of the 42 high utilizers was analyzed. There are a total of 25 members or 59.5% who have Aid to Needy and Disabled SSI (AND-SSI) benefits packages. Being AND-SSI seemed to be a common feature among these high utilizers of ED services, further analysis was conducted on these 25 Medicaid members. The following graphs demonstrate the areas of analysis.

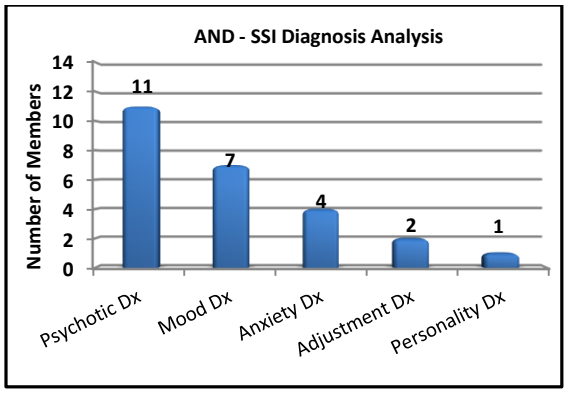




*One member had benefits under 2 categories during FY12.
**Axis Key:

AND-SSI	Aid to Needy and Disabled - SSI
FC	Foster Care
AFDC-A	Aid to Families with Dependent Children - Adults
AFDC-C	Aid to Families with Dependent Children - Children
BC-C	Baby Care – Children





*Some members have more than one rendering provider and/or capitated provider.

*Only Member age group 18-64 was analyzed. Some Members had more than one diagnosis. Total Members = 19.

The largest diagnostic category for members with AND-SSI is Psychotic Disorders. A full break down of the diagnosis and their categories is shown in the table below:

Row Labels	Count of Diagnosis
Adjustment Disorders	2
309.00	1
309.40	1
Anxiety and Stress Disorders	4
300.00	1
300.02	1
309.81	2
Mood Disorders	7
296.30	1
296.32	1
296.33	1
296.34	1
296.89	1
296.90	1
311.00	1
Personality Disorders	1
301.83	1
Schizophrenia/Psychotic Disorders	11
295.30	3
295.70	6
295.90	1
298.90	1
Grand Total	25

Note this is not an active pivot table.

Note: Diagnoses are based on mental health center encounter data not ED claims data.

AND-SSI Age Analysis

- The age range for a male was between 10 and 54 years of age.
- The age range for a female was between 21 and 52 years of age.
- The mean age for a male was 24.8 and 35.3 for females.
- The median age for a male was 23 and 33 for females.

Opportunities for improvement:

1. Decrease ED rate for AND with 3+ visits
2. Increase access to appropriate MH services

Actions:

1. AND category targeted first
2. Contact EDs at each MHC
3. The goal is to send each mental health center a full service profile of three AND-SSI members per center. For this project, the member must still be receiving services or had an ED visit in FY13. In order for a full service profile to be sent to the mental health center, the member must be served by the center to which they are capitated.
    a. Centennial Mental Health Center - was sent a full service profile for two members. Centennial only had one AND-SSI member and they were sent the profile of one other member who met the above criteria.
    b. North Range Behavioral Health - was sent a full service profile for three AND-SSI members.
    c. Touchstone Health Partners - was sent a full service profile for two AND-SSI members and another member who had a different benefit package. The member that was not AND-SSI was selected due to a 100% increase in ED services from FY12 to FY13.
4. Look at clinical profile

Final Assessment:

1. A monthly report will be sent to each mental health center with a list of members who had ED services. This report will be completed with a three month lag and will be cumulative for the Fiscal Year. Analyst will highlight duplicates as they occur.
2. The mental health centers will discuss their findings and interventions at monthly QI/UM Committee meetings.
3. The ED measure will continue to be monitored on a quarterly basis with the quarterly performance measure report.