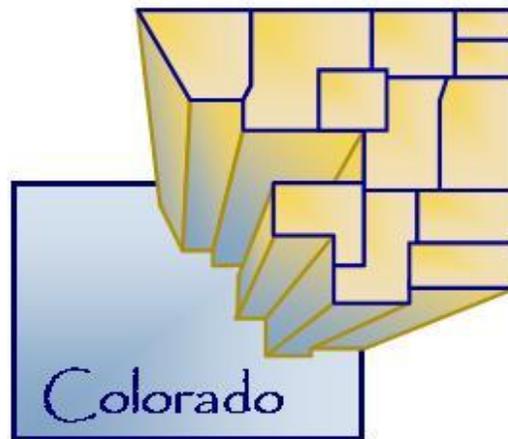


# Northeast Behavioral Health Partnership, LLC



## Annual Quality Report

Fiscal Year 2013-2014

## *Executive Summary*

Northeast Behavioral Health Partnership (NBHP) has a comprehensive Quality Assessment, Outcomes, and Performance Improvement Committee (QAOPI) program designed to ensure the highest quality services to its members and stakeholders. The NBHP QAOPI 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 2013-2014 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 2013-2014*

**Member Involvement:** NBHP's Quality Improvement and Utilization Management Committee continues to have a strong member presence. There were nine members on the committee during FY14.

**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 to all staff having contact with members, including both clinical and administrative staff. The e-mails provide specific tips for clinicians on working with a diverse population as well as general information about communication and cultural issues for all staff, which provide specific tips for clinicians in working with a diverse population. Additionally, NBHP has partnered with its MHCs 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 the Colorado Office of Behavioral Health's Mental Health Statistics Improvement Program (MHSIP) satisfaction survey. The Appropriateness of Care Domain scored 92.15% staff being culturally sensitive. The Fact Finders reports also shows the same high level of satisfaction related to cultural issues, 94.3% believe their counselor can meet their cultural needs. NBHP counties have a large population of refugees from other countries. Providers seek necessary training enabling them 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 to work with the Director of Member and Family Affairs and its provider centers to present quality improvement data at community/public forums. 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 maintained an average of 97.7% compliance with Access to Care standards for FY14. NBHP had some problems with outliers as member enrollment increased throughout the fiscal year, but always maintained compliance with the Access to Care standards.

**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 average score across all performance indicators was 1.94 which was the best score when compared to the other BHOs.

**Satisfaction Surveys:** NBHP's quality improvement personnel reviewed and presented satisfaction survey results from the Fact Finders' and MHSIP/YSS-F reports. . The Fact Finders' report typically has an N of 200, but CY 2013 only had an N of 160. The lower N makes comparing the data to previous years' results more difficult.

**Performance Improvement Project:** NBHP continued the performance improvement project to see if certain interventions would increase the penetration rate for Medicaid members 65 years or older. The baseline penetration rate reported for FY12 was 5.93%. For the remeasurement period 1 (FY13), NBHP was able to increase the penetration rate to 6.83%. The p-value was 0.0659.

## 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 2013-2014, NBHP providers offered an initial appointment within seven business days for **97.8%** of the **5371** requests for routine services. This rate is 2% lower than FY13, where NBHP providers were in compliance over **99.20%** of the time for **4577** requests for routine services; however, NBHP provided 17.3% more initial requests for routine services than during FY13.

**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 **13** requests for urgent services. This is comparable to the previous fiscal year's results. NBHP was also in compliance **100%** of the time for the emergency phone contact standard and provided 1260 emergency phone contacts throughout the fiscal year. 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 1070 in fiscal year 2012-2013 to 1260 in fiscal year 2013-2014. NBHP provided 989 Emergency Face-2-Face evaluations during FY14, which was an increase from FY13's 908 emergency evaluations. 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 apprised 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				
2013-2014	Q1 July-Sep	Q2 Oct-Dec	Q3 Jan-Mar	Q4 Apr-Jun
<b>Initial Authorization</b>	100%	100%	100%	100%
<b>Content Audits</b>				
<b>Initial Authorization</b>	100%	100%	100%	100%
<b>Timeliness Audits</b>				
<b>Concurrent Review Authorization</b>	100%	92%	100%	100%
<b>Content Audits</b>				
<b>Concurrent Review</b>	90.3%	96%	100%	100%
<b>Timeliness Audits</b>				
<b>Average Speed of Answer in Seconds</b>	7.6	6	7.3	5.33
<b>Abandonment Rate (over 30 seconds)</b>	0.52%	0.30%	0.46%	0.63%
<b>Annual Inter-rater reliability survey</b>	NA	77%	NA	NA

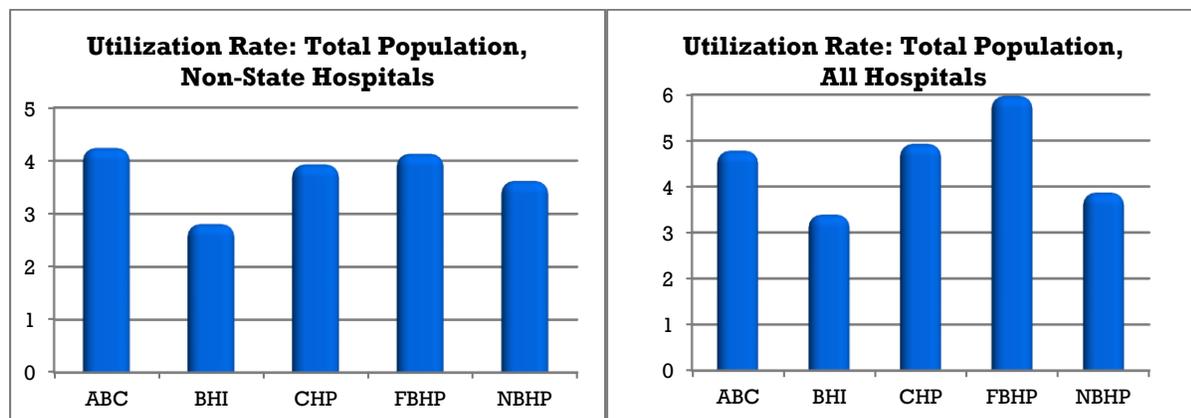
## *Performance Indicators*

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 2013-2014 fiscal year, the data represents activities conducted during fiscal year 2012-2013. 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.

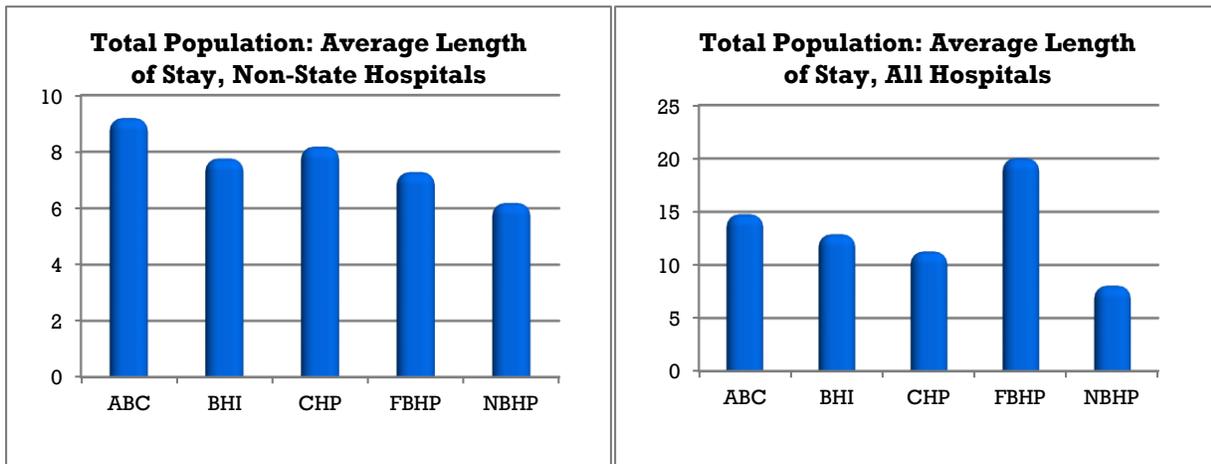


The graphs above present the overall rates for hospital admissions (all age groups) and provide comparisons between all behavioral health organizations. The statewide means for this indicator (as calculated by HCPF) for non-State hospitals is 3.69 and for all hospitals is 4.51. **For non-State hospitals NBHP’s rate of 3.62 is below the respective statewide mean and for all hospitals NBHP’s rate of 3.87 is below the statewide mean.** This is a substantial change for NBHP. For several fiscal years, NBHP’s rates have always been higher than the State average, especially for Non-State Hospital rates. For FY12 NBHP’s rates were 4.09 (Non-State Hospitals) and 4.33 (All Hospitals). The decreases between the two years are primarily accounted for in the adolescent and adult age categories. Adolescent rates decreased from 15.84 (Non-State) and 17.31 (All Hospital) **for FY12 to 14.32 (Non-State) and 15.50 (All Hospital) for FY13.**

## 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.

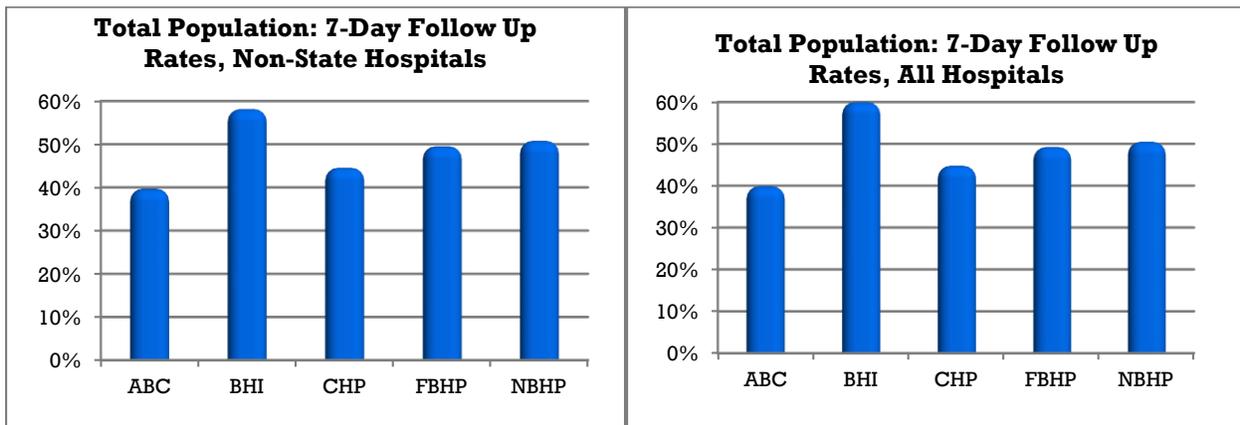


The data in graphs above presents the overall rates for hospital length of stay (all age groups) and provides comparisons between all behavioral health organizations. The statewide means for this indicator (as calculated by HCPF) for non-State hospitals is 7.93 and for all hospitals is 13.20. **NBHP's overall rates were below the statewide mean.** NBHP's overall means for this indicator were 6.19 days (non-State hospital) and 8.06 (all hospitals).

### Follow up Post Hospital Discharge

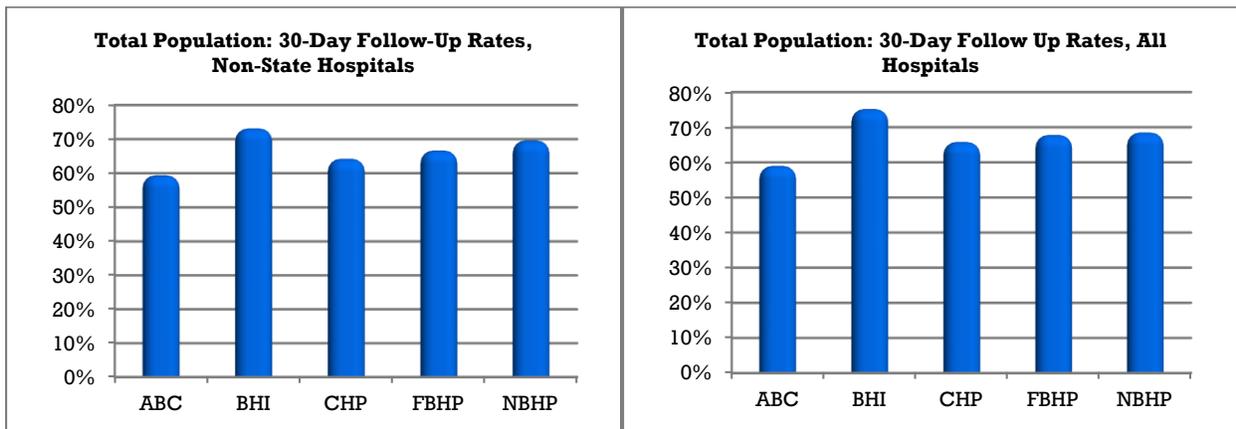
This indicator is a measure of the rate at which newly discharged individuals receive a face-to-face outpatient appointment within 7 or 30 days after leaving the hospital. It is measured by assessing the rate at which all individuals discharged from a mental health hospital attended a face-to-face outpatient 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.

## 7 Day Post Hospitalization Data



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 47.32% and for all hospitals is 48.00%. **In both cases, NBHP's rates of 50.79% (non-State hospitals) and 50.50% (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.

### 30 Day Post-Hospitalization Data



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 65.79% and for all hospitals is 66.83%. **In both instances, NBHP's mean rates for non-State hospitals (69.63%) and for all hospitals (68.50%) were above the statewide average.** These results are similar to the previous year, where NBHP's averages were 70.19% for non-State hospitals and 71.03% for all hospitals; whereas the statewide averages were 67.11% for non-State hospitals and 69.66% 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.

## Hospital Recidivism

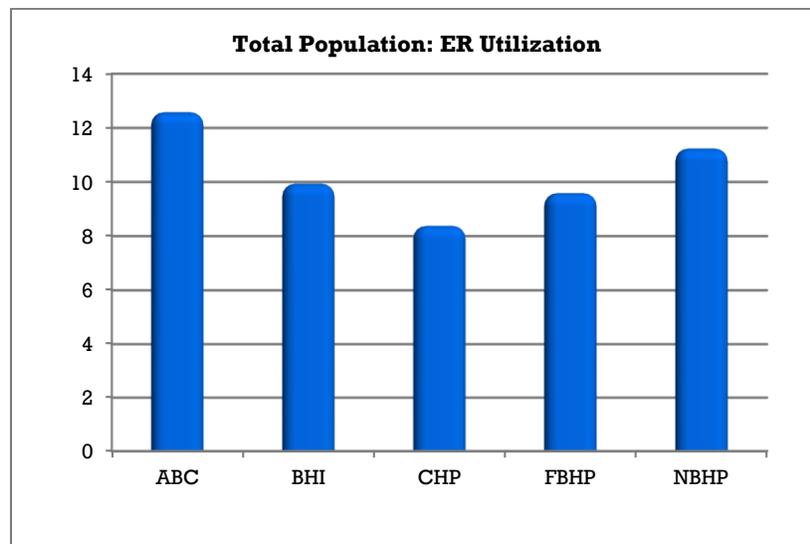
The hospital recidivism indicator measures the rate at which members within a managed care organization are re-admitted to a hospital within 7, 30, or 90 days after leaving the hospital. This indicator is measured by adding together the number of members readmitted to a hospital within a 7-, 30-, or 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 for most of the categories. 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 2.26%, which is below the statewide mean of 2.96%. Last year the NBHP's rate (1.55) was below the statewide average of 3.01%.
  - All Hospitals: NBHP's 7-day rates were 2.11%, which is below the statewide mean of 4.61%. Comparatively, NBHP's recidivism rate (1.76%) was below the statewide mean of 3.00% last year.
- 30-day Recidivism Rates
  - Non-State Hospitals: NBHP's 30-day rates were 4.19% and were below the statewide mean of 8.65%. In the previous year, NBHP's rate was 5.90%. NBHP was well below the state average with a rate of 8.75%.
  - All Hospitals: NBHP's 30-day rates were 4.83% and were below the statewide mean of 8.78%. The statewide average for the previous year was 9.11%, and NBHP's recidivism rate of 5.87% was below the statewide mean.
- 90-day Recidivism Rates
  - Non-State Hospitals: NBHP's 90-day rates were 7.42% and below the statewide mean of 14.70%. Last year, NBHP's 90-day rate was 10.87% and below the statewide mean of 15.56%.
  - All Hospitals: NBHP's 90-day rates were 8.76% and below the statewide mean of 14.91%. Last year, NBHP's 90-day rate was 11.73%, which was below the statewide mean of 16.34%.

The concerns from the FY12 Performance Measures do not seem to be an issue for the FY13 measures. NBHP will continue to monitor this measure through the quarterly performance measure report.

## 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 9.97. **NBHP’s rate was above the statewide mean with a utilization rate of 11.24.** This is a 19.5% increase compared to the previous year where the rate was 10.25. During FY 14, NBHP developed a new monthly report to be sent to Quality and Clinical staff at each mental health center. The report was completed on a three month lag and is cumulative for each fiscal year. Each center was given a full list of services provided to their capitated members during the fiscal year, to whom services were provided, where members received services, and notes members with multiple ED visits. This report excludes ED visits where an inpatient visit occurred within 24 hours. Both Touchstone and North Range mental health centers continue to have crisis evaluators in local emergency departments across the Northeastern region of the State.

## 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 13.82% which is a 6.1% increase compared to FY12's rate of 13.03.

- Age. See chart below. NBHP's penetration rates by age continue to be the second highest in the State.

Category	NBHP Rates	ABC Rates	BHI Rates	CHP Rates	FBHP Rates
<b>Child</b>	7.50%	5.99%	6.54%	7.06%	12.44%
<b>Adolescent</b>	20.85%	15.68%	16.32%	17.55%	22.80%
<b>Adult</b>	20.82%	19.44%	18.11%	20.15%	22.70%
<b>Older Adult</b>	6.83%	6.26%	5.48%	5.90%	7.86%

- Currently NBHP's PIP to increase penetration is in progress. FY12 was considered a baseline year. NBHP's efforts have increased the penetration rate but the results were not statistically significant.
- Race/Ethnicity: See chart below. An examination of BHO numbers by race/ethnicity reveals that penetration rates are comparable to those of other organizations.

Category	NBHP Rates	ABC Rates	BHI Rates	CHP Rates	FBHP Rates
<b>American Indian</b>	18.79%	17.32%	15.16%	10.60%	20.82%
<b>Asian</b>	6.27%	4.71%	4.51%	7.86%	6.91%
<b>Black</b>	14.57%	14.79%	12.53%	15.10%	23.51%
<b>Native Hawaiian/Other Pacific Islander</b>	9.36%	11.24%	10.21%	12.16%	21.57%
<b>Other</b>	17.85%	18.33%	14.26%	17.02%	19.45%
<b>Other-White</b>	18.03%	22.95%	17.97%	16.74%	21.89%
<b>Spanish American</b>	10.55%	8.06%	8.50%	10.84%	13.06%
<b>Unknown</b>	7.77%	9.17%	8.03%	9.29%	12.68%

- 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
<b>AFDC/CWP Adults</b>	15.17%	10.52%	12.52%	15.10%	15.44%
<b>AFDC/CWP Children</b>	9.46%	6.19%	7.24%	8.25%	13.73%
<b>AND/AB-SSI</b>	33.36%	34.69%	32.50%	29.45%	35.00%
<b>BC Children</b>	7.24%	7.30%	6.81%	7.23%	10.52%
<b>BC Women</b>	11.45%	10.28%	7.89%	14.38%	11.04%
<b>BCCP</b>	7.15%	15.69%	12.59%	14.85%	17.11%
<b>BUYIN: Working Adult Disabled</b>	32.28%	35.74%	35.11%	26.00%	62.59%
<b>Foster Care</b>	35.07%	47.08%	34.55%	30.82%	37.22%
<b>OAP-A</b>	6.75%	6.20%	5.38%	5.84%	7.78%
<b>OAP-B-SSI</b>	21.76%	23.80%	23.15%	21.56%	23.89%
<b>MAGI Adults</b>	44.02%	29.13%	35.63%	34.53%	43.63%
<b>BUYIN: Children w/Disabilities</b>	12.59%	15.03%	17.74%	13.04%	2.99%
<b>Overall:</b>	13.73%	11.77%	11.35%	13.25%	17.09%

NBHP's overall rate this year saw an increase by 6.1% when compared to the overall rate last year of 13.03%. NBHP saw a decrease in every Medicaid eligible category this year, except for BCCP, Foster Care, and OAP-B-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 FY14 Access to Care Report. The portion used for this report was the EMERGENCY FACE-TO-FACE CONTACTS data with a combined adult and child metric.

During FY14 there were 1949 requests for emergency face to face contacts. This is a 114.6% increase when compared to FY13 which had 908 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 most likely due to the increase in eligibility and the BHOs being awarded part of the SUD benefit since January 2014.

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

#### **Beneficiaries receiving greater than three crisis services**

The data set for this measure includes service codes H2011 and S9485. In the above section, the mental health centers report those numbers shown above and may be including more service codes, which is most likely the reason that the numbers in the below paragraph are much lower.

For FY14 data was collected for adult and youth age groups accessing greater than three mental health center based crisis services. There were a total of 400 beneficiaries who received crisis services (293 adults and 107 youths). Twenty-One of the 293 adults or 7.2% used greater than three services. This is a very slight increase from FY13 in which 5.8% of adults used greater than three services. Six of the 107 youths or 5.6% received greater than three services. This is a slight increase from FY13 in which 3.9% of youths used greater than three 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). The sample time frame was CY13.

### **Adults**

There were 41 cases in this group and both of the CCAR measures showed movement in the desired direction for improvement of symptoms. The movement for both measures was considered to be statistically insignificant. For CY13 a p value of 0.19 was reported for Mood Disturbance, and a p value of 0.70 was reported for Mental Functioning. The average change for Mental Functioning was -0.039 and Mood Disturbance was -0.187.

### **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. These results are similar to CY12. For CY13, a p value of 0.033 was reported for Mental Functioning and a p value of 0.024 was reported for Mood Disturbance. The average change for Mental Functioning was -0.358 and -0.024 for Mood Disturbance.

### **Children**

No children between the ages of 6-11 were in the data set for CY13.

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. The sample time frame was CY13. There were 70 cases in the 12-17 age group. This group demonstrated an average change of (-0.2) points. This change was found to be statistically significant with movement in the desired direction for improvement of symptoms ( $p= 0.01$ ). These results are similar to the previous calendar year. There were 139 cases in the 6-11 age group. This group demonstrated an average change of (-0.35) points. This change was found to be statistically significant with movement in the desired direction for improvement of symptoms ( $p<.01$ ). 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 FY10 PIP results indicated documentation issues within the electronic record system.

For CY13, there were a total of 670 beneficiaries under the age of 18 that had a primary diagnosis of ADHD. Sixty-four of these patients did not meet the criteria for the sample because they only had one mental health service. The remaining 606 beneficiaries that did have 2 or more services 294 had caregiver involvement. This is a decrease when compared to CY12. For CY12, there were 402 beneficiaries that had 2 or more services and all had caregiver involvement.

Recommendation: Continue to monitor for sustained improvement.

## School Based Services – Youth

### **Children age 6-11 (N = 40)**

Outcomes were collected from CCAR data measuring Mental Functioning and Social Functioning using the sample time period CY13. The change that occurred for both CCAR measures was in the desired direction. Average change was -0.750 for Mental Functioning and -0.500 for Social Functioning. These results are similar to CY12 where both measures were in the desired. The change for Social Functioning was statistically significant at 0.022 but Mental Functioning was not statistically significant at 0.063.

### **Adolescents age 12-17 (N = 67)**

Outcomes were collected from CCAR data measuring Mental Functioning and Social Functioning using the sample time period CY13. The change that occurred for both CCAR measures was in the desired direction. Average change was -1.400 for Mental Functioning and -1.833 for Social Functioning. The change for both CCAR domains was also statistically significant with Mental Functioning at 0.039 and Social Functioning at 0.006. This is an improvement over the previous year where only the Social Functioning domain was statistically significant with a p-value (<0.1).

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 114 beneficiaries who received peer services through NBHP. The data is described in the table below:

CMHC Name	Number of Members Per CMHC or BHO	Percentage of Beneficiaries
Centennial	0	0.0%
Touchstone	60	50.8%
North Range	58	49.2%
<b>Total:</b>	<b>118</b>	<b>100.0%</b>

Last year, changes were made to how the data was extracted from the data warehouse. In order for services to be included in the data set for this measure the provider licensure code must be a Peer Provider and the modifier 'TS' must be billed. The number of members receiving peer services has dropped compared to the previous year's data from 221 members receiving peer service to 118 members receiving peer services. There may be more members receiving peer services but the information may not have been entered into the mental health center's EHR systems with the requirements to be included in this measure.

Recommendation: Continue to monitor in FY15.

### Recovery Oriented Questionnaire

The below survey was developed as part of a three BHO focus study conducted during FY11. Information was collected on types of Peer Services being offered across the BHO's. An extensive list of possible peer services offered at community mental health centers was compiled based on Peer Service/Recovery literature and a qualitative interview with 2 Peer Service 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. The following results represent baseline data for future comparison.

NBHP demonstrated declines in some service areas such as Outreach to the Community, Outreach to Engage Clients, Political/Community Advocacy, Committee Membership, Educating Services on Recovery, Case Management, Life Skills Training, Transitional Assistance (Hospital and Tx Discharge), and Telephone Support. The percentage change reported was calculated by using the numerators from each year (FY \_Yes Response). The decline in services may be associated with the respondents experiencing difficulty finding employment with the mental health centers. For CY12 there were 18 surveys completed and for CY13 there were 18 surveys completed.

Type of Services Provided	FY 12 Results		FY 13 Results		Percentage Change
	FY 12 (Yes)	Percentage Yes	FY 13 (Yes)	Percentage Yes	
Outreach to the Community	11	61.1%	9	50.0%	-18.2%
Outreach to Engage Clients	16	88.9%	12	66.7%	-25.0%
Advocating for Clients	11	61.1%	12	66.7%	9.1%
Political/Community Advocacy	8	44.4%	5	27.8%	-37.5%
Peer Specialist Group Development	9	50.0%	11	61.1%	22.2%
Committee Membership	9	50.0%	6	33.3%	-33.3%
Educating Services on Recovery	15	83.3%	10	55.6%	-33.3%
Client Orientation to Mental Health Services	14	77.8%	15	83.3%	7.1%
Treatment Planning Support	16	88.9%	16	88.9%	0.0%
Medication Education &/or Appt. Prep	9	50.0%	11	61.1%	22.2%
Peer Led Groups	11	61.1%	14	77.8%	27.3%
Co-Facilitation of Clinical Groups	9	50.0%	9	50.0%	0.0%
Supporting Families	5	27.8%	9	50.0%	80.0%
Case Management	13	72.2%	12	66.7%	-7.7%
Life Skills Training	14	77.8%	13	72.2%	-7.1%
Counseling and Support	15	83.3%	16	88.9%	6.7%
Transitional Assistance at Tx Discharge	7	38.9%	5	27.8%	-28.6%
Crisis/Emergency Support	10	55.6%	13	72.2%	30.0%
Transitional Assistance at Hospital Discharge	6	33.3%	4	22.2%	-33.3%
Finding Housing	10	55.6%	11	61.1%	10.0%
Vocational Rehabilitation & Support	8	44.4%	11	61.1%	37.5%
Transportation Support	11	61.1%	14	77.8%	27.3%
Accessing Healthcare	7	38.9%	10	55.6%	42.9%
Assistance with Other Community Agencies	10	55.6%	12	66.7%	20.0%
Interpersonal Support	15	83.3%	16	88.9%	6.7%
Telephone Support	16	88.9%	14	77.8%	-12.5%
Recreation/Leisure Activity Coordination	11	61.1%	12	66.7%	9.1%

Percentage change is based on the numerator or the FY ( ) Yes Column.

## **IDDT - Adult**

Outcomes were collected on CCAR data measuring Mental Functioning and Sociability/Substance Abuse. Data was collected on a total of 16 members enrolled in the program. The change for Sociability/Substance Use was statistically insignificant ( $p=0.46$ ); however, the change for Mental Functioning was statistically significant (0.04) with movement in the undesired direction. Mental Functioning had a 0.5 average change with movement in the undesired direction. Sociability/Substance Use had an average change of 1 with movement in the undesired direction. This is different than CY12 where there was insignificant change in both Mental Functioning ( $p=0.40$ ) and Sociability/Substance Abuse ( $p=0.46$ ), with movement in the desired direction for Sociability/Substance Use and movement in the undesired direction for Mental Functioning.

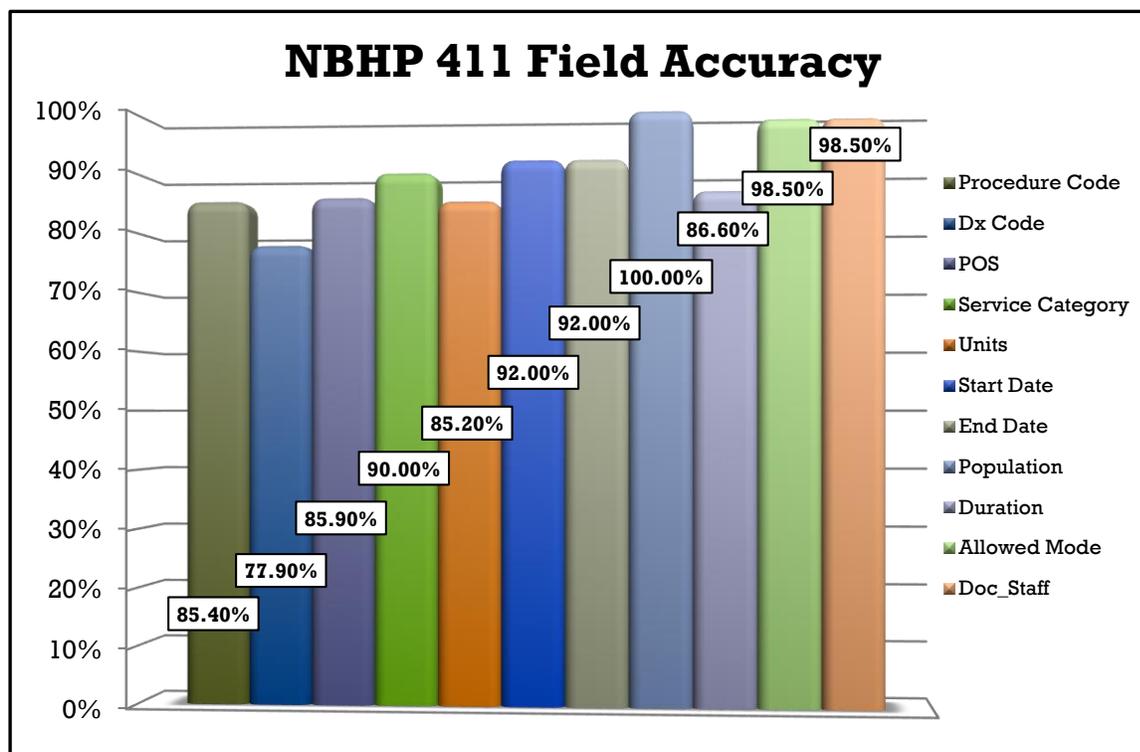
Recommendation: Continue to monitor this area for sustained improvement.

## 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 providers' 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 which could include the recoupment of paid claims or removal from the network. 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 the mental health centers conduct an audit 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. Below is a chart that demonstrates NBHP's field accuracy for the 411 audit.



During fiscal year 2013-2014, 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 2013-2014, NBHP recorded a total of 70 critical incidents, which was an increase 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 70 incidents are presented by severity type and treatment setting in the chart below. No trends or overarching concerns were noted; however the mental health centers did demonstrate more accurate reporting during FY14.

<b>Incident by Severity Level</b>	<b>Number</b>
Not an Incident	1
Minimal Risk	49
Moderate	5
Major	15
Sentinel	0
<b>Incident by Treatment Setting</b>	<b>Number</b>
ATU	25
Not in Treatment	2
Group Home	1
Outpatient	30
Residential	9
Case Mgmt	2
Crisis Residential Services	1

## *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. ECM 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 performance for similar persons, program, or facilities, and for this reason is the subject 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 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. For fiscal year 2013-2014 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.

### **NBHP Cultural Competency Committee**

The NBHP Cultural Competency Subcommittee is answerable to the Quality Improvement Department. During the fiscal year 2013-2014, NBHP's Cultural Competency committee met to undertake a variety of activities designed to increase culturally competent service delivery. In FY 2014, the NBHP cultural competency committee expanded their "Did You Know" email campaign into email blasts which are sent to all staff that have contact with members, including both clinical and administrative staff. The topics provide specific tips for clinicians who work with a diverse population as well as general information about culture and communication to administrative staff to improve their skills in serving members from diverse cultures.

## *Performance Improvement Project*

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:

### **Increasing Penetration for Medicaid Members Aged 65+**

The purpose of the PIP is to increase penetration in 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.

The intervention proposed in the 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.

FY13 was baseline to remeasurement 1. The penetration rate used for FY13 was calculated by HCPF and validated by HSAG. The penetration rate for FY13 was 6.83%. This yielded a Chi-Square of 3.3832 and a p-value of .0659. The resulting p-value is not considered a statistically significant increase. NBHP started its monthly mailings in January of 2013 and its first annual member mailing in December 2012. The low increase in the numerator could be due to the fact NBHP was only able to complete mailings in the last six months of the fiscal year. This is the

nature of the PIP process where interventions cannot be developed till data is analyzed which typically occurs midway through the PIP study year. NBHP has discussed this issue with both HCPF and HSAG.

In the previous year, NBHP had expressed concerns about an external validity issue because the denominator increasing could affect the results of the interventions. Medicaid eligibility is expected to increase due to the new healthcare laws. NBHP may increase the numerator by interventions, but the denominator may grow at a greater rate than the numerator causing the penetration rate to drop. NBHP had discussed analyzing eligibility files to assess for any abnormal or drastic increases. The analysis this year showed that there was an increase in the denominator for FY13 of 92 members. This increase appears to be in line with previous annual increases and was not a concern for FY13. NBHP will continue to monitor the denominator for this study and its potential impact on the goal of the PIP, which is to create a statistically significant increase in the penetration rate for adults 65 years old or older.

NBHP conducted data analysis on the impact of its mailing to measure the effectiveness of this intervention. Each member who received an informational packet from January 2013 to July 2013 was analyzed to see if the member had obtained a mental health service. As of July 2013, NBHP had mailed 221 informational packets and 8 of these members or 3.6% had obtained mental health services. It could be considered that most members who are 65 years or older are most likely on Medicare, as well. NBHP does receive Medicaid data in the form of encounter data for those members who are dual eligible, but if a dual eligible member were to see an independent provider that data most likely would not show up in the NBHP Medicaid claims data. When claims are submitted to Medicare by an independent provider, the secondary Medicaid data is forwarded to Medicaid fee-for-service for claims processing. The data analysis confirmed this for our population. This is an area of concern for the PIP because NBHP is not able to capture this information. This factor does not affect the validity of the penetration rate calculated by HCPF, but makes it harder for NBHP to judge the effectiveness of its interventions.

NBHP utilizes an automated report each month for the member's monthly mailing. This report was sent to the OMFA mailing office each month. It was discovered that around November 2013 that the automated system failed and two months of mailings were not completed. Also in January 2014, due to the large increases of newly eligible members each month ValueOptions has outsourced the monthly mailing for English speaking members. This was an area of concern that most likely affected our ability to outreach Medicaid members but was not an issue for the validity of the penetration rate calculated by HCPF.

NBHP implemented contacting primary care physicians to evaluate whether or not the brochure and fact sheet would be appropriate for offices throughout the region. A list generated by HCPF was used to contact offices where NBHP members had obtained services. After making many phone calls, it became apparent that the list was not a primary care physician list as it contained arthritis clinics, skin care clinics, acupuncture clinics, radiology labs, urology offices, surgical offices, etc. These offices did not feel that the brochures would be appropriate for the kinds of services offered and the patients they served. Thirteen primary care physician offices were contacted and six of those offices were interested in having the brochures and fact sheets available in their offices. The issue with sending information to primary care physicians is that there is no real way to measure how successful it was. Although

this was an area of concern for NBHP, it did not affect the validity of the penetration rate calculated by HCPF.

Even though the penetration rate increase was not statistically significant, NBHP did place important informational packets in the hands of 300 new Medicaid seniors. The brochure and informational packet contains information that will hopefully provide seniors with the information they need to seek help if/when they need it.

NBHP is aware of the special needs and barriers to behavioral health care treatment for older adults. NBHP will continue to partner with agency programs and specialty providers which provide assertive outreach to older adults with behavioral health problems. Our staff will also attend State-level committees for long term care services and our involvement with local senior service networking coalitions and local ARCH, working committees. NBHP will maintain relationships and coordinate care with traumatic brain injury, developmental disability, intellectual disability, Autism Spectrum Disorders, and other specialty based providers throughout our region.

NBHP's Integrated Care Management program facilitates relationships with specialty based providers and ensures continuity when Members with special health care needs present for services. NBHP's staff has attended the NADD, an association for persons with developmental disabilities and mental health needs, annual conference to gain training in providing behavioral health services and innovative, integrative programs for health care. NBHP has maintained a three-year, ongoing Membership with CO-CANDO, the Colorado Collaborative for Autism and Neurodevelopmental Disabilities Options. CO-CANDO provides an advocacy voice for disabled persons and their families; legislative lobbying for services and funding for evidence-based service programs; training opportunities for providers; and access to other needed services. Staff members have also attended Colorado Brain Injury Association regional conference and summit trainings to gain information about improving daily task functioning, providing effective behavioral health treatments and improving quality of life for Members with a traumatic brain injury and their families.

Due to contract changes for FY15, NBHP has requested that HCPF retire this PIP.

## *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.

During the 2013-2014 fiscal year, the workgroup prepared guidelines and other supporting materials for Obsessive Compulsive Disorder, Generalized Anxiety Disorder, Panic Disorder and Borderline Personality Disorder. These guidelines were subsequently reviewed and approved by the NBHP Quality Assessment, Outcomes, and Performance Improvement Committee. Following their approval, the guidelines were posted on the NBHP website and disseminated to network providers.

## *Recovery and Resiliency Initiatives*

During the fall of 2013, 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 2013-2014. These plans were reviewed at the November 2013 NBHP Quality Assessment, Outcomes, and Performance Improvement Committee. Additionally, each of the three provider centers presented summary updates at the previously mentioned meeting. During FY 2014, NBHP offered two peer specialist trainings. Approximately 35 clients, from each of the three behavioral health centers, participated in and completed the training. The training meets the requirements established in the 2009 RFP, titled "Core Competencies for Peer Specialists." These trainings provide participants who complete the training with documentation that the person has successfully completed the training and is qualified to work for a BHO or mental health center and offer peer services under the supervision of clinical staff at the agency (providing they meet other employment requirements). The Director worked with local NAMI affiliates to promote the trainings and services offered by NAMI. For fiscal year 2013-2014, each of the NBHP Provider centers met 80% of the goals in their Recovery Initiative Plans.

## *Systems Integration*

The Service Systems Integration Team strives to improve the quality of life for our members, partners and providers by innovatively bringing together resources, systems and strategies for better health care. Over the past year the team has continued some of our focused efforts, started new efforts and brought some projects to fruition.

Last year the team strengthened the Child Psychiatric Consultation Service program. This past year that program was grant funded and passed on to the Colorado Behavioral Health Care Council. The program is now called Child Psychiatric Access and Consultation for Kids. One of the team's former members, Mary Shatzer, is still heavily involved with that program. This program provides "curbside" psychiatric consultations to pediatricians dealing with behavioral disturbances in their patients. This is a valuable service in Colorado that attempts to bridge the gap between child psychiatric needs and the severe shortage of child psychiatrists.

The team has intensified its involvement with state and local departments of human service. A new team member, Lynne Bakalyan, has been recruited in this effort. Team Lead Paul Baranek has been elected as chairperson of the Finance Committee for El Paso counties HB 1451 effort, the REACH Program. The team is also involved in the Operations Committee and Executive Committee of that program. The state Department of Human Services is looking at this program closely as a model for the rest of the state. The team continues its involvement in the SB 94 programs as well as other HB 1451 programs in the southeast area of the state. Many presentations have been done for local DHS and foster care groups regarding our services. At a statewide level the team participates in the state DHS Core Services Director's quarterly meetings, where BHO issues can be addressed immediately as they are brought up, as well as other statewide DHS meetings.

Integration with physical health care services has been a major focus of the team this past year. Team member Vicki Linden's participation in efforts such as the Teen and Unintended Pregnancy Prevention workgroup and Chaffee County Health Coalition illustrate this effort. Other examples include integration and joint training efforts with RCCOs that the team has conducted and participation in the Worksite Wellness Work Team and Preventing Long Term illness Due to Obesity workgroup. The Team Lead is also point person for a new project on integrating physical and behavioral health data called Spectrum.

The team has increased its presence at statewide meetings to enhance our image as a leader in the field throughout Colorado. We participate in the Behavioral Health Transformation Council and the Systems of Care subcommittee. Team members work on the duals demonstration project involving payment reform and blended payment options. We are on the ICD10/DSM5 Conversion workgroup at the request of the Office of Behavioral Health. We were asked to provide feedback to the governor's 27-65 reform group on handling Dementia and Alzheimer's issues and participate in that workgroup.

Long Term Services and Supports and aging services remain a priority. Team member Lisa Keenan co-chairs the Care Coordination subcommittee to advise the governor and Paul Baranek is on the Entry Point/Eligibility subcommittee. The team is also involved in a workgroup addressing training issues for assisted living facilities and has recommended Mental Health First Aid training. We also participate in the Senior Behavioral Health and Wellness Coalition which has allowed us to forge valuable relationships with the community serving this population. Team member Vicki Linden is on the ADRC (Aging and Disability Resource Center- formerly ARCH) Council and the Senior Services Networking group.

Training and education has remained a priority. Over the past year the team has provided multiple trainings to community groups and providers on topics such as; Motivational Interviewing, the DSM5, Trauma Informed Care, Medicaid Behavioral Health Services, Suicide Assessment and Intervention, Integration of Behavioral and Physical Health Care Services, and Mental Health First Aid. In addition, team members have composed an LMS (learning management system) course on the six levels of integrated care and a glossary of integrated care terms that is now being made available on the CBHC website.

Perhaps one of the most important, though most difficult to quantify, functions of the team has been the multiple meetings with state and local agencies and community partners when issues arise. Most often, these issues can be resolved with information about what we can and cannot do. Sometimes these have involved creative solutions for individual problems. These often involve coordinating with our own internal departments as well as partner and community providers to fashion individual plans addressing the member's unique needs. Brokering cross system collaboration is frequently required such as in the treatment of eating disorders, co-occurring intellectual and developmental disabilities, services provided to DHS clients and other more complicated situations.

## 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 2013 Fact Finders' Member Satisfaction Survey (a telephonic survey conducted by a third-party vendor), the 2013 Mental Health Statistics Improvement Program survey (MHSIP), and the 2013 Youth Services Survey for Families (YSS-F), both of which are conducted by the OBH.

### 2013 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 number of members sampled each year is typically 200; however for CY 2013 there was a data submission error that caused the total N to be 160. 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
<b>N=</b>	113	39	152
<b>Completely Satisfied</b>	22.1%	23.1%	22.4%
<b>Very Satisfied</b>	38.01%	35.9%	37.5%
<b>Somewhat Satisfied</b>	31.0%	32.5%	31.6%
<b>Somewhat Dissatisfied</b>	6.2%	5.0%	5.3%
<b>Very Dissatisfied</b>	2.7%	7.5%	3.3%

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

	CMHC	Non-CMHC	Total
<b>N=</b>	118	41	159
<b>Excellent</b>	39.8%	58.5%	44.7%
<b>Very Good</b>	40.0%	19.5%	34.0%
<b>Good</b>	13.6%	14.6%	11.3%
<b>Fair</b>	7.6%	4.9%	6.9%
<b>Poor</b>	3.4%	2.4%	3.1%

**Is the office location convenient for you?**

	<b>CMHC</b>	<b>Non-CMHC</b>	<b>Total</b>
<b>N=</b>	117	40	157
<b>Convenient</b>	87.2%	87.5%	87.3%
<b>Not Convenient</b>	12.8%	12.5%	%

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

	<b>CMHC</b>	<b>Non-CMHC</b>	<b>Total</b>
<b>N=</b>	117	41	158
<b>Better</b>	60.7%	73.2%	63.9%
<b>About the Same</b>	30.0%	17.1%	26.6%
<b>Worse</b>	9.4%	9.8%	9.5%

**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?**

	<b>CMHC</b>	<b>Non-CMHC</b>	<b>Total</b>
<b>N=</b>	119	41	160
<b>Counselor</b>	71.4%	82.9%	74.4%
<b>Doctor</b>	18.5%	26.2%	16.2%
<b>Case Manager</b>	67.2%	9.5%	6.9%
<b>Other</b>	0.8%	0.0%	0.6%
<b>No Opinion</b>	2.5%	4.8%	1.9%

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

	<b>CMHC</b>	<b>Non-CMHC</b>	<b>Total</b>
<b>N=</b>	119	41	160
<b>Counselor Meets Needs</b>	94.1%	92.7%	93.8%%
<b>Counselor does not Meet Needs</b>	5.0%	7.1%	5.6%%
<b>No Opinion</b>	0.8%	0.0%	0.6%

**Do you feel your counselor protects your confidentiality?**

	<b>CMHC</b>	<b>Non-CMHC</b>	<b>Total</b>
<b>N=</b>	119	41	160
<b>Counselor Protects Confidentiality</b>	93.3%	100.0%	95.0%
<b>Counselor Does Not Protect Confidentiality</b>	0.8%	0.0%	0.6%
<b>No Opinion</b>	5.9%	0.0%	4.4%

**Have you talked with a peer specialist?**

	<b>CMHC</b>	<b>Non-CMHC</b>	<b>Total</b>
<b>N=</b>	75	16	91
<b>Talked to a peer specialist</b>	22.7%	6.2%	19.8%
<b>Have not talked to a peer specialist</b>	60.0%	87.5%	64.8%
<b>No Opinion</b>	17.3%	6.2%	15.4%

**Has your counselor involved you in decisions about your care?**

	<b>CMHC</b>	<b>Non-CMHC</b>	<b>Total</b>
<b>N=</b>	116	40	156
<b>Member Involved in Care Decisions</b>	90.5%	85.0%	89.1%
<b>Member Not Involved in Care Decisions</b>	9.5%	15.0%	10.9%

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

	<b>CMHC</b>	<b>Non-CMHC</b>	<b>Total</b>
<b>N=</b>	119	41	160
<b>Counselor Helped With Needed Changes</b>	79.8%	85.4%	81.2%
<b>Counselor Did Not Help With Needed Changes</b>	17.6%	9.8%	15.6%
<b>No Opinion</b>	2.5%	4.9%	3.1%

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

	CMHC	Non-CMHC	Total
N=	115	41	156
Got First Appointment As Soon As Desired	86.1%	87.8%	86.5%
Did Not Get Desired First Appointment	13.9%	12.2%	13.5%

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

	CMHC	Non-CMHC	Total
N=	102	35	137
Able To Get Appointment Within 7 Days	77.5%	85.7%	79.6%
Not Able To Get Appointment Within 7 Days	22.5%	14.3%	20.4%

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

	CMHC	Non-CMHC	Total
N=	118	40	158
30 Minutes or Less	89.0%	90.0%	89.2%
More Than 30 Minutes	11.0%	10.0%	10.8%

Is the office location convenient for you?

	CMHC	Non-CMHC	Total
N=	117	40	157
Convenient	87.2%	87.5%	87.3%
Not Convenient	12.8%	12.5%	12.7%

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=	75	16	91
More Confident Than a Year Ago	78.7%	87.5%	80.2%
Not More Confident	14.7%	12.5%	14.3%
No Opinion	6.6%	0.0%	5.5%

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=	74	16	90
Participates in Activities	29.7%	25.0%	28.9%
Do Not Participate in Activities	70.3%	75.0%	71.1%

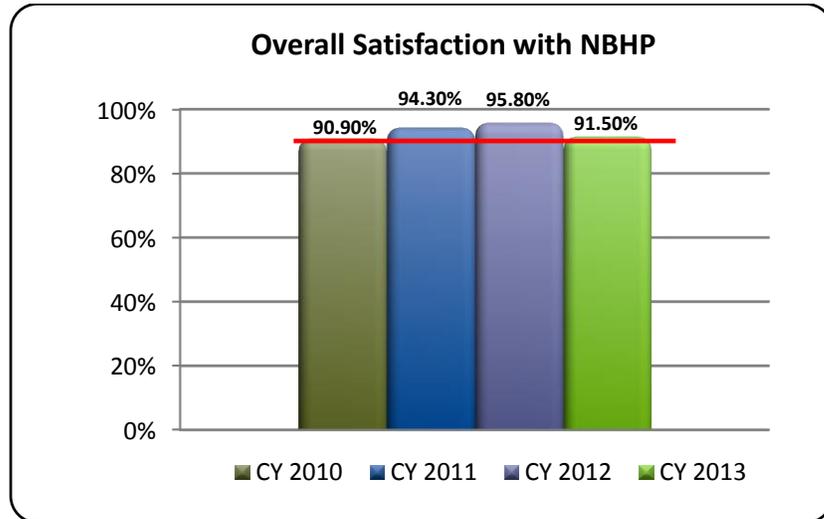
In the last year, have you stayed overnight in a hospital for any counseling or mental health services?

	CMHC	Non-CMHC	Total
N=	119	41	160
Have Received Services in Hospital	11.8%	22.0%	14.4%
Have Not Received Services in Hospital	88.2%	78.0%	85.6%

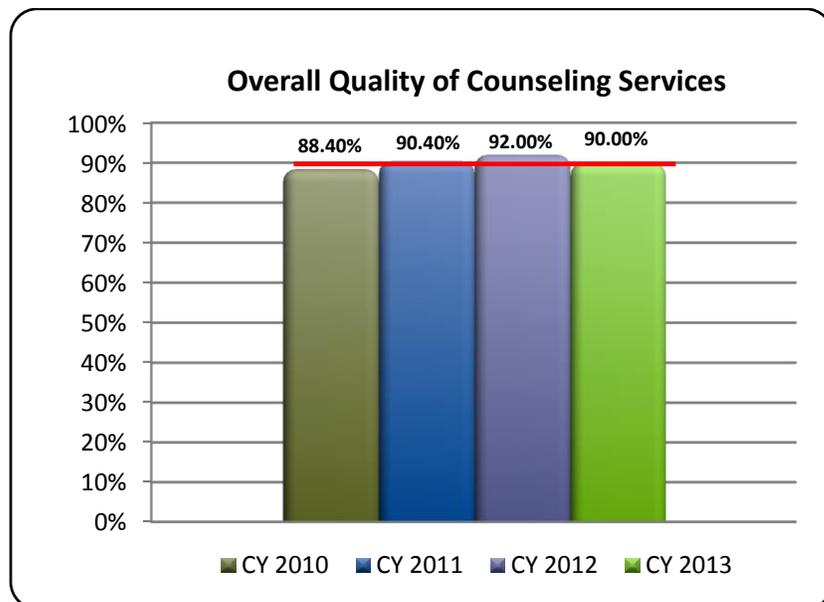
Are you satisfied or dissatisfied with the number of days approved for treatment in the hospital?

	CMHC	Non-CMHC	Total
N=	14	9	23
Satisfied	100.0%	88.9%	95.7%
Dissatisfied	0.0%	11.1%	4.3%

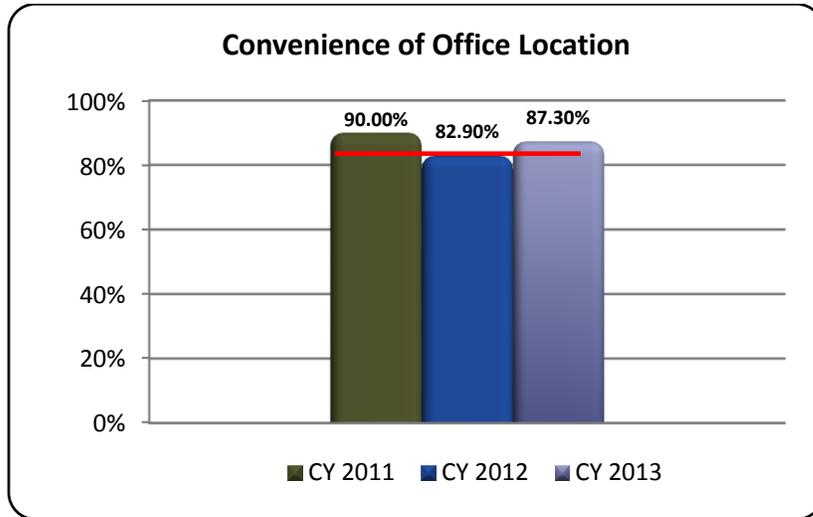
- Of the members asked about their satisfaction with mental health services, 91.5% of members indicated they were satisfied. This is a 4.3% absolute decrease in satisfaction with NBHP's services when compared to CY 2012. The rate of satisfaction continues to be above the benchmark of 90% and increasing annually. The rate most likely decreased due to the number of completed surveys being less during 2013.



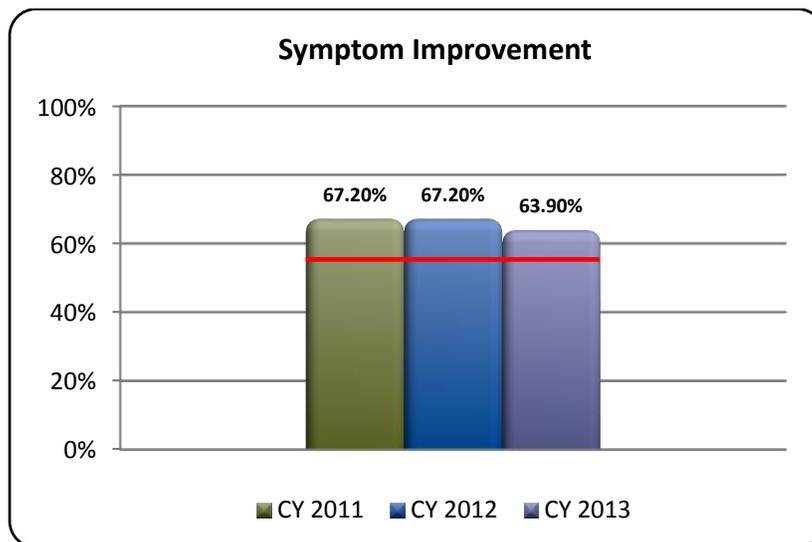
- 90% of members suggested they received quality services from their therapist. This is a 2.0% absolute decrease in perception of quality when compared to CY 2012 data. The perception of quality from members continues to remain around the benchmark of 90%. The rate most likely decreased due to the number of completed surveys being less during 2013.



- 87.3% of members indicated the distance travelled to meet with their therapist is not a problem. This is a 4.4% absolute increase when compared to CY 2012.



- When asked about how they were feeling compared to a year ago, 90.5% of members indicated they were better (63.9%) or about the same (26.6%). The better response is the element that is monitored for this survey question depicted in the graph below. This is a 3.3% absolute decrease when compared to CY 2012. The results are above the performance standard of 55% for the “better” response. This item will continue to be monitored. The rate most likely decreased due to the number of completed surveys being less during 2013.



## 2013 MHSIP

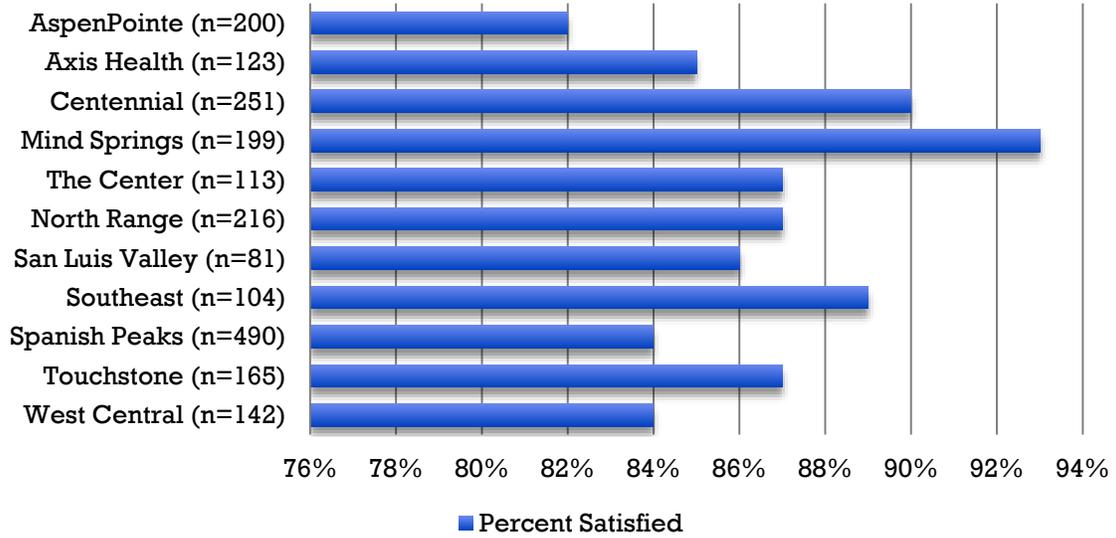
The Colorado Division of Behavioral Health (DBH) conducted the 2013 Mental Health Statistics Improvement Program (MHSIP) Member Survey. The survey was conducted in October 2013. NBHP coordinated efforts with another BHO (Colorado Health Partnerships-CHP) to collect overall MHSIP data for its respective 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:

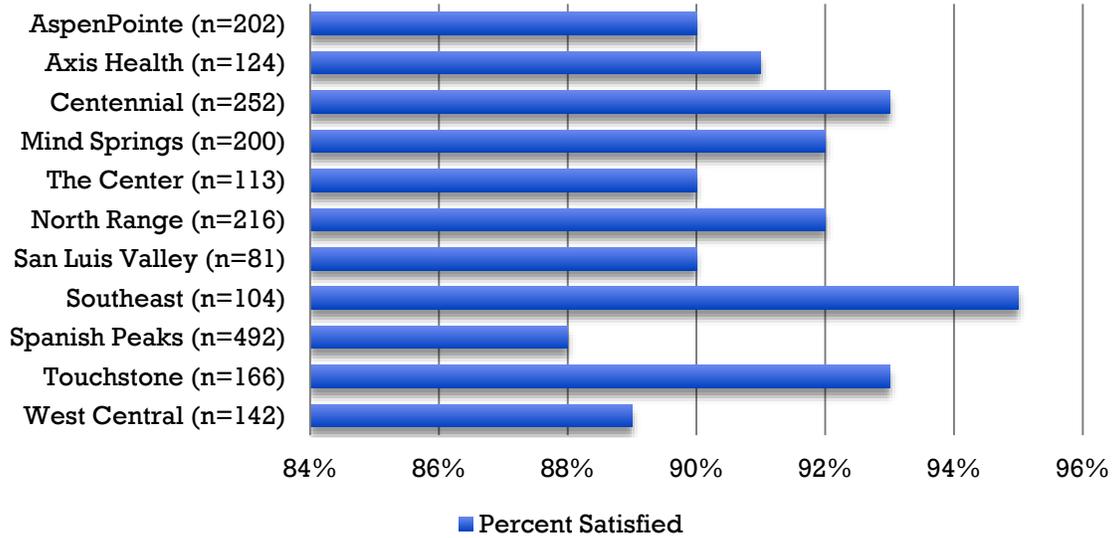
- Perception of Access 87.50%
- Perception of Appropriateness 92.15%
- Perception of Outcomes 74.25%
- Perception of Participation 84.95%
- Perception of Satisfaction 93.39%

NBHP maintained or improved in all categories. Below are graphs that depict how the each NBHP mental health center scored on the various domains of the MHSIP report. Colorado Health Partnership mental health centers are also shown in the graph because the report was a collaborative effort between the two BHOs.

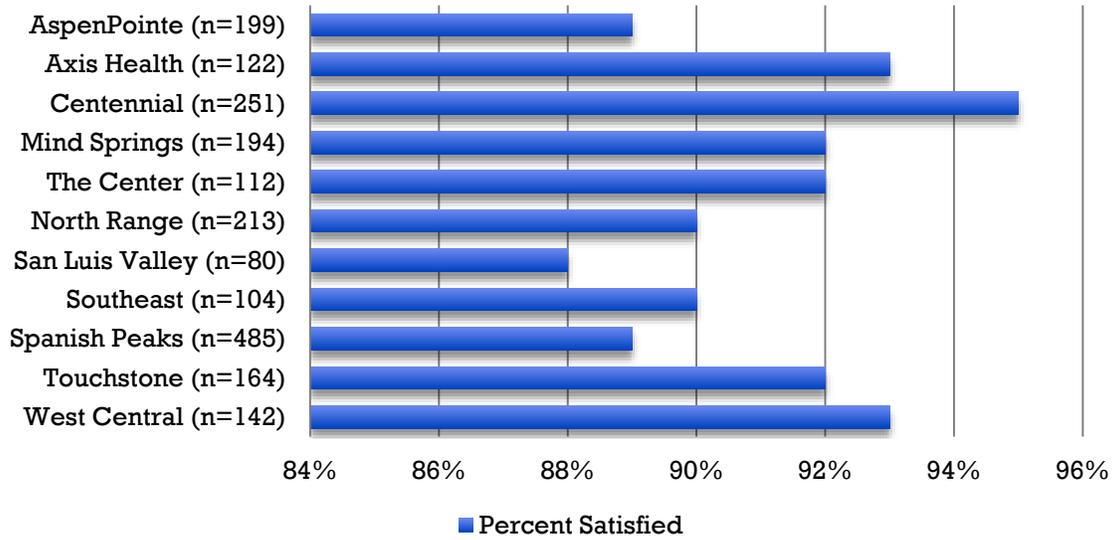
## MHSIP Access Domain



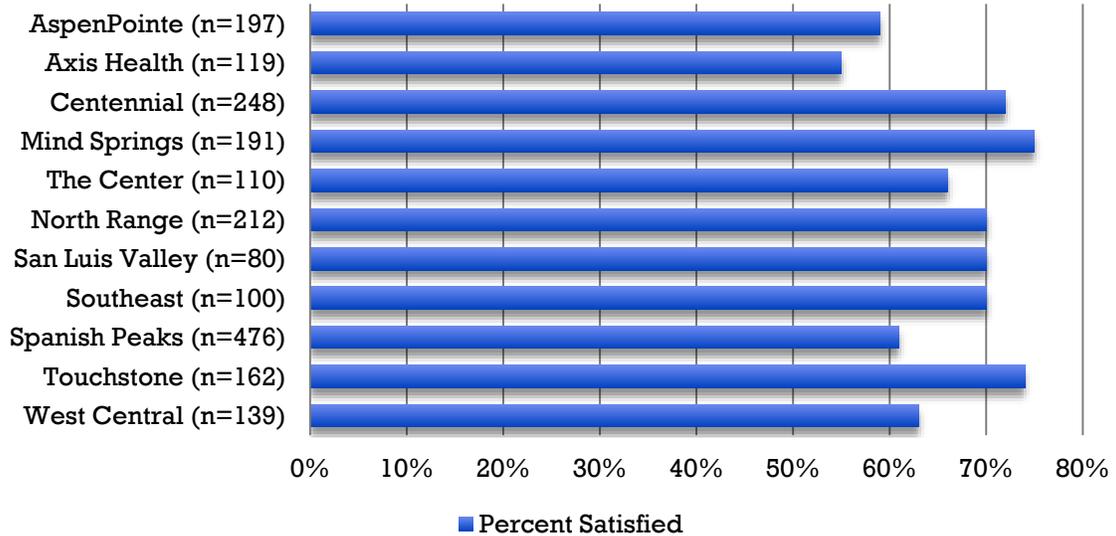
## MHSIP General Satisfaction Domain



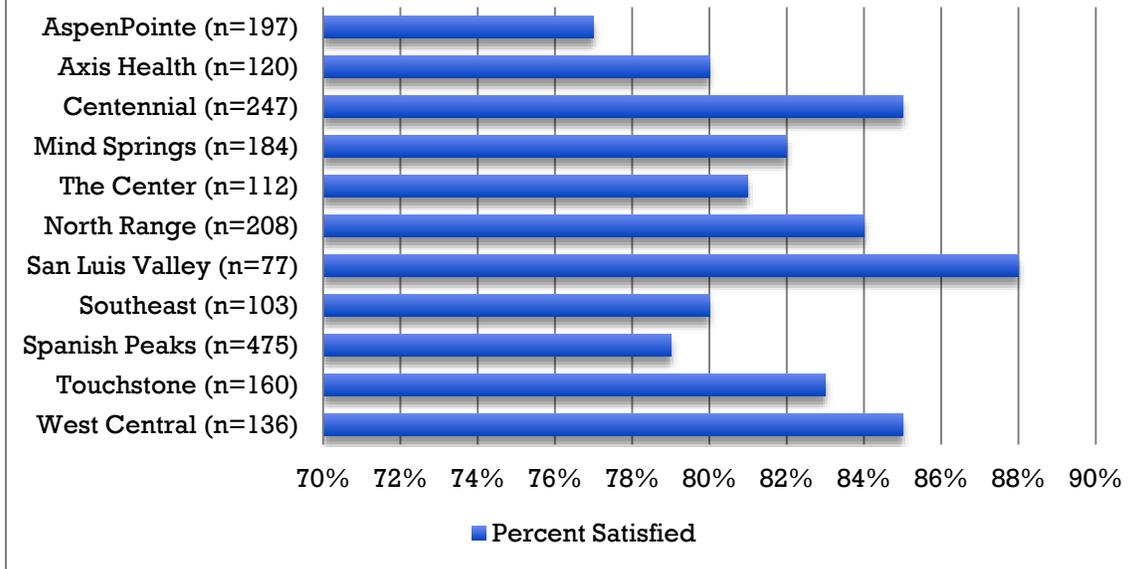
## MHSIP Appropriateness Domain



## MHSIP Outcomes Domain



## MHSIP Participation in Treatment Domain



### 2013 YSS-F

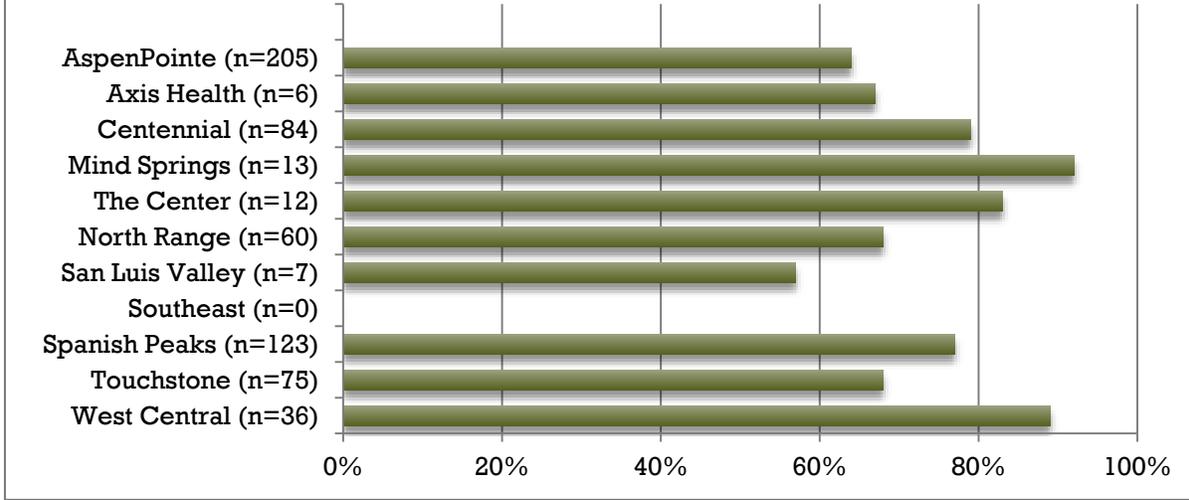
The Colorado Division of Behavioral Health (DBH) also conducted the 2013 Youth Satisfaction Survey for Families (YSS-F). The methodology and related issues are identical to the MHSIP survey. As with the MHSIP, NBHP coordinated efforts with another BHO (Colorado Health Partnerships-CHP) to collect overall 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 2013 survey are shown below:

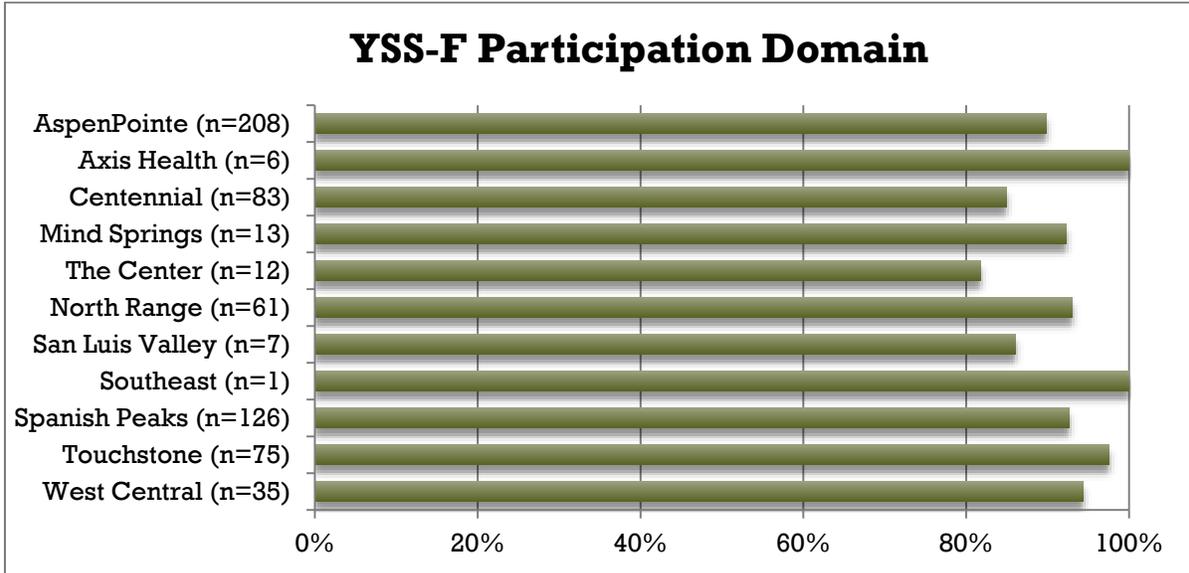
- Perception of Access 71.71%
- Perception of Appropriateness 86.76%
- Perception of Outcomes 56.72%
- Perception of Participation 91.96%
- Perception of Cultural Sensitivity 97.38%

NBHP maintained or improved in all categories except for the Perception of Access Domain, which realized a 7.29% absolute decrease. Below are graphs that depict how the each NBHP mental health center scored on the various domains of the MHSIP report. Colorado Health Partnership mental health centers are also shown in the graph because the report was a collaborative effort between the two BHOs.

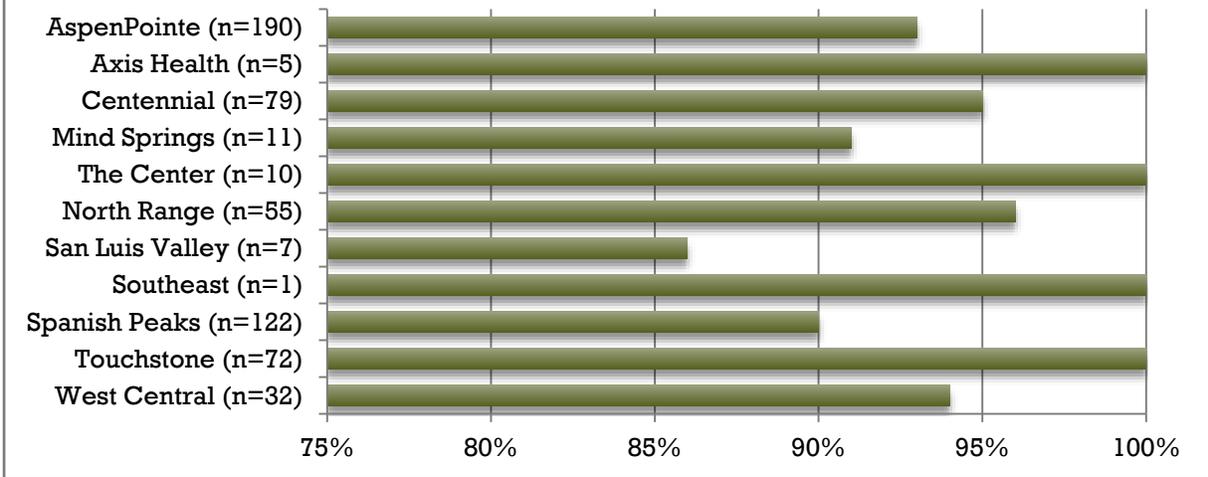
### YSS-F Access Domain



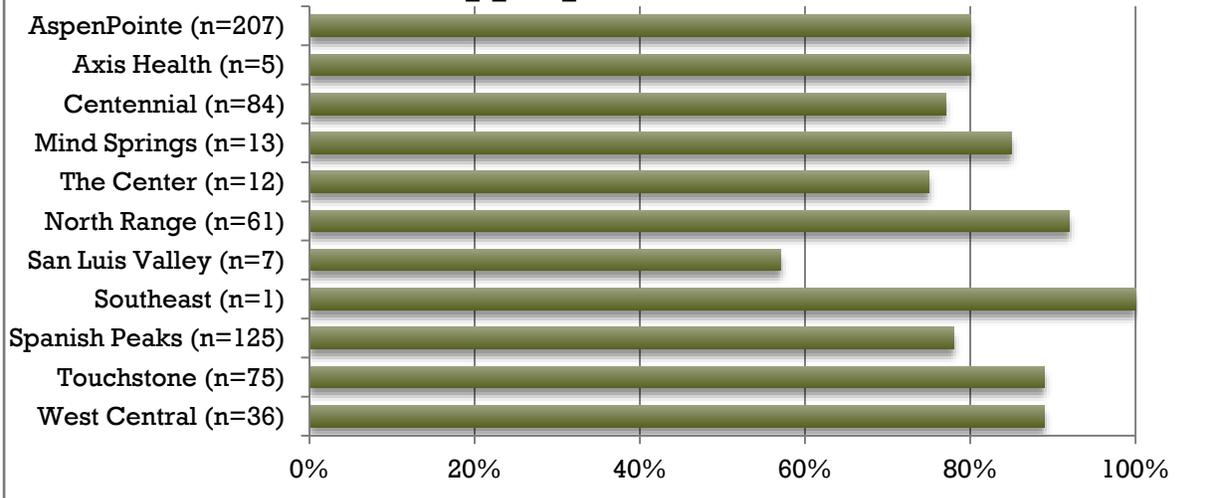
### YSS-F Participation Domain



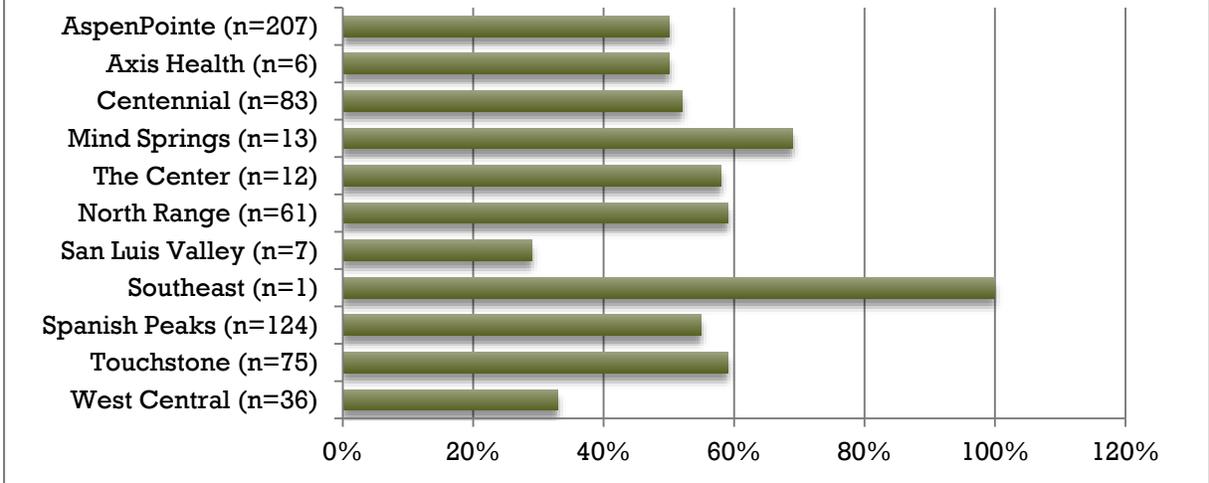
### YSS-F- Cultural Sensitiviy



### YSS-F Appropriateness of Care



## YSS-F - Outcomes Domain



## *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. Evidence based practices are evaluated in an annual EBP report while implementation is ensured through annual contract compliance audit. All core performance measures are reviewed by NBHP QIUMC and reported annually in NBHP Impact Analysis Report.

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. The quarterly versions were very useful to identify early patterns and could be addressed immediately versus a look-back analysis with the annual version.

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. Towards the end of the fiscal year many members of the QI-member committee had their terms expire. New members were selected and transitioned into their roles.

3. Ensure clinical practice standards and contract requirements, as applicable, are met by providers. Practice standards are monitored through quarterly chart audits while contract compliance is monitored through an annual audit.

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 on a quarterly basis. 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. All outcomes and performance indicators are reviewed by NBHP QIUMC and the NBHP Board and are reported annually in NBHP Impact Analysis Report.

Status: Met

During FY 14 data was systematically analyzed from multiple sources including outcomes in Evidence Based Practices, Performance Measures, Satisfaction Surveys, and Performance Improvement Projects and Focused Studies. NBHP QI department worked very closely with the finance department to review under and over utilization.

5. Assure Care Management Department Compliance with Established UM Standards. All UM indicators are reviewed by NBHP QIUMC and reported annually in NBHP Impact Analysis Report.

Status: Met

The performance of the care management 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.

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

Status: Partially Met

The final validation finding for NBHP's Increasing Penetration for Medicaid Members Aged 65+ PIP showed an overall score of 96 percent, a critical element score of 88 percent, and a Not Met validation status.

7. Ensure compliance with EQRO standards.

Status: Met

For the two standards (Coverage and Authorization of Services and Access and Availability) reviewed by HSAG, NBHP earned an overall compliance score of 100 percent. NBHP also scored a 100% on record review of denials. There were no required actions from this year's audit.

8. QAOP to evaluate the FY 2014 work plan and review Quality and Utilization Program Plans.

Status: Met

The QAOPi contributed to the FY 2014 work plan. 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 QAOPi 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 2013-2014, the NBHP Directors of Quality Improvement and Office of Member and Family Affairs 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 with our QAOPi committee and during this fiscal year the process for recruiting and ensuring proper representation from this group has been seamless.

Also of great importance in the NBHP quality efforts is the continued relationship between the local RCCOs 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.

NBHP ranked 1st or 2nd in the state on most annual performance measures. Although NBHP performs well on most measures there continues to be areas that warrant improvement. Additionally, rates of inpatient utilization among adolescents continue to warrant scrutiny. Emergency Department (ED) use is also a focus for NBHP. FY 14 focused on an analysis of the data on ED and inpatient. 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 NBHP Medical Director. The Clinical Peer Advisor and Clinical Director complement the leadership team, ensuring 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 FY14, the NBHP Service Center's clinical team expanded to include six Clinical Care Managers and five Clinical Service Assistants. Clinical Care Managers, or CCMs, are licensed clinicians who work closely with providers to direct care and achieve optimal treatment outcomes. CCMs attend daily rounds with the Medical Director to review complex cases. The Clinical Service Assistants, or CSAs, are not involved in clinical decision making, but they are able to assist members and providers with a variety of administrative activities related to service authorizations and referrals to network providers. Additionally, the NBHP utilization management team includes a Clinical Team Lead position, which was developed to focus on training, rapid problem resolution and process improvement. The Care Management staff is directly supervised by the Clinical Director who monitors the productivity and performance of the team.

Highlights from FY 2014 include:

- Implementation of daily clinical Rounds for discussion of complex cases;
- All UM staff completed the annual inter-rater reliability test;
- Successfully completed UM portion of the 2014 EQRO audit, earning a score of 100% compliance;
- Call responsiveness stats have been outstanding; less than 2% 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 the new substance use disorder benefit;
- 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 QAOPI 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 2013-2014 QIUMC:

#### Representatives from the MHCs:

- Centennial Mental Health Center – Two (2)
- Touchstone Health Partners – Four (4)
- North Range Behavioral Health – Four (4)
- Consumer Representatives – Nine (9)
  - 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. Peter Brodrick 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

