Annual QAPI Evaluation

Access Behavioral Care – Denver

Fiscal year 2015

Table of Contents

Executive Summary 3
- Key Metrics 4
- Colorado Access QAPI Program Organization and Structure 5

Membership 6
- Enrollment 6
- Penetration 7

Access to Care 8
- Service Accessibility 8
- Telephone Accessibility 10
- Increasing Youth Access to Mental Health Services 11
- Network Adequacy: Network Composition 12
- Network Adequacy: Cultural and Linguistic Needs 14
- Innovative Service Models: Telemedicine 16

Member and Family Experience 17
- Member Satisfaction: ECHO survey 17
- Member Grievances 19
- Quality of Care Concerns 21

Utilization Management 22
- Utilization Management Decisions 22
- Clinical Appeals 24
- Inter-rater Reliability 25

Performance Measures 27
- Reducing Over- and Under-Utilization of Services 27
- Improving Member Health and Safety 29
- Access to and Coordination of Care 31
- Performance Measure Validation 33

Best Practices 35
- Clinical Practice Guidelines 35
- Evidence-Based Practices: Adult 36
- Evidence-Based Practices: Child and Adolescent 38

Integrated Care Projects and Activities 40
- Adolescent Depression Screening and the Transition of Care to Behavioral Health 40
- Other Integrated Care Activities 41

Other Compliance Monitoring Activities 42
- External Quality Review Organization (EQRO) Audit 42
- Encounter Data Validation (411 Audit) 43
- Provider Medical Record Reviews 45

Executive Summary

The Colorado Access (COA) and Access Behavioral Care (ABC) Quality Assessment and Performance Improvement (QAPI) Program has a primary directive to develop quality initiatives and programs based on analysis of performance data to improve health outcomes for members. Quality assessment and performance improvement is integral to all aspects of ABC's operations and processes. Targeted interventions and work plans are selected for their potential to improve member health outcomes and satisfaction and to guide ABC's quality improvement program and compliance monitoring activities. Activities are designed to achieve continuous quality improvement, clinical and service excellence.

This report presents a summary of program activities and accomplishments during the contract fiscal year July 1, 2014 through June 30, 2015 (FY15). Much of ABC's performance was negatively impacted by the dramatic increase in membership, particularly in the Adults without Dependent Children (AwDC) aid category. A significant proportion of members in this expansion population may have had untreated or under-treated behavioral health (mental health and substance use disorder) issues and now are provided services at no cost, causing what's being called a "warehouse" effect. This has resulted in increased utilization of intensive services like the emergency department and inpatient services.

Despite the significant increase in membership, ABC's provider network has continued to meet and exceed the needs of this increased membership – ABC's penetration rates have significantly increased, showing that an increased proportion of members have not just been seeking services, but receiving them - and receiving them as expeditiously as their condition required, as evidenced by the continued high performance on Access to Care metrics.

ABC is committed to continuing to provide a cohesive system of managed behavioral health care that ensures access to community-based, clinically relevant, member- and family-centered services to Denver Medicaid Members. ABC emphasizes member recovery and empowerment in the delivery of comprehensive, coordinated, and culturally sensitive behavioral health services that meet or exceed State and community standards. ABC's diverse network of providers and community stakeholders shares this philosophy and commitment.

Key Metrics

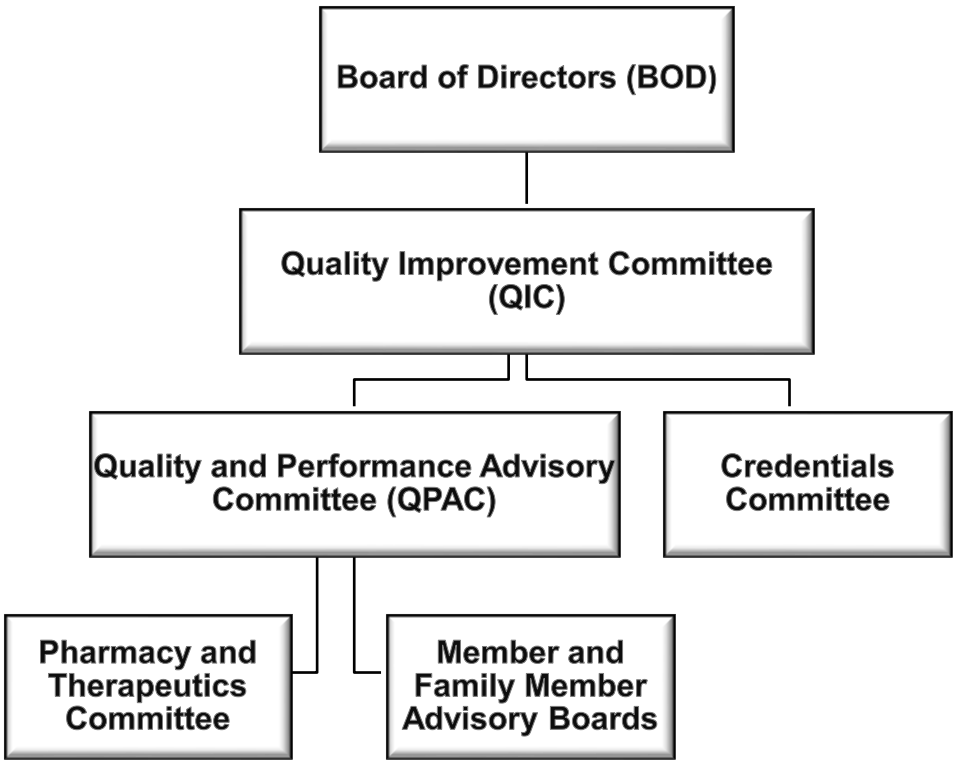
Measure		Goal	FY12	FY13	FY14	FY15
Penetration Rate (overall)		> 14.0%	11.5%	11.8%	14.3%	*
Utilization Monitoring	Inpatient Admits per 1000 members	< 6.0	5.6	4.2	4.8	*
	Inpatient Average Length of Stay	< 9.0	9.4	9.2	8.8	*
	Emergency Visits per 1000 members	< 12.0	11.2	12.6	14.6	*
Follow-up after Hospitalization	7 days	60%	42.6%	39.7%	46.2%	*
	30 days	75%	62.1%	59.4%	70.4%	*
Inpatient Readmission	7 days	< 5.0%	4.3%	1.9%	2.9%	*
	30 days	< 13.0%	11.5%	7.3%	11.7%	*
	90 days	< 20.0%	18.4%	13.3%	18.5%	*
Access to Services	Routine Care within 7 calendar days	100%	100%	100%	100%	100%
	Urgent Care within 24 hours	100%	100%	100%	100%	100%
	Emergent Care within 1 hour	100%	92%	94%	94%	96%
	% of members within 30 miles of provider	100%	100%	100%	100%	100%
Appeals	Resolution Timeliness	100%	100%	100%	100%	100%
	Appeal Rates	< 2.0	0.12	0.14	0.08	0.07
	% of Denials Overturned	NA	0.8%	0.7%	0.2%	1.6%
UM Decision Timeliness		97%	*	*	*	92.9%
Grievances Resolution Timeliness		100%	100%	99%	100%	100%
Quality of Care Concern Rate		< 2.0	*	0.017	0.014	0.016

*Data unavailable

Colorado Access QAPI Program Organization and Structure

The structure of the QAPI Program (illustrated below) is comprised of core committees with interface and support from a number of additional collaborative committees and key staff. Some committees include participating ABC network providers (non-employee) and ABC members.

A detailed description of the functions and membership of each committee can be found in the Colorado Access 2015 QAPI Program Description.



The structure enables the program to:

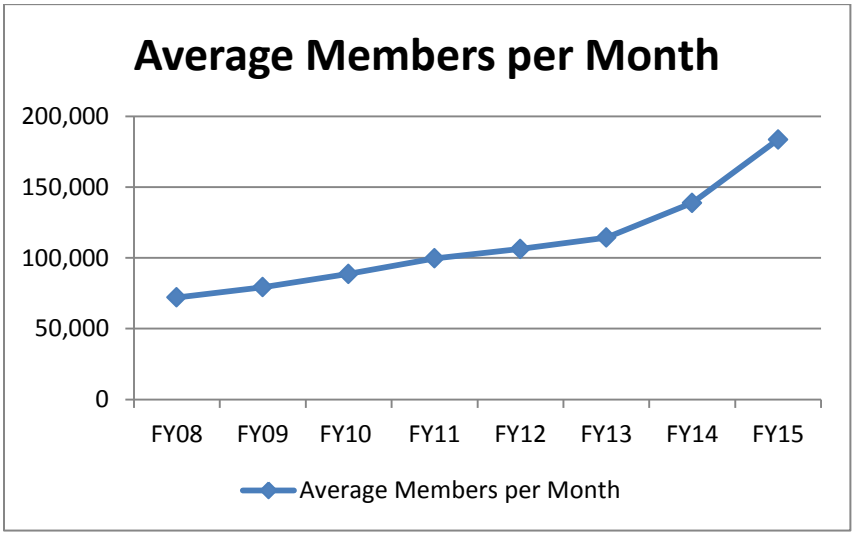
- Identify the most important quality assessment and performance improvement issues
- Obtain comprehensive feedback on the methods and results of its initiatives
- Use the results of quality assessment, performance improvement, and program evaluation activities to conceptualize and carry out efforts to enhance administrative services and the quality of clinical care.

Membership

Enrollment

ABC Membership continues to increase from previous years, with FY15 membership making a significant jump from an average of 138,850 in FY14 to an average of 183,542 member months in FY15. This spike in membership is attributed primarily to the continued Medicaid expansion, particularly in the AWDC (Adults without Dependent Children) aid category.

	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15
Average Members/Month	72,074	79,321	88,610	99,595	106,335	114,309	138,850	183,542



The effects of this increase in membership are demonstrated throughout this evaluation and are likely related to other increases experienced by COA, such as increases in inpatient and emergency department utilization. COA is working diligently to better understand the expansion population and their unique health needs, as many were previously uninsured.

The ABC membership is further broken down by age and aid category in the tables below.

Membership by Age	FY15
Children (0-12)	34%
Adolescent (13-17)	9%
Adult (18-64)	52%
Older Adult (65+)	5%

Membership by Aid Category)	FY15
Categorically Eligible Low-Income Adults (AFDC-A)	15%
Categorically Eligible Low-Income Children (AFDC-C)	40%
Disabled Individuals to 59 (AND-AB)	6%
Baby Care Adults (BCKC-A)	1%
Baby Care Children (BCKC-C)	2%
Foster Care (FC)	1%
Adults 65 and Older (OAP-A)	4%
Disabled Adults 60-64, (OAP-B)	1%
Adults without Dependent Children (AWDC)	28%

Penetration

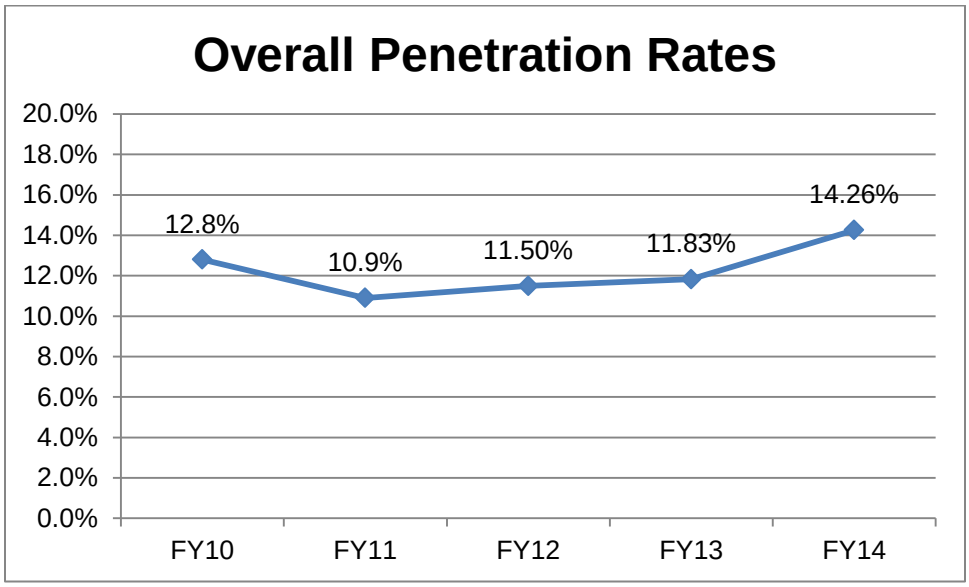
Penetration rates are calculated annually in order to measure the percentage of members who have received one or more behavioral health service. Please note that the penetration rates are presented through FY14. FY15 penetration rates are not calculated until fall 2015. FY15 penetration rates will be presented in the FY16 annual quality report.

Goal for FY15

- Maintain or increase overall penetration rate from previous fiscal year

Results and Analysis

FY14 penetration rates showed a significant increase from 11.83% in FY13 to 14.26%. This translates to nearly 8,000 additional members receiving services this year as compared to previous years. This demonstrates that not only has the ABC membership increased, but the newly eligible expansion population has been seeking services at a higher rate than previously existing populations.



Planned interventions and Goals for FY16

- ABC plans to continue focusing efforts on improving the foster care penetration rates by coordinating efforts with the Denver Department of Human Services and the Eastside Foster Care Clinic (DIBS).

Goal for FY16

- Maintain or increase overall penetration rate from previous year.

Access to Care

Service Accessibility

ABC and it's extensive provider network strive to provide timely access to routine, urgent, and emergent behavioral health services for members. ABC continued to work closely with the Mental Health Center of Denver (MHCD) and other high-volume providers to increase performance on access to care metrics.

ABC continues to re-educate providers on access to care standards via communication methods such as provider bulletins, posting of standards on the Colorado Access website, and direct communication with specific providers regarding access issues as they occur.

Access to Care Standards include the following:

- Routine Care available within 7 business days of request
- Urgent Care available within 24 hours of request
- Emergency face-to-face services available within 1 hour of request in urban/suburban areas and within 2 hours of request in rural/frontier areas
- Emergency phone services available within 15 minutes

Goals for FY15

- 100% compliance with Routine Care standards
- 100% compliance with Urgent Care standards
- 100% compliance with Emergency face-to-face standards
- 100% compliance with Emergency phone services standards

Results and Analysis

ABC consistently met the performance goals for three of the four access to care standards. Results are displayed below.

Access to Care Standard	FY13	FY14	FY15
Routine	100%	100%	100%
Urgent	100%	100%	100%
Emergency Face-to-face	94%	93.7%	95.7%
Emergency Phone	100%	100%	100%

While ABC did not meet the goal for emergency face-to-face services, all members who presented in the emergency department were medically triaged and stabilized upon arrival. ABC continues to receive feedback from local emergency departments that there is an upsurge in the overall volume of emergency mental health evaluation requests.

Planned Interventions

- Continue educating providers on access to care standards
- Continue to monitor access to care data on a quarterly basis per contractual requirements
- Collaborate with the Community Crisis Connections to obtain addition data around emergency face-to-face services (mobile and walk-in)

Goals for FY16:

- 100% compliance with Routine Care standards
- 100% compliance with Urgent Care standards
- 100% compliance with Emergency face-to-face standards
- 100% compliance with Emergency phone services standards

Telephone Accessibility

Monitoring reports are generated from COA's telephone system to provide information on calls from both providers and members, such as: the percentage of calls answered, number of calls abandoned, types of calls received, and the percentage of calls reverting to voice mail or overflow. Telephone statistics are reviewed every quarter by the Quality Improvement Committee and are used to evaluate adherence to performance goals.

Goals from FY15

- ≥ 80% of calls answered within 30 seconds
- ≤ 5% call abandonment rate
- ≤ 5% overflow to voicemail (overflow percentage)

Results and Analysis

As demonstrated below, COA surpassed all identified telephone accessibility goals for FY15.

Telephone Standard	FY13	FY14	FY15
30 Seconds	89.1%	88.5%	89.93%
Abandonment Rate	1.8%	2.3%	1.24%
Overflow Rate	1.1%	2.4%	1.70%

Top Reasons for Call	Number of Calls
Eligibility verification	6368
Claim status inquiry	3112
Provider search requests	735

Planned Interventions

- Continue tracking call results on a quarterly and annual basis
- Monitor call reasons and identify areas needing service improvement

Goals for FY16

- ≥ 80% of calls answered within 30 seconds
- ≤ 5% call abandonment rate
- ≤ 5% overflow to voicemail (overflow percentage)

Increasing Youth Access to Mental Health Services

The Quality Improvement Committee evaluated ABC utilization and penetration data in September 2012, which showed that children and teens had a much lower utilization rate than other behavioral health organizations (BHOs) across the state. The committee recommended that ABC focus improvement efforts on increasing overall access to mental health services for the youth population (Ages 5-17).

The goal of this performance improvement project (PIP) was to improve service access and to increase treatment utilization, as demonstrated by an increase in overall penetration rates for all behavioral health services for youth members. This age group was a potentially high-risk population, as there is a high prevalence of depression and suicide risk in the youth segment of the population, both nationally and statewide. This study topic addresses access to a broad range of mental health services including screening, referral, assessment, and treatment.

ABC developed a workgroup and held a number of stakeholder meetings in late 2012 and early 2013 and parent focus groups in May 2013 to identify barriers to mental health access and potential interventions. As a result, information about community mental health resources was widely distributed to primary care medical providers and members/families throughout the Denver metro region.

Results and Analysis

As demonstrated in the table below, the number of youth ages 5-17 that assessed mental health services increased from 4290 in calendar year (CY) 2012 to 10,504 in calendar year 2014. The Health Services Advisory Group (HSAG) validated the PIP submission for Re-measurement period 1 (CY13) and determined that all evaluation elements were met. HSAG did not validate this project for Re-measurement period 2 (CY14).

Evaluation Period	# of youth members receiving services	% of youth members receiving services
Calendar year 2012 (baseline)	4290	10.2%
Calendar year 2013	5417	11.3%
Calendar year 2014	10,504	13.8%

Planned Interventions

COA will not continue the formal monitoring of this project. However, COA has launched several public service announcements (PSA) on social media sites including Facebook, Twitter and You Tube. These PSAs will stress the importance of accessing mental health services and will highlight the state-wide Colorado Crisis Services number as a resource for kids and parents.

Network Adequacy: Network Composition

ABC has built and maintained an extensive provider network to maximize the range of availability and member choice. This network offers a comprehensive continuum of services and coverage that extends beyond ABC's state contracted service region. ABC is committed to sustaining a superior network of providers through a spectrum of community mental health centers, clinics, hospital-based facilities, other essential community-based resources, and contracts with individual community practitioners to provide accessibility to all covered behavioral health services for members.

ABC has continued to shape its extended provider network as the population of enrollees has grown, to ensure an appropriate mix and number of providers. New individual practitioners and organizational providers are added to the network as necessary to fill gaps, meet special needs, and ensure convenience and choice.

Goals from FY15

- Meet the geographical needs of members by assuring provider availability
- 100% of members have access to a provider within 30 miles

Results and Analysis

Due to the significant overlap in provider networks for both ABC-Denver and ABC-NE, the results below represent performance for the combined membership and provider networks for both regions.

Practitioners by Type	Total providers
Prescribers	**2389**
Licensed Mental Health Practitioners	**646**
Unlicensed Mental Health Practitioners	**215**
Case Manager/Mental Health Workers	**387**
Total	**3637**

Organizational Provider by Type	Total
Hospital	**50**
Mental Health Center	**18**
Federally Qualified Health Center	**82**
Residential Treatment Center	**16**
Total	**166**

ABC also monitors the geographic spread of members and providers in order to assure that our network meets the standard that all members have at least one provider within 30 miles of their home. At the close of FY15, 99.3% of ABC-Denver and ABC-NE members were within 30 miles of a contracted provider. The remaining 0.7% of members (2,397 members) were located in rural areas of the ABC-NE region. ABC continues to recruit in these rural areas for increased access and availability.

ABC Network Availability	FY13	FY14	FY15
Percentage of members with access to a provider within 30 miles	100%	100%	99.3%

Because ABC maintains an extensive network, the need for single case agreements or out-of-network activity is minimal. Single case agreements are only initiated when the existing network is not able to meet the specific needs of an individual member. The reason for single case agreements includes continuity of care when treatment was rendered by a prior treating provider who is not contracted with ABC or does not wish to be a contracted provider. During FY15, there were 20 single case agreements to serve ABC members.

ABC is confident the existing provider network is adequate for the population served, as there were no grievances related to care access or availability. Network adequacy will continually be monitored using member and provider feedback to determine whether additional specific recruitment efforts are needed.

Planned Interventions

- Continue to monitor network composition and needs. Ongoing efforts will be made to recruit providers with expertise in meeting special needs or special population issues, substance use disorders, fluency in Spanish, and prescribing capabilities.
- Recruitment of providers who serve foster care children
- Recruitment of providers who specialize in trauma-informed care
- Identify any gaps in specialty services available in the existing provider network

Goals for FY16

- Meet the geographical needs of members by assuring provider availability (100% of members have access to a provider within 30 miles)

Network Adequacy: Cultural and Linguistic Needs

A culturally diverse network provides services to members that account for cultural norms, language differences, other special needs, and diverse lifestyles. ABC strives to determine and ensure that its' provider network is inclusive enough to serve specific populations and meet special treatment needs.

Goals from FY15

- To continue to meet the cultural, ethnic, and linguistic needs of members by assuring a diverse provider network

Results and Analysis

ABC recruits and maintains contracts with practitioners and agencies with a variety of specialized cultural expertise and linguistic competency. Colorado Access also directly employs many multi-linguistic staff to assist members and facilitate service delivery.

ABC ensures that members and family members are informed of their right to have information and services provided in a language or format they are able to understand. ABC also informs providers of the availability of interpretive services and other resources. When services cannot be delivered in a member's primary language with existing resources, ABC and its core providers maintain contractual arrangements with agencies providing interpretation services. The table below demonstrates the number of providers fluent in languages other than English:

Language	Number of providers
Spanish	41
French	5
German	4
American Sign Language	4
Other	7

The Mental Health Center of Denver has a number of programs specifically designed to be responsive to members' cultural, linguistic, and special needs:

- **El Centro de las Familias**: Comprehensive mental health services provided to Denver's Latino community. All clinical, psychiatry, and support staff are bilingual.
- **Voz y Corazon**: A suicide prevention project that has been designed by teens, involves teens and supports teens. The organizations that joined in collaboration launched the project to value the healing power of culture, connectedness, and caring.
- **Deaf/Hard of Hearing Counseling Services**: A full range of outpatient services is available to individuals and families statewide. Staff is fully fluent in American Sign Language (ASL) and Signed English.
- **Living and Learning with HIV**: Services for members and their families, children, and significant others who are living with HIV or AIDS.

Other ABC provider agencies also have specialized expertise in cultural and linguistic competency, including:

- **Servicios de la Raza**: The mission of Servicios de La Raza is to provide and advocate comprehensive, culturally relevant human services primarily, but not limited to, the Spanish speaking population.
- **Asian Pacific Development Center (APDC)**: The Asian Pacific Development Center is a community-based organization serving the needs of a growing population of Asian American and Pacific Islander residents throughout Colorado. APDC operates a licensed Community Mental Health Clinic designated by the Colorado Department of Public

Health and Environment. APDC provides culturally competent services that include assessment, individual and group counseling, case management services, victim assistance services, mentorship, youth leadership programs, health promotion, interpretation/translation services, and cultural competency training and consultation.

- **Jewish Family Services (JFS)**: The mission of Jewish Family Services is to restore well-being to the vulnerable throughout the greater Denver community by delivering services based on Jewish values. JFS licensed therapists provide counseling and psychiatric care management for those with serious and persistent mental illness. JFS also provides services to ABC members under the Federal Refugee Program from Middle Eastern and African nations.
- **Rocky Mountain Survivors Center**: The Rocky Mountain Survivors' Center provides mental health services to survivors of torture and war trauma (and their families) to heal and rebuild their lives. Mental health services address emotional, cognitive, psychosocial, and somatic consequences of torture and/or war trauma; and support strengths and empower participants to build new futures in the community. Mental Health services include assessment, treatment, psychiatric evaluation, and medication management.
- **University of Colorado-Denver Refugee Mental Health Program**: Through the Refugee Health Program of Colorado and the University of Colorado Denver AF Williams Family Medicine Clinic, mental health treatment is available to refugees.
- **Developmental Disabilities Consultants**: Developmental Disabilities Consultants is a private mental health agency specializing in working with clients with developmental disabilities. They provide routine mental health outpatient services for children and adults, as well as home based mental health services for children. A specially trained behavioral specialist works with parents and children in their homes. They have a staff member trained specifically to work with members with closed head injuries.
- **Rocky Mountain Human Services (RMHS)**: provides services to children and adults with intellectual and developmental disabilities, including team based mental health care comprised of psychiatrists, psychologists, and behavior specialists.

ABC's commitment to diversity is exemplified by the company's cultural competency training requirement for all staff with an expanded module for managers on Generational Diversity. ABC has various modules of the cultural competency training that is offered to contracted health care professionals in the community, to help ensure that individuals have the knowledge and skills to deliver effective services to members of diverse backgrounds. During FY15, Colorado Access continued to offer and provide training to individuals, employees, contracted providers, practitioners, and community health centers on such topics as Basic Cultural Competency, Effective Communication When Using an Interpreter and Health Disparities.

Planned Interventions

- ABC will continue to evaluate network needs for providers with cultural/linguistic and other special needs expertise relative to the characteristics of the BHO membership.
- Provider contracting will continue efforts toward the recruitment and retention of providers and practitioners with cultural, linguistic, or special needs expertise.
- Cultural competency training will continue to be provided to staff and offered to network providers as requested.

Goals for FY16

- To continue to meet the cultural, ethnic, and linguistic needs of members by assuring a diverse provider network

Innovative Service Models: Telemedicine

Colorado Access has developed new technologies to increase access to behavioral health care for ABC members through telemedicine technology. Access Care Services and Access Care Technology are leaders in the telemedicine field. These innovative solutions provide capabilities for both members and providers.

Access Care Services: Provide clinical delivery models and services that facilitate real-time access to care, as well as coordination of care between members, providers, and systems.

Access Care Technology: Provides a telemedicine platform that enables real-time, video-based treatment in a high definition environment called Aveo™. The platform was specifically built for behavioral health but is highly scalable to multiple disciplines. At present, this technology is being utilized at the University of Colorado Depression Center.

This technology will provide increased access for members who may have difficulty getting care in traditional office settings or who may prefer virtual care. It will enable warm hand offs between providers and will facilitate smoother transitions of care.

In 2016 Access Care Services will continue to provide integrated telepsychiatry into the following sites:

- The Children's Health Place: Started seeing curbside consults in March 2015 and started seeing patients in April 2015
- Rocky Mountain Youth: First curbside dry run September 22, 2015. First patients scheduled for October 2015
- Sheridan Health Services: First curbside dry run September 28, 2015. First patients scheduled for October 2015
- Yuma Hospital District: First curbside scheduled for October 2015 and first patients scheduled for November 2015
- Horizon Pediatrics: First curbside scheduled for November 2015 and first patients scheduled for December 2015

COA estimated 10 curbside consults per month per site and 5 patients per site per month in 2015. In 2016 COA estimates 15 curbside consults per month per site and 10 patients per site per month, and adding one additional site at Denver Indian Health and Family Services.

Goal for FY16

- Launch telepsychiatry curbside consults in a minimum of 5 provider sites

Member and Family Experience

Member Satisfaction: ECHO survey

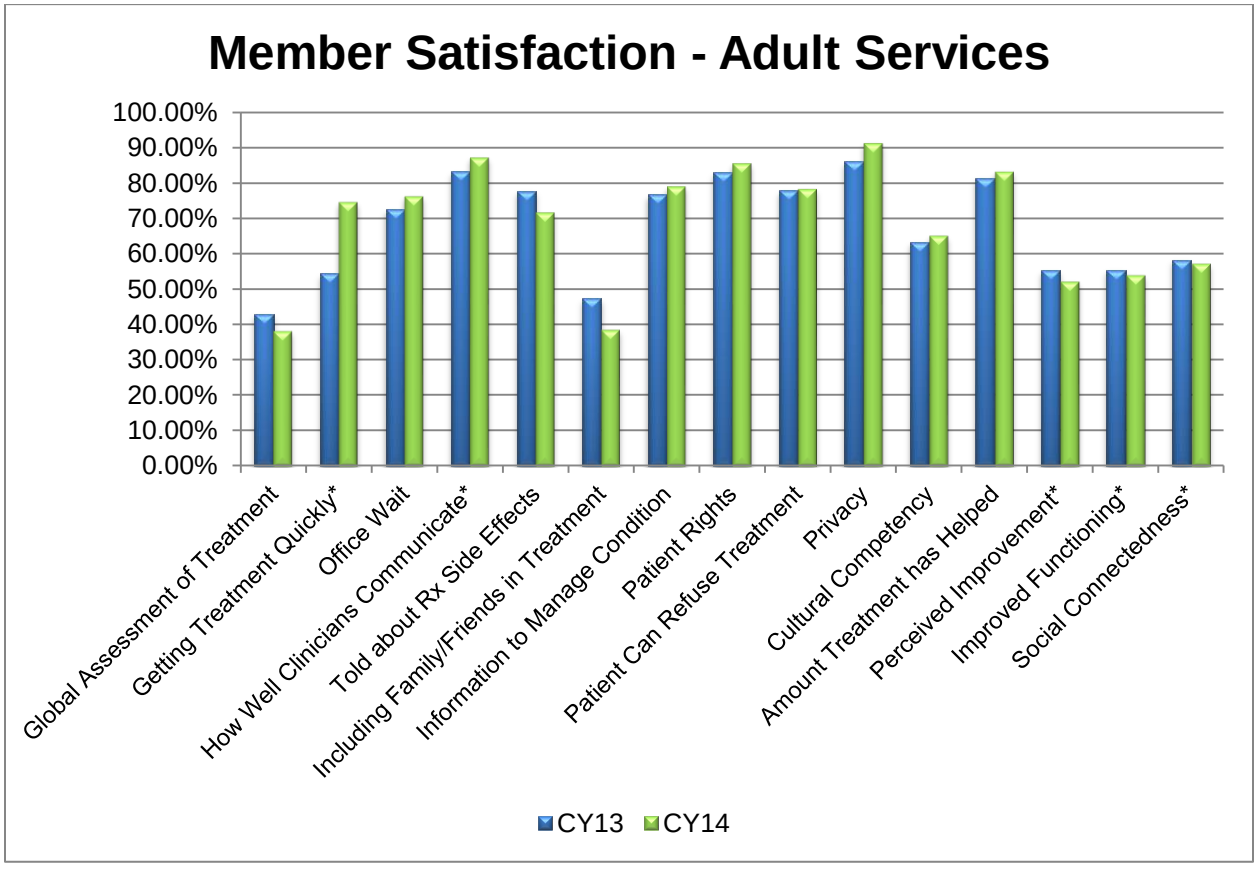
Member evaluation of the services offered by ABC is critical to the identification of opportunities to improve all aspects of care to our members. During FY15, the Department of Health Care Policy and Financing (HCPF) adopted a new survey instrument for the assessment of member satisfaction. The Experience of Care and Health Outcomes survey for Managed Behavioral Healthcare Organizations, Version 3.0 (ECHO) was modified to also include several items from the previous tool utilized. Two rounds of the ECHO were administered during FY15 – the first was administered from July 2014-October 2014 to a sample of members who had received services during calendar year 2013 (these results are labeled as CY13). The survey was administered again in the spring of 2015 to a sample of members who received services during calendar year 2014 (these results are labeled CY14).

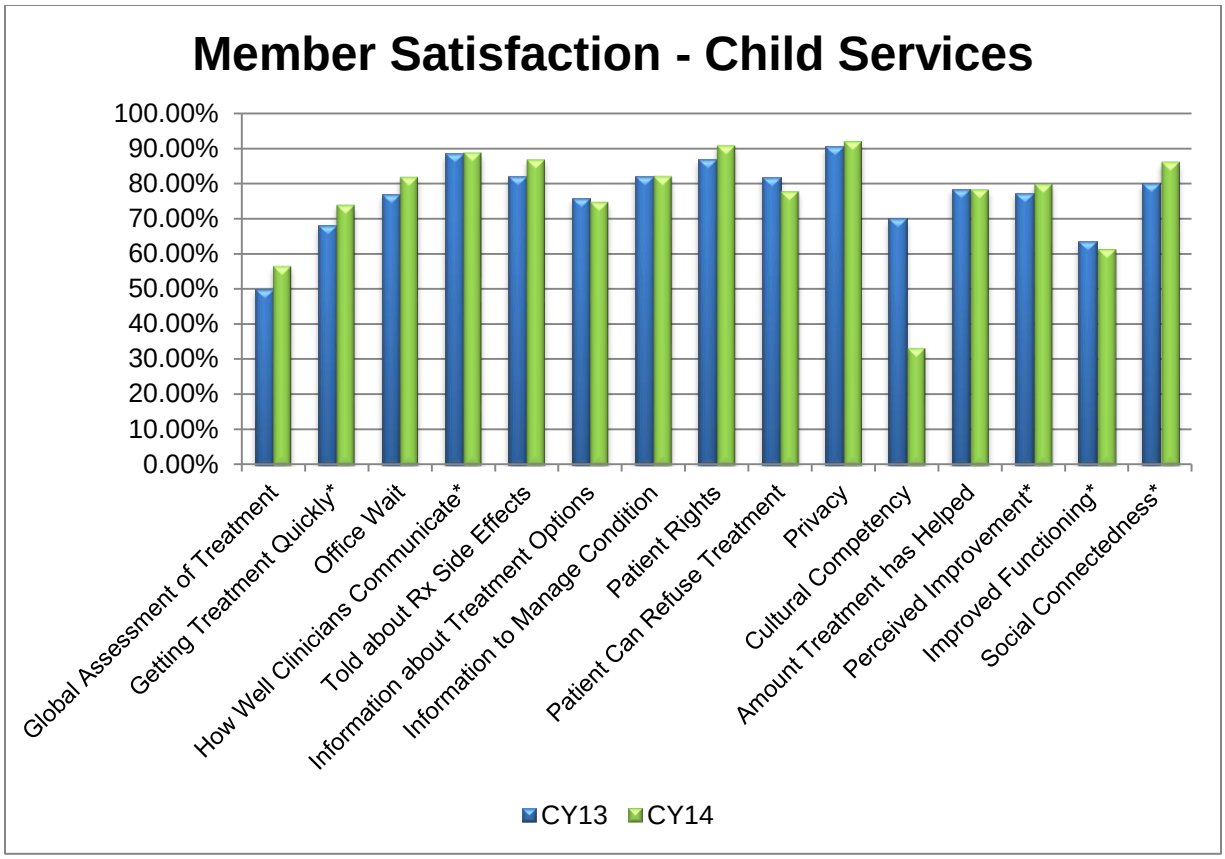
Goal from FY15

- To monitor member satisfaction with services offered by Colorado Access
- To establish a baseline assessment of satisfaction using the ECHO survey tool

Results and Analysis

The charts below reflect ABC Denver's performance on the ECHO survey for both children and adult for the past two survey cycles.





Survey results from both years showed very little variation and allow ABC to establish baseline performance on which to base future results.

The following table presents information about the response rates for both rounds of survey administration. It is noteworthy that the response rate for the second survey was significantly lower for both children and adults. ABC will continue to work with the Department and HSAG in order to return the most optimal response rates possible.

Survey Population	CY13	CY14
Adult Services	359	228
Child Services	192	156

Goals for FY16

- Meet or exceed ECHO satisfaction results from FY15

Member Grievances

Grievance data assists in the identification of potential sources of dissatisfaction with care or service delivery. Member grievance data is aggregated quarterly with review by the Quality Improvement Committee and submission to HCPF.

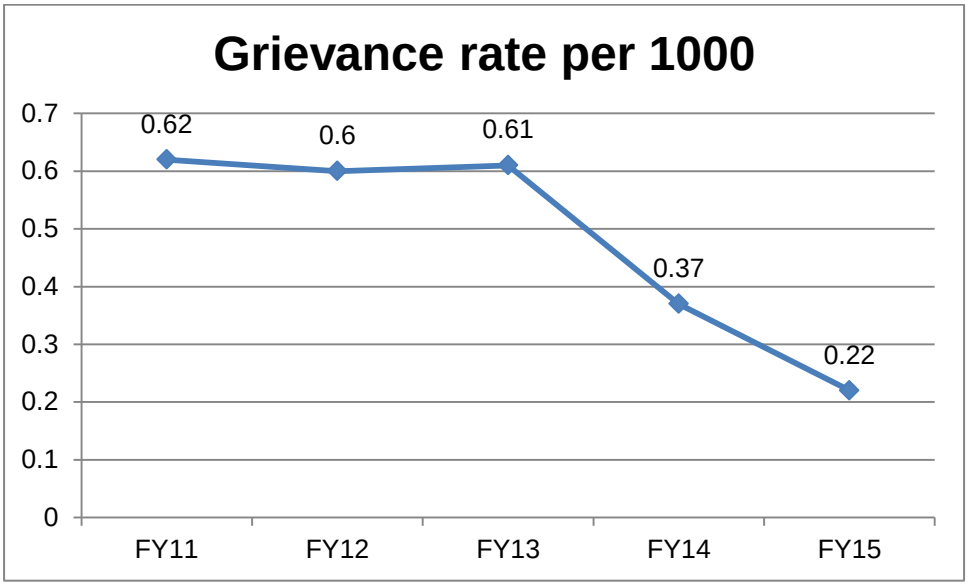
Goals from FY15

- 100% resolution within contractual timeframes
- < 2 grievances per 1000 members

Results and Analysis:

During FY15, a total of 44 grievances were filed. A breakdown of the grievances by category can be found in the table and chart below. The grievance rate per thousand for the total number of grievances was 0.22 grievances, which met the goal of less than 2.0 grievances per 1000 members.

Grievances by Category Type					
	FY11	**FY12**	**FY13**	**FY14**	**FY15**
Access & Availability	7	8	14	12	6
Clinical Care	0	1	0	20	20
Customer Service	38	48	42	13	9
Financial	10	7	12	5	2
Rights/Legal	0	3	1	0	3
Total	**55**	**67**	**69**	**50**	**40**



Out of 44 grievances, 31 (73.81%) were resolved within 15 business days; the remaining 11 grievances required an extension. For these 11 grievances, the appropriate grievance extension procedures were followed. Therefore, 100% of the 44 grievances were resolved according to contractual requirements.

Planned Interventions

- Continue to refine and improve documentation for grievance processing and reporting
- Continue close monitoring of grievance processing to ensure 100% compliance with timeliness
- Assess any significant trends or patterns, with continued attention to timeliness of resolution, satisfactory resolution, and adherence to state and federal regulations
- Continue education and outreach to members, families, and providers to ensure that they are informed of member rights and procedures for filing grievances
- Continue collaborative working relationships with Colorado Medicaid Managed Care Ombudsman Program staff

Goals for FY16

- 100% resolution within contractual timeframes
- < 2.0 grievances per 1000 members

Quality of Care Concerns

Colorado Access's Quality of Care (QOC) process identifies, investigates, and addresses potential quality of care concerns, including those involving physician providers. QOCs can be raised by members, providers, or COA staff and include all potential problems, concerns, or complaints concerning access to urgent or emergent care, delay or denial of care or services, after-hours services, professional conduct or competence, coordination of care, medication issues, diagnosis issues, service plan or delivery issues, or concerns with legal or member rights. QOCs are also triggered by care resulting in unexpected death, suicide attempts requiring medical attention, medication errors, or adverse medication effects requiring medical attention, preventable complication requiring medical attention, assault or accident related injuries requiring medical attention, or an at-risk client missing from a 24-hour facility.

Potential QOCs are forwarded to the Quality Improvement Department for initial investigation and are then submitted to the ABC Medical Director for review and a determination. Findings are confidential under peer review statutes.

Goal from FY15

- < 2.0 QOCs per 1000 members

Results and Analysis:
There were 3 QOCs reported for ABC Denver during FY15. This represents a rate of 0.02 per 1000 member months, well below the identified goal. This performance is consistent with previous years, as demonstrated in the table below.

QOC Rate	FY13	FY14	FY15
Number of QOCs Received	2	2	3
Average Membership	114,309	138,850	183,542
Rate per 1000 members	**.017**	**.014**	**.016**

Planned Interventions

- Continue to investigate and resolve quality of care concerns. Outcomes are monitored and incorporated into the provider re-credentialing process as applicable.
- ABC Quality Improvement staff will continue to work with Customer Service staff to ensure that all Quality of Care concerns are correctly identified and forwarded to Quality for investigation.

Goals for FY16

- < 2.0 QOCs per 1000 members

Utilization Management

Utilization Management Decisions

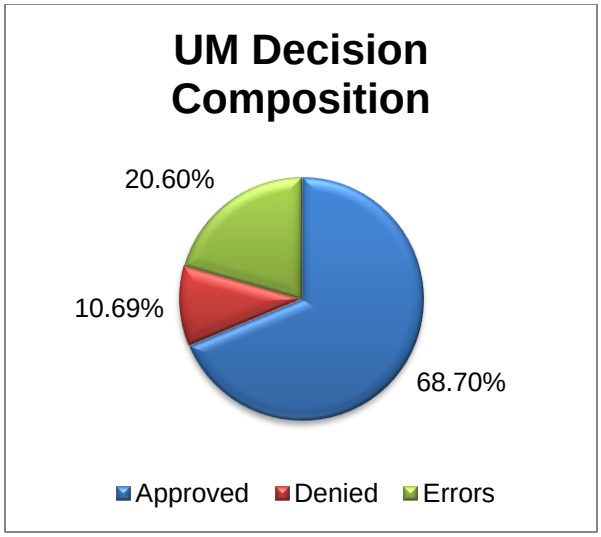
Timeliness of utilization management (UM) decision making is monitored regularly in order to assure that decisions are made according to contractual requirements and to support members' accessibility to services according to need. Patterns in decision making are analyzed in order to identify opportunities for improved efficiency and consistency among decision makers.

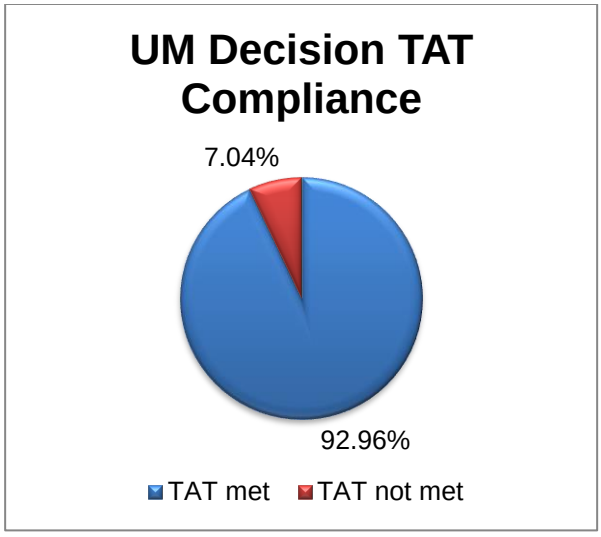
Goal from FY15

- 100% of UM decisions made according to timeliness standards

Results and Analysis

In FY15, Colorado Access began monitoring the timeliness of all UM decisions, both approvals and denials (historically, only timeliness of denials was monitored). Both the proportion of approvals to denials and the percentage of compliance with turn-around times (TAT) for all decisions are shown in the figures below.





During the fourth quarter of FY15, Colorado Access identified significant issues with data entry in the utilization management system used (Altruista). These data entry errors (such as missing request dates, errors in data entry, etc.) resulted in missing data for over 20% of all UM decisions for ABC. In addition, several miscommunications and workflow issues were identified that were causing non-compliance with decision timeframes, including decisions involving a single-case agreements. The quality team has worked in collaboration with the UM team in order to resolve these issues.

Strategies and planned interventions

- Significant training with UM staff regarding data entry mistakes, with emphasis on required fields. The monthly monitoring reports now also include detail on the errors made by staff member. In addition, Colorado Access has requested several updates to the Altruista system, including making various fields required entry before saving.
- The monthly monitoring report was also revised to include detail of missed TAT by staff member in order to provide more focused staff training around missed timeframes.

Goals for FY16

- Reduce UM decision error rate to at least 1%
- Improve TAT compliance to 97% or higher

Clinical Appeals

Members have the right to appeal any action that denies services or pharmaceuticals. Colorado Access tracks the number and types of appeals received in order to monitor for any decision patterns or possible issues related to the accessibility of services.

Goal from FY15

- 100% of appeals resolved within contractually required timeliness standards
- Monitor appeal rates for any patterns

Results and Analysis

Metrics for appeal volume for ABC for FY15 are listed in the table below. All appeals (100%) were resolved within contractually required timeframes. ABC experienced an increase in the percent of denials overturned (4 total). Each of the overturned appeals was an expedited request.

	FY12	FY13	FY14	FY15
Total number of appeals	13	16	15	13
% of denials appealed	5.3%	5.3%	3.1%	5.3%
Appeal rate (per 1000 members)	0.12	0.14	0.08	0.07
% of UM denials overturned	0.8%	0.7%	0.2%	1.6%

Planned Interventions

- ABC will continue to monitor appeal metrics on a quarterly basis to determine if this increase is stable or an outlier circumstance.

Goals for FY16

- Continue resolving 100% of appeals within contractually required timeliness standards
- Continue to monitor appeal rates for any patterns

Inter-rater Reliability

The utilization management inter-rater reliability analysis (IRR) was conducted to objectively assess level of consistency among UM decision makers and adherence to COA approved medical management criteria/guidelines.

The goal of the annual inter-rater reliability analysis is to minimize variation in the application of approved criteria and to:

- Evaluate staff's ability to identify potentially avoidable utilization
- Target any previously identified specific areas most in need of improvement
- Identify those staff needing additional training
- Avoid potential litigation due to inconsistently applied approved criteria/guidelines
- Meet specific contractual, regulatory agency, or accrediting agency requirements.

The Coordinated Clinical Services (CCS) Department is divided into physical health, behavioral health, and pharmacy specialty areas. The CCS Clinical/UM Staff who review physical health requests are licensed registered nurses and licensed practical nurses who apply clinical criteria and utilize clinical judgment within their scope of practice. The behavioral health review staff are licensed mental health professionals who apply clinical criteria and utilize clinical judgment within their scope of practice. The Intake Specialists have received specialized training in following scripted protocols to enter pre-authorizations for routine levels of care or specialty referrals that do not require the review of a licensed professional.

Coordinated Clinical Services/UM staff were evaluated using the McKesson InterQual® (IQ) Behavioral Health Criteria (Adult) Interrater Reliability Tools. The Intake Specialists were given a set of case studies and questions that involve approved scripted criteria/guideline application to determine if the request could be approved or required referral to the CCS Clinical Staff for further review. Each clinical area is then scored and reported separately.

Goal from FY15

- 90% agreement between raters, both intake and clinical

Results and Analysis

The overall score for the CCS Intake Staff was 93.3% which meets the 90% benchmark. The CCS Clinical/UM staff scored 69% overall on the Behavioral Health Criteria for Adults, which did not meet the 90% goal.

CCS Management Staff conducted individual focused coaching of staff regarding scripted guidelines and InterQual® criteria interpretation and use. All staff who did not pass with 90% or greater was required to attend an annual policy and procedure training, refresher course on how to apply InterQual® criteria, and review of tools/resources loaded on the 'Resource Page' in the clinical documentation system. It was determined that several of the IRR test questions were answered incorrectly by all staff members. The training focused most heavily on the concepts related to those questions. These individuals were re-tested after focused training completed in March 2015. The overall score for CCS Clinical Staff was 94.2% overall and 95.6% for the Behavioral Health Criteria for Adults, both of which meet the identified goal.

Planned Interventions

- Continue to conduct focused training with CCS Clinical Staff to improve the consistency of decision making.
- Continue collaboration between the CCS and quality departments in order to streamline IRR testing

Goals for FY16

- At least 90% inter-rater reliability between both intake and clinical staff in each area of area of pediatric and adult services

Performance Measures

Reducing Over- and Under-Utilization of Services

Please note that all performance measures are from FY14. FY15 measures are not calculated until fall 2015 and not validated until winter 2015-2016. FY15 performance measures will be presented in the FY16 annual quality report.

Goal from FY15

- Perform at or below BHO average for each measure

Hospital Readmissions

While 7-day readmission performance remained stable from FY13 to FY14, 30-day and 90-day readmissions experienced an increase. Dedicated ABC Care Managers work diligently to assist members in getting outpatient appointments post hospital discharge with the goal of preventing or reducing readmission rates. ABC also recently imbedded a care manager in the Denver Health Psychiatric Emergency Department to assist with more timely care management intervention. The Peer Specialist Team has also recently hired two additonal staff to work with members who have recently been in the Denver Health Emergency Department.

	FY12	FY13	FY14	FY14 BHO Ave	ABC goal
7-day readmissions	4.26%	2.77%	2.88%	3.18%	< 5.0%
30-day readmissions	11.41%	9.43%	11.66%	9.61%	< 13.0%
90-day readmissions	18.90%	15.90%	18.52%	15.98%	< 20.0%

Inpatient Utilization

The ABC UM and Care Management teams work with both providers and members in order to provide members with medically necessary treatment in the least restrictive settings. The relationships between these teams and the provider network allow for the identification of appropriate outpatient and subacute programs in order to reduce the need for inpatient treatment. Through these interventions, ABC was able to maintain performance consistent with both the previous year and with the BHO average.

	FY12	FY13	FY14	FY14 BHO Ave	ABC goal
Inpatient Utilization per 1000 members	5.58	4.78	4.78	4.36	< 6.0

Average Length of Stay

Because inpatient stays in state hospitals tend to be disproportionally longer than inpatient stays in a non-state hospital, average length of stay is calculated both for all hospitals (including state hospitals) and for non-state hospitals alone. The UM and Care Management teams continue to work diligently with inpatient providers on discharge planning and transitioning members to lower levels of care when medically appropriate following an inpatient stay. Care managers have also recently started attending bi-weekly meeting at the Colorado Mental Health Institute at Fort Logan in order to build relationships with the care teams and better assist with discharge planning.

	FY12	FY13	FY14	FY14 BHO Ave	ABC goal
All hospital	16.89	14.77	16.63	14.24	NA
Non-state hospitals	9.36	9.19	8.80	8.15	9.0

Emergency Department Utilization

ABC Customer Service and Care Management teams continue to work to help members find behavioral health providers as an alternative to the emergency department. ABC has also been collaborating with the new state-wide crisis services and promoting the use of the walk-in clinics as an alternative to the ED. However, ABC continues to experience an increase in ED usage over the past three years, largely due to the expansion population.

	FY12	FY13	FY14	FY14 BHO Ave	ABC goal
ED utilization per 1000 members	11.24	12.58	14.55	10.92	< 12.0

Goals for FY16

- Hospital Readmissions (7 day < 5%; 30 day < 13%; 90 day < 20%)
- Inpatient Utilization per 1000 (< 6.0)
- Average Length of Stay (< 9.0)
- ED Utilization (< 12.0)

Improving Member Health and Safety

Please note that all performance measures are from FY14. FY15 measures are not calculated until fall 2015 and not validated until winter 2015-2016. FY15 performance measures will be presented in the FY16 annual quality report.

Goal from FY15

- Perform at or above BHO average for each measure

Percentage of Members on Duplicate Antipsychotic

Certain clinical circumstances allow members occasionally to be prescribed two or more atypical antipsychotic medications at the same time. This indicator measures those members prescribed multiple atypical antipsychotic medications (for 120 days or more) in proportion to members who are prescribed only one atypical antipsychotic. Although ABC is currently performing above the BHO average, ABC has experienced improved performance over the past 3 years.

	FY12	FY13	FY14	FY14 BHO Ave
Redundant Atypical Antipsychotics	12.14%	11.77%	9.14%	7.07%

Depression and Medication Management/Monitoring

These indicators measure (1) the percent of members diagnosed with a new episode of major depression, treated with antidepressant medication, and who had at least three follow up contacts with a practitioner during the acute treatment phase (84 days or 12 weeks); and (2) percent of members who have been diagnosed with a new episode of major depression, treated with antidepressant medication, and maintained on antidepressants for at least 84 days (12 weeks). ABC continues to perform well above the BHO average for this measure, and will continue to monitor performance in this area.

	FY12	FY13	FY14	FY14 BHO Ave
Optimal Practitioner Contacts	46.67%	44.63%	50.18%	32.37%
Medication Monitoring	26.67%*	67.27%*	65.61%	58.91%

*Please note that FY12-FY13 data is not comparable to recent years due to a chance in calculation methodology

Improving Member Functioning

The Recovery Model focuses on empowering members not only in relation to their illness, but also for members to take charge of their entire lives. Two performance measures focus on improving overall member functioning, as measured by their living status. The Independent Living Status indicator measures the percent of clients, age 18 years and older, living independently, that maintain this status during the measurement period. The Progress Towards Independent Living Status indicator measures the percent of clients, age 18 years and older, who move to a less restricted place of residence, including independent living, during the measurement period. ABC will continue to monitor performance on these indicators for any opportunities for intervention.

	FY14	FY14 BHO Ave
Maintaining Independent Living	95.85%	95.06%
Progress Towards Independent Living	9.86%	11.91%

Adherence to Antipsychotics for Individuals with Schizophrenia

This indicator measures the percentage of members 19-64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. This measure is not broken out by BHO, only measured state-wide for all Medicaid providers.

	FY13	FY14
Antipsychotic adherence	75.85%	70.37%

Goals for FY16

- Continue to perform at or above BHO average for the following measures:
  - Percentage of members on duplicate antipsychotics
  - Antidepressant medication management
  - Adherence to antipsychotics for individuals with schizophrenia
- Collaborate with HCPF and HSAG on the calculation and validation of the following new performance measures (beginning in FY15 calculations)
  - Psychotropic utilization in children
  - Diabetes screening for individuals with schizophrenia or bipolar disorder using antipsychotics
  - Cardiovascular monitoring for people with diabetes and schizophrenia
  - Diabetes monitoring for people with diabetes and schizophrenia

Access to and Coordination of Care

Please note that all performance measures are from FY14. FY15 measures are not calculated until fall 2015 and not validated until winter 2015-2016. FY15 performance measures will be presented in the FY16 annual quality report.

Goal for FY15

- Perform at or above BHO average for each measure

Follow-up After Hospital Discharge

An outpatient visit with a mental health practitioner after discharge is recommended to make sure that the member's transition to the home or work environment is supported and that gains made during hospitalization are not lost. It also helps health care providers detect early post-hospitalization reactions or medication problems and provide continuing care.

Research has found that member access to follow-up care within 7 days of hospital discharge from hospitalization for mental illness is a strong predictor of a reduction in hospital readmission. Facility treatment may stabilize individuals with acute behavioral conditions, but timely and appropriate continued care is needed to maintain and extend improvement outside of the hospital. The period immediately following discharge from inpatient care is recognized as a time of increased vulnerability. Ensuring continuity of care by increasing compliance to outpatient follow up care helps detect early post-hospitalization medication problems and provides continuing support that improves treatment outcomes and reduces health care costs.

Due to the increased care management efforts in FY14, ABC results for FY14 show a significant improvement over the prior year. Care management teams continue to meet with hospital discharge planners to arrange timely follow up appointments and identify barriers to follow-up care, and reaching out to providers to confirm attendance at follow-up appointments. ABC also co-located a care manager at Denver Health to be permanently on-site to assist with coordinating care for members discharging from Denver Health.

	FY12	FY13	FY14	FY14 BHO Ave
7-day follow-up	42.46%	39.89%	46.15%	50.15%
30-day follow-up	62.15%	58.99%	70.36%	69.34%

Behavioral Health Engagement

This indicator measures the percent of members who receive four or more services within 45 days of their initial visit. As this is a fairly new measure, ABC is still determining an appropriate baseline. ABC Care Managers are actively working with members who need to engage in SUD treatment. ABC has a new SUD Coordinator (CAC III) who will help triage and engage members.

	FY13	FY14	FY14 BHO Ave
Mental health treatment engagement	34.23%	34.55%	37.11%
SUD treatment engagement	NA	29.46%	45.99%

Behavioral Healthcare Focal Point

This indicator measures the percent of adult members with SMI (Diagnosis of Schizophrenia, Bipolar Disorder, or Schizoaffective Disorder) who have a focal point of behavioral health care identified (three or more behavioral health services or 2 or more prescriber services in a 12 month period). The decrease in performance may be a result of a dramatic increase in newly enrolled members who may not have a designated BH provider during the second half of FY14. ABC care managers will continue to actively assist members who need help finding an appropriate behavioral health provider.

	FY12	FY13	FY14	FY14 BHO Ave
% of SMI members with focal point of BH	96.12%	90.68%	85.78%	87.61%

Improving Physical Healthcare Access

Physical healthcare access is defined by the total number of Members who received outpatient mental health treatment during the measurement period and had a qualifying physical healthcare visit during the measurement period. ABC continues to perform consistent with BHO averages. ABC will continue to assist members in getting connected to medical homes.

	FY12	FY13	FY14	FY14 BHO Ave
% of members with BH and PH visit	59.07%	86.36%	88.60%	89.24%

Goals for FY16

- Improve follow-up after hospital discharge rates (7-day: > 60%; 30-day > 75%)
- Continue to perform at or above BHO average for Mental Health Engagement measure
- Collaborate with HCPF and HSAG on the calculation and validation for each of the following new performance measures (beginning in FY15 calculations)
    - Initiation and Engagement of SUD Treatment
    - Members with physical health well-care visits

Performance Measure Validation

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

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

- Information Systems Capabilities Assessment Tools (ISCATs) were requested and received from each BHO and the Department. Upon receipt by HSAG, the ISCATs were reviewed to ensure that all sections were completed. The ISCATs were then forwarded to the validation team for review. The review identified issues or items that needed further follow-up.
- Source code (programming language) for performance measures was requested and was submitted by the Department and the BHOs. The validation team completed query review and observation of program logic flow to ensure compliance with performance measure definitions during the site visit. Areas of deviation were identified and shared with the lead auditor to evaluate the impact of the deviation on the measure and assess the degree of bias (if any).
- Performance measure reports for FY 2013-2014 were reviewed by the validation team. The team also reviewed previous reports for trends and rate reasonability.
- Supportive documentation included any documentation that provided reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. All supportive documentation was reviewed by the validation team, with issues or clarifications flagged for further follow-up.

FY14 Performance measures that were selected for validation were:

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

Goal for FY15

- 100% compliance score for performance measure validation

Results and Analysis

ABC achieved “met” status for all applicable elements in the performance measure validation process. The strengths and areas of improvement from the final HSAG report are listed below.

Strengths:

- Performance calculation and reporting were performed by the same cohesive team, with a high degree of technical expertise.
- In 2014, ABC experienced major system change, assumed responsibility for an additional product line (substance use disorder), and experienced an increase in membership. However, even with these changes, the BHO was able to provide quality services to its members and maintain its performance level throughout the year.

Suggested areas of improvement:

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

Planned Interventions

- Continue to collaborate with HCPF, HSAG, and the other BHOs to improve the performance measure validation process.

Goals for FY16

- 100% compliance score for performance measure validation

Best Practices

Clinical Practice Guidelines

Colorado Access adopts current, evidence-based, nationally recognized standards of care based on the needs of the membership. Each guideline is reviewed annually and approved by the Colorado Access Quality and Performance Advisory Committee (QPAC), comprised of physicians and providers from the Colorado Access provider network. Approved practice guidelines are available to members and providers on the Colorado Access website or by request.

Goals from FY15

- Adopt and disseminate evidenced-based nationally recognized guidelines that promote prevention and/or recommended treatment
- Promote access to and increase usage of recommended guidelines through provider and member education/outreach

Results and Analysis

Colorado Access completed significant process improvement regarding the tracking and review of clinical practice guidelines in FY15. COA has adopted a new tracking mechanism, a specific timeline for review, a new format for guideline review by medical directors, and a new format for guideline review and approval by QPAC. This has resulted in increased efficiency and improved communication between quality staff, medical directors, and committee members.

Colorado Access has adopted the following behavioral health guidelines:

Behavioral Health Practice Guidelines	
Adolescent alcohol and substance use screening, brief intervention and referral to treatment (the CRAFFT tool)	Adult alcohol and substance use screening, brief intervention and referral to treatment (SBIRT)
Attention Deficit Hyperactivity Disorder	Bipolar Disorder (Adult)
Metabolic Monitoring of Adults Prescribed Antipsychotics	Bipolar Disorder (Child)
Substance Use Disorders	Major Depressive Disorder

Planned Interventions

Colorado Access experienced significant success in the process improvement efforts that were implemented in FY15. COA hopes to continue expanding these efforts into the guideline dissemination aspects of the clinical guideline process to create a streamlined process of updating the guidelines on the website and distributing guidelines to providers through the provider newsletter.

Goal for FY16

- Adopt and disseminate evidence-based nationally recognized guidelines that promote prevention and/or recommended treatment
- Promote access to and increase usage of recommended guidelines through provider and member education/outreach

Evidence-Based Practices: Adult

ABC and network providers are dedicated to providing members with quality services, including evidenced-based and promising practices (EBPs). During FY15, ABC worked with network providers to monitor the EBPs offered to adult members. The details of the EBP monitoring activity is listed below.

Practice/ Program	Provider	Performance Measures and Benchmarks/Goals
PHQ-9 Screening	Colorado Coalition for the Homeless	**Number and percent of members screened annually** Result: 3,864 (52.81%)
		Percent of members with a 20% or greater reduction in PHQ-9 scores Goal: At least 30 percent of members will experience a 20 percent or greater reduction in PHQ-9 scores Result: 50.74%
PRICARE Enhanced	MHCD	**Number of members treated in the clinic annually** Result: 27 COA members have been served. This is out of 61 total PRICARE consumers
		Percent of members with tests ordered that have results recorded in the EMR for BMI, blood pressure/pulse Goal: 90% of members will have biometric measures listed in medical record Result: As of May 2015 100% of consumers had BP/pulse information recorded in EHR. 85% had BMI information
Seeking Safety	Colorado Coalition for the Homeless	**Number of members entering the group** Result: 14
		Outcome Rating Scale (ORS) and Session Rating Scale (SRS) Goal: Establish benchmark for Seeking Safety Brief Adherence Scale Results: • ORS - 20.38 (out of 40) • SRS - 31.99 (out of 40) • How well group was facilitated - 2.48 (out of 3) • How helpful facilitator was to participants - 2.85 (out of 3) How helpful group interaction was to participants - 2.67 (out of 3)
ACT	MHCD	**Number of members served** Result: 726 COA members have been served
		Recovery Markers Inventory Goal: > 70% Result: 68%
		Dartmouth ACT Fidelity Scale Goal: > 75% Result: 83% (goal met)
WHAM (Whole Health Action Management)	COA and BHI	**Number of members who enroll in a WHAM group** Result: 16
		WHAM Completion Rates Goal: Establish baseline Results: 6% (1 member of 16)
Tobacco cessation	Bruner Family Medicine	**Percent of members over age 13 screened for tobacco use** Goal: 75% Result: 92.08%
		Percent of members given medical message about tobacco use Goal: 50% Result: 45% (goal not met)

Practice/ Program	Provider	Performance Measures and Benchmarks/Goals
Integrated Dual Diagnosis Treatment (IDDT)	MHCD	**Number of members served** Result: 872 COA members have been served for FY 14
		Recovery Markers Inventory including substance use scales Goal: 70% Result: 66%
		IDDT Fidelity Scale Goal: > 74% Results: 84%
The 2Succeed program	MHCD	**Number of members served annually** Result: 339 COA members have been served
		Percent placed in employment Goal: > 25% Result: 53%
		Dartmouth Supported Employment Fidelity Measure Goal: > 100 on 125 point scale Results: The October, 2014 fidelity review result was 104/125 and considered “good fidelity.”

Planned Interventions

- Continue to support the ABC high-volume providers utilizing evidence-based and promising practices and improving the various metrics selected for monitoring (fidelity, volume, effectiveness, etc.)
- Streamline the process by which providers can submit the metrics associated with their evidence-based practices

Goal for FY16

- To measure and report performance in evidence-based and promising practices for the adult population

Evidence-Based Practices: Child and Adolescent

ABC and network providers are dedicated to providing members with quality services, including evidenced-based and promising practices (EBPs). During FY15 ABC worked with network providers to monitor the EBPs offered to child and adolescent members. The details of the EBP monitoring activity is listed below.

Practice/ Program	Provider	Performance Measures and Benchmarks/Goals
Seeking Safety	ARTS	**Number of members served** Results: no ABC members served during this reporting period
		Seeking Safety Brief Adherence Measure Results: no data to report during this period
Encompass	Denver Health	**Number of members served** Result: 58
		Pre- and post-screening for SUD, MDD, ADHD, and Anxiety MDD: decrease average CDRS scores from 59.6 to 51.7 ADHD: decrease average ADHD checklist score from 26 to 15.67 Anxiety: decrease average score on anxiety scale from 65.5 to 58.5 SUD: decrease average days using substances from 11.06 days to 5.11 days
Functional Family Therapy	Savio House	**Number of members served** Result: 12
		Fidelity to FFT model Goal: 4.0 Result: 3.9
Crisis Stabilization Team	Devereux Cleo Wallace	**Number of crisis interventions** Result: 11
		Crisis clinician deployed to family home within 2 hours of call Goal: 100% compliance Result: 100% compliance with standard
Trauma Focused CBT	Savio House	**Number of members served** Result: 11 (7 completed, 4 in progress)
		Resolution of Trauma per Child PTSD Symptom Scale (CPSS) Goal: 90% Result: 100% of 7 completed showed reduction in symptoms
Trauma Focused CBT	MHCD	**Therapist Evaluation Survey** Goal: establish baseline Result: Overall TES 76.32%
		Youth Evaluation Survey Goal: establish baseline Result: Overall YES 91.03%
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	MHCD	**Fidelity to SPARCS model** Goal: > 80% on fidelity scale Result: 100%
		Pre- and post- Trauma Symptom Checklist for Children (TSCC) Goal: reduction in symptoms Result: data for COA members not available at this time
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	MHCD	**Number of members served** Result: 3 total, 1 COA member
		CBITS Fidelity Measurement Goal: Fidelity > 80% Result: 100%

Practice/ Program	Provider	Performance Measures and Benchmarks/Goals
School Based Services	MHCD	**Therapist Evaluation Survey (TES)** Goal: establish baseline/benchmark Results: Overall TES 74.20%
		Youth Evaluation Survey (YES) Goal: establish baseline/benchmark Result: Overall YES 91.03%
Multi-Systemic Therapy (MST)	Savio House	**Number of members served** Result: 46 total (36 completed, 10 in progress)
		Involvement in juvenile justice system (percent completed tx with no new criminal charges resulting in higher level placement) Goal: establish baseline/benchmark Result: 72%
Multi-Systemic Therapy (MST)	UCH	**Number of members served** Result: 18
		Involvement in juvenile justice system (percent with no new arrests) Goal: establish baseline/benchmark Result: 89%
Multidimensional Treatment Foster Care (MTFC)	Savio House	**MTFC Behavioral Goals** Goal: establish baseline Result: 0%. Only one ABC member in program, was unsuccessful discharge
		Successful Discharge from program Goal: > 66% Result: 0%. Only one ABC member in program, was unsuccessful discharge
Intensive Case Management	MHCD	**Percent with legal involvement** Goal: establish baseline Result: 55%
		Percent with out-of-home placement Goal: < 10% of children enrolled Result: 25/248 (10%)

Planned Interventions

- Continue to support the ABC high-volume providers utilizing evidence-based and promising practices and improving the various metrics selected for monitoring (fidelity, volume, effectiveness, etc.)
- Streamline the process by which providers can submit the metrics associated with their evidence-based practices

Goal for FY16

- To measure and report performance in evidence-based and promising practices for the child and adolescent population

Integrated Care Projects and Activities

Adolescent Depression Screening and the Transition of Care to Behavioral Health

During FY15, Colorado Access developed a Performance Improvement Project (PIP) in collaboration with the three COA RCCO regions (2, 3, and 5) and the other overlapping BHOs (ABC-NE and Behavioral Healthcare, Inc.) aimed at improving adolescent depression screening and the transition of care to a behavioral health provider. Member who screen positive for depression (V40.9 with a 99420 CPT code) will be followed to determine if they attended a follow up visit with a behavioral health provider. A core workgroup from each of these entities has been working diligently to identify barriers in this transition and meet with community and provider stakeholders to improve the transition from primary care to behavioral health, if clinically appropriate.

Results and Analysis

The project has seen several early successes in supplemental, self-reported data, including an increase in the number of providers completing depression screenings with member. The workgroup is in the process of securing pilot sites in each region to test out interventions such as electronic referrals. One test site (Region 3/BHI) has begun the pilot and is currently troubleshooting issues with the electronic referral system. Colorado Access hopes to secure a pilot site in each of the other two regions during FY16.

However, the billing and coding for depression screenings continues to be a barrier to capturing valid data for this project. Due to the continued issues with billing, coding, and capturing valid data, COA hopes to obtain supplemental data regarding the number of depression screenings being administered at high-volume FQHC providers such as Clinica, Salud, and Colorado Coalition for the Homeless during FY16.

Planned Interventions

- Secure pilot sites in the ABC and ABC-NE BHO regions
- Obtain supplemental data from high volume providers about the administration of depression screenings
- Submit baseline data to HCPF and HSAG as contractually required

Goals for FY16

- Improve rates of adolescent depression screening
- Improve rates of transition from primary care to behavioral healthcare when clinically appropriate

Other Integrated Care Activities

Colorado Access endorses and embraces HCPF's goal that by 2019, 80 percent of Coloradans will have access to coordinated systems of care that provide integrated primary and behavioral health care. Important to the success of integration is the recognition that individuals living with complex health conditions are often involved with multiple systems of care and that addressing the social determinants of health is critically important to improving health outcomes. In addition, Colorado Access is developing and leveraging diverse solutions, offering a unique menu of behavioral health innovations, and employing multiple approaches to meet the individualized needs of primary care practices and patient populations.

This section includes several highlights of the integrated care activities taking place within ABC and Colorado Access. For more information, please reference the Quarterly Integrated Care Reports submitted by ABC.

Strategy: Leverage care management to support care integration
Colorado Access has engaged a consultant to develop a comprehensive re-design work plan that focuses on outcomes, efficiencies, and seamlessly interfacing with members and the community.

Strategy: Implement tele-behavioral health services for youth
Six primary care practices have committed to using telepsychiatry services – two clinics are regularly using the virtual platform for direct care and consultation; two clinics are completing training and practice sessions with anticipated use for patients in October/November 2015; and two clinics are currently completing staff technical training.

Strategy: Co-located behavioral health and primary care services
Colorado Access has successfully facilitated both the co-location of behavioral health services in primary care settings and the co-location of primary care services in behavioral health settings.

- Co-located behavioral health services in primary care setting:
    - Partnership with the Mental Health Center of Denver, South Federal Family Practice, and Creative Treatment Options
    - Partnership with Arapahoe Douglas Mental Health Network, Doctor's Care, and Behavioral Healthcare Inc.
    - Partnership with Children's Medical Center and Mental Health Center of Denver
    - Partnership with Mental Health Center of Denver and Horizon Pediatrics
    - Partnership with Mental Health Center of Denver and Rocky Mountain Youth Clinic
- Co-located primary care services in behavioral healthcare setting:
    - Partnership with Mental Health Center of Denver and Denver Health
    - Partnership with Sunrise Clinic and Summit Stone Health Partners
    - Partnership with Sunrise Clinic and North Range Behavioral Health
- Fully integrated practices (BHO reimbursement for behavioral health services in primary care settings): Partnerships with Kaiser, Denver Health, Colorado Coalition for the Homeless, Inner City Health, and Banner Health

Other Compliance Monitoring Activities

External Quality Review Organization (EQRO) Audit

HCPF and HSAG conducted the FY15 site review on four sets of focused standards:

- Member Information
- Grievance System
- Provider Participation and Program Integrity
- Subcontracts and Delegation

Goal from FY15

- Achieve an overall compliance score that is greater than or equal to previous year's performance

Results and Analysis

ABC's results from the FY15 site review are displayed in the table below.

Standard	# applicable elements	# Met	# Partially Met	# Not Met	Score
Member Information	20	20	18	1	90%
Grievance System	26	26	2	1	88%
Provider Participation and Program Integrity	14	14	14	0	100%
Subcontracts and Delegation	6	6	6	0	100%
Totals	**66**	**61**	**3**	**2**	**92%**

Standard	# applicable elements	# Met	# Not Met	Score
Grievances	30	28	2	93%
Appeals	58	54	4	93%
Totals	**66**	**61**	**2**	**93%**

Numerous strengths were noted for ABC in each of the four areas reviewed. However, HSAG identified five required actions in the areas of Member Information and Grievance System, including some addition information or revised information in the member handbook, and requirements for providers and subcontractors. ABC is in the process of implementing each of the required corrective actions. While ABC performed well on the site visit review overall, the goal to meet or exceed performance from last year was not met, as ABC scored 96% and 100% on the previous year's desktop review and records reviews, respectively.

Goal for FY16

- Achieve a compliance score of 95% or above on the EQRO site visit

Encounter Data Validation (411 Audit)

ABC is required to perform an annual Encounter Validation Audit to assess the validity of the claims and encounters submitted by network providers as compared to the documentation of services as required by the Uniform Services Coding Standards Manual. For the 2014 calendar year, HCPF selected 137 claims from three service categories on which to focus the review: Residential services, prevention/early intervention services, and clubhouse/drop-in center services. ABC utilized an outside contractor to complete the audit.

Results and Analysis

The table below lists the elements that were scored for each encounter and a breakdown of audit scores by service program category.

Program Service Category Comparison			
	CY12	CY13	CY14
Overall - all categories	86%	91%	84%
Prevention/Early Intervention Services	79%	94%	90%
School-Based Services	89%	90%	NA
Drop-In Center Services	91%	87%	80%
Residential Services	NA	NA	83%

ABC provider performance appears to be somewhat inconsistent; performance has fluctuated over the past three years. The introduction of residential services seems to have decreased performance drastically; this is the first time that many residential providers have been included in the annual encounter validation audit, and therefore for many, the first time they have received feedback related to claim submission and medical record documentation. ABC will continue to work with providers through corrective action plans and more thorough medical record reviews. Details of this year's provider performance are outlined below.

Requirement Name	Numerator	Denominator	% Compliance
Procedure Code	374	411	91.00%
Diagnosis Code	334	411	81.27%
Place of Service	249	411	60.58%
Service Program Category	387	411	94.16%
Units	321	411	78.10%
Start Date	409	411	99.51%
End Date	409	411	99.51%
Appropriate Population	409	411	99.51%
Duration	406	411	98.78%
Allowed Mode of Delivery	409	411	99.51%
Staff Requirement	190	411	46.23%

Each year, HSAG pulls a random sample of the 411 claims to perform an over-read audit in order to check the accuracy of audit methodology of the behavioral health organizations. This provides ABC with inter-rater reliability scores between the internal audit team and the state's external quality review organization. The below table reflects the combined scores for all BHOs on the over-read audit and the individual scores for ABC. ABC achieved perfect agreement with HSAG on ten of eleven audit elements, resulting in near-perfect agreement overall.

Requirement Name	All BHOs	ABC
Overall	**97.1%**	**99.7%**
Procedure Code	97.9%	96.7%
Service Category	99.3%	100%
Diagnosis	100%	100%
POS	100%	100%
Units	99.3%	100%
Start Date	100%	100%
End Date	100%	100%
Population	100%	100%
Duration	100%	100%
Mode of Delivery	100%	100%
Minimum Staff Requirements	96.4%	100%

Planned Interventions
ABC will continue to educate and train providers on proper medical record documentation. Follow up with providers to ensure that corrective actions have been implemented as required.

Goals for FY16

- Improve provider scores to 90% overall compliance
- Maintain over-read score with HSAG of 90% or higher

Provider Medical Record Reviews

ABC conducted a provider medical record audit in FY15. This activity was designed to engage providers in review of their medical record documentation practices with oversight by ABC.

Providers were selected based on volume of unique members seen or service specialty. The ABC Executive Director and ABC Leadership Team determine the rotation for provider selection. Other criteria may include providers who have failed previous medical record audits, or providers who have been identified by Compliance, Provider Network Services or through other quality audit activities.

The number of clinical records audited is based on volume of members seen, with a minimum of two records reviewed per provider. A minimum of five providers are selected for each audit period. The ABC Quality Program Manager provided oversight of the medical record audit process including record requests, record reviews, and compilation of results. Quality staff also conducted multiple follow-up discussions with the participating providers to explain results, provide education about documentation standards, or suggest corrective action. The Medicaid Compliance Officer was responsible for any recovery of overpayment.

ABC considers performance of 85% or higher to be a passing score. Providers who do not pass the audit are required to remedy any issues identified. Corrective and follow-up actions may include: provider education about medical record documentation standards, EHR system changes, documentation template alterations, a re-audit, and/or initiation of a recovery of overpayment. Providers are sent written results of the audit including any required follow up actions.

ABC audited a total of five network providers: three facilities that had not been previously audited, and two facilities that performed poorly on last year's audit. Audit elements focused on clinical documentation of key elements in the assessment (17 audit elements for adult members, 15 for child) and treatment plan (8 audit elements). Elements are based on contract requirements, general documentation standards, and clinical best practice.

Goal from FY15

- To ensure that medical record documentation standards are met
- Provide network practitioners with feedback and take corrective actions as needed

Results and Analysis

ABC reviewed ten clinical records from each of the five network providers selected. While some providers had minor areas of concern, each provider passed the audit overall. The results are listed below.

Provider	Overall score
A	96%
B	99%
C	90%
D	97%
E	85%

Planned Interventions
ABC plans to streamline and re-vamp the medical record review process – this will include working in collaboration with the Compliance Department to develop an audit process that evaluates medical records for both clinical documentation and encounter data validation in order to give providers the most meaningful feedback possible regarding their documentation and claims submission.

Goal for FY16

- Ensure that medical record documentation standards are met
- Provider network providers with feedback and implement corrective action as needed