

**Foothills Behavioral Health Partners (FBHPartners)
Quality Assessment, Performance Improvement & Outcomes Program
Description and Plan FY '12**

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QUALITY IMPROVEMENT PROGRAM DESCRIPTION

Overview

Foothills Behavioral Health Partners' (FBHP) Quality Assessment Performance Improvement and Outcomes (QAPIO) program is a continuous and systematic process of assessing, measuring, monitoring, and improving the quality of behavioral health care for its members. Through the QAPIO program the frequency and intensity of behavioral health disorders are proactively identified, prioritized, intervened upon and tracked for historical improvement. The QAPIO program actively solicits maximum input from clients, families, advocates, the Department, providers, and all community stakeholders. FBHP's QAPIO program complies with 42 C.F.R. Section 438.200 and its scope includes, but is not limited to, all of the following elements of member services:

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| • Access and Availability | • Coordination and Continuity of Care |
| • Quality and Appropriateness of Care | • Recovery and Resiliency |
| • Outcomes of Care | • Member Satisfaction |

The primary goals of the QAPIO program are to:

- Ensure access to appropriate, coordinated, and effective behavioral health services for members;
- Implement uniform and active monitoring and review of provider performance to facilitate ongoing performance improvement;
- Analyze, report and improve FBHP's performance in achieving desired client outcomes; and
- Provide leadership in state-of-the-art quality improvement methods and the integration of these methods within the system of care.

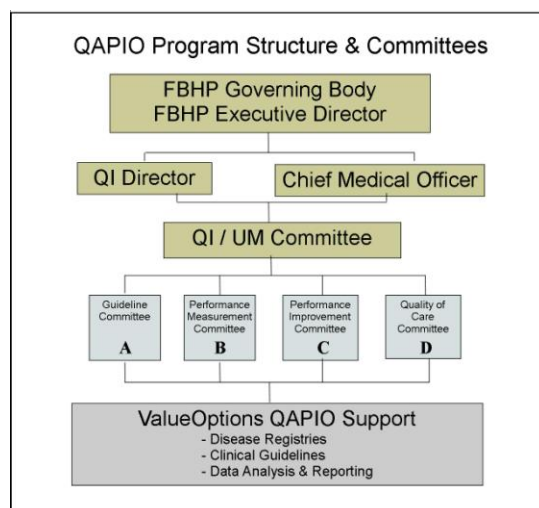
Throughout FBHP, quality is reflective of a leadership commitment and operating style that inspires trust, teamwork, and continuous improvement within the partnership, which includes FBHP staff, the Mental Health Center Serving Boulder and Broomfield Counties, Jefferson Center for Mental Health, ValueOptions, the Stakeholder Council, clients and families, providers, and the Department. This FBHP management philosophy supports commitment to superior client-focused clinical services that are culturally and age-appropriate, cost effective, recovery-oriented, and family-centered.

QAPIO Program Structure

FBHP's QAPIO program promotes excellence through a quality culture that is purposely integrated into all of FBHP's structure and operations. This approach enables evaluation of the quality, appropriateness and outcomes of care, the ability to pursue challenging care improvement and the meaningful involvement of clients and family members served. The figure and committee descriptions below provide detailed information on this program structure and reporting lines.

Quality Improvement/Utilization Management (QI/UM) Committee

The QI/UM Committee is the central body providing program oversight for both the QAPIO and UM Programs. The Quality Improvement (QI) Director and Chief Medical Officer co-chair the QI/UM Committee, which meets quarterly to conduct its responsibilities. The integration of the QI and UM Committees enhances the quality management functions at FBHP. QI/UM Committee membership represents all FBHP stakeholders and includes, at a minimum, the following representatives:



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| <ul style="list-style-type: none"> • FBHP member and family member • UM & QI Coordinators, from partner mental health centers • Clinical Director, ValueOptions • Executive Director, FBHP • QI Director, FBHP (Co-Chair) | <ul style="list-style-type: none"> • Member & Family Affairs Director, FBHP • IPN Provider • Quality Management Director, ValueOptions • Medical Directors from partner mental health centers • Chief Medical Officer, FBHP (Co-Chair) |
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The QI/UM Committee ensures that FBHP meets the needs of its members, overall and by population groups, in relation to access and availability, quality and appropriateness, outcomes of care, coordination of care, recovery and resiliency, and member satisfaction. In addition, the QI/UM Committee monitors the UM program to ensure member access to and appropriate utilization of services. The QI/UM Committee accomplishes these responsibilities through the following major tasks:

- Review, revision and approval of the QI program description and work plan;
- Review and approval of the QI/UM Annual and Quarterly Reports;
- Prioritizing, supporting and monitoring Performance Improvement Projects;
- Ensuring successful implementation of the QI Work Plan and UM program; and
- Monitoring and reviewing QI and UM activities within designated committees.

QI/UM Subcommittee Responsibilities

A) Performance Measurement – accomplishing all QAPIO program goals specific to performance and outcomes measurement, including all required Department performance indicators and all UM Program measurement goals.

B) Performance Improvement – reviewing and monitoring performance data, recommending Performance Improvement Projects (PIPs) and ensuring implementation and satisfactory completion of all PIPs and Focused Studies.

C) Clinical Guidelines – designing and implementing FBHP’s clinical practice guidelines.

D) Quality of Care – reviewing and determining disposition for provider quality of care concerns.

ValueOptions QAPIO Program Support Services

FBHP’s partnership with ValueOptions provides a significant advantage for the FBHP QAPIO program. The QI/UM and other QAPIO committees have access to ValueOptions’ local and national resources, including a portfolio of well-researched clinical and UM guidelines, experience in meeting both Utilization Review Accreditation Commission (URAC) and the National Committee for Quality Assurance (NCQA) standards and national leadership in developing performance indicators and designing performance improvement programs in behavioral health.

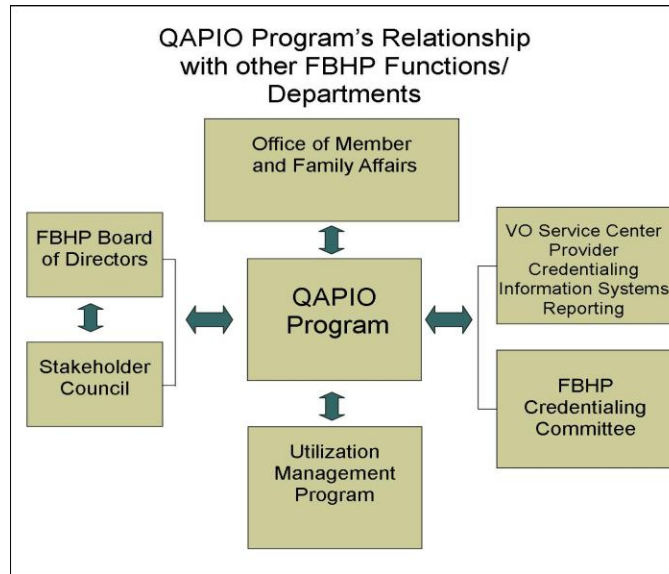
One key area of expertise is ValueOptions’ experience with developing disease registries and establishing disease management programs. With ValueOptions’ support, two disease registries are planned for development in FY 2010. The first is a Schizophrenia Disease Registry, which will allow FBHP to collect basic demographic data, clinical information such as co-morbid diagnoses, severity indices from the CCAR, primary locus of treatment, pharmacy data (when available), and outcome measures. This Registry will strengthen information on treatment outcomes, assist in the development of best practices, and provide the basis for performance improvement plans and focused studies.

The second registry will support a disease management effort to address disparity in life expectancy of members with severe mental illness and a medical co-morbidity. Health information on eligible members will be monitored through this registry, using established guidelines and protocols. In addition, interventions to improve member health and ensure adherence to health care appointments will be utilized and tracked, enhancing QAPIO program efforts at care coordination for this at risk population.

QAPIO Program’s Relationship with Other FBHP Functions and Departments

Because of the broad scope of responsibilities of the QAPIO program across the FBHP network, there is a significant bi-directional interplay of data reporting and advising between QAPIO staff and committees, other FBHP departments and FBHP board and advisory committees.

Additionally, FBHP’s partnership with ValueOptions offers opportunities to build upon the extensive quality improvement experience of this organization. The figure below depicts the areas requiring the highest level of ongoing reporting, interaction and collaboration.



- ValueOptions Service Center and FBHP Credentialing Committee:** The ValueOptions Service Center functions of credentialing, utilization management and information systems and reporting and FBHP Credentialing Committee processes and decisions are closely linked to all QAPIO program activities, including performance measurement, monitoring, reporting and performance improvement, all of which require timely and accessible data. ValueOptions utilizes an integrated health information system that captures unique data elements across the system of care and includes processes to ensure data and reports are valid and accurate, as well as easily accessible to QAPIO program staff and QAPIO committees.

The FBHP Credentialing Committee receives provider specific information from both the QAPIO program and the ValueOptions Service Center, such as member grievances, concerns from client surveys, medical record review issues, and any untoward utilization patterns, all of which inform, in particular, the re-credentialing process. Quality-of-care issues identified in the Credentialing Committee alert the QAPIO program as to system level changes needed, such as policy revisions.

- Office of Member and Family Affairs:** A strong collaborative relationship is in place between the Office of Member and Family Affairs (OMFA), their Member and Family Advisory Board (MFAB) and the QAPIO program. Specific examples include the documentation and trend analysis of member grievances and appeals; and the cooperative management of ongoing initiatives aimed at expanding and improving recovery and resiliency services within the FBHP provider network. The Director of OMFA advises the QAPIO Committee regarding priority client and family issues. In addition, the QI Director regularly attends the meetings of the MFAB, which, with its composition of members and their families, is an important stakeholder of the QAPIO program. MFAB's input directly informs QAPIO program planning and priorities.

- **Utilization Management:** Essential links, in particular the ongoing sharing of performance information and collaborative performance improvement efforts, exist between the Utilization Management (UM) and QAPIO programs. A key method for maintaining this linkage is the co-chairing of the QI/UM Committee by the QI Director with the Chief Medical Officer, who is responsible for overseeing the UM program. Examples of information that flow between the two programs include appropriate utilization of more restrictive care, such as hospitalizations, progress of clients in decreasing level of care needs, information regarding provider care that falls outside of FBHP care standards, and monitoring of over and under-utilization data. Combining the UM and QI Committees allows for maximum input into both QI and UM issues relevant to FBHP's quality of care.
- **FBHP Board of Directors and FBHP Stakeholder Council:** FBHP's Board of Directors and Stakeholder Council provide partner, client, and family, and community oversight to the QAPIO program, ensuring that the program is effectively and efficiently assessing and improving member services. The QI Director reports quarterly on QAPIO program progress to the Board and the Council. The Stakeholder Council provides a unique opportunity for a collaborative and coordinated approach to performance improvement, with membership from such diverse community groups as child welfare, education, public health, substance abuse and development disability providers and advocacy organizations.

FOOTHILLS BEHAVIORAL HEALTH PARTNERS (FBHPartners)

QUALITY IMPROVEMENT WORK PLAN FY '12

FBHP develops an annual Quality Improvement Plan (QI Plan) to guide its performance improvement activities. The QI Plan describes in detail the QAPIO program activities of performance indicator development and refinement, ongoing and time-limited performance improvement projects or focused studies and other monitors to ensure quality care. QI Plan activities derive from a number of sources of information about quality of care and service issues. These include client and family feedback, Department and Federal requirements, national public behavioral health agendas and initiatives, for example, the Institute of Medicine's Quality Chasm Series, FBHP-specific utilization information, such as hospital recidivism and issues identified through performance evaluation.

Structure of the Plan

The QI Plan includes five essential Quality of Care dimensions:

- *Access to Care: Ensuring that members have ready access to all necessary services within the comprehensive FBHP network;*
- *Member and Family Service and Satisfaction: Enhancing member and family satisfaction with FBHP service quality and care outcomes;*
- *Care Quality and Appropriateness: Analyzing and supporting continual improvement of FBHP clinical and administrative processes in order to achieve the highest standard of care, with care processes that are recovery oriented, evidence-based and culturally sensitive;*
- *Outcomes of Care: Developing a well-designed system of outcome measurement to ensure that FBHP provider services are linked to positive outcomes and objective progress toward client resilience and recovery; and*
- *Care Coordination and Integration: Ensuring provider procedures support effective behavioral health and physical health coordination and support, through evaluation and innovative models of integration.*

Responsibility for the Plan

The QI Director (Director), with oversight from the QI/UM Committee, has overall responsibility for the QI Plan, including its development, implementation and evaluation. Annually, the Director drafts a QI Plan based on an evaluation of the previous year's QI Plan; input from clients, families and providers; results from the Department's External Quality Review and changes or additions to the Department's performance requirements. The draft QI Plan is submitted to the QI/UM Committee for review and approval and then to the Department for final approval. The Director is responsible for keeping the QI/UM Committee informed of the current status of the QI Plan and FBHP performance, through monthly updates and quarterly reports.

Quality Dimension #1: ACCESS TO CARE

Access to Care Issues	Indicator/Benchmark/Goal	Plan	Timetable
Monitoring Status			
1a. Timeliness of response to Emergency and Urgent Requests	1a. 1. Hours to emergency contact Standard: By phone within 15 minutes of initial contact; 100% in person within 1 hour of request in urban/suburban areas. Goal: Maintain standard 100% of the time 1a. 2. Hours to urgent face to face contact Standard: Within 24 hours of contact Goal: Maintain standard 100% of the time	1a. 1 & 2. Monitor quarterly indicator results compared to goal. Implement improvement project and/or provider corrective action if below standard for two quarters.	1a. 1 & 2 On-going – review quarterly with QI/UM committee
1b. Timeliness of response to first routine offered appt	1b. Days to first routine offered appointment date Standard: 100% within 7 business days. Goal: Maintain standard 100% of the time	1b. Monitor quarterly indicator results compared to goal. Implement improvement project and/or provider corrective action if below standard for two quarters	1b. On-going – review quarterly with QI/UM committee
1c. Overall Member access	1c. Overall Access: Proportion of Medicaid eligible Members who receive a FBHPartners provider service (rolling 12-month) overall, by age group, and population category. Benchmark: Overall BHO penetration rates, total, by age group and eligibility category, FY '11 Goal: Above the previous fiscal year BHO penetration rates overall and for all age groups and eligibility categories.	1c. Monitor indicator results Quarterly (12 month period) compared to goal using overall BHO FY '10 as benchmark. Consider improvement project if two quarterly reports indicate below BHO percent.	1c. On-going – review quarterly with QI/UM committee
1d. Phone response	1d. Member call abandonment rates Benchmark: <3% Goal: Below the benchmark percent call abandonment rate	1d. Monitor indicator results quarterly compared to goal. Consider improvement project if goal not met for two quarters.	1d. On-going – review quarterly in QI/UM committee

Access to Care Issues	Indicator/Benchmark/Goal	Plan	Timetable
1e. Mental Illness Waiver Members Access	1e. Percent members with MI waiver, both living in an ACF or overall, with one or more behavioral health service in previous 12 months Goal: Maintain percent at 90% or above of members with MI waiver, with one or more behavioral health service in previous 12 months.	1e. Monitor indicator results quarterly compared to goal. Consider improvement project if goal not met for two quarters.	1e. On-going – review quarterly in QI/UM committee
1f. Follow-up after residential treatment	1f. Percent members discharged from residential treatment with an offered outpatient appointment within 7 days. Goal: Trend of increasing percent through the fiscal year.	1f. Monitor indicator results quarterly compared to goal. Consider improvement project if goal not met for two quarters.	1f. On-going review quarterly in QI/UM committee
1g. Behavioral Health Focal Point of Care	1g. Percent adult members with bipolar or schizophrenic illness with three or more visits in the study period Goal: Percent at or above BHO overall for FY '10	1g. Monitor annually	1g. Review annually in QI/UM committee
Development Status			
1h. Access to outpatient care after initial assessment	1h. Average number of days to a follow-up face-to-face contact, after the intake. Goal: Determine criteria, feasibility of measurement, and standard. Evaluate as a standard access measure.	1h. Achieve goal	1h. Before the end of FY '12

Quality Dimension #2: MEMBER AND FAMILY SERVICE AND SATISFACTION (Grievance monitoring in Appendix A)

Client/Family Service/Satisfaction Issue	Indicator/Standard/Benchmark/Goal	QI Initiative/Plan	Timeline for QI Initiative/Plan
Monitoring Status			
2a. Client/family Perception of Access	<p>2a 1. Percent adult respondents agreeing with the MHSIP six Access domain items Benchmark: Percent overall agreement, Access domain items, for all BHOs, FY '10 Goal: FBHPartners' internal survey results will, at a minimum, be above the lower confidence interval for the BHO's overall percent agreement</p> <p>2a 2. Percent family respondents agreeing with YSS-F two Access Domain items Benchmark: Percent overall agreement, Access domain items, for all BHOs, FY '11 Goal: FBHPartners' internal survey results will, at a minimum, be above the lower confidence interval for the BHO's overall percent agreement</p>	<p>2a 1 & 2. Monitor performance on this indication comparing quarterly FBHPartners' internal survey results with overall BHO FY '11 percent agreement.</p> <p>Consider improvement project if FBHPartners' results below confidence interval on two quarters</p>	<p>2a 1 & 2 On-going- monitor quarterly in QI/UM committee</p>
2b. Client Perception of Overall Satisfaction with Service	<p>2b. Percent Adult consumers agreeing With the three MHSIP overall satisfaction domain items. Benchmark: Percent overall agreement for all BHOs for Overall Satisfaction Domain, FY '11 Goal: FBHPartners' internal survey results will, at a minimum, be above the lower confidence interval for BHOs overall percent agreement</p>	<p>2b. As indicated in 2a</p>	<p>2b. As indicated in 2a</p>
2c. Client/family Perception of Outcomes	<p>2c 1. Percent adult respondents agreeing with the eight Outcome domain items</p>	<p>2c 1 & 2 As indicated in 2a</p>	<p>2c. 1 & 2 As indicated in 2a</p>

Client/Family Service/Satisfaction Issue	Indicator/Standard/Benchmark/Goal	QI Initiative/Plan	Timeline for QI Initiative/Plan
	<p>of the MHSIP survey</p> <p>Benchmark: Percent overall agreement for all BHOs for Outcome domain items, FY '11</p> <p>Goal: FBHPartners' internal survey percent agreement for the eight items, at a minimum, will be above the lower confidence interval for the BHOs overall percent agreement</p> <p>2c 2. Percent family respondents agreeing with the six Outcome domain items on the YSS-F survey</p> <p>Benchmark: Percent overall agreement for all BHOs for the Outcome domain items, FY '11</p> <p>Goal: FBHPartners' internal survey percent agreement for the six items, at a minimum, will be above the lower confidence interval for the BHOs overall percent agreement</p>		
<p>2d. Client/family perception of care quality and appropriateness</p>	<p>2d. 1. Percent adult consumer agreement with the nine Quality and Appropriateness of Service domain items on the MHSIP</p> <p>Benchmark: Percent overall agreement for all BHOs for the Quality and Appropriateness domain items, FY '11</p> <p>Goal: FBHPartners' internal survey percent agreement for the nine items, at a minimum, will be above the lower confidence interval for the BHO overall percent agreement</p> <p>2d. 2. Percent family respondents agreeing with the four Cultural</p>	<p>2d. 1 & 2 As indicated in 2a</p>	<p>2d. 1 & 2 As indicated in 2a.</p>

Client/Family Service/Satisfaction Issue	Indicator/Standard/Benchmark/Goal	QI Initiative/Plan	Timeline for QI Initiative/Plan
	<p>Sensitivity and 6 Appropriateness Domain items on the YSS-F survey</p> <p>Benchmark: Percent overall agreement for all BHOs for the Cultural Sensitivity and Appropriateness domain items, FY '11</p> <p>Goal: FBHPartners' internal survey percent agreement for the four items, at a minimum, will be above the lower confidence interval for the BHO overall percent agreement.</p>		
2e. Consumer/family participation in treatment	<p>2e. 1. Percent adult consumer agreement with the two Participation in Treatment Planning domain items on the MHSIP</p> <p>Benchmark: Percent overall agreement, Participation domain items, for all BHOs, FY '11</p> <p>Goal: FBHPartners internal survey percent agreement for the two items, at a minimum, will be above the lower confidence interval for the BHO overall percent agreement</p> <p>2e 2. Percent family respondents agreeing with YSS-F three Participation in Treatment Domain items</p> <p>Benchmark: Percent overall agreement, Access domain items, for all BHOs, FY '11</p> <p>Goal: FBHPartners' internal survey results will, at a minimum, be above the lower confidence interval for the BHO's overall percent agreement</p>	2e. 1 & 2 As indicated in 2a	2e. 1 & 2 As indicated in 2a.

Quality Dimension #3: CARE QUALITY and APPROPRIATENESS (EBP Implementation monitoring Appendix B)

Quality/Appropriateness of Care Issue	Indicator/Standard or Benchmark/Goal	QI Initiative Plan	Timetable for QI Initiative/Plan
Monitoring Status			
3a. Coordination/timeliness of hospital follow-up	3a. 7 and 30 day rates of follow-up visit post-hospital discharge all hospital Benchmark: 7 and 30 day rates - Overall BHOs FY '11 Goal: At or above benchmark for Overall BHO's 7 and 30 day follow-up rates	3a. Monitor follow-up rates quarterly (12-month periods) comparing with overall BHO rates previous fiscal year Consider performance improvement project if provider rates below benchmark for two quarters	3a. On-going – review quarterly in QI/UM committee
3b. Appropriate utilization, psychiatric hospitalizations	3b. 1. Number psychiatric hospital discharges/1,000 Members all hospital and nonstate Benchmark: hospital admits/1,000 BHO FY '11 Goal: At or within a standard deviation of the benchmark, overall BHO 3b. 2. Discharge hospital length of stay, all hospital and non-state hospital Benchmark: Discharge LOS – Overall BHOs FY '11 Goal: At or below the benchmark, overall BHO	3b. 1&2. As indicated in 3a Consider performance improvement project if provider rates not within standard deviation of benchmark for two quarters	3b. 1&2. On-going – review quarterly in QI/UM committee
3c. Recovery-oriented services and programs	3c. Percent clients/family who respond positively or are satisfied with their voice and role on FBHPartners and MHC provider committees and advisory groups Goal: Implement, according to recommendations from FY '10 report	3c. Achieve goal by end of 2 nd qtr	3c. Review results with QI/UM committee 2 nd qtr
3d. Under-utilization of services post hospital discharge	3d. 1. Percent of clients (by youth and adult) discharged from hospital and not readmitted within 7 days, with three or more clinical	3d. 1 & 2. Monitor quarter; consider improvement	3d. 1 & 2 Review in QI/UM committee quarterly

Quality/Appropriateness of Care Issue	Indicator/Standard or Benchmark/Goal	QI Initiative Plan	Timetable for QI Initiative/Plan
	<p>visits (not case management), one of which, for adults, is a prescriber visit, within 30 days of discharge</p> <p>Goal: Quarterly trend, 12 month rolling, indicates increasing percent of clients with three or more clinical visits within 30 days of discharge</p>	<p>plan if trend shows decreasing percent for two quarters</p>	
<p>3e. Percent clients taking duplicative antipsychotic medication</p>	<p>3e. Percent of clients prescribed an atypical antipsychotic that are prescribed two or more atypical antipsychotic medications for 120 days or more</p> <p>Goal: At or below the overall FY '11 BHO percent; investigate accuracy and importance of this indicator as a quality of care measure</p>	<p>3e. Monitor annually and investigate outliers</p>	<p>3e. Review in QI/UM beginning with FY '11 results</p>
<p>3f. Effective Acute Phase antidepressant medication management</p>	<p>3f. 1. The percent of newly diagnosed and treated members with major depression who remained on an antidepressant medication for at least 84 days (12 weeks)</p> <p>Goal: At or above the overall BHO percent; investigate accuracy and importance of this indicator as a quality of care measure</p> <p>2. The percent of newly diagnosed members with major depression who are prescribed an antidepressant and who had 3 follow-up contacts, one of which with a prescriber, within a 12 week period.</p> <p>Goal: At or above the overall BHO percent; investigate accuracy and importance of this indicator as a quality of care measure</p>	<p>3f. 1&2 Monitor annually and investigate outliers</p>	<p>3f. Review in QI/UM beginning with FY '11 results</p>
Development Status			

Quality Dimension #4: CARE COORDINATION AND INTEGRATION:

Coordination & Integration Concern	Indicator/Standard/Goal	QI Initiative/Plan	Timetable QI Initiative/Plan
Monitoring Status			
4a. Identified PCP in the client medical record	4a. Percent members, by youth and adults, with an identified PCP in the medical record Goal: Trend of increasing percent of clients with an identified PCP in the medical record	4a. Monitor quarterly.	4a. Review in QI/UM committee quarterly
4b. Member access to PCP	4b. Percent members (by youth and adults) who received outpatient mental health treatment during the fiscal year with a qualifying physical healthcare visit Goal: At or above the BHO overall percent	4b. Monitor annually	4b. Review in QI/UM committee quarterly
4c. Care Coordination with PCP	4c. Percent members with a prescriber visit, with a care coordination letter sent to the PCP annually Goal: Trend of increasing percent of members with a prescriber visit that have a care coordination letter sent to their PCP annually	4c. Monitor quarterly	4c. Review in QI/UM committee quarterly
Development Status			
4d. Frequent ED visits for physical health issues for Members with a MI Waiver	4d. Percent members with MI Waiver and a behavioral health service in the last 12 months, with 3 or more ED visits for physical health issues Goal: Develop baseline FY '12 and finalize performance improvement goal	4d Achieve goal	4d Review in QI/UM committee 2 nd qtr FY '12
4e. Improvement in perceived physical health functioning, adults with SMI	4e. Mean change from admit to 12 months post, physical health component score (PCS) on the SF-12. Goal: Determine feasibility and establish procedures for administering the SF-12 for members treated by partner MHCs with schizophrenia and bipolar disorders and determine Improvement goal.	4e. Achieve goal	4e. Complete end of FY '12

Quality Dimension #5: OUTCOMES AND EFFECTIVENESS OF CARE

Outcome of Care Concern	Indicator/Standard/Goal	QI Initiative/Plan	Timetable QI Initiative/Plan
Monitoring Status			
5a. Hospital readmissions, 7, 30, and 90 days after discharge	5a. 7, 30 and 90-day hospital recidivism rates Benchmark: Annual overall BHO 7, 30, and 90-day recidivism rates, FY '11 Goal: At or below benchmark, overall BHO 7, 30, and 90 day recidivism rates	5a. Monitor rates quarterly (12-month periods) comparing with overall BHO rates previous fiscal year Consider performance improvement if provider rates above benchmark at end of fiscal year	5a. On-going – review quarterly in QI/UM committee
5b. Outpatient crisis care effectiveness	5b. Number of ED visits/1,000 Members that do not result in hospitalization (rolling 12-month) Benchmark: Annual overall BHO ED visits/1,000 Members, FY '11 Goal: Below the BHO ED visits/1,000 rate	5b. Monitor indicator quarterly (12-month periods) compared with overall BHO rates previous fiscal year Improvement project implemented to address high rate of Youth ED utilization (see Appendix A)	5b. On-going – review quarterly in QI/UM committee Report project status quarterly to QI/UM committee
5c. Maintenance and improvement in independent living status	5c. 1. Percent members maintaining independent living status in 12 month period Goal: At or above 95% 2. Percent members progressing toward independent living Goal: Above the BHO percent previous fiscal year	5f. Monitor quarterly	5f. Review in QI/UM quarterly, beginning with Q2
Development Status			
5d. Improvement in symptom severity children up to age 12 years	5d.1. Mean change in mental functioning and physical health admit to discharge 2. Mean change in sociability admit to discharge 3. Mean change in mood disturbance and family admit to discharge	5d. Complete goal and begin monitoring end of FY '12	5d. Review in QI/UM as needed to achieve goal

	Goal: Establish goal for these three symptom indicators and establish monitor status		
5e. Improvement in symptom severity youth 12-18 years	5e. 1. Mean change in mental functioning 2. Mean change in Sociability 3. Mean change in Depression/suicidality Goal: Establish goal for these three symptom indicators and establish monitor status	5e. Complete goal and begin monitoring end of FY '12	5e. Review in QI/UM as needed to achieve goal
5f. Improvement in symptom severity adults	5f. 1. Mean change mental functioning 2. Mean change in sociability/substance use 3. Mean change in mood disturbance Goal: Establish goal for these three symptom indicators and establish monitor status	5f. Complete goal and begin monitoring end of FY '12	5f. Review in QI/UM as needed to achieve goal
5g. Improvement in recovery and resiliency	5g. 1. Mean change in resiliency for children 2. Mean change in resiliency for adolescents 3. Mean change in recovery for adults Goal: Establish goal for these three recovery/resiliency indicators and establish monitor status	5g. Complete goal and begin monitoring end of FY '12	5g. Review in QI/UM as needed to achieve goal
5h. Improvement in perceived mental health functioning, Adults	5h. Mean change from admit to 12 months post, mental health component score (MCS) of the SF-12. Goal: Consider monitoring change in the mental health component score of the SF-12 for adults as a self-report outcome measure. As indicated establish procedures for administering & determine goal	5h. Complete goal	5h. End of FY '12

Appendix A
Performance Improvement Plan, FY '12

I. Performance Improvement Projects (PIP)/Focused Studies:

Focused Study: Design of a Healthcare Management Program

Began: July 2011

Description of Problem: Individuals with severe mental illness, more specifically those with schizophrenia or bipolar disorder, are more likely than the general population to develop chronic medical conditions, including cardiovascular disease, diabetes, obesity and metabolic problems, that have been associated with higher mortality rates for this population. These risks are associated with the effects of antipsychotic medication, particularly atypical antipsychotics, as well as lifestyle issues, including smoking, lack of exercise, and poor dietary habits.

The overall purpose of this focused study is to understand specific gaps as well as how much of a gap exists in the PMHC adherence to a best practice protocol for healthcare management and monitoring of these risk factors and at what level the study population falls, in regard to well-accepted health behaviors. This focused study will complete all preparatory steps for implementing a Healthcare Management Program Performance Improvement Project in FY 2012-2013, which will include an enhanced PMHC electronic medical record (EMR), a well-designed set of clinical interventions (Healthcare Management guideline or protocol), and a health monitoring registry to assist the care management team in consistent implementation of the guideline or protocol.

Study Questions:

1. What are the best practice components of a Physical Healthcare Management Guideline, based on the most recent literature and current provider practices that are shown to improve health for individuals with severe mental illness?
2. What are the gaps, both type and amount, in guideline adherence, as documented in the study populations' electronic medical record (EMR)?
3. What are current methods, as described in the literature and used in current practice, for surveying and evaluating the study population's health behaviors?
4. What types of self-reported health behaviors impact members' prevention and management of CVD and/or diabetes?

Interventions:

1. Revision of the Physical Healthcare Management Guideline
2. Development of an audit tool for measurement periods
3. Identification of necessary enhancements to the EMR to support guideline adherence

4. Adoption or development of a survey to assess health behaviors

Measures:

1. The percent of the study population's electronic medical record (EMR) with $\geq 80\%$ of key Healthcare Management guideline components documented during the focus study period.
2. The percent of the study population reporting a moderate level of self-reported health behaviors during the focus study period (moderate level will be based on the literature regarding required health behaviors to achieve this level).

Study Timeline: Audit study period: 1/1/11-12/31/11; Health survey study period: 1/1/12-7/1/12

ED visit PIP

Began: January 2009

Description of Problem: The intent of this project is to reduce emergency department utilization for members 17 years and younger and their families, for behavioral health concerns that could be either prevented or better addressed in an outpatient setting. FBH/FBHP FY '08 ED utilization/1,000 members, for children 0-12 years and adolescents 13-17 years, were at 2.59/1,000 and 24.46/1,000 respectively, both of which were more than one standard deviation above the overall BHO rates, at 2.11 and 16.83 respectively. Additional analysis of FBH/FBHP's youth ED visits indicated that only about a fourth of the youth had not had a contact with a provider and more than half had a provider contact within seven days of the ED visit. Although a portion of the youth Members with an ED visit had never seen a provider it appears that most have, suggesting an opportunity to improve care and prevent ED visit utilization for many youth Members. Because FBH/FBHP does not consider ED visits an appropriate or effective method of treatment for its Members FBH/FBHP began a performance improvement project to improve behavioral health crisis care access and crisis prevention education and treatment in order to significantly reduce youth member ED visit utilization.

Study Question: Do focused interventions to improve behavioral health crisis care and crisis prevention education and treatment for families and youth significantly reduce total ED visit rates for youth, age 0-17 years of age?

Interventions:

1. Develop and distribute an informational flyer to Members annually, and new Members monthly, on procedures for accessing emergency services through FBHP's two partner MHCs, Jefferson Center and MHCBBC, rather than going to the emergency room

2. Develop and implement a crisis planning form to be used by youth programs/teams with families/youth. Eventual goal is for the form to be integrated in the EMR.
3. Develop either a TIPs sheet for Families (MHCBBC) and/or Emergency Service handout (JCMH) that provides additional assistance to families/youth in managing crisis or accessing MHC emergency service to assist in crisis management.
4. Establish procedures for follow-up of youth seen by the MHC in the ED. At MHCBBC the Child Crisis Dept contacts the clinician to ensure appropriate follow-up visit; at Jefferson Center the clinician follows up with a call to solicit specific information about the ED visit and ensure adequate follow-up.

Measures

1. The rate of ED visits per 1,000 Members age 0-18 in the study period

Re-measurement Status: First re-measurement completed FY '09 with significant improvement/reduction in youth ED visit rates. For FY '12 – submit study results for second re-measurement and complete PIP.

Planning for next PIP proposal FY '12

FBHPartners will need to develop and submit an additional PIP proposal once the ED visit PIP is approved for retirement in Spring 2012.

Steps:

1. Organize PIP committee
2. Needs assessment to discern possible projects
3. Possible topics: Peer services

II. Other Quality Improvement Activities, FY '11

1. Hospital Recidivism:

FBHPartners' hospital recidivism rates at the end of third quarter, FY '11, 7 day, 30 day, and 90 day were above the BHO rates, FY '10. FBHP has developed a workgroup to assess causes to increased recidivism and implement strategies to reduce rates in FY '12.

2. Access to care: Members with a MI Waiver:

FBHPartners tracked, through FY '11, on a quarterly basis, the percent of members with a MI Waiver with one or more behavioral health service in the last 12 months, with a goal of 90%. There was a decreasing percent of these members with a behavioral health contact through this fiscal year. FBHPartners will investigate this decrease and implement a strategy for increasing this percent during FY '12.

3. Monitoring Provider Quality of Care Concerns

Continue to monitor trends in provider quality of care concerns, reporting to QI/UM committee annually, including improvements implemented as a result of this monitoring effort.

4. Practice Guideline Development Three Year Plan (began FY '11)

FBHPartners established revised procedures for practice guideline development, to begin FY 11. A key component of the new procedures is to work collaboratively with one of two BHOs in the ValueOptions partnership (NBHP) to establish consistent guidelines throughout the two provider networks. The following 3 year plan was established:

FY '11:

Depression
Suicide Prevention

FY '12:

Schizophrenia
ADHD
Bipolar Disorder
Posttraumatic Stress Disorder

FY '13:

Cognitive Behavioral Therapy
Reactive Attachment Disorder
Eating Disorders

5. Establish program to increase post-partum screenings with appropriate tools in medical offices following new mothers.
6. Monitor Grievances for any unusual trends in type or QOC concerns.

Appendix B
Implementation and Reporting Plan
FY 2011-2012
FBHPartners Evidence-Based Practices

FY '10 and FY '11: Five EBPs/Best Practices implemented

Integrated Dual Diagnosis Treatment (IDDT): Jefferson Center; Adults
Supported Employment: Jefferson Center; Adults
Functional Family Therapy (FFT): Jefferson Center and MHP (youth)
Families Together: Jefferson Center (youth)
Multi-systemic Therapy (MST): Jefferson Center (youth)

FY '12: Six EBPs/Best Practices planned for implementation

Senior Reach: Jefferson Center and MHP (senior adults)
Assertive Community Treatment (ACT): MHP (adults)
Wellness Management & Recovery (WMR): MHP (adults)
Dialectical Behavior Therapy (DBT): Jefferson Center and MHP (adults)
Trauma-based Cognitive Based Therapy: Jefferson Center (youth)
CrossRoads: Jefferson Center (youth)

FY '13: Seven EBPs/Best Practices planned for implementation

Psychosocial Rehabilitation: MHP (adults)
Peer Services: Jefferson Center and MHP (adult)
Intensive Case Management/Wraparound:
Tobacco Education and Prevention Youth: Jefferson Center and MHP
Home-based Community Infant Program: MHP (children)
Brief Solution-Focused Treatment: Jefferson Center and MHP
Psycho-Education for Families: Jefferson Center (adults)

Reporting

By EBP/Best practice, beginning with initial implementation date;

1. Descriptive and clinical information regarding members treated in the program, including length of stay in the program
2. Results of fidelity assessments pre-implementation

3. Summary of a minimum of two outcomes
4. Recommendations for expanding program and improving reporting