Quality Improvement Annual Report, FY ‘11
Foothills Behavioral Health Partners

Report Submitted to:
Colorado Department of Health Care Policy and Financing
QI Section

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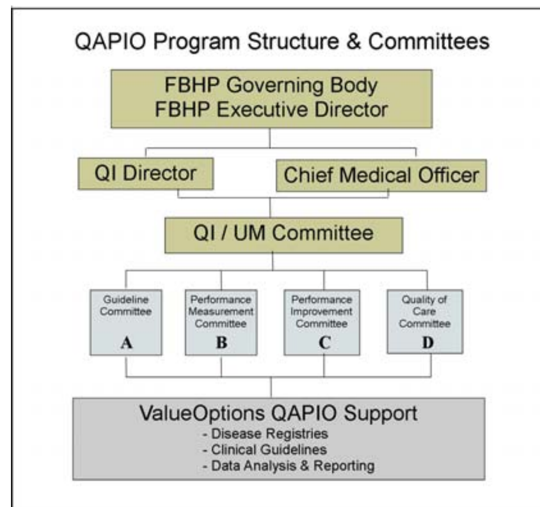
Description and Organizational Chart of Quality Committees

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:

- FBHP member and family member
- UM & QI Coordinators, from partner mental health centers
- Clinical Director, ValueOptions
- Executive Director, FBHP
- QI Director, FBHP (Co-Chair)
- Member & Family Affairs Director, FBHP
- IPN Provider
- Quality Management Director, ValueOptions
- Medical Directors from partner mental health centers
- Chief Medical Officer, FBHP (Co-Chair)

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.

Summary: QI Program Evaluation

Access to Care:

Successes

- 99.6% of Members with an emergency face-to-face request were seen within one hour.
- 99.7% of Members with routine intake requests were offered an appointment with 7 days, even with a 30% increase from FY ‘10.
- Maintained close to a 20% penetration rate and goals for penetration by age group and eligibility category, even with an significant increase 25% in the AFDC-A eligibility category of AFDC-A from FY ‘10
- Met goal for call abandonment rates <3%.

Areas for Improvement

- Project to increase percent of members with a MI Waiver that received one or more behavioral health visit to $\geq$ 90%
- Develop routine report on length of time to first appointment after intake
- Monitor penetration rates closely given continued increase in membership in eligibility categories that do not utilize behavioral health services

Customer Service and Satisfaction:

Successes

- Met goal for percent agreement for state MHSIP survey for the Overall Service, Outcome, and Care Quality and Appropriateness domains
- Met goal for percent agreement for state YSS-F survey for the Access and Participation in Treatment domain
- Improvement in return rate for internal MHSIP/YSS-F but not yet back to FY ’09 rates

Areas for Improvement

- Consider a different client survey or survey procedure if rates do not improve with 4th qtr FY ’11 administrations
- Analyze and consider project to improve MHSIP Access domain results
- Potential improvement opportunities in narrative comments. Partner MHCs to investigate and make recommendations

Care Quality, Appropriateness:

Successes

- Continue to be above FY ’10 BHO follow-up rate for 7 and 30 days after hospital discharge
- Below overall FY ’10 BHO hospital utilization/1,000 Members, all hospital and non-state hospital
- Below overall FY ’10 BHO non-state hospital ALOS

- Implemented four of five EBPs scheduled in FY ‘11
- Established three-year plan for developing practice guidelines

Areas for Improvement

- Complete Voice and Role Survey in early FY ‘12
- Monitor closely the underutilization measure for FY ’12, as follow-up percent is decreasing

Care Coordination and Integration

Successes

- Developed Focus Study for a Healthcare Management Program, began implementation in July FY ‘12
- Developed baseline data for members with an MI Waiver and three or more physical health ED visits

Areas for Improvement:

- Ensure consistent reporting of percent clients with a PCP and percent with a care coordination letter sent
- Establish effective procedures for follow-up of medical offices requesting assistance in implementing a post-partum depression screening tool
- Establish plan with MHCs for follow-up of MI Waiver members with three or more physical health ED visits

Outcomes and Effectiveness of Care

Successes

- Although recidivism rates are increasing they are still below BHO rates for FY ‘10
- Overall and adolescent ED rates/1,000 are below the FY ’10 BHO rate;

Areas for Improvement

- Implement project to identify strategies for reducing hospital recidivism

Introduction

The FY'11 Quality Improvement Plan, for FBHPartners, included five major dimensions by which to monitor performance and to identify improvement opportunities. Below is FBHPartners' year-end performance analysis of each of the QI Plan performance indicators, the status of FBHPartners' QI Plan developmental indicators, as well as a summary and status of its performance improvement projects, evidence-based practice implementation, internal satisfaction survey report, and other QI activities.

I. Analyses of Performance Indicators

Quality Dimension #1: ACCESS TO CARE

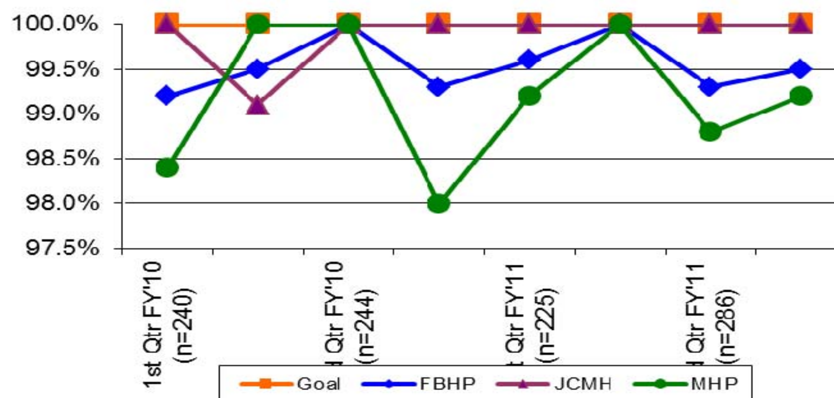
A. Response time for emergency (standard – 100% by phone within 15 minutes; 100% face-to-face within one hour)

Response time for urgent requests (100% within 24 hours):

FBHP's goal was to consistently meet the standard for these two Access to Care indicators.

FBHP Performance: For emergency phone contacts 99.96% (n=10005) were answered within 15 minutes; for emergency face-to-face requests, 99.6% (n=963) of clients were seen in 1 hour (Figure 1). For urgent requests, all (100%) or 40 clients were seen within 24 hours.

Figure 1. Percent Consumers with Emergency Request Seen within Standard of One Hour, FY '10 and FY '11, by FBHP and the Partner MHCs



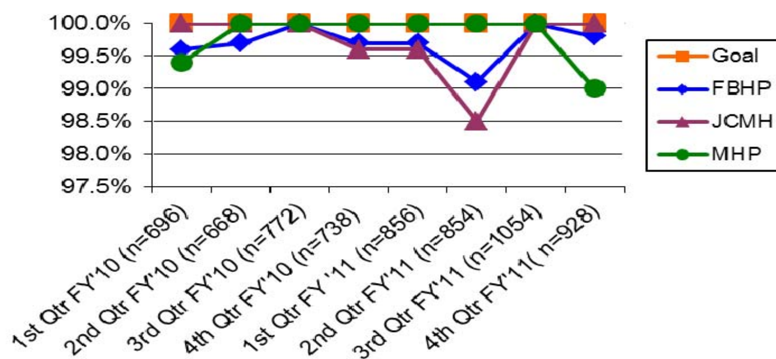
Assessment of Performance: FBHP met the goal for urgent performance indicators through FY '11. FBHP did not meet the goal for emergency face-to-face and emergency phone but was close, at 99.6% and 99.96% respectively.

B. Time to first offered routine intake (100% offered appointment in seven business days)**:**

FBHP's goal was to consistently meet the standard for this access to care indicator.

FBH Performance: There were 3727 requests for a routine intake appointment during FY '11, about a 30% increase from FY '10; 99.7% of those requesting an intake were offered an appointment in seven days (Figure 2). There were 11 clients offered intake appointments within 8-14 days and two after 15 days.

Figure 2. Percent Routine Intake Requests with Offered Appointment within 7 Business Days, FY '10 and FY '11, by FBHP and the Partner MHCs



Assessment of Performance: FBHP did not meet the goal for this Access indicator, but was close, at 99.7% (Figure 2). There were two appointments offered at more than 15 days, one was in the IPN provider network and the other was a client at a partner mental health center (PMHC). The error at the PMHC was secondary to a new employee not following access procedures. These providers were trained on the standard and appropriate procedures.

C. Overall Member Access

Penetration rate overall and by age group & eligibility category

FBHP's goal was to be above the overall BHO penetration rates for all categories, as calculated by the Department, FY '10 and to maintain, given the large increase in membership, the FBHP overall penetration for FY '10, at or above 20%.

FBHP Performance: FBHP's overall penetration rates, end of FY '11, at 18.8%, was below the goal of 20%, but continues to be above the FY '10 overall BHO rate of 13.5% (Figure 3). FBHP's penetration rates, for all age categories, end of FY '11, were above the BHO FY '10 rates, although there was a trend downward in all of these age groups. In addition, FBHP's penetration rates for all eligibility categories, end of FY '11, were above the BHO rates for FY '10, but again there was a trend downward, particularly in the AFDC-A and C and the OAP-A eligibility groups (Table 1). Decreasing penetration in the AFDC-A and C categories may be secondary to the large increase in membership, at 25% and 8.5% respectively, from the first quarter of FY '11.

Figure 3. Penetration Rate Overall by Membership FY '11

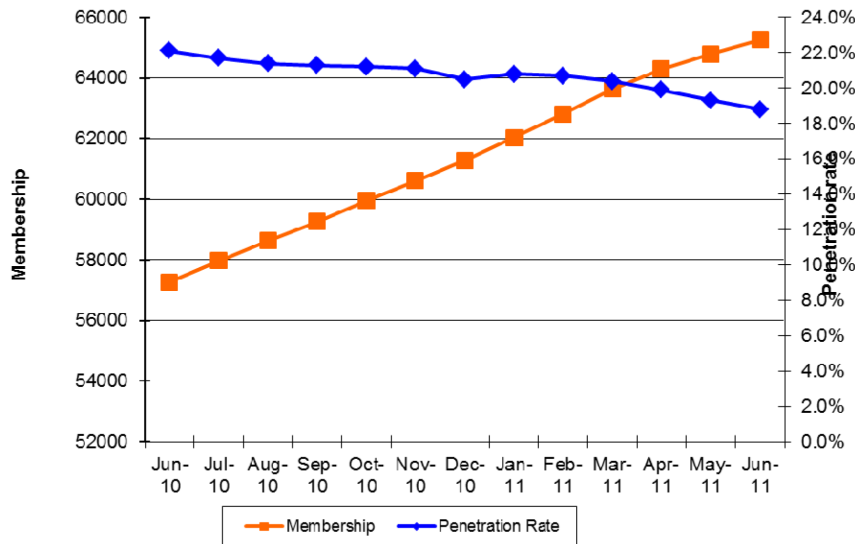


Table 1 Penetration, Age Group and Eligibility Category, FY '11

Age Group	BHO FY'10	1st Qtr FY'11	2nd Qtr FY'11	3rd Qtr FY'11	4th Qtr FY'11
0-12 yr (n)	7.6%	14.7% n=27,833	14.4% (n=28,459)	14.5% (29,070)	13.2% (n=29,725)
13-17 yr (n)	20.8%	32.1% (n=6,103)	32.4% (n=6,304)	31% (n=6,572)	28.4% (n=6,755)
18-64 yr (n)	21.9%	29.3% (n=20,165)	27.8% (n=21,300)	27.5% (n=22,714)	25.5% (n=23,515)
65+ (n)	6.9%	12.4% (n=5,170)	11.7% (n=5,218)	9.1% (n=5,276)	8.8% (n=5,264)

Eligibility Group	BHO FY'11	1st Qtr FY'11	2nd Qtr FY'11	3rd Qtr FY'11	4th Qtr FY'11
AND, AB, OAP-B (n) (n)	31.8%	35% (n=8,191)	34.7% (n=8,313)	35.3% (n=8,479)	34.1% (n=8,554)
BC-A, AFDC-A (n)	18.3%	24.2% (n=11,665)	22.5% (n=12,647)	21.6% (n=13,797)	20% (n=14,556)
BC-C, AFCD-C (n)	9.7%	16.9% (n=31,498)	16.2% (n=32,356)	16.6% (n=33,344)	14.8% (n=34,184)
Foster Care (n)	39.6%	38.8% (n=2,496)	38.4% (n=2,511)	39.4% (n=2,525)	38.1% (n=2,501)
OAP-A (n)	7%	12.3% (n=5,138)	11.7% (n=5,177)	9% (n=5,217)	8.6% (n=5,195)

Assessment of Performance: FBHP did not meet the goal of maintaining a 20% penetration rate but met all of the other goals for this indicator. The overall penetration rate is draft and because of delay in encounters/claims there may be

a slightly higher rate; will await final calculation by the Department before determining a plan for improvement.

D. Phone response:
FBHPs goal was that monthly call abandonment rates would be below the benchmark of 3%. Total calls include all three BHOs who partner with ValueOptions.

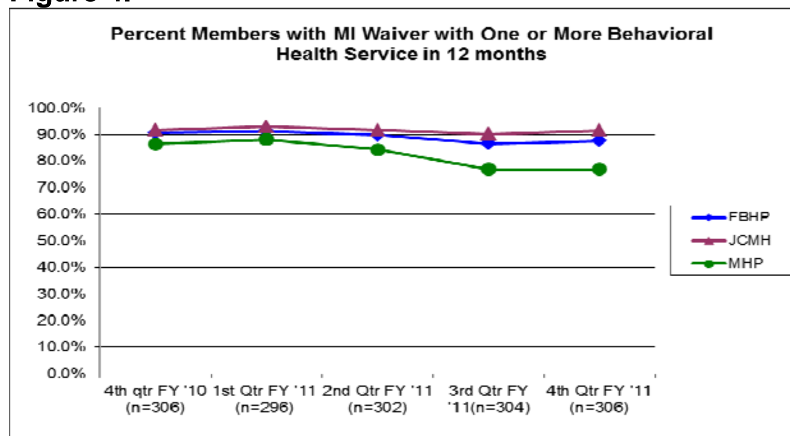
FBHP Performance: FBHP call abandonment rates were below the 3% benchmark through June, 2011. There were a total of 23,116 calls through the ValueOptions call center with an average abandonment rate of 0.83%.

Assessment of Performance: FBHP/ValueOptions call abandonment rates were consistently below the 3% benchmark; FBHP met its goal for this access indicator.

E. Mental Illness Waiver Member Access:
FBHPs goal was that the percent of members with a MI Waiver with one or more behavioral health service will be at or above 90%.

FBHP Performance**:** The percent of members with a MI Waiver, with one or more behavioral health service, was at 87.5% (n=306) at the end of FY '11. This was a decrease from the beginning of the fiscal year, at 91.2% (Figure 4).

Figure 4.



Assessment of Performance: FBHP did not meet the goal for this performance indicator. A performance improvement project is planned for FY '12 to address this access issue.

F. Ensuring a behavioral health home – Member's with severe and persistent mental illness (SPMI) (Development Measure)
FBHPs' goal was to work with HCPF in defining criteria for the new performance measure and calculate FBHPs' FY '10 performance.

***Assessment of Performance*:** FBHP met the goal for this development measure. Results for FY ’10 indicate that 90.4% of members with SMI received at least three clinical services and/or two prescriber services in the fiscal year. This was slightly higher than the BHO rate of 89.5%

G. Length of time to first appointment after intake (development measure)
FBHPs goal was to develop procedures to measure mean number of days to second appointment after the initial assessment and to develop procedures/survey of clients with an intake who are transferred to another therapist for on-going treatment.

Assessment of Performance: FBHP did not meet the goal for this indicator and continued this as a development measure in FY ’12.

H. Follow-up after residential treatment (development measure)
FBHPs goal was to establish an indicator to monitor follow-up after residential discharge to ensure an appointment within seven business days.

Assessment of Performance: FBHP has not yet met the goal for this access indicator. FY ’11 data needs to be analyzed to establish a baseline. This will be completed by 2nd qtr and FY ’12 data will then be monitored.

QUALITY DIMENSION #2: Member and Family Service and Satisfaction

A. Client and family perception of access to service:
FBHP’s goal, for this MHSIP and YSS-F domain indicator, was that FBHP’s state percent agreement results would be within the lower limit of the p=.05 confidence interval of the overall BHO percent agreement

FBHP Performance: FBHP results, for the Access domain percent agreement for the FY ’11 MHSIP and YSS-F BHO state survey, were 78.4% (n=134) and 80.8% (n=72) respectively. The BHO overall percent agreement, for this MHSIP domain, was 84.4%, with a confidence interval of 82.1%-86.7%. FBHP MHSIP results were below the lower confidence interval. The BHO overall percent agreement for this YSS-F domain was 80.8%, with a confidence interval of 77.8%-83.8%. FBHP YSS-F results were within the confidence interval.

Assessment of Performance: FBHP did not meet its goal for percent agreement for the MHSIP Access domain but did meet the goal for the YSS-F. This is the first year MHSIP and YSS-F client survey data, using the new procedure of administration, was available for analysis. MHSIP Access data, by item and MHC, will be conducted to assess improvement opportunities.

B. Client perception of overall service
FBHP’s goal is the same as for section A, but specific to the MHSIP, as there is not an overall service domain on the YSS-F.

FBHP Performance: FBHP results, for the Overall Service domain percent agreement for the FY '11 MHSIP was 89.6% (n=125). The BHO overall percent agreement, for this MHSIP domain was 91.2%, with a confidence interval of 89.4%-93%. FBHP MHSIP results were with the confidence interval.

Evaluation of Performance: FBHP met its goal for percent agreement for this MHSIP domain.

C. Client/Family perception of outcomes:
FBHP's goal is the same as for section A.

FBHP performance: FBHP results, for the Outcomes domain percent agreement for the FY '11 MHSIP and YSS-F BHO state survey, were 64.8% and 54.2% respectively. The BHO overall percent agreement, for this MHSIP domain, was 66.6%, with a confidence interval of 57.3%-65.3%. FBHP MHSIP results were within the confidence interval. The BHO overall percent agreement, of this YSS-F domain, was 61.3%, with a confidence interval of 77.8%-83.8%. FBHP YSS-F results were below the lower limit of the confidence interval.

Evaluation of Performance: FBHP met the goal for this MHSIP domain but did not meet the goal for the YSS-F. Further analysis will be conducted by item for the YSS-F survey to assess for an improvement opportunity, keeping in mind the small sample size for the YSS-F survey.

D. Client perception of care quality and appropriateness
FBHP's goal is the same as for section A.

FBHP performance: FBHP results, for the Care Quality and Appropriateness domain percent agreement for the FY '11 MHSIP and YSS-F BHO state survey, were 89.3% and 78.1% respectively. The BHO overall percent agreement, for this MHSIP domain, was 89.2%, with a confidence interval of 86.3%-92.1%. FBHP MHSIP results were within the confidence interval. The BHO overall percent agreement, for this YSS-F domain, was 84%, with a confidence interval of 81%-87%. FBHP YSS-F results were below the lower limit of the confidence interval.

Evaluation of Performance: FBHP met the goal for this MHSIP domain but did not meet the goal for the YSS-F. Further analysis will be conducted by item for the YSS-F survey to assess for an improvement opportunity, keeping in mind the small sample size for the YSS-F survey.

E. Client perception of participation in treatment
FBHP's goal is the same as for section A.

FBHP performance: FBHP results, for the Participation domain percent agreement for the FY '11 MHSIP and YSS-F BHO state survey, were 74.4% and 92.9% respectively. The BHO overall percent agreement, for this MHSIP

domain, was 78.6%, with a confidence interval of 76%-81.2%. FBHP MHSIP results were below the confidence interval. The BHO overall percent agreement, for this YSS-F domain, was 91.3%, with a confidence interval of 88.8%-93.8%. FBHP YSS-F results were within the confidence interval.

Evaluation of Performance: FBHP did not meet the goal for this MHSIP domain but met the goal for the YSS-F. Further analysis will be conducted by item for the MHSIP survey to assess for an improvement opportunity.

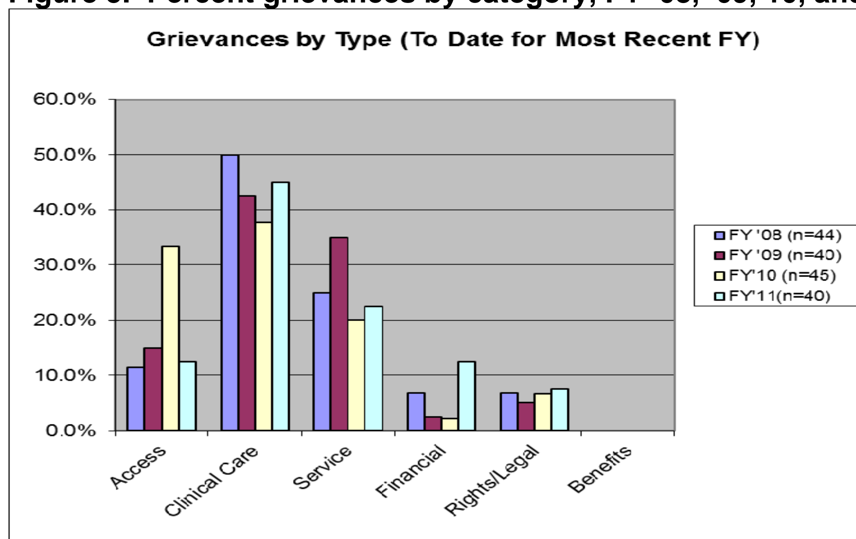
F. Client complaints about service (grievances)

FBHP's goal, for this indicator, was to analyze type of grievances and assess for any quality of care concerns and improvement opportunities.

FBHP performance: A four year trend analysis of type of grievances is provided in Figure 5. In FY '11 there were 40 grievances. The highest percent of grievances had to do with clinical care, at 45% and customer service, at 22.5%. The most common types of clinical care grievances had to do with professional conduct or competence and the most common type of customer service grievance had to do with discourteous/rude treatment by clinical staff. Grievances specific to customer service, increased from FY '10.

More than half (55%) of clients, with grievances in FY '11, agreed with the BHO's decisions on the grievances. This was a lower percent agreement than was reported in the previous three fiscal years. No quality of care concerns or trends regarding specific providers were identified related to the FY '11 grievances.

Figure 5. Percent grievances by category, FY '08, '09,'10, and '11



Evaluation of performance**:** The Director of Client and Family Affairs provided a summary of grievances and appeals on a quarterly basis to the QI/UM committee. There were no specific trends or patterns that suggesting a quality of care concern regarding specific providers or provider groups nor any clear

process of care improvement opportunities. FBHP will continue to monitor quarterly in the QI/UM committee.

QUALITY DIMENSION #3: CARE QUALITY and APPROPRIATENESS

A. Coordination/Timeliness of Hospital Follow-up:

FBHPs goal was to be at or above the FY ’10 overall BHO 7 and 30 day follow-up rates, suggesting appropriate hospital follow-up for clients. FBHP’s performance, on this indicator, is monitored quarterly.

FBHP Performance: In FY ’11 FBHP’s rate of follow-up at 7days after discharge, end of 3rd Qtr, was 58% (n=239), which was considerably above the overall BHO rate of 48.2%; FBHP 30 day follow-up was at 76%, which was above the overall BHO rate of 67.3% (Figure 6 & 7). Because of the 30 day lag for this indicator FBHP performance, FY ’11, is through 3rd Qtr.

Figure 6. Percent Hospital Follow-up Appointment 7 Days after Discharge, 12 month Period Ending with the Quarter, FY ’10 and ‘11

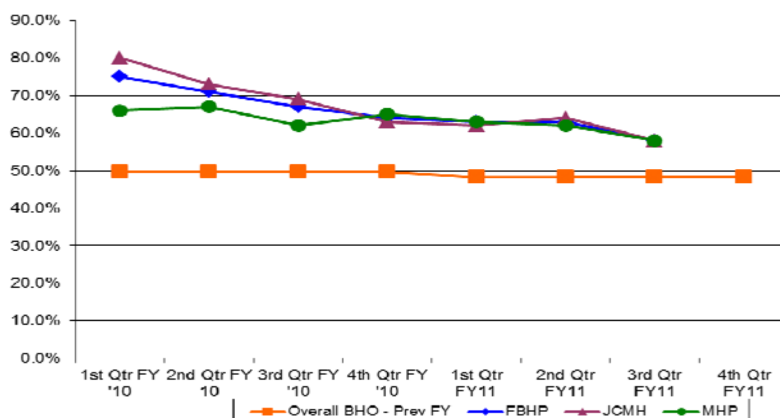
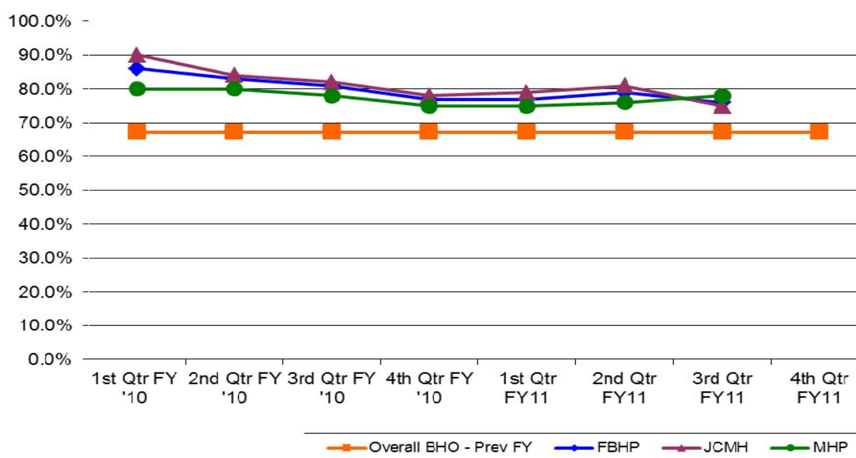


Figure 7. Percent Hospital Follow-up Appointment 30 Days after Discharge, 12 month Period Ending with the Quarter, FY ’10 and ‘11



Assessment of Performance: FBHP's 7 and 30 day follow-up rate was above the overall BHO rate in FY '10, although there is a trend of decreasing percent through the fiscal year. FBHP met its goal for this indicator.

B. 1. Appropriate Utilization, Psychiatric Hospitalization (over-utilization measure): Number psychiatric hospital admits/1,000

FBHP's goal was to be below the overall BHO hospital utilization/1,000 Members for the previous fiscal year, suggesting that hospital services are not being over-utilized and outpatient and crisis services are not under-utilized. FBHP performance, on this indicator, is monitored quarterly.

FBHP Performance: FBHP FY '11 all hospitalization utilization rate was 5.4/1,000 (n=354), which was lower than the FY '10 overall BHO rate of 5.8/1,000 and slightly less than FBH FY '10 rate of 6.1/1,000 (Figure 8). FBHP FY '11 non-state hospital utilization rate was 3.2/1,000 (n=211), which was lower than the FY '10 overall BHO non-state hospital rate of 3.8/1,000 (Figure 9).

Figure 8. All Psychiatric Hospital Utilization Rates per 1,000, 12 Month Period Ending with the Quarter, FY '10 and '11

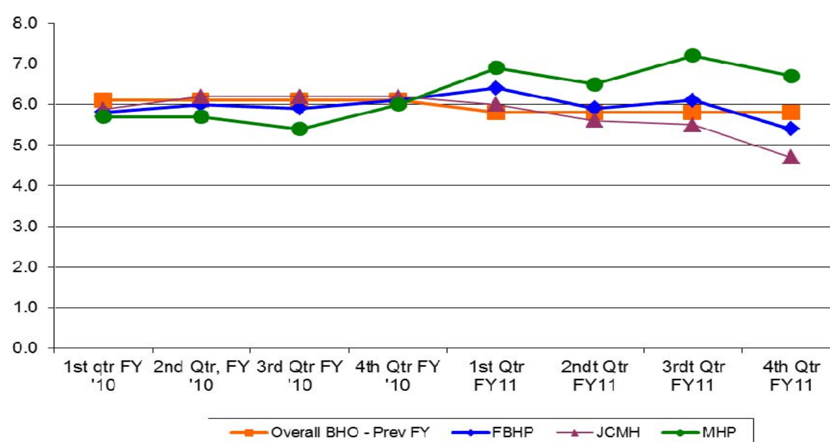
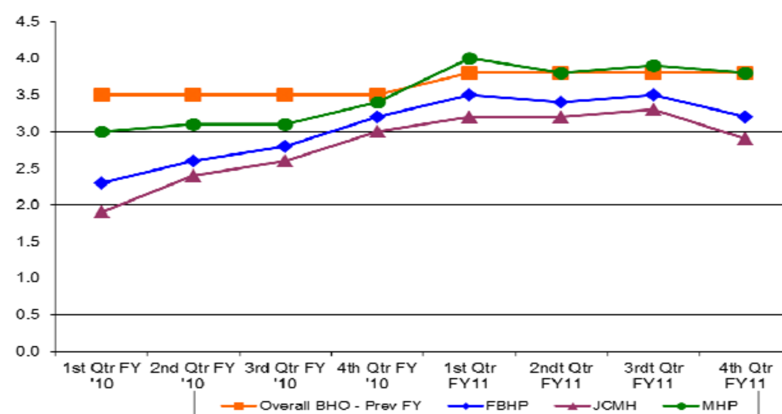


Figure 9. Non State Psychiatric Hospital Utilization Rates per 1,000, 12 Month Period Ending with the Quarter, FY '10 and '11



Evaluation of Performance: FBHP met its goal for this indicator.

2. Hospital discharge length of stay (LOS)

FBHP's goal was to be below the overall BHO hospital LOS from the previous fiscal year, suggesting that hospital services are not being over-utilized and outpatient and crisis services are not under-utilized. FBHP performance, on this indicator, is monitored quarterly.

FBHP Performance: FBHPs' FY '11 mean LOS at hospital discharge was 14.8 days, which was above the overall FY '10 BHO rate of 13.9 days and the FBHP FY '10 rate of 13.4 days (Figure 10). FBHPs' FY '11 mean LOS non-state hospital discharge was 6.3 days, which was below the FY '10 BHO rate of 7.2 days (Figure 11).

Figure 10. All Psychiatric Hospital Average LOS at Discharge, 12 Month Period Ending with the Quarter, FY '10 and '11

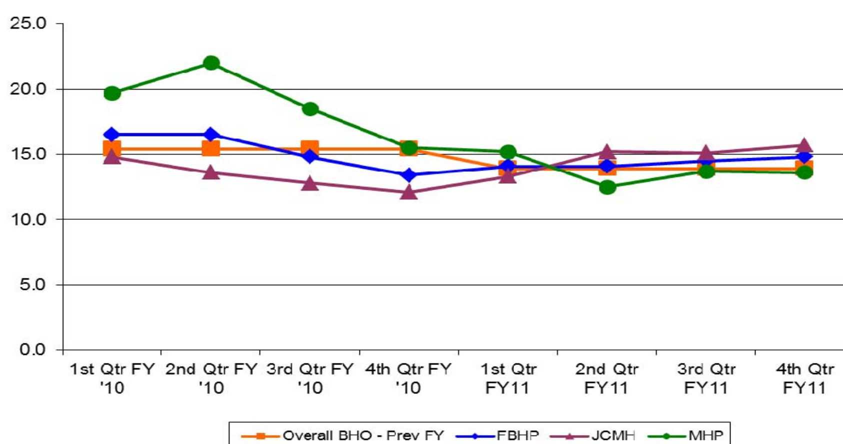
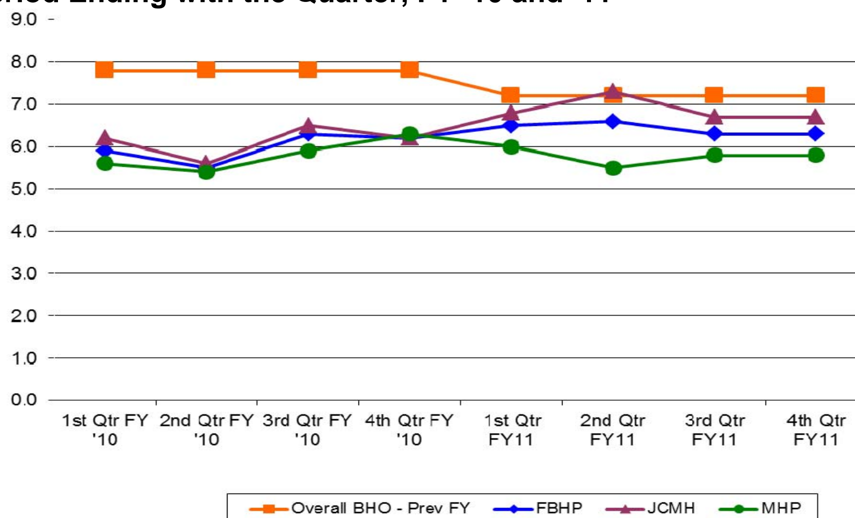


Figure 11. Non-state Psychiatric Hospital Average LOS at Discharge, 12 Month Period Ending with the Quarter, FY '10 and '11



Evaluation of Performance: FBHP did not meet the goal for the all hospital LOS indicator, but was close, and did meet the goal for the non-state hospital LOS indicator. The all hospital LOS will be monitored closely for increasing LOS.

C. Recovery-oriented services and programs

FBHPs goal was to conduct an annual survey with clients/family members that service on the FBHP and partner MHC boards, committees, and advisory groups, assessing their satisfaction with their voice and role on these committees.

FBHP performance: The survey will be conducted in FY ’12 and reported by the end of the second quarter.

Evaluation of performance: FBHP will assess performance once the survey is completed.

D. Implementation of evidence-based practices

FBHP’s goal, for this indicator, was to ensure implementation of FY ’11 EBPs, including measurement of fidelity and establishing outcome measurement.

FBHP performance: FBHP implemented four of five FY ’11 EBPs that were planned in the RFP (see Appendix B for the EBP Implementation Report).

Evaluation of performance: FBHP was close to meeting its goal on this implementation plan. One EBP was not implemented in the required timeframe.

E. Under-utilization of service post hospital discharge:

FBHP’s goal, for this indicator, was to have a trend of increasing percent, during the fiscal year, of clients with two or more prescriber visits and eight or more clinical visits within 90 days of hospital discharge.

FBHP performance: For FY ’11, there was a steady decrease in percent clients with two or more prescriber within 90 days of hospital discharge, ending with 42.4% (n=329) (Figure 12). The decrease from FY ’10 was about 12.3%. In addition there was a steady decrease through FY ‘11 in percent clients with eight or more clinical visits within 90 days of hospital discharge, ending with 62.2% (Figure 13). There was an 8.5% decrease from FY ’10.

Figure 12. Percent of clients with two or more prescriber visits within 90 days after hospital discharge 12 month period ending with the quarter

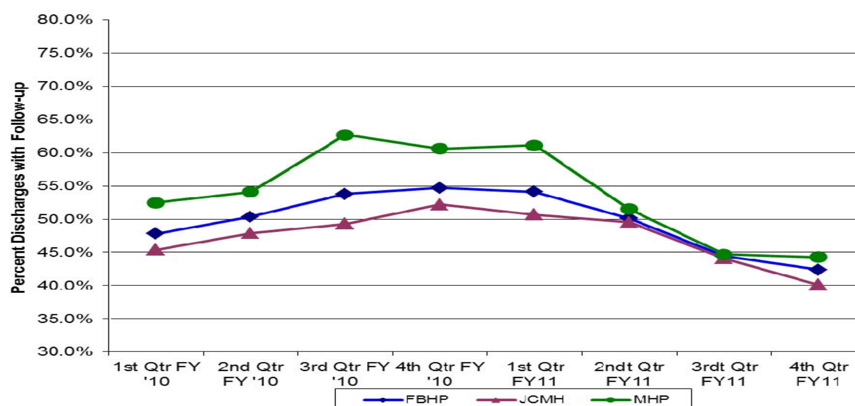
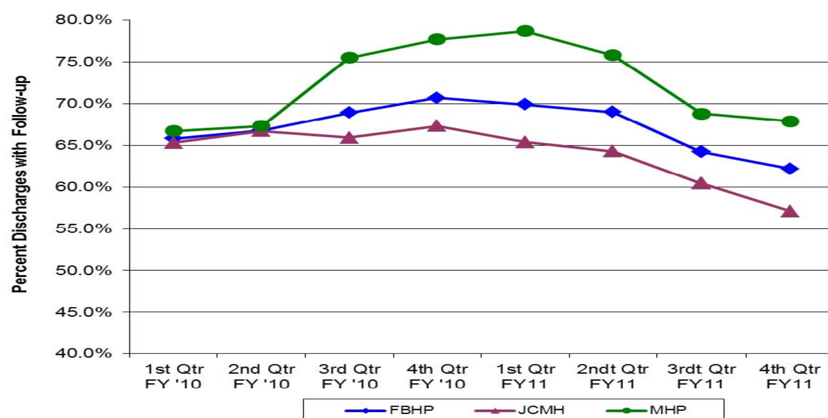


Figure 13 Percent of clients with eight or more clinical visits within 90 days after hospital discharge, 12 month period ending with the quarter



Evaluation of performance: FBHP did not meet the goal for this indicator. A revision to this indicator was made in the FY '12 QI Plan to focus on follow-up within 30 days of discharge, to be consistent with a utilization measure. Further investigation will be conducted if there are continued results showing similar problems in adequate follow-up in 1st Qtr FY '12 with the new measure.

F. Quality of antipsychotic prescribing practice (development indicator)

FBHPs' goal was to finalize criteria for this indicator and complete the FY '10 measurement, with a plan to move to monitoring status in FY '12.

FBHP Performance: FBHP completed this goal. FY '10 results indicated that there were 6.1% of clients received two atypical antipsychotic medications for more than 120 days. This was slightly lower than the BHO overall percent of 6.2%

G. Effective acute phase treatment – members with a new episode of depression prescribed antidepressant medication (development indicator)

FBHPs' goal was to finalize criteria for the new performance measure and calculate FBHPs' FY '10 performance.

Assessment of Performance: FBHP met the goal for this development measure. Two performance indicators were calculated for FY '10. The first was the percent of members with a new episode of depression treated with an antidepressant and maintained on the medication for at least 12 weeks. FBHP percent was at 49%; the BHO overall percent was at 49.6%. The second indicator was the percent of members with a new episode of depression treated with an antidepressant and receiving at least three follow-up contacts within 12 weeks. FBHP percent was at 43.8%; the BHO overall percent was at 37.1%. Both of these indicators will be on monitoring status in the FY '12 QI Plan.

H. Utilization by service category (development measure)
FBHPs' goal was to finalize criteria for the new performance measure and calculate FBHPs' FY '10 performance.

Assessment of Performance: FBHP met the goal for this indicator. Four utilization rates were calculated.

- Inpatient – FBHP rate was 2.4% (n=12,621); Overall BHO was 3.8%
- Intensive outpatient – FBHP rate was 0.71%; Overall BHO was 1%
- Outpatient – FBHP rate was 58.4%; Overall BHO was 81.1%
- ED Visit – FBHP rate was 2.4%; Overall BHO was 5.4%

I. Nursing Facility LOS (development measure)
FBHP's goal was to work with HCPF and the Long Term Care Benefits Division to establish a database of members placed in a nursing facility for a primary behavioral health disorder and their LOS. Concern is whether or not these members have an active plan for discharge to a more independent living arrangement.

Assessment of Performance: FBHP did not meet the goal for this indicator. The HCPF workgroup, addressing nursing facility residents with behavioral health disorders, is no longer in place. FBHP will work with the two MHCs to consider alternative procedures for establishing this database.

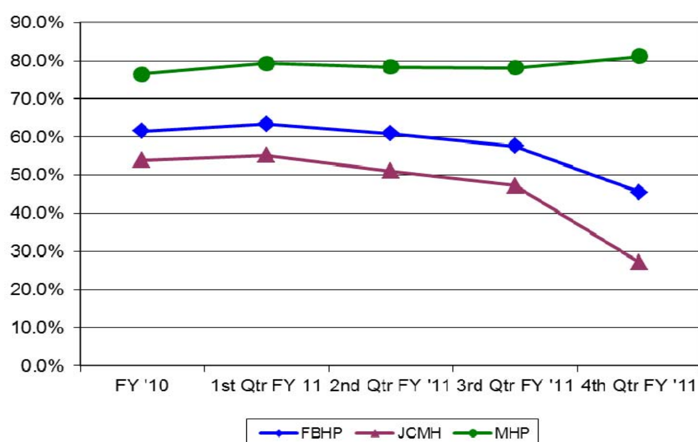
Quality Dimension #4: Care Coordination and Integration

A. Client access to medical care
FBHP's goal was to have a trend of increasing percent of clients with services at the partner MHC's with an indentified PCP

FBHP Performance: Through FY '11 there was a significant decrease in proportion of clients with services at the partner MHCs with an identified PCP, with less than half (45.5%, n=4406) with a reported PCP at the end of the fiscal year (Figure 14). This was a decrease of 16% from FY '10. MHP reported an increase percent, at the end of FY '11 of 4.7%, compared to FY '10, with final

percent of members with an identified PCP of 81.2%. Jefferson Center reported a significant decrease in percent of 26.8% from FY'10 and, at year end reported an overall percent of members with an identified PCP of 27.1%.

Figure 14. Percent of clients receiving partner MHC services with an identified PCP at the end of the quarter



Evaluation of Performance: FBHP did not meet this goal. There was a revision to Jefferson Center procedures for tracking a client's PCP midway through the fiscal year, with a loss in information on this field. Jefferson Center is presently working on this report and expects to have accurate data by first quarter, FY '12.

B. Percent clients with an identified PCP and receiving prescriber service with a coordination of care letter to the PCP

FBHP's goal was to establish a baseline percent, in FY '10, of percent clients receiving prescriber service with a coordination of care letter sent to the PCP and begin monitoring this percent on a quarterly basis.

FBHP performance: FBHP established reporting procedures with the two MHCs on this indicator, with a beginning baseline, for FY '10 of 53.6% (n=1388). MHP continued to report quarterly and, at the end of FY '11 there was a 19.2% increase, from FY '10, in percent clients with a prescriber visit and an annual coordination of care letter sent, with a final percent of 78%. Jefferson Center, as indicated above, revised their procedures for tracking and reporting on coordination of care letters and was unable to provide this report after the first quarter of FY '11.

Evaluation of performance: FBHP did not complete this goal. Jefferson Center has indicated that they can begin reporting accurate data for this indicator by first quarter, FY '12.

C. Increasing percent physicians at Member's post-partum visit that conduct a depression screening (development measure)

FBHPs' goal was to work with HCPF in finalize criteria for this new performance measure and calculate FBHPs' FY '10 performance.

Assessment of Performance**:** FBHP met the goal for this development measure. Percent of a sample of medical offices called using an approved depression screening instrument was at 50% (n=20). BHO overall percent was 49%. FBHP will maintain this indicator as a development measure, as more work needs to be done on the criteria.

D. Client access to PCP (development measure)

FBHPs' goal was to finalize criteria for this new performance measure and calculate FBHPs' FY '10 performance.

Assessment of Performance: FBHP met the goal for this development measure. Percent of adult members with one or more behavioral health visit and one or more approved physical health visit was 77.3% (n=3820). The overall BHO percent was 80.3%. Children will be added to this measure and FBHP will monitor this in FY '12.

E. High physical health ED utilization, members with an MI Waiver (development measure)

FBHPs' goal was to establish a database and baseline for this development measure in FY '11.

Assessment of Performance: FBHP met the goal for this development measure. For the 12 month period ending with FY '11 83.3% (n=48) of members with a MI Waiver had three or more ED visits for physical health reasons. This measure will continue in development status for FY '12 as FBHP works with the partner mental health centers to develop an acceptable plan for intervention.

Quality Dimension #5: Outcomes and Effectiveness of Care

A. Hospital Recidivism

FBHP's goal was to be below the overall BHO 7, 30, and 90 recidivism rates for the previous fiscal year, indicated that hospital services are not being over-utilized and there is appropriate hospital follow-up in place. FBHP performance, on this indicator, is monitored quarterly.

FBHP performance: FBHP's FY '11 seven day recidivism rate all hospital, end of the third quarter, was 3.6% (n=387), compared to the BHO FY '10 rate of 3.7% (Figure 15). FBHP FY '11 30 day recidivism rate, at the end of the third quarter, was 11.1%, compared to the BHO FY '10 rate of 10.5% (Figure 16). Last, FBHP FY '11 90 day recidivism rate, end of the third quarter, was 18.6% compared to the BHO FY '10 rate of 18.9% (Figure 17).

Figure 15. 7 Day Recidivism Rates, 12 Month Period Ending with the Quarter

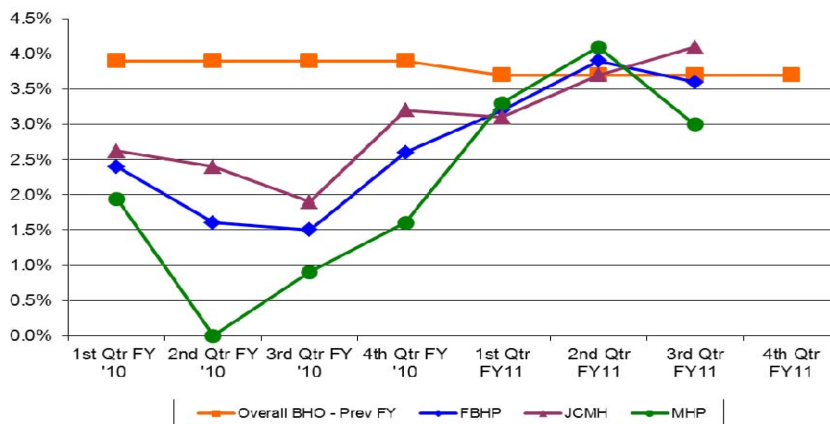


Figure 16. 30 Day Recidivism Rates, 12 Month Period Ending with the Quarter

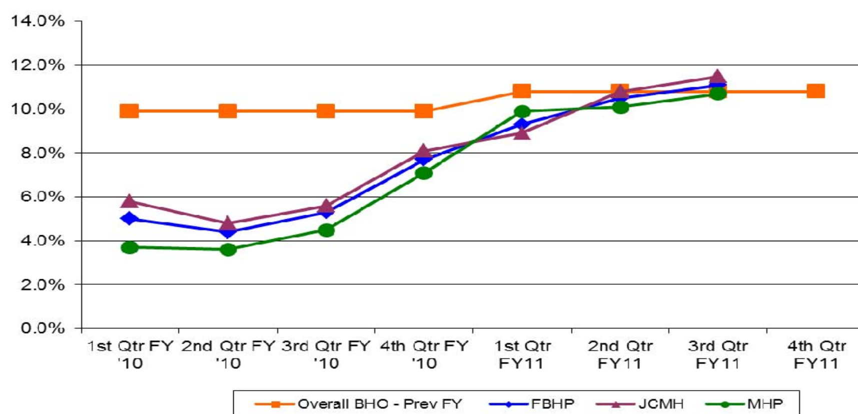
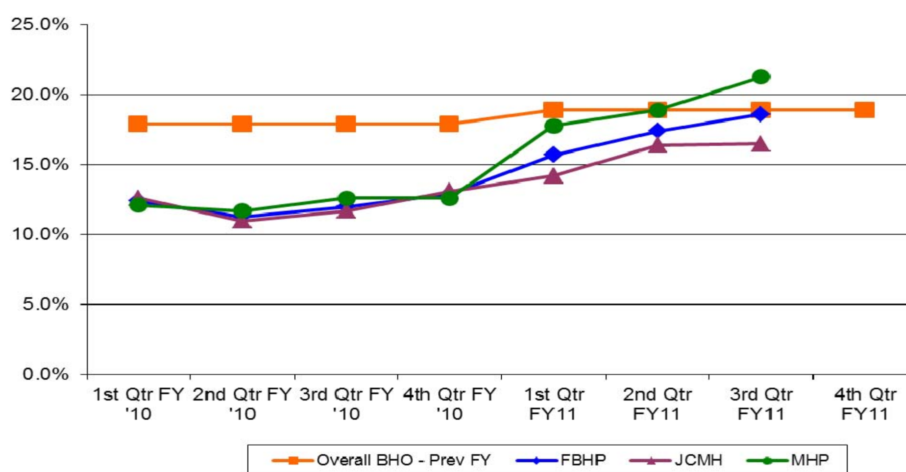


Figure 17. 90 Day Recidivism Rates, 12 Month Period Ending with the Quarter



Evaluation of Performance: FBHP met the goal for the 7 and 90 days recidivism rates but did not meet the goal for the all hospital 30 recidivism rate. FBHP recidivism rates increased through FY '11 for all three

indicators. FBHP has implemented, with the partner mental health centers a performance improvement project, FY ’12, to address increasing recidivism rates.

B. Member Access Outpatient/Crisis Care

FBHP’s goal was to be below the overall BHO ED visits/1,000 Members for the previous fiscal year, suggesting that ED services are not being over-utilized and outpatient and crisis services are not under-utilized. FBHPs’ performance, on this indicator, is monitored quarterly.

***FBHP Performance*:** In FY ’11, end of the 3rd quarter, FBHP had 6.0 ED visits/1,000 Members that did not result in a hospitalization. This was below the overall FY ’10 BHO rate of 8/1,000 Members (Figure 18) and a decrease in the FY ’10 FBHP rate of 6.4/1,000. ED visits by youth age group indicate a slight increase for youth, age 0-12 years, from 1.5/1,000 in FY ’10 to 1.9/1,000 in FY ’11. For adolescents, age 13-17 years, there was a decrease, from 14.8/1,000 to 10.7 in FY ’11 (Figure 19 & 20).

Figure 18. ED Visits/1,000 Members, 12 Month Period Ending with the Quarter

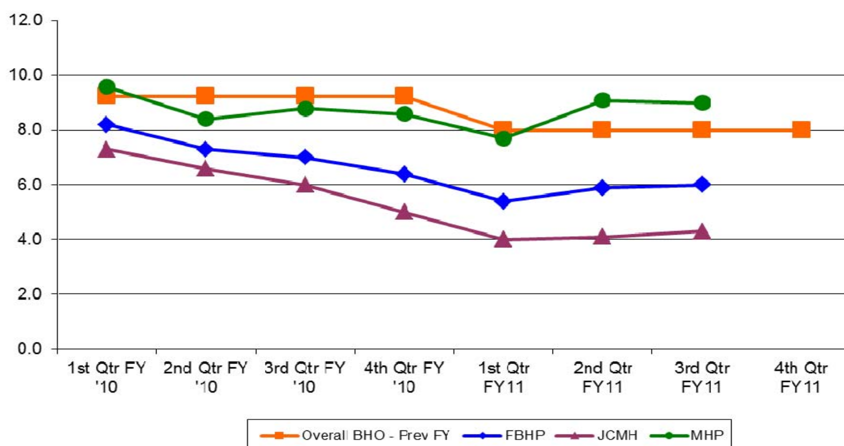


Figure 19. Child ED Visits/1,000, 12 month Period Ending with the Quarter

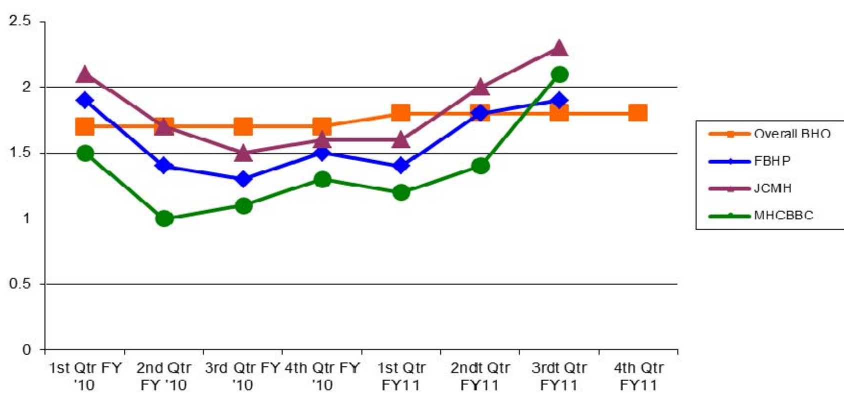
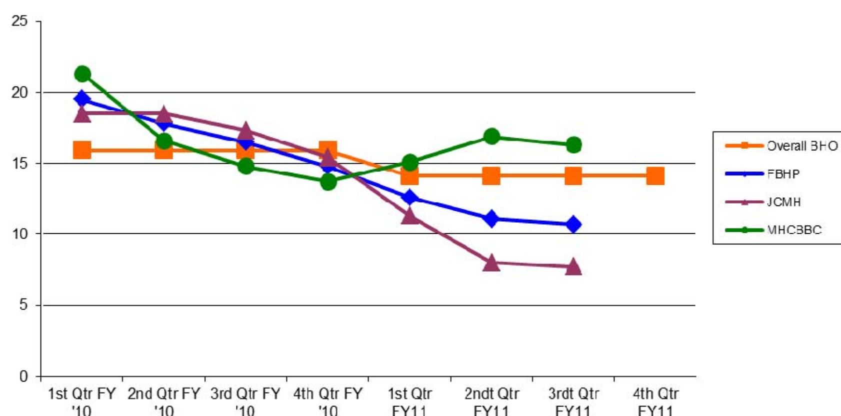


Figure 20. Adolescent ED Visits/1,000, 12 month Period Ending with the Quarter



Assessment of Performance: FBHP achieved its goal for FY '11, as ED visits/1,000 was below the overall BHO rate for FY '10. In addition, youth ED visits for age 13-17 years have decreased, which indicates possible effects from the ED visit performance improvement project to decrease youth ED visits

C. Outcomes for Implemented EBPs

FBHPs' goal for this indicator was to assess and report on outcomes for members treated in EBPs.

FBHP Performance: FBHP met this goal (see EBP report Appendix B)

D. Improvement in Symptom Severity youth (development indicator)

FBHPs' goal was to finalize criteria for the new performance measure and calculate FBHPs' FY '10 performance.

Assessment of Performance: FBHP met the goal for this development measure. See Table 2 and 3 for FY '10 results for this indicator. This indicator will continue as a development measure for FY '12 as the QI/UM Committee determines an appropriate goal for these subscales.

Table 2 Child CCAR Symptom Subscale Mean Scores Pre and Post FY 10

Symptom Severity Subscale	FBHP Pre Mean Score	FBHP Post Mean Score
Mental Func/Physical Health	2.65	2.16
Sociability	3.29	2.58
Mood disturb/Family	3.56	2.71

Table 3 Adolescent CCAR Symptom Subscale Mean Scores Pre and Post FY '10

Symptom Severity Subscale	FBHP Pre Mean Score	FBHP Post Mean Score
Mental Functioning	2.95	2.31
Sociability	3.69	2.91
Depression/Suicidality	3.67	2.55

E. Improvement in Symptom Severity adult (development indicator)
FBHPs' goal was to finalize criteria for the new performance measure and calculate FBHPs' FY '10 performance.

Assessment of Performance: FBHP met the goal for this development measure. See below for FY '10 results. This indicator will continue as a development measure for FY '12 as the QI/UM Committee determines an appropriate goal for these subscales.

Table 4 Adult CCAR Symptom Subscale Mean Scores Pre and Post FY '10

Symptom Severity Subscale	FBHP Pre Mean Score	FBHP Post Mean Score
Mental Functioning	3.29	2.59
Sociability/Substance Use	2.91	2.41
Mood Disturbance	3.81	2.83

F. Improvement in independent living for members with severe mental illness (development measure)
FBHPs' goal was to finalize the two indicators under these two new performance measures and calculate FBHPs' FY '10 performance.

Assessment of Performance: FBHP met the goal for this development measure. There was an error in calculation of the two indicators under this measure, percent members with SMI maintaining independent living and percent members with SMI progressing toward independent living. This will be corrected for the FY '11 calculation. Both of the indicators will be on monitoring status for the FY '12 QI Plan.

G. Improvement in resiliency and recovery for members with severe emotional disorders and severe mental illness
FBHPs' goal was to finalize criteria for this new performance measure and calculate FBHPs' FY '10 performance.

Assessment of Performance: FBHP met the goal for this development measure. See Table 5 for FY '10 results.

Table 5 CCAR Recovery/Resiliency Subscale Mean Scores Pre and Post FY '10

Recovery/Resiliency Subscale	FBHP Pre Mean Score	FBHP Post Mean Score
Adult Recovery	3.99	3.69
Adolescent Resiliency	4.76	3.52
Child Resiliency	3.72	2.88

H. Outcomes: Implemented EBPs
FBHPs' goal was to establish procedures for tracking specified outcome measures for EBPs implemented in FY '11

Assessment of Performance: FBHP met the goal (see Appendix B for report)

II. Performance Improvement Projects/Focus Study – Summary and Update

A. Coordination of Care PIP:

Began: 9/1/08

Description of Problem: The intent of this PIP is to improve coordination of care between physical and behavioral health providers for clients with Medicaid who are receiving behavioral health services and whose behavioral health diagnosis includes schizophrenia, schizoaffective disorder, or bipolar disorder. This subset of clients, within these three diagnostic groups, have been found to have a significantly shorter life span than the normal population and are likely to develop chronic physical conditions, including cardiovascular disease, diabetes, asthma, and emphysema. This population is also more likely that the rest of the population to have key risk factors, such as smoking obesity, hypertension, hyperlipidemia, and poor dietary habits. Unfortunately, although individuals with chronic medical conditions can be treated and at risk factors modified or eliminated, there is, at present, a failure to detect, treat, and collaborate in the care of co-occurring medical conditions with a severe mental illness.

Study Question: Do targeted interventions improve coordination of care between physical and behavioral health providers for consumers with a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder, as measured by the percent of the study population with a physical health office visit and the percent of the study population with documentation of coordination of care in the behavioral health record?

Interventions:

1. Develop and implement an electronic coordination of care letter from the behavioral health care provider, completed at initial evaluation and annually, that: a) introduces the PCP that the prescriber as seen their patient b) summarizes psychotropic medications prescribed, c) requests specified medical information from the PCP, and d) indicates interest on collaborating in treating the patient.
2. Develop method for tracking, within the client medical record, whether or not the client has a PCP and the name of the PCP. Establish method for reporting this information
3. Establish procedures for ensuring clients have a PCP or assist in obtaining one; also that the client, as appropriate, completes an annual medical office visit.

Measures:

1. The percent of the study population with one or more preventive or ambulatory medical office visits during the measurement period.
2. The percent of the study population with one or more medical visits with documentation of coordination of care letter in the behavioral health record.

Re-measurement status: First re-measurement was completed. There was a non-significant increase from baseline in study indicator #1 and significant, at p<.0001, increase in study indicator #2. Results from re-measurement indicated a significant increase in study indicator #1 and non-significant increase in study indicator #2.

Performance Indicator	Baseline	1st re-measurement	2nd re-measurement
#1 Percent study population with one or more medical office visits	69.5%	71.1% (NS increase)	77.7%**
#2 Percent those with medical office visits with coordination of care activity	2.2%	37.5%*	41.1% (NS increase)

*Significant increase at p<.0001 between baseline and 1st re-measurement

**Significant increase at p<.001 between 1st re-measurement and 2nd re-measurement

Sustained improvement status: This PIP was retired in FY '11. See below on information regarding sustained improvement of the two study indicators.

Study Indicator #1: Although not significant, there was a demonstrated improvement in study indicator #1 from baseline to re-measurement 1 and a significant improvement, at p=.05, from re-measurement 1 to re-measurement 2, indicating that over time there has been a sustained improvement in the percent of the study population with one or more preventive or ambulatory medical office visit. There may be random variations in the data between the study periods, in, for example, the degree of medical claims lag, or population changes, in demographic characteristics, although a few key study population characteristics were monitored and there was general stability in mean age, diagnosis, and co-morbidity of health conditions and substance abuse.

Study Indicator #2: There was a significant, at p=.05, demonstrated improvement in study indicator #2, from baseline to re-measurement 1, and, although not significant, an improvement from re-measurement 1 to re-measurement 2, indicated that over time there has been a sustained improvement in the percent of the study population with a care coordination letter during each measurement period. There may be random variations in the data, between the study periods, in, for example, errors in the computer processes for one or two days, and population differences, e.g. an increase or decrease in the study population's willingness to sign a release to send a care coordination letter.

B. 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 was completed for FY '09 with a significant reduction in youth ED visit rates/1,000. Second re-measurement indicated a non-significant decrease between re-measurement 1 and re-measurement 2. See table below.

Performance Indicator	Baseline	1st re-measurement	2nd re-measurement
#1 The rate of ED visits per 1,000 members age 0-18 that do not result in a hospitalization	6.48 per 1,000	4.84 per 1,000*	3.88/1,000 (NS decrease)

*significant decrease at p=0.0114

C. Focused Study: Design of a Healthcare Management Program
Development Began: FY '11
Focus Study Start Date: 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:
4. Revision of the Physical Healthcare Management Guideline
5. Development of an audit tool for measurement periods
6. Identification of necessary enhancements to the EMR to support guideline adherence
7. Adoption or development of a survey to assess health behaviors

Measures:

1. The percent of the study population's electronic medical record (EMR) with >=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: 1/1/12-7/1/1

III. Other Improvement Projects and Quality of Care Monitors, FY ‘10

A. Quality of care concerns.

A report regarding quality of care concerns and actions taken, in FY ’11, is provided in Appendix B.

B. 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 (status: completed)
Suicide Prevention (status: completed)

FY ’12:

Schizophrenia (completed)
ADHD
Bipolar Disorder
Posttraumatic Stress Disorder

FY ’13:

Cognitive Behavioral Therapy
Reactive Attachment Disorder
Eating Disorders

Appendix A

Evidence-based/Promising Practice Implementation
FY ’11 Annual Report

Prepared by:
Barbara Smith, Director of Quality Improvement
Kiara Marienau, Coordinator Quality Improvement

Introduction

Foothills Behavioral Health Partners (FBHPartners), with the partner mental health centers (MHCs) set out in the RFP 18 evidence-based or promising practices to be implemented over a three year period, 10 for adults and eight for children and youth. FBHPartners responsibility, through the Quality Assurance Performance Improvement Program (QAPI) was to develop and implement, with the MHCs, a system of outcome measurement and procedures for reporting information for each practice and to assess the program's fidelity to the model.

Results

Three EBPs and one Promising Practice were implemented in FY '10. The three EBPs were Integrated Dual Diagnosis Treatment (IDDT), Supported Employment (SE), Functional Family Therapy (FFT). The implemented promising practice was Families Together. In FY '11, three EBP's, including Multisystemic Therapy (MST), Assertive Community Treatment (ACT), and Wellness Management and Recovery (WMR), as well as one promising practice, Senior Reach, were implemented. Results are provided for each program, including descriptive information, fidelity assessment or reassessment according to program model, and outcomes.

Integrated Dual Diagnosis Treatment (IDDT)

Program Description/Start Date/Initial Fidelity Assessment:

IDDT, an EBP for the treatment of clients with a severe mental illness (SMI) and a co-occurring substance abuse disorder, was implemented 1/1/10 at Jefferson Center. The pilot phase began 1/1/09. Fidelity to the EBP was assessed for the two Jefferson Center programs during the pilot phase. The adult outpatient IDDT program received a fidelity score of 4.0 on a Likert scale of "1" not implemented to ""5" fully implemented. The intensive IDDT program received a fidelity score of 4.0, with the element of "pharmacological treatment" not assessed due to 100% turnover of prescribers in this program. Fidelity in the two programs will be assessed annually.

Outcome Measures:

1. **Goal:** Improvement in the mean alcohol and drug severity composite index from the Addiction Severity Index (ASI).
   Instrument or Measure: The alcohol composite index includes six items, including days of use and intoxication in the past 30 days; client rating on how troubled he/she is by alcohol problems; how important treatment is for these problems, and how much the client reports spending on alcohol. A similar composite for drug use severity includes 13 questions, 11 regarding specific drug use, how troubled the client is by the drug use, and how important treatment is now. The ASI is administered at program admission and every 12 months while in the program.
2. **Goal:** Improvement in the CCAR recovery subscale mean score.

Instrument or Measure: The recovery subscale includes five items: hope, activity involvement, social support, empowerment, and interpersonal. Each item has a Likert response scale, completed by staff, with “1” as no problem in this area to “9” severe problem in this area.

Results:

Descriptive Information: There were 19 clients with Medicaid that were served by the IDDT program between 1/1/09 and 6/30/11 (Table 1). Seven clients began between 1/1/09 and 6/30/10, and an additional 12 in FY’ 11. The average age was approximately 34 years. All but one of the clients had a severe mental illness diagnosis, the largest percent (42.1%) with schizophrenia, and all had a secondary substance abuse diagnosis, the largest percent (57.9%) with alcohol abuse or dependence. All were Jefferson Center clients before starting the IDDT program, with an average MHC to date length of stay of about four and a half years; average LOS in the IDDT program to date was about one year and seven months. Initial ASI Lite scores reported suggested a much higher severity composite score for alcohol versus drugs. The initial CCAR recovery subscale mean was 4.22 (n=17), indicating, according to staff, that clients entering IDDT were beginning to establish protective factors/elements of the Recovery model.

Table 1 IDDT Client Characteristics (n=19)

Characteristic	**Percent/mean**
Mental Health Diagnosis	
Schizophrenia	8 (42.1%)
Bipolar Disorder	4 (21.1%)
Depression	4 (21.1%)
PTSD	2 (10.5%)
Adjustment Disorder	1 (5.3%)
Substance Abuse Diagnosis	
Alcohol Abuse/Dependence	11 (57.9%)
Cannabis Dependence	3 (15.8%)
Polysubstance Dependence	3 (15.8%)
Cocaine Dependence	2 (10.5%)
Mean Age (range)	34.2 (22.5-50.3)
Mean MHC LOS to date (months)	54 (12.4-170.3)
Mean Program LOS to date (months)	20.8 (4.5-38.5)
ASI Mean Score (initial) (n=19)	
Alcohol Abuse	.29 (0-.89)
Drug Abuse	.08 (0-.23)
CCAR Mean Recovery Score (initial) (n=17)	4.22 (2-7.2)

Fidelity Reassessment: The four outpatient IDDT fidelity elements with a “3” or less score were reassessed in FY’11 (Table 2). The reassessment indicated that, for

outpatient, the fidelity score was updated to 4.3. Two of the elements moved from a score of 3 to a 4, and two remained at a 3, including “Family Psychoeducation on Dual Diagnosis” and “Secondary Interventions for Substance Abuse Treatment Non-responders.”

Table 2

Fidelity Score	**Pre Score**	**FY ’11 Annual Score**
Outpatient	4.0	4.3

Outcomes: Nineteen clients completed 12 months of IDDT treatment and fourteen remained in the program at the end of FY ‘11. There were 15 clients with a completed pre and post CCARs either at discharge or at 12 months, and eight clients who completed a pre and post ASI (Table 3). Mean scores on the ASI for alcohol abuse increased slightly over 12 months, while the drug abuse scale decreased. There was about a one point decrease in Mean Recovery Score, indicating improvement in key areas associated with recovery, such as hope, activity and social engagement.

Table 3: Results IDDT Outcome Goals (n=19)

Outcome Goal	**Time 1Score**	**Time 2 Score (met goal)**
Improvement in ASI lite (n=9)		
Drug	.08	.06 (met)
Alcohol	.29	.31 (not met)
Improvement in CCAR recovery subscale	4.22	3.01 (met)

Supported Employment (SE)

Program Description/Start Date/Initial Fidelity Assessment: Supported Employment, an EBP for assisting clients with a severe mental illness (SMI) obtain competitive employment, was implemented 7/1/10 at Jefferson Center, with the pilot phase beginning 7/1/09. Fidelity to the SE model was assessed during the pilot phase, with the program receiving a score of 3.5 on a Likert scale of “1” not implemented to “5” fully implemented. Fidelity will be assessed annually.

Outcome Measures:

1. **Goal:** Fifty percent of clients were competitively employed within fiscal year
   Instrument or Measure: Percent of clients who were enrolled during the fiscal year that obtained employment at some point during the fiscal year
2. **Goal:** Improvement in the CCAR recovery subscale mean score.
   Instrument or Measure: The recovery subscale includes five items: hope, activity involvement, social support, empowerment, and interpersonal. Each item has a Likert response scale, completed by staff, with “1” as no problem in this area to “9” severe problem in this area.

Results:

Descriptive Information: A total of 45 clients with Medicaid have been enrolled in the SE program since implementation 7/1/09 (Table 4). Fourteen clients began in FY '10, and an additional 31 entered the program in FY '11. Client mean age was about 37 years old, with depression as the most common diagnosis (40%). All were clients of Jefferson Center before started the SE program, with a mean MHC LOS of approximately 4 years; mean SE program LOS was about six months.

Table 4. Characteristics of all SE Clients (n= 45)

Characteristic	**Percent/mean**
Mental Health Diagnosis	
Depression	18 (40%)
Bipolar Disorder	8 (17.8%)
Mood Disorder NOS	7 (15.6%)
Schizophrenia	5 (11.1%)
Anxiety	3 (6.7%)
PTSD	3 (6.7%)
Adjustment Disorder	1 (2.2%)
Mean Age (range)	37.2 (18.2 – 57)
Mean LOS MHC to date - months	47.8 (2.6-258.5)
Mean Program LOS to date - months	6 (.03– 22.6)

Fidelity Reassessment: All fidelity elements with a "3" or less score were reassessed in FY '11(Table 5), and received an updated average score of 3.8. Of the 13 items that had original scores of 3 or less, seven moved from a 3 to a 4 based on program changes that had been made. The remaining items with a score of 3 or less will be reassessed in 12 months.

Table 5

Fidelity Score	**Pre Score**	**FY '11 Annual Score**
Supported Employment	3.5	3.8

Outcomes: There are 19 clients who completed a CCAR update, and demonstrated an overall improvement in mean Recovery Score, indicating an increase in protective factors within the recovery model (Table 6). There were 12 clients (26.7%) that were employed at some time during FY '11.

Table 6: Results SE Outcome Goals

Outcome Goal	**Time 1Score**	**Time 2 Score (met goal)**
Improvement in CCAR recovery subscale	3.4	2.9 (met)
Employment Status	NA	12 (26.7%) (not met)

Functional Family Therapy (FFT)

Program Description/Start Date/Initial Fidelity Assessment: FFT is an EBP that includes a multi-systemic approach to prevention and intervention with high risk adolescents and their families. FFT was implemented at Jefferson Center and MHP 7/1/10, with a pilot phase beginning 1/1/10. Clinician fidelity to FFT is assessed weekly and program fidelity at least 2x/year by an external entity, FFT, Inc.

Outcome Measures:

1. **Goal:** Youth remain in their home at the completion of treatment (at least 80%)
   Instrument or Measure: Percent of youth remaining in their home at the completion of treatment
2. **Goal:** Youth and parents indicate improved family functioning on the Client Outcome Measure (COM) instrument (at least 70%)
   Instrument or Measure: Client Outcome Measure (COM) includes six items measuring improvement in family functioning using a Likert scale with "1" = "things are worse" and "5" indicated "very much better." Improvement is demonstrated by percent with a score of $\geq$ 3 on all six items for youth and for parents (two indicators).

Results:

Descriptive Information: FFT has provided services to 101 youth and their families since EBP implementation; 26 youth that started the FFT program during the pilot period 1/1/10 through 6/30/10, and an additional 75 began in FY '11 (Table 7). The mean age of the youth was 14.7 years; most common diagnosis was depression (34.7%) followed by adjustment disorder (21.8%). Mean LOS in the program was 5.4 months.

Table 7. Characteristics of Initial FFT Clients (n=101)

Characteristic	**Percent/mean**
Mental Health Diagnosis	
Depression (includes mood disorder NOS)	35 (34.7%)
Adjustment Disorder	20 (21.8%)
Attention Deficit/Disruptive Behavioral Disorder	16 (15.8%)
PTSD/Anxiety Disorders	14 (13.8%)
Oppositional Defiant Disorder	8 (7.9%)
Other: RAD, Impulse Control, Psychotic disorder NOS	7 (6.9%)
Bipolar Disorder	1 (.99%)
Mean Age (range)	14.7 (9.9 – 17.7)
Mean Program Discharge LOS (months) (n=67)	5.4 (.9-11.5)

Outcomes: Of the 67 youth that completed the program 57 (85%) remained in their home at discharge (Table 8). Of the 34 families that completed the Client Outcome Measures, 24 (70.6%) of youth and parents indicated improved family functioning, with at least a score of “3” or higher on all six COM items.

Table 8: Results FFT Outcome Goals (n=67)

Outcome Goal	Time 1Score	Time 2 Score (met goal)
Percent youth in home	NA	85% (met)
Client Outcome Measures	NA	70.6% (met)

Families Together

Program Description/Start Date/Initial Fidelity Assessment: Families Together is a Promising Practice that assists families in crisis where at least one youth is at risk for placement outside of the home. Families Together was implemented 7/1/10 at Jefferson Center, with a pilot phase beginning 1/1/10. Because there were no fidelity assessments in place for this practice, the FBHPartners’ QI Program staff, based on the literature and in collaboration with the program Director, designed a fidelity tool. Fidelity was assessed during the pilot phase, with the program receiving a score of 3.6 on a Likert scale of “1” not implemented to “4” fully implemented. Fidelity will be reassessed annually.

Outcome Measures:

1. **Goal:** Families maintain goals after program completion (at least 80%)
   Instrument or Measure: Percent families maintaining goals achieved at discharge and 6 months post discharge
2. **Goal:** Percent families with an average rating of 3.5 or above on the five outcome items in the Family Satisfaction Questionnaire (at least 80%)
   Instrument or Measure: Percent families with an average rating of 3.5 or above on the five outcome items in the Family Satisfaction Questionnaire. These five items relate to perception of positive change within the family, and are measured using a Likert scale with “1” = strongly disagree and “5” indicated “strongly agree.”

Results:

Descriptive Information: There were 167 families with Medicaid that began Families Together between 1/1/10 and 6/30/11 (Table 9). The identified client was a child for the majority (89.8%) of families. The most common diagnosis for children was adjustment disorder (34.7%), followed by ADHD (22%). The mean age of the children was 10.6 years and average LOS to discharge was three and a half months.

Table 9: Characteristics of Initial Families Together Clients (n = 167)

Characteristic	**Percent/mean**
Mental Health Diagnosis	
Identified Client - Child (n=150)	
Adjustment Disorder	52 (34.7%)
ADHD	33 (22.0%)
Depression	19 (12.7%)
Oppositional Defiant/Conduct	14 (9.3%)
Anxiety/PTSD	13 (8.7%)
Other (autism, cognitive, psychotic nos, sexual abuse)	8 (5.3%)
Behavioral-other (intermittent-explosive, disruptive)	7 (4.7%)
Bipolar	4 (2.7%)
Identified Client – Parent (n=17)	
Depression	8 (47.1%)
Adjustment Disorder	4 (23.5%)
Bipolar Disorder	3 (17.6%)
Anxiety/PTSD	2 (11.8%)
Mean Age (range)	
Identified Client – Child (n=150)	10.6 (2-18)
Mean Program LOS to Discharge in months (n=134) (range)	3.5 (.6-11.1)

Fidelity Reassessment: Fidelity was reassessed on items with a score of 3 or less in FY ’11 (Table 10), and there was no change in the fidelity score. Fidelity average score remained at 3.6. Items that remained at a score of 3 or less will be reassessed in 12 months.

Table 10

Fidelity Score	**Pre Score**	**FY ’11 Annual Score**
Families Together	3.6	3.6

Outcomes: There were 99 families that have completed the program to date (Table 11). Of those, all but 1 youth (98.9%) remained in the home upon completion. For those that completed the program at least six months prior to reporting (n=56), 35 were able to be reached for the six month follow up. Of those 35, all but one (97%) were still in the home, and the majority (87.5%) reported maintenance of goals at 6 months follow up. Of those that responded to the Family Satisfaction Survey (n=38), 33 (86.8%) had an average rating of 3.5 or higher on outcome items indicating they perceived positive changes within the family after completion of the program.

Table 11: Results Families Together Outcome Goals

Outcome Goal	Time 1Score	Time 2 Score (met goal)
Percent youth in home at discharge (n=99)	NA	98.9% (met)
Percent youth in home at 6 months (n=35)	NA	97% (met)
Maintenance of goals at 6 mo (n=32)	NA	87.5% (met)
Family Satisfaction at 6 mo (n=38)	NA	86.8% (met)

Multisystemic Therapy

Program Description/Start Date/Initial Fidelity Assessment: MST is an evidence based practice providing intensive family and community based services to juvenile offenders who are at risk of out of home placements (foster care, group homes, correctional facilities, etc.). MST was implemented at Jefferson Center on 7/1/2010. Clinician fidelity to MST is assessed weekly and program fidelity at least annually by an external entity.

Outcome Measures:

1. **Goal:** Youth remain in the home at the end of the program (at least 80%)
   Instrument or Measure: Percent of youth remaining in the home at the end of the program
2. **Goal:** Youth completion treatment and completion of goals (at least 80%)
   Instrument or Measure: Percent of youth who completed treatment/goals

Results:

Descriptive Information: There were 16 clients with Medicaid who began MST services between 7/1/2010 and 6/30/2011 (Table 12). The most common diagnosis was Oppositional Defiant Disorder (31.3%) followed by Depressive and Mood Disorders (25%). The average age was about 15 years old, and the average LOS in the program was about 3 months.

Table 12: Characteristics of Initial MST clients (n=16)

Characteristic	Percent/mean
Mental Health Diagnosis	
Oppositional Defiant Disorder	5 (31.3%)
Depressive/Mood Disorder NOS	4 (25%)
ADHD	2 (12.5%)
Conduct Disorder	2 (12.5%)
Adjustment Disorder	1 (6.3%)
Disruptive Behavior Disorder	1 (6.3%)
PTSD	1 (6.3%)
Mean Age (range)	15.2 (13-17)
Mean Program LOS to discharge – months (n=9)	3.05 (.97-4.17)

Outcomes: Eight of the 16 clients have completed the program, with all (100%) still living in the home at discharge. All 8 who completed also completed the treatment goals at discharge (Table 13).

Table 13: Results MST Outcome Goals (n=8)

Outcome Goal	Time 1Score	Time 2 Score (met goal)
Percent youth in home at discharge	NA	100% (met)
Percent youth completed goals	NA	100% (met)

Senior Reach

Program Description/Start Date/Initial Fidelity Assessment: Senior Reach (SR) is a promising practice developed in collaboration with two mental health centers (Jefferson Center and MHP) and a local senior center. SR was designed to increase community partnerships to identify and outreach isolated or at risk older adults and to increase access to mental health treatment, case management, referral assistance and wellness services. SR was implemented at Jefferson Center and MHP 1/1/2011. Because there wasn't a standard fidelity assessment in place for this practice FBHPartners' along with MHC QI departments and the SR Program Director designed a tool based on the key components. Fidelity was assessed on 17 items using a Likert scale of "1" not implemented to "3" fully implemented. The average item score was 2.82, with only three items received a score of 2. These three items were all related to documentation of clinical services. Fidelity will be reassessed annually.

Outcome Measures:

1. **Goal:** Reduction in social isolation
   Instrument or Measure: Social isolation is measured by a single self-report item on the case management assessment , and is administered within the first 3 sessions, and at program discharge
2. **Goal:** Reduction in depression score
   Instrument or Measure: Depression score is based on self report geriatric depression scale, and is administered within the first 3 sessions and at program discharge

Results:

Descriptive Information: SR served 21 older adults with Medicaid between 1/1/2011 and 6/30/2011 (Table 14). The average age was approximately 73 years old, and average program LOS was 1 ½ months. The majority of clients did not have a mental health diagnosis, and of those who did, depression was most common.

Table 14: Characteristics of Initial Senior Reach clients (n=21)

Characteristic	Percent/mean
Mean Age (range)	73.6 (60.4-94.8)
Mean Program LOS to discharge – months (n=18)	1.7 (.01-5.3)

Outcomes: Seven seniors completed pre and post outcome measures (Table 15). Mean scores for both the geriatric depression scale as well as the social isolation measure decreased from admission to discharge.

Table 15: Results Senior Reach Outcome Goals (n=7)

Outcome Goal	Time 1Score	Time 2 Score (met goal)
Geriatric Depression Scale	7.2	5.7 (met)
Social Isolation Measure	2.2	1.8 (met)

Assertive Community Treatment (ACT)

Program Description/Start Date/Initial Fidelity Assessment: Assertive Community Treatment (ACT) is an evidence based practice that utilizes a team approach to treatment of clients with severe and persistent mental illness, with a focus on comprehensive, recovery oriented services, including support with housing, employment, case management, psychiatric and other services. ACT was implemented at MHP 7/1/10. Annual fidelity assessments are required by the State Division of Behavioral Health, and are conducted by MHP, using a 23 item assessment with a Likert scale of "1" does not meet criteria to "5" meets and exceeds criteria all of the time. The program received an average item score of 3.87 on the most recent fidelity assessment completed in October, 2010. There were 7 items with a score of 3 or less. Fidelity will be reassessed annually.

Outcome Measures:

1. **Goal:** Improvement in the CCAR recovery subscale mean score.
   Instrument or Measure: The recovery subscale includes five items: hope, activity involvement, social support, empowerment, and interpersonal. Each item has a Likert response scale, completed by staff, with "1" as no problem in this area to "9" severe problem in this area.
2. **Goal:** Progress in independent living
   Instrument or Measure: Movement to less restrictive living environment based on CCAR living arrangement item

Results:

Descriptive Information: Three clients have received ACT services between 6/1/10 and 6/30/11 (Table 16). All three have a severe mental illness (SMI) diagnoses. The average age is 31.7, and an average LOS, to date, of about 10 months.

Table 16: Characteristics of Initial ACT clients (n=3)

Characteristic	Percent/mean
Mental Health Diagnosis	
Bipolar Disorder	2 (66.7%)
Schizophrenia	1 (33.3%)
Mean Age (range)	31.7 (23-48)
Mean Program LOS to date – months (n=3)	10.6 (7.4-14.9)

Outcomes: All three clients remain in the program. Of those three, only one has a completed initial and annual update CCAR. That individual demonstrated progress in independent living, from residential to independent living, with no change on the improvement in recovery subscale, at annual update.

Wellness Management & Recovery

Program Description/Start Date/Initial Fidelity Assessment: Wellness Management and Recovery is an evidence based practice, providing recovery based group therapy for clients with Serious Mental Illness (SMI), with a focus on relapse prevention, psychoeducation, and coping skills training. WMR was implemented at MHP 1/1/11. Fidelity was assessed during the pilot phase, and WMR received an average fidelity score of 3.4, on a Likert scale of "1" not implemented to ""5" fully implemented. Fidelity will be reassessed annually.

Outcome Measures:

1. **Goal:** Completion of class
   Instrument or Measure: Percent of clients that complete the WMR class
2. **Goal:** Improvement in QOL (quality of life measure)
   Instrument or Measure: Four items on the self-report QOL measure, related to social life, participation in community activities, ability to take care of self, and self-esteem.

Results:

Descriptive Information: There were five clients who began the WMR group at MHP in September 2011 and initial demographic information is provided (Table 17). The average age is 51.3, and average LOS in the MHC prior to WMR group was about one year. All five clients had distinct mental health diagnoses.

Table 17: Characteristics of Initial WMR clients (n=5)

Characteristic	Percent/mean
Mental Health Diagnosis	
Schizophrenia	1 (20%)
Depression	1 (20%)
Anxiety	1 (20%)
Other	2 (40%)
Mean Age (range)	51.3 (31.6-64)
Mean MHC LOS (range)	12.3 (.5-19.1)

Outcomes: There are no outcomes currently available for this EBP. Initial scores on the quality of life measures indicate that all but one client reported poor or fair quality of life related to social life and participation in the community, and all but two poor or fair related to self-esteem.

Summary and Recommendations:

This report describes the six EBP's and two promising practices that have been implemented in FY '10 and FY '11 at FBHPartners' Mental Health Centers. Included is updated demographic information on clients served, as well as fidelity and outcome measures.

The four EBP/Promising practices implemented in FY '10 demonstrated improvement in data collection and reporting, allowing for more accurate analysis of the population being served by these programs. This was demonstrated by an increased number of clients being reported on in these programs in FY '11.

Data on outcomes indicates that four of the programs met their goals related to client improvement in key areas of functioning: Functional Family Therapy (FFT), Families Together (FT), Multisystemic Therapy (MST), and Senior Reach. Supported Employment (SE) and Integrated Dual Diagnosis Treatment (IDDT) both met one outcomes goal and not the other. Clients in IDDT failed to demonstrate improvement on ASI scores related to alcohol abuse. Supported Employment (SE) demonstrated an overall improvement in mean Recovery Score of clients, however, did not meet the goal of 50% of clients obtaining employment status within the fiscal year.

Of the four EBP/Promising practices implemented in FY '11, ACT and WMR reported low numbers of Medicaid clients accessing those programs. Outcomes were not reported on these programs due to length of implementation.

Below are recommendations related to data collection, reporting, and program access:

1. EBP program managers need to ensure outcome instruments/surveys are completed as required.
2. Continue to track and report information on a 6-month basis to monitor outcome reporting, standardize reporting procedures, and improve accuracy of data reported.
3. The Medicaid population served in the ACT and WMR programs is low. Request MHP review procedures to ensure clients with Medicaid are informed of these programs.
4. Work with MHC's to ensure that the recovery oriented programs are focused on providing services to appropriate clients with severe mental illness.

Appendix B

Foothills Behavioral Health Partners (FBHPartners)
Quality of Care Concern (QOCC) Report
FY '11

There were two QOCCs reported to FBHPartners' Medical Director and Quality Improvement Director that met the threshold for further action and were followed up through the Quality of Care Committee. Below is the detail on these QOCCs, including the specific issue, type of facility/provider, and action taken.

One of the QOCCs involved a psychiatric hospital. The issue included a problem in delay of treatment. A corrective action plan (CAP) was requested. Additional documentation was provided clarifying the delay. An education letter was sent requesting improved documentation when the start of medication is delayed.

The other QOC was a partial hospital program. The issue included a failure to follow proper standards of care for a client with an eating disorder. The partial hospital program terminated the staff member who failed to provide appropriate care and an educational letter was sent to the program administration.

QOC issue	Date	Facility/IPN	Action Taken/Follow-up
Delay in treatment	3/10/11	Psychiatric hospital	Requested corrective action plan; with additional information FBHP withdrew CAP but provided documentation education
Failure to follow standard of practice	4/12/11	Partial Hospital	Educational Letter from FBHP and staff terminated