Quality Management Program Evaluation Summary

(AHCCCS Contract Year July 1, 2012 – September 30, 2013)

Bureau of Quality and Integration

Division of Behavioral Health Services

I. Introduction

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) implemented a Fiscal Year 2013 (FY13) Quality Management (QM) Plan describing the strategic direction of the ADHS/DBHS QM program for FY13. The Plan and the Work Plan adopted five goals related to performance measures; incident, accident and death (IAD) reports; performance framework and dashboard; performance improvement project; and oversight and monitoring. The 2013 Work Plan was developed with technical assistance (TA) from the Arizona Health Care Cost Containment System (AHCCCS) QM Department. Goals were restructured to be measurable, and more detailed definitions were given to strategies and correlating action items. The Bureau of Quality and Integration (BQ&I), formerly known as the Bureau of Quality Management Operations (BQMO), conducted ongoing trending through quarterly reviews. Feedback from the AHCCCS QM Department resulted in the Office of Performance Improvement (OPI) initiating processes to analyze data to better understand causal relationships. Additional feedback obtained from the AHCCCS Oversight Review related to data analysis prompted DBHS to hire an Office Chief for the Office of Information Management (OIM) with extensive experience in data analysis. OIM will be taking an active role in analyzing data received for all departments in BQ&I to meet or exceed AHCCCS expectations regarding data analysis and trending.

The five goals, strategies and actions adopted by BQ&I in the 2013 Work Plan are listed below.

1. ADHS/DBHS will improve performance by 20% for the Behavioral Health Service Plan (BHSP) performance measure rates, while meeting the minimum performance standard (MPS) for:
    a. Behavioral Health Service Provision (BHSPv) measure - MPS 85%
    b. Access to Care measure (ATC) measure - MPS 90%
    c. Coordination of Care (CoC) measure - MPS 85%

2. ADHS/DBHS will increase the timely reporting of IADs from 50% in FY12 to 75% by the end of FY13.

3. BQ&I will share timely information about key social and clinical indicators with DBHS stakeholders and the community on a quarterly and annual basis.

4. Through the AHCCCS-DBHS Collaborative CoC Performance Improvement Project (PIP), DBHS will facilitate the process of improving coordination of care provided to AHCCCS members receiving both medical and behavioral health services through the exchange of opiate and benzodiazepine prescribing and other clinical information between medical and behavioral health providers. The main purpose of this information sharing is to reduce morbidity and/or mortality among these members. ADHS/DBHS is also implementing an AHCCCS mandated 30 days Readmission Performance Improvement Project. The purpose of this PIP is to decrease the rate of inpatient readmissions among AHCCCS members within 30 days of a previous

discharge, in order to improve quality of life, promote patient-centered care, and reduce unnecessary health care utilization and costs.

5. ADHS/DBHS will improve the service delivery system for behavioral health recipients through the oversight and monitoring process.

A number of strategies and actions were implemented during FY13 to accomplish the aforementioned goals. The following chart depicts the goals, strategies, and actions listed in the FY13 Work Plan. Section II, **Progress toward Goals in the FY 2013 Work Plan** (beginning on page 8 of this document), will analyze the results of the activities taken to accomplish each goal/strategy. Whenever possible, trends identified through monitoring activities will be presented. For the purpose of continuous quality improvement, some goals will be brought forward to the new 2014 Work Plan (Attachment A). BQ&I presented all findings to the QM Committee for review and discussion. Recommendations from the QM Committee and Leadership Team concerning areas requiring additional focus will be added to the 2014 Work Plan.

Goal	Strategy	Action
1. Performance Measures Improve performance by 20% for BHSP while meeting MPS for: a. BHSPv b. ATC c. CoC	**Strategy 1: BHSP** Continue with strategy implemented in April 2012: ☐ Checklist minimum Requirements ☐ Award of Excellence for Providers with stellar service plans Impact of interventions will be evaluated for FY13	**BHSP:** ☐ Quarterly chart audits/reviews using 90/10 sample by GSA by Adult and Children ☐ RBHAs not demonstrating upward trend for two consecutive quarters will conduct barrier analysis to identify providers with poor performance ☐ DBHS will require Corrective Action Plan (CAP) outlining performance required, description of deficiency, notice given to provider, TA provided, actions taken to remedy problem
	Strategy 2: BHSPv DBHS will conduct quality assurance check of BHSP and	**BHSPv:** ☐ OPI and the Bureau of Business

	BHSPv internal processes to assure alignment between performance measures	Information Systems (BIS) will collaborate to identify areas of improvement within service categories/subcategories on BHSP and encounter data ☐ Service categories/ subcategories will be reviewed for accuracy and inclusiveness ☐ Identified areas of improvement will be addressed accordingly
	Strategy 3: ATC and CoC DBHS will meet the MPS and continue to: ☐ Conduct quarterly review activities ☐ Provide focused TA when needed ☐ Issue and Monitor CAPs when appropriate	**ATC and CoC:** ☐ DBHS will conduct analysis of these PMs based upon the BQ&I Specs Manual ☐ DBHS will provide focused TA for RBHA(s) failing to: * Meet MPS for two consecutive quarters * Demonstrate an improvement in PM for two consecutive quarters ☐ DBHS will require Corrective Action Plan (CAP) outlining performance required, description of deficiency, notice given to provider, TA provided, actions taken to remedy problem
2. IADs	**Strategy:** DBHS will revise IAD database to capture timeliness (≤ seven business days) of IAD submission from provider	**IADs:** ☐ IAD database revisions to include: o Date of incident o Date incident

	RBHA and from RBHA to DHS	reported to provider o Date incident reported to RBHA o Date reported to DBHS ☐ DBHS QOC staff will provide TA to T/RBHAs regarding: o Accurate documentation of dates on IAD form o Monitoring and tracking of IAD submission timelines ☐ DBHS will issue CAPs to T/RBHAs not submitting IADs within DBHS timeframes for two consecutive months
3. **Performance Framework and Dashboard**	**Strategy:** BQMO will update the DBHS Performance Framework and Dashboard website on a quarterly and annual basis as described below: ☐ **Quarterly – QM Performance Measures and MM/UM (LOS and Readmit) data will be posted as follows:** o March 31st o June 30th o September 30th o December 31st ☐ **Annually by January 31st of each year:** o National Outcome Measures (NOMS) o Annual Consumer Survey	**Performance Framework and Dashboard:** BQMO will: ☐ Enforce timely receipt of information from BIS, Network, and other Offices in BQMO ☐ Organize Performance and Outcome data indicators into four categories, which are reported in a series of scorecards that collectively for the Performance Dashboard: o Access to Services o Service Delivery o Coordination/ Collaboration o Impact on Quality of Life

	o Provider Network Geo-mapping	☐ Performance and Outcome data indicators will be sent to the Communication and IT departments two weeks prior to the deadline to ensure current information is available on the Performance Framework and Dashboard website
4. CoC PIP	**Strategy:** During FY2013, DBHS to assist CoC workgroup to develop: ☐ Risk Criteria ☐ Interventions based upon identified risks ☐ Planning for re-measurement timelines	**CoC PIP:** ☐ DBHS will continue to cohost meetings between AHCCCS Acute Care Health Plans and DBHS RBHAs (CoC workgroup) to facilitate dialogues on development of Risk Criteria ☐ DBHS will assist in the implementation of interventions based upon root cause analyses performed by CoC workgroup ☐ DBHS will foster the development of project timelines, including re-measurement, etc.
5. Oversight and Monitoring	**Strategy:** DBHS will conduct semi-annual site visits and an annual Administrative Review to monitor and oversee RBHA: ☐ Provider Monitoring ☐ Quality of Care ☐ Peer Review ☐ Credentialing ☐ Medical Record Review	**Oversight and Monitoring:** DBHS will verify that each RBHAs Annual QM Plan includes sufficient details about **provider monitoring** activities by: ☐ Reviewing/approving RBHA Annual QM Plans ☐ Evaluating activities related to provider monitoring ☐ Providing TA to RBHAs with insufficient provider monitoring plans.

		DBHS will validate RBHA adherence to the **Provider Monitoring Plan** by: ☐ Conducting data validation activities ☐ Reviewing RBHA calendar of site visits ☐ Verifying TA provided ☐ Reviewing CAPs issued ☐ Validating CoC data submitted ☐ Requiring CAPs for RBHAs found non-compliant with provider monitoring plan ☐ Presenting data validation results to the QM Committee for discussion and recommendations DBHS will adhere to the **Quality of Care Review** requirements in accordance with AHCCCS AMPM and the DBHS QOC Policy (QM 2.7) by: ☐ Conducting Inter Rater Reliability (IRR) among DBHS QOC team staff on a weekly basis to ensure consistency in review findings and recommendations ☐ Monitoring all IAD Reports received from each T/RBHA ☐ Investigating all unknown deaths and suicides ☐ Investigating all questionable incidents and accidents reported by T/RBHAs ☐ Monitoring each T/RBHAs tracking and trending of QOC concerns and QOC CAPs during semi-annual data validation audits. ☐ Providing oversight of each T/RBHAs QOC

		Policy and process ☐ Validating that CAPs have been initiated for focused QOC reviews that previously resulted in a CAP ☐ Presenting on-site review and validation results to the DBHS QM Committee Meeting for discussion and recommendations DBHS will ensure the RBHAs compliance with **Peer Review** requirements by: ☐ Reviewing policies and protocols ☐ Reviewing Committee agendas to ensure that Peer Review meetings are held, at a minimum, on a quarterly basis ☐ Reviewing sign-in/Confidentiality Statement documents to ensure there is no breach in confidentiality ☐ Verifying that meeting minutes are signed and approved by the RBHA Chief Medical Officer (CMO) DBHS will conduct an Annual Administrative Review of the T/RBHAs to assess **Credentialing** processes by: ☐ Reviewing policies and protocols ☐ Validating a sample of T/RBHA individual and organizational Provisional, Initial, and Recredentialing records. DBHS will conduct an Annual Administrative Review of the T/RBHAs to assess their **Medical Record Review** processes by:

		☐ Reviewing policies and protocols ☐ Reviewing the T/RBHA Medical Record Review tool ☐ Validating a sample of T/RBHA reviewed Medical Records

II. Progress toward Goals in the FY 2013 Work Plan:

Goal 1- Performance Measures: - Improve performance by 20% for BHSP while meeting/maintaining the MPS for:

a. BHSPv
b. ATC
c. CoC

The results for Goal 1 Performance Measures are depicted in table1 below:

Table 1

Performance Measure	FY 2013 Statewide Annual Performance	Met/Not Met
Behavioral Health Service Plan (BHSP): The percent of AHCCCS members with current service plans that incorporate the needs and service recommendations identified in their assessments.	Adult: 82% Children: 80% DDD Adult: 81.25% DDD Children: 70.83% CMPD: 79.25%	MPS: 85% 2013 Goal: Adults: 69.6% Children: 58.8% (20% increase from FY2012 with an attempt to meet MPS of 85%) **Goal Met but MPS not yet achieved**
Access to Care (ATC): Appointment Availability for Routine Assessments and Routine Appointments: The percent of AHCCCS members referred for or requesting behavioral health services for which the first service was provided within 23 days of the initial assessment.	Adult: 91.25% Children: 90.4% Maintained Statewide MPS	MPS: 90% 2013 Goal: Maintain MPS **Met**

Coordination of Care with Acute Contractors/PCPs (COC 2): The percent of AHCCCS members for whom behavioral health service providers communicate behavioral health clinical and contact information with the member's Primary Care Physician (PCP) and/or Health Plan	Adult: 89% Children: 89% Maintained Statewide MPS	MPS: 85% 2013 Goal: Maintain MPS **Met**
Behavioral Health Service Provision (BHSPv): The percent of AHCCCS members who received the services that were recommended in their service plans.	Adult: 77.13% Children: 81.94% MPS Not Maintained	MPS: 85% 2013 Goal: Maintain MPS **Not met** to date

Behavioral Health Service Plan - Adult and Children –

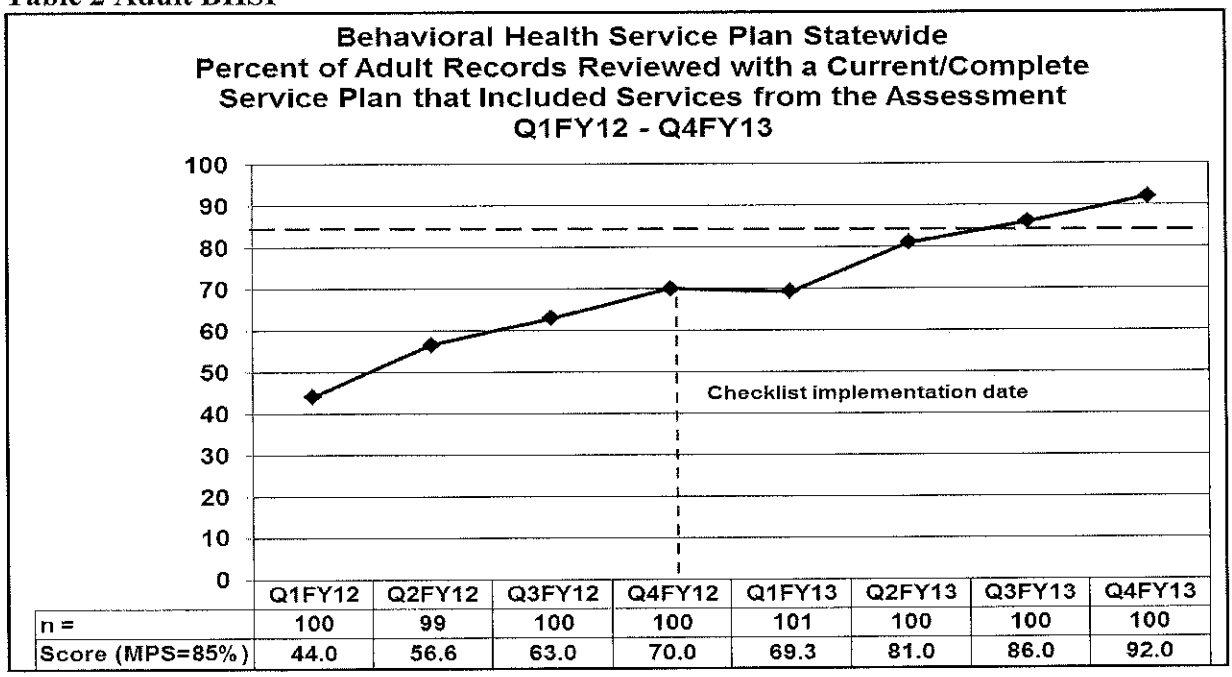
A Statewide performance improvement initiative to improve the Behavioral Service Plan performance measure began in April 2012. Based on a root cause analysis, it was determined that there was no process in place to ensure that all components of the service plan were completed. A "Checklist" was developed and implemented as a performance improvement initiative that focused on ensuring that all components of the behavioral health service plan were completed. Contractor performance on the Behavioral Health Service Plan performance measures were tracked and trended, and based on the implementation date of the checklist, statewide improvement in the service plan performance measure was associated with the checklist initiative. The goal for the DBHS for FY13 was for the RBHAs to increase their BHSP scores by 20% from their FY12 scores while attempting to meet the 85% MPS.

In FY12, the statewide annual performance for this measure for Adults and Children was 58% and 49% respectively. DBHS' goal for FY13 was to increase performance for this measure by 20%, placing the new goals at 69.6% for Adults and 58.8% for Children. The FY13 Statewide Annual Performance for this measure was 82% for Adults (see Table 2 below) and 80% for Children (see Table 3 below); significantly surpassing and meeting the goal DBHS set for this measure, but not quite meeting the AHCCCS MPS of 85%. Excellence Awards were not given to Provider Organizations for outstanding service plans in FY13.

Performance on the BHSP for Adults and Children receiving services through the Department of Developmental Disabilities (DDD), as well as for Children receiving services through the Comprehensive Medical and Dental Program (CMDP) is difficult to evaluate due to the small numbers represented in the total "n" for the measure. Contractual requirements for FY14 with AHCCCS and DDD have resulted in the need to ensure that a representative sample is drawn for each performance measure based upon population/payor source.

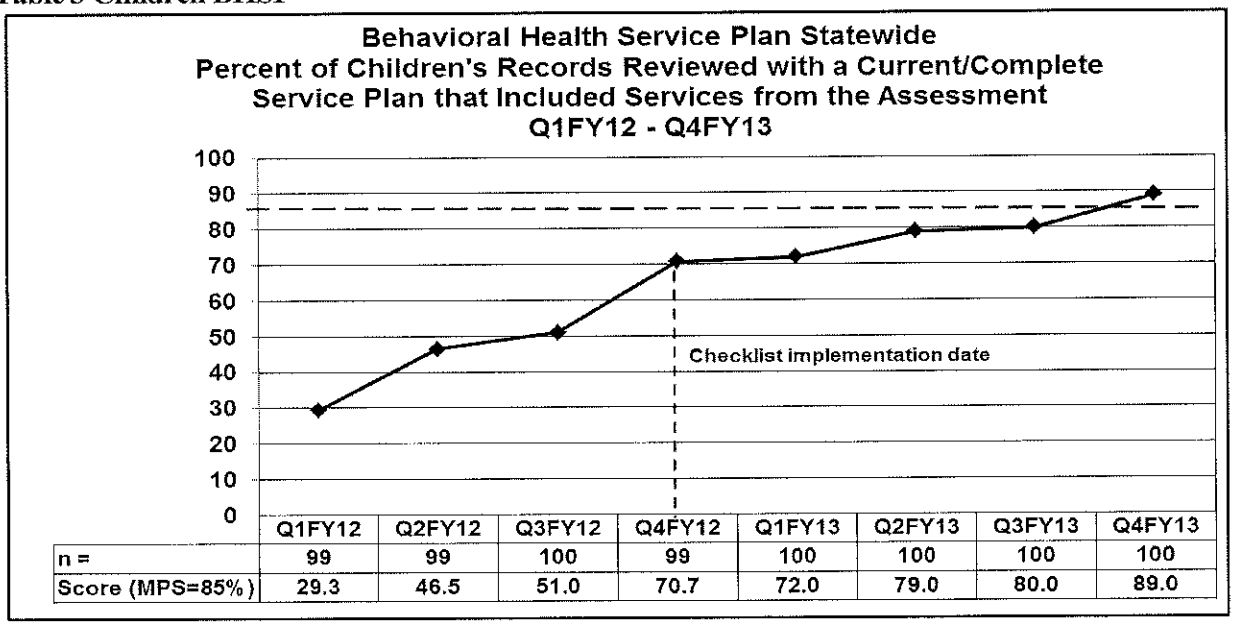
Due to the need for sustainable improvement by RBHA providers to maintain the MPS, DBHS has decided to continue the BHSP as a performance measure in FY14.

Table 2 Adult BHSP



	Q1FY12	Q2FY12	Q3FY12	Q4FY12	Q1FY13	Q2FY13	Q3FY13	Q4FY13
n =	100	99	100	100	101	100	100	100
Score (MPS=85%)	44.0	56.6	63.0	70.0	69.3	81.0	86.0	92.0

Table 3 Children BHSP



	Q1FY12	Q2FY12	Q3FY12	Q4FY12	Q1FY13	Q2FY13	Q3FY13	Q4FY13
n =	99	99	100	99	100	100	100	100
Score (MPS=85%)	29.3	46.5	51.0	70.7	72.0	79.0	80.0	89.0

Access to Care (ATC) – Adult and Children

As a Statewide measure, ADHS/DBHS met the Access to Care measure for Adults and Children despite a 2% and 1% decrease respectively by population from FY12 to FY13. The decrease was not statistically significant; therefore, DBHS considers the goal to be met. Although NARBHA and CPSA increased their performance in this measure, neither reached the MPS despite initiating the following interventions:

NARBHA: 88.5% Adult
88.5% Children

1) Monitor 100% of new episode of care members to ensure timely access to service, through development of more timely reporting mechanism.
2) Develop more real time reports of evaluation of providers and for use by the providers

CPSA: 86.75% Adult
87.5% Children

1) Conduct quarterly analysis of all performance measures with results forwarded to each CSP
2) CPSA QM provided technical assistance to each CSP and provided focused interventions to those providers with low scores on ATC

Since AHCCCS retired the ATC measure as it is currently designed, ADHS/DBHS closed the CAPs given to NARBHA and CPSA on October 01, 2013. .

Coordination of Care:

NARBHA received a CAP for CoC for Adults and Children. Through a root cause analysis, NARBHA determined that they were auditing more elements than what was required for the performance measure. New tools were implemented to reflect practices in other GSAs and State scoring methodology. NARBHA did not meet the MPS for adults for this measure.

Magellan received a CAP for Children. In March 2013, Magellan placed three Community Provider Networks on notice to cure, administered sixteen letters of concern to GMH/SA providers offering TA via QM. In June of 2013, updated tracking of Provider CAPs showed 100% compliance. Magellan scored 89.5%, surpassing the 85% MPS.

In comparison to FY12 results, the Adult PM was maintained, and there was a 4.6% increase in this measure for Children. Due to the fact that the Statewide MPS for this measure was maintained, DBHS considers this goal to be met.

Although CoC is no longer considered a PM for FY14, DBHS will continue to monitor this contractually mandated requirement during the mid-year Onsite Monitoring and Oversight

Review (OMOR), to ensure that the RBHAs are continuing to perform coordination activities with Acute Care Providers.

Behavioral Health Service Provision – Adult and Children –

Four out of six RBHAs (NARBHA, Cenpatico 3 & 4, and Magellan) received a CAP for adults BHSPv; while one (NARBHA) also received a CAP for children. Based upon three quarters worth of data (there is a claims lag in measure coupled with the ability of the RBHA to challenge results), and despite the interventions listed below for each RBHA, it is anticipated that ADHS/DBHS **will not meet or maintain** the FY13 Minimum Performance Standard (MPS). In fact, Behavioral Health Service Provision for both Adults (76%) and Children (79.7%) experienced a significant decrease when compared to FY12 results which were 93% for Adults and 91% for Children. Due to the decrease in this measure, and some potential problems with the methodology of this measure (small "n's" due to records considered only if BHSP is met; potential errors resulting from lack of clear services listed in the BHSP), DBHS decided to retain BHSPv as a performance measure for FY14 with some significant changes to the methodology (see Attachment K – BQ&I Specifications Manual)

Adult and Children Interventions by RBHA:

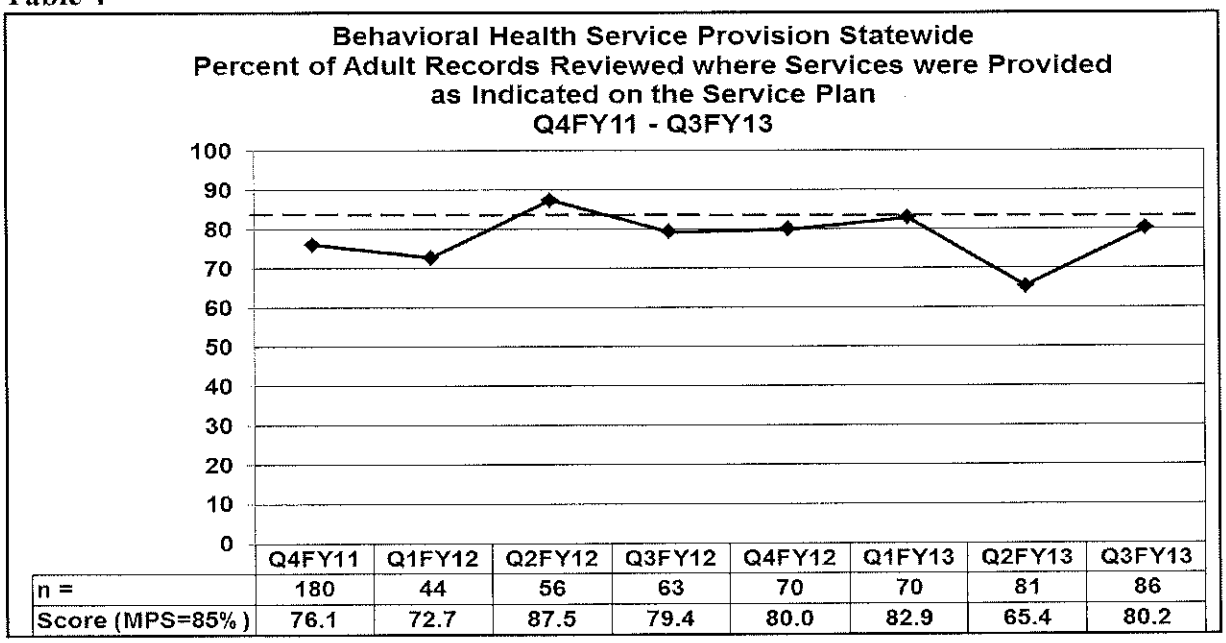
NARBHA: Significantly expanded monitoring and oversight of measure by requiring Providers to submit 30 records per quarter for an encounter based, data driven report. This report enabled NARBHA to drill down to determine root causes specific to the unique needs of each provider.

Cenpatico 3 & 4: Instituted an aggressive PIP, which was implemented RBHA wide in 2013, focusing on:

1) Agency improvement of their electronic health record tracking and reporting capabilities
2) Assuring agencies were listing service codes as well as descriptions on their ISPs
3) Holding BHPs as well as agencies responsible for insufficient performance
4) Imposed financial sanctions on agencies failing to meet the MPS.

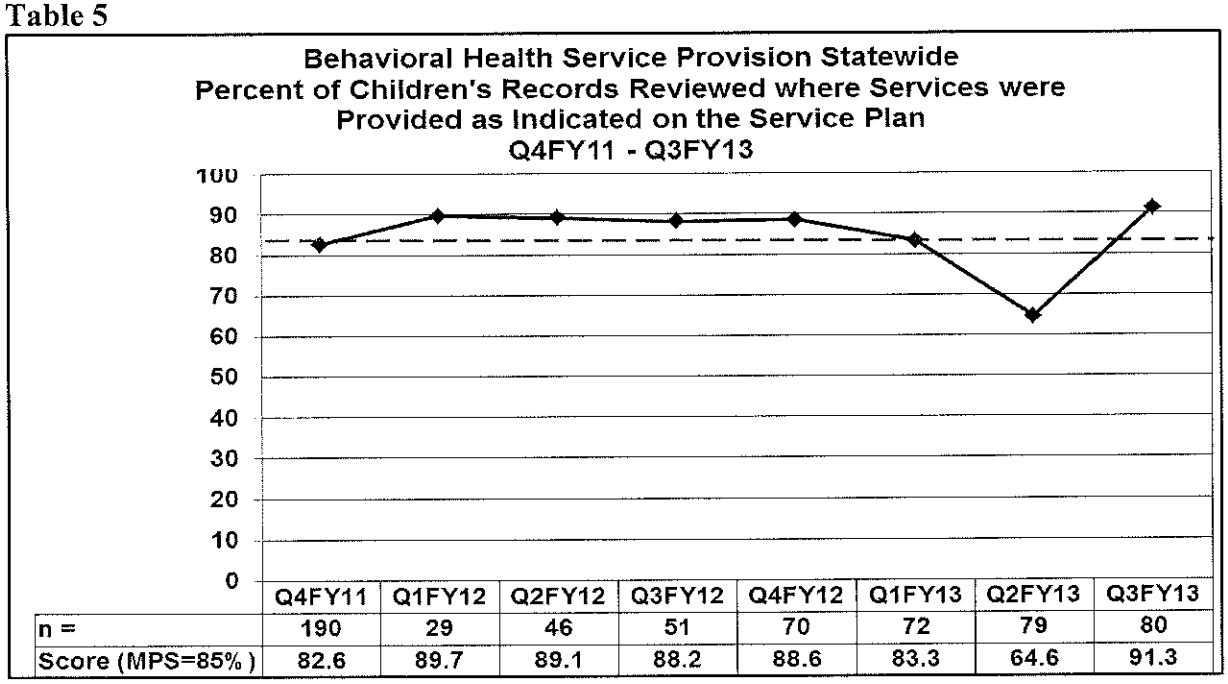
Magellan: Performed a root cause analysis that determined the BHSP Checklist was not being utilized, the ISP included too many goals for the BHP to realistically address, Clinical supervision lacked oversight of ISP goals, and monitoring was too infrequent. Magellan instituted Provider CAPs requiring a quarterly self-audit. Magellan provided TA based upon the audit findings.

Table 4



	Q4FY11	Q1FY12	Q2FY12	Q3FY12	Q4FY12	Q1FY13	Q2FY13	Q3FY13
n =	180	44	56	63	70	70	81	86
Score (MPS=85%)	76.1	72.7	87.5	79.4	80.0	82.9	65.4	80.2

Table 5



	Q4FY11	Q1FY12	Q2FY12	Q3FY12	Q4FY12	Q1FY13	Q2FY13	Q3FY13
n =	190	29	46	51	70	72	79	80
Score (MPS=85%)	82.6	89.7	89.1	88.2	88.6	83.3	64.6	91.3

Results for DDD Adults and Children as well as for CMDP children for the BHSPv have not met MPS as indicated below:

DDD Adult: 36.1%

DDD Children: 66.66%
CMDP: 74.2%

Currently, the "n" for the BHSPv measure is based upon the number of records that pass the BHSP measure. As a result, the denominator can be extremely low, for example, for Q1FY13 through Q3FY13, eight (8) DD Adult records, sixteen (16) DD Children records, and forth-five (45) CMDP records were included in this measure for the three (3) quarters.

Contractual requirements for FY2014 with AHCCCS and DDD have resulted in the need to ensure that a representative sample is drawn for each performance measure based upon population/payor source.

Annual results on Performance Measures by GSA for by Adult and Children

Table-6 and Table-7 present FY 2013 Annual results by GSA/RBHA for each performance measure as well as by Adult and Children. Quarterly results by GSA/RBHA were presented in the QM Committee Meeting on 11/20/2013.

Table 6: FY 2013 ADULT Performance Measures Results by GSA and RBHA

	Behavioral Health Service Plan	Access to Care	Behavioral Health Service Provision	Coordination of Care
GSA/RBHA	MPS: 85%	MPS:90%	MPS: 85%	MPS: 85%
GSA-1 NARBHA	84%	88.5%	76.66%	78%
GSA-2 Cenpatico	76.5%	94.25%	71.33%	87.75%
GSA-3 Cenpatico	86.25%	94.25%	72.33%	92.5%
GSA-4 Cenpatico	83.75%	96.75%	92%	88%
GSA-5 CPSA	79.5%	86.75%	75.66%	94%
GSA-6 Magellan	82.25%	92%	72.33%	95.5%
Statewide	**82%**	**92.08%**	**77.12%**	**89.3%**

Due to the fact that the above performance measures were retired on September 30, 2013, all CAPS initiated in January 2013 were closed. Eight new performance measures were mandated by AHCCCS. These performance measures began October 01, 2013. The first measurement for the new performance measures will be in January 2014. (For more information on the CY14 Performance Measures see the 2014 Work Plan, and 2014 QM Plan.)

Based on ADHS/DBHS evaluation of strategies and activities carried out during FY 13, Goal-1 was Substantially MET.

Goal 2- IADs - Improve timeliness of IAD submission

During FY13, a baseline measurement was conducted to determine the existing level of T/RBHA adherence to the IAD reporting requirements. The statewide timely IAD submission to DBHS during FY12 was 50%. As a result of these findings, a new Work Plan goal was created, to increase the timely reporting of IAD Reports (T/RBHA to DBHS within 9 days of the reported incident date) from 50% in FY12 to 75% in FY13.

- DBHS Office of Quality of Care (OQOC) improved its QOC database capabilities to be able to more accurately enter and monitor information related to IAD submissions.
- A requirement was initiated and technical assistance was provided for T/RBHAs to date-stamp all IAD forms to indicate the date each was received from the provider/provider agency.

As of the 5/15/13 QM Committee Meeting, the statewide average submission time since FY12 had decreased 12%, from 14.7 to 13 days, while the number of IADs received within 9 days of the incident increased 10.1%, from 49.4% to 54.4%.

During Q4 of FY 13, DBHS IAD and QOC processes were significantly revised under the direction of the Chief Medical Officer to be more closely aligned with AHCCCS processes and requirements. OQOC also received extensive technical assistance from AHCCCS CQM to facilitate the changes. The two major objectives of this initiative were to empower the T/RBHAs' ownership of IAD form reviews and QOC investigation processes, and to clarify and adjust the role of OQOC to oversight, monitoring, and technical assistance provision. Because of the scope and intensity of this project, the goal to improve IAD submission timeliness was given a lower priority in order to dedicate limited OQOC resources to the successful implementation of the larger process change.

Although some improvements in IAD processes and timelines were achieved during FY13, based on ADHS/DBHS evaluation of strategies and activities performed, Goal 2 was Partially Met during the measurement period.

Goal 3 - Performance Framework and Dashboard

BQ&I will share timely information about key social and clinical indicators with DBHS stakeholders and the community on a quarterly and annual basis.

Sharing meaningful and accurate information is a priority for ADHS/DBHS. The Performance Framework and Dashboard had been enhanced in FY12 to further align with the Division's goals of communication and transparency, as well as the new website design. Dashboard content is organized into four categories:

- Outcomes – Impact on Quality of Life
- Access to Services
- Service Delivery
- Coordination/Collaboration

Within these categories are representative measures from various sources. Outcomes are reported from the National Outcomes Measures, an annual review based on demographic data submitted by TRBHAs. The Annual Consumer Survey, annual geomapping, and a quarterly performance measure contribute to the Access to Services category. Service Delivery is sourced from the Annual Consumer Survey and two quarterly performance measures, and the Coordination/Collaboration category reflects quarterly information, including a performance measure and utilization data.

Building upon the FY12 enhancements, in FY13 BQ&I developed additional processes and structure to facilitate regular, appropriate, and comprehensive updates of the Dashboard. A FY13 Dashboard Checklist and Updates document was created in support of these goals. The BQ&I process called for all metrics to be presented to the Quality Management or Medical/Utilization Management Committee, as appropriate, before being posted on the Dashboard.

There were challenges in meeting the schedule outlined in our FY12 Work Plan. Changes to the implementation of the Access to Care performance measure were under consideration, and a corresponding deep dive investigation of the methodology was carried out; decisions about final quarterly rates delayed Dashboard postings. Personnel changes within BQ&I prompted modifications to Committee meeting dates, with corresponding altered availability of information for the Dashboard. When metrics were available for posting, deadlines were met. There will be Dashboard changes in FY14 as new performance measures are adopted. The Office of Information Management will enlist the participation of stakeholders in defining those changes. To help avoid scheduling problems in the future, a BQ&I-wide timeline of deliverables and Committee meetings will be used to further facilitate our meeting the goals of timely and accurate sharing of information.

Based on ADHS/DBHS evaluation of strategies and activities carried out during FY13, Goal 3 was partially met. ADHS/DBHS will continue this Goal in FY14 to ensure accurate information about key metrics are shared with stakeholders in a timely manner.

Goal 4- Performance Improvement Projects

The requirement to submit a self-selected PIP for ADHS/DBHS was waived by AHCCCS in FY12. However, DBHS/OPI directed its resources to collaborate with AHCCCS to implement the Coordination of Care Performance Improvement Project (Improving Coordination of Care for Acute-Care Members Receiving Behavioral Health Services) with AHCCCS Health Plans and RBHAs. In addition, DBHS/OPI collaborated with AHCCCS to implement the 30 day Readmission Performance Improvement Project.

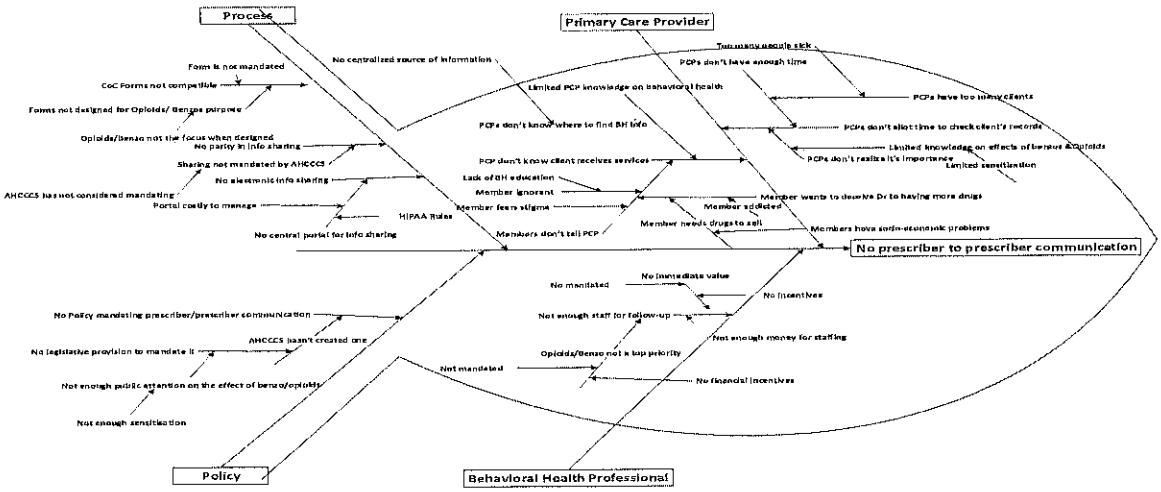
Coordination of Care PIP

ADHS/DBHS coordinated meetings between Health Plans and RBHAs on 1/18/12, 3/1/12, 5/24/12, 6/28/12, 7/27/12, and 9/28/12. Please read meeting summaries (attached "CoC PIP Meeting Summaries") for information regarding meeting content.

Data sharing planning was completed and first data sharing began on August 10, 2012, which was successful. Discussion regarding data sharing will continue and will be ongoing to help resolve any issues that may arise. ADHS/DBHS/BQ&I also prepared the baseline data for the Coordination of Care (CoC) Performance Improvement Project (PIP), and provided it to AHCCC

In 2013, ADHS/DBHS/BQ&I led a workgroup that performed a root cause analysis to barriers of Coordination of Care.

Root Cause Analysis: Using the Fishbone Diagram



The root cause analysis provided the basis for designing a set of interventions to improve the limited coordination of care between behavioral health medical providers and primary care physicians.

The ADHS/DBHS is leading its contractors (RBHAs) in different intervention groups of the PIP, to begin implementation in 2014. ADHS/DBHS will continue to host and facilitate the different PIP workgroup meetings and provide technical assistance where necessary. ADHS/DBHS also initiated RBHA specific meetings to deliberate and resolve barriers to collaborative efforts between the RBHAs and the AHCCCS Acute Plans.

Readmission PIP

The purpose of this PIP is to decrease the rate of inpatient readmissions among AHCCCS members within 30 days of a previous discharge, in order to improve quality of life, promote patient-centered care, and reduce unnecessary health care utilization and costs.

ADHS/DBHS requested each behavioral health contractor, (RBHA) to provide monthly data by Geographic Service Area (GSA) for all Title XIX/XXI Adults and Children as well as Seriously Mentally Ill (SMI) adults who were readmitted to the same level of care within 2 to 30 days of being discharged. Members who were discharged and admitted into the same level of care on the same day or a day after the discharge were not considered in the calculation.

For data analysis and reporting purposes on both the statewide and the GSA level, ADHS tracked, trended, and analyzed aggregate data for readmissions to Office of Behavioral Health Licensing (OBHL) licensed Level I and Level II facilities, by funding group, behavioral health category, and age group. Level I facilities are defined as inpatient psychiatric hospitals, sub-acute facilities, and residential treatment centers that provide a structured treatment setting with 24 hour supervision and an intensive treatment program including medical support services. Level II facilities are defined as behavioral health agencies providing a structured residential treatment setting with 24 hour supervision and counseling or other therapeutic activities for persons who do not require on-site medical services, under the supervision of an on-site or on-call behavioral health professional (BHP).

Data for readmission rates was tracked quarterly and trended over several quarters. Trends were monitored for outliers and unstable processes. While run charts were used to monitor outliers, control charts were used to identify special cause variations, and to evaluate the stability of the process.

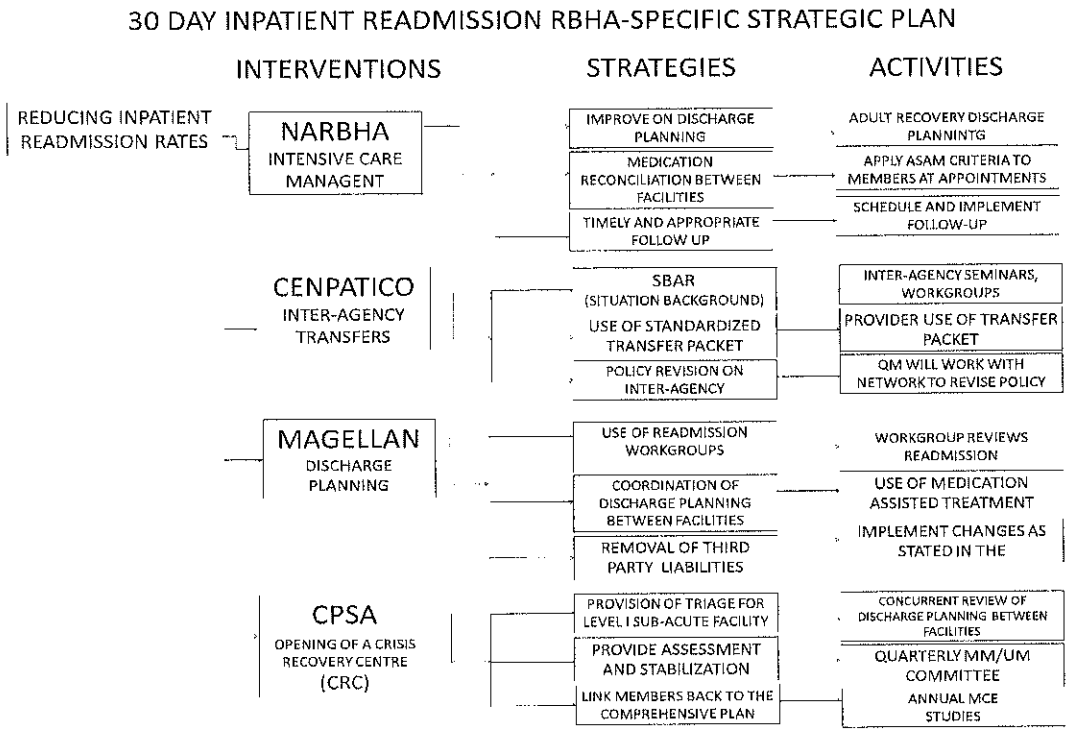
The analyses were presented by GSA to the Medical Management/Utilization Management (MM/UM) Committee for discussion and recommendations. Contractors who performed below expectations were notified and requested to take steps to improve their readmission rates within a given time frame. Subsequent tracking, trending, and analyses were performed to evaluate the impact of the contractor's actions and further recommendations were made where changes were undesirable.

Data analyses by GSA indicated process instability in some GSAs and though readmission rates for most GSAs were stable, GSAs 2 and 4 showed unstable processes- irregular spikes in rates as shown on figure 1.

In addition, current research, studies and best practice guidelines from similar projects nationwide point to new ways of improving 30 days readmission rates to psychiatric hospitals.

Thusly, to ensure process stability in the GSAs and incorporate best practice guidelines, a slight change was made to the methodology- Each contractor was required to perform a root cause analysis to barriers of its thirty days readmission to psychiatric hospital and re-design interventions based on the findings of the root cause analyses. Utilizing best practice guidelines from similar projects nationwide, each contractor designed a set of interventions and strategies to reduce readmission rates as shown in the 30 Day Impatient Readmission RBHA-Specific Strategic Plan

Figure 1



Goal 5 - Monitoring and Oversight Activities:

DBHS and its Contractors will monitor the service delivery system to improve services for behavioral health recipients. This goal in the ADHS/DBHS FY13 QM Work Plan pertained to monitoring and oversight activities. These efforts focused not only on the frequency that ADHS/DBHS QM reviews Contractor data, conducts validation reviews and implements corrective actions, but on the process used to monitor RBHA activities.

DBHS developed five (5) strategies to meet FY13 Goal on Monitoring and Oversight Activities. This goal was met through DBHS performing the following activities:

- Review of T/RBHA QM Plans

- Oversight of RBHA Provider Monitoring Activities
- Oversight of T/RBHA QOC and IAD Processes
- Oversight of RBHA Peer Review Process
- Mid-year site visits and the Annual Administrative Review

Review of T/RBHA QM Plans: ADHS/DBHS/BQ&I evaluated T/RBHA QM Plans with respect to the adequacy of provider monitoring activities. All of the T/RBHA Plans were approved by BQ&I; however, OPI did recommend enhancements to the T/RBHAs (with the exception of Magellan who did not receive any recommendations for improvement) QM Plan submissions. The three areas requiring additional areas of focus were:

QM Evaluation

- The QM evaluation does not contain enough detail.
- There should be more focus on the trending and analysis that guided specific actions taken throughout the year as well as an assessment of those actions.
- The QM evaluation did not adequately provide evidence of follow-up timelines for revisions to the QM/PI Plan.

2013 QM Work Plan

- The work plan should be more inclusive of the activities which are occurring and should be sufficient to reach the goals and objectives.
- The goals and objectives should be measurable
- The methodology should be more specific

Monitoring Section

- The QM/PI Program scope of monitoring and evaluation must be comprehensive. It must incorporate the activities used by the Contractor, and demonstrate how these activities will improve the quality of services and the continuum of care in all service sites.
- Information and data gleaned from QM monitoring and evaluation that shows trends in quality of care issues should be used in developing PI projects. Selection of specific monitoring/evaluation activities should be appropriate to each specific service site.
- Contractors must develop work plans for taking appropriate actions to improve care if problems are identified

Oversight of RBHA Provider Monitoring Activities: During site visits, DBHS/BQ&I staff reviewed T/RBHAs' provider monitoring activities against the activities presented by each T/RBHAs in their annual QM Plan. For the RBHAs, calendar validation, CAP monitoring and tracking, provider activity monitoring, and validation of provider data were reviewed.

DBHS/BQ&I staff also monitored progress on providers' Corrective Action Plans issued by the T/RBHAs. DBHS/BQ&I site visits to the RBHAs occurred in February and March 2013. DBHS/BQ&I staff did not visit the TRBHA during FY13 but did conduct the Annual

Administrative Review with the T/RBHAs from September through November of 2013. The schedule of site visits for DBHS/BQ&I review of RBHA provider monitoring activities, as well as the results of the onsite activities were shared with the QM Committee.

Oversight of RBHA QOC and IAD Process: Incident, Accident, Death (IAD) reporting forms were received, reviewed for completeness, and screened for potential Quality of Care Concerns by all T/RBHAs. They were also submitted to DBHS by each T/RBHA based on a weekly schedule developed by the DBHS Quality of Care (QOC) Office. ADHS/DBHS received IAD or QOC requests from AHCCCS, DBHS Customer Services, Office of Human Rights, and other stakeholders.

During FY 13, DBHS/QOC staff provided intensive and frequent technical assistance to T/RBHAs regarding compliance with IAD submission and review requirements. As previously mentioned, during Q4 of FY 13, DBHS IAD and QOC processes were revised under the direction of the Chief Medical Officer to more closely align them with AHCCCS processes and requirements.

Please see the attached "IADs 2013" summary of counts by category and TRBHA. The data analyst tracked each RBHA's trending of IAD and QOC concerns enabled the DBHS QOC Office to more effectively track and trend IADs and QOCs. Late in FY 12, ADHS/DBHS revised and updated the IAD and QOC database which of trended data was presented on 11/20/2013 for QM Committee feedback and recommendations.

Progress on the QOC corrective action plans was monitored during the onsite Oversight and Monitoring audit completed in February and March 2013 and the on-site Administrative Review conducted in October/November 2013.

The QOC staff provided on-site oversight of each RBHA's QOC policy and QOC protocols in October, 2013, during the Annual Administrative Review (see T/RBHA Administrative Review results in the following section.) After the Administrative Review on-site activities were completed, DBHS OQOC staff conducted customized RBHA-specific IAD and QOC technical assistance sessions with all RBHA staff.

Oversight of RBHAs Peer Review Process: ADHS/DBHS conducted on-site oversight and monitoring activities Feb/March 2013 and the annual on-site OQOC portion of the DBHS Administrative Review was conducted in October/November 2013 for each RBHA (attached "QOC Data Validation Feedback and Summaries"). Peer Review policy and protocols were reviewed to ensure compliance with ADHS/DBHS Peer Review Policy QM 2.6 and AHCCCS requirements (AMPM Chapter 910-3). The Peer Review Committee process, meeting minutes, and agenda were also reviewed to ensure the maintenance of confidentiality. Below are the preliminary Administrative Review Results for Peer Review by RBHAs (Tribal Behavioral Health Authorities are not contractually required to conduct Peer Review):

RBHA	Preliminary Administrative Review Findings for Peer Review
Magellan	100% Full Compliance
CPSA	100% Full Compliance
NARBHA	100% Full Compliance
Cenpatico	100% Full Compliance

Mid-year Onsite Monitoring and Oversight Visits: DBHS/BQ&I conducts mid-year site visits to monitor T/RBHA compliance with delegated functions and to ensure that the QM and MM/UM programs meet ADHS/DBHS and AMPM Chapter 900 and Chapter 1000 requirements. During site visits DBHS staff also monitors progress on all RBHA-initiated QOC CAPs and additional corrective action plans issued by ADHS.

FY13 RBHA visits occurred in February/March 2013. During site visits, calendar validation, CAP monitoring and tracking, provider activity monitoring, validation of provider data, Peer Review and IAD/QOC processes were reviewed. The Office of Performance Improvement (OPI) initiated a new monitoring tool, the Onsite Monitoring and Oversight Review (OMOR) tool. Due to feedback from AHCCCS during the ADHS/DBHS Operational Review, OPI staff is revising the existing OMOR, and developing new site visit tools to ensure RBHAs' provider monitoring activities are captured effectively. Tools are being finalized and will be used during site visit activities in FY14.

Annual Admin Review: ADHS/DBHS conducts an Administrative Review (similar to AHCCCS' Operational Review) of its contracted Tribal and Regional Behavioral Health Authorities each year. The QM Section includes 18 standards that are mainly focused on T/RBHA compliance with QM Structure, Governing Body, QOC and IAD process, Credentialing/ Re-credentialing, Peer Review Processes and Medical Record Review.

FY13 ADHS/DBHS Annual Administrative Review was conducted in September through November of 2013. A standard QM tool was used to review each T/RBHA's QM program, policies/procedures, staffing requirements, QOC and Peer Review processes, Credentialing requirements and processes, and the Medical Record Review validation. Administrative Review draft results were officially shared with RBHAs through the ADHS/DBHS Bureau of Compliance, Office of Audit and Evaluation in December 2013. The T/RBHAs challenged some of the findings. Challenges were reviewed, with a final report provided to Compliance in December. Below are two separate tables depicting the preliminary scores for the FY13 Annual Administrative Review:

RBHA FY13 QM Administrative Review
Preliminary Scores

ADHS/DBHS Standard	Magellan	NARBHA	Cenpatico	CPSA
QM1: The governing body and the Contractor are accountable for all Quality Management/Quality Improvement (QM/QI) program functions.	FC 100%	FC 100%	FC 100%	FC 100%
QM2: The Contractor has the appropriate staff employed to carry out Quality Management Program administrative requirements.	FC 100%	FC 100%	FC 100%	FC 100%
QM3: The Contractor has a structure and process in place for both Contractor-initiated and ADHS/DBHS-initiated quality of care/abuse/complaint investigations, for member/system resolution.	FC 100%	FC 100%	FC 100%	FC 100%
QM4: The Contractor has a structure in place for trending quality-of-care and member complaints to make member/system improvements.	FC 100%	FC 100%	FC 100%	FC 100%
QM5: Contractor has a process for verifying initial credentialing-of all organizational providers (including but not limited to, behavioral health residential treatment facilities, inpatient facilities, Outpatient providers and other BH facilities).	FC 100%	FC 100%	FC 100%	FC 90%
QM6: Contractor has a process for re-credentialing of all organizational providers (including but not limited to, behavioral health residential treatment facilities, outpatient providers and other BH facilities.	FC 93.3%	FC 100%	FC 100%	FC 100%
QM7: The Contractor's provisional credentialing process meets the AHCCCS required timelines.	FC 90%	FC 100%	FC 100%	PC 68.3%
QM8: The Contractor's credentialing and re-credentialing of physicians and other licensed health care providers meets the AHCCCS requirements.	FC 96.7%	FC 100%	FC 93.3%	FC 100%
QM9: The Contractor ensures credentialing, re-credentialing, and provisional credentialing of the providers in their contracted provider network.	FC 100%	FC 100%	FC 97%	FC 100%
QM10: The Contractor monitors that organizational providers maintain comprehensive medical records.	FC 95%	FC 95%	FC 100%	FC 100%
QM11: The Contractor monitors that organizational providers maintain comprehensive medical records that include, at minimum, identification information, demographic information, member initial and past medical histories.	FC 100%	FC 100%	FC 100%	FC 100%
QM12: The Contractor monitors that Behavioral Health Professionals maintain comprehensive records that include at a minimum: current problem listing; current medications; documentation of coordination of care; and information releases.	FC 100%	FC 100%	FC 100%	FC 100%

QM13: The Contractor monitors that providers document in the member's record whether or not the adult member has been provided information on advance directives and whether an advance directive has been executed.	FC 100%	FC 100%	FC 100%	FC 100%
QM14: The Contractor has a structure in place for a Quality Management Program that includes administrative requirements related to the peer review process. (RBHAs Only)	FC 100%	FC 100%	FC 100%	FC 100%
QM15: The Contractor conducts PIPs to assess the quality and appropriateness of its service provision and to improve performance.	FC 100%	PC 60%	SC 80%	NC 20%
QM16: The Contractor maintains a health information system that collects, integrates, analyzes, and reports data necessary to implement its QM/QI Program.	FC 100%	FC 100%	FC 100%	FC 100%
QM17: The health information system data elements include at least the following information to guide the selection of and meet the data collection requirements for quality improvement requirements.	FC 100%	FC 100%	FC 100%	FC 100%
QM18: The Contractor has a structure in place for a Quality Management Program that includes administrative requirements for oversight and accountability for all functions and responsibilities described in AMPM Chapter 900 that are delegated to other entities. (If Applicable)	FC 100%	FC 100%	FC 100%	FC 100%

TRBHA FY13 QM Administrative Review
Preliminary Scores

ADHS/DBHS Standard	Gila River	Pascua Yaqui	WMAT
QM1: The governing body and the Contractor are accountable for all Quality Management/Quality Improvement (QM/QI) program functions.	FC 100%	FC 100%	NC 0%
QM2: The Contractor has the appropriate staff employed to carry out Quality Management Program administrative requirements.	NC 34%	NC 34%	NC 0%
QM3: The Contractor has a structure and process in place for both Contractor-initiated and ADHS/DBHS-initiated quality of care/abuse/complaint investigations, for member/system resolution.	FC 100%	PC 71%	NC 0%
QM4: The Contractor has a structure in place for trending quality-of-care and member complaints to make member/system improvements.	FC 100%	FC 100%	NC 0%
QM5: Contractor has a process for verifying initial credentialing-of all organizational providers (including but not limited to, behavioral health residential treatment facilities, inpatient facilities, Outpatient providers and other BH facilities).	FC 100%	FC 100%	NC 0%

QM6: Contractor has a process for re-credentialing of all organizational providers (including but not limited to, behavioral health residential treatment facilities, outpatient providers and other BH facilities.	FC 100%	FC 100%	NC 0%
QM7: The Contractor's provisional credentialing process meets the AHCCCS required timelines.	FC 100%	FC 100%	NC 0%
QM8: The Contractor's credentialing and re-credentialing of physicians and other licensed health care providers meets the AHCCCS requirements.	SC 75%	FC 100%	NC 0%
QM9: The Contractor ensures credentialing, re-credentialing, and provisional credentialing of the providers in their contracted provider network.	FC 94%	NC 31%	NC 0%
QM10: The Contractor monitors that organizational providers maintain comprehensive medical records.	FC 95%	PC 65%	NC 0%
QM11: The Contractor monitors that organizational providers maintain comprehensive medical records that include, at minimum, identification information, demographic information, member initial and past medical histories.	FC 100%	FC 100%	NC 0%
QM12: The Contractor monitors that Behavioral Health Professionals maintain comprehensive records that include at a minimum: current problem listing; current medications; documentation of coordination of care; and information releases.	FC 100%	PC 55%	NC 0%
QM13: The Contractor monitors that providers document in the member's record whether or not the adult member has been provided information on advance directives and whether an advance directive has been executed.	FC 100%	NC 0%	NC 0%
QM14: The Contractor has a structure in place for a Quality Management Program that includes administrative requirements related to the peer review process. (RBHAs Only)	IO	IO	IO
QM15: The Contractor conducts PIPs to assess the quality and appropriateness of its service provision and to improve performance.	IO	IO	IO
QM16: The Contractor maintains a health information system that collects, integrates, analyzes, and reports data necessary to implement its QM/QI Program.	IO	IO	IO
QM17: The health information system data elements include at least the following information to guide the selection of and meet the data collection requirements for quality improvement requirements.	IO	IO	IO
QM18: The Contractor has a structure in place for a Quality Management Program that includes administrative requirements for oversight and accountability for all functions and responsibilities described in AMPM Chapter 900 that are delegated to other entities. (If Applicable)	IO	IO	IO

Full Compliance (FC) 90-100%

Substantial Compliance (SC) 75-89%
Partial Compliance (PC) 50-74%
Non-Compliance (NC) 0-49%

Not Scored (NS) Not Scored - baseline year
Information Only (IO)

All RBHAs received Full Compliance for implementing a QM program as per ADHS and AHCCCS requirements during the Annual Administrative Review in FY13.

Pascua Yaqui was noncompliant for QOC functions (Standard QM 2, QM3 and QM4); and Gila River was substantially compliant for QM 13 (Medical Record Review Standard). Pascua Yaqui will receive a Corrective Action for noncompliance after final results are shared with T/RBHAs.

Based on ADHS/DBHS evaluation of strategies and activities carried out during FY13, Goal 5 was MET. ADHS/DBHS will continue this goal in FY14.

In addition, BQ&I staff and the ADHS/DBHS Business Information Bureau (BIS) implement data quality edits for the files received from the T/RHBAs as follows:

- Confirm data submissions are accurate (Error rate not to exceed 5 percent in any field for three consecutive months)
- Ensure that all submissions not meeting the requirements are returned for resubmission.
- Take Corrective Action if a pattern of inaccuracy is established.
- Present data and analysis to the QM Committee for approval prior to submission
- ADHS/DBHS Leadership Committee and AHCCCS

The Claims and Encounters processing side of the Division's Client Information System (CIS), which is necessary for completing any review of member service utilization – a major component of the QM/QI Program – tracks submission timeliness, acceptance rates and denial reasons, and monitors contractor's performance in correcting pended or denied encounters and their subsequent resubmission, per the requirements found within the AHCCCS' Encounter Manual.

Acceptance rates for all Form types is calculated daily and the Division contacts the RBHAs in instances where their daily acceptance rate falls below 80% in order to identify and troubleshoot any problems they may be experiencing. Currently, the RBHAs' daily encounter acceptance rate is approximately 98%.

The Demographics side of CIS, which contains member assessment information, including Axial Diagnoses and Behavioral Health Category, is monitored through the previously-noted monthly reports and contains extensive pre-processor edit checks to help ensure that only

valid and logical data is submitted, and subsequently stored, for the members in the behavioral health system.

Like encounters, the Division monitors demographic acceptance rates on a daily basis and provides feedback and assistance when the T/RBHAs require support. **The T/RBHA's daily demographic acceptance rate is approximately 90%.**

The ADHS/DBHS data are used for the following reports submitted to AHCCCS:

- Annual QM Plan, Work Plan, and Evaluation
- Annual Consumer Survey
- QM Quarterly Report (QOC report)
- ADHS/ DBHS BQ & I Specifications Manual (Information Only)

ADHS/DBHS Annual Consumer Surveys

The Consumer Surveys are a valuable source of information, providing direct feedback from members about their experience with behavioral health services. The results identify areas of satisfaction as well as opportunities for improvement. ADHS/DBHS, T/RBHAs, and contracted service providers jointly conduct statewide consumer surveys during each fiscal year. Each year, two surveys are administered based on the Substance Abuse and Mental Health Services Administration's (SAMSHA's) Mental Health Statistics Improvement Program (MHSIP) consumer surveys: The Adult Consumer Survey and The Youth Services Survey for Families (YSS-F).

The surveys request independent feedback from Title XIX/XXI adults and families of youth receiving services through Arizona's publicly funded behavioral health system. The surveys measure consumers' perceptions of behavioral health services in relation to the following domains:

- General Satisfaction
- Access to Services
- Service Quality/Appropriateness
- Participation in Treatment
- Outcomes
- Cultural Sensitivity
- Improved Functioning
- Social Connectedness

Within ADHS/DBHS, Consumer Survey results are:

- Reviewed by the ADHS/DBHS Quality Management (QM) Committee;

- Used by the QM Committee as a critical information source to drive system improvements through RBHA contracts and QM Plans;

- Incorporated into the Annual Performance Improvement Reports to provide a comprehensive update on performance across contractual performance measures; and
- Used for certain Performance Incentive System calculations.

Survey outcomes are also:

- Disseminated to ADHS/DBHS stakeholders and consumers via the ADHS/DBHS website and Performance Dashboard;
- Submitted to these national organizations as part of federal grant requirements for use in national reporting and evaluation:
  - The National Association of State Mental Health Program Directors' (NASMHPD)
  - National Research Institute (NRI)
  - Western States Decision Support Group (WSDSG)
  - Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health Statistics Improvement Program (MHSIP)

The fiscal year 2013 Surveys were conducted from April through May 2013. Adult and Youth Survey results are summarized as follows:

Summary of the 2013 Adult Survey Results:

Statewide:

- The domains with the highest scores in 2013 for the adult population in the 2013 survey results are: *General Satisfaction, Service Access and Service Quality and appropriateness.*

- *General Satisfaction* domain improved by five percent representing a statistically significant score with a P-value of 0.01 when compared to the 2012 results.

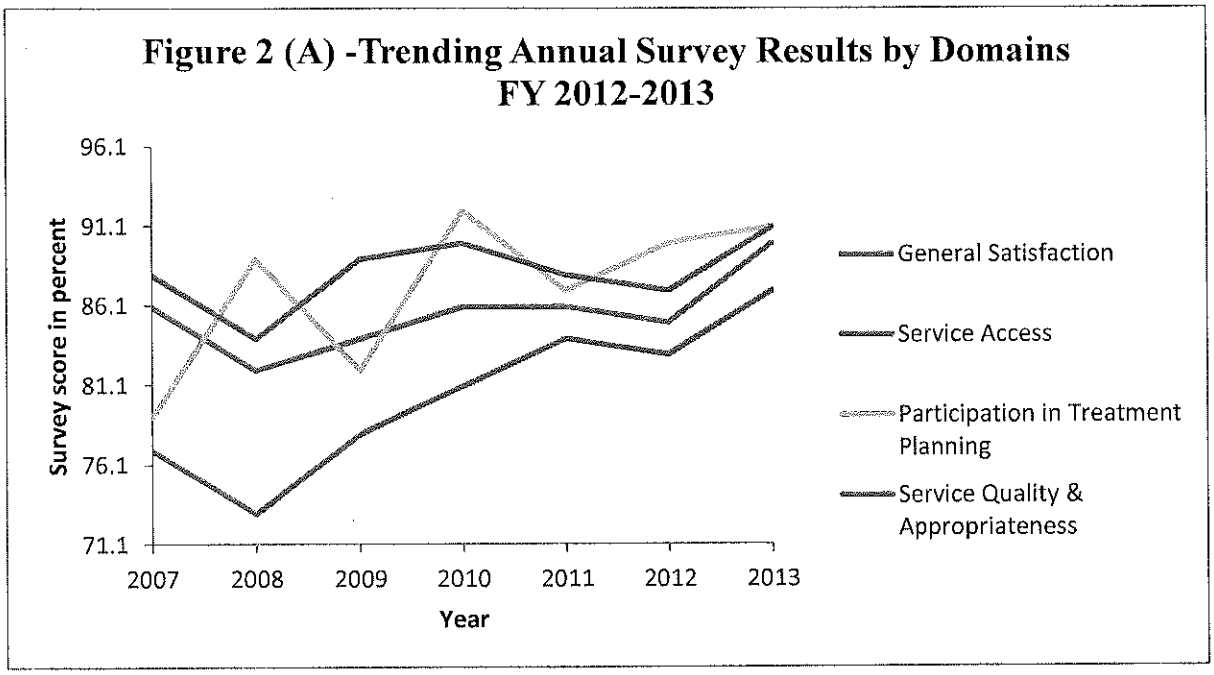
- *Service Quality and Appropriateness* increased by four percent from the 2012 score, indicating a statistical significance with a P-value of 0.21 when compared to the 2012 results.

- *Service Access* also showed an increase of four percent from the 2012 results. This was however not statistically significant.

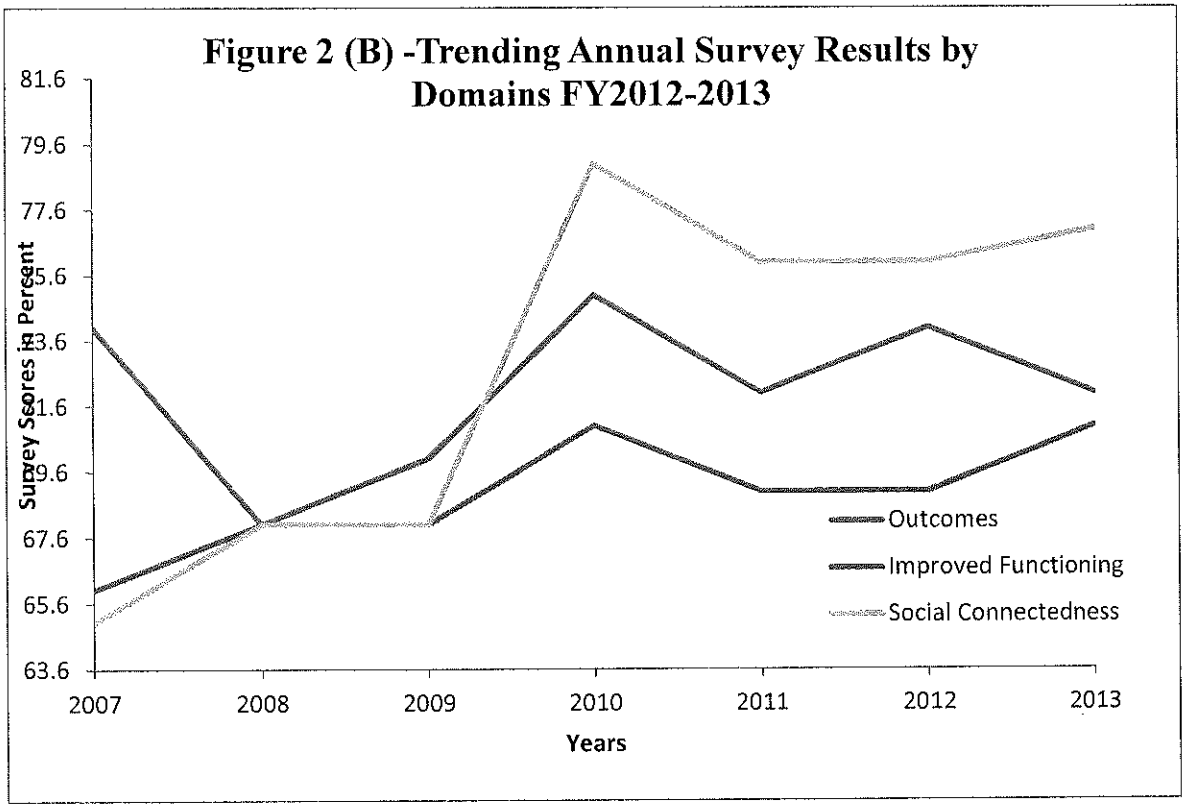
- *Outcomes* domain showed a slight decrease by two percent.

- *Social Connectedness* and *Improved Functioning* domains both showed a slight increase by one and two percent respectively from the 2012 survey results.

Domains	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
General Satisfaction	86%	82%	84%	86%	86%	85%	90%
Service Access	77%	73%	78%	81%	84%	83%	87%
Participation in Treatment Planning	79%	89%	82%	92%	87%	90%	91%
Service Quality & Appropriateness	88%	84%	89%	90%	88%	87%	91%



Domains	2007	2008	2009	2010	2011	2012	2013
Outcomes	74%	68%	70%	75%	72%	74%	72%
Improved Functioning	66%	68%	68%	71%	69%	69%	71%
Social Connectedness	65%	68%	68%	79%	76%	76%	77%



RBHA Specific:

- Magellan (GSA 6) showed a statistically significant increase in two domains: *General Satisfaction* ($P \leq 0.003$), *and Service Quality* ($P \leq 0.02$), which may be attributed to Magellan's initiatives during FY2012.

- Cenpatico (GSA 3) showed statistically significant change in the Social Connectedness domain ($P \leq 0.005$)

RBHA Specific Adult Initiatives

Cenpatico and CPSA submitted to ADHS/DBHS some initiatives for the adult population to address deficiencies identified in their Consumer Survey report:

Cenpatico recognized the statistically significant decreases in *Outcomes* and *Functioning* domains for GSA 2 in the 2012 survey and reported actions planned to address these areas.

- Cenpatico developed a Performance Improvement Plan (PIP) in December 2012 that included the collection of a quarterly satisfaction survey to measure its consumer satisfaction with providers in each GSA.

- Cenpatico will maintain this practice, and plans to enhance the survey in January 2013 with particular attention to these domains.
- Feedback from the surveys will be shared with Cenpatico's QM Committee and its provider network each quarter.
- After two quarters of collecting results from the new 2013 survey, Cenpatico will assess each of its geographic areas for the need of targeted interventions where the need for improvement is indicated.

ADHS/DBHS requires Cenpatico to regularly report updates on these initiatives to ensure there is a positive impact and performance improvement. ADHS/DBHS will meet and discuss with Cenpatico about trends in survey results.

CPSA acknowledged the need for improvements specifically in the *Service Access* and *Service Quality & Appropriateness* domains. Listed below are steps CPSA is implementing to improve and meet the needs of consumers.

- CPSA continues to maintain frequent communication with members to ensure coordination of, and access to, behavioral health services among Comprehensive Service Providers and other community resources.
- CPSA maintains an Audio Visual Library on the website that includes a comprehensive overview of member-centered educational materials intended to educate and empower members. CPSA will continue to improve its website to be more inclusive of information and training opportunities for members and families.
- CPSA shares these results with all Comprehensive Service Providers (CSP) and expects implementation of improvements in their systems to meet and exceed the needs of members.
- CPSA QM staff continues to audit comprehensive Service Provider medical charts and provide real-time feedback to Comprehensive Service Provider staff on key MHSIP indicators.
- CPSA Compliance Committee is working on issues around system-wide sub-contract tracking systems and any specific compliance issues that the CPSA Comprehensive Service Provider Team cannot resolve.
- CPSA continues to involve peers in the support of members through the Recovery Support Initiative and the development of Recovery Support Centers established within the CSPs.
- CPSA implemented a pilot program utilizing the Outcomes Rating Scale and the Session Rating Scale in order to elicit ongoing member feedback to improve treatment or service outcomes.

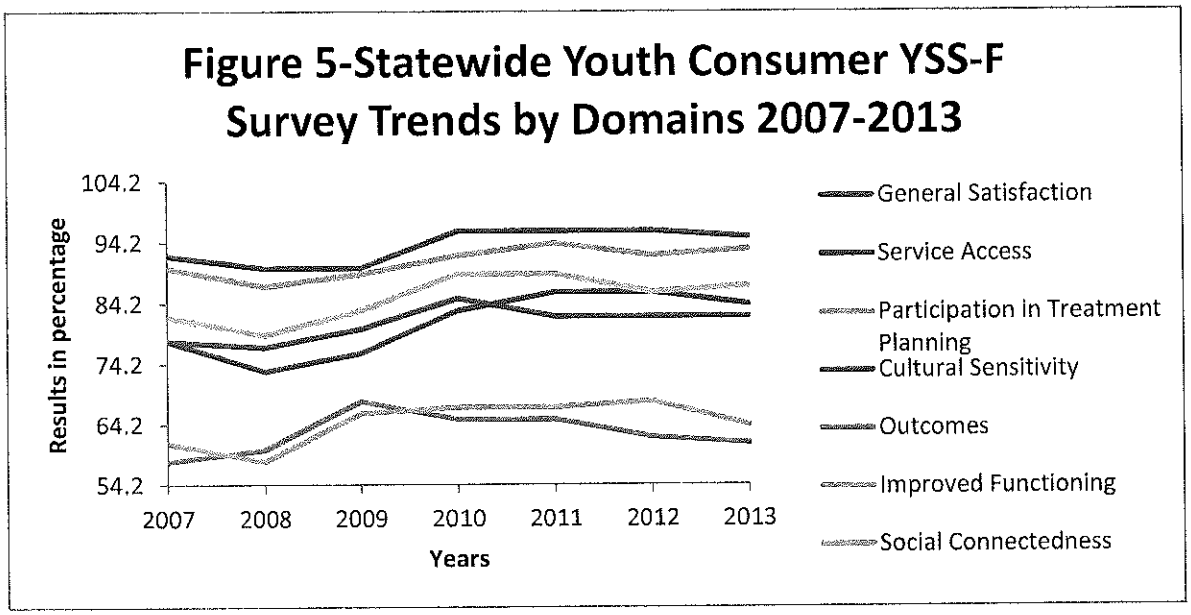
Summary of the 2012 YSS-F Survey Results:

Statewide:

- Significant declines were noted in the 2013 statewide youth survey results compared to 2012.
- *Service Access* and the improved functioning domains showed a percentage decrease from the 2012 results.
- *Social Connectedness* domain increased by two percentage points.

Additionally,

- *Improved Functioning* domain increased in score by one percentage point from 2012.
- *General Satisfaction domain* showed no change in percentage points between the 2012 and 2013



RBHA Specific:

- Cenpatico (GSA 2) showed significant increase in the *Service Access* and *Outcomes* domains but experience slight percentage decreases in *Participation and Treatment* and *Social Connectedness* domains
- CPSA (GSA 5) experienced percentage decreases in three domains: *Improved Functioning, Social Connectedness and Outcomes*

RBHA Specific YSS-F Initiatives

CPSA recognizes the declines in certain domains of the Youth Consumer survey and has developed plans and activities to improve performance in the *Outcomes* domain of the youth survey. CPSA plans to utilize performance improvement projects as a strategic to improve scores in the youth consumer survey. Specifically, Comprehensive Service Providers have addressed some of the following in their PIPs:

- In order to guide service planning and service provision in a way that aligns with the MHSIP, CSPs are choosing to continue to incorporate MHSIP outcome indicators into forms used by clinical services, that will be utilized at the beginning of every appointment to address where members feel they are in treatment relative to outcomes attributable to treatment. Staff representatives from QM, Clinical services and Customer Service Committees have been meeting to create these forms as well as a process for staff to discuss these eight indicators with the members.

    - This is an opportunity for staff to address what may or may not be working in treatment, allowing the opportunity for members to address outcomes with their clinical team on a consistent basis. This PIP initiative was a huge focus for the Adult providers in 2012 and once again appeared to make a significant impact based on the Outcome domain scores. Some of the youth providers are choosing to address the Outcomes Indicator language more specifically in the CFT agenda, by implementing this language into the CFT Agenda forms, and calling on CFT coaches to monitor the effectiveness of this language within the CFT. The effectiveness of these tools will be closely evaluated in the 2013 Corrective Action Plans across the CPSA Children's system.

- CSPs are choosing to continue to conduct internal biannual audits to assess compliance. Any identified trends in this audit structure would lead to QM interventions and implementation of new strategies based on the results of these audits.

- Continued incorporation of MHSIP Outcomes domain language in assessment tools will allow for a better assessment of progress, or lack thereof, by the members of the clinical team and guardians/parents/caregivers.

- CSPs have continued to focus on the accuracy and effectiveness of maintaining highly functioning Electronic Medical Records in order to better track members and their progress while coordinating care with other agencies that may be addressing member care as well.

- CSPs have also created work groups comprised of Clinical and QM staff, who are addressing how to incorporate, identify, communicate and document outcomes with the Child and Family Team. Many CSPs report that though this is a current occurrence the focus on documenting these actions in a way that clearly defines outcomes must be addressed.

- CSPs are creating additional Service Planning Training in hopes of creating more meaningful measures and goals with members. This strategy should directly impact the perception of Outcomes with members.

- CSPs have implemented the Customer Service/Cultural Liaison positions to focus on increasing customer satisfaction.

- CSP's have implemented consumer advisory boards to encourage the consumer voice in efforts to provide the highest quality services to consumers.

- CSPs are also providing training by RSS staff at New Employee Orientation and at CM sites. The training will focus on recovery and strengths-based language. MHSIP outcomes language will be discussed as examples for clinicians to use when engaging members in the discussion of progress.

Magellan identified domains that did not perform well during the 2013 survey and has put in place some activities to improve the scores. To improve the scores in the Youth Outcome, Improved Functioning and Service Access domains for example,

- In October 2013, analysis began to determine the reasons recipients do not feel their services are positively impacting their outcomes began through the existing committee structure as well as a Child Provider Meeting and Workgroup. Two areas were targeted for improvement: 1.) limited feedback delivered to individuals and families regarding the progress towards goals, and 2.) staff members do not consistently focus interactions / services based on the person's goals, preferences and needs. Performance Improvement Plans will be implemented to address these areas. The Clinic Advisory Committees will also be asked to solicit feedback from recipients. The Customer Service Committee will review information and PIP updates on a routine basis and put forward further recommendations.

NARBHA recognizes the opportunity to use the information from the 2013 MHSIP Survey to make system

Improvements, and will participate in statewide initiatives with ADHS/DBHS to continue to improve scores for each domain. Special attention will be placed around the *Outcomes* and *Improved Functioning* domains, which continue to receive the lowest scores from both Adult and Youth surveys.

- As part of their strategy, NARBHA survey outcomes are reported to the Quality Management Committee, the NARBHA Leadership Council, ADHS/DBHS, Responsible Agencies, the NARBHA Board of Directors and all NARBHA staff. Performance Improvement and Quality Management will provide continuous technical assistance throughout the survey process, assisting Responsible Agencies to identify opportunities

to improve the survey process, response rates and results. Targeted technical assistance is provided when there is a substantial decrease in overall results from the prior year

Statewide Improvement Opportunities

ADHS/DBHS recognizes the opportunity to use the information from the 2013 survey results to make system improvements, and will implement statewide initiatives with the RBHAs to continue to improve scores for each domain. Special attention will be placed around the *Outcomes* and *Improved Functioning* domains, which continue to receive the lowest scores from both Adults and Children. DBHS will also carry out a performance improvement project to improve on the number of surveys responses that are returned. A comprehensive plan to re-engineer the consumer survey distribution process includes a review of the time of the year when the surveys are distributed, increase consumer education on the relevance of the survey to systems improvement, and increase monitoring of the use of survey results by all ADHS/DBHS contractors to drive systems improvement.

In addition to general statewide initiatives, RBHA-specific activities are undertaken as part of standard ADHS/DBHS processes, as appropriate. Survey results are shared with the RBHAs, and they are required to respond with analysis of any problem areas, along with plans for improvement. ADHS/DBHS reviews their conclusions and plans, and monitors implementation and progress.

ADHS/DBHS Initiatives

Below are ADHS/DBHS initiatives for both the Children and Adult systems of care that address *Outcomes, Improved Functioning, Service Access* and *Social Connectedness*:

Adult Initiatives:

- The 2013-2014 ADHS/DBHS Adult System of Care (ASOC)-Strategic Plan (SP) establishes goals and objectives for statewide network development priorities in part through a review of State and GSA network analysis, review of data sets, community input, and the identification of best practices efforts that are designed to assist individuals moving through recovery and increasing the quality of life outcomes. The analyses of the ASOC-strategic plan and the 2012 and 2013 Adult and Youth Consumer Survey identified similar priorities. For example:

- An objective in the ASOC-SP is to increase the employment rate for persons with Serious Mental Illness (SMI), General Mental Health (GMH) and Substance Abuse (SA). The Outcomes domain of the Consumer Survey addresses a person's ability to: 1) control his/her life, 2) operate in school, and work environment, and 3) do better in social situations; by achieving the improvement in employment rate in ASOC-SP, ADHS/DBHS expected an increase in the Outcomes domain. However, based on the 2013 survey results, there was a decrease in the *Outcome* domain by two percentage points. ADHS/DBHS will perform a root cause analysis of the drop in scores in the outcome domain and develop a plan with its contractors to improve scores.

- The ASOC-SP includes an objective to increase the percentage of peers and family members satisfied with their access to services which was identified as an area needing improvement in the Consumer Survey Report. Additionally, ASOC-SP includes strategies to conduct statewide discussion on the awareness and community needs around Trauma Informed Care.

System Initiatives:

- ADHS/DBHS, along with family members and recipient input, developed the *Behavioral Health System Performance Framework and Dashboard* as a means to evaluate the effectiveness of the system using standardized measures, such as family and recipient identified outcomes, the National Outcomes Measures (NOMs) and ADHS/DBHS/BQMO performance metrics.

- ADHS/DBHS continues to routinely update its Behavioral Health System Performance Framework and Dashboard, providing transparency, accountability, and increased consumer education regarding ADHS/DBHS performance measures.

- ADHS/DBHS as part of the survey re-engineering process has initiated a plan through the office of Performance Improvement and the Office of Information Management to carryout correlation analyses between the survey results and other appropriate performance measures to identify and utilized any indicators that associate survey results to performance measures.

- ADHS/DBHS has also increase information sharing of survey results and initiatives between departments of the ADHS/DBHS. The Office of Information Management, the Office of Performance Improvement and the Office of Costumer Service have expanded information sharing of survey results. This is in addition to existing collaboration between the office of information management and the Adult System of Care in the use of survey results to drive systems improvement.

Children's Initiatives:

- ADHS/DBHS continues to use the System of Care Practice Review (SOCPR) process developed by the University of South Florida to assess Child and Family Team (CFT) practice for youth and families with complex needs. These intensive case reviews include outcomes-focused questions to ensure CFTs are identifying and tracking outcomes as well as evaluating the effectiveness of provided services and improved functioning. Consumer Survey results are shared with all divisions at DBHS, including the Children's System of Care so the areas needing improvement can be addressed. 180 SOCPR reviews were conducted last year with another 180 scheduled for FY13. There were also more than one thousand Brief Practice Reviews (BPR's) conducted via telephonic interviews with caregivers. The reviews are conducted at the individual provider level and are used to develop annual performance improvement plans. The plans are approved by DBHS and monitored by the RBHA with regular updates provided to DBHS.

- For FY10, ADHS/DBHS earmarked approximately five million dollars of additional funding to the RBHAs to increase the number of case managers with reduced caseloads. During the course of FY10, there was an increase of approximately 104 case managers statewide serving children with complex needs. In total this focused effort has developed approximately 469 case managers statewide as of the end of the FY11 fiscal year. ADHS/DBHS continues to monitor the availability of case managers with reduced caseloads for children with complex needs through the 2013 Fiscal year.

- The continued emphasis on in-home direct support services, as established by the *Meet Me Where I Am (MMWIA)* Campaign, has been a valuable resource to children and families with the most complex needs. These services put direct support workers in homes, schools and communities at the times and for as many hours as necessary to meet the family's needs, leading to improved functioning and better outcomes.

- ADHS/DBHS continues to monitor and promote development of generalist direct support programming through the use of a SE Modifier to track encounter activity and through regular program updates.

ADHS/DBHS continues to promote family and youth involvement in the Children's Behavioral Health System. In partnership with family-run organizations, efforts are focused on building and sustaining an infrastructure and agency culture to support and involve youth and family members at all levels of the system.

III. Conclusion:

Based on ADHS/DBHS evaluation of strategies and activities carried out during FY13, all of the goals were not met. However, areas of improvement were identified and the FY14 work plan has been developed with measurable goals and strategies. ADHS/DBHS will be able to

measure the effectiveness of implementation strategies that were identified in the FY14 work plan.

ADHS/DBHS successfully incorporated member and family input into the QM program by regularly reviewing member complaint and QOC data in the QM Committee. The ADHS/DBHS OQOC developed a standardized report template for complaint analysis and included it in the BQI Specification Manual to further strengthen the use of this data in RBHA QM programs.

ADHS/DBHS also incorporated member and family input into the QM process by administering the Annual Consumer Survey for adults and families of children receiving behavioral health services. FY 2013 ADHS/DBHS Annual Consumer Survey Results will be submitted to AHCCCS on 01/06/2014.

Arizona Department of Health Services
Division of Behavioral Health Services
Quality Management Work Plan:
Behavioral Health
Integration
October 1, 2013 – September 30, 2014

Goal	Strategy/Objective	Action Items	Responsible Party	Start Date	End Date	Quarterly Updates
Goal 1. Performance Measures: Behavioral Health a) Inpatient Utilization (behavioral health-related primary diagnosis) *(days/1,000)* **AHCCCS MPS: 480** **AHCCCS Goal: 430** b) Emergency Department (ED) Utilization (behavioral health-related primary diagnosis) *(visits/1,000)* **AHCCCS MPS: 1405** **AHCCCS Goal: 1265** c) Hospital Readmissions (behavioral health-related primary diagnosis) *(within 30 days of discharge)* **AHCCCS MPS: 0.93** **AHCCCS Goal: 0.81** d) Follow-Up After Hospitalization (within 7 days) (behavioral health-related primary diagnosis) **AHCCCS MPS: 50%** **AHCCCS Goal: 80%**	**Strategy - Performance Measures: Behavioral Health** ADHS/DBHS will work with the RBHAs regarding the 8 new and 2 revised PMs during this first year. ADHS/DBHS will continually monitor these PMs and: 1. Collaborate with cross-functional Offices/areas such as MM/UM, MCH/EPSDT/Dental to discuss results and strategize focused TA. 2. Provide TA as necessary regarding methodology, monitoring, and quarterly reports. 3. Review results and progress during the QM Committee to obtain cross-functional guidance. 4. Collaborate with the BIS and OIM to drill down and analyze encounter data to assist RBHAs in meeting MPS with the use of data specific to each RBHAs unique circumstances 5. Collaborate with AHCCCS at the end of FY14 to review PM results and discuss potential need to adjust	• After receipt of data from BIS, OPI and OIM will conduct further analysis to identify trends per quarter. • ADHS/DBHS will conduct TA as indicated to assist the RBHA in barrier identification and effective interventions. • RBHAs will be required to submit Quarterly Reports detailing PM results, barriers, trends, monitoring activities, and actions taken to improve results. • ADHS/DBHS will collate individual RBHA Quarterly Report submissions, and submit a final Quarterly Report to AHCCCS.	Office of Performance Improvement (OPI)/Office of Medical Management /Utilization Management (MM/ UM)/ Maternal Child/EPSDT/Dental Coordinator (MCH/ EPSDT)/ Office of Business Information (BIS)/Office of Information Management (OIM)	10/01/13	9/30/14	

Goal	Strategy/Objective	Action Items	Responsible Party	Start Date	End Date	Quarterly Updates
e) Follow-Up After Hospitalization (within 30 days) (behavioral health-related primary diagnosis) **AHCCCS MPS: 70%** **AHCCCS Goal: 90%**	MPS which ***may*** result in: ➢ Adjusting the methodology for the PM ➢ Adjusting the MPS and Goal for the measure					
f) Access to Behavioral Health Provider (encounter for a visit) within 7 days of being designated as "active care" for an initial visit **AHCCCS MPS: 75%** **AHCCCS Goal: 90%** g) Access to Behavioral Health Provider (encounter for a visit) within 23 days of being designated as "active care" for an initial visit **AHCCCS MPS: 90%** **AHCCCS Goal: 95%**	**(f & g) Strategies:** ADHS/DBHS will: 1. Collaborate with the BIS and OIM regarding ATC encounter data 2. RBHA QM Coordinators to investigate registering all licensed independent BH providers with AHCCCS 3. Collaborate with AHCCCS at the end of FY14 to review PM results and discuss: o Potential need to adjust MPS which ***may*** result in: ➢ Adjusting the methodology for the PM ➢ Adjusting the MPS and Goal for the measure	**(f & g) Action Items**: • ADHS/DBHS will drill down and analyze encounter data to determine common codes RBHAs use for ATC and whether they are captured in the methodology • Collaborate with the RBHA QM Coordinators to urge all licensed independent BH providers to register with AHCCCS so that BHP codes can be used on encounters	OPI/BIS/OIM/ RBHA QM Coordinators	10/01/13	9/30/14	
h) EPSDT Participation (18-20 year olds) **AHCCCS MPS: 68%** **AHCCCS Goal: 80%**	h) Per discussion with AHCCCS, codes used to calculate the EPSDT Participation rate are Acute Care Medical codes not used by RBHA providers	h) DBHS/OPI will continue to collaborate with the RBHA QM Coordinators to encourage the BH Providers to remind parents/guardians of the importance of making and attending EPSDT mandated appointments.	OPI/RBHA QM Coordinators	10/01/13	9/30/14	

Goal	Strategy/Objective	Action Items	Responsible Party	Start Date	End Date	Quarterly Updates
i) Behavioral Health Service Plan – revised measure **MPS: 85%** **Goal: 90%** j) Behavioral Health Service Provision – revised measure **MPS: 85%** **Goal: 90%**	i & j The methodology for the BHSP and BHSPv measures from CY13 were modified. Thus the **Strategy/Objective** is to ensure that: o The BHSP PM is accurately and effectively monitoring the completion of the BHSP o The service plans clearly identify BH services needed o The services identified as necessary in the BHSP are actually provided to BH recipients (BHRs)	i) • Review a 90/10 quarterly sample of BHSPs that is representative of the ADHS/DBHS populations served by the T/RBHAs (i.e. SMI, GMH/SA, DDD, CDP) • .Monitor BHSPs for required elements including but not limited to: o BHSPs that are signed, dated, and co-signed by a BHP if necessary o BHSPs that use codes and/or language for services provided in the BH Covered Services Guide j) • Collaborate with Consultant and/or OIM to update BHSPv database to include codes and/or language for services provided in the BH Covered Services Guide • Update BHSPv database to include sections for: inter-rater reliability, consultation with peers, comments	OPI/OIM	10/01/13	9/30/14	
Performance Measures: Integration (anticipated implementation date: April 01, 2014) a) Inpatient Utilization (*days/1,000*) **AHCCCS MPS: 480** **AHCCCS Goal: 430** b) Emergency Department (ED) Utilization (*visits/1,000*) **AHCCCS MPS: 1405** **AHCCCS Goal: 1265** c) Hospital Readmissions (*within 30 days of discharge*) **AHCCCS MPS: 0.85** **AHCCCS Goal: 0.81**	**Strategies for Integrated SMI RBHA PMs** ADHS/DBHS will work closely with the new Integrated SMI RBHA regarding the 24 AHCCCS, and 2 DBHS PMs during this first year. ADHS/DBHS will continually monitor all PMs and: 1. Collaborate with cross-functional Offices/areas such as MM/UM, MCH/EPSDT/Dental to discuss results and strategize focused TA. 2. Provide TA as necessary regarding methodology, monitoring, and quarterly reports.	• After receipt of data from BIS, OPI and OIM will conduct further analysis to identify trends per quarter. • ADHS/DBHS will conduct TA as indicated to assist the RBHA in barrier identification and effective interventions.	Office of Performance Improvement (OPI)/Office of Medical Management /Utilization Management(MM/ UM)/ Maternal Child/EPSDT/Dental Coordinator (MCH/ EPSDT)/ Office of Business Information	TBD	TBD	

Goal	Strategy/Objective	Action Items	Responsible Party	Start Date	End Date	Quarterly Updates
d) Follow-up After Hospitalization (all cause) within 7 Days **AHCCCS MPS: 50%** **AHCCCS Goal: 80%** e) Follow-up After Hospitalization (all cause) within 30 Days **AHCCCS MPS: 70%** **AHCCCS Goal: 90%** f) Access to PCP **AHCCCS MPS: 75%** **AHCCCS Goal: 90%**	3. Review results and progress during the QM Committee to obtain cross-functional guidance. 4. Collaborate with the BIS and OIM to drill down and analyze encounter data to assist Integrated SMI RBHA in meeting MPS	• Integrated SMI RBHA will be required to submit Quarterly Reports detailing PM results, barriers, trends, monitoring activities, and actions taken to improve results. • ADHS/DBHS will submit an Integrated SMI RBHA Quarterly PM Report to AHCCCS. Annual review of PMs with AHCCCS so that changes can be made to MPS and/or PMS as necessary to assure that ADHS/DBHS is capturing the appropriate information needed to improve performance	(BIS)/Office of Information Management (OIM)			
g) Access to Behavioral Health Provider (encounter for a visit) within 7 days of being designated as "active care" for an initial visit **AHCCCS MPS: 75%** **AHCCCS Goal: 85%** h) Access to Behavioral Health Provider (encounter for a visit) within 23 days of being designated as "active care" for an initial visit **AHCCCS MPS: 90%** **AHCCCS Goal: 95%**	**(g & h) Strategies:** ADHS/DBHS will: 1. Collaborate with the BIS and OIM regarding ATC encounter data. 2. Collaborate with AHCCCS at the end of FY14 to review PM results and discuss: o Potential need to adjust MPS which may result in: ➢ Adjusting the methodology for the PM ➢ Adjusting the MPS and Goal for the measure 3. Per discussion with AHCCCS, codes used to calculate the EPSDT Participation rate are Acute Care Medical codes not used by RBHA providers	**(g & h) Action Items:** • ADHS/DBHS will drill down and analyze encounter data to determine whether the ATC PM as it is written will be problematic to the Integrated SMI RBHA as it is anticipated by the RBHAs to be. • ADHS/DBHS will review encounter data to determine whether there are differences meeting this PM for co-located providers versus separate Acute and BH Provider offices. • ADHS/DBHS will determine what codes are commonly used by the Integrated SMI RBHA use for ATC and whether they are captured in the methodology. • ADHS/DBHS will collaborate with the Integrated SMI RBHA QM Coordinator to urge all licensed independent BH providers to register with AHCCCS so that BHP codes can be used on encounters	OPI/BIS/OIM			

Goal	Strategy/Objective	Action Items	Responsible Party	Start Date	End Date	Quarterly Updates
Comprehensive Diabetes Management: i) HbA1c Testing **AHCCCS MPS: 77%** **AHCCCS Goal: 89%** j) LDL-C Screening **AHCCCS MPS: 70%** **AHCCCS Goal: 91%** k) Eye Exam **AHCCCS MPS: 49%** **AHCCCS Goal: 68%** l) Diabetes Admissions, short-term complications **AHCCCS MPS: TBD** **AHCCCS Goal: TBD** ***Asthma:*** m) Adult asthma Admission Rate **AHCCCS MPS: TBD** **AHCCCS Goal: TBD** n) Use of Appropriate Medications for People with Asthma **AHCCCS MPS: 68%** **AHCCCS Goal: 93%** ***Flu Shots for Adults*** o) Ages 50-64 **AHCCCS MPS: 75%** **AHCCCS Goal: 90%**	**Strategy: Diabetes Management, Asthma, Flu Shots for Adults, Chronic Obstructive Pulmonary Admissions, Congestive Heart Failure Admissions, HIV/AIDS Medical Visits** 1) Establish a baseline for the acute medical performance measures 2) Monitor progress 3) Provide TA as needed 4) Review results in QM Committee Meeting 5) Determine effectiveness of interventions used by Integrated SMI RBHA to address PMs	**Actions: Diabetes Management, Asthma, Flu Shots for Adults, Chronic Obstructive Pulmonary Admissions, Congestive Heart Failure Admissions, HIV/AIDS Medical Visits** • Complete hiring process for Performance Improvement Specialist – Integration. • PI Integration Specialist to: o develop monitoring tools Acute Medical PMs o collaborate with Integrated SMI RBHA regarding Best Practices related to successful interventions: ➢ Disease Care and Case Management Programs ➢ Provider education ➢ Provision of clinical tools to PCP offices ➢ Work with BH Providers re: prevalence of diabetes, asthma, COPD, and CHF among BHRs diagnosed with SMI due to medications, life style, social, environmental conditions.	OPI/Performance Improvement Specialist – Integration/OIM			

Goal	Strategy/Objective	Action Items	Responsible Party	Start Date	End Date	Quarterly Updates
p) Ages 65+ **AHCCCS MPS: 75%** **AHCCCS Goal: 90%** q) Annual monitoring for patients on persistent medications: Combo Rate **PHASED IMPLEMENTATION – TABLED FOR CYE 14** r) Chronic obstructive pulmonary disease admissions **AHCCCS MPS: TBD** **AHCCCS Goal: TBD** s) Congestive heart failure admissions **AHCCCS MPS: TBD** **AHCCCS Goal: TBD** t) HIV/AIDS: Medical visit **AHCCCS MPS: 75%** **AHCCCS Goal: 90%** u) Timeliness of prenatal care — prenatal care visit in the first trimester or within 42 days of enrollment **AHCCCS MPS: 80%** **AHCCCS Goal: 90%**	Collaborate with ADHS/DBHS Maternal Child/EPSDT/Dental Coordinator.	*Timeliness of Prenatal Care (1st prenatal care visit in the first trimester or within 42 days of enrollment)* • ADHS/DBHS will collect and monitor the GSA 6 Integrated RBHA data and analyze for trends ADHS/DBHS will monitor GSA 6 Integrated RBHA deliveries using the DBHS Monthly Pregnancy and Delivery report and claim/encounter data and analyze for trends • Continue to monitor to determine if meeting MPS and goals	OPI/MCH/EPSDT/ Dental Coordinator			

Goal	Strategy/Objective	Action Items	Responsible Party	Start Date	End Date	Quarterly Updates
v) Postpartum Care Rate **AHCCCS MPS: 64%** **AHCCCS Goal: 90%**		*Postpartum Care Rate (postpartum visit within 60 days of delivery)* • ADHS/DBHS will collect and monitor the GSA 6 Integrated RBHA data and analyze for trends • ADHS/DBHS will monitor GSA 6 Integrated RBHA deliveries using the DBHS Monthly Pregnancy and Delivery report and claim/encounter data and analyze for trends • Continue to monitor to determine if meeting MPS and goals				
w) EPSDT Participation, members aged 18 to 21 **AHCCCS MPS: 68%** **AHCCCS Goal: 80%**		*EPSDT participation rate:* • ADHS/DBHS will collect and monitor the GSA 6 Integrated RBHA EPSDT claims encounter data EPSDT tracking form data and analyze for trends • ADHS/DBHS will collect and monitor the GSA 6 Integrated RBHA EPSDT appointment reminder notification activity data and analyze for trends • Establish MPS and Goals based on analysis • Continue to monitor to determine if meeting MPS and goals- Chart audit and Administrative review	OPI/MCH/EPSDT/ Dental Coordinator			
x) CAHPS Health Plan Survey v 4.0 - Adult Questionnaire with Supplemental Items	Results from the CAHPS survey will not be used as an official PM rate; rather, AHCCCS will meet with contractors following receipt of survey results to discuss and plan future interventions, which may include opportunities to sustain positive feedback or Corrective Action Plans in areas of lower satisfaction.					

Goal	Strategy/Objective	Action Items	Responsible Party	Start Date	End Date	Quarterly Updates
y) Behavioral Health Service Plan **MPS: 85%** **Goal: 90%** z) Behavioral Health Service Provision **MPS: 85%** **Goal: 90%**	y & z) **Strategy/Objective** is to ensure that: • The BHSP PM is accurately and effectively monitoring the completion of the BHSP • The service plans clearly identify BH services needed • The services identified as necessary in the BHSP are actually provided to BH recipients (BHRs)	y) • Review a 90/10 quarterly sample of BHSPs that is representative of the ADHS/DBHS populations served by the T/RBHAs (i.e. SMI, GMH/SA, DDD, CDP) • Monitor BHSPs for required elements including but not limited to: o BHSPs that are signed, dated, and co-signed by a BHP if necessary o BHSPs that use codes and/or language for services provided in the BH Covered Services Guide z) • Collaborate with Consultant and/or OIM to update BHSPv database to include codes and/or language for services provided in the BH Covered Services Guide • Update BHSPv database to include sections for: inter-rater reliability, consultation with peers, comments				
Goal 2. Quality of Care Investigations: Behavioral Health and Integrated Care During FY2014, ADHS/DBHS will increase the timely completion of T/RBHA-submitted Quality of Care Resolution Reports over the baseline measurement of compliance with the AHCCCS-mandated 30-day timeline.	**Strategy:** • Establish baseline measurement of QOC compliance with 30-day timeline for all T/RBHAs and Statewide • Establish T/RBHA-specific targets for timeliness based on initial baseline measurement of compliance • Establish Statewide Minimum Performance Standard (MPS) for Resolution Report timeliness.	**<u>Quality of Care Investigations:</u>** • DBHS Quality of Care (QOC) staff will monitor T/RBHA timeliness of Resolution Report submissions • QOC staff will: • provide technical assistance to T/RBHA QOC staff regarding timeliness of Resolution Report submissions • present quarterly results of Resolution Report timeliness to the DBHS QM Committee and RBHA QM Coordinators Meeting • ADHS/DBHS OQOC will issue Corrective Action Plans to T/RBHAs not submitting Resolution Reports within established timeframes for two consecutive months.	Office of Quality of Care	10/01/13	9/30/14	

Goal	Strategy/Objective	Action Items	Responsible Party	Start Date	End Date	Quarterly Updates
Goal 3. AHCCCS-DBHS Current Mandated Collaborative Performance Improvement Projects (PIP): The ultimate goal of this Performance Improvement Project (PIP) is to improve coordination of care provided to AHCCCS members who are receiving both medical and behavioral health services through the exchange of opiate and benzodiazepine prescribing and other clinical information between medical and behavioral health providers, in order to reduce morbidity and/or mortality among these members.	**Strategy:** During FY 2014, ADHS/DBHS to assist COC workgroup to: • Create and coordinate collaborative workgroups between Acute Health Plans and Regional Behavioral Health Authorities • Provide accommodation to PIP large group monthly meetings • Provide Technical Assistance to the PIP collaborative groups on the use of Continuous Quality Improvement Techniques and Tools to ensure adherence to sound PIP methodology	**COC-PIP** - Identify areas of collaboration between Acute Health plans and RBHAs and initiate workgroups as needed - Coordinate workgroups consisting of Acute Health Plans and RBHAs - ADHS/DBHS continue to host meetings between AHCCCS Health Plans and ADHS/DBHS RBHAs and the COC workgroup to facilitate dialogues on the development of Risk Criteria. - ADHS/DBHS will assist in the coordination of the implementation of interventions determined by the PIP. - ADHS will foster the development of project timelines, the use of the PDSA model and other performance improvement tools.	PIP Coordinator /Office of Performance Improvement	10/01/13	9/30/14	
Goal 4. AHCCCS-DBHS Current Mandated 30 Readmissions Performance Improvement Projects (PIP): The purpose of this Performance Improvement Project is to decrease the rate of inpatient readmissions among AHCCCS members within 30 days of a previous discharge, in order to improve quality of life, promote patient-centered care, and reduce unnecessary health care utilization and costs.	**Strategy:** • Use of the Balanced Score Card to integrate and coordinate contractors interventions to achieve statewide improvement in readmission rates • Use of the FOCUS-PDSA Model to ensure an effective use of the PDSA model in the PIP process	- Develop a strategy plan to integrate interventions from all four RBHAs into a holistic strategic plan to achieve statewide improvement - Review and work with contractor to design interventions that are consistent with statewide strategic plan - Mandate each contractor to perform Root Cause Analyses to their specific barriers to Readmission rates	PIP Coordinator/Office of Performance Improvement	10/01/13	9/30/14	

Goal	Strategy/Objective	Action Items	Responsible Party	Start Date	End Date	Quarterly Updates
◦ The goal is to demonstrate a statistically significant reduction for inpatient readmissions and sustain this reduction for one year.	• Ensure the use of inter-rater reliability to guarantee consistency where more than one person is involved in collecting data. • Use of workgroups for problem-solving and task completion	◦ Require each contractor to provide a plan showing steps and strategies for implementing their interventions to ensure the effective use of the PDSA model ◦ Provide Technical Assistance to contractors on the development and use of inter-rater reliability tools ◦ Require every contractor to develop a policy and process for inter-rater reliability				
Goal 5. Annual Consumer Survey: The goal of the Annual Consumer Survey is to request independent feedback from Title XIX/XXI adults and families of youth receiving services through Arizona's publicly funded behavioral health system. The surveys measure consumers' perceptions of behavioral health services in relation to six domains. The objective is to use the Annual Consumer Survey as a critical source of information to drive system improvements through RBHA contracts and QM Plans	**Strategy:** • Re-design the consumer survey process to improve on the quality of data obtained from through adequate response rates • Establish collaborative between ADHS/DBHS offices to share and utilize survey results for systems improvements • Glean valuable information from survey results the detail analyzes	◦ Initiate and encourage contractors to use small workgroups for brainstorming and problem solving ◦ Encourage the use of work plans and work breakdown structures to facilitate implementation of interventions ◦ Evaluate survey results to identify performance gaps. ◦ Initiate and coordinate workgroups with contractors to brainstorm and implement interventions to improve survey process ◦ Initiate and coordinate discussion groups within between offices within the ADHS/DBHS on the relevance of consumer survey results. ◦ Complete a process map of current survey process to identify redundancies and opportunities for improvement ◦ Initiate discussions with the contractors to identify barriers and decide on intervention strategies ◦ Share analyses of survey results with other departments to encourage shared understanding and use of survey results ◦ Perform correlation studies between survey results and appropriate performance measures to improve health outcomes.	PIP Coordinator/Office of Information Management	10/01/13	9/30/14	

Goal	Strategy/Objective	Action Items	Responsible Party	Start Date	End Date	Quarterly Updates
Goal 6. Oversight and Monitoring ADHS/DBHS will improve the service delivery system for behavioral health recipients.	**Strategy:** • ADHS/DBHS will conduct a mid-year site visit and an annual Administrative Review to monitor and oversee RBHA: • Provider Monitoring • Quality of Care • Peer Review • Credentialing • Medical Record Review	**Oversight and Monitoring** • ADHS/DBHS will verify that each RBHA's Annual QM Plan includes sufficient details about the provider monitoring activities by: • Reviewing and approving RBHA Annual QM Plans • Evaluating the activities related to provider monitoring • Providing T/A to RBHAs with insufficient provider monitoring plans. • ADHS/DBHS will validate RBHA adherence to the Provider Monitoring plan by: • Conducting data validation activities during which the RBHA's provider monitoring activities will be reviewed • Reviewing the RBHA's calendar of site visits • Verifying that TA was provided • Reviewing all CAPs issued (if any) and following up on CAP monitoring • Validating data for Coordination of Care performance measures • Requiring a CAP or issuing a warning if a RBHA is found non-compliant with its Provider monitoring plan. • Presenting data validation results to the QM committee for discussion and recommendations. • ADHS/DBHS will adhere to Quality of Care Review requirements in accordance with AHCCCS AMPM and the ADHS/DBHS QOC Policy (QM 2.7) by : • Conducting regular Peer Review meetings with Chief Medical Officer, Deputy Chief Medical Officer, and DBHS QOC team staff basis to ensure consistent review of QOC investigation findings, corrective actions, and recommendations.	Office of Quality of Care/Office of Performance Improvement	10/01/13	9/30/14	

Goal	Strategy/Objective	Action Items	Responsible Party	Start Date	End Date	Quarterly Updates

		• Monitoring all Incident, Accident, and Death Reports received from each RBHA
		  • Investigating all unknown deaths and suicide Deaths
		  • Investigating all questionable incidents an accidents reported by RBHAs
		• Monitoring each RBHA's tracking and trending of QOC concerns and QOC corrective action plans during semi-annual on-site oversight and monitoring.
		• Providing oversight of each RBHA's QOC policy and QOC process.
		• Conducting focused reviews of QOC cases that previously resulted in a CAP
		• Presenting oversight and monitoring results to the ADHS/DBHS QM Committee Meeting for discussion and recommendations
		
		ADHS/DBHS will ensure RBHA's compliance with **Peer Review** requirements by:
		• Reviewing policies and protocols
		• Reviewing Committee agendas to ensure that Peer Review meetings are held, at a minimum, on a quarterly basis
		• Reviewing the sign-in/Confidentiality Statement to ensure there is no breach in confidentiality,
		• Verifying that meeting minutes are signed and approved by the RBHA Chief Medical Officer
		
		ADHS/DBHS will conduct an Annual Administrative Review of the RBHA to assess **Credentialing** processes by:
		• Reviewing policies and protocols
		• Validating a sample of RBHA provisional, organizational and individual credentialing and re-credentialing records.				

Goal	Strategy/Objective	Action Items	Responsible Party	Start Date	End Date	Quarterly Updates
		ADHS/DBHS will conduct an Annual Administrative Review of the RBHA to assess the Medical Record Review process by: • Reviewing policies and protocols, Reviewing the RBHA Medical Record Review tool • Validating a sample of RBHA reviewed Medical Records				
Goal 7. Performance Framework and Dashboard The BQ&I through the Office of Information Management (OIM) will continue to prepare and present Dashboard QM measures to the Quality Management Committee for review and approval. OIM will maintain Dashboard discussions in Leadership Team meetings to assess the effectiveness of the System. Update the Dashboard quarterly to reflect updates on the QM measures from the QM and UM/MM committees	• Initiate Dashboard discussion Meetings to review updates to the Dashboard, obtain feedback on the impact of the Dashboard and implement initiatives to continuously improve on the Dashboard. • Include Dashboard QM measure in the agenda of leadership meetings.	• Dashboard discussion will be included the QM and UM/MM Committee. • OIM will plan and lead discussions on the Dashboard with other Offices of the BQ&I	Office of Information Management/Office of Performance Improvement	10/01/13	09/01/14	

EXHIBIT 910-1

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT PROGRAM CHECKLIST

EXHIBIT 910-1

QM/PI Plan Checklist

Contractor: Click here to enter text.

Acute ☐ ALTCS ☐ First Round ☐ Second Round ☐

BBA AND AMPM SECTION	CHAPTER 900 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI)	LOCATION, PAGE # & PARAGRAPH	ACCEPTED	EXPLANATION IF NOT ACCEPTED
	PROGRAM EVALUATION			
Instructions: The Contractor must formally evaluation and document the effectiveness of the QM/PI Program strategy and activities. This QM/PI Program Evaluation must be done at least annually and include the following:				
BBA: 438.240(e)(1)(i) BBA: 438.240(e)(2) AMPM: 910-C-1-k	1. An evaluation of the previous year's activities must be submitted as part of the QM/PI Plan after review by the Contractor's governing or policy making body.		☐	
BBA: n/a AMPM: 910-C-1-a,b,c,d, f	2. Summary of all QM/PI Activities: a. Title/name of each activity b. Measurable goals and/or objective(s) related to each activity c. Contractor departments or units and staff positions involved in QM/PI activities d. Description of communications and feedback related to QM/PI data and activities e. Action to be taken for improvement - Corrective Action Plan (CAP)		☐	
BBA: n/a AMPM: 910-C-g	3. Documentation of continued monitoring to evaluate the effectiveness of the actions of interventions and other follow-up activities.		☐	
BBA: n/a AMPM: 910-C-e	4. An evaluation of outcomes utilizing qualitative data, including a statement describing if goals/objectives were met completely, partially or not at all.		☐	
BBA: n/a AMPM: 900-1-c	5. Trends identified through QM/PI activities and resulting actions taken for improvement.		☐	
BBA: n/a AMPM: 910-C-1-h	6. Rationale for changes in the scope of the QM/PI Program and Plan (and when reported to AHCCCS). If no changes were made, include a statement that no changes were made.		☐	
BBA: n/a AMPM: 910-C-1-j	7. Review, evaluation and approval by the QM/PI Committee of any changes to the QM/PI Plan. If no changes were made, include a statement that no changes were made.		☐	
BBA: n/a AMPM: 910-C-1-i	8. Necessary follow-up with targeted timelines for revisions made to the QM/PI Plan. If no changes were made, include a statement that no changes were made.		☐	
	WORK PLAN			
Instructions: The Contractor must develop an annual work plan that supports the Contractor's QM/PI goals and objectives. This Work Plan must be submitted with the QM/PI Plan and must include the following:				
BBA: n/a AMPM: 910-B-1 AMPM: 920-A-2-a	9. A description of all planned activities/tasks for both clinical care and other covered services.		☐	

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BBA: n/a AMPM: 910-B-2 AMPM: 920-A-2-b	10. Targeted implementation and completion dates for QM measurable objectives, activities and PI projects.		☐	
BBA: n/a AMPM: 910-B-3 AMPM: 920-A-2-c	11. Methodologies to accomplish measurable goals and objectives.		☐	
BBA: n/a AMPM: 910-B-4 AMPM: 920-A-2-d	12. The inclusion of behavioral health goals and objectives.		☐	
BBA: n/a AMPM: 910-B-5 AMPM: 920-A-2-e	13. Staff positions responsible and accountable for meeting established goals and objectives.		☐	
BBA: n/a AMPM: 920-C-1-(a-b)	14. A description of how the Contractor will develop work plans for taking appropriate actions to improve care if problems are identified. This description must specify: a. the types of problems that require correction action b. the person or body responsible for making the final determination regarding quality issues.		☐	
BBA: n/a AMPM: 920-C-1-c-(i-vi)	15. The work plan must include a description of member/provider action(s) to be taken: education, technical assistance, monitoring, evaluation, change in processes, counseling, termination, referrals, etc. (If an adverse action is taken with a provider due to a quality of care concern, the Contractor must report the adverse action to the AHCCCS Clinical Quality Management Unit).		☐	
BBA: n/a AMPM: 920-C-1-d	16. Work plan must include documentation of the assessment and effectiveness of actions taken.		☐	
	PROGRAM DESCRIPTION			
Instructions: The Contractor must develop a written QM/PI Plan that addresses the Contractor's proposed methodology to meet or exceed the standards and requirements of AMPM Chapter 900. The Program Scope must be comprehensive and demonstrate how the Contractor's activities will improve the quality of services and the continuum of care in all service sites. The QM/PI Plan must be in paginated detail and include the following: *Note: If the descriptions and processes are only included in referenced QM/PI Plan policies, please include the policies.				
BBA: n/a AMPM: 910-A AMPM: 920-B-2	17. Description of how program activities will improve the quality of care and service delivery for enrolled members.		☐	
BBA: 438.202(b) AMPM: 900-5	18. A description of how the QM/QI Program must include input from employed or affiliated providers and consumers (BBA requirement).		☐	
BBA: n/a AMPM: 910-A-1-a	19. A description of how the Contractor will ensure ongoing communication and collaboration between the QM/PI Program and the other functional areas of the organization (such as, but not unlimited to: medical management, behavioral health, member services and case management).		☐	
BBA: n/a AMPM: 910-A-1	20. The Contractor's QM/PI Program must be administered through a clear and appropriate administrative structure. The governing or policy-making		☐	

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	body must oversee and be accountable for the QM/PI program.			
BBA: n/a AMPM: 910-A-1-b	21. The roles and responsibilities of the governing body or policy making body, the Medical Director, the QM/PI Committee, the Contractors executive management and the QM/PI Program staff.		☐	
BBA: n/a AMPM: 910-A-1-c	22. An organizational chart that delineates the reporting channels for QM/PI activities and the relationship to the Contractor Medical Director and Executive Management.		☐	
BBA: n/a AMPM: 910-A-2-a-(i-v)	23. The membership for the Contractor's QM/PI Committee which must include, at a minimum the: a. Medical Director, or the Associate Medical Director when the Medical Director is unable to attend, as the chairperson of the Committee b. QM/PI Manager c. representation from the functional areas within the organization d. representation of contracted or affiliated providers serving AHCCCS members e. appropriate clinical representatives.		☐	
BBA: n/a AMPM: 910-A-2-b	24. A description of how the Medical Director is responsible for implementation of the QM/PI Plan and how he/she has substantial involvement in the assessment and improvement of QM/PI activities.		☐	
BBA: n/a AMPM: 910-A-2-d	25. The Contract must have an identifiable, structured QM/PI Committee that is responsible of QM/PI functions and responsibilities. There must be a description of how often the QM/PI Committee will meet. The Committee must meet quarterly or more frequently		☐	
BBA: n/a AMPM: 910-A-2-e	26. A description of how the QM/PI Committee will review the QM/PI Program objectives, policies, and procedures at least annually and modify or update them as necessary.		☐	
BBA: n/a AMPM: 910-A-2-f	27. A description of how the QM/PI Committee will develop procedures for QM/PI responsibilities and the processes of how each QM/PI function and activity will be clearly documented.		☐	
BBA: n/a AMPM: 910-A-2-g	28. A description of how the QM/PI Committee will develop and implement procedures to ensure that Contractor staff and providers are informed of the most current QM/PI requirements, policies, and procedures.		☐	
BBA: n/a AMPM: 910-A-2-h	29. A description of how the QM/PI Committee will develop and implement procedures to ensure that providers are informed of information related to their performance such as results of studies, AHCCCS Performance Measures, profiling data, medical record review results.		☐	
BBA: n/a AMPM: 910-A-3	30. A description of the Contractor's peer review process of which the purpose is to improve the quality of medical care provided to members by practitioners and providers.		☐	

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BBA: n/a AMPM: 910-A-3-k	31. A description of how the peer review process is used to analyze and address clinical issues.		☐	
BBA: n/a AMPM: 910-A-4-e	32. A process to ensure that staff having contact with members or providers such case managers, customer service, provider relations, and Behavioral Health Coordinators are trained on how to refer suspected quality of care issues to quality management. This training must be provided during new employee orientation and annually thereafter.		☐	
BBA: n/a AMPM: 920-B-3	33. A description of how information and data gleaned from QM monitoring and evaluation that shows trends in quality of care issues may be used in developing PI projects.		☐	
BBA: n/a AMPM: 920-C-1-(e-f)	34. Detailed methods for internal dissemination of findings and resulting work plans to appropriate staff and/or network providers, and methods of dissemination of pertinent information to AHCCCS Administration and/or regulatory boards and agencies.		☐	
BBA: n/a AMPM: 910-A-5	35. A description of how delegated activities are integrated into the overall QM/PI program and the methodologies for oversight and accountability of all delegated functions.		☐	
BBA: n/a AMPM: 960-D-2	36. A description of the process by which the delegated entity or subcontractor reports incidences of healthcare acquired conditions, abuse, neglect, exploitation, injuries, and unexpected death to the Contractor.		☐	
BBA: n/a AMPM: 910-A-5-b	37. A description of how the Contractor will include information from delegated entities for purposes of tracking, trending, reporting, process improvement, and re-credentialing.		☐	
BBA: n/a AMPM: 910-A-5-c	38. A description of how the Contractor will evaluate an entity's ability to perform the delegated activities prior to delegation.		☐	
BBA: n/a AMPM: 910-A-5-e-(i-iii)	39. A process to review and monitor the performance of the entity and the quality of services provided on an ongoing basis and a formal review as least annually. Monitoring should include but is not limited to utilization, member/provider satisfaction and quality of care/service concerns.		☐	
BBA: n/a AMPM: 910-A-6-a	40. A description of the Contractor's method(s) for monitoring and evaluating its service delivery system and provider network.		☐	
BBA: n/a AMPM: 910-A-6-d	41. A description of the Contractor's initial credentialing process for individual providers.		☐	
BBA: n/a AMPM: 910-A-6-d	42. A description of the Contractor's re-credentialing process for individual providers.		☐	
BBA: n/a AMPM: 950-B	43. Providers who are not licensed or certified must be included in the credentialing process and profiled.		☐	
BBA: n/a AMPM: 910-A-6-d	44. A description of the Contractor's initial assessment of organizational providers contracted with the Contractor.		☐	
BBA: n/a AMPM: 910-A-6-d	45. A description of the Contractor's initial re-assessment of organizational providers contracted with the Contractor.		☐	

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BBA: n/a AMPM: 910-A-6-d AMPM: 950-D	46. A description of the Contractor's temporary/provisional credentialing process for individual providers. Contractor's must have polices and procedure to address granting of temporary/provisional credentials when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process.		☐	
BBA: n/a AMPM: 950-B-3	47. If the Contractor delegates to another entity any of the responsibilities of credentialing/re-credentialing or selection of providers that are required by this Chapter, it must retain the right to approve, suspend or terminate any provider selected by that entity.		☐	
BBA: n/a AMPA: 950-B-3	48. The QM/PI committee or other peer review body is responsible for over-site regarding delegated credentialing or re-credentialing decisions.		☐	
BBA: n/a AMPM: 950-B-4-a	49. Policies must reflect the direct responsibility of the Medical Director (or designee) for the oversight of the process and delineate the role of the credentialing committee.		☐	
BBA: n/a AMPM: 950-B-4-b	50. Written policies must indicate the utilization of participating Arizona Medicaid network providers in making credentialing decisions.		☐	
BBA: n/a AMPM: 950-D	51. The Contractor must follow the primary source verification process of initial credentialing when granting temporary/provisional credentialing. Providers working in a Federally Qualified Health Center (FQHC) – or look-a-like, as well as hospital employed physicians, must be credentialed using the temporary/provisional credentialing process.		☐	
BBA: n/a AMPM 950-D	52. The Contractor must review and approve that provider through the credentialing committee. The contractor must render a decision regarding temporary/provisional credentialing within 14 calendar days from receipt of a complete application.		☐	
BBA: n/a AMPM: 950-F	53. Description of the process used by the Contractor that ensures that, prior to contracting and credentialing, the subcontractor or delegated entity has established policies and procedures that meet AHCCCS requirements.		☐	
BBA: n/a AMPM: 960-A	54. Each Contractor must develop policies and procedures for reviewing, evaluating and resolving issues raised by enrolled members and contracted providers. All issues must be addressed regardless of source (external or internal).		☐	
BBA: n/a AMPM: 960-B-1	55. There must be documentation of each concern raised, when and from whom it was received and the projected time frame for resolution.		☐	
BBA: n/a AMPM: 960-B-2-(a-d)	56. A description of how the Contractor will determine of whether an issue is to be resolved through the Contractor's established a. quality management process. b. grievance and appeals process. c. process for making initial determinations of coverage and payment issues.		☐	

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	d. process for resolution of disputed initial determinations.			
BBA: n/a AMPM: 960-B-3	57. Acknowledgement of receipt of the issue and explaining to the member or provider the process to be followed in resolving his or her issue through written correspondence.		☐	
BBA: n/a AMPM: 960-B-4	58. Assisting the member or provider as needed in completing forms or taking other necessary steps to obtain resolution of the issue.		☐	
BBA: n/a AMPM: 960-B-5	59. Ensuring confidentially of all member information.		☐	
BBA: n/a AMPM: 960-B-6	60. Informing the member or provider of all applicable mechanisms for resolving the issue external of the Contractor process		☐	
BBA: n/a AMPM: 960-B-7	61. Documenting all processes (include detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each grievance and appeal.		☐	
BBA: n/a AMPM: 960-C-1-(a-f)	62. Contractors must develop and implement policies and procedures that address analysis of quality of care issues through: a. identification of the quality of care issue. b. initial assessment of the severity of the quality of care issues. c. prioritization of action(s) needed to resolve immediate care needs when appropriate. d. eview of trend reports obtained from the Contractor's quality of care data system to determine possible trends related to the provider(s) e. research, including but not limited to: a review of the log of events, documentation of conversation, and medical record review. f. quantitative and qualitative analysis of the research.		☐	
BBA: n/a AMPM: 960-C-2-(a-e)	63. The Contractor must have a process to assure that action is taken when needed by: a. developing an action plan to reduce/eliminate the likelihood of the issue reoccurring. b. determining, implementing and documenting appropriate interventions. c. monitoring and documenting the success of the interventions. d. incorporating interventions into the organization's QM program if successful. e. assigning new intervention/approaches when necessary.		☐	
BBA: n/a AMPM: 960-C-3	64. A process to provide resolution of the issue. Member and system resolutions may occur independently from on another.		☐	
BBA: n/a AMPM: 960-C-4	65. A process to determine the level of severity of the quality of care issue.		☐	

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BBA: n/a AMPM: 960-C-5	66. A description of how the Contractor will notify the appropriate regulatory agency and/or AHCCCS of quality of care issues for further research/review or action.		☐	
BBA: n/a AMPM: 960-C-6	67. A process to refer the issue to the Contractor's peer review committee when appropriate.		☐	
BBA: n/a AMPM: 960-C-7	68. A description of how the Contractor will report to AHCCCS CQM Unit, when adverse action is taken with a provider due to a quality of care concern.		☐	
BBA: n/a AMPM: 960-C-8	69. A process of how the Contractor determines the level of substantiation.		☐	
BBA: n/a AMPM: 960-C-9	70. A process of notifying the appropriate regulatory/licensing board or agency and AHCCCS when a health care professional's organizational provider or other provider's affiliation with their network is suspended or terminated because of quality of care issues		☐	
BBA: n/a AMPM: 960-C-10-(a-b)	71. A process for documenting the criteria and process for closure of the review including but not limited to: a. a description of the problem, including new allegations identified during the investigation/review process. b. written response from or summary of the documents received from referrals made to outside agencies such as accrediting bodies, or medical examiner.		☐	
BBA: n/a AMPM: 960-D-1-a	72. A description of how the Contractor will track and trend quality of care issues for quality improvement.		☐	
BBA: 488.242(b)(3) AMPM: 910-A-7	73. Descriptions of the process used by the Contractor's health information system to collect, integrate, analyze and report data necessary to implement the QM/PI program.		☐	
BBA: n/a AMPM: 910-A-6-c	74. A description of how the contractor will ensure medical records and communication of clinical information for each member reflect all aspects of member care, including ancillary and behavioral health services.		☐	
BBA: n/a AMPMA: 940-2-(a-c)	75. Contractors must implement appropriate policies and procedures to ensure that the organization and its providers have information required for: a. effective and continuous member care through accurate medical record documentation of each member's health status, changes in health status, health care needs and health care services provided. b. quality review. c. an ongoing program to monitor compliance with those policies and procedures.		☐	
BBA: n/a AMPM: 940-3-b	76. Each Contractor must implement policies and procedures that address medical records and the methodologies to be used by the organization to ensure that providers maintain a legible medical record of each enrolled member, is well organized and kept up to date.		☐	

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BBA: n/a AMPM: 910-A-6-c	77. Policies must address processes for digital (electronic) signatures when electronic documents are utilized.		☐	
BBA: n/a AMPM: 940-3-c	78. A member may have numerous medical records kept by various health care providers however, the Primary Care Physician (PCP) must maintain a comprehensive record.		☐	
BBA: n/a AMPM: 940-3-d	79. The QM Program implements policies and procedures that include requirements of the PCPs referrals to, coordination of care with, and transfer of care to Behavioral Health providers.		☐	
BBA: n/a AMPM: 910-A-6-b	80. A description of how members' rights and responsibilities are defined, implemented, and monitored.		☐	
	PERFORMANCE IMPROVEMENT			
BBA: n/a AMPM: 910-A-6-f	81. A description of how the Contractor's planned activities will meet or exceed AHCCCS mandated performance measures and performance improvement project goals.		☐	
BBA: 438.240(e)(1)(i) BBA: 438.240(a) BBA: 438.240(b) BBA: 438.240(c)(1-3) AMPM: 970-B-d-i	82. Description of a process for internally measuring and reporting to AHCCCS the Contractor's performance for contractually mandated performance measures, using standardized methodology established or adopted by AHCCCS. The Contractor must use the results of the AHCCCS contractual performance measures (from its internal measurement and rates reported by AHCCCS) in evaluating its quality assessment and performance improvement program. Report performance measures in a table format.		☐	
BBA: n/a AMPM: 970-B-1-b-(i-v)	83. Description of a process for developing an evidence-based corrective action plan, which utilizes the Plan-Do-Study-Act, (PDSA) cycle when the Contractor' performance falls below the minimum level established by AHCCCS.		☐	
BBA: 438.240(a)(1) BBA: 438.240(b)(1) BBA: 438.240(d)(1) BBA:438.240(e)(1)(ii) BBA: 438.240(e)(2) AMPM: 970-B-1-(i-vii)	84. Description of a process to develop and initiate interventions that result in significant demonstrable improvement, sustained over time, in its performance for the performance indicators being measured. Contractors should utilize Plan-Do-Study-Act, (PDSA) process to test changes (interventions) and refine them as necessary.		☐	
BBA: 438.240(e)(1) BBA: 438.240(d)(2) AMPM: 980-B-(1-2)	85. The Contractor has reported to AHCCCS annually its interventions, analysis of interventions and internal measurements, changes or refinements to interventions and actual or projected results from repeat measurements, as directed by AHCCCS, using the PIP Reporting Template (Exhibit 980-2).		☐	