

***ValueOptions NorthSTAR***  
***Dallas County Service Delivery Area***  
***SFY 2016 1st Quarter***  
***QUARTERLY QUALITY IMPROVEMENT ACTIVITY REPORT***

ValueOptions Quality Management Department submits the Quarterly Quality Improvement Activity Report as specified in the DSHS NorthStar Contract. This report addresses program activities for the first quarter (9/01/15-11/30/15) of the 2016 State fiscal year. The following areas will be addressed in this report:

- **Status of Quality Management Work Plan**
- **Quality Improvement Activities**
- **Results of Quality Indicators**
- **Remedial/Corrective actions**
- **Assessment of Quality Management Program**

***QUALITY IMPROVEMENT PLAN /WORKPLAN***

The Quality Management Committee met on October 27, 2015 and December 15, 2015 to the status of the 2015 QMUM Work Plan.

**FOCUS STUDIES**

**Texas NorthSTAR URAC Quality Improvement Projects (QIP):** There are two current QI Projects (QIP) that includes all NorthSTAR Enrollees (Medicaid and Non-Medicaid).

- 1. Increasing Prescriber Engagement in NorthSTAR Mental Health consumers that are assigned to a Mental Health Provider (SPN-Specialty Provider Network).**
  - a. **Summary:** Based on a NorthSTAR contractual requirement for an appointment with a prescriber within 7-days or 14-days after hospital discharge.
  - b. Annual measure that is the same quarter annually to control for seasonality issues and occurs the first quarter of the State Fiscal Year (SFY) which is September 1 to November 30.
  - c. This measure is based on prescriber claims after hospitalization.
  - d. **The focus is to improve SPN performance in providing member access to timely prescriber appointments after hospital discharge.** Ongoing interventions have included providing daily admission reports to each SPN to inform them of their members admitted to the hospital as well as weekly discharge reports. Clinical Outcome reports are provided quarterly to SPN providers and they receive an incentive if they meet the performance standard. They are also provided measure detail in order to review opportunities related to members not seen by a prescriber within 7 or 14 days.

- e. **New Interventions:** In late 2014, we added a Hospital Discharge Brochure designed to be a resource to discharging patients including addressing transportation needs and what to bring/expect at the first clinic appointment. Throughout 2015, QM staff attended monthly Individual SPN Provider Operations/Clinical Meetings to review performance on clinical outcome measures and other quality initiatives. We also continued to facilitate Hospital/SPN meeting quarterly in 2015 to address hospital and SPN discharge coordination barriers and to identify best practices. Some of these have included an actual appointment time versus a walk-in appointment. Most SPNs now have dedicated Hospital Liaison staff for discharge planning and coordination. Most SPNs are also doing reminder calls to the individual prior to the appointment.

**Outcomes:**

**Most Recent Remeasure:** Discharges from 9/1/2014-11/30/2014 represent the population assessed. Due to the claims lag, members are assigned by provider authorizations within 7 days of discharge.

**7-Day Prescriber Engagement 27%**

*Numerator: 426 consumers seen by prescribers*

*Denominator: 1606 hospital discharges during this quarter*

**14-Day Prescriber Engagement 35%**

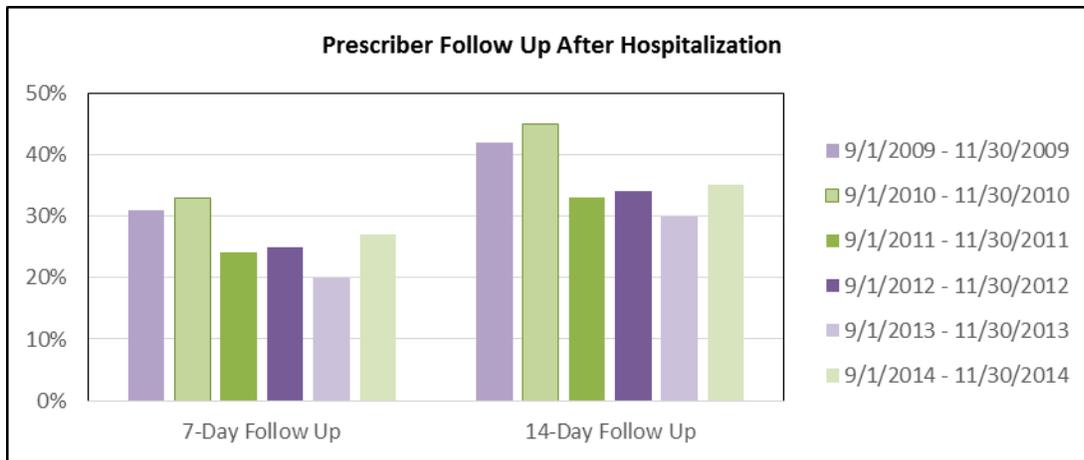
*Numerator: 536 consumers seen by prescribers*

*Denominator: 1521 hospital discharges during this quarter*

**There was an improvement from the previous measure of 20% for 7 day and 30% for 14 day prescriber appointment. Below are the trended outcomes since the baseline measure:**

**Prescriber Follow Up**

	<b>7-Day Follow Up</b>	<b>14-Day Follow Up</b>
9/1/2009 - 11/30/2009	31%	42%
9/1/2010 - 11/30/2010	33%	45%
9/1/2011 - 11/30/2011	24%	33%
9/1/2012 - 11/30/2012	25%	34%
9/1/2013 - 11/30/2013	20%	30%
9/1/2014 - 11/30/2014	27%	35%



**2. QIP: Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment in NorthSTAR Medicaid and Non-Medicaid Members (IET)**

- a. **Summary:** Based on HEDIS® methodology that was implemented due to the HHSC recognizing this was an area of opportunity. NorthSTAR demographic data for 2013 showed that one third of membership had an AOD diagnosis.
- b. Population for this measure includes youth (ages 13-17) and adults (ages 18+).
- c. Initiation measure is the percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
- d. Engagement measure is the percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
- e. **The focus has been to educate providers on this measure and to explore how SPN and Substance Use Disorder (SUD) providers can impact this measure.** This is a relatively new QIP with a baseline annual measure and a recent 1<sup>st</sup> annual remeasure. The most recent remeasurement shows a decline in both Initiation and Engagement measures for the full population of adults and youth. There was an improvement of the Youth (age 13-17) population. There was a 3 percentage point improvement in the Youth Initiation from the baseline to the first remeasurement. There was a 2.3 percentage point improvement in the Youth Engagement.
- f. **New Interventions:** Updated the Hospital Discharge Brochure in late 2014 with Substance Use Disorder (SUD) Referral Phone number with the following, *“If you think you may need to cut down or stop using alcohol or other substances, call ValueOptions at 1-888-800-6799 for referrals or ask your clinic for more information on where to get help.”*
- g. **New Provider Interventions:** Added discussion to SUD Provider Meeting and SPN Provider Meetings as well as held a Hospital/SUD Provider Meeting

to address care coordination and referrals to SUD services. A key barrier identified was that the SUD Intensive Outpatient Service (IOP) code was not included in the measure and since this is as National HEDIS® measure, no additions to the methodology is allowed. We were able to run the data with the IOP code when we gave providers their member detail information. Hospital Treatment Record reviews were performed with feedback to several hospitals on the need for more specific SUD discharge referrals. A SUD Provider Program Description was created to assist hospitals in understanding what services and which populations an SUD provider serves.

**Outcomes:** The outcomes below are for the combined Youth and Adult population:

Total number initiated in treatment = 1854 of the 7,267 episodes.  
 Total number engaged in treatment = 936 of the 7,267 episodes

**Overall Total Number of Index Episodes:** 7,267

**Percent Initiated:** 25.5 %

**Percent Engaged:** 12.9 %

**Initiation**

	Total	# Initiated	% Initiated	Goal >=
Baseline	7856	2217	28.2%	36.0%
First Remeasure	7267	1854	25.5%	36.0%

**Engagement**

	Total	# Engaged	% Engaged	Goal >=
Baseline	7856	1089	13.9%	16.2%
First Remeasure	7267	936	12.9%	16.2%

**Texas Engagement Center Medicaid Performance Improvement Projects (PIP):**

NorthSTAR has two current Medicaid Performance Improvement Projects (PIP). Both of these projects include only the NorthSTAR Medicaid population. In 2016, HHSC has recommended to discontinue the IET PIP and continue the FUH PIP.

These include the following:

**1. Improving Follow-Up After Hospitalization for Mental Illness in NorthSTAR Medicaid Enrollees within 7 and 30 Days (FUH)**

- a. Based on HEDIS® methodology that was a topic selected by HHSC to begin interventions on 2/1/2014. The initial baseline was on Calendar Year 2012 with HHSC providing the data. The State requested we replace this data with 2013 as the true baseline data. 2013 data was received in November 2014. ValueOptions 2013 data was used to conduct the barrier analysis and develop interventions.

- b. This will be an ongoing PIP topic selected by HHSC for 2015 and 2016. Calendar Year 2014 data was received from HHSC in October 2015. This is based on claims data provided by HHSC.

**Outcomes:**

**7 and 30 Day Follow-Up (FUH )**

**7 and 30-Day Follow-Up**

	<b>7-Day Follow Up</b>	<b>30-Day Follow Up</b>
2013 CY Baseline	32.50 %	58.44%
2014 CY 1 <sup>st</sup> Remeasurement	32.26%	56.33%

Note that Calendar Year 2012 data was initially provided by HHSC and identified this measure as an opportunity for NorthSTAR. There was strong improvement from 2012 to 2013. There was a 10 percentage point improvement from 2012 to 2013 in the 30-Day Follow-Up Appointment measure and an 8 percentage point improvement in the 7-Day Follow-Up Appointment measure. The 2014 data was very similar to the 2013 data with a slight decline.

**2. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) in NorthSTAR Medicaid Enrollees**

- a. Based on HEDIS® methodology and was a PIP topic selected by HHSC to begin interventions on 2/1/2014. The initial baseline was on Calendar Year 2012 with HHSC providing the data. The State requested we replace this data with 2013 as the true baseline data. 2013 data was received in November 2014. ValueOptions 2013 data was ran to conduct the barrier analysis and develop interventions.
- b. This PIP topic was selected by HHSC for 2015 with the 2014 Calendar Year data received from HHSC in October 2015. HHSC did not select this as a PIP topic for NorthSTAR for 2016. This is an ongoing QIP topic for NorthSTAR population included Medicaid and Non-Medicaid Enrollees.

**Outcomes:**

**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**

	<b>Initiation</b>	<b>Engagement</b>
2013 CY Baseline	20.05%	5.28%
2014 CY 1 <sup>st</sup> Remeasurement	18.86%	5.24%

There was slight decline between the baseline in 2013 and the remeasurement in 2014. One key barrier as discussed under the IET QIP section above is the omission of the IOP service code in the methodology for this measure. We have continued to work on improving this measure by providing results with member detail to our SPN providers as well as presenting results and discussions with our Substance Use Disorder Providers.

***OTHER QUALITY IMPROVEMENT ACTIVITIES (RECOVERY):***

During 4th quarter, DSHS learning collaborative calls continued for ACT, COPSD, UM and ANSA/CANS Technical Assistance webinars. Audits of TRR elements continue to reflect a focus on Illness Recovery Management and Person Centered Recovery Planning. SPN and SPN Quality Meetings. Providers are encouraged to share success stories and best practices for TRR protocols, especially for the array of Children’s protocols. Person Centered Recovery Planning remains to be a focus of provider quality meetings.

**REPORT ON STANDARD ACCESS Measures**

The following provides a status update of certain access measures and a summary of any quality improvement activities related to each measure. Data was obtained from 9/1/2015-11/30/2015, except for the 7 and 30 day follow-up measures. This data was based on the time period of 5/1/2015-7/31/2015 in order to allow adequate time for claims payment.

Reporting Measure	Data Source	Current Result	Limitations to Data Source	Initiation of any Quality Improvement Activities (provide summary)
Telephone response (ASA and Abandonment Rate)	Avaya Phone system data	<p><b>Customer Service:</b></p> <p>ASA: 20.33 sec</p> <p>Abandonment Rate: 2.15 %</p> <p><b>Clinical:</b></p> <p>ASA: 18.33 sec</p> <p>Abandonment Rate: 2.27 %</p>	None	Customer Service and Clinical met the ASA and abandonment rate standards for this quarter.

<p>Timeliness of appointments w/in:</p> <p><u>Routine:</u> 14 calendar days</p> <p><u>Urgent:</u> 24 hrs.</p> <p><u>Emergent:</u> Immediately</p>	<p>Member Complaints</p> <p>Provider Relations Office-Site Audits</p>	<p>Access Complaints total = 2</p> <p>2-Routine 0-Urgent 0-Emergent</p> <p><b>Office Site Audits (Y= 4)</b></p> <p>100 % Routine Urgent Emergent</p>	<p>Data obtained from viewing appointment schedules and assessing provider's appointment scheduling process may not be consistent with members' experience.</p>	<p>Appointment access is monitored and reported through the complaint process as well as with office site audits.</p>
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Reporting Measure	Data Source	Current Result	Limitations to Data Source	Initiation of any Quality Improvement Activities (provide summary)
Ambulatory Follow-Up to Hospitalization 7 days and 30 days MH	Claims	<p>45.5% <b>7 days</b> (668/1469)</p> <p><b>61.2% 30 days</b> ( 795/1299)</p>	Measures based on paid claims are subject to claims payment lag.	Both follow-up measures are higher than the previous quarter.
30 Day Readmission MH	Authorizations	<p><b>16.7%</b> (320/1920)</p>		30-day Readmission MH was lower than the previous quarter.
30-Day Readmission Rate-SUD	Authorizations	<p><b>8.8%</b> (97/1104)</p>		30-day Readmission CD was lower than the previous quarter.

## ***CLINICAL AUDITS:***

During 1st quarter, QM conducted one SPN Audit and one ACT Follow-up audit. Additionally, ValueOptions facilitated corrective action for the DSHS Mystery Call Surveys.

The first SPN audit was conducted over an extended time period due to the size of the provider population and the volume of files reviewed. Some of the ACT files were reviewed on site and half were sent to ValueOptions for review. The SPN Audit results included a Treatment Record Review audit with an overall passing score of 89% with opportunities in Recovery/Treatment Plans. At every SPN audit, there is emphasis and discussion regarding members' meaningful life role/recovery goals and using strengths in all aspects of treatment. ACT Fidelity Self-Reviews on the DACTs form were completed by the provider and interviews with all ACT Team Leads were conducted to review the strengths and opportunities for each team. Highlights include integration of Primary Care for physical health, use of Peer Providers, incorporation of more trauma-informed services, and use of groups facilitated by different staff to assist in meeting the element of a team approach. ACT opportunities included lack of documentation of coordination with hospitals for admissions and discharges, monitoring frequency of individual contacts based on individual needs to ensure needs are addressed and use of Real Life Goals. The provider noted that they had created a Peer Review process for auditing Individual Clinical Supervision files and Person Centered Recovery Planning. For HR/Credentialing audit, it was difficult to determine if all the content and elements were present for several elements. The auditor scheduled additional time with Metrocare staff to review training modules in more depth. Peer reviews for supervision appear to be on the right track for improving supervision with some positive examples highlighted to provider. All staff were appropriately licensed and credentialed.

The next audit planned was a follow-up ACT services audit for a SPN based on previous findings that ACT services were not recovery oriented. Previous audit results noted the use of behavioral contracts and compliance-focused interventions. Training for ACT Team in Person Centered Planning, IMR and recovery orientation were recommended. ACT charts were requested along with a request for provider to complete an ACT Fidelity Self-Review. The audit was in progress at the time of this report.

Follow-up requests for additional information was conducted for previous CAPs by facilities audited during the previous quarter.

### **Assessment of Provider Access to Services**

Measurements of Access to Services were conducted during 1st quarter. ValueOptions received the results DSHS Mystery Call audits for Phone Access that were conducted during September, October and November. September 2015 DSHS Mystery Call results were discussed in the SPN meeting. In addition to individual monthly call results, DSHS averaged each SPN's Mystery Call results from April through September of 2015. Three out of 9 SPNs monitored for this period had a cumulative score below 83% and required a Plan of

Correction (POC). ValueOptions also submitted a POC related to oversight, monitoring activities and ongoing technical assistance to the NorthSTAR SPNs related to meeting TAC standards including 412.105 Accountability 412.161, Screening and Assessment 412.161, and Automated System 412.314. Corrective Action Plans were requested for NorthSTAR SPN providers who had any barriers to Phone Access in the TAC required areas, which were submitted to DSHS. ValueOptions provided feedback and technical assistance to SPNs on TAC requirements and opportunities for improvement.

In October, all but two SPNs passed the DSHS Mystery Calls. Responses were requested from 2 SPNs on how they would address the opportunities. Feedback was also given to a SPN that passed to improve how insurance information is explained. Additionally, for the 3 SPN CAPs submitted for Apr-Sep measurement, two SPNs were requested by DSHS to revise their CAPs to more specifically address how phone issues still occurred and how their CAP will seek to prevent those issues. Those 2 revised CAPs were submitted and accepted by DSHS. In November, SPN Mystery Call results and related TAC references were addressed in the SPN Quality Meeting.

For November DSHS Mystery Calls, all SPNs passed the call surveys. Results were sent to SPNs and individual results were discussed in bi-monthly individual SPN calls. ValueOptions will continue to address any opportunities related to Access to Services.

## RESULTS OF QUALITY INDICATORS

**Telephone Access:** Monitoring of call abandonment rates and answer yielded the following results for this quarter.

### Clinical Calls:

Month	Number of Calls Received	Abandonment Rate < 5 %	Speed of Answer <30 sec.
Sept 2015	1, 940	2.58%	20 seconds
Oct 2015	1, 573	1.40%	16 seconds
Nov 2015	1,419	2.82%	19 seconds

Clinical average speed of answer (ASA) met performance targets for all 3 months to be answered by a live person within 30 seconds. The abandonment rate was also well within the 5% or less target for the quarter.

**Customer Service:**

Month	Number of Calls Received	Abandonment Rate < 5 %	Speed of Answer <30 sec.
Sept 2015	5,873	1.96%	22 seconds
Oct 2015	5,570	2.93%	21 seconds
Nov 2015	4,881	1.56%	18 seconds

Customer Service average speed of answer (ASA) met performance targets for all 3 months to be answered by a live person within 30 seconds. Abandonment rate was also well within the performance target for this quarter.

**Medical Necessity Appeals**

The following table presents information concerning medical necessity appeals for this quarter.

**Medicaid Medical Necessity Appeals**

Month	Adverse Determinations	Level 1 Appeals	Level 1 Appeals Reversed	Level 2 Appeals	Level 2 Appeals Reversed
Sept 2015	85	29	5	2	0
Oct 2015	78	42	7	5	1
Nov 2015	69	21	3	1	0

**Non-Medicaid Medical Necessity Appeals**

Month	Adverse Determinations	Level 1 Appeals	Level 1 Appeals Reversed	Level 2 Appeals	Level 2 Appeals Reversed
Sept 2015	120	40	4	3	1
Oct 2015	83	43	2	3	0
Nov 2015	38	13	6	2	0

No significant trends for this quarter.

## Administrative Appeals

### Medicaid Administrative Appeals

Month	Level 1 Appeals Rec'd/Closed	Level 1 Appeals Reversed	Level 2 Appeals Rec'd/Closed	Level 2 Appeals Reversed
Sept 2015	51/54	20	6/7	1
Oct 2015	52/48	14	2/5	0
Nov 2015	29/47	11	2/2	0
Quarter Totals	<b>132/149</b>	<b>45</b>	<b>10/14</b>	<b>1</b>

There were 132 Medicaid Level 1 administrative appeals received for this reporting period, with 149 appeals that were closed. This was an increase from the previous quarter for Level I appeals received and closed. For Medicaid Level II appeals, there were a total of 10 received and 14 closed for this reporting period. This was down from the previous quarter. All Medicaid Level I and Level II appeals were closed within 30 calendar days.

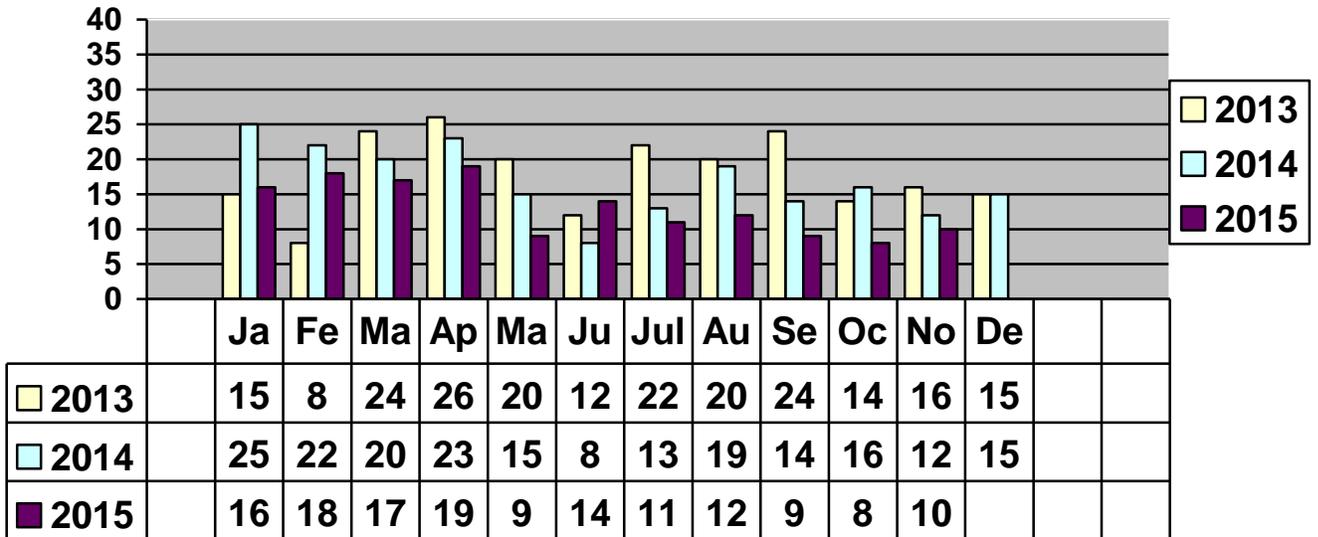
### Non-Medicaid Administrative Appeals

Month	Level 1 Appeals Rec'd/Closed	Level 1 Appeals Reversed	Level 2 Appeals Rec'd/Closed	Level 2 Appeals Reversed
Sept 2015	52/49	18	8/13	0
Oct 2015	62/54	14	7/8	2
Nov 2015	26/54	14	7/7	0
Quarter Totals	<b>140/157</b>	<b>46</b>	<b>22/28</b>	<b>2</b>

There were 140 Non-Medicaid Level 1 administrative appeals received for this reporting period, with 157 appeals that were closed. This was a decrease from the previous quarter for Level I appeals received and closed. 46 out of 157 closed appeals were reversed or overturned. For Non-Medicaid Level II appeals, there were a total of 22 received and 28 closed for this reporting period. All Non-Medicaid Level I and Level II appeals were closed within 30 calendar days.

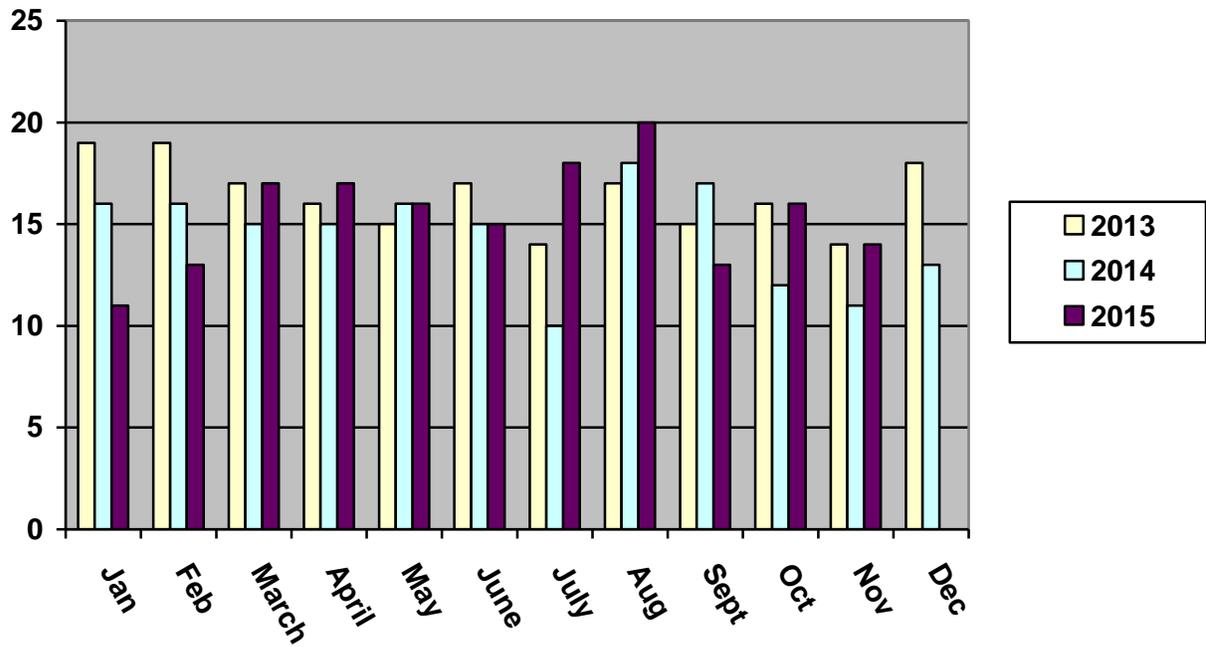
## Complaints/Grievances

### Complaint #s Comparison



Complaint volume in November (10) is the highest for this quarter with September (9) following and then October (8). Overall, a total of (27) complaints were received for this quarter which is a decrease from last quarter (37). Quality Management continues to work closely with providers and other departments to resolve complaints in a timely manner.

### Average Turnaround Time



	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
2013	19	19	17	16	15	17	14	17	15	16	14	18
2014	16	16	15	15	16	15	10	18	17	12	11	13
2015	11	13	17	17	16	15	18	20	13	16	14	

**Complaints/Grievances Complaint reporting by Medicaid/Non-Medicaid was split out as of March 2015. Note that the complaint categories include Access and Availability, QOC (Quality of Care), E/C (Enrollment/Claims), and QOS (Quality of Service), UR (Utilization Review).**

### Medicaid Complaints

Month	Complaints Received	Complaints Received Categories	Complaints Closed	Closed Complaints Average TAT
Sept 2015	5	Access/Availability, QOC, UR	4	11.5
Oct 2015	3	Access/Availability, QOC	4	18.8
Nov 2015	6	QOC, QOS	3	9.3
Quarter Totals	<b>14</b>		<b>11</b>	<b>39.6</b>

### Non-Medicaid Complaints

Month	Complaints Received	Complaint Received Categories	Complaints Closed	Closed Complaints Average TAT
Sept 2015	4	Access/Availability, Enrollment/Claims, QOC	7	12.7
Oct 2015	5	QOC, UR	5	13.0
Nov 2015	4	Access/Availability, QOC	5	16.2
Quarter Totals	<b>13</b>		<b>17</b>	<b>41.9</b>

### Claims Processing

Claims Data:	August 2015	September 2015	October 2015	November 2015
Mechanical Accuracy	99.94%	99.97%	99.96%	99.98%
Financial Accuracy	99.88%	99.46%	99.67%	100.00%
% Processed in 30 calendar days	100.00%	100.00%	100.00%	99.96%

Claims performance measures all were within contractual and regulatory standards. August numbers were included in this report due to not being available in the previous report.

**Enrollee/Provider Events: Behavioral Health Education and Recovery (BHER)**

Numbers will be included in this next report.

**Provider Training:**

Month	Provider Trainings	Number of Attendees
Sept 2015	0	n/a
Oct 2015	1	7
Nov 2015	4	96
<b>Total # of Trainings = 5</b>		
<b>Total # of Attendees = 103</b>		

Provider annual Compliance Training on Fraud, Waste, and Abuse was conducted during this quarter with good provider participation.

**Credentialing and Recredentialing:**

Indicator	Sept 2015	Oct 2015	Nov 2015
# Initial Credentialed	0	1	0
Average TAT Initial CR (in days)	n/a	2	n/a
# Recredentialled	5	0	4
Average TAT Recred (in days)	55	n/a	106
% Recredentialled Files Completed within 36 month TAT	100%	n/a	43%

**National Goals**

Initial TAT – 25 days or less

Recredentialing Completed within 36 months – 90%

Recredentialing turnaround did not meet the performance target for November in this quarter. Process improvements had been previously put in place with strong performance reported in the previous quarter. Four providers were recredentialled with an average turnaround of 106 days with a target of 25 days or less. Provider non-compliance with completion of paperwork contributed to the additional days.

## UM Average Daily Census

### Medicaid Enrollees ADC

Month	Inpatient	Residential Rehabilitation
Sept 2015	60.4	18.7
Oct 2015	60.1	21.3
Nov 2015	50.7	27.9

### Non-Medicaid Enrollees ADC

Month	Inpatient	Residential Rehabilitation
Sept 2015	231.9	48.9
Oct 2015	225.1	45.1
Nov 2015	196.1	52.2

Average daily census trends show similar inpatient results for Medicaid Enrollees from the previous quarter with an increase in October and November in Residential Rehabilitation. Non-Medicaid Enrollees had similar Inpatient and Residential Rehabilitation average daily census when compared to the previous quarter. No significant trends identified.

## ASSESSMENT OF THE QUALITY MANAGEMENT PROGRAM

NorthSTAR ValueOptions QM Projects	Target
Complete 2015 QM/UM Program Evaluation	April 26, 2016
Complete 2016 QM/UM Program Descriptions and QM/UM Work Plan	April 26, 2016
QI Project: Improving Access to Prescriber Appointments within 7 and 14 days after hospital discharge.	June 28, 2016
QI Project: Initiation and Engagement of Alcohol and Other Drug Treatment (IET) Indigent and Medicaid	June 28, 2016
2016 Consumer Satisfaction Survey (to QMC)	August 23, 2016
Coordination of Care in Children" Project 2015	April 26, 2016
PIP: 7 and 30 Day Follow-Up After Hospital Discharge (FUH)	August 23, 2016
PIP: Initiation and Engagement of Alcohol and Other Drug Treatment (IET) Medicaid: Retired for 2016 per HHSC. Will continue monitoring through the QIP.	June 28, 2016