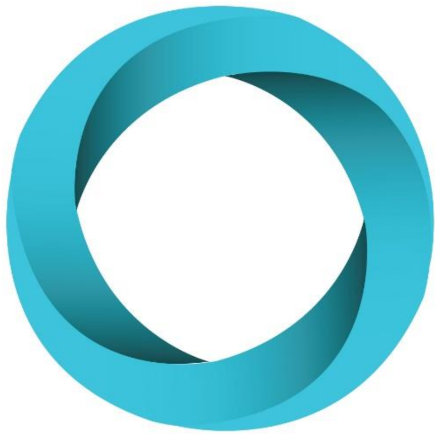

BEHAVIORAL
HEALTHCARE
PROVIDERS

Quality Management and Improvement
2015 Year-end Report

Behavioral Healthcare Providers
Quality Management and Improvement Program
2015 Year-end Report

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Behavioral Healthcare Providers
Quality Management and Improvement Program
2015 Year-end Report

Introduction

Behavioral Healthcare Providers (BHP) began 2015 with a comprehensive quality plan description and annual work plan. In response to changes in client needs, BHP business, and clinical needs, we made minor changes and adjustments to the description and work plan throughout the year. This year-end report highlights BHP's accomplishments and performance concerning our responsibilities of quality management and the improvement in the delivery of behavioral health care. Aligning with the year-end report is the **Quality Management and Improvement (QM&I) Program Description** and **Annual Work Plan**.

The **QM&I Program Description** is a relatively static document, as it is comprehensive and states our intent on monitoring performance and implementing clinical activities focused on ensuring the most beneficial care for the member. Minor changes to this document may occur as standards change so that it reflects the current accepted management responsibilities. Following approval by the BHP Quality Improvement Committee (QIC) and the BHP Board of Directors, the QM&I Program document stands as our foundation for quality management throughout our organization. Any subsequent material changes are brought to the QIC and Board's attention for approval as they occur.

The **2016 Annual Work Plan** identifies monitoring and clinical activities BHP continues to monitor and/or implement. This document is more dynamic in nature and in the coming year reflects a continuation of established monitoring, clinical and preventive health activities implemented or in process during 2016.

In 2014 BHP pursued full National Committee for Quality Assurance (NCQA) accreditation for Managed Behavioral Health Organizations. After an intensive internal audit and NCQA off-site and on-site reviews we received notification in August, 2014 that we were awarded full NCQA accreditation status. Full accreditation is granted for a period of three years to those plans that have an excellent program for continuous quality improvement and meet NCQA's rigorous standards. BHP is very proud of this significant achievement and will continue to maintain all NCQA standards in 2016.

BHP has several different types of quality activities. One section of these activities is related to the creation and implementation of several clinical screening and behavioral health screening activities. These activities focus on: (1) Disseminating to the network four clinical practice guidelines: one related to the assessment and treatment of ADHD, one for the assessment of Depression, one for assessment of Substance Use disorders, and one for assessment of Bipolar related disorders. (2) Implementing a screening program for co-occurring disorders and an additional screening program targeting symptoms of Generalized Anxiety Disorder.

BHP has also developed several clinical measurement activities in an effort to improve clinical issues relevant to our members. These activities have designated monitoring and data collection elements which allow us to analyze the current scope of the activities and amend them if the intended purpose does not appear to be addressed. NCQA specifies that at least three meaningful quality clinical activities are implemented, and in 2015 we maintained four activities. BHP has also developed specific quality improvement activities for the services delivered through the sites that use the Diagnostic Evaluation Center (DEC) system. In 2014 BHP discontinued the chart audit quality activities to focus on alternative ways of measuring and promoting quality of care provided to members, however, in 2015 these chart audits were re-instated and re-designed to measure provider adherence to BHP's Clinical Practice Guidelines. A summary of this activity and the results are outlined below.

The quality monitoring activities identified continue to reflect current accepted practices and management requirements. The **Annual Work Plan** provides tracking and documentation of detailed information on each of our monitoring and quality activities. This data allows us to draw conclusions about the effectiveness of each quality monitoring activity and make changes if necessary. It also lays the foundation for year to year comparisons, as many of the activities require ongoing monitoring. In general, the annual work plan register contains the following information:

- Report/Project name
- Report/ Project goal
- NCQA Standard
- Quantifiable Measure; if applicable
- Performance goal: if applicable
- Benchmark: if applicable
- Responsible staff
- Reviewed by
- Timeframe

The information or data elements tracked for each includes, as applicable: date, measurements, analysis, actions required, and follow up. Whereas NCQA requires that we monitor most of our management activities at least annually, most of the monitoring activities are monitored on a monthly by BHP Quality Staff and reviewed quarterly by the Clinical and Operations Team and Quality Improvement Committee (QIC) for final oversight.

Overall, BHP's management and staff continue to demonstrate their commitment to helping people reach their potential and to enhancing the behavioral health system through innovation. Our efforts continue to build upon the structures that BHP needs in order to impact behavioral services and fulfill its contractual obligations. This report highlights the Scope of Activities monitoring results, current status on the clinical and preventive health activities, and areas for continued improvement. In conclusion, the report provides a final evaluation of the effectiveness of the Quality Management and Improvement Program and its various activities.

Scope of Activities

The scope of our activities includes clinical services, member services, and screening services/preventive health activities. In clinical services, BHP monitors the effectiveness of our utilization management process in reviewing a request for treatment and notifying the provider of the outcome, complaints and appeals related to clinical care, internal record keeping, treatment record keeping of practitioners and clinical quality activities. Member services activities include a member's ability to access BHP services (telephone access and abandonment), network availability and accessibility, and member satisfaction. Preventive health activities include screening for and education about selected diagnoses. This report summarizes the efforts and performance in each area.

Patient Safety

BHP demonstrates our commitment to patient safety by incorporating safety elements into existing activities. As BHP has always had a commitment to overall patient care, elements of patient safety are found in our existing processes. It is evident that the activities BHP has engaged in have, at their core, a concern for patient physical and mental safety needs. In brief, these include:

- Coordination of Care with Primary Care Providers
- Clinical Measurement Activities
- On-Site Reviews of Practitioners
- Utilization Management Review Process
- Disease Management Support
- Complex Case Management Services
- Chemical Health Treatment Follow-up
- Diagnostic Evaluation Center Quality Activities

More information on each of these patient safety elements is described further in this report.

Utilization Management Quality Activities – Clinical Activities

Timeliness of Utilization Management Decisions

A timely response to a request for service is an important element in the utilization management process. The monitoring results are displayed below. NCQA allows for a one time extension of the timeframe for completing our process when, due to circumstance out of our control, a decision is not able to be made such as not receiving all clinical information necessary to complete the review. These standards are currently reflected in BHP policies.

BHP staff met the 95% performance goal in 2015 for all categories. BHP continues to monitor reports daily, and flag all cases not complete 6 days after receipt of the treatment plan or phone update. These are reviewed by the department manager to ensure that deadlines are met.

BHP UM monitoring includes weekly, monthly and quarterly reports that summarize individual staff performance as well as overall department performance. Breakdown by department and individual staff allows BHP to address and quickly resolve identified issues throughout the year. Based on the analysis of the results for each standard, it is clear that the BHP UM staff continue to consistently demonstrate a high standard of performance.

Timeliness of UM Decisions Data

UM Decision Type	Decision Outpatient	Decision Facility	Decision Denial Outpatient	Decision Denial Facility	Extension Outpatient	Extension Facility	Extension Denial Outpatient	Extension Denial Facility
2013 % Total	99.06%	97.58%	99.14%	100%	100%	N/A	N/A	N/A
2014 % Total	98.95%	99.49%	NA	100%	NA	NA	NA	NA
2015 % Total	98.56%	99.82%	NA	100%	NA	NA	NA	NA

The historical data for Utilization Management along with designations and definitions can be provided upon request.

Consistency in Applying Clinical Criteria – Inter-rater Reliability

On a quarterly basis, BHP evaluates the consistency with which UM staff applies the criteria in decision making. Using a statistically-valid method, the Department Manager selects sample case profiles. All Utilization Management (UM) staff, inclusive of the doctoral level licensed psychologists and primary consultant physician reviewers, review the information and make a utilization management decision consistent with the level of care guidelines.

Inter-rater reliability standards for cases processed by Care Management (CM) staff that may involve a higher level of review adhere to the following process:

- The Manager will review the decisions to ensure that staff appropriately forwarded a case on to the appropriate reviewer, when required.
- The Manager reviews these cases to ensure that, when appropriate, the CM authorized services based on the presence of criteria as defined in policy.

For cases reviewed by the Psychologist or Psychiatrist Reviewer:

- It is expected that all Reviewers will make the same decision to approve, deny or partially approve on the same cases where the attending practitioner is not a physician; these cases require an MD review.
- It is expected that for partial authorizations on inpatient cases, the Reviewers will approve the same number of days, within reason, not to exceed a seven day difference.
- It is expected for determinations to deny that the Reviewers identify the clinical criterion not met that supports the decision. The Reviewers are expected to identify all criteria that apply. When there is more than one identified criterion for a denial or partial authorization, it is expected that the Reviewers show agreement within a quantity of one selected criteria.

Inter-rater Reliability Results

	Psychiatrists	Psychologists	UM Staff
2013	Agreement on 11/11 cases (100%)	Agreement on 10/10 cases (100%)	Agreement on 11/11 cases (100%)
2014	Agreement on 11/12 cases (91.67%)	Agreement on 13/13 cases (100%)	Agreement on 13/13 cases (100%)
2015	Agreement on 8/8 cases (100%)	Agreement on 9/9 cases (100%)	Agreement on 9/9 cases (100%)

Practitioner Satisfaction with UM Process

The 2015 data indicates that there were no practitioner initiated complaints about BHP's UM processes. We are pleased to note that there have been zero practitioner initiated complaints since 2009. The Operations Director, Quality Assurance Manager, Psychologist Reviewer, or Medical Director review and respond to all practitioner complaints depending on the nature of the complaint. Based on the absence of complaints over the last several years, BHP concludes that practitioners are overall satisfied with BHP's UM processes.

Specific data on the categories and types of complaints, as well as complaint history is available upon request.

Clinical Quality Case Reviews

Clinical quality case reviews occur when there is evidence or concern of poor quality care. These types of concerns include evidence of prescribing inappropriate medication, making inappropriate diagnoses, engaging in sexual relations with a patient, etc. UM staff continually review cases within the department and with the Medical Director. The UM staff takes an assertive role in discussions with practitioners to ensure that comprehensive care is occurring in a timely manner. If there is a concern related to poor quality of care or patient safety the case is reviewed by the Clinical Operations team and action is taken as needed.

Disease Management Support Program

The Disease Management Support Program is a patient- centered health management program that was implemented in June 2006. This is not a formal quality activity, but is recognized as an activity that positively impacts the care of members. With this program, BHP seeks to:

- Better manage the care and health of both chronically ill members and those members who are at high-risk for a subsequent acute care event;
- Improve clinical outcomes and compliance with care standards;
- Lower total health care cost;
- Increase member satisfaction.

BHP uses the following proactive disease management interventions: support and encouragement provided to the patient and/or family for the patient to attend outpatient follow-up after an inpatient episode of care, post-discharge telephone contact by a licensed BHP care management staff to answer questions, and treatment or online wellness resources are provided.

To achieve these goals, BHP focuses on:

- Ensuring outpatient follow- up services prior to the discharge from an inpatient unit
- Making telephone calls to members, after discharge, to provide ongoing support

BHP care manager actively works with hospital staff to ensure that members are discharged with outpatient follow-up appointment(s) already in place. These appointments may include outpatient therapy, medication management, mental health partial hospitalization, day treatment programs, and/or chemical dependency treatment. If a member is discharged without an appointment, BHP care manager contact the member to offer assistance in scheduling follow up care.

Following a member's discharge from the hospital, the BHP care manager reaches out to the member to offer assistance and support in the transition to a lower level of care. A BHP care manager makes the calls with the intent of ensuring that the member has an aftercare plan, appropriate follow-up appointments, and does not need assistance in other areas such as transportation to appointments or daily life issues. The number of contacts with a member is determined by clinical need and/or patient request. Members who cannot be reached due to disconnected phones or failure to respond to phone calls, etc. are mailed a letter offering assistance and self-help materials specific to the member's diagnosis.

BHP will continue to work toward expanding the BHP Disease Management program in 2015 to provide more specialized and intense work with patients with complex and chronic conditions.

Complex Case Management – Personalized Outreach Program

In 2015, BHP offered complex case management services to members who may benefit from additional support and follow-up. Complex case management is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

Some of the services provided through complex case management are:

- Discussing treatment goals and treatment options
- Helping members find providers for psychological care services
- Scheduling assistance for appointments with psychological care practitioners, if desired

Outreach by a care manager is available to members to offer assistance in determining available resources, developing and implementing a treatment plan with goals, and also to provide monitoring and follow up. The goal of complex case management is to help members regain optimum health through improved functioning. Beginning in 2015, complex case management services was offered by BHP care management staff through our new Personalized Outreach Program (POP). In 2015, 136 patients entered into the program and 5 patient completed the program. The remaining 131 patients are still receiving personalized outreach.

Network Quality Activities

Clinical Record Reviews and Office Practice – On-Site Visits

In order to ensure the quality, safety, and accessibility of the office sites of providers within the BHP network, BHP has implemented on-site office visits. A site visit is conducted if there is a member complaint related to a provider's office site. During a site visit, BHP staff conducts a treatment record keeping review and office practice review. This review includes an analysis of the physical accessibility and appearance of the office, the adequacy of waiting room and clinical space, and the adequacy of treatment record keeping. BHP's standard is that providers meet at least 80% of elements reviewed within the site visit and treatment record keeping audit. All providers who fall below this standard are reviewed within the Clinical Operations meeting to determine appropriate action. If a provider falls below the 80% standard, at a minimum, an action plan is requested from the provider and BHP will evaluate the effectiveness of those actions at least every six months. In 2015, BHP visited 4 office sites to conduct an office practices review and treatment record keeping review. A passing score for the practitioner/office site is present when at least 80% of the elements within the site visit are passed. All four sites visits results in a passing score for 2015.

A thorough description of BHP's treatment record keeping review and office practice review are available upon request.

Clinical Chart Audits

In 2015 BHP re-instituted the Clinical Chart Audit activity to monitor practitioner adherence to BHP's Clinical Practice Guidelines. The Quality Improvement Committee and Clinical Team selected two measures from the following guidelines to measure adherence to: Assessment of Depression, Assessment of ADHD, Treatment of ADHD, Assessment of Bipolar, and Coordination of Care. Since 2015 was a data collection year for this activity a goal has not yet been determined. The goal will be established for the 2016 year by the Clinical Team upon review of 2015 data. Claims were analyzed and it was determined that there were 120 member charts that would be eligible to be audited. In keeping a 95% confidence level and a confidence interval of 5, a total of 70 charts were reviewed for a representative sample. Additionally, a total of 63 practitioners were involved in this review in 2015. Results for 2015 are listed below.

CLINICAL PRACTICE GUIDELINE MEASURE	SAMPLE SIZE n=70	2015 RESULTS – Percentage of Passing Charts
Depression Measure 1	n=37	53.62%
Depression Measure 2	n=44	63.77%
ADHD Treatment Measure 1	n=6	8.70%
ADHD Treatment Measure 2	n=6	8.70%
ADHD Assessment Measure 1	n=9	13.04%
ADHD Assessment Measure 2	n=8	11.59%
Bipolar Measure 1	n=3	4.35%
Bipolar Measure 2	n=4	5.80%
Coordination of Care Measure 1	n=52	76.36%

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Coordination of Care Measure 2	n=37	53.62%

Clinical Measurement Activities

Chemical Health Treatment Access

The purpose of this activity is to assist patients identified as chemically abusive or dependent in starting a recommended chemical health (CH) treatment program. It is BHP's goal to obtain CH treatment program attendance information for at least 90% of patients identified as needing CH treatment. When BHP is notified by a provider that a patient is recommended to pursue chemical health treatment, Care Management staff calls the patient to facilitate the start of treatment and address any barriers to beginning treatment. Care Management staff will contact the patient within 1 business day. In addition to assisting in getting the member into chemical health treatment, Care Management staff will inquire if the patient has any current mental health concerns and will offer to schedule a mental health appointment for the patient when appropriate.

In 2015, BHP staff reached 103 patients, 38.83 % of those members identified as those recommended to a CH treatment program and 61.17% were unreachable via telephone. In addition 7.69% of members with identified mental health concerns, that were reached, were scheduled a mental health appointment by BHP staff. BHP understands that assisting in the member's admission to a CD treatment facility is the first step in getting these members to treatment. It is possible that the member may not follow through with treatment as recommended. If this happens, BHP's efforts to continue assisting are limited due to personal privacy issues.

In previous years contacted included sending the final letter, this year contacted only includes a verbal exchange between the patient/family member and BHP staff. When we analyzed our performance against our performance goal we believed that we could provide better services by doing more to connect with the patients.

According to 2015 data:

- 59 patients (57.28%) entered treatment,
- 1 patients (.97%) refused treatment, and
- 1 patients (.97%) stated an intent to attend treatment, and
- 5 patients (4.85%) were unreachable.

Chemical Health Treatment Access Report			
Time frame	Number identified as High-Risk CD	Percentage contacted	Performance Goal
2013	355	89.86%	80%
2014	109	97.25%	90%
2015	103	95.14%	90%

Historical data for High-Risk Chemical Dependency services is available upon request.

Primary Access

It is the belief of BHP that behavioral health conditions in patients of all ages are more treatable with early detection from Primary Care Providers. In 2014, BHP developed a quality activity to facilitate scheduling for patients referred to a behavioral health appointment by their primary care provider. From October 2009 through December 2012, intake staff assisted in scheduling behavioral health appointments for patients from five primary care clinics. In January 2013, the Primary Access program was updated and expanded to include all Fairview Primary Care Clinics that are a part of the Fairview Medical Group (FMG). From January 2013 through December 2013, Intake staff assisted in scheduling patients and followed up on all appointments to determine appointment attendance. Starting December 2013, Intake staff also began following up on cancelled/failed appointments for all FMG patients to assist in rescheduling.

When BHP intake staff receive notification from a primary care provider that a patient would benefit from behavioral health services, the Intake staff makes 3 telephone calls to offer scheduling assistance. If after the third (3) phone attempt the patient is still not reached, a follow-up letter is sent. Once contact is made with the patient, intake staff schedule a first time behavioral health appointment for them, using the BHP SchedulR as their first line in scheduling. In 2015, intake staff scheduled 3,353 (44.98%) appointments for Primary Access members. If an appointment is scheduled, intake staff follow-up and document if the patient attends their scheduled appointment

DEC Coordination of Care

Improving coordination of care between behavioral and medical providers has been a long-term BHP quality initiative. It is our belief that members receive the best care when their providers are in communication with one another. In the 4th quarter of 2014 BHP collected data regarding coordination of care between the DEC services and primary care providers. Initial data indicated that when a primary care or medical provider is identified, the DEC exchanges information 34.99% of the time. Based on these results, BHP set a goal of coordination at least 50% of the time in 2015. Several steps were taken to improve coordination between the DEC services and primary care providers including: assessor education and attempting to simplify the process of obtaining a release of information. Monitoring of this activity will occur on a monthly basis in 2016.

DEC Coordination Results

Timeframe	Totals	Coordination
4th Quarter, 2014	# of Total Assmts: 3,308 # of Assmts with PCP Identified: 823 # of Assmts with coordination with PCP: 288	In cases which a PCP is identified coordination occurred 34.99% of the time.
2015	# of Total Assmts: 14,183 # of Assmts with PCP Identified: 3,883 # of Assmts with coordination with PCP: 1,924	In cases which a PCP is identified, coordination occurred 49.55% of the time.

De-escalation of Patients in Crisis

As part of BHP's screening program, the PHQ-9 is administered to members 18 years of age and older who call in to BHP. When a member receives a score of 15 or higher on the PHQ-9, responds affirmatively to question nine of the PHQ-9 indicating suicidality, or affirmatively responds that they are "in- crisis," the member is triaged with a licensed BHP staff member. In 2015, BHP implemented a new quality measurement activity related to this process. The purpose of the activity is to identify members who may be in need of crisis services as early as possible in order to help de-escalate them and give them access to appropriate appointments.

The licensed BHP staff person will assess the member in order to determine their needs and attempt to de-escalate them. BHP staff will then connect the member with appropriate services based on the assessment of the licensed staff. Cases will fall into one of four categories: routine, urgent, non-life threatening emergency, and life-threatening emergency. Licensed staff will attempt to de-escalate the member and thus increase the number of cases rated "routine." Additional training has be provided to licensed staff to handle patient crisis calls. Additionally, in order to further support the member, all triaged members will be offered a behavioral health appointment, and followed up on for additional services if needed.

For this activity BHP looks at the total number of cases triaged as a crisis call and the number of those cases that are rated "routine." BHP has set a goal of 40% or more of cases that are triaged will be rated "routine." In 2015, BHP triaged a total of 196 members to a licensed staff member. Of those, 134 cases (68.36%) were rated "routine" upon conclusion of their conversation with a licensed staff member, thus meeting our goal in 2015. Monitoring will occur on a quarterly basis in 2016 for this activity.

De-escalation of Patients Results

Timeframe	Totals	Percentage
2014	Total number of cases triaged: 166 Number of cases triaged rated routine: 84	50.60% of cases triaged were rated routine.
2015	Total number of cases triaged: 196 Number of cases triaged rated routine: 134	68.36% of cases triaged were rated routine

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Diagnostic Evaluation Center (DEC) Quality Activities

The University of Minnesota Medical Center - Fairview (UMMC-F) emergency department (ED) was the first to use the DEC® System in July 2002, and this service continues to be a primary quality initiative for BHP. The ability to immediately exchange medical records electronically, made possible through the use of the DEC Application, provides significant advances in patient care as it vastly improves the disconnected flow of clinical and treatment information while also adhering to applicable HIPAA and HITECH regulations.

Coordination of care is further improved as the DEC System is able to connect patients immediately to follow up care through the BHP developed web-based scheduling tool, the SchedulR®. Community providers and programs set aside appointment times for therapy, medication management, day treatment, chemical health assessments and more. All patients seen in a hospital setting, a psychiatrist and/or an ED physician are consulted on all final dispositions. BHP audit staff ensures the accuracy of the release of information on a daily basis. In addition, BHP audit staff contact practitioners, clinics and programs to inform them of their patient's assessment and disposition. Practitioners can access the assessment by logging on to the DEC System or by BHP audit staff faxing or mailing a copy of the assessment to the office, if needed.

BHP has also implemented processes aimed at ensuring follow up appointments were attended and, if appointments were not attended, assisting with rescheduling appointments.

Current sites:

- University of Minnesota Medical Center (UMMC), 2002
- Fairview Southdale Hospital, 2006
- Fairview Ridges Hospital, 2007
- Children's Hospital, Minneapolis and Saint Paul campuses, 2012
- School district 916, 2013
- School district 191, 2014
- School district 194, 2014
- School district 196, 2014
- School district 199, 2014
- School district 917, 2014

Telehealth Sites:

- Fairview Northland Medical Center, 2007
- Fairview Ridges Hospital, 2007
- Fairview Partners, 2012
- Fairview Lakes Medical Center, 2012
- CentraCare Health – Monticello, 2014
- Fairview Range, 2016

Contracted and Non-Contracted Data Combined

"Contracted" refers to patients who are insured by a payer with whom we have a contract for the DEC services. "Non-Contracted" refers to patients who received the same assessment, but are not insured by a plan contracted with BHP for the DEC services (appointment scheduling). The information below indicates the total number of assessments, both contracted and non-contracted, for all DEC physical and telehealth locations.

	2013	2014	2015
Number of Assessments	10,973	12,217	14,183

In addition to the daily and weekly monitoring that occurs, BHP hosts a monthly quality review meeting for each DEC site. This meeting is an opportunity to review portions of our clinical tool based on risk assessment, diagnostic assessment supported by clinical data, and final disposition supported by clinical data. The committee also looks to see that consultants are using the tool in a consistent manner and may have feedback about how the information is documented. Feedback obtained from this meeting is then passed along to the respective DEC assessor.

Member Services – Member Experience

Included in member services are activities that monitor member satisfaction, complaints and appeals, telephone access and abandonment, practitioner accessibility and availability (care windows).

Member Satisfaction Survey

Member satisfaction surveys are sent on a weekly basis to all members who received an authorization for services in the proceeding ninety (90) days. The results are reviewed quarterly and combined in the final year-end outcomes for year 2015. BHP established a performance goal of 80% or higher of respondents responding as neutral, satisfied or very satisfied (response of 3, 4 or 5).

In 2015, 2,706 member surveys were sent out and 388 were returned, resulting in a return rate of 14.33%. In 2015, the results for the member survey exceeded the expectation of 80% in every category with the exception of one. The year-end results indicate that a majority of the respondents are either very satisfied or satisfied with BHP's services and practitioners. The question that fell below the standard of 80% was related to exchange of information between the member’s practitioner and primary care provider.

Satisfaction data is subjective; it should be taken as an indicator of the member’s perceived satisfaction with care and services. The process of obtaining member satisfaction results will continue into 2016.

For the calendar year 2015, there were no appeals related to member satisfaction.

In addition to satisfaction data, BHP surveys basic demographic characteristics of the respondents. If an identified culturally specific population of more than 10% exists, BHP must explain our process for meeting those culturally specific needs. The greatest numbers of respondents are Caucasian between the ages of 18-64.

The questions are broken down to meet NCQA standards according the member services, accessibility, availability and acceptability.

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Commercial Member Satisfaction Survey Results

Question	2013 Survey Results (n=443)	2014 Survey Results (n=484)	2015 Survey Results (n=388)
1. How satisfied were you with the convenience of the clinic location?	94.04%	96.24%	95.82%
2. How satisfied were you with the convenience of clinic hours?	96.79%	96.45%	96.85%
3. How satisfied were you that your practitioner understood your issues?	90.09%	92.86%	93.18%
4. How satisfied were you with the effectiveness of the therapy you received?	87.56%	91.18%	91.78%
5. How satisfied were you that your privacy was maintained?	97.93%	98.74%	98.94%
6. How satisfied were you with the professionalism and courteous manner of the BHP staff?	96.56%	96.04%	98.09%
7. How satisfied were you with reaching BHP services after business hours?	91.79%	95.75%	93.64%
8. How satisfied were you with scheduling your first appointment through BHP staff?	94.47%	96.12%	93.94%
9. How satisfied were you with the method of authorizing your care by BHP?	96.61%	96.89%	97.41%
10. If you required a follow-up appointment, was it offered to you within 10 days?	85.84%	87.77%	85.61%
11. Did your practitioner talk to you about exchanging information with your primary care physician/medical provider?	65.80%	70%	70%

Member Demographic Survey Data

Ethnicity

	2013	2014	2015
African/American	13.74%	2%	**3%**
Asian/Pacific	4.47%	3%	**3%**
Caucasian	65.50%	87%	**88%**
Hispanic	1.76%	2%	**1%**
Native American	1.92%	2%	**1%**
Other	8.79%	5%	**2%**
Hmong	2.56%	0%	**0%**
Somali	**1.28%**	**0%**	**0%**

Age

	2013	2014	2015
0-12	10.17%	8%	**7%**
13-17	8.27%	10%	**10%**
18-64	78.06%	69%	**73%**
65 +	**3.50%**	**13%**	**10%**

Historical satisfaction survey data and demographic characteristics are available upon request.

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Chemical Health Patient Satisfaction

In 2010 BHP contracted with significantly more chemical health programs, and in response to this change our quality program began expanding to include these services. The first quality activity designed for these services was a patient satisfaction survey. Together with our Quality Committee and our Operations Team we designed a survey to measure patient satisfaction with chemical health services. The survey is sent to members 30 days after we receive notification that they began chemical health treatment.

BHP has set a goal of 80% or higher of respondents responding as neutral, satisfied or very satisfied. Of the 103 surveys that were sent out in 2015, 15 were returned for a response rate of 14.56%. There were four questions that fell below the goal of 80% related to the treatment program details. This is the first time three of these questions have fallen below the goal of 80%. The results are reviewed by the BHP Clinical Team and the BHP Quality Improvement Committee. BHP will continue to monitor chemical health satisfaction survey results in 2016 on a quarterly basis.

CH Patient Satisfaction Survey Results

	2013 (n = 18)	2014 (n = 17)	2015 (n =15)
1. The treatment program I participated in was helpful.	88.89%	93.75%	73.33%
2. The staff at my treatment program met my individual treatment needs.	83.33%	93.75%	73.33%
3. I feel satisfied with my ongoing care plan or long-term recovery plan created during treatment.	88.89%	93.75%	73.33%
4. The treatment program addressed other needs of mine. Examples of other needs might include things like medical and/or mental health issues, personal safety, employment, housing and childcare.	82.35%	75%	73.33%
5. I would recommend this treatment program to others who are looking for treatment.	83.33%	93.75%	80.00%
6. The rules and expectations of the treatment program were made clear to me.	94.44%	87.50%	80.00%

DEC Patient Satisfaction Survey

In 2009, BHP implemented a new satisfaction survey for patients seen at DEC sites. This survey obtains satisfaction information from all “Contracted” patients who were not admitted to an inpatient level of care. BHP management reviews survey data on a quarterly basis and aims to improve DEC services. Results continue to indicate that overall patients are satisfied with the care they receive. In 2015, 5,989 DEC surveys were sent out and 404 were returned; yielding a response rate of 6.75%. Patient satisfaction surveys showed overall that 81.59% of patients were satisfied with the care they received, once again meeting our goal of more than 80%. Within this overall score there were three questions that fell below the performance goal. These questions will continue to be monitored and will be addressed as needed.

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DEC Patient Satisfaction Survey Results

	2013 (n = 345)	2014 (n = 396)	2015 (n = 404)
1. The person that met with me was professional.	90.96%	90.81%	90.48%
2. The person that met with me understood my problems.	80.99%	79.59%	81.00%
3. I was satisfied with the result of my visit.	75.80%	73.28%	74.00%
4. My discharge plan was thoroughly explained to me.	81.23%	83.42%	84.42%
5. My follow-up appointment was scheduled in a timely way.	84.28%	80.49%	80.54%
6. I would come back to this emergency department if I had a similar problem in the future.	79.71%	73.78%	78.68%
Overall %	82.14%	80.23%	81.59%

Member Complaints and Appeals

BHP tracks both informal (telephonic) and formal (written) complaints. Informal complaints, by definition are often resolved at the time of the call. Formal complaints require a written response. BHP tracks both types of complaints and the time required to resolve complaints. Our standard is to resolve informal complaints within ten (10) days of receipt and formal complaints within thirty (30) days of receipt.

In 2015, BHP received 5 informal complaint and no formal complaints.

In addition to informal and formal complaint data, the member satisfaction survey allows for written comments from the respondent. BHP quality staff reads these comments, documents and tracks the negative comments. Of the member and chemical health satisfaction surveys returned in 2015, 40 (10.18%) contained negative comments.

A review of all practitioner specific complaints was completed. This includes informal, formal and member satisfaction comments. We identify all practitioners with three or more complaints and determine if this is equal to or greater than 5% of total number of complaints for the year. For those that are 5% or higher, a review of the complaint detail is done by the clinical team to determine the percentage of complaints that are clinical in nature. If concern arises from this review further action is taken as deemed necessary.

Zero practitioners had three complaints for the calendar year 2015.

Specific data on the categories and types of complaints is available upon request.

Member Services - Accessibility of Services

Telephone Access and Abandonment

Telephone access refers to a caller's ability to reach a non-recorded voice within thirty seconds (approximately six rings). Telephone access is monitored via a manual process where a BHP staff calls both of the BHP main telephone extensions and documents the number of rings until a live voice answers the line. The designated staff member makes weekly calls totaling a minimum of 20 calls per month.

For 2015, the average number of rings was 1.19 and 100% of the calls were answered within 6 rings. Results from this monitoring process reveal that members can reach BHP services. Our favorable telephone access rate reflects our commitment to quality customer service.

Telephone abandonment rates refer to members who abandon their call (hang up) prior to reaching an intake staff. The BHP Intake department is responsible for handling practitioner and member services telephone calls. The telephone system automatically sets a higher priority to member calls and passes these calls through to an Intake Staff according to this priority. For practitioners, a voice mail option is available in which they may leave their information in a voice mail rather than waiting on hold. In addition, BHP developed a web-based authorization request tool that allows practitioners to obtain authorizations online. The performance standard is to have an annual member abandonment rate of 5% or less.

The abandonment rate in 2015 was 1.38 %. BHP will continue to monitor access and abandonment on a minimum of a quarterly basis in 2016.

Telephone Access Results		
Calendar Year	**Number of Rings**	**Percentage**
2013	1.08	100%
2014	1.05	100%
2015	1.19	100%

Telephone Abandonment Results	
Calendar Year	**Abandonment Rate**
2013	3.27% member calls abandoned
2014	1.56% member calls abandoned
2015	1.38% member calls abandoned

Historical data on telephone access and abandonment is available upon request.

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Care Windows Reports

This report identifies the length of time from the request for service to the first appointment BHP can offer within a thirty-mile drive. The care window report is based on a query that identifies the date of the member call and the first offered appointment by BHP intake staff. The data below lists access timeframes for routine, urgent, life-threatening and non-life-threatening emergency appointments for physicians and therapists combined. NCQA stipulates that members with non-life threatening emergencies be seen within 6 hours, members with urgent needs have access to care within 48 hours, members with routine issues within 10 days.

BHP met the care window performance goal of 100% in 2015. These results are combined totals of Therapy and Psychiatry appointments. The percentages indicate that BHP is meeting its performance goal. Throughout the year, we review more detailed data on a monthly basis. We review data for each level of acuity and separate out psychiatry and psychotherapy. If an appointment falls outside the standard, the case is reviewed to ensure that all efforts are being made to meet the members' needs concerning gender, insurance, location and specialty; this allows us to identify any specific access issues as they arise within each specialty. In addition, BHP has data on the appointment the member accepted. A review of this data indicates that even if the member declines our first offered appointment, BHP can still find an appointment within the NCQA standard care windows that the patient accepts. Through the availability of our network, BHP consistently meets our care window performance goals. Overall, the high percentages indicate a strong commitment and effort to ensure that patients are seen in a timely way.

Care Window Results

Year Percent Meeting Standard	2013	2014	2015
Routine **(appt. offered within 10 days)**	100%	100%	100%
Urgent **(appt. offered within 48 hrs.)**	100%	100%	100%
Non-Life Threatening **(refer to ER)**	100%	100%	100%
Life Threatening **(refer to ER)**	100%	100%	100%
OVERALL TOTALS	**100%**	**100%**	**100%**

Historical data on Care Windows is available upon request.

Practitioner Accessibility and Availability

For 2015, BHP has the potential responsibility for the network management of approximately 50,902 enrolled lives. BHP has taken interest and concern in ensuring access to culturally specific providers. The BHP contracted network of 3,016 practitioners (2,905- Therapists, 156-Physicians) contains the following cultural and language competencies: African American, Native American, Middle Eastern, Hispanic, Hmong, American Sign Language, Cantonese, French, Spanish, Russian, Hebrew, Somali, Yoruba/Nigerian and several Eastern European languages to name a few and over 30 recorded different languages in all. In addition, BHP's contracted network has practitioners in 70 Minnesota counties, 17 Wisconsin counties, 3 North Dakota counties, and 1 South Dakota county. BHP also has access to the AT&T language line and has identified language interpreters that can be used to serve cultural needs as they arise.

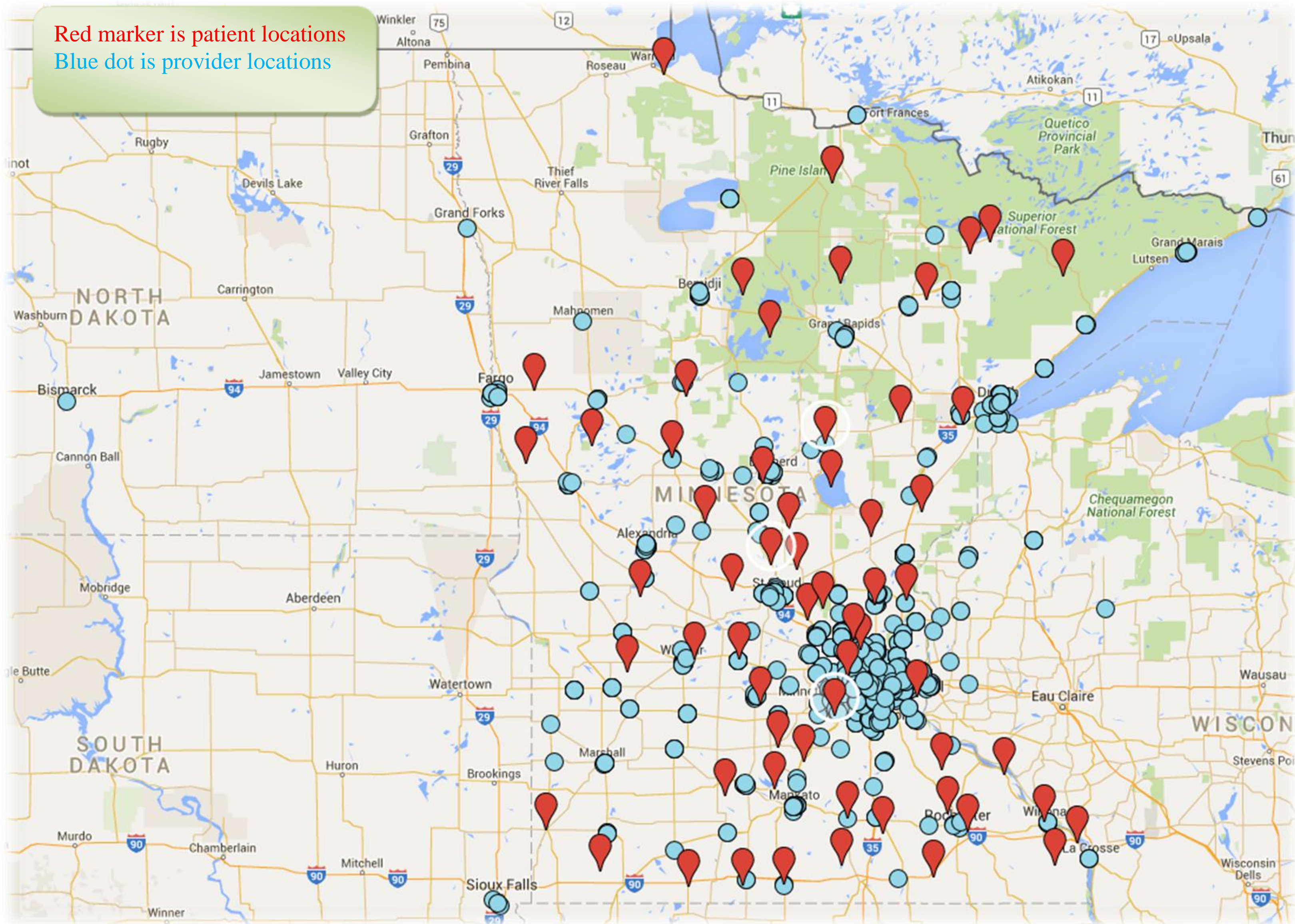
BHP's network evaluation policy is outlined below:

- By geographic region:
- Overall numeric standard; and
- Practitioner licensure-level standard

A geographic network analysis report was run according to policy. BHP members currently reside in 62 counties across the United States. The table below outlines the network availability performance goals and results. While BHP did not meet the performance goal in all counties, BHP has contracted with a number of practitioners that provide telehealth services and would be able to provide services to members living in those counties. As mentioned above, 85% of BHP members live within eight counties in MN and BHP met performance standards for all types of providers within those 8 counties. From this report we can determine that most members can easily access providers within their geographic region. BHP will continue to analyze network availability and will seek to add providers in counties in which we are not currently meeting standards. In addition, BHP has not received any informal or formal complaints related to access of care.

2015 Network Availability Performance Goals and Results	
Type of Provider	**Performance Goal Ratio Standard (Provider : Member)**
MD Providers	156:25451
All Prescribers (MD and Non-MD)	212:25451
Doctoral Providers (Non- Prescriber)	863:50902
Non-Doctoral, Non-Prescriber Providers	3219:50902
All Psychotherapy (Non-Prescriber) Providers	2041:25451

BHP Network Provider Map



Preventive Health and Screening Programs

Behavioral Health Screening Programs

The Quality Management and Improvement Program description states that BHP is committed to implementing up to two preventive health/behavioral health screening programs designed to benefit the member while improving the delivery of care. BHP believes that behavioral health screening is the first step in the process of identifying and treating mental health and substance use concerns.

BHP has two defined behavioral health screening programs; one is designed to screen for co-existing mental health and substance use disorders, the other is designed to screen for Generalized Anxiety Disorder. These screening programs assist BHP staff in identifying potential mental health and substance use concerns in members. BHP uses the results of these screening programs to help members access and schedule appropriate behavioral health services and also coordinates care by relaying the results of the screening program to any providers or practitioners the member is scheduled with. These screening programs are currently administered to eligible members through BHP's Intake department and through the Complex Case Management Program.

Chemical Health Preventative Activities

When members have a chemical health assessment or treatment appointment scheduled, BHP sends a follow up letter with information on the expectations for the type of service as well as a reference form with additional information. The reference form is as list of contacts that the member can access for services or treatment, information about addiction, and resources throughout the state that the member can connect with. The member is encouraged to follow through with their scheduled appointment and to contact BHP for any further services.

Conclusion

The BHP Quality staff spent a large part of 2015 focusing efforts on maintaining previous quality activities and adding additional NCQA required quality activities. The efforts made this year overall provide BHP and its Board with the necessary data to ensure that BHP's mission, vision and goals are being carried out. It should be noted that most of our existing monitoring functions did not warrant major interventions throughout the year. However, we did modify the access to chemical health program based on our evaluation and analysis of the program. When necessary, we do have processes in place through the plan description and policies that specify appropriate action.

This report serves as a comprehensive summary of the efforts and actions taken during 2015. Awareness of quality monitoring and quality reporting continues to gain interest and approval in the BHP network. In addition, it appears that many other health plans and health systems have also taken an interest in this degree of identifying and delivering quality care. BHP continues to function ahead of the curve with our quality improvement goals and programs. The BHP Board, Management, and staff can conclude that they made significant strides toward accomplishing a level and standard of care and service that supports BHP's mission "dedicated to enhancing behavioral health through innovation."

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