# Appendix A. RSN Profiles

The profiles in this appendix summarize each RSN's overall performance in measures of access, timeliness, and quality, and in meeting regulatory and contractual standards, including those for PIPs. Components of the Access, Timeliness, and Quality measures were abstracted from individual EQR reports delivered to DBHR throughout the year.

RSN scores, strengths, and opportunities for improvement were based on Acumentra Health's compliance review of each RSN.

[This page intentionally left blank]

# Chelan-Douglas Regional Support Network (CDRSN)

| Activity | |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Strengths** | **Opportunities for Improvement** |
| **Delivery Network — Fully Met (5 out of 5)** | |
| • RSN's contract requires providers to maintain the appropriate number, mix, and geographic distribution of practitioners to meet access needs. Provider agencies have changed their practices to accommodate after-hours, evening, and weekend appointments.<br>• RSN monitors second opinion requests through Ombuds reports and tracking logs received quarterly from providers. | |
| **Coordination and Continuity of Care — Fully Met (5 out of 5)** | |
| • RSN monitors quality and appropriateness of care for enrollees with specialized needs by reviewing service authorization requests and service utilization, meeting monthly with agency clinical directors, performing onsite audits, reviewing clinical records, and conducting enrollee satisfaction surveys. | |
| **Coverage and Authorization of Services — Fully Met (5 out of 5)** | |
| • RSN maintains a database to track all enrollees who have been admitted to and discharged from the hospital. | |
| **Provider Selection — Substantially Met (4.2 out of 5)** | |
| • RSN's contracts outline the providers' responsibility to ensure that their practitioners are credentialed and to participate in the RSN's annual credentialing review. | • RSN needs to follow the same credentialing procedure for its staff as for provider agency personnel. |
| **Subcontractual Relationships and Delegation — Fully Met (5 out of 5)** | |
| | |
| **Practice Guidelines — Fully Met (4.7 out of 5)** | |
| | • RSN needs to implement a process to review and update its practice guidelines. |
| **QA/PI Program —Fully Met (4.8 out of 5)** | |
| • RSN has a well-documented and comprehensive quality management program.<br>• RSN's ISCA committee, representing each provider agency, meets monthly and reviews data validation reports to ensure submission of complete, logical, and consistent data. | • Although the RSN summarizes the results of its programs and audit reviews through various reports to the clinical directors and advisory board, the RSN needs to consolidate that information into a single annual summary and incorporate the information into the RSN's ongoing quality management program. |
| **Certification and Program Integrity — Substantially Met (4.0 out of 5)** | |
| • RSN's compliance plan and contracts require all providers to have administrative and management arrangements or procedures in place to guard against fraud and abuse. | • CDRSN needs to update its compliance plan to address internal management and administrative controls to guard against fraud and abuse. |
| CDRSN, headquartered in East Wenatchee, contracts with providers to deliver comprehensive and culturally sensitive mental health services to eligible adults, children, and their families throughout Chelan and Douglas counties. CDRSN's philosophy is to achieve and maintain members' highest level of functioning in the community and discourage inappropriate placement of people in state institutions. During CY 2011, CDRSN provided outpatient services to 1,818 out of 27,141 (6.7%) Medicaid enrollees. | |
| Data source: Chelan-Douglas RSN 2012 External Quality Review Report (Acumentra Health). | |

# Chelan-Douglas Regional Support Network (continued)

## Activity

### Performance Improvement Projects (PIPs)

| Strengths | Opportunities for Improvement |
|---|---|
| **Nonclinical—Increased Penetration Rate for Older Adults: Fully Met (89 out of 90)** | |
| • Well documented study design.<br>• Intervention involved community partners. | • CDRSN needs to adjust the remeasurement period so that it follows the initiation of the intervention.<br>• CDRSN should consider supervising follow-up on referrals. |
| **Clinical—Permanent Supported Housing: Fully Met (88 out of 90)** | |
| • Well documented study design.<br>• Multi-faceted project involved community partners and peer support; housed 42 individuals. | • CDRSN needs to discuss how intervention activities in the community influence the selected indicator (a reduction in homelessness), and consider revising the indicator to avoid confounding factors. |

### Information Systems Capabilities Assessment (ISCA)

The 2011 ISCA resulted in four recommendations for improvement. As of the 2012 follow-up review, CDRSN had finished implementing a recommendation related to upgrading its data servers, and was in the process of implementing the remaining three recommendations.

### Encounter data validation

| Field | Chart matches electronic data | | Different validation result |
|---|---|---|---|
| | Acumentra Health | CDRSN | |
| ***Results from multiple encounters and a mix of services*** | ***(N=83)*** | ***(N=83)*** | ***(N=83)*** |
| Procedure code | 96.3% | 98.8% | 2 (2.4%) |
| Provider type | 98.8% | 98.8% | 0 (0.0%) |
| Minutes of service | 98.8% | 98.8% | 0 (0.0%) |
| Service location | 98.8% | 98.8% | 0 (0.0%) |
| Service date | 98.8% | 98.8% | 0 (0.0%) |
| Progress note matches service code | 97.6% | NA | NA |

***Encounter data validation process review***

| Strengths | Opportunities for Improvement |
|---|---|
| • CDRSN's sampling procedure is appropriate in terms of both sample size and the process for selecting a random sample. | • To reduce the potential for error involved in the manual manipulation of MS Excel formulas, CDRSN should develop a database to capture the EDV results, with reports that show summary results for each agency and for the entire RSN. |

# Clark County Regional Support Network (CCRSN)

| Activity | |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Strengths** | **Opportunities for Improvement** |
| **Delivery Network — Fully Met (4.7 out of 5)** | |
| • To meet access and availability timelines, the RSN's provider agencies have made significant changes that include open access, double booking, and expanded hours to include Saturdays and evening hours.<br>• In 2011, the majority of indicators for access and availability met the 90% threshold. | • RSN has not updated its Geo Access map since the previous review in 2008. The RSN needs to review the map and update information on its enrollee population.<br>• RSN needs to review and revise all policies and procedures at least every three years to ensure compliance.<br>• RSN needs to provide additional training for providers on second opinions. |
| **Coordination and Continuity of Care — Fully Met (4.8 out of 5)** | |
| • RSN's annual chart audit includes a comprehensive clinical review, covering intake assessments, referrals, cultural specialist consultations, treatment planning, progress notes, medication supervision, and discharge planning. | • **Finding:** RSN lacks a policy on providing direct access to specialists for enrollees with specialized needs and for measuring and monitoring direct access. |
| **Coverage and Authorization of Services — Fully Met (4.7 out of 5)** | |
| • RSN's policy calls for the care manager to make an authorization decision within 24 hours of receiving a request for services. | • **Finding:** RSN lacks a mechanism to ensure consistent application of review criteria for authorization decisions made by the medical director and the on-call medical director. |
| **Provider Selection — Fully Met (4.6 out of 5)** | |
| • RSN performs yearly oversight of subcontractors' credentialing practices through a sample chart review to ensure that agencies are checking for exclusions from participating in federal healthcare programs. | • **Finding:** RSN lacks a process to determine whether all RSN staff, volunteers, and committee and board members are eligible to participate in federal healthcare programs. |
| **Subcontractual Relationships and Delegation — Fully Met (5 out of 5)** | |
| | |
| **Practice Guidelines — Fully Met (4.7 out of 5)** | |
| | • RSN does not monitor the use of its practice guidelines. |
| **QA/PI Program — Fully Met (4.8 out of 5)** | |
| • Through analyses based on penetration rates, encounter data, and length-of-stay information for higher levels of care, the RSN identified the need to improve performance in two areas: (1) facilitating early access to care and (2) helping people at higher levels of care make transition to more appropriate levels of care. | • RSN needs to report on the evaluation of its quality management program annually. |
| **Certification and Program Integrity — Fully Met (4.5 out of 5)** | |
| • RSN's fraud and abuse policy defines the RSN's commitment to comply with all federal and state standards. Sections of the policy address expectations for proper accounting, record keeping, and provisions of the False Claims Act. | • Although the compliance officer has attended several classes on compliance, Acumentra Health recommends that the compliance officer attend a program to become certified. |
| CCRSN coordinates public mental health services in Clark County as a prepaid mental health plan, under governance of the Board of Clark County Commissioners. An appointed Mental Health Advisory Board, including consumer and family representatives, meets regularly and advises the commissioners on policy matters. As of December 2011, CCRSN provided outpatient services to 6,000 out of 85,767 (7.0%) Medicaid enrollees. | |
| Data source: Clark County RSN 2012 External Quality Review Report (Acumentra Health). | |

# Clark County Regional Support Network (continued)

## Activity

### Performance Improvement Projects (PIPs)

| Strengths | Opportunities for Improvement |
|---|---|
| **Nonclinical—Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization: Substantially Met (69 out of 90)** | |
| • Well documented study design.<br>• The intervention plan activates outpatient providers, using face-to-face contacts and client reminders. | • CCRSN needs to complete the intervention and present study results. |
| **Clinical—Employment Outcomes for Adult Consumers: Fully Met (100 out of 100)** | |
| • Well documented study design.<br>• Multi-faceted project with strong support from community partners. | • CCRSN needs to retire this PIP, now in its fifth year, and choose a new topic. |

### Information Systems Capabilities Assessment (ISCA)

The 2011 ISCA resulted in one finding and three recommendations for improvement, related to data security and to enrollment systems. As of the 2012 follow-up review, CCRSN had finished implementing all four recommendations.

### Encounter data validation

| Field | Chart matches electronic data | | Different validation result |
|---|---|---|---|
| | Acumentra Health | CCRSN | |
| ***Results from multiple encounters and a mix of services*** | ***(N=82)*** | ***(N=82)*** | ***(N=82)*** |
| Procedure code | 89.0% | 93.9% | 4 (4.9%) |
| Provider type | 89.0% | 100.0% | 9 (11.0%) |
| Minutes of service | 91.5% | 100.0% | 7 (8.5%) |
| Service location | 82.9% | 93.9% | 11 (13.4%) |
| Service date | 98.8% | 100.0% | 1 (1.2%) |
| Progress note matches service code | 97.6% | 100.0% | 2 (2.4%) |

***Encounter data validation process review***

| Strengths | Opportunities for Improvement |
|---|---|
| • MS Excel data-entry tool used by providers supports calculation of reporting statistics and is robust enough to automatically adjust the calculations as the template is modified for each provider. | • CCRSN needs to develop a system that will facilitate single entry of results and that contains static tables with a fixed number of variables.<br>• CCRSN needs to develop a more complete form with a place to record service location, to enable accurate comparison of chart and electronic data for service code and provider type.<br>• CCRSN needs to include crosswalk data in the EDV tool for each encounter record. |

# Grays Harbor Regional Support Network (GHRSN)

| Activity | |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Strengths** | **Opportunities for Improvement** |
| **Delivery Network — Fully Met (4.7 out of 5)** | |
| • RSN monitors network capacity through service penetration reports, utilization reports, annual compliance review, Quality Review Team surveys, and complaints and grievances.<br>• RSN's providers submit monthly reports of wait times from request for service to assessment, and from assessment to first routine visit. If a provider does not meet access standards, the RSN initiates a corrective action plan. | • **Finding:** RSN lacks a policy/procedure on second opinions.<br>• **Finding:** RSN's enrollee handbook does not present information on covering approved out-of-network services adequately and in a timely manner. |
| **Coordination and Continuity of Care — Fully Met (4.8 out of 5)** | |
| • RSN holds community resource staffing meetings at least twice a month, at which enrollees and other interested parties can review treatment plans and desired outcomes. | • **Finding:** RSN lacks formal policies and procedures on providing direct access to specialists. |
| **Coverage and Authorization of Services — Fully Met (5 out of 5)** | |
| • RSN monitors the use of crisis and stabilization services weekly, monthly, and yearly by reviewing data from crisis clinic utilization reports, performing site visits and chart reviews, conducting member surveys, tracking and analyzing enrollee complaints and grievances, and reviewing reports on the volume of Medicaid enrollees served in community hospitals. | |
| **Provider Selection — Fully Met (4.6 out of 5)** | |
| • RSN's policy requires the contracted agencies to check for excluded providers on a monthly basis. RSN also monitors its own staff monthly and maintains a database of results. | • RSN needs to revise its credentialing policy to include all contracted providers and agencies in the credentialing and recredentialing process. |
| **Subcontractual Relationships and Delegation — Fully Met (5 out of 5)** | |
| | |
| **Practice Guidelines — Fully Met (5 out of 5)** | |
| | |
| **QA/PI Program — Fully Met (4.8 out of 5)** | |
| • RSN conducts a comprehensive review of each provider's contract compliance, including a detailed analysis of performance measures and quality indicators. | • RSN needs to implement a procedure to ensure that backup processes are in place to enable submission of accurate and timely encounter data. |
| **Certification and Program Integrity — Fully Met (4.5 out of 5)** | |
| • RSN uses outlier analysis to monitor for fraud and abuse. Every other month, the RSN screens all outpatient service encounters for three types of outliers: single services over three hours in length, enrollees who receive more than eight services in a single month, and those with more than eight hours of total service in a month. | • Although the RSN's compliance officer is well versed in program integrity issues and has attended training provided by the state, Acumentra Health recommends that he attend a certified compliance training program. |
| GHRSN, headquartered in Aberdeen, authorizes all Medicaid-funded mental health services provided in Grays Harbor County. The RSN contracts with two regional providers—Seattle-based Sea Mar Community Health Center and Olympia-based Behavioral Health Resources—to provide outpatient mental health services. BHR operates a crisis clinic in Hoquiam. As of December 2011, GHRSN provided outpatient services to 1,730 out of 18,874 (9.2%) Medicaid enrollees. | |
| Data source: Grays Harbor RSN 2012 External Quality Review Report (Acumentra Health). | |

# Grays Harbor Regional Support Network (continued)

## Activity

### Performance Improvement Projects (PIPs)

| Strengths | Opportunities for Improvement |
|---|---|
| **Nonclinical—Improving Enrollee Engagement: Partially Met (52 out of 90)** | |
| • Itemized intervention plan. | • GHRSN needs to demonstrate that the PIP topic is a priority concern, and explain how the intervention improves enrollee outcomes or processes of care. |
| **Clinical—Reducing Self-Reported Symptoms of Depression Through Participation in Group Psychotherapy: Substantially Met (62 out of 90)** | |
| • Sound study design; uses a validated measurement tool. | • GHRSN needs to clarify details on the intervention and indicator measurement. |

### Information Systems Capabilities Assessment (ISCA)

The 2011 ISCA resulted in seven recommendations in the areas of information systems, staffing, hardware systems, enrollment systems, and provider data. As of the 2012 follow-up review, GHRSN had not finished implementing any of these recommendations but had made progress in implementing most.

### Encounter data validation

| Field | Chart matches electronic data | | Different validation result |
|---|---|---|---|
| | Acumentra Health | GHRSN | |
| ***Results from multiple encounters and a mix of services*** | ***(N=81)*** | ***(N=82)*** | ***(N=80)*** |
| Procedure code | 87.7% | 87.8% | 6 (7.5%) |
| Provider type | n/a | Not checked | n/a |
| Minutes of service | 86.4% | 15.9% | 69 (86.3%) |
| Service location | 72.8% | 67.1% | 8 (10.0%) |
| Service date | 95.1% | 96.3% | 5 (6.3%) |
| Progress note matches service code | 87.7% | 89.0% | 17 (21.3%) |

***Encounter data validation process review***

| Strengths | Opportunities for Improvement |
|---|---|
| • High rates of matching were found between electronic and chart data for each demographic field reviewed.<br>• GHRSN's sampling procedure is adequate and the sample size is appropriate and proportional.<br>• Formulas used in the MS Excel tool to calculate percentages of matching between electronic and chart data are adequate. | • GHRSN needs to implement the provider type check as required by the state contract for EDV.<br>• GHRSN should develop a database system to perform the EDV. |

# Greater Columbia Behavioral Health (GCBH)

| Activity | |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Strengths** | **Opportunities for Improvement** |
| **Delivery Network — Fully Met (4.8 out of 5)** | |
| • RSN's care coordinators maintain data on all requests for out-of-network services, and they periodically report the results to the quality improvement committee.<br>• RSN's committee on multicultural competency meets quarterly to address issues related to diversity, staff training, and language barriers. RSN offers cultural diversity training to the provider agencies. | • **Finding:** RSN does not track and monitor all requests for second opinions. |
| **Coordination and Continuity of Care — Fully Met (5 out of 5)** | |
| • RSN contract requires practitioners to involve the enrollee's primary care provider in developing and implementing the treatment plan. RSN performs clinical record audits to ensure compliance. | |
| **Coverage and Authorization of Services — Fully Met (5 out of 5)** | |
| • RSN brought its service authorization process in-house as of November 2011. Interviews with a provider agency indicated that the review process is working well. | |
| **Provider Selection — Fully Met (4.6 out of 5)** | |
| | • **Finding:** RSN lacks a mechanism to monitor the results of its credentialing and recredentialing process. |
| **Subcontractual Relationships and Delegation — Fully Met (5 out of 5)** | |
| | |
| **Practice Guidelines — Substantially Met (4.3 out of 5)** | |
| | • **Finding:** RSN does not review and update its practice guidelines to ensure that they still apply to enrollees' needs and include any updated clinical recommendations. |
| **QA/PI Program — Fully Met (4.7 out of 5)** | |
| • RSN has a well-documented and comprehensive quality management program, encompassing all aspects of the RSN's services. | • **Finding:** RSN lacks a mechanism to detect, identify, and monitor for over- and underutilization of services. |
| **Certification and Program Integrity — Fully Met (4.5 out of 5)** | |
| | • To ensure complete objectivity, the RSN should consider assigning compliance responsibilities to someone other than the chief financial officer.<br>• Acumentra Health recommends that the compliance officer attend training to become certified. |
| GCBH, headquartered in Kennewick, is a 12-member government consortium providing public mental health services for 11 counties and the Yakama Nation in south central Washington. A citizen's advisory board advises the GCBH board of directors, reviews and provides comments and/or recommendations on plans and policies, and serves on workgroups and committees of GCBH. As of December 2011, GCBH provided outpatient services to 14,207 out of 185,218 (7.7%) Medicaid enrollees.. | |
| Data source: Greater Columbia Behavioral Health 2012 External Quality Review Report (Acumentra Health). | |

# Greater Columbia Behavioral Health (continued)

## Activity

### Performance Improvement Projects (PIPs)

| Strengths | Opportunities for Improvement |
|---|---|
| **Nonclinical—Improving Early Engagement in Outpatient Services: Substantially Met (79 out of 100)** | |
| • Well documented data elements and data collection plan. | • GCBH needs to demonstrate that the PIP topic is a priority concern, explain how the intervention relates to the selected indicator, and interpret the overall results of the project. |
| **Clinical—Impact of Care Management on Child Readmissions to Inpatient Care: Substantially Met (58 out of 90)** | |
| • Well documented data elements and data collection plan. | • GCBH needs to demonstrate that the PIP topic is a priority concern, and explain how the planned intervention addresses issues identified in the local system. |

### Information Systems Capabilities Assessment (ISCA)

The 2011 ISCA resulted in six recommendations for improvement in the areas of information systems, staffing, security, and administrative data. As of the 2012 follow-up review, GCBH was still in the process of implementing all six recommendations.

### Encounter data validation

| Field | Chart matches electronic data | | Different validation result |
|---|---|---|---|
| | Acumentra Health | GCBH | |
| ***Results from multiple encounters and a mix of services*** | ***(N=82)*** | ***(N=82)*** | ***(N=82)*** |
| Procedure code | 100.0% | 97.6% | 2 (2.4%) |
| Provider type | 98.8% | 100.0% | 1 (1.2%) |
| Minutes of service | 98.8% | 100.0% | 1 (1.2%) |
| Service location | 100.0% | 100.0% | 0 (0.0%) |
| Service date | 100.0% | 100.0% | 0 (0.0%) |
| Progress note matches service code | 97.5% | 91.5% | 9 (11.1%) |

***Encounter data validation process review***

| Strengths | Opportunities for Improvement |
|---|---|
| • GCBH has a very high rate of accuracy and matches between the agency and RSN electronic data for both demographic and encounter data fields. | • GCBH needs to develop a computerized algorithm to select a random sample of encounters.<br>• GCBH should develop the database entry tool to include reports that can show the summary statistics presently calculated in MS Excel. |

# King County Regional Support Network (KCRSN)

| Activity | |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Strengths** | **Opportunities for Improvement** |
| **Delivery Network — Fully Met (4.7 out of 5)** | |
| • RSN monitors network sufficiency by evaluating service penetration, service utilization patterns, geographic locations, time, distance, and physical access, as well as reports that identify gender, age, ethnicity, and special populations served. | • RSN needs to implement a process to monitor requests for second opinions.<br>• RSN needs to continue to work with contracted providers to ensure timely access to routine care and services for children. |
| **Coordination and Continuity of Care — Fully Met (5 out of 5)** | |
| • RSN policies and procedures identify special healthcare needs of children, geriatric enrollees, people with disabilities, people with co-morbid diagnoses, and the chronically ill. | |
| **Coverage and Authorization of Services — Fully Met (5 out of 5)** | |
| • RSN uses a team of professionals to perform utilization management, coordinate treatment plans for enrollees with special needs, and facilitate out-of-network services. | |
| **Provider Selection — Fully Met (5 out of 5)** | |
| • RSN's annual renewal of all provider contracts includes completing a credentialing application and verifying that the agency meets licensing and exclusion requirements. Recredentialing also includes review of grievances, extraordinary occurrences, solvency, and fiscal status. | |
| **Subcontractual Relationships and Delegation — Fully Met (5 out of 5)** | |
| • RSN described a thorough review process prior to delegating any activities, which includes reviewing financial data, staff trainings, and policies and procedures. | |
| **Practice Guidelines — Fully Met (4.7 out of 5)** | |
| | • **Finding:** RSN lacks a process to review and update its practice guidelines. |
| **QA/PI Program — Fully Met (4.8 out of 5)** | |
| • RSN's annual reviews of contracted providers address HIPAA, security compliance, and service encounter verification. | • RSN needs to complete an evaluation of its QA/PI program annually. |
| **Certification and Program Integrity — Fully Met (5 out of 5)** | |
| • RSN's fraud and abuse policy defines commitment to comply with all federal and state standards. The policy also addresses expectations for proper accounting, and record keeping. | |
| KCRSN, managed by the county's Mental Health, Chemical Abuse and Dependency Services Division, provides services and supports for adults with chronic mental illness and for severely emotionally disturbed children living in the county. The RSN administers services provided by a certified vendor pool of community mental health centers. A citizen advisory board provides policy direction, prioritizes and advocates for service needs, and oversees evaluation of services. As of December 2011, KCRSN provided outpatient services to 30,609 out of 270,032 (11.3%) Medicaid enrollees. | |
| Data source: King County RSN 2012 External Quality Review Report (Acumentra Health). | |

# King County Regional Support Network (continued)

## Activity

### Performance Improvement Projects (PIPs)

| Strengths | Opportunities for Improvement |
|---|---|
| **Nonclinical—Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization: Fully Met (86 out of 100)** | |
| • Well documented study design. | • KCRSN needs to relate the intervention to the selected indicator, and discuss the role of outpatient providers.<br>• KCRSN needs to retire this PIP, now in its fifth year, and choose a new topic. |
| **Clinical—Metabolic Syndrome Screening and Intervention: Fully Met (80 out of 90)** | |
| • Innovative study design activated agency participation in the PIP process.<br>• Implementation issues and study results were reported in detail. | • KCRSN needs to provide more details on topic selection, data sources, and definitions at each provider agency to increase confidence in the results; and discuss the project results from the RSN perspective.<br>• KCRSN needs to retire this PIP, now in its fifth year, and choose a new topic. |

### Information Systems Capabilities Assessment (ISCA)

The 2011 ISCA resulted in four recommendations for improvement. As of the 2012 follow-up review, KCRSN had begun implementing two recommendations related to hardware systems, but had taken no action on recommendations related to security and administrative data.

### Encounter data validation

| Field | Chart matches electronic data | | Different validation result |
|---|---|---|---|
| | Acumentra Health | KCRSN | |
| ***Results from multiple encounters and a mix of services*** | ***(N=83)*** | ***(N=84)*** | ***(N=83)*** |
| Procedure code | 89.2% | 96.4% | 6 (7.2%) |
| Provider type | 98.8% | 98.8% | 2 (2.4%) |
| Minutes of service | 100.0% | 98.8% | 1 (1.2%) |
| Service location | 100.0% | 98.8% | 1 (1.2%) |
| Service date | 100.0% | 98.8% | 1 (1.2%) |
| Progress note matches service code | 89.2% | n/a | n/a |

***Encounter data validation process review***

| Strengths | Opportunities for Improvement |
|---|---|
| • KCRSN's EDV procedure is adequate in terms of both sample size and the process for drawing a random sample.<br>• KCRSN had very high levels of matching between agency-level electronic data and the data submitted to ProviderOne. | • KCRSN should develop a database system to display the EDV fields to be reviewed and capture the results in the database.<br>• KCRSN needs to explore an approach to using the total eligible population, not only those enrollees meeting continuous benefit authorization criteria, for the random sample. |

# North Central Washington Regional Support Network (NCWRSN)

| Activity | |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Strengths** | **Opportunities for Improvement** |
| **Delivery Network — Fully Met (4.8 out of 5)** | |
| • RSN reviews, at least biennially, statistics including Medicaid enrollment and service penetration rates, enrollee ethnicities and languages spoken, encounter volumes, numbers and types of mental health professionals, and geo-mapping data. | • **Finding:** RSN lacks a formal mechanism to monitor and track second opinions occurring within its provider network.<br>• RSN needs to follow its written policy and procedure for implementing corrective action.<br>• RSN needs to ensure that all agencies provide cultural specialist consultations per state regulations and contract provisions. |
| **Coordination and Continuity of Care — Fully Met (4.7 out of 5)** | |
| • Each month, RSN reviews clinical records to ensure that treatment plans are developed in a timely manner and to ensure coordination of care. | • **Finding:** RSN lacks a policy for identifying and assessing enrollees who have specialized healthcare needs. |
| **Coverage and Authorization of Services — Partially Met (3.4 out of 5)** | |
| • RSN providers enter authorization requests into an electronic record system. The RSN reviews authorizations to ensure that the requested services meet level-of-care requirements. If further information is needed, RSN will consult with the requesting agency. Letters are issued to the enrollee and the practitioner when an authorization is entered into the system. | • **Finding:** RSN lacks a mechanism to ensure consistent application of review criteria for authorization decisions.<br>• **Finding:** During 2011, RSN did not consistently follow procedures to ensure timely authorization of services.<br>• **Finding:** RSN lacks written policies and procedures for providing crisis, stabilization, and post-hospital follow-up services. RSN does not monitor use of crisis services. |
| **Provider Selection — Fully Met (5.0 out of 5)** | |
| • RSN monitors all practitioners' credentialing files annually. | |
| **Subcontractual Relationships and Delegation — Fully Met (5 out of 5)** | |
| | |
| **Practice Guidelines — Substantially Met (3.7 out of 5)** | |
| | • **Finding:** RSN lacks a mechanism for periodically reviewing and updating its practice guidelines.<br>• **Finding:** RSN lacks documentation of the dissemination of its practice guidelines. |
| **QA/PI Program — Substantially Met (3.8 out of 5)** | |
| • After RSN determined that an agency was underdiagnosing enrollees with three general diagnoses—depression, psychosis, and anxiety—the RSN provided training to help the agency perform better assessments and identify the most accurate diagnosis. | • **Finding:** RSN lacks a formal planned QA/PI program, a QI committee, and an overall process for evaluating the effectiveness of its activities.<br>• RSN needs to continue working to improve the validity of its performance data. |
| **Certification and Program Integrity — Fully Met (4.5 out of 5)** | |
| • RSN has a well-developed website listing the RSN's policies and procedures, compliance plan, and training classes. | |
| NCWRSN formerly administered local mental health systems in Adams, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, and Stevens counties. In October 2012, NCWRSN merged with the Spokane County RSN to form a multi-county RSN. As of December 2011, NCWRSN provided outpatient services to 3,737 out of 66,360 (5.6%) Medicaid enrollees. | |
| Data source: North Central Washington RSN 2012 External Quality Review Report (Acumentra Health). | |

# North Central Washington Regional Support Network (continued)

| Activity | |
|---|---|
| **Performance Improvement Projects (PIPs)** | |
| **Strengths** | **Opportunities for Improvement** |
| **Nonclinical—Improving the Submission of Correct and Timely Reauthorization Requests: Minimally Met (18 out of 90)** | |
| | • NCWRSN needs to select a study topic related to enrollee outcomes or processes of care; and define the study question, indicator, and data sources. |
| **Clinical—Provision of Outpatient Mental Health Services via TeleHealth System: Minimally Met (29 out of 90)** | |
| • Established the importance of the PIP topic for the local Medicaid population. | • NCWRSN needs to document the study design. |
| **Information Systems Capabilities Assessment (ISCA)** | |
| The 2011 ISCA resulted in 17 recommendations in the areas of information systems, hardware systems, security, administrative data, and enrollment systems. The recommendations included two findings related to information systems and security. As of the 2012 follow-up review, NCWRSN had begun addressing all recommendations, with implementation in various stages of progress. | |
| **Encounter data validation** | |

| Field | Chart matches electronic data | | Different validation result |
|---|---|---|---|
| | Acumentra Health | NCWRSN | |
| ***Results from multiple encounters and a mix of services*** | ***(N=82)*** | ***n/a*** | ***n/a*** |
| Procedure code | 96.3% | It was not possible to compare NCWRSN's EDV results directly with Acumentra Health's results because the RSN did not save its results, which had been recorded on paper. | |
| Provider type | 98.8% | | |
| Minutes of service | 80.5% | | |
| Service location | 80.5% | | |
| Service date | 98.8% | | |
| Progress note matches service code | n/a | | |

| ***Encounter data validation process review*** | |
|---|---|
| **Strengths** | **Opportunities for Improvement** |
| • NCWRSN used an adequate sampling procedure. | • NCWRSN should develop a database or electronic data-entry system to record its EDV results. |

# North Sound Mental Health Administration (NSMHA)

| Activity | |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Strengths** | **Opportunities for Improvement** |
| **Delivery Network — Fully Met (5 out of 5)** | |
| • RSN tracks the frequency of requests for second opinions.<br>• Several provider agencies have successfully initiated same-day access. | |
| **Coordination and Continuity of Care — Fully Met (4.7 out of 5)** | |
| • RSN ensures care coordination by routinely auditing clinical records and by tracking and analyzing complaints and grievances. | • Although improvement has been made in meeting clinical documentation standards for treatment planning, some agencies regressed from the previous year's performance. RSN needs to continue to provide training and to closely monitor the agencies not meeting the documentation standards. |
| **Coverage and Authorization of Services — Fully Met (5 out of 5)** | |
| • RSN monitors the use of crisis and stabilization services by performing site visits, chart reviews, and member surveys, and by tracking and analyzing member complaints and grievances. | |
| **Provider Selection — Fully Met (5 out of 5)** | |
| • RSN's contracts outline the providers' responsibility to ensure that their practitioners are credentialed and to participate in the RSN's annual credentialing review. | |
| **Subcontractual Relationships and Delegation — Fully Met (5 out of 5)** | |
| • RSN conducts an annual review of providers' policies, credentialing files, financial reports, compliance plan, QI plan and activities, grievances, crisis logs, and staff training. | |
| **Practice Guidelines — Fully Met (4.7 out of 5)** | |
| • RSN's clinical guidelines reflect enrollees' needs and address topics such as depression, eating disorders, co-occurring disorders, attention deficit disorders, person-centered recovery and resiliency, and dementia. | • Several guidelines are outdated. RSN needs to implement provisions to review and update the practice guidelines to ensure that they still apply to enrollees' needs and include any updated clinical recommendations. |
| **QA/PI Program — Fully Met (4.8 out of 5)** | |
| • RSN's PIPs are multiyear projects that were selected to address unmet needs affecting many RSN enrollees.<br>• RSN maintains a key indicator dashboard that includes average daily census, denials, average calls, percentage meeting dispatch time of less than 2 hours, stabilization bed percentage, law enforcement drop-offs, and other indicators. | • RSN's QA/PI program document should define more clearly the scope of services included in the quality management program.<br>• Year-end program evaluation should describe the RSN's achievements and should include EQR findings, agency audit results, subcontract monitoring activities, consumer grievances, and service verification. |
| **Certification and Program Integrity — Fully Met (5 out of 5)** | |
| • RSN's annual administrative audit confirms that each provider has the necessary processes in place, including a whistle-blower policy/procedure and standards of conduct. | |
| NSMHA, headquartered in Mount Vernon, serves public mental health enrollees in Island, San Juan, Skagit, Snohomish, and Whatcom counties. A nine-member board of directors drawn from each county's executive and legislative branches of government sets the RSN's policy direction, and a citizen advisory board provides independent advice to the board and feedback to local jurisdictions and service providers. As of December 2011, NSMHA provided outpatient services to 9,543 out of 183,195 (5.2%) Medicaid enrollees. | |
| Data source: North Sound Mental Health Administration 2012 External Quality Review Report (Acumentra Health). | |

# North Sound Mental Health Administration (continued)

## Activity

### Performance Improvement Projects (PIPs)

| Strengths | Opportunities for Improvement |
|---|---|
| **Nonclinical—Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization: Fully Met (96 out of 100)** | |
| • Established the importance of the topic for the local Medicaid population.<br>• Well documented data elements. | • NSMHA needs to define valid measurement periods, and present complete and consistent data.<br>• NSMHA needs to retire this PIP, now in its fifth year, and choose a new topic. |
| **Clinical—Decrease in the Days to Medication Evaluation Appointment After Request for Service: Fully Met (89 out of 100)** | |
| • Established the importance of the topic for the local Medicaid population.<br>• Well developed intervention plan. | • NSMHA needs to define valid measurement periods and data elements, and present complete and consistent data.<br>• NSMHA needs to discuss lessons learned and how confounding factors affected the study results. |

### Information Systems Capabilities Assessment (ISCA)

The 2011 ISCA resulted in 13 recommendations in the areas of information systems, hardware systems, security, administrative data, enrollment systems, and provider data. As of the 2012 follow-up review, NSMHA had discontinued its contract with Raintree Systems, addressing two recommendations and making one no longer applicable. NSMHA was in the process of implementing six other recommendations. NSMHA had made no progress in addressing four recommendations related to hardware systems, data security, and encounter data auditing.

### Encounter data validation

| Field | Chart matches electronic data | | Different validation result |
|---|---|---|---|
| | Acumentra Health | NSMHA | |
| ***Results from multiple encounters and a mix of services*** | ***(N=83)*** | ***(N=83)*** | ***(N=83)*** |
| Procedure code | 98.8% | 100.0% | 1 (1.2%) |
| Provider type | 97.6% | 100.0% | 2 (2.4%) |
| Minutes of service | 97.6% | 100.0% | 2 (2.4%) |
| Service location | 98.8% | 100.0% | 1 (1.2%) |
| Service date | 100.0% | 100.0% | 0 (0.0%) |
| Progress note matches service code | 100.0% | n/a | n/a |

***Encounter data validation process review***

| Strengths | Opportunities for Improvement |
|---|---|
| • NSMHA's sampling procedure is adequate and sample size is appropriate. | • NSMHA needs to establish a testing system, including code review, to ensure that EDV systems are working before using those systems in the field. |

# OptumHealth Pierce Regional Support Network (OPRSN)

| Activity | |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Strengths** | **Opportunities for Improvement** |
| **Delivery Network — Fully Met (4.8 out of 5)** | |
| • By analyzing geo mapping data, RSN identified the need to increase the number of provider agencies in the Gig Harbor service area.<br>• RSN emphasizes same-day access to service intakes. RSN has exceeded the state's performance measure for providing an intake within 14 calendar days of request for services. | • RSN needs to implement a mechanism to track and monitor second opinions received and managed at the contracted provider agencies. |
| **Coordination and Continuity of Care — Fully Met (5 out of 5)** | |
| • RSN and MultiCare partnered to develop a Mobile Integrated Health Care team to provide physical and behavioral healthcare services to people who do not have PCPs. | |
| **Coverage and Authorization of Services —Fully Met (5 out of 5)** | |
| • Provider agencies are notified electronically within one working day of authorization decisions.<br>• RSN's care managers review individuals who have had four or more crisis service encounters during the previous month to explore the reasons for the encounters. | |
| **Provider Selection — Fully Met (5 out of 5)** | |
| • RSN's QA/PI manager performs monthly exclusion checks on all employees and contractors. | |
| **Subcontractual Relationships and Delegation — Fully Met (5 out of 5)** | |
| • Results of RSN's annual reviews of each network provider are presented to the providers, Quality Management Committee, mental health advisory board, governing board, and Consumer and Family Advisory Committee. | |
| **Practice Guidelines — Fully Met (4.7 out of 5)** | |
| | • **Finding:** RSN lacks a policy on the dissemination of practice guidelines. |
| **QA/PI Program — Fully Met (4.8 out of 5)** | |
| • RSN requires the contracted agencies to provide monthly data certifications. RSN staff performs data completeness and quality checks of the data arriving from providers. | • RSN should expand its year-end program evaluation to include EQR findings, agency audit results, subcontract monitoring activities, consumer grievances, service verification, and recommendations for the coming year. |
| **Certification and Program Integrity — Fully Met (4.8 out of 5)** | |
| • RSN requires all staff to receive multiple web-based trainings on fraud, waste, and abuse. RSN emphasizes that employees are a key resource in helping to reduce fraud, waste, and abuse in the healthcare system. | • RSN should request confirmation of which members of provider agency staff have received annual training on fraud and abuse.<br>• RSN's compliance committee should meet on a regular basis, rather than only when fraud and abuse issues are identified. |
| OptumHealth, a subsidiary of UnitedHealth Group, began operating the Pierce County RSN in 2009, headquartered in Tacoma. A mental health advisory board, approved by the seven-member governing board, meets monthly to review issues of concern and relevance to mental health consumers and their families. OPRSN has more than 5 million public-sector members nationwide, including 156,055 Medicaid enrollees in Pierce County at the end of 2011, when OPRSN had a service penetration rate of 6.7% (10,433). | |
| Data source: OptumHealth Pierce RSN 2012 External Quality Review Report (Acumentra Health). | |

# OptumHealth Pierce Regional Support Network (continued)

## Activity

### Performance Improvement Projects (PIPs)

| Strengths | Opportunities for Improvement |
|---|---|
| **Nonclinical—Consumer Residential Satisfaction: Substantially Met (62 out of 90)** | |
| • Involves an ambitious effort to develop integrated community housing in multiple phases.<br>• Uses a validated measurement tool. | • OPRSN needs to develop a method to evaluate satisfaction for the entire study population.<br>• OPRSN needs to provide more information on the intervention, including authorization criteria for residents to move. |
| **Clinical—Consumer Voice in Treatment Planning: Fully Met (88 out of 90)** | |
| • Sound study design.<br>• Well documented data collection plan. | • OPRSN needs to provide clear and consistent definitions of the study periods.<br>• OPRSN needs to provide more information on how overall results were calculated from the stratified sample. |

### Information Systems Capabilities Assessment (ISCA)

The 2011 ISCA resulted in eight recommendations for improvement in the areas of staffing, hardware systems, security, administrative data, and enrollment systems. As of the 2012 follow-up review, OPRSN had finished implementing one recommendation related to its enrollment system, and was in the process of implementing the remaining recommendations.

### Encounter data validation

| Field | Chart matches electronic data | | Different validation result |
|---|---|---|---|
| | Acumentra Health | OPRSN | |
| ***Results from multiple encounters and a mix of services*** | ***(N=63)*** | ***(N=63)*** | ***(N=63)*** |
| Procedure code | 87.3% | 100.0% | 8 (12.7%) |
| Provider type | 61.9% | 100.0% | 24 (38.1%) |
| Minutes of service | 79.4% | 100.0% | 13 (20.6%) |
| Service location | 87.3% | 100.0% | 8 (12.7%) |
| Service date | 91.9% | 100.0% | 5 (8.1%) |
| Progress note matches service code | 90.3% | n/a | n/a |

***Encounter data validation process review***

| Strengths | Opportunities for Improvement |
|---|---|
| • OPRSN's sampling procedure is adequate in terms of sample size and in selecting a random sample.<br>• OPRSN's MS Excel tool, which is used to analyze results, contains no formula errors. | • OPRSN should develop a database system to reduce the potential for error involved in recording EDV results twice. |

# Peninsula Regional Support Network (PRSN)

| Activity | |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Strengths** | **Opportunities for Improvement** |
| **Delivery Network — Fully Met (5 out of 5)** | |
| • Through data on referrals to out-of-network services, the RSN identified a need to develop its own program and protocols and to train its own therapists on eating disorders to meet enrollees' needs. | |
| **Coordination and Continuity of Care — Fully Met (4.7 out of 5)** | |
| • Network providers must ensure coordination with other service delivery systems responsible for meeting enrollees' identified needs. RSN monitors this function during monthly and annual records review, through complaints and grievances, and through input from consumers. | • RSN needs to continue its efforts to ensure that enrollees' treatment plans are updated to include recommendations from primary care providers, allied healthcare providers, and cultural specialists. |
| **Coverage and Authorization of Services — Fully Met (5 out of 5)** | |
| • RSN monitors authorizations through face-to-face discussions with providers, review of enrollee survey feedback, review of grievances and appeals, and chart audits. | |
| **Provider Selection — Fully Met (4.6 out of 5)** | |
| • RSN's compliance officer requires monthly attestation from each agency that all staff, board members, volunteers, interns, and subcontractors have been screened for federal exclusion. | • RSN's credentialing procedure needs to include a process for routinely verifying the qualifications of the RSN's licensed staff. |
| **Subcontractual Relationships and Delegation — Fully Met (5 out of 5)** | |
| • RSN monitors delegated activities both monthly and yearly. | |
| **Practice Guidelines — Fully Met (5 out of 5)** | |
| • RSN's practice guidelines are incorporated into utilization management protocols, enrollee education, and the network provider training plan. | |
| **QA/PI Program — Fully Met (4.8 out of 5)** | |
| • RSN uses multiple methods to detect over- and underutilization, such as reviewing enrollees' charts to examine clinical appropriateness and the match between authorized service level and services provided. | • RSN did not perform a QA/PI program evaluation for 2011. RSN should evaluate its QA/PI program annually, reviewing RSN accomplishments, service performance, PIPs, customer satisfaction, fidelity to guidelines, coordination of services, and recommendations for the coming year. |
| **Certification and Program Integrity — Fully Met (4.5 out of 5)** | |
| • RSN's corporate compliance officer (CCO), who also has the title of program integrity officer, oversees the monitoring and reporting of matters pertaining to compliance. The CCO has direct access to PRSN's legal advisors and the authority to report and investigate concerns. | • RSN should consider organizing a compliance committee apart from the QI committee. Members of the separate committee would include compliance officers and financial representatives from the contracted agencies.<br>• Acumentra Health recommends that RSN's compliance officer attend formalized training on compliance and fraud and abuse. |
| PRSN, headquartered in Port Orchard, is a consortium of the mental health programs of Clallam, Jefferson, and Kitsap counties, administered by Kitsap County. The executive board, comprising nine county commissioners, has policy and oversight responsibilities. As of December 2011, PRSN provided outpatient services to 4,960 out of 54,438 (9.1%) Medicaid enrollees. | |
| Data source: Peninsula RSN 2012 External Quality Review Report (Acumentra Health). | |

# Peninsula Regional Support Network (continued)

## Activity

### Performance Improvement Projects (PIPs)

| Strengths | Opportunities for Improvement |
|---|---|
| **Nonclinical—Weight Monitoring: Fully Met (72 out of 90)** | |
| • Well documented study design. | • The topic is nearly identical to the previous PIP and the other current PIP. |
| **Clinical—Healthy Living Program: Substantially Met (67 out of 90)** | |
| • Established the importance of the topic for the local Medicaid population. | • The topic is nearly identical to the previous PIP and the other current PIP.<br>• PRSN needs to develop a valid study design.<br>• The intervention may not be feasible.<br>• Staff changes interrupted continuity in the study plan. |

### Information Systems Capabilities Assessment (ISCA)

The 2011 ISCA resulted in seven recommendations for improvement. As of the 2012 follow-up review, PRSN had implemented a recommendation related to creating an accessible repository of provider profile information for members, and was in the process of implementing five other recommendations. Acumentra Health continues to recommend, as in 2011, that PRSN submit encounter data to DBHR more often than once a month.

### Encounter data validation

| Field | Chart matches electronic data | | Different validation result |
|---|---|---|---|
| | Acumentra Health | PRSN | |
| ***Results from multiple encounters and a mix of services*** | ***(N=78)*** | ***(N=82)*** | ***(N=78)*** |
| Procedure code | 100.0% | 100.0% | 0 (0.0%) |
| Provider type | 98.7% | 100.0% | 1 (1.3%) |
| Minutes of service | 100.0% | 98.8% | 1 (1.3%) |
| Service location | 100.0% | 100.0% | 0 (0.0%) |
| Service date | 100.0% | 100.0% | 0 (0.0%) |
| Progress note matches service code | 98.7% | 100.0% | 1 (1.3%) |

***Encounter data validation process review***

| Strengths | Opportunities for Improvement |
|---|---|
| • PRSN's sampling procedure is adequate in terms of sample size and in selecting a random sample.<br>• PRSN had very high levels of matching for both demographic and encounter data elements. | • PRSN should develop a database, or use programming involving a commercial statistical package, to calculate its EDV results. |

# Southwest Regional Support Network (SWRSN)

| Activity | |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Strengths** | **Opportunities for Improvement** |
| **Delivery Network — Fully Met (5 out of 5)** | |
| • RSN is commended for its network resource management plan for 2011–2012, which describes the interdependent relationship between RSN's target populations, network resources, and monitoring and reporting structure.<br>• RSN requires all second opinion requests to be documented on a Consultation Report Form. | |
| **Coordination and Continuity of Care — Fully Met (5 out of 5)** | |
| • RSN's monthly chart audit includes a comprehensive clinical review, covering intake assessments, referrals, treatment planning, progress notes, medication supervision, and discharge planning. | |
| **Coverage and Authorization of Services — Fully Met (5 out of 5)** | |
| • RSN uses the crisis center for stabilization services or as a step-down from more restrictive settings. RSN states that crisis services are available to the entire community through the Crisis Response line, and those services are not denied to anyone within the community. | |
| **Provider Selection — Fully Met (5 out of 5)** | |
| • RSN's policy on credentialing and recredentialing is concise and includes administrative and clinical chart reviews as well as a walkthrough of each agency to ensure compliance with policies on confidentiality and seclusion and restraint. | |
| **Subcontractual Relationships and Delegation — Fully Met (5 out of 5)** | |
| | |
| **Practice Guidelines — Fully Met (5 out of 5)** | |
| • RSN requires each provider agency to attend monthly meetings, at which RSN policies, procedures, and practice guidelines are reviewed, and new guidelines may be discussed and/or adopted and disseminated. | |
| **QA/PI Program — Fully Met (5 out of 5)** | |
| • RSN monitors utilization of inpatient and outpatient services to detect trends in over- and underutilization. In 2011, RSN provided Dialectical Behavior Therapy training for providers after finding high utilization by enrollees with symptomology that included emotional dysfunctions. | |
| **Certification and Program Integrity — Fully Met (4.5 out of 5)** | |
| | • Although the compliance officer has attended trainings offered by the state on fraud and abuse, Acumentra Health recommends formal training for compliance certification. |
| SWRSN, based in Longview, is a division of the Cowlitz County Human Services Department. A citizen advisory board appointed by the county board of commissioners reviews and provides recommendations on policies and programs. As of December 2011, SWRSN provided outpatient services to 2,818 out of 26,724 (10.5%) Medicaid enrollees. | |
| Data source: Southwest RSN 2012 External Quality Review Report (Acumentra Health). | |

# Southwest Regional Support Network (continued)

## Activity

### Performance Improvement Projects (PIPs)

| Strengths | Opportunities for Improvement |
|---|---|
| **Nonclinical—Reporting Mental Health Specialist Consultations: Substantially Met (55 out of 90)** | |
| • Established the importance of the topic for the local Medicaid population.<br>• Well documented data elements for the study population. | • SWRSN needs to conduct an analysis of the issue to plan an intervention that addresses identified needs.<br>• SWRSN needs to develop a valid study design and data collection methods. |
| **Clinical—Treatment Plan Review Following Extraordinary Events: Substantially Met (57 out of 90)** | |
| • Established the importance of the topic for the local Medicaid population.<br>• Well documented data collection plan. | • SWRSN needs to describe why this topic was prioritized as an area of concern; clarify data elements for the study population; and provide more details on the intervention. |

### Information Systems Capabilities Assessment (ISCA)

The 2011 ISCA resulted in 10 recommendations for improvement, including a recommendation for Cowlitz County's Central Services Department. As of the 2012 follow-up review, SWRSN had finished implementing three recommendations related to information systems, administrative data, and security, and was in the process of implementing the remaining recommendations.

### Encounter data validation

| Field | Chart matches electronic data | | Different validation result |
|---|---|---|---|
| | Acumentra Health | SWRSN | |
| ***Results from multiple encounters and a mix of services*** | ***(N=82)*** | ***(N=81)*** | ***(N=81)*** |
| Procedure code | 100.0% | 95.1% | 4 (5.0%) |
| Provider type | 97.6% | 96.3% | 5 (6.0%) |
| Minutes of service | 100.0% | 95.1% | 4 (5.0%) |
| Service location | 98.8% | 96.3% | 2 (2.5%) |
| Service date | 100.0% | 96.3% | 3 (3.7%) |
| Progress note matches service code | 98.8% | n/a | n/a |

***Encounter data validation process review***

| Strengths | Opportunities for Improvement |
|---|---|
| • SWRSN's encounter records show a very high level of agreement between the clinical records and the associated electronic data for most fields checked.<br>• SWRSN's sampling procedure is adequate.<br>• SWRSN's MS Access tool stores data correctly and its reporting function displays data appropriately. | • SWRSN needs to remove enrollees and encounters selected previously for EDV from future sampling.<br>• SWRSN should use the data-entry functionality of its MS Excel tool to record results and establish a more automated method to calculate the summary result statistics.<br>• SWRSN needs to choose the most accurate provider type to record practitioner credentials. |

# Spokane County Regional Support Network (SCRSN)

| Activity | |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Strengths** | **Opportunities for Improvement** |
| **Delivery Network — Fully Met (5 out of 5)** | |
| • RSN's monthly contract compliance reports from provider agencies track the number of enrollee requests for second opinion. | |
| **Coordination and Continuity of Care — Fully Met (5 out of 5)** | |
| • RSN performs annual clinical reviews of network providers to monitor how treatment has addressed cultural needs other than ethnicity that affect the consumer, including religious, socioeconomic, and geographic factors and whether recommendations are included in treatment planning. | |
| **Coverage and Authorization of Services — Fully Met (5 out of 5)** | |
| • RSN's clinical record audits include reviewing the timeliness of intake and follow-up services. RSN's monthly access report tracks by agency the reasons for delay in services to enrollees.<br>• RSN assisted in establishing a second evaluation and treatment center to meet consumers' needs while reducing the number of boarding days in the emergency room. | |
| **Provider Selection — Fully Met (4.6 out of 5)** | |
| • RSN monitors the credentialing process at each agency yearly. | • RSN needs to ensure that contracted agencies have mechanisms in place to verify that all clinicians' licenses are up to date. |
| **Subcontractual Relationships and Delegation — Fully Met (5 out of 5)** | |
| • RSN monitors delegated activities monthly and yearly. Annual reviews are well organized and include overall results, a detailed narrative, and corrective action. | |
| **Practice Guidelines — Fully Met (4.7 out of 5)** | |
| • RSN has trained its providers on the approved practice guidelines, and monitors the implementation of the guidelines through clinical record reviews. | • RSN needs to implement procedures to review and update its guidelines to ensure that they still apply to enrollees' needs, and to incorporate any updated clinical recommendations. |
| **QA/PI Program — Fully Met (4.7 out of 5)** | |
| • RSN staff members review monthly encounter reports for trending purposes and notify provider agency and RSN administration when service activity is higher or lower than expected. A threshold of 20% difference from expected activity is grounds for notification. | • RSN's annual report needs to document key activities in the quality management program, such as performance improvement activities, metrics describing how the RSN reached its performance goals, barriers and accomplishments, monitoring results, and ongoing improvement needs. |
| **Certification and Program Integrity — Fully Met (5 out of 5)** | |
| • RSN trains contracted providers and staff on HIPAA and fraud and abuse. RSN provides a template for providers to use when developing their own compliance programs. | |
| SCRSN is housed within Spokane County's Community Services Division, which administers public mental health services for the county and reports to the Board of County Commissioners. SCRSN contracts with several dozen providers of community support, adult residential, and inpatient mental health services for Medicaid enrollees. As of December 2011, SCRSN provided outpatient services to 9,054 out of 104,779 (8.6%) Medicaid enrollees. | |
| Data source: Spokane County RSN 2012 External Quality Review Report (Acumentra Health). | |

# Spokane County Regional Support Network (continued)

## Activity

### Performance Improvement Projects (PIPs)

| Strengths | Opportunities for Improvement |
|---|---|
| **Nonclinical—Improvement in Inpatient Capacity and Placement Using Evaluation and Treatment: Fully Met (81 out of 90)** | |
| • Project involved partnerships with community hospitals to collect data. | • SCRSN needs to standardize measurement periods, provide more details on the intervention, and clarify the outcomes for individual enrollees. |
| **Clinical—Increased Continuity of Care as a Result of Rehabilitation Case Management: Fully Met (91 out of 100)** | |
| • Well documented study design.<br>• Provided thoughtful discussion of barriers to improvement. | • SCRSN needs to provide more details on the intervention, and analyze the effects of confounding factors. |

### Information Systems Capabilities Assessment (ISCA)

The 2011 ISCA resulted in five recommendations for improvement, including one finding, all related to data security. As of the 2012 follow-up review, SCRSN had made progress in addressing all recommendations.

### Encounter data validation

| Field | Chart matches electronic data | | Different validation result |
|---|---|---|---|
| | Acumentra Health | SCRSN | |
| ***Results from multiple encounters and a mix of services*** | ***(N=78)*** | ***(N=82)*** | ***(N=78)*** |
| Procedure code | 96.2% | 97.6% | 5 (6.4%) |
| Provider type | 88.5% | 100.0% | 9 (11.5%) |
| Minutes of service | 85.9% | 96.3% | 12 (15.4%) |
| Service location | 88.4% | 98.8% | 8 (10.3%) |
| Service date | 98.7% | 97.6% | 3 (3.9%) |
| Progress note matches service code | 94.9% | 100.0% | 4 (5.1%) |

***Encounter data validation process review***

| Strengths | Opportunities for Improvement |
|---|---|
| • SCRSN's EDV procedures perform adequately.<br>• SCRSN's MS Access tool, which is used to capture the results of the EDV and report summary statistics, performs those functions well. | • SCRSN needs to incorporate review of ethnicity data into its EDV activities. |

# Thurston-Mason Regional Support Network (TMRSN)

| Activity | |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Strengths** | **Opportunities for Improvement** |
| **Delivery Network — Fully Met (4.9 out of 5)** | |
| • RSN monitors enrollee access to second opinions by reviewing provider logs and treatment documentation, second opinion requests, enrollee complaints and grievances, provider processes, and encounter data. | • The 2009 review cited RSN for not including information on out-of-network services in its enrollee manual. As of the 2012 site visit, RSN still had not revised the handbook to incorporate this information. Since then, TMRSN has submitted documentation demonstrating the inclusion of this material in the handbook. |
| **Coordination and Continuity of Care — Fully Met (5 out of 5)** | |
| • QI initiatives in 2011 focused on developing meaningful treatment plans, with special attention placed on enrollee participation and strength-based discharge planning. | |
| **Coverage and Authorization of Services — Fully Met (4.7 out of 5)** | |
| | • RSN needs to develop and implement a procedure for inter-rater reliability testing to ensure consistent application of criteria for authorization decisions. |
| **Provider Selection — Fully Met (5 out of 5)** | |
| • RSN has a policy on monitoring the U.S. Office of Inspector General's list of excluded providers against its own lists of providers, including RSN staff. Provider agencies submit monthly reports to the RSN. | |
| **Subcontractual Relationships and Delegation — Fully Met (5 out of 5)** | |
| • RSN has a comprehensive process for monitoring delegated functions. | |
| **Practice Guidelines — Fully Met (4.7 out of 5)** | |
| | • RSN needs to routinely review and update its practice guidelines to ensure that they still apply to enrollees' needs and incorporate any updated clinical recommendations. |
| **QA/PI Program — Fully Met (4.8 out of 5)** | |
| • RSN's 2011 year-end evaluation presents information about complaints and grievances, access, population served, outpatient and inpatient visits, and crisis, stabilization, and evaluation and treatment services. | • RSN needs to develop a method for tracking and analyzing requests by enrollees to change practitioners. |
| **Certification and Program Integrity — Fully Met (4.8 out of 5)** | |
| | • RSN's compliance committee should meet regularly.<br>• RSN should consider organizing a compliance committee separate from the quality management committee.<br>• Acumentra Health recommends that the compliance officer attend formal training on compliance and fraud and abuse. |
| TMRSN, headquartered in Olympia, administers public mental health services for Thurston and Mason counties. The RSN contracts with Olympia-based Behavioral Health Resources and Seattle-based Sea Mar Community Health Centers to provide outpatient, crisis, residential, and inpatient services, and with Providence St. Peter Hospital for geropsychiatric services. As of December 2011, TMRSN provided outpatient services to 4,838 out of 54,513 (8.9%) Medicaid enrollees. | |
| Data source: Thurston-Mason RSN 2012 External Quality Review Report (Acumentra Health). | |

# Thurston-Mason Regional Support Network (continued)

## Activity

### Performance Improvement Projects (PIPs)

| Strengths | Opportunities for Improvement |
|---|---|
| **Nonclinical—Increasing Percentage of Medicaid Clients Who Receive an Intake Service Within 14 Days of Service Request: Fully Met (87 out of 90)** | |
| • Established the importance of the topic for the local Medicaid population.<br>• Well documented data elements for the study population. | • Two major confounding factors reduced confidence in the study results: the indicator was redefined during the intervention, so it was almost always positively met; and the intervention was not applied to the entire study population. |
| **Clinical—High-Fidelity Wraparound: Substantially Met (64 out of 90)** | |
| • Well documented study design.<br>• The intervention involves community partners. | • TMRSN needs to complete the intervention and present study results. |

### Information Systems Capabilities Assessment (ISCA)

The 2011 ISCA resulted in six recommendations for improvement in the areas of information systems, hardware systems, security, and administrative data. As of the 2012 follow-up review, TMRSN had begun addressing all of these recommendations, with implementation in various stages of progress.

### Encounter data validation

| Field | Chart matches electronic data | | Different validation result |
|---|---|---|---|
| | Acumentra Health | TMRSN | |
| ***Results from multiple encounters and a mix of services*** | ***(N=79)*** | ***(N=82)*** | ***(N=79)*** |
| Procedure code | 81.0% | 100.0% | 15 (19.0%) |
| Provider type | 67.1% | 100.0% | 26 (32.9%) |
| Minutes of service | 81.0% | 97.6% | 13 (16.5%) |
| Service location | 22.8% | 64.6% | 32 (40.5%) |
| Service date | 87.3% | 61.0% | 38 (48.1%) |
| Progress note matches service code | 86.7% | n/a | n/a |

***Encounter data validation process review***

| Strengths | Opportunities for Improvement |
|---|---|
| • Formulas contained in the MS Excel tool submitted by TMRSN are adequate for calculating the percentages of matching. | • TMRSN should develop a database system to facilitate the data entry of EDV results and to support the calculation of summary statistics.<br>• TMRSN uses a randomizer website and needs to ascertain whether the approach used results in a sampling procedure in which the same enrollees are not more likely to be selected in repeated samples. |

# Timberlands Regional Support Network (TRSN)

| Activity | |
|---|---|
| **Regulatory and Contractual Standards** | |
| **Strengths** | **Opportunities for Improvement** |
| **Delivery Network — Fully Met (5 out of 5)** | |
| • RSN monitors timeliness of access to care by reviewing access data, reports listing enrollees served and hours of service by age and provider, time from first request for services to intake, complaints and grievances, and surveys.<br>• RSN website is accessible in many different languages, and lists resources and best practices related to needs of children, ethnic minorities, people with co-occurring mental health and substance disorders, geriatric, and gay/lesbian/bisexual/ transgender individuals. | |
| **Coordination and Continuity of Care — Fully Met (5 out of 5)** | |
| • RSN monitors care coordination through monthly clinical utilization reviews. Monitoring reports are reviewed quarterly by the Quality Management Committee (QMC). | |
| **Coverage and Authorization of Services — Fully Met (5 out of 5)** | |
| • RSN tracks and monitors the use of crisis services by reviewing crisis reports and emergency department reports, and by interviewing hospital staff. | |
| **Provider Selection — Fully Met (4.6 out of 5)** | |
| • RSN requires monthly attestation from each provider agency that the agency has reviewed all staff, board members, volunteers/interns, and subcontractors for federal exclusion. | • **Finding:** RSN's policy on credentialing does not include provisions for credentialing and recredentialing of the RSN's own staff. |
| **Subcontractual Relationships and Delegation — Fully Met (5 out of 5)** | |
| | |
| **Practice Guidelines — Fully Met (5 out of 5)** | |
| • RSN monitors contracted providers' compliance with the practice guidelines through clinical utilization reviews and administrative and clinical audits. | |
| **QA/PI Program — Fully Met (5 out of 5)** | |
| • RSN uses multiple methods to detect over- and underutilization, such as reviewing charts to determine the match between authorized service level and service provision, and reviewing reports on trends in inpatient utilization, including length of stay at the evaluation and treatment center. | |
| **Certification and Program Integrity — Fully Met (4.5 out of 5)** | |
| | • RSN should consider organizing a compliance committee separate from the QMC. Members of this separate committee would include provider agency and county representatives with expertise in compliance and finance.<br>• Acumentra Health recommends that RSN's compliance officer attend formal training on compliance and fraud and abuse. |
| TRSN, headquartered in Cathlamet, administers mental health services for Medicaid enrollees in Lewis, Pacific, and Wahkiakum counties. As of December 2011, TRSN provided outpatient services to 2,403 out of 25,066 (9.6%) Medicaid enrollees.. | |
| Data source: Timberlands RSN 2012 External Quality Review Report (Acumentra Health). | |

# Timberlands Regional Support Network (continued)

## Activity

### Performance Improvement Projects (PIPs)

| Strengths | Opportunities for Improvement |
|---|---|
| **Nonclinical—Improving Coordination of Care and Outcomes: Fully Met (73 out of 90)** | |
| • Well documented study design.<br>• Study topic focuses on integration of physical and behavioral health. | • TRSN needs to provide consistent documentation of intervention details and data in the study results.<br>• This PIP is in its fourth year and has not presented complete study results. |
| **Clinical—Improving Treatment Outcomes for Adults Diagnosed with a New Episode of Major Depressive Disorder: Substantially Met (70 out of 90)** | |
| • Well documented study design; uses a validated measurement tool. | • Baseline data were affected by poor clinician adherence to the practice guideline; reported results were unclear.<br>• TRSN needs to collect remeasurement data and interpret the results in terms of statistical and clinical significance. |

### Information Systems Capabilities Assessment (ISCA)

The 2011 ISCA resulted in five recommendations for improvement in the areas of information systems, hardware systems, security, and administrative data. The recommendations included one finding related to data security. As of the 2012 follow-up review, TRSN had finished implementing a recommendation related to hardware replacement, and was in the process of implementing the remaining recommendations.

### Encounter data validation

| Field | Chart matches electronic data | | Different validation result |
|---|---|---|---|
| | Acumentra Health | TRSN | |
| ***Results from multiple encounters and a mix of services*** | ***(N=80)*** | ***(N=80)*** | ***(N=80)*** |
| Procedure code | 100.0% | 100.0% | 0 (0.0%) |
| Provider type | 95.0% | 97.5% | 2 (2.5%) |
| Minutes of service | 100.0% | 100.0% | 0 (0.0%) |
| Service location | 100.0% | 100.0% | 0 (0.0%) |
| Service date | 100.0% | 100.0% | 0 (0.0%) |
| Progress note matches service code | 100.0% | 100.0% | 0 (0.0%) |

***Encounter data validation process review***

| Strengths | Opportunities for Improvement |
|---|---|
| • TRSN's EDV procedure is adequate in terms of both sample size and the process for drawing a random sample.<br>• TRSN encounter records show high levels of matching between the agency-level electronic data and the data submitted to ProviderOne. | • TRSN should develop a database system, such as MS Access, to input the EDV data and display encounter-level and summary results in database reports. |

# Appendix B. MCO Profiles

The profiles in this appendix summarize each MCO's overall performance in measures of access, timeliness, and quality, and in meeting regulatory and contractual standards, including those for PIPs.

MCO scores for compliance with regulatory and contractual standards were calculated from ratings in the TEAMonitor reports, and strengths and opportunities for improvement were derived from the written TEAMonitor reviews. Scores and comments for the Access, Timeliness, and Quality measures were derived from the 2012 Performance Measure Comparative Analysis Report produced by Acumentra Health.

NOTE: TEAMonitor results for Asuris Northwest Health's regulatory/contractual compliance and PIP reviews are combined with the results for Regence BlueShield because the two plans share administrative functions and resources.

[This page intentionally left blank]

# Asuris Northwest Health (ANH)

| Measure | Score | Measure | Score |
|---|---|---|---|
| **Access to Care*** | | | |
| Infant WCC Visits (6 visits) | — | | |
| Child WCC Visits | 59.9% | | |
| Adolescent WCC Visits | 33.3% ▼ | | |
| **Timeliness of Care*** | | | |
| Postpartum Care After 21–56 days | 62.3% | | |
| **Quality of Care*** | | | |
| Childhood Immunizations (Combo 2) | — | | |
| Childhood Immunizations (Combo 3) | — | | |
| Diabetes Care (HbA1c test) | — | | |
| **Regulatory and Contractual Standards—Percent of elements met**** | | | |
| Availability of Services | 100% | Emergency and Post-stabilization Services | 100% |
| Furnishing of Services (Timely Access) | 100% | Enrollee Rights | 100% |
| Program Integrity | 100% | Enrollment and Disenrollment | 100% |
| Claims Payment | 100% | Grievance Systems | 100% |
| Primary Care and Coordination | 100% | Practice Guidelines | 100% |
| Enrollees with Special Healthcare Needs | 100% | Provider Selection (Credentialing) | 100% |
| Patient Review and Coordination | 75% | QA/PI Program | 100% |
| Coverage and Authorization of Services | 100% | Subcontractual Relationships/Delegation | 100% |
| **Performance Improvement Projects (PIPs)**** | | | |
| **Clinical** | | **Nonclinical** | |
| Improving the Rate of Childhood Immunizations | Partially Met | Improving Employees' Understanding of Cultural Competency and Health Disparities | Not Met |
| Well-Child Visits With a Disparity Aspect Involving the Hispanic Population | Not Met | | |
| Asuris Northwest Health, an "unbranded" subsidiary of Regence BlueShield, was licensed in 2002. ANH provides coverage for Medicaid clients in Spokane County, serving less than 1% of Healthy Options enrollees. ANH insures approximately 59,000 lives, about 8% of whom are Medicaid enrollees. Approximately 77% of Medicaid clients are 18 years of age or younger. | | | |

— Sample size was smaller than the minimum required during the reporting year.

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).

*Data source: 2012 Performance Measure Comparative Analysis Report.

**Data source: 2012 TEAMonitor report. Scores include results for both Regence BlueShield and ANH.

A list of plan **strengths** and **opportunities for improvement** appears on the reverse side. ⇨

# Asuris Northwest Health (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Access to Care*** | |
| | • Scored below the state average on Child WCC Visits, but not significantly lower.<br>• Scored significantly below the state average on Adolescent WCC Visits. |
| **Timeliness of Care*** | |
| | • Scored below the state average on Postpartum Care, but not significantly lower. |
| **Quality of Care*** | |
| | |
| **Regulatory and Contractual Standards**** | |
| Met 100% of elements for:<br>• Availability of Services<br>• Furnishing of Services (Timely Access)<br>• Program Integrity<br>• Claims Payment<br>• Primary Care and Coordination<br>• Enrollee with Special Healthcare Needs<br>• Coverage and Authorization of Services<br>• Emergency and Post-stabilization Services<br>• Enrollment and Disenrollment<br>• Enrollee Rights<br>• Grievance Systems<br>• Practice Guidelines<br>• Provider Selection (Credentialing)<br>• QA/PI Program<br>• Subcontractual Relationship/Delegation | Met 75% of elements for:<br>• Patient Review and Coordination |
| **Performance Improvement Projects (PIPs)**** | |
| • TEAMonitor commended RBS/ANH's efforts to reduce disparity in WCC visit rates between the Hispanic and non-Hispanic populations, though the project's degree of success cannot be gauged from the PIP submission. | • Both clinical PIPs are hindered by weak, passive interventions, lack of written analysis, and inadequate documentation. The MCO submitted no action plan for refreshing its interventions as required by TEAMonitor.<br>• In 2012, RBS/ANH submitted the same nonclinical PIP as in 2011, with no update to demonstrate an active project. The PIP did not address specific corrective actions required by TEAMonitor. |

*Data source: 2012 Performance Measure Comparative Analysis Report.
**Data source: 2012 TEAMonitor report.

# Columbia United Providers (CUP)

| Measure | Score | Measure | Score |
|---|---|---|---|
| **Access to Care*** | | | |
| Infant WCC Visits (6 visits) | 55.0% | | |
| Child WCC Visits | 59.8% | | |
| Adolescent WCC Visits | 31.1% ▼ | | |
| **Timeliness of Care*** | | | |
| Postpartum Care After 21–56 days | 60.3% | | |
| **Quality of Care*** | | | |
| Childhood Immunizations (Combo 2) | 65.0% | | |
| Childhood Immunizations (Combo 3) | 60.6% ▼ | | |
| Diabetes Care (HbA1c test) | 83.3% | | |
| **Regulatory and Contractual Standards—Percent of elements met**** | | | |
| Availability of Services | 100% | Emergency and Post-stabilization Services | 100% |
| Furnishing of Services (Timely Access) | 100% | Enrollee Rights | 100% |
| Program Integrity | 100% | Enrollment and Disenrollment | 100% |
| Claims Payment | 100% | Grievance Systems | 100% |
| Primary Care and Coordination | 100% | Practice Guidelines | 100% |
| Enrollees with Special Healthcare Needs | 100% | Provider Selection (Credentialing) | 100% |
| Patient Review and Coordination | 100% | QAPI Program | 100% |
| Coverage and Authorization of Services | 100% | Subcontractual Relationships/Delegation | 100% |
| **Performance Improvement Projects (PIPs)**** | | | |
| **Clinical** | | **Nonclinical** | |
| Improving Well-Child Visit Rates | Partially Met | Decreasing Inappropriate Emergency Department Utilization | Partially Met |
| Improving Childhood Immunization Rates | Partially Met | | |
| Columbia United Providers was established in 1993 and began providing coverage for Medicaid enrollees in 1994. CUP serves approximately 8.4% of Healthy Options enrollees, including those with CHIP and BH-Plus coverage in Clark, King, and Pierce counties. CUP insures 68,615 lives, 86.1% of whom are covered by Medicaid. About 83.9% of Medicaid enrollees are 19 years of age or younger. | | | |

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
*Data source: 2012 Performance Measure Comparative Analysis Report.
**Data source: 2012 TEAMonitor report.

A list of plan **strengths** and **opportunities for improvement** appears on the reverse side.

# Columbia United Providers (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Access to Care*** | |
| | • Scored below the state average on Infant and Child WCC visits, but not significantly below. Scored significantly below the state average on Adolescent WCC visits. |
| **Timeliness of Care*** | |
| | • Scored below the state average on Postpartum Care, but not significantly below. |
| **Quality of Care*** | |
| Scored above the state average on HbA1c tests, but not significantly above the state average. | • Scored below the state average on Childhood Immunizations, Combo 2 and Combo 3. Scored significantly below the state average on Combo 3. |
| **Regulatory and Contractual Standards**** | |
| • Met 100% of elements for all standards reviewed | |
| **Performance Improvement Projects (PIPs)**** | |
| • CUP's clinical PIPs exhibited improved documentation, with data presented in clear, easy-to-read tables.<br>• CUP implemented five interventions for the nonclinical PIP in 2011, which together reduced inappropriate ER usage. The PIP reporting format showed clinic-specific ER usage, with drill-down of information to the clinic level. | • The clinical PIPs were unsuccessful in improving immunization and WCC visit rates; in fact, these measures declined.<br>• The interventions (outreach calls to parents) were not implemented until late 2011 and did not affect the measures.<br>• Planned follow-up activities were not robust or aggressive. |

*Data source: 2012 Performance Measure Comparative Analysis Report.
**Data source: 2012 TEAMonitor report.

# Community Health Plan (CHP)

| Measure | Score | | Measure | Score |
|---|---|---|---|---|
| **Access to Care*** | | | | |
| Infant WCC Visits (6 visits) | 54.3% | | | |
| Child WCC Visits | 63.8% | | | |
| Adolescent WCC Visits | 39.9% | | | |
| **Timeliness of Care*** | | | | |
| Postpartum Care After 21–56 days | 60.1% | | | |
| **Quality of Care*** | | | | |
| Childhood Immunizations (Combo 2) | 77.4% | ▲ | | |
| Childhood Immunizations (Combo 3) | 72.8% | ▲ | | |
| Diabetes Care (HbA1c test) | 83.0% | | | |
| **Regulatory and Contractual Standards—Percent of elements met**** | | | | |
| Availability of Services | 100% | | Emergency and Post-stabilization Services | 100% |
| Furnishing of Services (Timely Access) | 100% | | Enrollee Rights | 100% |
| Program Integrity | 100% | | Enrollment and Disenrollment | 100% |
| Claims Payment | 100% | | Grievance Systems | 89% |
| Primary Care and Coordination | 100% | | Practice Guidelines | 100% |
| Enrollees with Special Healthcare Needs | 100% | | Provider Selection (Credentialing) | 100% |
| Patient Review and Coordination | 88% | | QA/PI Program | 100% |
| Coverage and Authorization of Services | 100% | | Subcontractual Relationships/Delegation | 100% |
| **Performance Improvement Projects (PIPs)**** | | | | |
| **Clinical** | | | **Nonclinical** | |
| Well-Child Exams: Improving HEDIS Rates | Met | | Improving Customer Service Representative Handling of Benefit Calls | Not Met |

Community Health Plan of Washington provides managed care for more than 300,000 individuals and families throughout Washington. CHP is the state's largest insurer of the Basic Health Plan, the second largest plan serving Medicaid enrollees under Healthy Options and S-CHIP, and the only insurer for the Disability Lifeline Program. In 20111, CHP received Commendable Accreditation from NCQA in its commercial, Medicaid, and Medicare products. The health plan's delivery system includes more than 540 primary care clinics, 2,365 primary care providers, 13,571 specialists, and 100 hospitals. CHP also features an incentive program that rewards its members for getting the preventive care they and their families need.

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
*Data source: 2012 Performance Measure Comparative Analysis Report.
**Data source: 2012 TEAMonitor report.

A list of plan **strengths** and **opportunities for improvement** appears on the reverse side. ⇨

# Community Health Plan (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Access to Care*** | |
| • Scored above the state average on Child and Adolescent WCC Visits, but not significantly higher. | • Scored below the state average on Infant WCC Visits, but not significantly lower. |
| **Timeliness of Care*** | |
| | • Scored below the state average on Postpartum Care, but not significantly lower. |
| **Quality of Care*** | |
| • Scored significantly higher than the state average on Combo 2 and Combo 3 immunizations. Scored above the state average on the Diabetes Care measure, but not significantly higher. | |
| **Regulatory and Contractual Standards**** | |
| Met 100% of elements for:<br>• Availability of Services<br>• Furnishing of Services (Timely Access)<br>• Program Integrity<br>• Claims Payment<br>• Primary Care and Coordination<br>• Enrollees with Special Healthcare Needs<br>• Enrollment and Disenrollment<br>• Practice Guidelines<br>• Provider Selection (Credentialing)<br>• Subcontractual Relationships/Delegation<br>• Coverage and Authorization of Services<br>• Emergency and Post-stabilization Services<br>• Enrollee Rights<br>• QA/PI Program<br><br>Met 88–89% of elements for:<br>• Patient Review and Coordination<br>• Grievance Systems | |
| **Performance Improvement Projects (PIPs)**** | |
| • CHP's clinical PIP has shown consistent execution over time. Additional data from the project are incorporated at the MCO and provider levels to improve monitoring of performance.<br>• The nonclinical PIP sets a worthy goal of improving the accuracy and completeness of responses to benefit inquiries. | • For the clinical PIP, CHP needs to develop refreshed interventions with an eye toward future improvements. CHP may wish to target interventions to address cultural and linguistic barriers to WCC visits. The MCO needs to expand its barrier analysis to continue improvement efforts.<br>• According to TEAMonitor, the nonclinical PIP was poorly designed and did not adequately define measurable indicators of improved service. CHP needs to reexamine its sampling methodology; specify a plan for data collection and analysis that ensures valid and reliable data; and improve the analytics (linking findings to interventions), including barrier analysis. |

*Data source: 2012 Performance Measure Comparative Analysis Report.
**Data source: 2012 TEAMonitor report.

# Group Health Cooperative (GHC)

| Measure | Score | Measure | Score |
|---|---|---|---|
| **Access to Care*** | | | |
| Infant WCC Visits (6 visits) | 60.6% | | |
| Child WCC Visits | 63.3% | | |
| Adolescent WCC Visits | 45.5% ▲ | | |
| **Timeliness of Care*** | | | |
| Postpartum Care After 21–56 days | 69.3% ▲ | | |
| **Quality of Care*** | | | |
| Childhood Immunizations (Combo 2) | 65.0% | | |
| Childhood Immunizations (Combo 3) | 64.0% | | |
| Diabetes Care (HbA1c test) | 85.1% | | |
| **Regulatory and Contractual Standards—Percent of elements met**** | | | |
| Availability of Services | 100% | Emergency and Post-stabilization Services | 50% |
| Furnishing of Services (Timely Access) | 100% | Enrollee Rights | 100% |
| Program Integrity | 100% | Enrollment and Disenrollment | 100% |
| Claims Payment | 100% | Grievance Systems | 95% |
| Primary Care and Coordination | 100% | Practice Guidelines | 100% |
| Enrollees with Special Healthcare Needs | 100% | Provider Selection (Credentialing) | 100% |
| Patient Review and Coordination | 63% | QA/PI Program | 80% |
| Coverage and Authorization of Services | 75% | Subcontractual Relationships/Delegation | 75% |
| **Performance Improvement Projects (PIPs)**** | | | |
| **Clinical** | | **Nonclinical** | |
| Improving Well-Child and Well-Adolescent Visit Rates | Met | Increasing Percentage of Members with Race and Ethnicity Data | Met |
| Improving Childhood Immunization Rates | Met | | |
| Group Health Cooperative, a nonprofit health care system established in 1947, provides coverage for Medicaid clients in six counties in Washington, serving about 3% of Healthy Options enrollees, including those with S-CHIP and BH+ coverage. All of GHC's clients receive care in GHC-owned and operated primary care medical centers. GHC insures more than 625,000 lives, of whom 3% are insured by Medicaid. Approximately 80% of Medicaid clients are 18 years of age or younger. | | | |

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
*Data source: 2012 Performance Measure Comparative Analysis Report.
**Data source: 2012 TEAMonitor report.

A list of plan **strengths** and **opportunities for improvement** appears on the reverse side.

# Group Health Cooperative (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Access to Care*** | |
| • Scored above the state average on Infant and Child WCC Visits. Scored significantly above the state average for Adolescent WCC visits. | |
| **Timeliness of Care*** | |
| • Scored significantly higher than the state average on Postpartum Care. | |
| **Quality of Care*** | |
| • Scored above the state average on Diabetes Care measure, but not significantly higher. | • Scored below the state average on Combo 2 and Combo 3 immunizations, but not significantly lower. |
| **Regulatory and Contractual Standards**** | |
| Met 100% of elements for:<br>• Availability of Services<br>• Furnishing of Services (Timely Access)<br>• Program Integrity<br>• Claims Payment<br>• Primary Care and Coordination<br>• Enrollees with Special Healthcare Needs<br>• Enrollment and Disenrollment<br>• Practice Guidelines<br>• Provider Selection (Credentialing)<br>• Enrollee Rights<br><br>Met 80–95% of elements for:<br>• QA/PI Program<br>• Grievance Systems | Met 50–75% of elements for:<br>• Patient Review and Coordination<br>• Coverage and Authorization of Services<br>• Emergency and Post-stabilization Services<br>• Subcontractual Relationships/Delegation |
| **Performance Improvement Projects (PIPs)**** | |
| • GHC's clinical PIP on WCC visits has earned a "Met" score in each of the past four years. Project documentation includes an excellent description of barriers and interventions and a graphical display of data over time.<br>• The immunization PIP uses a best-practice intervention: a social marketing campaign and development of a training toolkit for providers to address parents' hesitancy to have their children vaccinated.<br>• TEAMonitor commended the nonclinical PIP as a best-practice project, using objective, measurable indicators, sound barrier analysis, and meaningful interventions that were followed by a significant increase in the collection of race and ethnicity data for members. | • For the PIP on WCC visits, GHC needs to consider refreshed interventions to sustain improvements on these measures. |

*Data source: 2012 Performance Measure Comparative Analysis Report.
**Data source: 2012 TEAMonitor report.

# Kaiser Permanente Northwest (KPNW)

| Measure | Score | Measure | Score |
|---|---|---|---|
| **Access to Care*** | | | |
| Infant WCC Visits (6 visits) | — | | |
| Child WCC Visits | 83.3% ▲ | | |
| Adolescent WCC Visits | 47.7% | | |
| **Timeliness of Care*** | | | |
| Postpartum Care After 21–56 days | — | | |
| **Quality of Care*** | | | |
| Childhood Immunizations (Combo 2) | — | | |
| Childhood Immunizations (Combo 3) | — | | |
| Diabetes Care (HbA1c test) | — | | |
| **Regulatory and Contractual Standards—Percent of elements met**** | | | |
| Availability of Services | 100% | Emergency and Post-stabilization Services | 100% |
| Furnishing of Services (Timely Access) | 100% | Enrollee Rights | 100% |
| Program Integrity | 100% | Enrollment and Disenrollment | 100% |
| Claims Payment | 100% | Grievance Systems | 100% |
| Primary Care and Coordination | 100% | Practice Guidelines | 100% |
| Enrollees with Special Healthcare Needs | 100% | Provider Selection (Credentialing) | 100% |
| Patient Review and Coordination | 100% | QA/PI Program | 100% |
| Coverage and Authorization of Services | 100% | Subcontractual Relationships/Delegation | 100% |
| **Performance Improvement Projects (PIPs)**** | | | |
| **Clinical** | | **Nonclinical** | |
| Improving Well-Child Visit Rates | Met | Regional Appointment Center Call Answer Timeliness | Met |

Kaiser Permanente Northwest, a subsidiary of Kaiser Foundation Health Plan, was established in 1945 and began providing coverage for Medicaid enrollees in two counties in southwestern Washington in 1993. KPNW insures about 480,300 lives, fewer than 1% of whom are insured by Washington Medicaid. About 80% of Medicaid clients are 18 years of age or younger. KPNW's commercial product line has been accredited by NCQA since May 1995.

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
— Sample size was less than the minimum required during the reporting year.
*Data source: 2012 Performance Measure Comparative Analysis Report.
**Data source: 2012 TEAMonitor report.

A list of plan **strengths** and **opportunities for improvement** appears on the reverse side. ⇨

# Kaiser Permanente Northwest (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Access to Care*** | |
| • Scored significantly higher than the state average on Child WCC Visits. Scored above the state average on Adolescent WCC Visits, but not significantly higher. | |
| **Timeliness of Care*** | |
| | |
| **Quality of Care*** | |
| | |
| **Regulatory and Contractual Standards**** | |
| • Met 100% of elements for all standards reviewed | |
| **Performance Improvement Projects (PIPs)**** | |
| • KPNW's clinical PIP shows consistent execution over time and uses excellent visual displays of data in table and graph form, including trend analysis.<br>• Over the years, the nonclinical PIP has improved call-response times so much that KPNW made its measure more stringent, reducing the expected response time from 90 to 30 seconds. Interventions have changed over time in response to analysis of the factors driving outcomes. | • Regarding the clinical PIP, KPNW attributed this year's decline in adolescent WCC visit rates to the late start of the most recent intervention—Interactive Voice Response (IVR) phone calls to enrollees with follow-up letters as needed. KPNW planned activities to augment the IVR calls and refresh interventions.<br>• The current goal of the nonclinical PIP (80% of calls answered within 30 seconds) has proved unsustainable. |

*Data source: 2012 Performance Measure Comparative Analysis Report.
**Data source: 2012 TEAMonitor report.

# Molina Healthcare of Washington (MHW)

| Measure | Score | Measure | Score |
|---|---|---|---|
| **Access to Care*** | | | |
| Infant WCC Visits (6 visits) | 59.0% | | |
| Child WCC Visits | 65.5% | | |
| Adolescent WCC Visits | 45.8% ▲ | | |
| **Timeliness of Care*** | | | |
| Postpartum Care After 21–56 days | 68.2% ▲ | | |
| **Quality of Care*** | | | |
| Childhood Immunizations (Combo 2) | 72.2% | | |
| Childhood Immunizations (Combo 3) | 69.0% | | |
| Diabetes Care (HbA1c test) | 83.5% | | |
| **Regulatory and Contractual Standards—Percent of elements met**** | | | |
| Availability of Services | 100% | Emergency and Post-stabilization Services | 100% |
| Furnishing of Services (Timely Access) | 100% | Enrollee Rights | 92% |
| Program Integrity | n/a | Enrollment and Disenrollment | 100% |
| Claims Payment | 100% | Grievance Systems | 89% |
| Primary Care and Coordination | 100% | Practice Guidelines | 100% |
| Enrollees with Special Healthcare Needs | 50% | Provider Selection (Credentialing) | 100% |
| Patient Review and Coordination | 88% | QA/PI Program | 80% |
| Coverage and Authorization of Services | 75% | Subcontractual Relationships/Delegation | 100% |
| **Performance Improvement Projects (PIPs)**** | | | |
| **Clinical** | | **Nonclinical** | |
| Improving Well-Child Visit Rates | Partially Met | Pharmacy Authorization Turnaround Times | Met |
| Improving Childhood Immunization Rates | Partially Met | | |

Established in 1995, Molina Healthcare of Washington provides coverage for Medicaid enrollees in 34 counties across Washington. MHW is the largest Medicaid provider, serving approximately 50% of Healthy Options enrollees, including those covered by CHIP and Basic Health-Plus. MHW insures approximately 355,000 lives, 96% of whom are covered by Medicaid. About 78% of Medicaid clients are 18 years of age or younger. MHW is accredited by NCQA for its Medicaid product lines.

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
*Data source: 2012 Performance Measure Comparative Analysis Report.
**Data source: 2012 TEAMonitor report.

A list of plan **strengths** and **opportunities for improvement** appears on the reverse side. ⇨

# Molina Healthcare of Washington (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Access to Care*** | |
| • Scored significantly higher than the state average on Adolescent WCC visits. Scored above the state average on Infant and Child WCC visits, but not significantly higher. | |
| **Timeliness of Care*** | |
| • Scored significantly higher than the state average on Postpartum Care. | |
| **Quality of Care*** | |
| • Scored above the state average on Combo 2 and Combo 3 immunizations and on the Diabetes Care measure, but not significantly higher. | |
| **Regulatory and Contractual Standards**** | |
| Met 100% of elements for:<br>• Availability of Services<br>• Furnishing of Services (Timely Access)<br>• Claims Payment<br>• Primary Care and Coordination<br>• Emergency and Post-stabilization Services<br>• Enrollment and Disenrollment<br>• Provider Selection (Credentialing)<br>• Practice Guidelines<br>• Subcontractual Relationships/Delegation<br><br>Met 80–92% of elements for:<br>• QA/PI Program<br>• Grievance Systems<br>• Enrollee Rights<br>• Patient Review and Coordination | Met 50–75% of elements for:<br>• Coverage and Authorization of Services<br>• Enrollees with Special Healthcare Needs |
| **Performance Improvement Projects (PIPs)**** | |
| • Clinical PIPs were generally well documented. TEAMonitor cited the format of MHW's barrier and intervention lists as a particular strength.<br>• The nonclinical PIP has shown real improvement in reducing the time it takes the MCO to authorize a prescription. Provider and enrollee satisfaction survey results, added to the data collection and analysis plan in 2012, afford an additional measure of success. | • Ongoing interventions for both clinical PIPs are mostly passive, involving reminders sent to providers and members. MHW needs to revisit its interventions and consider using more active strategies to achieve and sustain improvement in WCC and immunization measures.<br>• For the nonclinical PIP, MHW may wish to consider whether the volume of pharmacy authorization requests correlates to turnaround times, and gear its possible interventions toward periods with peak authorization requests. |

*Data source: 2012 Performance Measure Comparative Analysis Report.
**Data source: 2012 TEAMonitor report.

# Regence BlueShield (RBS)

| Measure | Score | Measure | Score |
|---|---|---|---|
| **Access to Care*** | | | |
| Infant WCC Visits (6 visits) | 61.6% | | |
| Child WCC Visits | 57.9% | | |
| Adolescent WCC Visits | 36.7% | | |
| **Timeliness of Care*** | | | |
| Postpartum Care After 21–56 days | 57.2% ▼ | | |
| **Quality of Care*** | | | |
| Childhood Immunizations (Combo 2) | 68.9% | | |
| Childhood Immunizations (Combo 3) | 67.2% | | |
| Diabetes Care (HbA1c test) | 77.9% | | |
| **Regulatory and Contractual Standards—Percent of elements met**** | | | |
| Availability of Services | 100% | Emergency and Post-stabilization Services | 100% |
| Furnishing of Services (Timely Access) | 100% | Enrollee Rights | 100% |
| Program Integrity | 100% | Enrollment and Disenrollment | 100% |
| Claims Payment | 100% | Grievance Systems | 100% |
| Primary Care and Coordination | 100% | Practice Guidelines | 100% |
| Enrollees with Special Healthcare Needs | 100% | Provider Selection (Credentialing) | 100% |
| Patient Review and Coordination | 75% | QA/PI Program | 100% |
| Coverage and Authorization of Services | 100% | Subcontractual Relationships/Delegation | 100% |
| **Performance Improvement Projects (PIPs)**** | | | |
| **Clinical** | | **Nonclinical** | |
| Well-Child Visits With a Disparity Aspect Involving Hispanic Population | Not Met | Improving Employees' Understanding of Cultural Competency and Health Disparities | Not Met |
| Improving the Rate of Childhood Immunizations | Partially Met | | |
| Regence BlueShield, incorporated in 1997, provides coverage for Medicaid enrollees in nine counties in central and western Washington. RBS serves approximately 6% of Healthy Options enrollees, including those covered by S-CHIP. RBS insures approximately 908,000 lives, 5% of whom are insured by Medicaid. Approximately 82% of Medicaid clients are 18 years of age or younger. | | | |

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
*Data source: 2012 Performance Measure Comparative Analysis Report.
**Data source: 2012 TEAMonitor report. Scores include results for Asuris Northwest Health.

A list of plan **strengths** and **opportunities for improvement** appears on the reverse side.

# Regence BlueShield (continued)

| Strengths | Opportunities for improvement |
|---|---|
| **Access to Care*** | |
| • Scored above the state average on Infant WCC visits, though not significantly higher. | • Scored below the state average on Child and Adolescent WCC Visits, though not significantly lower. |
| **Timeliness of Care*** | |
| | • Scored significantly below the state average on Postpartum Care. |
| **Quality of Care*** | |
| • Scored above the state average on Combo 3 immunizations, but not significantly higher. | • Scored below the state average on Combo 2 immunizations and the Diabetes Care measure, but not significantly lower. |
| **Regulatory and Contractual Standards**** | |
| Met 100% of elements for:<br>• Availability of Services<br>• Furnishing of Services (Timely Access)<br>• Program Integrity<br>• Claims Payment<br>• Primary Care and Coordination<br>• Enrollee with Special Healthcare Needs<br>• Coverage and Authorization of Services<br>• Emergency and Post-stabilization Services<br>• Enrollment and Disenrollment<br>• Enrollee Rights<br>• Grievance Systems<br>• Practice Guidelines<br>• Provider Selection (Credentialing)<br>• QA/PI Program<br>• Subcontractual Relationship/Delegation | Met 75% of elements for:<br>• Patient Review and Coordination |
| **Performance Improvement Projects (PIPs)**** | |
| • TEAMonitor commended RBS/ANH's efforts to reduce disparity in WCC visit rates between the Hispanic and non-Hispanic populations, though the project's degree of success cannot be gauged from the PIP submission. | • Both clinical PIPs are hindered by weak, passive interventions, lack of written analysis, and inadequate documentation. The MCO submitted no action plan for refreshing its interventions as required by TEAMonitor.<br>• In 2012, RBS/ANH submitted the same nonclinical PIP as in 2011, with no update to demonstrate an active project. The PIP did not address specific corrective actions required by TEAMonitor. |

*Data source: 2012 Performance Measure Comparative Analysis Report.
**Data source: 2012 TEAMonitor report.

# Appendix C: Elements of Regulatory and Contractual Standards

The interagency TEAMonitor group reviews MCOs' compliance with elements of access, quality, and timeliness required by federal managed care regulations and Healthy Options contract provisions. Acumentra Health reviews RSNs' compliance with a similar set of regulations and DBHR contract provisions that apply to managed mental health care.

Table C-1 itemizes the relevant provisions in the Healthy Options and DBHR contracts. Some of the listed provisions apply only to physical or to mental health care. Table C-2 lists the elements of each regulatory standard, with citations from the Code of Federal Regulations (CFR) and a summary description of each element.

**Table C-1. Contract provisions related to access, timeliness, and quality.**

| Contract provisions | Healthy Options or *RSN* contract section(s) |
|---|---|
| **Access to care** | |
| The MCO/RSN must provide enough information to enable enrollees to make informed decisions about enrollment and to understand benefit coverage and how to obtain care. For physical health care, written information must discuss how to choose and change PCPs, identifying available PCPs by location, languages spoken, qualifications, and practice restrictions, and how to obtain emergency services, hospital care, and services outside the service area. The MCO must provide information on available specialists, informed consent guidelines, advance directives, grievance procedures, covered benefits, well-child care, translation and interpretation services, and how to obtain a second opinion. For mental health care, RSNs must use the DBHR-published benefits booklet to notify enrollees of their benefits, rights, and responsibilities. | 5.2; *5.1* |
| The MCO/RSN must ensure ***equal access*** for enrollees and potential enrollees with communication barriers. For oral communication, the MCO/RSN must provide free interpreter services for those with a primary language other than English. The MCO/RSN must ensure that written materials are available in a form that can be understood by each enrollee and potential enrollee, and must translate generally available written materials into prevalent non-English languages. | 5.3; *5.1.1.4–5.1.1.5* |
| The MCO/RSN must maintain and monitor a ***provider network*** sufficient to serve enrollee needs, including out-of-network services as medically necessary. The MCO/RSN must consider factors such as the expected service utilization by the Medicaid population, the number and types of providers required, the geographic locations of providers and enrollees, and enrollees' cultural, ethnic, racial, and language needs. | 7.2–7.3; *7.12* |
| The MCO/RSN's provider network must meet ***distance standards*** in each service area. For physical health care, two PCPs must be available within 10 miles for 90 percent of enrollees in an urban service area, and one PCP must be available within 10 miles in a rural service area. Similar standards exist for obstetrics, pediatric or family practice, and hospital and pharmacy services. For mental health care, service sites must be available within a 30-minute drive in rural areas, within a 90-minute drive in large rural geographic areas, and within a 90-minute public transportation trip in urban areas. | 7.9; *7.13* |
| Each MCO must provide all medically necessary ***specialty care*** for enrollees in its service area, whether within or outside the provider network. The MCO must help providers obtain timely referrals to specialty care. | 7.12 |
| **Timeliness of care** | |
| The MCO/RSN must meet state standards for ***timely access*** to care. For physical health care, designated services must be available 24 hours a day, seven days a week by telephone. Preventive care office visits must be available from the enrollee's PCP or another provider within 30 calendar days; routine care visits, within 10 calendar days; urgent, symptomatic visits within 48 hours; and emergency care, 24 hours a day, seven days a week. For mental health care, the RSN must offer a routine intake evaluation appointment within 10 business days of an enrollee's request. Emergent mental health care must occur within 2 hours of a request, and urgent care must occur within 24 hours of a request. The time period from request to first routine services appointment may not exceed 28 calendar days. | 7.4–7.7; *7.6* |

| Contract provisions | Healthy Options or *RSN* contract section(s) |
|---|---|
| **Quality of care** | |
| "Quality" means "the degree to which a Contractor increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge (42 CFR 438.320)." | 3.52 |
| MCOs must cover ***medically necessary services*** related to preventing, diagnosing, and treating health impairments, achieving age-appropriate growth and development, and attaining, maintaining, or regaining functional ability. RSNs must provide a list of 18 specific services when they are medically necessary. The MCO/RSN must provide covered services in the amount, duration, and scope required by DSHS. | 15.1; *13.5* |
| The MCO/RSN must adopt ***practice guidelines***, disseminate them to providers, and use them in decision making for utilization management, enrollee education, service coverage, and other areas. The guidelines must be evidence-based, consider enrollee needs, be adopted in consultation with contracting professionals, and be reviewed and updated regularly. | 8.7; *7.11* |
| The MCO/RSN must guarantee ***enrollee rights***, including the right to be treated with respect and with consideration for dignity and privacy; to be informed of available treatment options and alternatives; to participate in decisions regarding their health care; to be free from unnecessary restraint or seclusion; and to request and receive copies of their medical records and ask that they be amended. RSN enrollees must have individual service plans, developed with the participation of enrollees and their families. Each RSN must provide an independent mental health ombuds to inform enrollees of their rights and help them resolve complaints and grievances. | 11.1; *10.1–10.5* |
| The MCO/RSN must maintain written policies and procedures for ***advance directives*** that meet state and federal requirements and must provide for staff and community education concerning these policies. | 11.3; *10.6* |
| For physical health care, the MCO must ensure that each enrollee has an ***appropriate source of primary care*** and must allow each new enrollee to choose a PCP, to the extent possible and appropriate. For mental health care, the RSN must offer each enrollee a choice of providers. | 11.4; *7.14* |
| Each MCO must allow ***enrollees with special health care needs*** (SHCN) who use a specialist frequently to retain the specialist as a PCP or to be allowed direct access to specialists for needed care. | 11.5 |
| The MCO/RSN must have and maintain a ***utilization management program*** that includes mechanisms for detecting both underutilization and overutilization of services furnished to enrollees. | 12.1; *7.10* |
| The MCO/RSN must meet state and federal requirements for ***service authorization***, including timely notification of providers and enrollees in the event that the contractor denies an authorization request. The notice must explain the reasons for denial and the procedures for filing an appeal or requesting expedited resolution. | 12.2; *7.7–7.8* |
| MCO/RSN ***grievance systems*** must meet standards regarding procedures and time frames for grievances, appeals, and access to the hearing process. | 14; *12* |
| Each MCO must provide female enrollees with ***direct access to a women's health specialist*** within the provider network as needed to provide routine and preventive care. The MCO must ensure that hospital delivery maternity care is provided in accordance with state law. | 15.4–15.5 |

| Contract provisions | Healthy Options or *RSN* contract section(s) |
|---|---|
| For physical health care, each MCO must ensure ***continuity of care*** for enrollees in an active course of treatment for a chronic or acute medical condition and must prevent the interruption of medically necessary care. For mental health care, the RSN must ensure coordination with other service delivery systems responsible for meeting needs identified in the enrollee's individual service plan, including primary medical care and services such as education, child welfare, drug and alcohol, developmental disabilities, aging and adult services, corrections, and juvenile justice. | 15.6; *10.3.3* |
| Each MCO must ensure ***coordination of care*** for enrollees through their PCPs, including initiating and coordinating referrals for specialty care. The MCO must identify enrollees with SHCN and ensure that they receive individualized treatment plans that ensure integration of clinical and nonclinical disciplines and services. Each RSN must help to coordinate mental health care for enrollees admitted for psychiatric inpatient services; provide follow-up care for enrollees treated in an emergency room; facilitate communication between physical and mental health providers about Early Periodic Screening, Diagnosis, and Treatment for enrollees under age 21; and have a plan for coordinating services with chemical dependency and substance abuse, criminal justice, and other allied systems. | 15.7–15.8; *13.8–13.11* |
| Each MCO must maintain a ***Quality Assessment and Performance Improvement*** program that meets federal regulatory requirements. The program must include a Quality Improvement Committee that oversees quality functions, an annual work plan, and an annual program evaluation. Each RSN's quality management program must include an annual review of community mental health agencies within the network. | 8.1; *8.1–8.2* |
| The MCO/RSN must conduct ***performance improvement projects*** (PIPs) designed to achieve significant sustained improvement in areas expected to have a favorable effect on health outcomes and enrollee satisfaction. Each MCO/RSN must conduct and submit to DSHS at least one clinical and one nonclinical PIP. If any of the MCO's HEDIS rates for well-child care fall below 60%, the MCO must implement a clinical PIP designed to increase the rates. If the MCO's HEDIS rates for Combo 2 childhood immunizations fall below 70% in 2008 or below 75% in any subsequent year, the MCO must implement a clinical PIP. The MCO may be required to conduct a CAHPS-related nonclinical PIP and to participate in a yearly statewide PIP. The RSN's PIPs may address topics identified by DBHR for statewide improvement or identified by the RSN for local improvement. | 8.2; *8.2.5* |
| For physical health care, each MCO must report *HEDIS* ***performance measures*** according to NCQA specifications. The contract specifies measures to be submitted each year. Each RSN must show improvement on a set of performance measures specified and calculated by DBHR. If the RSN does not meet DBHR-defined improvement targets on any measure, the RSN must submit a performance improvement plan. | 8.3; *8.3* |
| The MCO must meet state standards for placement of enrollees in the ***Patient Review and Coordination program***. This program is designed to determine and coordinate care for enrollees who have used medical services at a frequency or amount that is not medically necessary. Elements of the standards include guidelines, placement, appeals, and notification. | 15.17 |

**Table C-2. Elements of regulatory standards for managed care.**

| CFR section | Description |
|---|---|
| **438.206 Availability of Services**<br>438.206(b)(1)(i-v) Delivery network<br>438.206(b)(2) Direct access to a women's health specialist<br>438.206(b)(3) Provides for a second opinion<br>438.206(b)(4) Services out of network<br>438.206(b)(5) Out of network payment | Maintain and monitor a network of providers sufficient to provide adequate access to all services covered under the contract; provide female enrollees with direct access to women's health specialists; provide for second opinions; cover out-of-network services adequately and timely if necessary; meet contract standards. |
| **438.206(c) Furnishing of Services**<br>438.206(c)(1)(i) through (vi) Timely access<br>438.206(c)(2) Cultural considerations | Meet state standards for timely access to care and services; provide hours of operation for Medicaid enrollees that are no less than the hours for any other patient; make services available 24 hours a day, 7 days a week, when medically necessary; deliver services in a culturally competent manner to all enrollees. |
| **447.46 Timely Claims Payment by MCOs**<br>447.46 Timely claims payment | Meet standards requiring the contractor and any subcontractors to pay or deny 95% of all claims within 60 days of receipt and to pay 99% of "clean" claims within 90 days of receipt. |
| **438.608 Program Integrity Requirements** | Maintain administrative and management arrangements or procedures, including a mandatory compliance plan, designed to guard against fraud and abuse. |
| **438.208 Primary Care and Coordination**<br>438.208(b) Primary care and coordination of health care services | Ensure that each enrollee has an ongoing source of appropriate primary care and a person or entity responsible for coordinating healthcare services for the enrollee; ensure that medically necessary care for enrollees is not interrupted; facilitate orderly transfers when necessary; coordinate enrollees' healthcare services with community-based organizations. |
| **438.208(c) Additional Services for Enrollees with Special Health Care Needs**<br>438.208(c)(1) Identification<br>438.208(c)(2) Assessment<br>438.208(c)(3) Treatment plans<br>438.208(c)(4) Direct access to specialists | Implement mechanisms to identify and assess enrollees with special healthcare needs; develop individual treatment plans for these enrollees; provide direct access to specialists as necessary. |
| **438.210 Coverage and Authorization of Services**<br>438.210(b) Authorization of services<br>438.210(c) Notice of adverse action<br>438.210(d) Timeframe for decisions<br>438.210(e) Compensation for UM decisions | Meet requirements for a formal utilization management program, oversight of practitioners, written criteria for clinical decision making, and mechanisms to detect under- and overutilization of services. |
| **438.114 Emergency and Post-stabilization Services** | Establish policies and procedures for covering and paying for emergency and post-stabilization care services. |

| CFR section | Description |
|---|---|
| **438.100 Enrollee Rights**<br>***(a) General rule***<br>438.100(a) General rule<br>438.10(b) Basic rule<br>438.10(c)(3) Language – non-English<br>438.10(c)(4) and (5) Language – oral interpretation<br>438.10(d)(1)(i) Format, easily understood<br>438.10(d)(1)(ii) and (2) Format, alternative formats<br>438.10(f) General information<br>438.10(g) Specific information<br>438.10(h) Basic rule<br>438.100(b)(2)(iii) Specific rights<br>438.100(b)(2)(iv) and (v) Specific rights<br>438.100(b)(3) Specific rights<br>438.100(d) Compliance with other federal/state laws | Federal regulations include comprehensive language governing enrollee rights; Healthy Options contract requirements address advance directives, enrollee choice of primary care provider, access to specialty care for enrollees with special healthcare needs, prohibition on charging enrollees for covered services, and affirmation of provider/enrollee right to communicate freely regarding needs and services. |
| | |
| **438.226 Enrollment and Disenrollment**<br>438.226 and 438.56(b)(1) - (3) Disenrollment requested by the MCO, PIHP<br>438.56(c) Disenrollment requested by the enrollee<br>438.56(d) Procedures for disenrollment<br>438.56(d)(5) MCO grievance procedures<br>438.56(e) Timeframe for disenrollment determinations | Establish policies, procedures, and mechanisms to ensure appropriate process for disenrollment. |
| | |
| **438.228 Grievance Systems**<br>438.228 Grievance systems<br>438.402(a) The grievance system<br>438.402(b)(1) Filing requirements - Authority to file<br>438.402(b)(2) Filing requirements - Timing<br>438.402(b)(3) Filing requirements - Procedures<br>438.404(a) Notice of action - Language and format<br>438.404(b) Notice of action - Content of notice<br>438.404(c) Notice of action - Timing of notice<br>438.406(a) Handling of grievances and appeals - General requirements<br>438.406(b) Handling of grievances and appeals - Special requirements for appeals<br>438.408(a) Resolution and notification: Grievances and appeals - Basic rule<br>438.408(b) and (c) Resolution and notification: Grievances and appeals - specific timeframes and extension of timeframes<br>438.408 (d) and (e) Resolution and notification: Grievances and appeals- Format of notice and Content of notice of appeal resolution<br>438.408(f) Resolution and notification: Grievances and appeals-Requirements for State fair hearings<br>438.410 Expedited resolution of appeals<br>438.414 Information about the grievance system to providers and subcontractors<br>438.416 Recordkeeping and reporting requirements<br>438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending<br>438.424 Effectuation of reversed appeal resolutions | Meet requirements regarding a defined grievance and appeal process for enrollees, including access to the state Fair Hearing system; policies, procedures, and standard notices to enrollees; acknowledgement of grievances and investigation and resolution of all relevant issues. |

| CFR section | Description |
|---|---|
| **438.240 Performance Improvement Projects**<br>438.240(b)(1) Basic elements of MCO and PIHP quality assessment and performance improvement programs<br>438.240(d) Performance improvement projects<br>438.240(e)(1)(ii) Program review by the state | Design PIPs to achieve, through ongoing measurement and interventions, significant improvement sustained over time, favorable effect on health outcomes and enrollee satisfaction. |
| | |
| **438.236 Practice Guidelines**<br>438.236(b)(1-4) Adoption of practice guidelines<br>438.236(c) Dissemination of [practice] guidelines<br>438.236(d) Application of [practice] guidelines | Promulgate and maintain practice guidelines based on reliable and valid clinical evidence, and use the guidelines to guide clinical decision making. |
| | |
| **438.214 Provider Selection (Credentialing)**<br>438.214(a) General Rules and 438.214(b) Credentialing and recredentialing requirements<br>438.214(c) and 438.12 Nondiscrimination and provider discrimination prohibited<br>438.214(d) Excluded providers<br>438.214(e) State requirements | Adhere to state policies and procedures based on NCQA credentialing standards. |
| | |
| **438.240 Quality Assessment and Performance Improvement Program**<br>438.240(a)(1) Quality assessment and performance improvement program - General rules<br>438.240(b)(2) and (c), and 438.204(c) Performance measurement<br>438.240(b)(3) Basic elements of MCO and PIHP quality assessment and performance improvement – detect both over and underutilization of services<br>438.240(b)(4) Basic elements of MCO and PIHP quality assessment and performance improvement – assess care furnished to enrollees with special health care needs<br>438.240(e) Basic elements of MCO and PIHP quality assessment and performance improvement – evaluating the program | Meet standards for QAPI program structure with written program descriptions, work plan, and evaluation. |
| | |
| **438.230 Subcontractual Relationships and Delegation**<br>The MCO oversees functions delegated to subcontractor:<br>438.230 (a) and (b) Subcontractual relationships and delegation | Meet requirements for MCO oversight of delegated entities responsible for providing care and services; subcontract language regarding solvency, provider nondiscrimination, assigned responsibilities, and other provisions consistent with federal regulations in this area, such as reimbursement rates and procedures. |

[This page intentionally left blank]

# Appendix D. PIP Review Procedures

TEAMonitor reviews the performance improvement projects (PIPs) conducted by the contracted MCOs, while Acumentra Health reviews the PIPs conducted by RSNs. Although both sets of reviews are based on the federal protocol for validating PIPs, the review procedures differ somewhat (most notably in scoring methods), as outlined below.

## TEAMonitor PIP Review Steps

| ACTIVITY 1: Assess the Study Methodology |
|---|
| **Step 1. Review the Selected Study Topic(s)** |
| 1.1. Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care and services? |
| 1.2. Did the PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? |
| 1.3. Did the PIPs, over time, include all enrolled populations; i.e., did not exclude certain enrollees such as those with special healthcare needs? |
| **Step 2: Review the Study Question(s)** |
| 2.1. Was/were the study question(s) stated clearly in writing? |
| **Step 3: Review Selected Study Indicator(s)** |
| 3.1. Did the study use objective, clearly defined, measurable indicators? |
| 3.2. Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? |
| **Step 4: Review the Identified Study Population** |
| 4.1. Did the plan clearly define all Medicaid enrollees to whom the study question and indicators are relevant? |
| 4.2. If the plan studied the entire population, did its data collection approach capture all enrollees to whom the study question applied? |
| **Step 5: Review Sampling Methods** |
| 5.1. Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? |
| 5.2. Did the sample contain a sufficient number of enrollees? |
| 5.3. Did the plan employ valid sampling techniques that protected against bias? |
| **Step 6: Review Data Collection Procedures** |
| 6.1. Did the study design clearly specify the data to be collected? |
| 6.2. Did the study design clearly specify the sources of data? |
| 6.3. Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? |
| 6.4. Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? |
| 6.5. Did the study design prospectively specify a data analysis plan? |
| 6.6. Were qualified staff and personnel used to collect the data? |
| **Step 7: Assess Improvement Strategies** |
| 7.1. Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? |

| Step 8: Review Data Analysis and Interpretation of Study Results |
|---|
| 8.1. Was an analysis of the findings performed according to the data analysis plan? |
| 8.2. Did the plan present numerical PIP results and findings accurately and clearly? |
| 8.3. Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? |
| 8.4. Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities? |
| **Step 9: Assess Whether Improvement Is "Real" Improvement** |
| 9.1. Was the same methodology as the baseline measurement used, when measurement was repeated? |
| 9.2. Was there any documented, quantitative improvement in processes or outcomes of care? |
| 9.3. Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? |
| 9.4. Is there any statistical evidence that any observed performance improvement is true improvement? |
| **Step 10: Assess Sustained Improvement** |
| 10.1. Was sustained improvement demonstrated through repeated measurements over comparable time periods? |

| ACTIVITY 2. Verify Study Findings (Optional) |
|---|
| 1. Were the initial study findings verified upon repeat measurement? |

| ACTIVITY 3. Evaluate Overall Validity and Reliability of Study Results |
|---|
| **Check one:** |
| ☐ High confidence in reported PIP results |
| ☐ Confidence in reported PIP results |
| ☐ Low confidence in reported PIP results |
| ☐ Reported PIP results not credible |
| ☐ Enough time has not elapsed to assess meaningful change |

## PIP scoring

TeaMonitor assigned each PIP a score of "Met," "Partially Met," or "Not Met" by using a checklist of elements deemed essential for meeting the standards specified by the Centers for Medicare & Medicaid Services. The checklist appears on the following page.

**To achieve a "Met" the PIP must demonstrate <u>all of the following twelve (12) elements</u>:**

- ☐ The topic of the PIP must reflect a problem or need for Medicaid enrollees.
- ☐ Study question(s) stated in writing.
- ☐ Relevant quantitative or qualitative measurable indicators documented.
- ☐ Description of the eligible population to whom the study questions and identified indicators apply.
- ☐ A sampling method documented and determined prior to data collection.
- ☐ The study design and data analysis plan proactively defined.
- ☐ Specific interventions undertaken to address causes/barriers identified through data analysis and QI processes (e.g., barrier analysis, focus groups, etc).
- ☐ Numerical results reported, e.g., numerator and denominator data.
- ☐ Interpretation and analysis of the results reported.
- ☐ Consistent measurement methods used over time or if changed, the rationale for the change is documented.
- ☐ Sustained improvement demonstrated through repeat measurements over time (baseline and at least two follow-up measurements required).
- ☐ Linkage or alignment between the following: data analysis documenting need for improvement; study question(s); selected clinical or non-clinical measures or indicators; and results.

**To achieve a "Partially Met" the PIP must demonstrate <u>all of the following seven (7) elements</u>:**

- ☐ The topic of the PIP must reflect a problem or need for Medicaid enrollees.
- ☐ Study question(s) stated in writing.
- ☐ Relevant quantitative or qualitative measurable indicators documented.
- ☐ A sampling method documented and determined prior to data collection.
- ☐ The study design and data analysis plan proactively defined.
- ☐ Numerical results reported, e.g., numerator and denominator data.
- ☐ Consistent measurement methods used over time or if changed the rationale for the change is documented.

**A "Not Met" score results <u>from NOT demonstrating any one (1) of the following</u>:**

- ☐ The topic of the PIP does not reflect a problem or need for Medicaid enrollees.
- ☐ Study question(s) not stated in writing.
- ☐ Relevant quantitative or qualitative measurable indicators not documented.
- ☐ A sampling method is not documented and determined prior to data collection.
- ☐ The study design and data analysis plan is not proactively defined.
- ☐ Numerical results, e.g., numerator and denominator data are not reported.
- ☐ Consistent measurement methods are not used over time and no rationale provided for change in measurement methods, as appropriate.

# Acumentra Health PIP Review Steps

Assessing the PIP methodology consists of the following 10 steps.

**Step 1:** Review the study topic
**Step 2:** Review the study question
**Step 3:** Review the selected study indicator(s)
**Step 4:** Review the identified study population and sampling methods
**Step 5:** Review the data collection procedures
**Step 6:** Assess the improvement strategy
**Step 7:** Review the data analysis and interpretation of study results
**Step 8:** Assess the likelihood that reported improvement is "real" improvement
**Step 9:** Assess whether the RSN has documented additional interventions or modifications
**Step 10:** Assess whether the RSN has sustained the documented improvement

Each step addresses the extent to which the PIP complies with a particular standard in the CMS protocol. The specific criteria for assessing compliance with each standard are listed on the following pages.

## Step 1. Review the study topic

**Criterion 1.1. The topic was based on relevant information.**

The topic must reflect the demographics, prevalence of diagnoses, potential risks, or service needs of the RSN's Medicaid population. Examples of relevant information from which the topic may be selected include

- utilization patterns that reflect deficiencies in service
- enrollee or provider input
- data from surveys or from grievance or appeals processes that indicate underlying issues in care or services
- data comparing the RSN's performance in standardized measures with the performance of comparable organizations

**Criterion 1.2. The topic was determined through a systematic selection and prioritization process.**

The topic must aim to improve care and services for a large portion of the RSN's Medicaid population. Examples of evidence for a systematic selection and prioritization process include

- descriptions of data that support the topic selection
- documentation of opportunities for soliciting enrollee or provider input

*Example—clinical:* Developing an algorithm to standardize prescribing patterns for specific diagnoses

*Example—nonclinical:* Assessing and improving the accessibility of specific services; reducing disparities in services provided to minority enrollees as compared with non-minority enrollees; designing processes to improve care coordination

## Step 2: Review the study question

**Criterion 2.1. The RSN has clearly defined the question the study is designed to answer.** The question

- is stated so as to create a framework for data collection, analysis, and interpretation
- can be answered quantitatively or qualitatively by the PIP study

## Step 3: Review the selected study indicator(s)

Each project should use at least one quality indicator for tracking performance and improvement.

**Criterion 3.1. The indicator is an objective, measurable, clearly defined, unambiguous statement of an aspect of quality to be measured.** The indicator statement clearly identifies

- who—the eligible population
- what—the care or service being evaluated
- when—the specific care or service time frame

The indicator description includes

- *definition of the denominator:* the eligible population, identifying inclusions and exclusions (criteria used to determine the eligible population, such as age, gender, and diagnosis and enrollment status)
- *definition of the numerator:* the outcome achieved or service rendered to the eligible population
- dates of service, procedure codes for administrative data, or acceptable medical record data
- the basis for adopting the indicators (e.g., that they are generally used in the industry—these are preferred; or if the RSN developed its own indicators either at the outset of the study or as a means of narrowing the focus for the study, a description of how the indicator was developed)

**Criterion 3.2. The indicator can measure enrollee outcomes, enrollee satisfaction, or processes of care strongly associated with improved enrollee outcomes.**

- Indicators for clinical care should include at least some measure of change in mental health status or functional status or process-of-care proxies for these outcomes.
- Process measures may be used as proxies for outcomes only if validity has been established in the literature or by expert consensus.

## Step 4: Review the identified study population and sampling methods

**Criterion 4.1. The study population is clearly defined and includes all RSN enrollees who are eligible for the study.** The study population

- represents the RSN's entire Medicaid population that fits the eligibility criteria described by the indicators
- is defined in terms of enrollment time frames

If the study population is an "at risk" subpopulation,

- the RSN has clearly defined the risk and the subpopulation
- the RSN has provided a rationale for selecting the subpopulation

The RSN may use a sample for the study. *If a sample is used,* the RSN must

- provide the rationale for using a sample
- explain the sampling methodology that produced a representative sample of sufficient size (see below)

**Criterion 4.2. When the study includes the RSN's entire eligible population, the data collection approach captures all eligible enrollees.**

**Criterion 4.3. If a sample is used, the RSN has described the method for determining the sample size.**

If a clinical or service condition is being studied for first time, the true prevalence or incidence is not likely to be known. Large samples would be needed to establish a valid baseline. The sampling methodology should include the

- rationale for the size of the sample based on the RSN's eligible population
- frequency of the occurrence being studied
- confidence interval and acceptable margin of error

**Criterion 4.4. The sampling methodology is valid and protects against bias.**

The description establishing validity and bias protection should include

- a description of the sampling type (e.g., probability or nonprobability; stratified random or convenience)
- the rationale for selecting the sampling type

**Criterion 4.5. The sample is large enough to allow calculation of statistically meaningful measures.**

## Step 5: Review the data collection procedures

The data collection process must ensure that the data collected on the indicator(s) are valid and reliable. Validity indicates the accuracy of the data. Reliability indicates the repeatability or reproducibility of a measurement.

**Criterion 5.1. The study design clearly specifies the data to be collected.**

- Data elements are defined unambiguously.
- Descriptive terms (e.g., "high," "medium," "low") are defined numerically.

**Criterion 5.2. The data sources are clearly identified.**

- Examples of data sources include medical records, encounter and claim systems, or surveys.
- Time frames for collecting baseline and remeasurement data are specified.

**Criterion 5.3. The study design describes a systematic method of collecting valid and reliable data on all enrollees to whom the indicator(s) apply.**

- *For administrative data* (claims or encounter data), the data are complete and include all data submitted by providers. If data collection is automated, the RSN has provided the data specifications and algorithms used.
- *For medical record abstraction* or review of other primary sources, the RSN has documented the steps taken to ensure that the data were consistently extracted and recorded.

**Criterion 5.4. *For manual data collection,* the data collection instrument produces consistent, accurate data that are appropriate for the study indicator(s) and that can be used over the study time period.**

- The data abstraction process is documented, including a data collection instrument with clear guidelines and definitions.
- Reviewer training is documented, including guidelines, definitions, instructions on how to use the instrument, and instructions on how to handle situations not covered in the documentation.
- Methods of ensuring inter-rater reliability are provided.

**Criterion 5.5. The study design includes a prospective data analysis plan that specifies**

- whether qualitative or quantitative data or both are to be collected
- whether data are to be collected on the entire population or a sample
- whether measures are to be compared to previous results or similar studies; if comparing measures between two or more studies, the appropriate statistical test must be identified
- whether the PIP is to compare to the performance of different sites or clinics; if comparing performance of two or more entities, the statistical design and analysis must reflect the comparisons

**Criterion 5.6. *For manual data collection,* the study design includes the rationale and staff qualifications for the data abstraction.** The documentation

- indicates that staff received training on the use of the data collection instrument
- indicates the inter-rater reliability of the data collection instrument

## Step 6: Assess the improvement strategy

An improvement strategy is defined as an intervention or set of interventions designed to change behavior at an institutional, practitioner, or enrollee level. The effectiveness of the interventions is determined by measuring a change in performance based on the quality indicator(s).

**Criterion 6.1. The RSN has reported on at least one intervention undertaken to address causes or barriers identified through the quality improvement process.** The interventions were

- systemic—i.e., designed to affect a wide range of participants through long-term system change
- timed to effect change after the baseline measurement and prior to remeasurement
- effective in improving the indicator for the population(s) studied
- reasonably expected to result in measured improvement
- free of major confounding variables that were likely to affect outcomes

### Step 7: Review the data analysis and interpretation of study results

The RSN calculated its performance in the indicators by adhering to appropriate statistical analysis techniques as defined in a data analysis plan.

**Criterion 7.1. The analysis of the findings adheres to a data analysis plan that used an appropriate statistical methodology.**

**Criterion 7.2. The study results, including numerical results and findings, are presented in a manner that provides accurate, clear, and easily understood information.**

**Criterion 7.3. The analysis identifies**

- baseline and remeasurement data
- the statistical significance of any differences between these data sets
- any factors that influenced comparability
- any factors that threatened the validity of the findings

**Criterion 7.4. The analysis is based on continuous quality improvement and focused on delivery system processes.**

- The interpretation of the success of the PIPs included lessons learned and identified barriers to success or presented a hypothesis about less-than-optimal performance.
- Follow-up activities addressed the barriers identified.

### Step 8: Assess the likelihood that reported improvement is "real" improvement

The reported improvement represents "real" change and is not due to a short-term event unrelated to the intervention or to chance.

**Criterion 8.1. The RSN has used the same methodology for measuring the baseline as for conducting remeasurement, or the RSN has described and justified a change in measurement methodology.**

**Criterion 8.2. The analysis discussion includes documentation of**

- quantitative improvement in processes related to the study question
- improvements in associated outcomes of care

**Criterion 8.3. The analysis discussion describes clearly how the interventions relate to the improvement in performance.**

**Criterion 8.4. The analysis includes an appropriate calculation of statistical significance, with a discussion of the test used to calculate significance.** (There is no required level of significance.)

### Step 9: Assess whether the RSN has documented ongoing or additional interventions or modifications

The RSN has documented sustained improvement by remeasuring performance on the initial study indicator(s) at regular intervals. (*Note:* Interventions may be modified between remeasurement periods to address barriers or to take advantage of study findings.)

**Criterion 9.1. The RSN has documented ongoing or additional interventions or modifications that are based on earlier data analyses.**

### Step 10: Assess whether the RSN has sustained the documented improvement

**Criterion 10.1. Sustained improvement is demonstrated by additional remeasurements conducted over comparable time periods.**

## PIP scoring

Each compliance standard has a potential score of 100 points for full compliance, with lower scores for lower levels of compliance. The scores for each standard are weighted and combined to determine the overall PIP score, as shown in Table D-1.

**Table D-1. Weighting of standard scores in overall PIP score.**

| Standard | Criterion number(s) | Scoring weight |
|---|---|---|
| **Demonstrable Improvement** | | |
| **1** Selected study topic is relevant and prioritized | 1.1, 1.2 | 20% |
| **2** Study question is clearly defined | 2.1 | 10% |
| **3** Study indicator is objective and measurable | 3.1, 3.2 | 10% |
| **4** Study population is clearly defined and, if sample is used, appropriate methodology is used | 4.1, 4.2, 4.3, 4.4, 4.5 | 10% |
| **5** Data collection process ensures that data are valid and reliable | 5.1, 5.2, 5.3, 5.4, 5.5, 5.6 | 10% |
| **6** Improvement strategy is designed to change performance based on the quality indicator | 6.1 | 10% |
| **7** Data are analyzed and results interpreted according to generally accepted methods | 7.1, 7.2, 7.3, 7.4 | 10% |
| **8** Reported improvement represents “real” change | 8.1, 8.2, 8.3, 8.4 | 10% |
| | **Demonstrable Improvement Score** | **90%** |
| **Sustained Improvement** | | |
| **9** RSN has documented additional or ongoing interventions or modifications | 9.1 | 5% |
| **10** RSN has sustained the documented improvement | 10.1 | 5% |
| | **Sustained Improvement Score** | **10%** |
| | **Overall PIP Score** | **100%** |

The overall score is weighted 90% for demonstrable improvement in the first year (Standards 1–8) and 10% for sustained improvement in later years (Standards 9–10). Thus, for a PIP that has completed one remeasurement, the maximum overall score is 90 points (90% x 100 points for full compliance). If the PIP has progressed to a second remeasurement, enabling reviewers to assess sustained improvement, the maximum score is 100 points. Table D-2 shows a scoring calculation for a PIP with both demonstrable and sustained improvement.

**Table D-2. Example scoring worksheet.**

| Standard | Compliance rating | Assigned points | Weight | Points score |
|---|---|---|---|---|
| **Demonstrable Improvement** | | | | |
| 1 | Fully met | 100 | 20% | 20.0 |
| 2 | Fully met | 100 | 10% | 10.0 |
| 3 | Partially met | 50 | 10% | 5.0 |
| 4 | Partially met | 50 | 10% | 5.0 |
| 5 | Fully met | 100 | 10% | 10.0 |
| 6 | Minimally met | 25 | 10% | 2.5 |
| 7 | Partially met | 50 | 10% | 5.0 |
| 8 | Partially met | 50 | 10% | 5.0 |
| | | **Demonstrable Improvement Score** | | **62.5** |
| **Sustained Improvement** | | | | |
| 9 | Substantially met | 80 | 5% | 4.0 |
| 10 | Partially met | 50 | 5% | 2.5 |
| | | **Sustained Improvement Score** | | **6.5** |
| | | | **Overall PIP Score** | **69.0** |

If graded on the 90-point scale (i.e., before a second remeasurement), this PIP would earn an overall rating of Substantially Met. If graded on the 100-point scale (following a second remeasurement), the PIP would earn the same overall rating.