

# IDAHO BEHAVIORAL HEALTH PLAN QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT QUARTERLY REPORT



**OPTUM**<sup>TM</sup>

*July - September,  
2015*

The Idaho Behavioral Health Plan (IBHP) Quality Management and Improvement (QMI) report summarizes Optum Idaho's Quality Management and Utilization Management (QMUM) for Calendar Year 2015. It provides an overview of outcomes data, through Quarter 3, 2015, for Medicaid outpatient mental health and substance use disorder services managed by IBHP in the state of Idaho.

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## **Executive Summary**

The quarterly report of Optum's Quality Management and Utilization Management (QMUM) Program's performance reflects Medicaid members whose benefit coverage is provided through the Idaho Behavioral Health Plan (IBHP) and administered by Optum Idaho.

Optum's comprehensive Quality Assurance and Performance Improvement (QAPI) program encompasses outcomes, quality assessment, quality management, quality assurance, and performance improvement. The QAPI program is governed by the QAPI committee and includes data driven, focused performance improvement activities designed to meet the State of Idaho Department of Administration for the Department of Health and Welfare (IDHW) and federal requirements. These contractual and regulatory requirements drive Optum's key measures and outcomes for the IBHP.

Optum Idaho's QAPI Program utilizes key measures, outcomes and other types of measures to evaluate and improve the services we provide to IBHP members. The QAPI Committee routinely monitors performance of key measures and outcomes as part of Optum Idaho's *Outcomes Management and Quality Improvement Work Plan*. The Work Plan document is included in the 2015 Quality Performance section of this report.

Key indicator performance and outcomes are reported within each of the following performance domains:

- Geographic Availability of Providers
- Member Accessibility to Care and Services
- Member Experience
- Member Protections and Safety
- Provider Monitoring and Relations
- Utilization Management and Care Coordination
- Performance Improvement
- Claims Payment

The purpose of this document is to share with internal and external stakeholders Optum's performance, outcomes and improvement activities related to services we provide to IBHP members and contracted providers. Information outlined in this report highlights calendar year (CY) 2015 quarterly performance for Quarter 3 (July 1 – September 30) and provides comparative performance from previous quarters, which includes Quarter 1 (January 1 – March 31) and Quarter 2 (April 1 – June 30).

## **Overall Effectiveness and Highlights**

Optum Idaho monitors performance measures as part of our Outcomes Management and Quality Improvement Work Plan. In Quarter 3, 2015, thirty-two (32) key performance measures were monitored as highlighted in the 2015 Quality Performance Measures and Outcomes section in this report. Performance targets are based on contractual, regulatory or operational standards. For this reporting period, Optum met or exceeded performance for 29 (91%) of the total key measures. This high level of operational effectiveness further validates Optum's commitment to IBHP members and families in transforming the behavioral health care system in the State of Idaho.

While the following three (3) key measures did not meet the established performance goals, two of the three measures—Adverse determination decisions made within 14 business days from request and Service requests are processed within 14 business days from request-- were less than 1% away from meeting the performance goal. Optum has improvement action plans in place to monitor and improve performance. A detailed account of barriers, opportunities and interventions are outlined within the report for each measure:

- Adverse determination decisions made within 14 business days from request
- Service requests are processed within 14 business days from request
- Provider Overall Satisfaction

Optum strives to improve the health of IBHP members through better quality of care and increased access to evidence-based services. In Quarter 3, 2015, Optum drove the following strategies to further increase member access to care by;

- Encouraging existing providers to expand service offerings
- Targeting recruitment of providers who are not yet in our network
  - providers from our commercial plans
  - providers in other payor networks
- Encouraging the use of tele health
- Narrowing mileage for those without access by recruiting providers in closest possible proximity

Although Optum does not manage inpatient hospitalization services, Optum Idaho routinely monitors its utilization, to promote necessary outpatient transitions and services. In Quarter 3, 2015 IDHW reported the lowest number of member inpatient discharges, 30-day hospital readmissions, and rate of hospital readmissions since Optum Idaho began. The member readmission rate dropped nearly 20% in Quarter 3 from the previous quarter, which is excellent when reviewing the service continuum.

In addition to Optum's operational performance strategy, we are dedicated to working in partnership with all community stakeholders to implement an accountable, outcomes-driven, recovery-centered system focused on improving member care.

In collaboration with Idaho Federation of Families and Idaho Parents Unlimited, Optum Idaho held its first InTouch Community Conversation across the state during Quarter 3.

The purpose of this event was to bring awareness and education around the critical topic of disruptive behavior disorders in children and what treatment options are available for families.

As part of the overall system transformation efforts in Idaho, it was also our goal to deliver the message that every person has a voice and parents and guardians in particular need to be aware of their options and expect answers from providers in what their child's diagnosis is and what treatments are available.

The event was live in Boise and was simulcast statewide to six additional regions in order to deliver the same message and engage in dialogue, at the same time, throughout the state.

Throughout seven regions, nearly 100 people attended the event which was well received by attendees who repeatedly asked for additional forums on other topics. Planning for 2016 forums are now underway based on the community feedback.

The recorded presentation is available on the Optum Idaho website at [www.optumidaho.com](http://www.optumidaho.com).

Additional community outreach efforts to transform and improve the behavioral health system of care during the third quarter included:

- Working with provider agencies across the state on their transformational efforts in how to best serve members in the evolving system. One provider in particular in Eastern Idaho who was willing to share their story to help others, was then profiled in the local newspaper.
- Educating others on the importance of appropriately managing members who have high-risk health needs. Through presentations and one-to-one conversations, Optum continues to inform key stakeholders on the various ways it assists members including those with significant health issues.
- Conducting Mental Health First Aid training courses in communities around the state. Trainings took place on the Duck Valley Indian Reservation and in Challis, Idaho with a focus on rural and cultural needs. Optum performs these trainings through a partnership with The Speedy Foundation, a local organization dedicated to preventing suicide through education and outreach in the community. The partnership recognizes that just as people are trained to administer CPR or the Heimlich maneuver in an emergency situation, Idahoans should also be equipped with the tools to recognize and respond appropriately to assist friends, family members and colleagues who are suffering from mental health, emotional or substance use issues.
- Working with state leaders, regional behavioral health boards and legislators on the importance of providers transitioning to evidence-based practices in a member-centric system of care.
- Promoting our recovery and resiliency model through media placements across the state including in on-air interviews and newspaper articles.

## 2015 Quality Performance Measures and Outcomes

Measure	Goal	January - March 2015	April - June 2015	July - September 2015	Performance Status
<b>Geographic Availability of Providers</b>					
Area 1 - requires one provider within 30 miles for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties.	100%	99.8%	99.7%	99.8%	Met*
Area 2 - requires one provider within 45 miles for the remaining 41 counties not included in Area 1 (37 remaining within the state of Idaho and 4 neighboring state counties)	100%	99.9%	99.9%	99.8%	Met*
<b>Member Accessibility to Care and Services</b>					
<b>Idaho Behavioral Healthplan Membership</b>					
Membership Numbers	NA	282,058	286,394	287,120	NA
<b>Call Standards</b>					
Total Number of Calls	NA	1206	1122	1094	NA
Percent Answered within 30 seconds	≥80%	92.4%	90.6%	88.5	Met
Average Speed of Answer (seconds)	≤30 Seconds	12.1	12.0	14.1	Met
Abandonment Rate	≤3.5%	1.8%	2.20%	2.2	Met
<b>Urgent and Non-Urgent Access Standards</b>					
Urgent Appointment Wait Time (hours)	48 hours	11.7	35.5	23.1	Met
Non-Urgent Appointment Wait Time (days)	10 days	5.8	5.4	3.1	Met
<b>Member Experience/ Member Satisfaction Survey</b>					
Experience with Optum Idaho Staff and Referral Process	≥85%	85.5%	Based on the Member Satisfaction Survey sampling methodology, Q2 & Q3 data is not yet available		Met
Experience with the Behavioral Health Provider Network	≥85%	91.0%		Met	
Experience with Counseling or Treatment	≥85%	91.9%		Met	
Overall Experience	≥85%	92.2%		Met	
<b>Member Protections and Safety</b>					
<b>Notification of Adverse Benefit Determinations</b>					
Number of Adverse Benefit Determinations	NA	417	523	462	NA
Adverse Determination Decision within 14 Days	100%	99.5%	100.0%	99.4%	Not Met
Initial Verbal Notification on Same Day	100%	100.0%	100.0%	100.0%	Met
Written Notification Sent within 1 Business Day	100%	97.6%	98.6%	99.6%	Met*
<b>Grievances (appeal of adverse determination)</b>					
Number of Grievances	NA	26	29	21	NA
Member Grievance Turnaround time	≤30 days	9	10	17	Met
<b>Complaint Resolution and Tracking</b>					
Number of Complaints	NA	37	42	26	NA
Percent of Complaints resolved within Turnaround time	5 days	100.0%	100.0%	100.0%	Met
Number of Quality of Service Complaints	NA	35	40	21	NA
Percent Quality of Service Resolved within Turnaround time	100% within ≤10 days	97.0%	100.0%	100.0%	Met
Number of Quality of Care Complaints	NA	2	2	5	NA
Percent Quality of Care Resolved within Turnaround time	≤30 days	100.0%	100.0%	100.0%	Met
<b>Critical Incidents</b>					
Number of Critical Incidents Received	NA	12	16	15	NA
Percent Ad Hoc Reviews Completed within 5 business days from notification of incident	100%	100.0%	100.0%	100.0%	Met
<b>Response to Written Inquiries</b>					
Percent Acknowledged ≤2 business days	100%	100.0%	100.0%	100.0%	Met

Measure	Goal	January - March 2015	April - June 2015	July - September 2015	Performance Status	
<b>Provider Monitoring and Relations</b>						
<b>Customer Service Line</b>						
Total Number of Calls	NA	3577	4138	3315	NA	
Percent Answered within 30 seconds	≥80%	97.1%	94.6%	97.3%	Met	
Average Speed of Answer (seconds)	≤30 Seconds	5	10	5.5	Met	
Abandonment Rate	≤3.5%	0.65%	1.11%	0.71%	Met	
<b>Network Treatment Record Reviews</b>						
Number of Audits	NA	66	69	76	NA	
Credentialing Audit (Percent overall score)	≥ 85%	97.0%	97.3%	97.0%	NA	
Recredentialing Audit (Percent overall score)	≥ 85%	97.0%	95.3%	95.2%	NA	
Ongoing Monitoring (Percent overall score)	≥ 85%	91.0%	89.9%	91.0%	NA	
Quality of Care (Percent overall score)	≥ 85%	96.0%	90.5%	94.5%	NA	
Percent of Audits that Required a Corrective Action Plan	NA	12.1%	13.0%	22.4%	NA	
<b>Provider Disputes</b>						
Number of Provider Disputes	NA	24	18	1	NA	
Average Number of Days to Resolve Provider Disputes	≤30 days	16	2	8	Met	
<b>Provider Satisfaction</b>						
Overall Provider Satisfaction	≥85%	63.0%	67.0%	64.0%	Not Met	
<b>Utilization Management and Care Coordination</b>						
<b>Service Authorization Requests</b>						
14-Day Turnaround Time for Processing Service Requests	100%	98.1%	99.1%	99.3%	Not Met	
<b>Post Discharge Follow-Up</b>						
Number of Inpatient Discharges	NA	Started tracking April, 2015.	626	No data due to reporting lag.	NA	
Number of Members with Follow-Up Appointment within 7 Days	NA		336		NA	
Percent of Members with Follow-Up Appointment within 7 Days	NA		53.7%		NA	
<b>Field Care Coordination</b>						
Total Referrals to FCCs	NA	188	175	211	NA	
Average Number of Days Case Open to FCC	NA	78.7	61.6	38.9	NA	
<b>Readmissions</b>						
Number of Members Discharged	NA	839	848	789	NA	
Percent of Members Readmitted within 30 days	NA	20.1%	20.3%	16.3%	NA	
<b>Inter-Rater Reliability</b>						
Inter-Rater Reliability testing has been deferred until Q1 2016 due to role out of Clinical Model 2.1 in August, 2015.	NA	Completed Annually			NA	
<b>Peer-Review Audits</b>						
PhD Peer Review Audit Results	≥ 88%	93.0%	100.0%	100.0%	Met	
MD Peer Review Audit Results	≥ 88%	100.0%	98.0%	100.0%	Met	
<b>Wellness Assessment Utilization and Follow-Up</b>						
Total Wellness Assessments Administered						
	Adults	NA	4121	3802	3515	NA
	Youth	NA	5429	4847	4287	NA
4-Month Response Received						
	Adults	NA	164	175	136	NA
	Youth	NA	103	120	86	NA
<b>Claims</b>						
Claims Paid within 30 Calendar Days	90%	99.9%	99.9%	99.9%	Met	
Claims Paid within 90 Calendar Days	99%	100.0%	99.9%	100.0%	Met	
Dollar Accuracy	99%	99.9%	99.8%	100.0%	Met	
Procedural Accuracy	97%	99.5%	99.7%	100.0%	Met	

\*performance is viewed as meeting the goal due to established rounding methodology (rounding to the nearest whole number)



## Q3 Performance Analysis by Category

### Quality Assurance Core Documents and Policy Review

**Methodology:** The Quality Assurance Performance Improvement (QAPI) Committee, as part of the annual review of all Quality Improvement Core Documents and Policies and Procedures, reviews the documents at monthly meetings.

**Analysis:** The documents indicated below were reviewed during Q1 and Q2. No additional documents or policies were reviewed during Q3.

**Core Documents reviewed during Q1.**

- 2015 Quality Improvement Plan
- Outcomes Management Work Plan

**Core Document reviewed during Q2.**

- 2014 Annual Evaluation

**The following is a tracking of the Annual Review of the Optum Idaho Policies & Procedures and the 2015 Review Dates.**

Annual Review of Optum Idaho Quality Assurance Policies - 2015			
Optum Idaho Policy Name	Initial Development Date	Previous QAPI Review Date	2015 Review Date (*Sent to National Policy Committee)
1. Optum Idaho Monitoring Important Aspects of Care and Services	August 2013	6/17/14	5/19/15*
2. Optum Idaho Performance Improvement Projects	August 2013	6/17/14	6/16/15*
3. Optum Idaho QAPI Program Evaluation	August 2013	6/17/14	6/16/15*
4. Optum Idaho Quality Improvement Plan	August 2013	6/17/14	6/16/15*
5. Optum Idaho Treatment Record Documentation	August 2013	7/15/14	7/21/15*
6. Optum Idaho Quality of Care Audits	August 2013	7/15/14	7/21/15*
7. Optum Idaho Provider Monitoring Plan	August 2013	7/15/14	7/21/15*
8. Optum Idaho Supervisory Protocol	December 2013	7/15/14	May* (Monika Mikkelsen)
9. Optum Idaho QAPI Committee Structure	August 2013	7/15/14	7/21/15*
10. Optum Idaho Outcomes Management and Quality Improvement Work Plan	August 2013	7/15/14	7/21/15*
11. Optum Idaho External Audits	August 2013	7/15/14	5/19/15*
12. Optum Idaho Provider Site Audits	September 2013	8/19/14	7/21/15*
13. Optum Idaho QOS Complaints and QOC Concerns	August 2013	8/19/14	1/20/15*
14. Optum Idaho Critical Incidents	January 2015* (NEW)	NA	NA
15. Optum Idaho Member Grievances and Appeals of Adverse Actions	August 2013	8/17/14	Internal Dept. Review

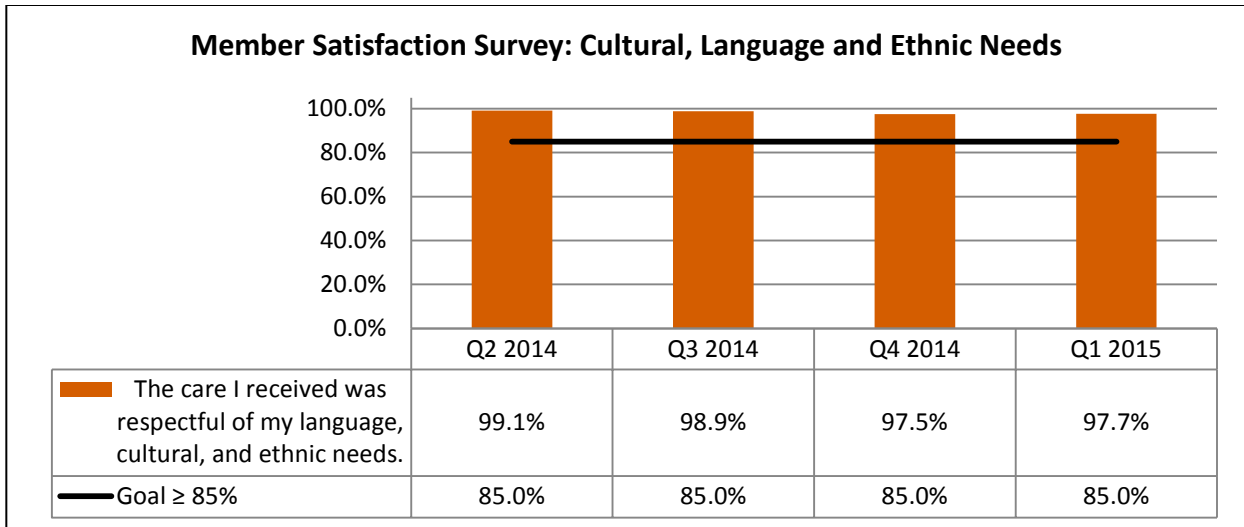
## Availability of Providers

### Language and Culture

**Methodology:** Optum strives to provide culturally competent behavioral health services to its Members. Optum uses U. S. Census results to estimate the ethnic, racial, and cultural distribution of our membership. Below is a table listing the 2010 census results for ethnic, racial and cultural distribution of the Idaho Population. Optum uses the Member Satisfaction Survey to gauge whether the care that the member receives is respectful to their cultural and linguistic needs.

2010 Idaho Census Results for Ethnic, Racial and Cultural Distribution of Population								
Total Population (Estimate)	Hispanic or Latino*	White	Black or African American	American Indian & Alaska Native alone	Asian alone	Native Hawaiian & Other Pacific Islander alone	Some other race alone	Two or more races
1,567,582	11.2%	89.1%	0.7%	1.4%	1.2%	0.1%	5.1%	2.5%

**Analysis:** Hispanic or Latino counted for 11.2% of the Idaho population. This is the second highest population total, with White consisting of 89.1% (ethnic and racial backgrounds can overlap which explains for the percentage total > 100%). The Member Satisfaction Survey results show that 97.7% of members believe the care they received was respectful of their language, cultural, and ethnic needs. Based on the Member Satisfaction Survey sampling methodology, Q1 2015 data is the most recent results available.



**Barriers:** Based on the above analysis, no barriers were identified.

**Opportunities and Interventions:** No opportunities for improvement were identified.

### Results for Language and Culture

**Methodology:** Optum provides language assistance that is relevant to the needs of our members who (a) speak a language other than English, (b) are deaf or having hearing impairments, (c) are blind or have visual impairments, and/or (d) have limited reading ability. These services are available 24 hours a day, 365 days per year.

Quarterly Performance Results:

Language Assistance Requests by Type	# of Requests
Member Written Communication Translated to Spanish (Annual Member Mailing)	1
Member Written Communication Formatted to Large Print (Annual Member mailing)	0
Mental Health First Aid (MHFA) Training Materials Translated to Spanish	0

**Analysis:** During Q3, we responded to one (1) request received by a member for language translation for annual member mailing. No other requests were received.

**Barriers:** Based on the above analysis, no barriers were identified.

**Opportunities and Interventions:** No opportunities for improvement were identified.

## Geographic Availability of Providers

**Methodology:** GeoAccess reporting enables the accessibility of health care networks to be accurately measured based on the geographic locations of health care providers relative to those of the members being served. On a quarterly basis, Optum Idaho runs a report using GeoAccess™ software to calculate estimated drive distance, based on zip codes of unique members and providers/facilities. Performance against standards will be determined by calculating the percentage of unique members who have availability of each level of /service provider and type of provider/service within the established standards.

Optum Idaho’s contract availability standards for “Area 1” requires one (1) provider within 30 miles for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties. For the remaining 41 counties (37 remaining within the state of Idaho and 4 neighboring state counties) in “Area 2” Optum Idaho’s standard is one (1) provider in 45 miles.

### Quarterly Performance Results:

Geographic Availability of Providers	Performance Goal	Q1 2015	Q2 2015	Q3 2015
Area 1 (within 30 miles)	100%	99.8%	99.7%	99.8%
Area 2 (within 45 miles)	100%	99.9%	99.9%	99.8%

**Analysis:** Optum Idaho continues to meet contract availability standards. During Q3, Area 1 and Area 2 availability standards were met at 99.8%. Our performance is viewed as meeting the goal due to established rounding methodology (rounding to the nearest whole number).

As of September 2015, the IBHP had 5027 providers practicing in 612 locations, which consists of individually credentialed and roster clinicians and agencies. The Optum Idaho regional network management team actively managed accessibility through continued recruitment of new providers to the network. Along with recruitment of new providers from our commercial plans and other payor networks, Optum encouraged existing providers to expand service offerings, and encouraged the use of telehealth. In rural areas of Idaho, Optum continued to narrow mileage expectations for member access by recruiting provides in the closest possible proximity to members.

**Barriers:** Based on the above analysis, no barriers were identified.

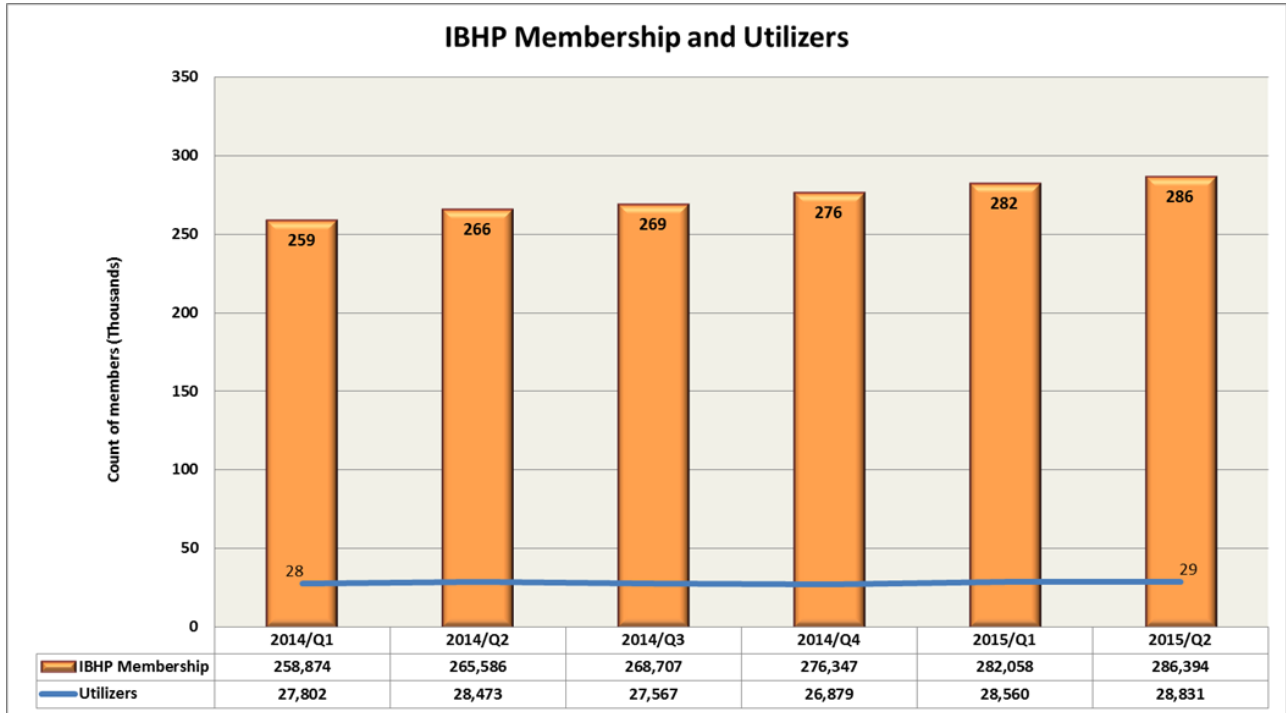
**Opportunities and Interventions:** No opportunities for improvement were identified.

## Member Accessibility to Care and Services

### Idaho Behavioral Health Plan Membership

**Methodology:** The Idaho Department of Health and Welfare (IDHW) sends IBHP Membership data to Optum Idaho on a monthly basis. “Membership” refers to IBHP members with the Medicaid benefit. “Utilizers” refers to the number of Medicaid members who use Idaho Behavioral Health Plan services. Due to claims lag, data is reported one quarter in arrears.

Quarterly Performance Results:



**Analysis:** While membership numbers increased slightly, the utilizers remained steady.

**Barriers:** Based on the above analysis, no barriers were identified.

**Opportunities and Interventions:** No opportunities for improvement were identified.

## Call Standards

**Methodology:** Optum provides access to care 24 hours a day, seven days a week, 365 days per year through our toll-free Member Access and Crisis Line. This line is answered by a team of Masters-level behavioral health clinicians who are trained to assess the member's needs, provide counseling as appropriate, and refer the member to the most appropriate resources based on the member's needs. Optum Idaho receives a Member Access and Crisis Line Biannual Report from our vendor, ProtoCall Services, Inc.

To ensure we met our member's needs in a timely and efficient manner, Optum Idaho established performance targets that exceeded IBHP contractual targets for average speed to answer (120 seconds) and call abandoned rate ( $\leq 7\%$ ). Data source is Avaya's Communication system (ProtoCall).

### Quarterly Performance Results:

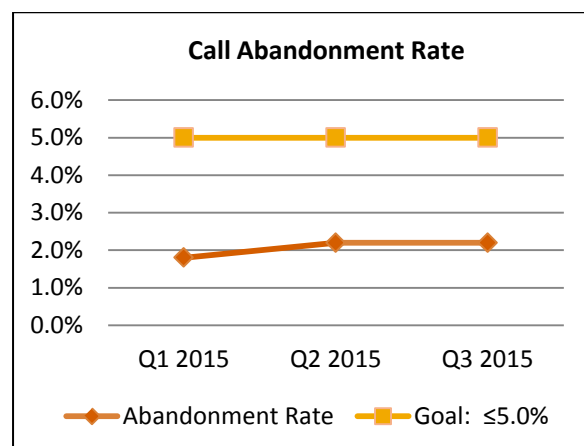
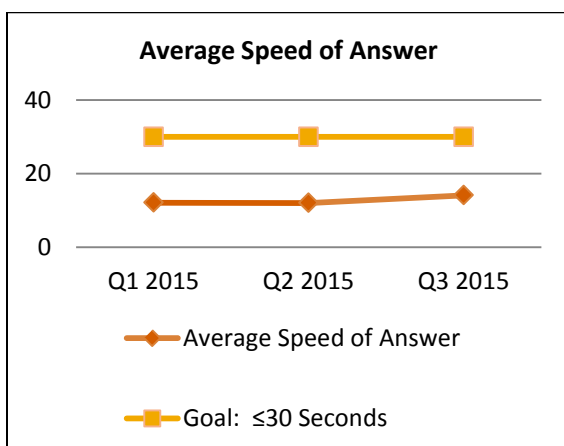
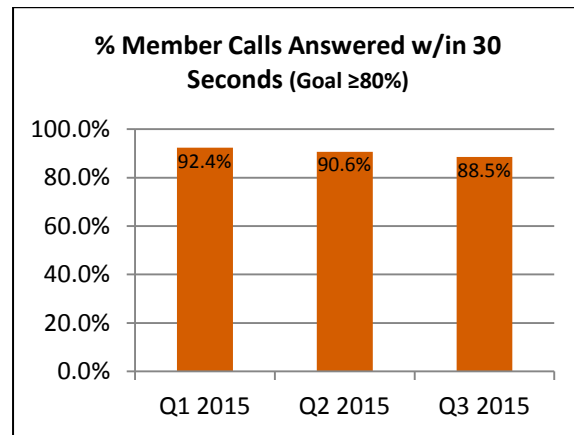
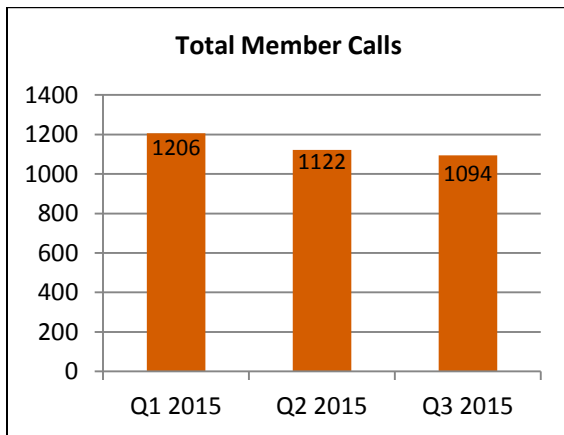
Member Service Line	Optum Idaho Standards	IBHP Contract Standards	Q1 2015	Q2 2015	Q3 2015
Total Number of Calls	NA	NA	1206	1122	1094
Percent of Calls Answered Within 30 Sec	$\geq 80\%$	None	92.4%	90.6%	88.5%
Average Speed of Answer	$\leq 30$ Seconds	120 seconds (2 minutes)	12.1 sec	12.0 sec	14.1 sec
Abandonment Rate	$\leq 3.5\%$	$\leq 7\%$	1.8%	2.2%	2.2%

In addition, Optum Idaho generates a Member Access and Crisis Line Bi-annual Report to analyze additional measures related to the types and outcomes of calls received. The table below represents the bi-annual performance for the top-five primary issues identified in clinical calls made to the Member Access Line. This information along with call access standards are reviewed routinely to by our Member Advisory Committee to monitor trends and service gaps. The top 5 Clinical Call Types are identified in the table below.

## Top 5 Clinical Call Types

January – June 2014		July – December 2014		January – June 2015	
33%	Alcohol/Drugs	29%	Alcohol/Drugs	38%	Alcohol/Drugs
14%	Child	15%	Anxiety	16%	Child
11%	Depression	13%	Child	10%	Depression
8%	Anxiety	9%	Depression	9%	Anxiety
4%	Medication	4%	Medication	4%	Medication

**Analysis:** During Q3, the Member Services and Crisis Line received a total of 1,094 calls. To date, Optum Idaho has exceeded established performance for call standards in each quarter of the 2015 calendar year. In Q3, we answered 88.5% of calls in 30 seconds (goal  $\geq 80\%$ ), with an average speed to answer of 14.1 seconds (goal 30 seconds) and an abandoned rate of 2.2% that meets both the Optum Idaho Standards goal of  $\leq 3.5\%$  and the IBHP Contractual Standards goal of  $\leq 7.0\%$ .



**Barriers:** Based on the above analysis, no barriers were identified.

**Opportunities and Interventions:** No opportunities for improvement were identified

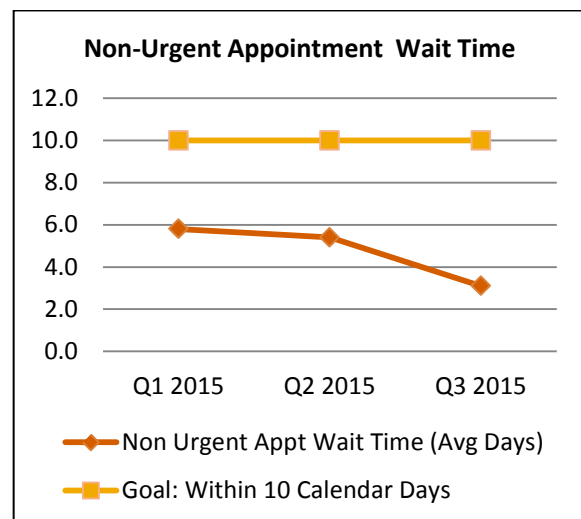
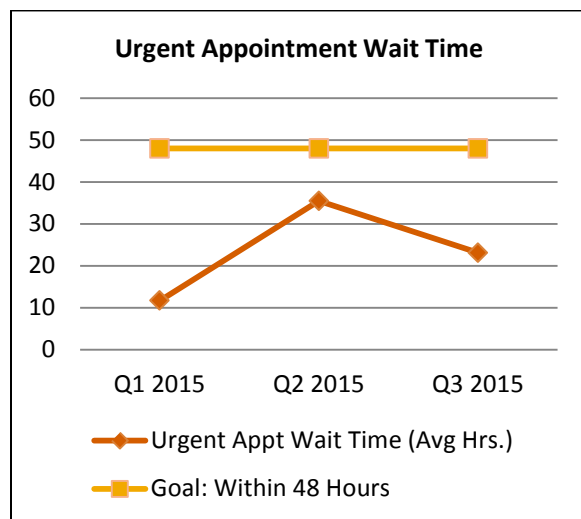
## Urgent and Non-Urgent Access Standards

**Methodology:** As part of our Quality Improvement Program, and to ensure that all members have access to appropriate treatment as needed, we develop, maintain, and monitor a network with adequate numbers and types of clinicians and outpatient programs. We require that the network providers adhere to specific access standards for *Urgent Appointments* being offered within 48 hours and *Non-urgent Appointments* being offered within 10 business days of request. Urgent and non-urgent access to care is monitored via monthly provider telephone polling by the Network team. Access to Treatment data is pulled from ProtoCall, Linx, and an internal Excel tracking spreadsheet. The report captures the data of members receiving behavioral health services, the average time taken to receive authorization for services, and the average time until an appointment with a provider.

### Quarterly Performance Results:

Urgent/Non-Urgent Appointment Wait Time	Performance Goal	Q1 2015	Q2 2015	Q3 2015
Urgent Appointment Wait Time	Within 48 hours from request	11.7 hours	35.5 hours	23.1 hours
Non-Urgent Appointment Wait Time	Within 10 days from request	5.8 days	5.4 days	3.1 days

**Analysis:** The performance goal for Urgent Appointment wait time is 48 hours. During Q3, the Urgent Appointment Wait time decreased from 35.5 hours in Q2 to 23.1 hours during Q3, again meeting the performance goal. The performance goal for non-urgent appointment wait time is an appointment within 10 days. This goal was again met during Q3 at 3.1 days.





**Barriers:** Based on the above analysis, no barriers were identified.

**Opportunities and Interventions:** No opportunities for improvement were identified.

## Member Experience/Member Satisfaction Survey

### Member Satisfaction Survey

**Methodology:** Optum monitors Idaho Medicaid enrollees' satisfaction with behavioral health services using the online and mailed versions of the Optum Idaho Member Satisfaction Survey. The surveys were designed in collaboration with IDHW. The mailed version is fielded quarterly, while the online version is accessible to members 24 hours a day on the Optum Idaho and Optum Idaho Live and Work Well websites.

The member survey is outsourced to the Center for the Study of Services (CSS), which is a NCQA-certified vendor. Mailed surveys are administered quarterly in English with Spanish translation available. The mailed survey is administered via two mailings, with second mailing being sent as a reminder to non-respondents

Members who have received outpatient or medication services within the Optum network in the last 90 days are eligible to participate. As of the survey mail date, members 18 years of age and older and members 15 years of age and younger are eligible to be surveyed (please note that for members 15 years of age and younger, the survey packet is addressed to the parent of the member not to the youth directly, and for members 18 years of age and older the member is addressed directly). Members must be eligible for services at the time of the survey and have granted permission to mail to their address on record. Members who have accessed services in multiple quarters are eligible for the survey only once every 12 months.

A random sample of individuals eligible for the survey is then selected. Only mailed survey responses are used in our annual data analysis due to the limitations in validating the members who respond to our online survey methods. However, all responses submitted from our online portal are reviewed.

The member survey tool includes 26 items. Survey questions represent the following experience domains.

- *Experience with Optum Idaho staff and referral process* (composite score of qsts 2-7)
- *Experience with provider network* (composite score of qsts 10-14)
- *Experience with counseling and treatment* (composite score of qsts 15-23)
- *Overall experience* (qst 25, % respondents selected 'Excellent', 'Very Good', or 'Good')

Quarterly Performance Results:

Member Overall Satisfaction Survey	Performance Goal	Q2 2014	Q3 2014	Q4 2014	Q1 2015*
Experience w/Optum ID Staff and Referral Process	≥85%	86.4%	80.1%	84.7%	85.5%

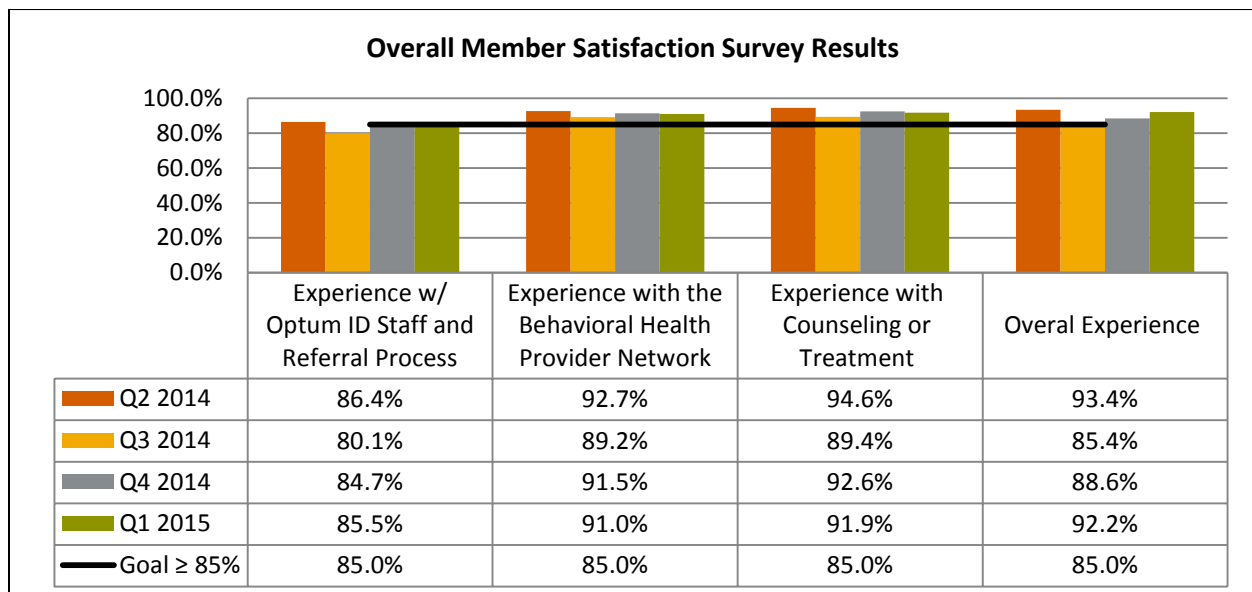
Experience with the Behavioral Health Provider Network	≥85%	92.7%	89.2%	91.5%	91.0%
Experience with Counseling or Treatment	≥85%	94.6%	89.4%	92.6%	91.9%
Overall Experience	≥85%	93.4%	85.4%	88.6%	92.2%

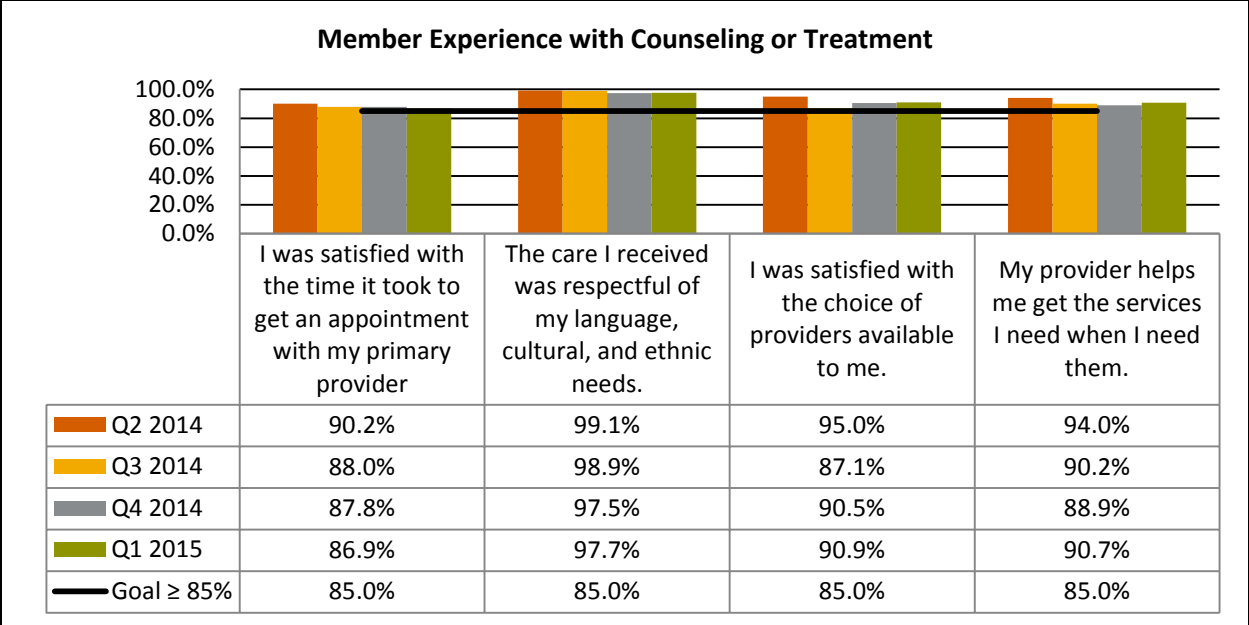
\* Based on the Member Satisfaction Survey sampling methodology, Q1 2015 data is the most recent results available.

**Analysis:** During Q1, the rate of member’s Overall Experience with Behavioral Health services was at 92.2%, an increase from 88.6% during Q4, 2014. Member’s experience with Optum ID Staff and Referral Process increased from 84.7% during Q4 to 85.5% during Q1. While Member’s experience with the Behavioral Health Provider Network decreased slightly from 91.5% during Q4 to 91.0% during Q1 and Member’s overall experience with counseling and treatment decreased slightly from 92.6% during Q4 to 91.9% during Q, both met the performance goal of ≥85%.

Four additional questions, related to the member’s experience with counseling and treatment, were also evaluated. The results include:

- 86.9% (↓from 87.8% during Q4, 2014) of members were satisfied with the time it took to get an appointment with their primary provider.
- 97.7% (↑ from 97.5% during Q4, 2014) of members were satisfied that the care they received was respectful of their language, cultural, and ethnic needs.
- 90.9% (↑ from 90.5% during Q4, 2014) of members were satisfied with the choice of providers available to them.
- 90.7% (↑ from 88.9% during Q4, 2014) of members were satisfied that their provider helps them get the services they need when they need them.





**Barriers:** Based on the above analysis, no barriers were identified.

**Opportunities and Interventions:** No opportunities for improvement were identified.

**Member Protections and Safety**

Optum’s policies, procedures and guidelines, along with our quality monitoring programs, are designed to help ensure the health, safety and appropriate treatment of our members. These guiding documents are informed by national standards such as NCQA (National Committee for Quality Assurance) and URAC (Utilization Review Accreditation Commission).

Case reviews are conducted in response to requests for coverage for treatment services. They may occur prior to a member receiving services (pre-service), or subsequent to a member receiving services (post-service or retrospective). Case reviews are conducted in a focused and time-limited manner to ensure that the immediate treatment needs of members are met, to identify alternative services in the service system to meet those needs; and to ensure the development of a person-centered plan, including advance directives.

As part of our ongoing assessment of our overall network, Optum evaluates, audits, and reviews the performance of existing contracted providers, programs, and facilities.

**Notification of Adverse Benefit Determination**

**Methodology:** Adverse Benefit Determinations (ABD’s) are maintained in the ARTT (Appeals Reporting Tracking Tool) database.

Quarterly Performance Results:

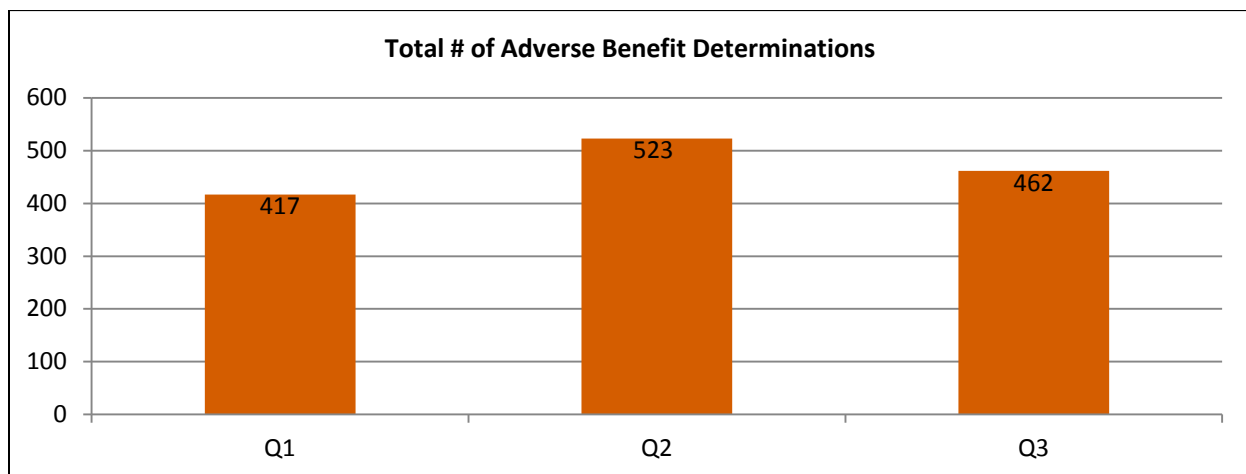
Notification of ABD	Performance Goal	Target	Q1 2015	Q2 2015	Q3 2015
Total # ABD's	NA	NA	417	523	462
Adverse Determination Decision	Decision is made within 14 days from request	100%	99.5%** (415)	100.0%* (523)	99.4% (459)
Initial Verbal Notification to Provider	Verbal notice of decision is provided the same day of determination	100%	100%	100%	100%
Written Notification	Written notice is sent within 1 business day following verbal notification	100%	97.6%* (407)	98.6%* (516)	99.6% (460)

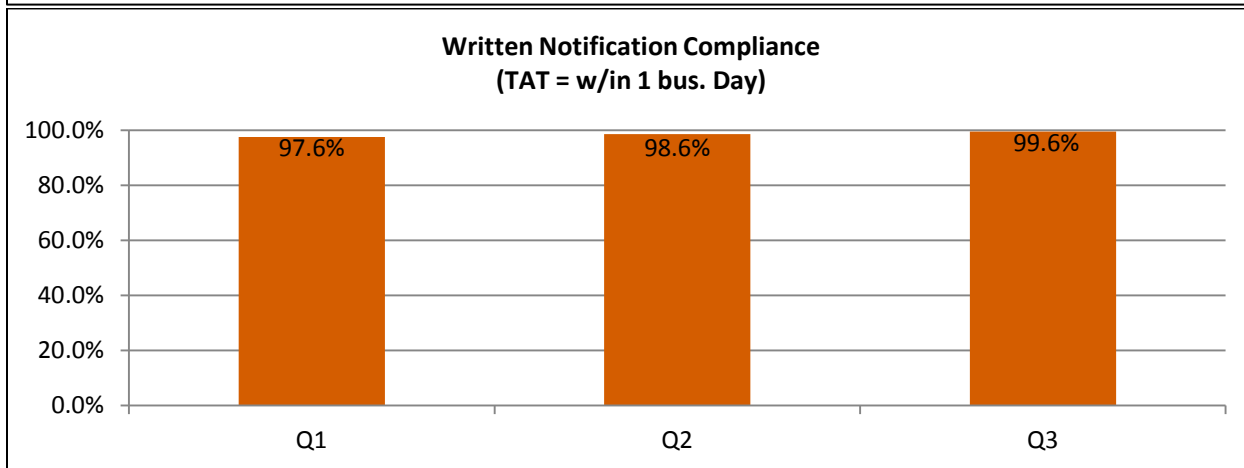
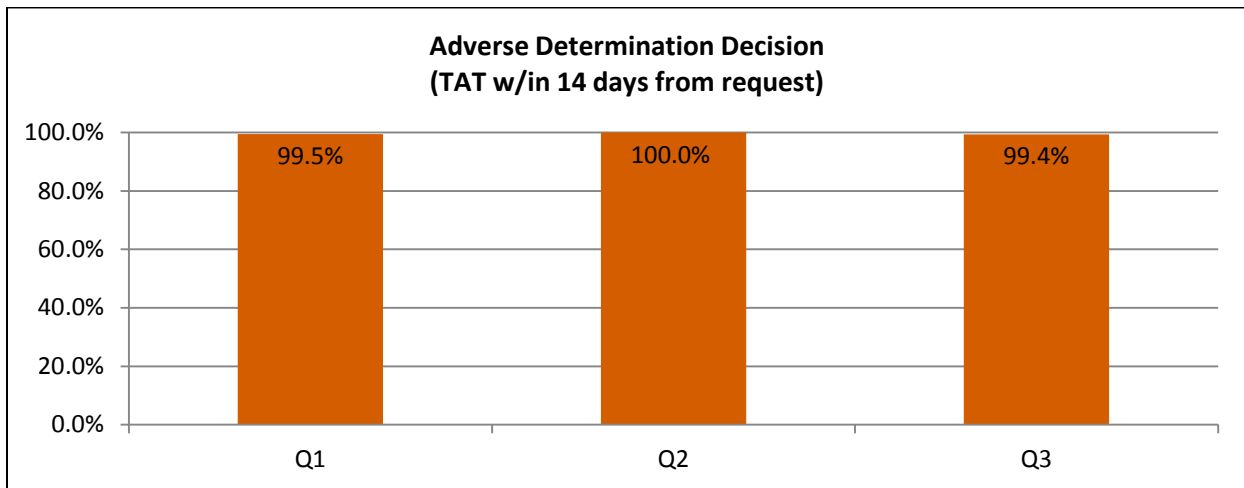
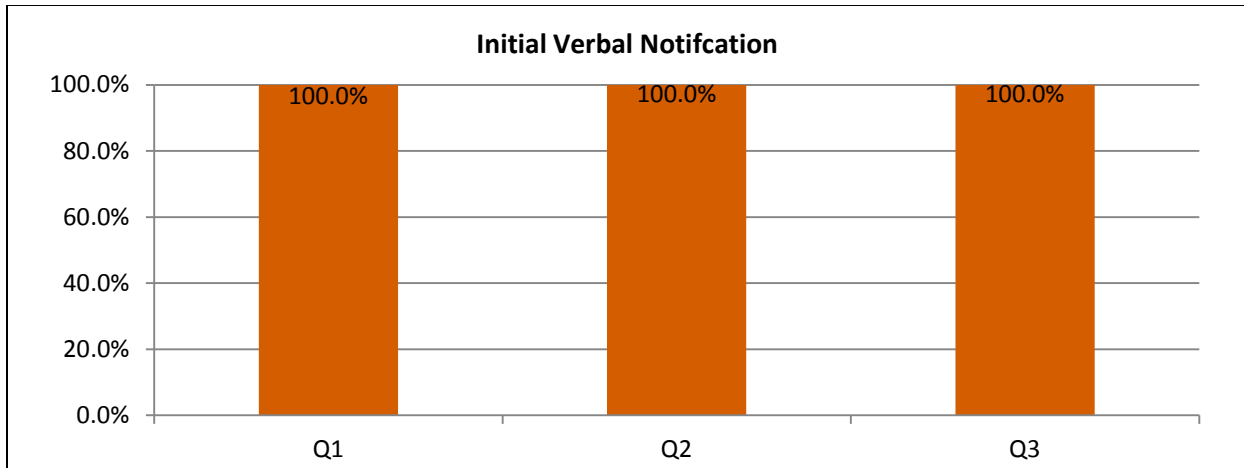
\*Percentages were modified from the original quarterly report (approved by QAPI 08/18/2105) to correct timeframes not met due to "holidays", in which the Optum offices were closed.

\*\*Percentage reflects the correct numerator.

**Analysis:** During Q3, there were 462 ABD's. This is a decrease from 523 during Q2. When a request for services is received, Optum has 14 days to review the case and make a determination to authorize services or deny services in total or in part. Our internal turnaround time of 100% fell slightly below in Q3 at 99.4% with 3 requests not meeting the 14 day timeframe. All 3 were out of compliance due to Peer Reviewer determination being made one day outside of the 14 day performance goal. Initial Verbal Notification performance (verbal notice of decision being provided on the same day of determination) was met at 100%

Once a determination is made to deny or reduce services, Optum has 1 business day following the verbal notification to mail a notice of action to member and provider. During Q3, our performance is viewed as meeting the goal due to established rounding methodology (rounding to the nearest whole number).





**Barriers:** The 3 late cases were due to a transition of new Peer Reviewer staff completing direct Peer Reviews with providers and learning new documentation requirements.

**Opportunities and Interventions:** Continue to monitor for Peer Reviewer training needs.

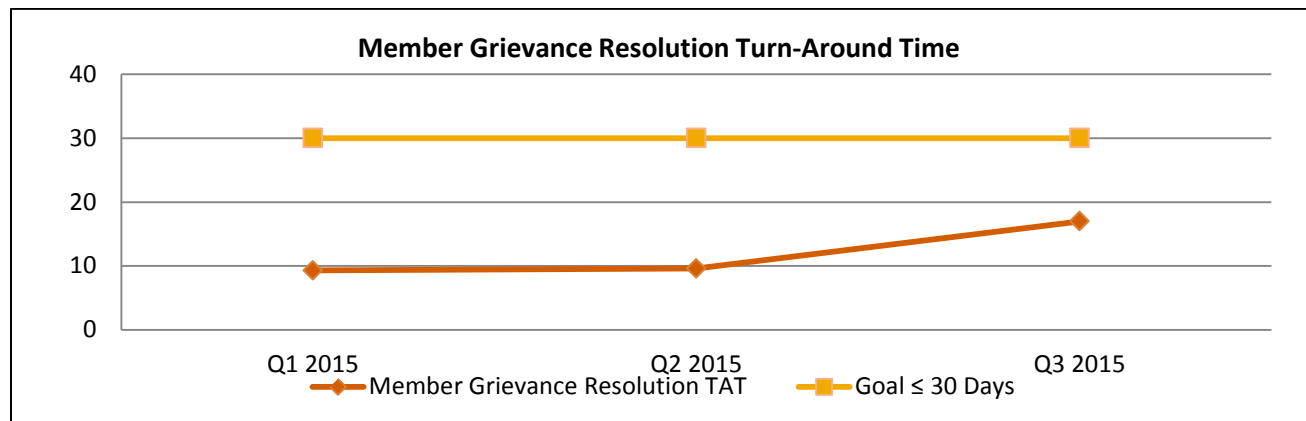
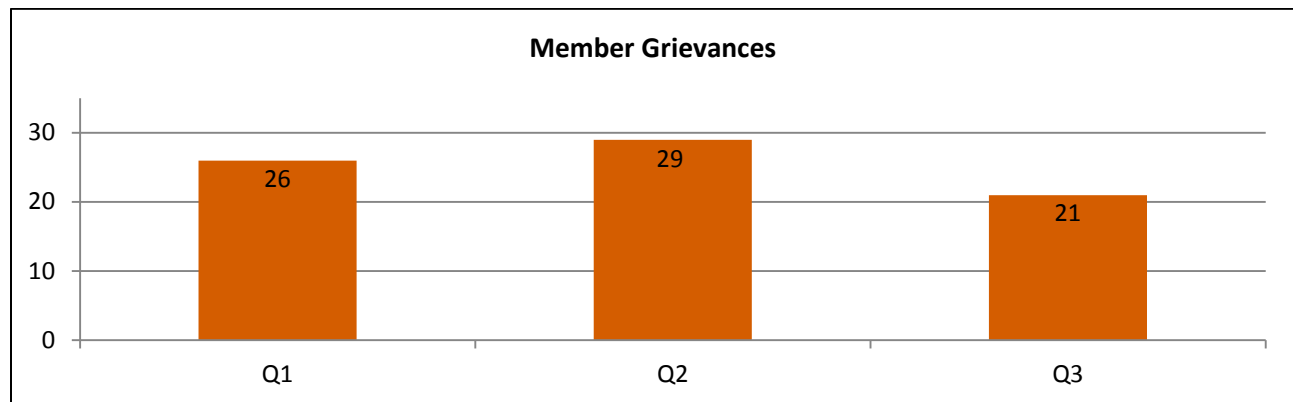
## Grievances

**Methodology:** Optum Idaho recognizes the right of a member, authorized representative or provider or agency, acting on behalf of a member, to request that Optum Idaho conduct a review of an adverse action that resulted in member financial liability or denied service, which is called a grievance. Optum Idaho makes a decision and provides notice of resolution within 30 calendar days from receipt.

Quarterly Performance Results:

Grievances	Performance Goal	Q1 2015	Q2 2015	Q3 2015
# of Member Grievances	NA	26	29	21
Average # of Days to Resolution	30 Days	9	10	17

**Analysis:** During Q3, 2015, there were a total of 21 member grievances. We have consistently met the 30 day turnaround time for this measure.



**Barriers:** Based on the above analysis, no barriers were identified.

**Opportunities and Interventions:** No opportunities for improvement were identified.

## Complaint Resolution and Tracking

**Methodology:** A complaint is an expression of dissatisfaction logged by a member, a member's authorized representative or a provider concerning the administration of the plan and services received. This is also known as a Quality of Service (QOS) complaint. A concern that relates to the quality of clinical treatment services provided by an individual provider or agency in the Optum Idaho network is a Quality of Care (QOC) concern.

Complaints are collected and grouped into the following six (6) broad categories: Benefit, Service (and Attitude), Access (and Availability), Billing & Financial, Quality of Care, and Privacy Incident.

Optum Idaho maintains a process for recording and triaging Quality of Care (QOC) Concerns and Quality of Service (QOS) complaints, to ensure timely response and resolution in a manner that is consistent with contractual and operational standards. The timeframes for acknowledgement and resolution for complaints are as follows:

Complaint Resolution and Tracking Timeframes	Acknowledged	Resolved
Quality of Service (QOS) Complaints	5 Business Days	10 Business Days
Quality of Care (QOC) Concerns	5 Business Days	30 Days

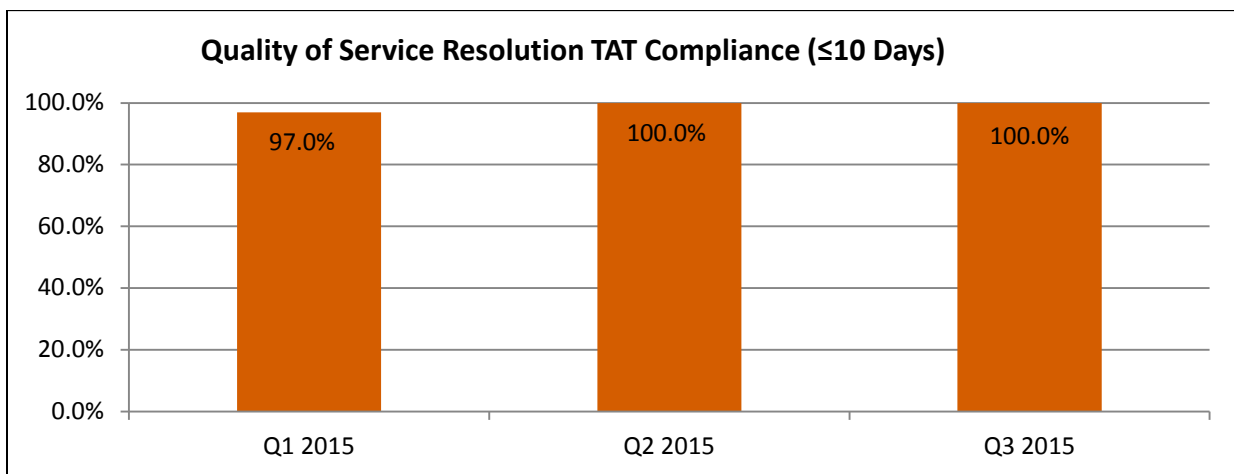
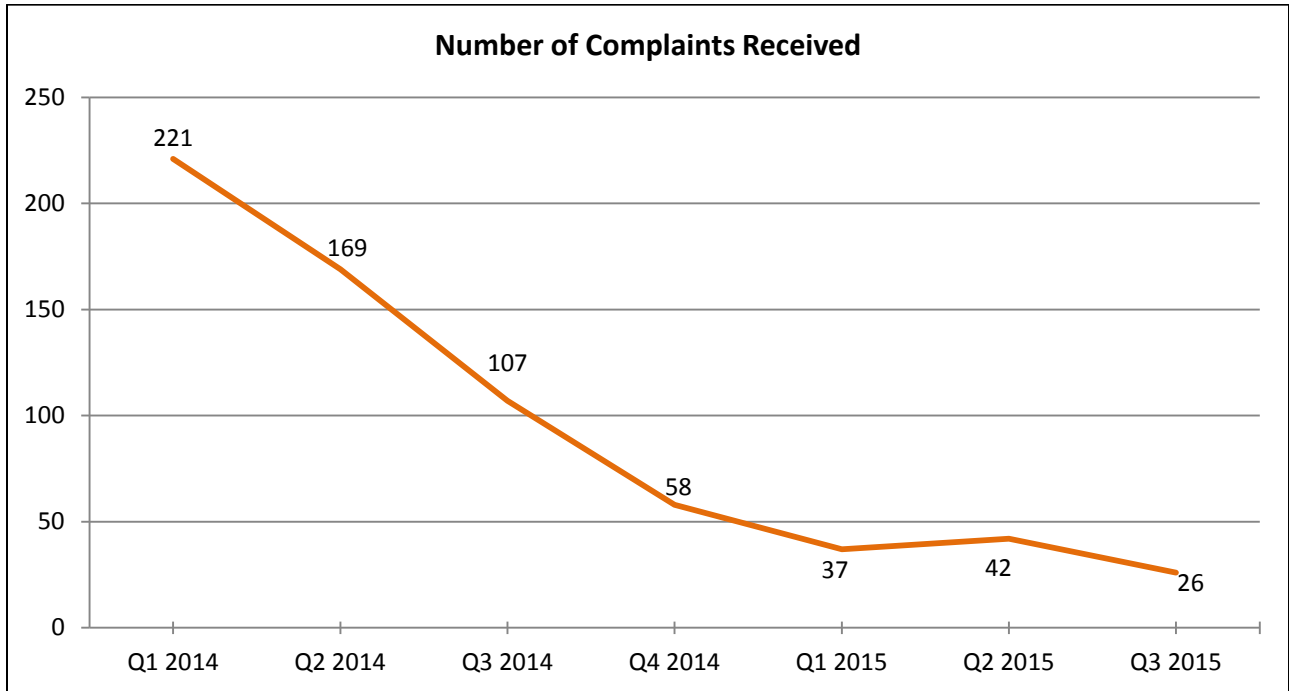
### Quarterly Performance Results:

Complaints – Quality of Service and Quality of Care	Performance Goal	Q1 2015	Q2 2015	Q3 2015
Number of Complaints Received	NA	37	42	26
% Complaints Acknowledged w/in TAT	5 Days	100%	100%	100%

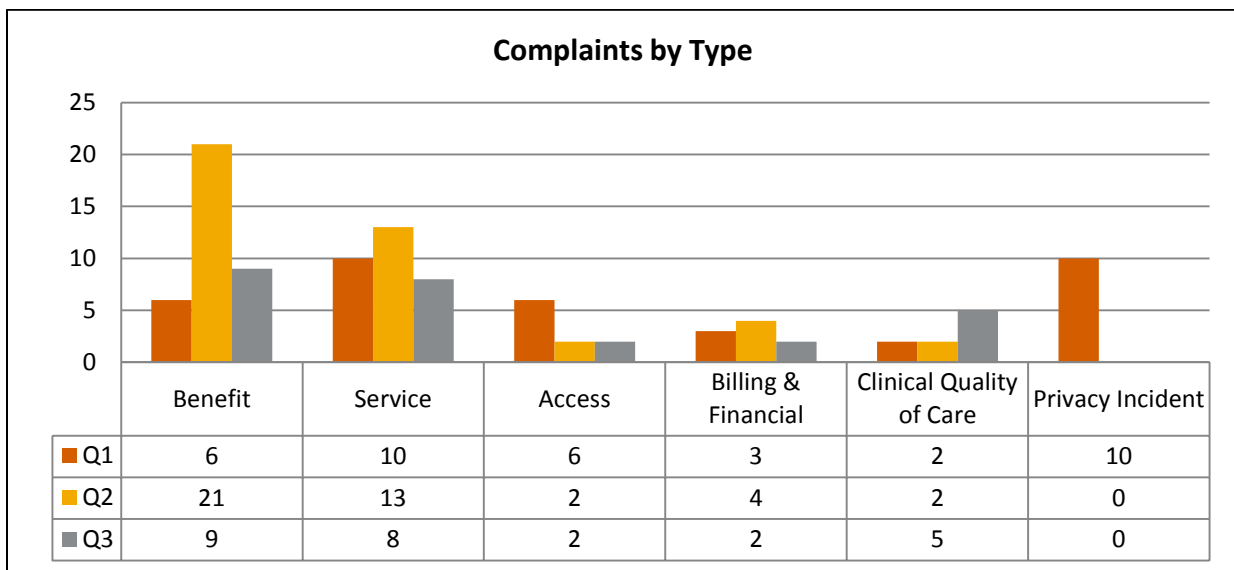
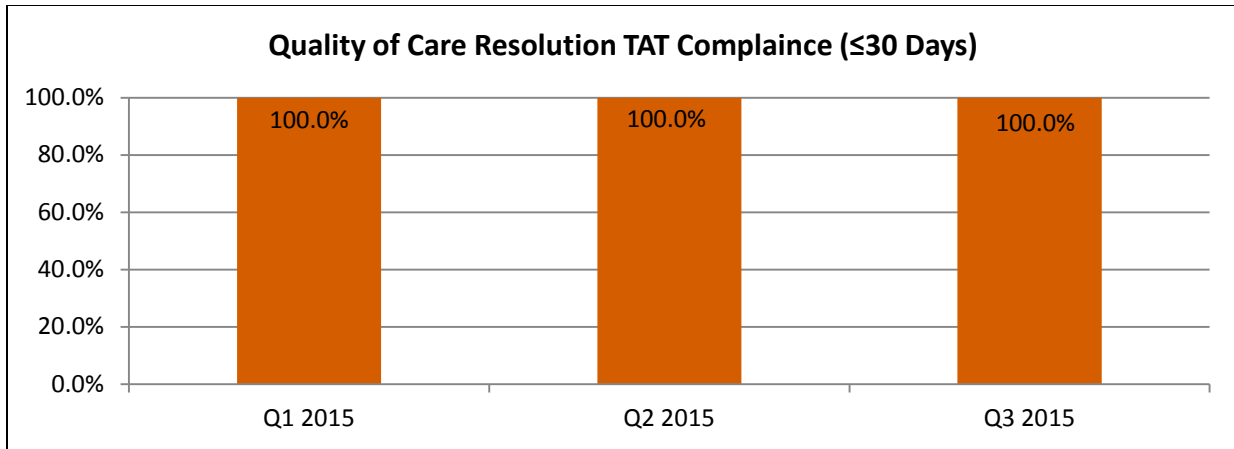
**Analysis:** In Q3, Optum logged a total of 26 complaints, which is a decrease from Q2 (42) totals. Of the total complaints logged in Q3, twenty-one (21) were identified as Quality of Service and 5 were Quality of Care. In Q3, Optum met the goal of 100% for resolution timeframes for both QOS complaints (10 business days) and QOC concerns (30 days).

Overall the volume of complaints has been on the decline since Q3, 2014 (107), however we have noted increases which resulted from system changes, For example in Q2 complaints

related to “benefit” increased to 21 from 6 in Q1. The increase in Q2 was related to complaints about revisions made to Optum Idaho’s case management Level of Care Guidelines. In Q3, benefit complaints dropped back to single digits with 9 complaints logged.







**Barriers:** Based on the above analysis, no barriers were identified.

**Opportunities and Interventions:** No opportunities for improvement were identified.

### Critical Incidents

**Methodology:** To improve the overall quality of care provided to our members, Optum Idaho employs peer reviews for occurrences related to members that have been identified as potential Critical Incidents (CI). Providers are required to report potential Critical Incidents to Optum Idaho within 24 hours of being made aware of the occurrence. A Critical Incident is a serious, unexpected occurrence involving a member that is believed to represent a possible Quality of Care Concern on the part of the provider or agency providing services, which has, or may have, detrimental effects on the member, including death or serious disability, that occurs during the course of a member receiving behavioral health treatment. Optum Idaho classifies a Critical Incident as being any of the following events:

- A completed suicide by a member who was engaged in treatment at any level of care at the time of the death, or within the previous 60 calendar days.

- A serious suicide attempt by a member, requiring an overnight admission to a hospital medical unit that occurred while the member was receiving treatment services.
- An unexpected death of a member that occurred while the member was receiving agency based treatment or within 12 months of a member having received MH/SA treatment.
- A serious injury requiring an overnight admission to a hospital medical unit of a member occurring on an agency's premises while the member was receiving agency-based treatment.
- A report of a serious physical assault **of a member** occurring on an agency's premises while in agency-based treatment.
- A report of a sexual assault **of a member** occurring on an agency's premises while in agency-based treatment.
- A report of a serious physical assault **by a member** occurring on an agency's premises while the member was receiving agency-based treatment.
- A report of sexual assault **by a member** occurring on an agency's premises while the member was receiving agency-based treatment.
- A homicide that is attributed to a member who was engaged in treatment at any level of care at the time of the homicide, or within the previous 60 calendar days.
- A report of an abduction of a member occurring on an agency's premises while the member was receiving agency-based treatment.
- An instance of care ordered or provided for a member by someone impersonating a physician, nurse or other health care professional.
- High profile incidents identified by the IDHW as warranting investigation.

Optum has a Sentinel Events Committee (SEC) to review Critical Incidents that meet Optum's definition of sentinel events. Optum Idaho has a Peer Review Committee (PRC) to review Critical Incidents that do not meet Optum's definition of sentinel event. The SEC and PRC make recommendations for improving patient care and safety, including recommendations that the Provider Quality Specialists conduct site audits and/or record reviews of providers in the Optum network as well as providers working under an accommodation agreement with Optum to provide services to members. The SEC and PRC may provide providers with written feedback related to observations made as a result of the review of the Critical Incident. Critical Incident Ad-hoc review is completed within 5 days from notification of incident.

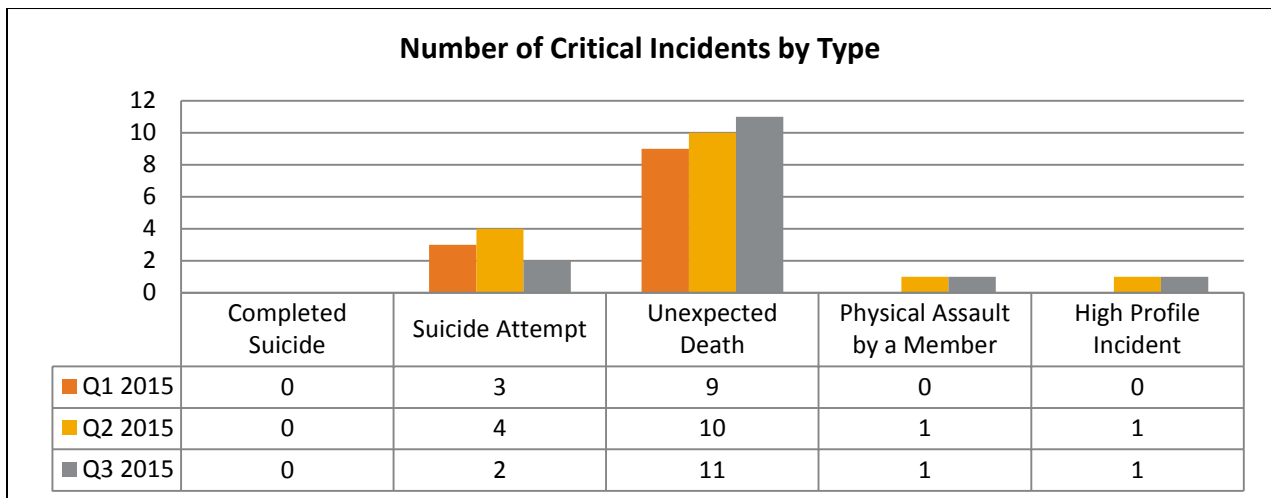
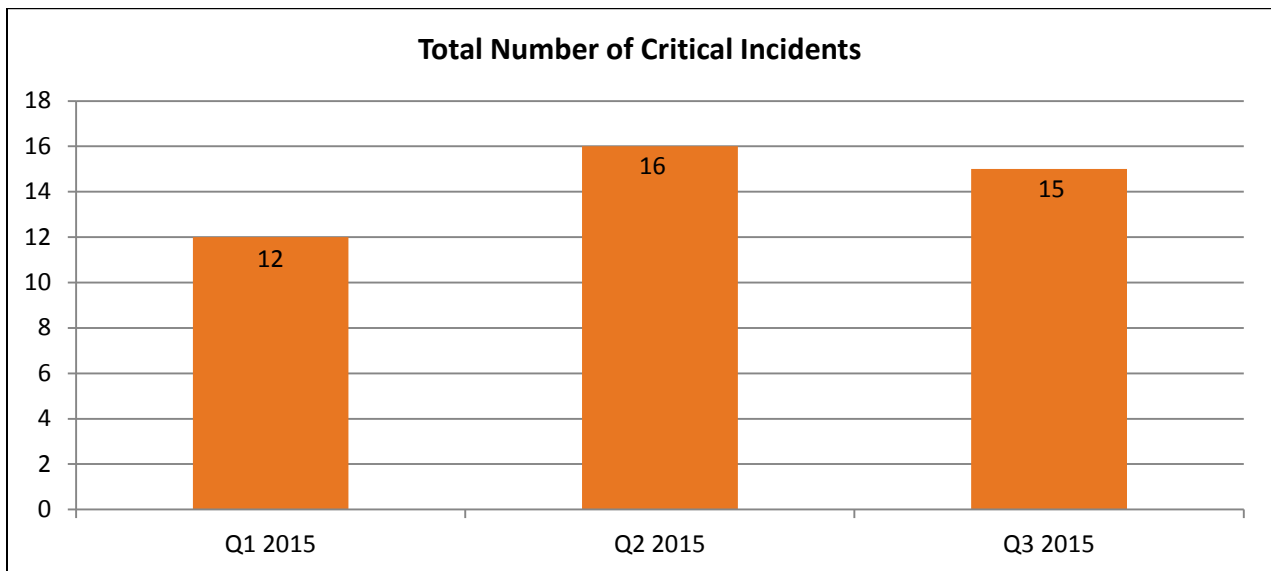
Quarterly Performance Results:

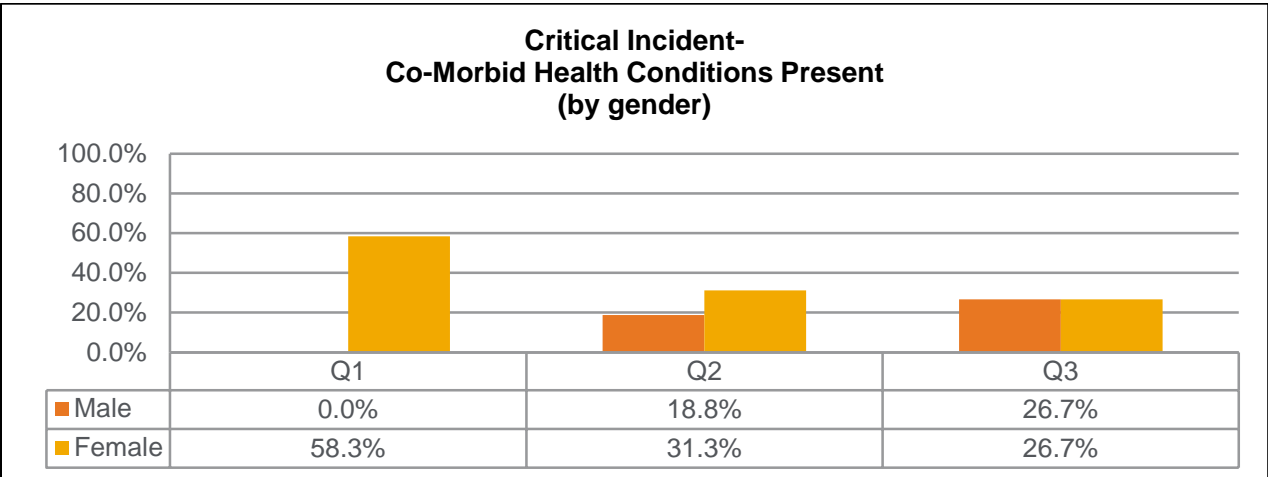
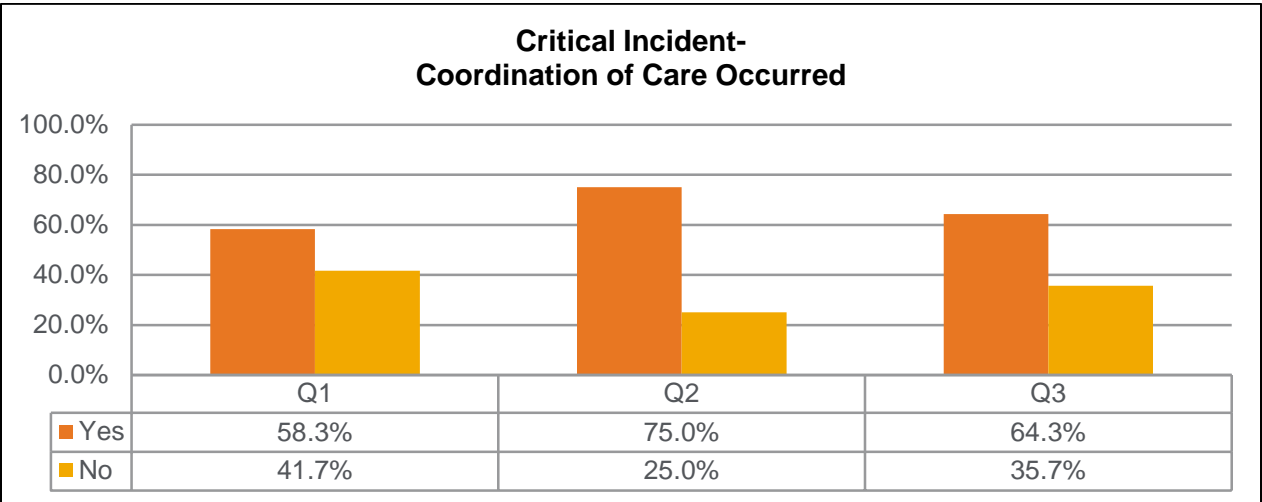
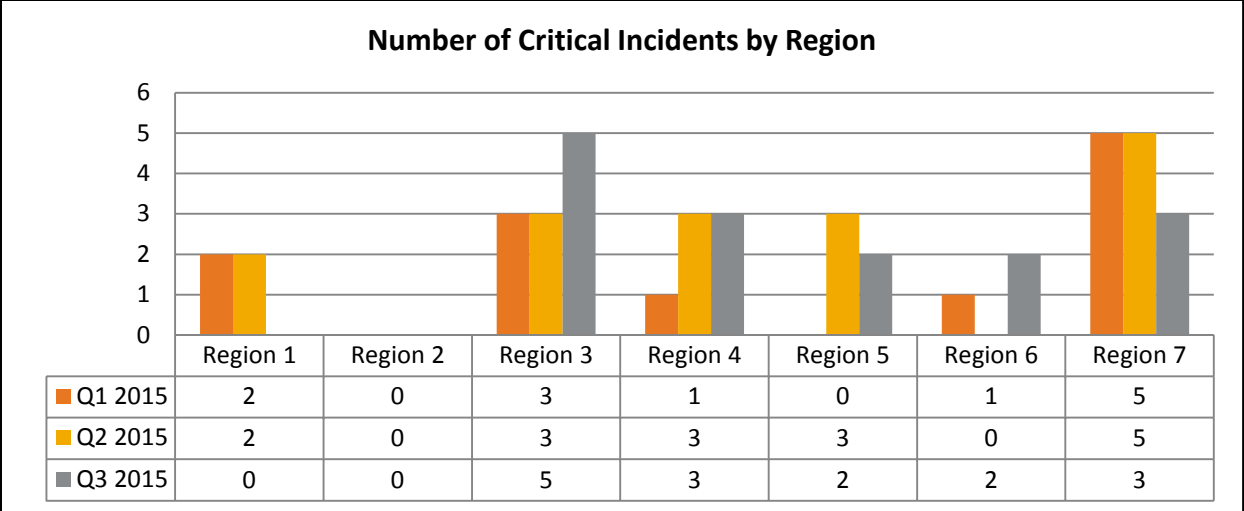
Critical Incidents	Performance Goal	Q1 2015	Q2 2015	Q3 2015
# of CI's Received	NA	12	16	15
CI Ad-hoc Review: % completed within 5 business days from notification of incident	100%	100%	100%	100%

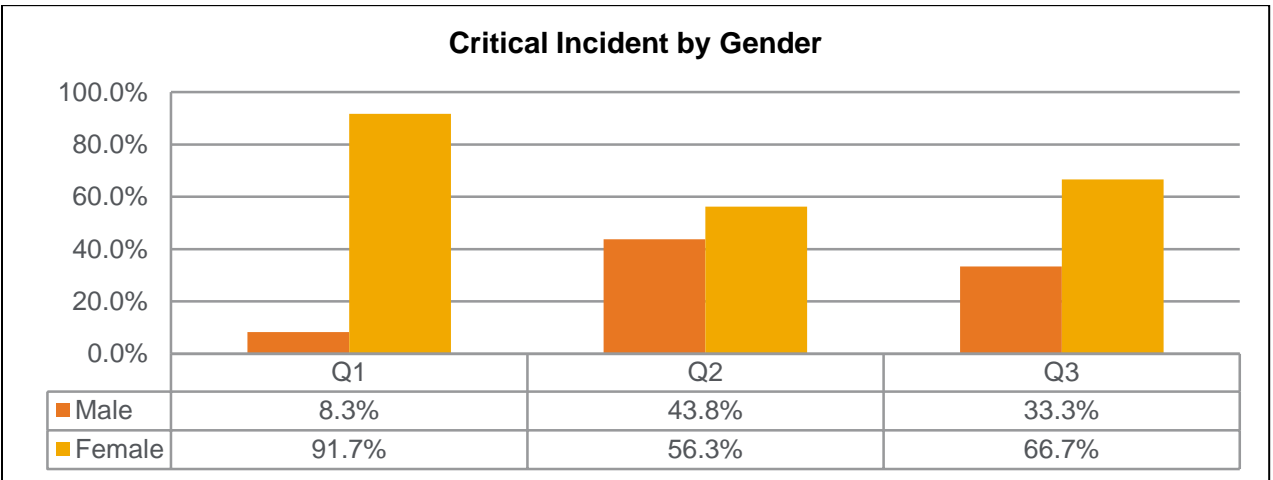
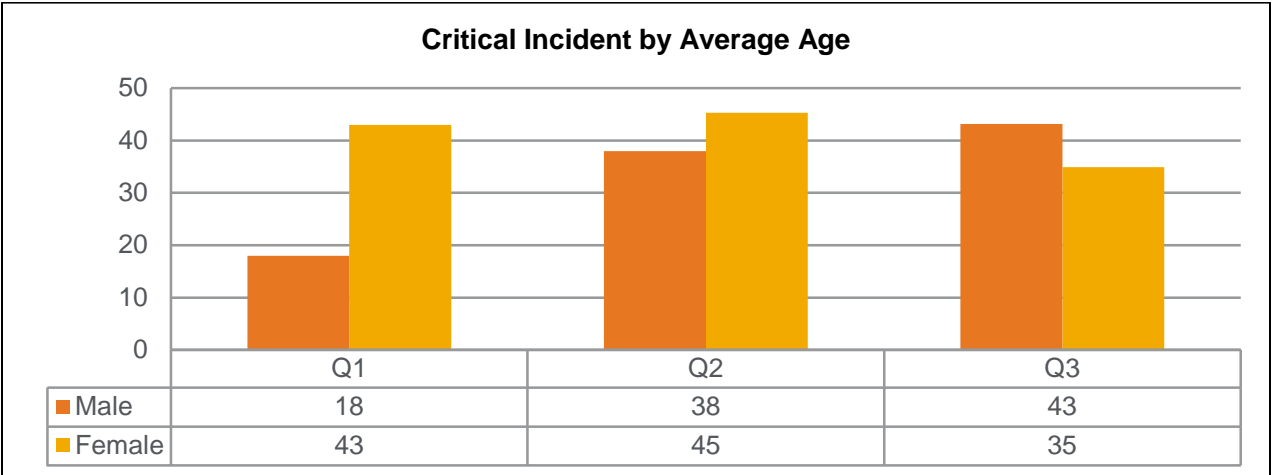
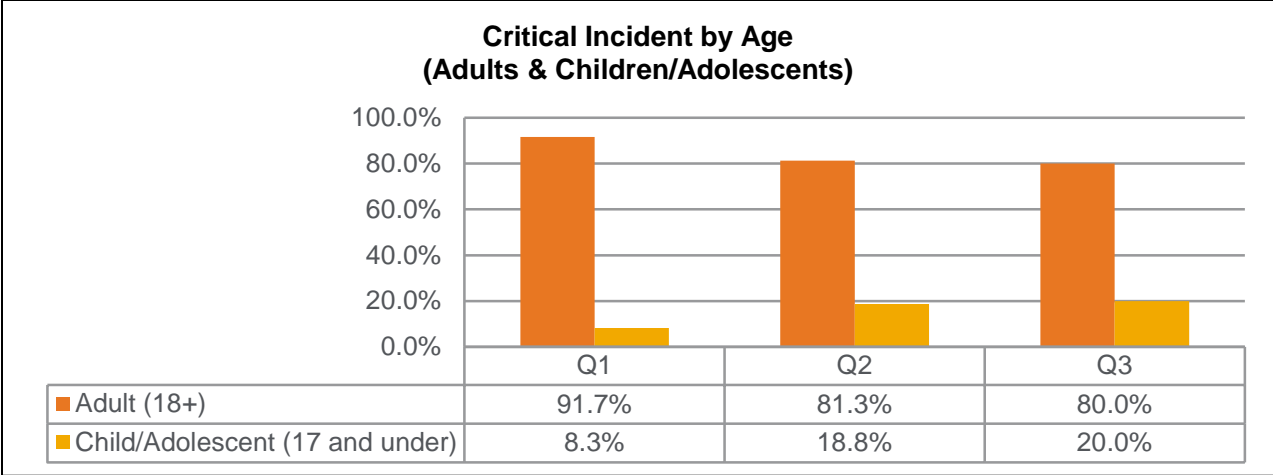
**Analysis:** There were 15 Critical Incidents reported during Q3. The turnaround time for Ad-Hoc Committee review within 5 business days from notification of incident was met. Of the 15 Critical Incidents reported, 11 were from Unexpected Deaths, 2 were from Suicide Attempts, 1 from Physical Assault by a member and 1 from a High Profile Incident. There have not been

any reports of completed suicides to date for 2015. Regionally, 5 of the 15 Critical Incidents occurred in Region 3, three (3) in Region 4, two (2) in both Regions 5 and 6 and 3 in Region 7.

Medical records related to the member involved in the Critical Incident, were reviewed and it was noted that 64.3% of cases reported during Q3 indicated there was coordination of care between the behavioral health provider and the Primary Care Provider (PCP). Co-morbid health conditions were noted in 26.7% of male members with a Critical Incident and 26.7% of female members. Eighty percent (80%) of the cases reported in Q3 were adults (18+) and 20% were children/adolescents (17 and below). Further analysis shows that the average age for males was 43 and females 35. Of Critical Incidents reported during Q3, 33.7% were males and 66.7% were females. No providers were put on unavailable status due to a Critical Incident.







**Barriers:** Based on the above analysis, no barriers were identified.

**Opportunities and Interventions:** No opportunities for improvement were identified.

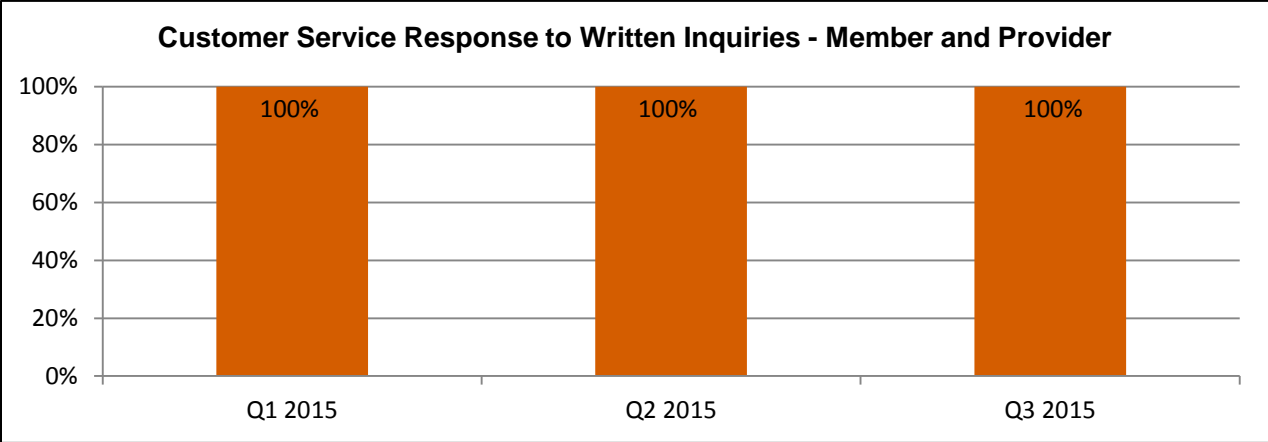
**Response to Written Inquiries**

**Methodology:** Our Optum Idaho contract outlines our need to respond to all phone calls, voice mail and email/written inquiries on the same or within two (2) business days. This data is maintained and tracked in an internal database by Customer Service.

Quarterly Performance Results:

Customer Service Response to Written Inquiries	Performance Goal	Q1 2015	Q2 2015	Q3 2015
Percentage Acknowledged ≤ 2 business days	100%	100%	100%	100%

**Analysis:** The data summarizes Optum Idaho Customer Service responsiveness to written inquiries to both members and providers. The data indicates that the standard of 100% acknowledged within 2 business days was met during Q3.



**Barriers:** Based on the above analysis, no barriers were identified.

**Opportunities and Interventions:** No opportunities for improvement were identified.

**Provider Monitoring and Relations**

Optum Idaho monitors provider adherence to quality standards via site visits and ongoing review of quality of care concerns, complaints/grievances, significant events and sanctions/limitations on licensure. In coordination with the Optum Idaho QI Department, Optum Idaho staff conducts site visits for:

- Facilities not accredited by an acceptable accrediting agency
- All providers are subject to network monitoring site visits
- Quality of Care (QOC) concerns and significant events, as needed

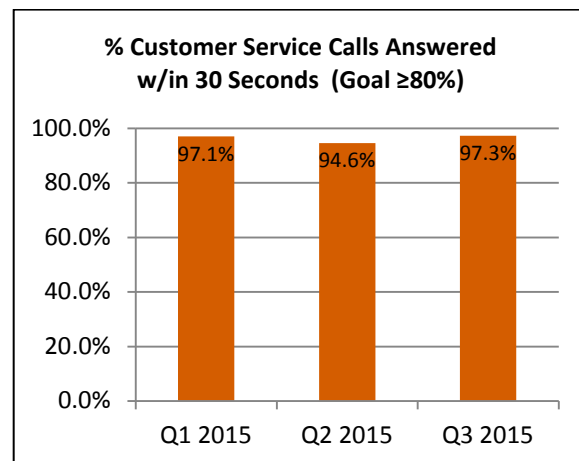
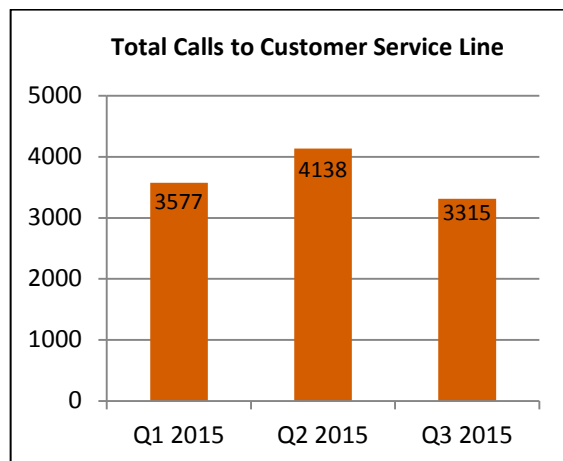
## Customer Service Line

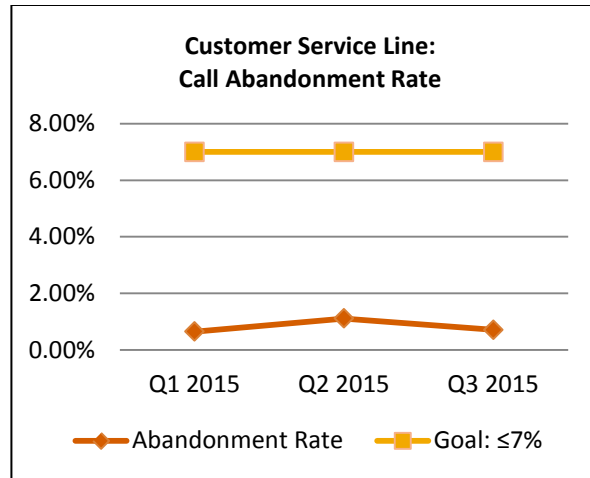
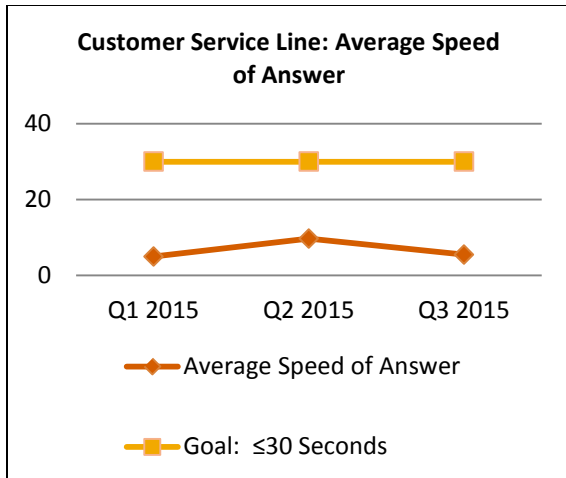
**Methodology:** The Customer Service Line is primarily to serve providers, IDHW personnel and any other stakeholders to contact Optum Idaho. To ensure the needs of our providers and stakeholders are met in a timely and efficient manner, Optum established performance targets that exceeded IBHP contractual targets for average speed to answer (120 seconds) and call abandoned rate ( $\leq 7\%$ ) as shown in the grid below.

Quarterly Performance Results:

Customer Service Line	Optum Idaho Standards	IBHP Contract Standards	Q1 2015	Q2 2015	Q3 2015
Total Number of Calls	NA	NA	3577	4138	3315
Percent of Calls Answered Within 30 Sec	$\geq 80\%$	None	97.1%	94.6%	97.3%
Average Speed of Answer	$\leq 30$ Seconds	120 seconds (2 minutes)	5 sec	10 sec	5.5 sec
Abandonment Rate	$\leq 3.5\%$	$\leq 7\%$	0.65%	1.11%	0.71%

**Analysis:** The total number of provider calls during Q3 was 3315. This was a decrease from 4138 calls during Q2. The percent of calls answered within 30 seconds was at 97.3% an increase from Q2 (94.6%) remaining above our goal of  $\geq 80\%$ . The average speed of answer was at 5.5 seconds during Q3, again meeting our goal of  $\leq 30$  seconds. The call abandonment rate during Q3 was 0.71% continuing to meet both the Optum Idaho internal goal of  $\leq 3.5\%$  and the IBHP Contract Standard of  $\leq 7\%$ .





**Barriers:** Based on the above analysis, no barriers were identified.

**Opportunities and Interventions:** No opportunities for improvement were identified.

### Network Treatment Record Reviews

**Methodology:** The Optum Provider Quality Specialists completes treatment record reviews and site audits to facilitate communication, coordination and continuity of care and to promote efficient, confidential and effective treatment, and to provide a standardized review of practitioners and facilities on access, clinical record keeping, quality, and administrative efficiency in their delivery of behavioral health services.

Monitoring audits occur through site visits and treatment record reviews. The main objectives are: determine the clinical proficiency of the Optum Idaho network by conducting site audits and implementing performance measurement; provide quality oversight of the Optum Idaho network; and educate providers on the clinical “best practice” and effective treatment planning.

The provider will receive verbal feedback at the conclusion of the site visit and written feedback within 30 days of the site visit. Scores above 85% are considered passing. A score between 80-84% requires submission of a corrective action plan. A score of 79% or below requires submission of a corrective action plan and participation in a re-audit within 4 – 6 months. Audit types and scores are tracked in an internal Excel tracking spreadsheet.

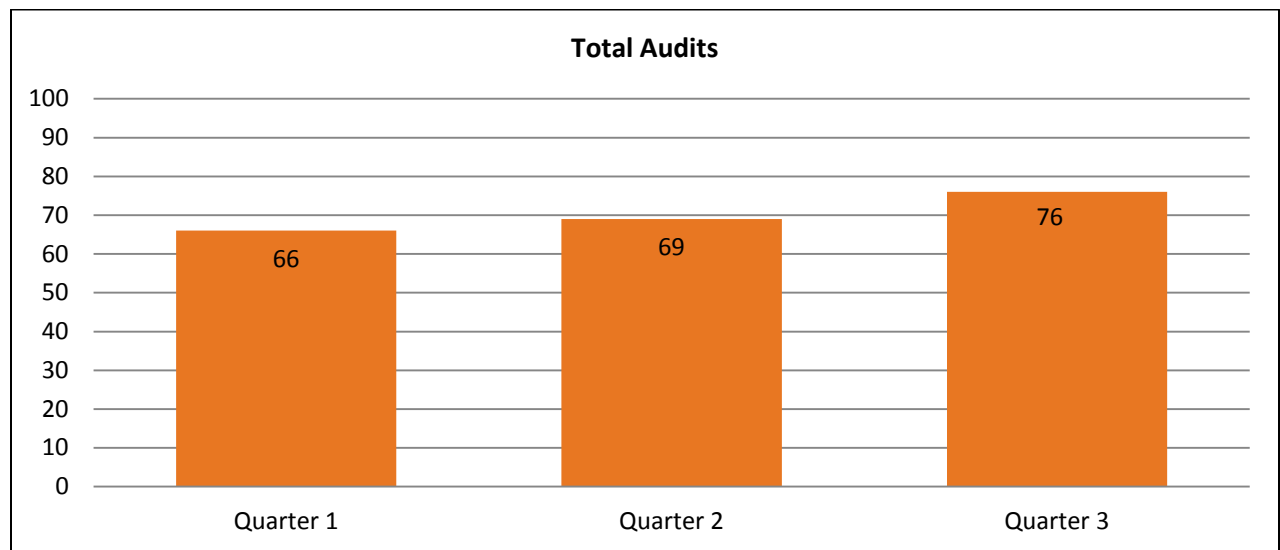
Quarterly Performance Results:

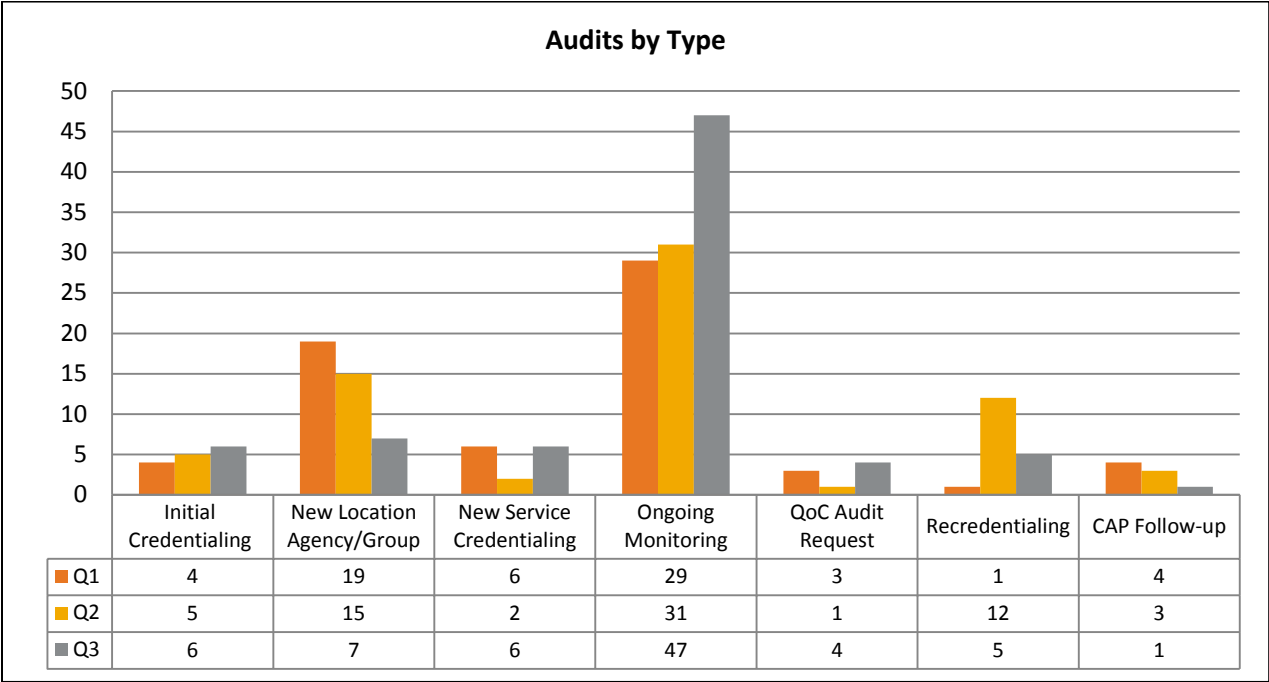
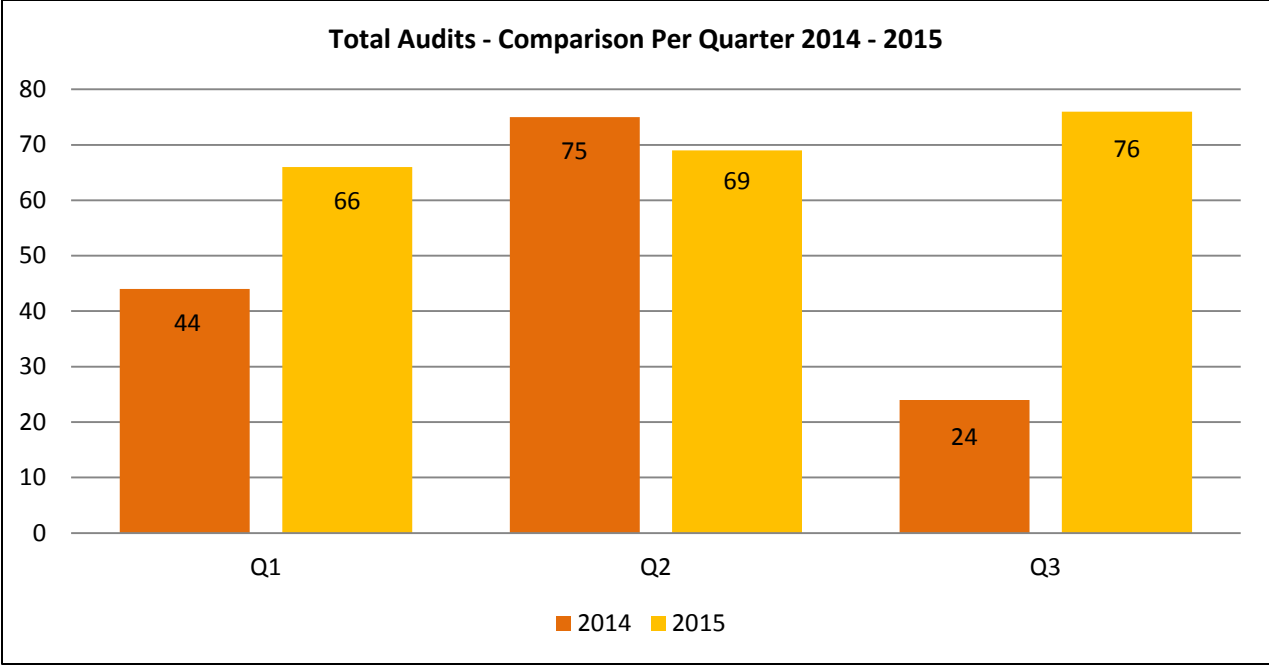
Treatment Record Audit	Performance Goal	Q1 2015	Q2 2015	Q3 2015
# of Audits Conducted	NA	66	69	76
Credentialing Audit (% overall score)	85%	97.0%	97.3%	97.0%
Recredentialing Audit (% overall score)	85%	97.0%	95.3%	95.2%
Ongoing Monitoring (% overall score)	85%	91.0%	89.9%	91.0%

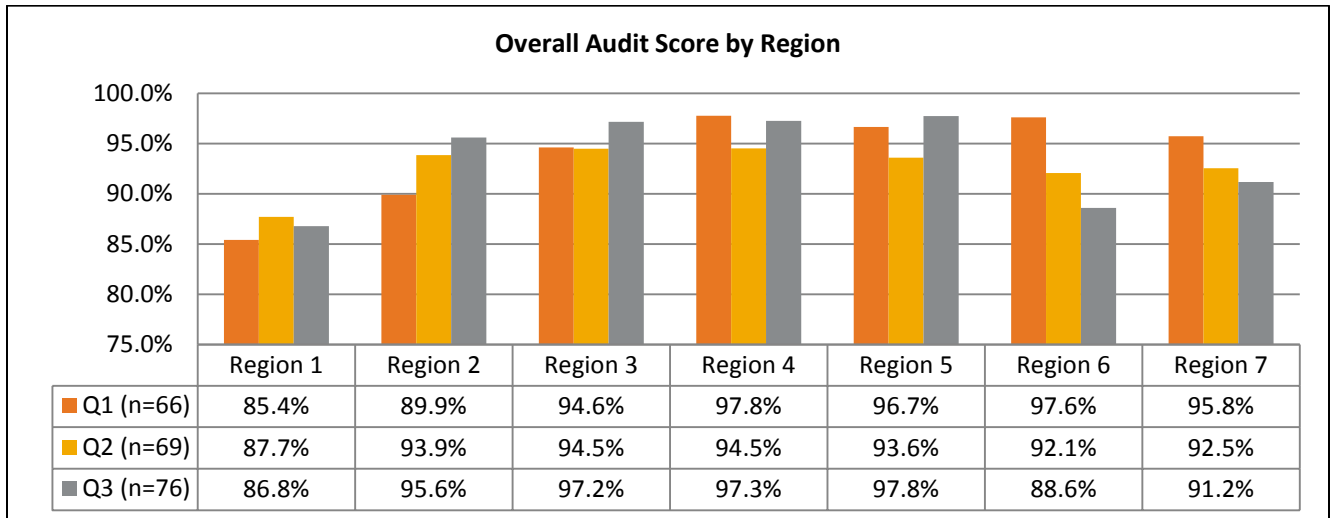
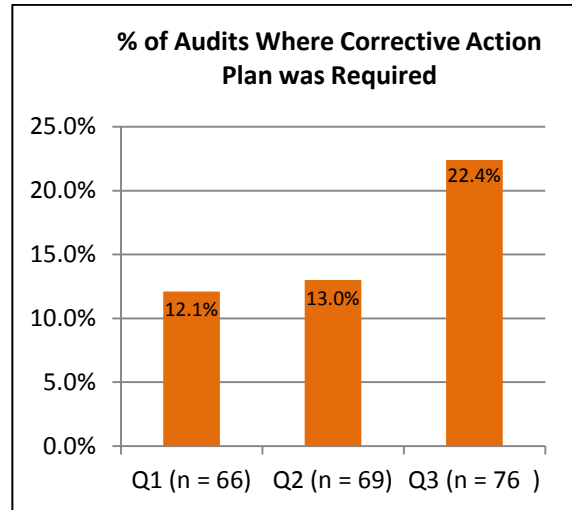
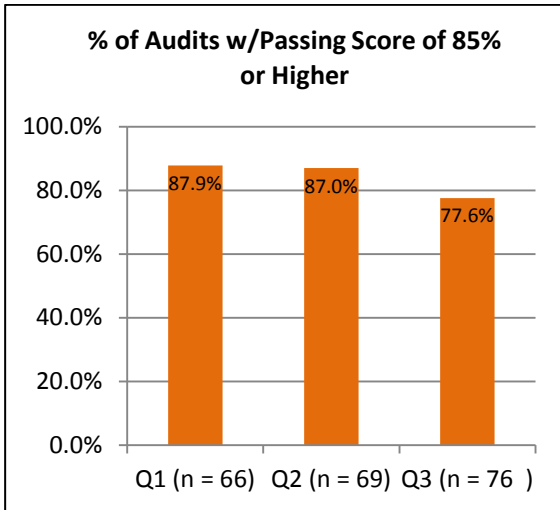


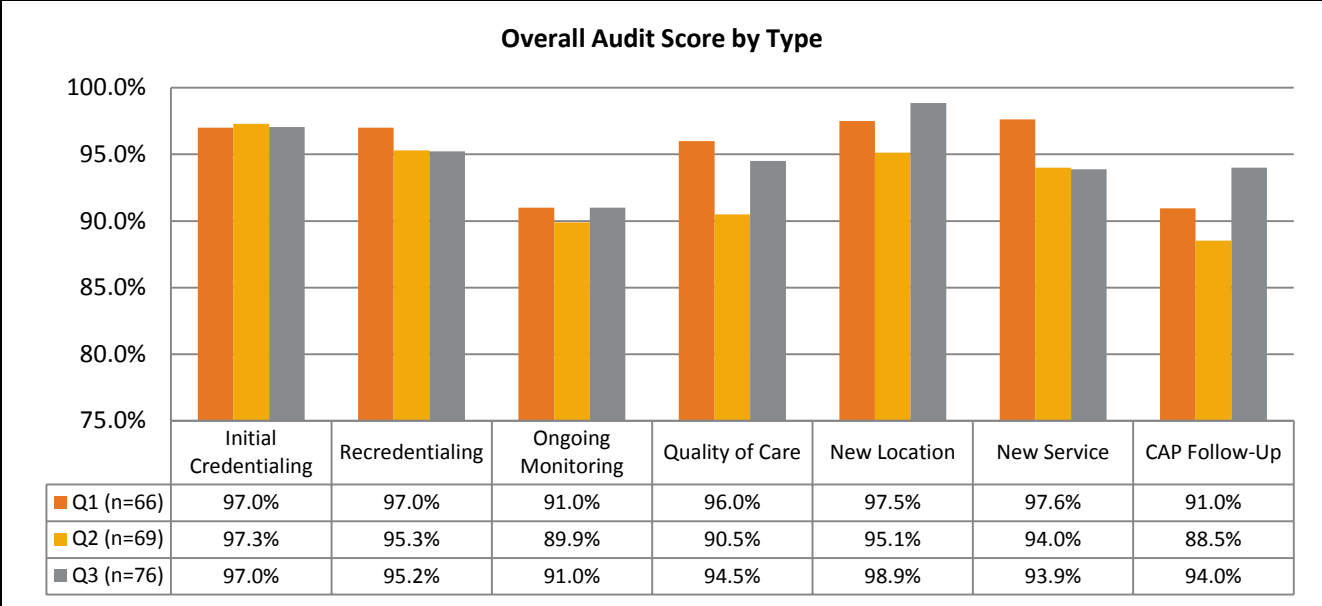
Quality of Care (% overall score)	85%	96.0%	90.5%	94.5%
% of Audits Requiring a Corrective Action Plan	NA	12.1%	13.0%	22.4%

**Analysis:** During Q3, 76 audits were completed. This is an increase from 69 audits completed during Q2. A total of 211 audits have been completed during the first three quarters of 2015, which is an increase from 154 audits completed during the first three quarters of 2014. During Q3, 77.6% of audits received a passing score. Corrective action plans were implemented for 22.4% of the audits that were completed during Q3. Overall audit scores per region and per audit type are reflected in graphs below.

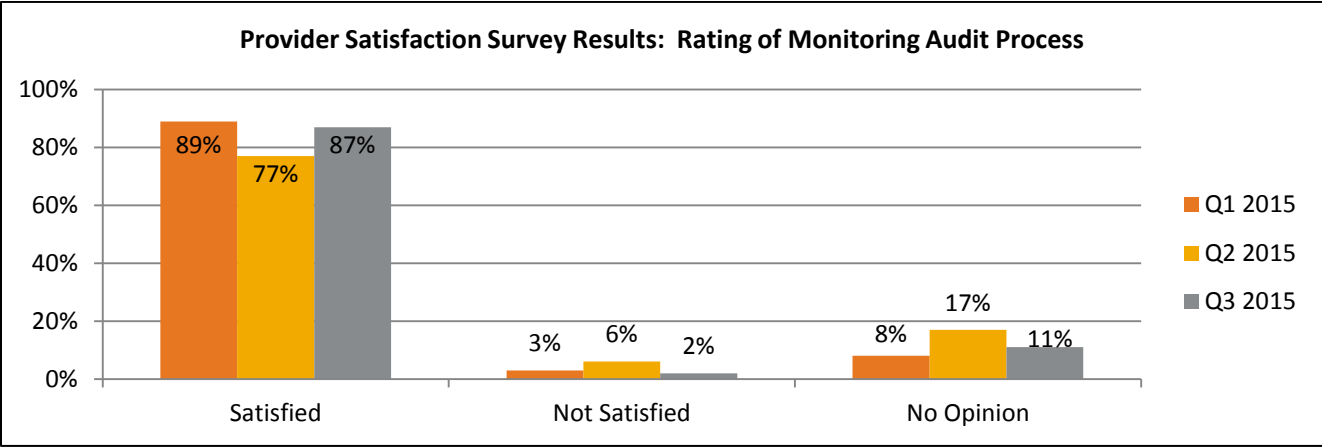


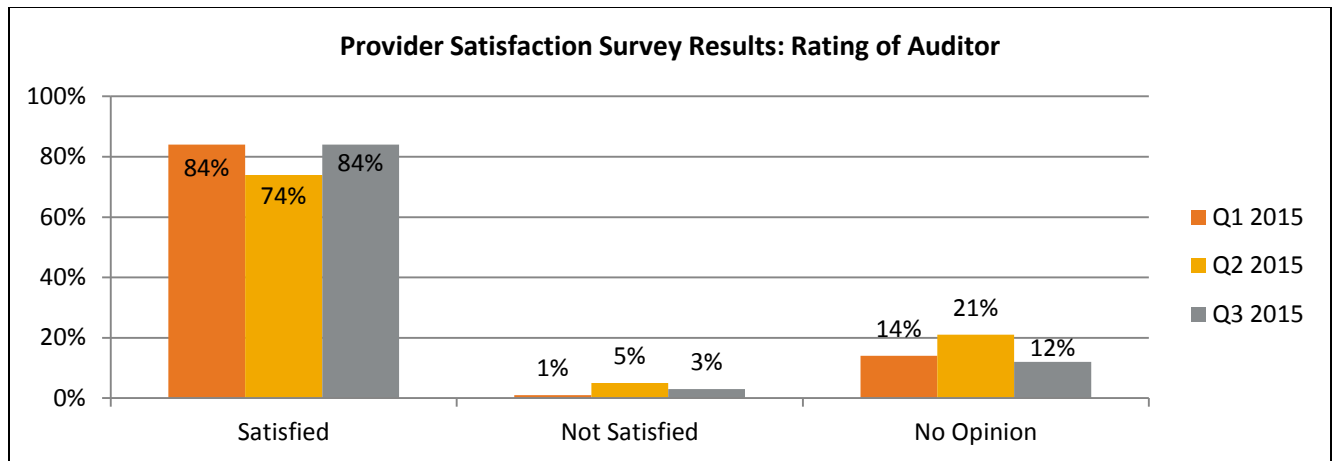






Also, network providers are given the opportunity to rate the Provider Quality Monitoring Audits in the Provider Satisfaction Survey. Included in this report are the results from the Provider Satisfaction survey for Q1, Q2, and Q3, 2015, in the areas of Provider Satisfaction with Quality Monitoring Audit Process and Satisfaction with Auditors. During all three quarters, Providers have stated that they have been satisfied with the audit process and with the auditors. Data related to this is shown in the graphs below.





**Barriers:** Based on the above analysis, no barriers were identified.

**Opportunities and Interventions:** No opportunities for improvement were identified.

### Coordination of Care

**Methodology:** To coordinate and manage care between behavioral health and medical professionals, Optum requires providers to obtain the member’s consent to exchange appropriate treatment information with medical care professionals (e.g. primary care physicians, medical specialists). Optum requires that coordination and communication take place at: the time of intake, during treatment, the time of discharge or termination of care, between levels of care and at any other point in treatment that may be appropriate. Coordination of services improves the quality of care to members in several ways:

- It allows behavioral health and medical providers to create a comprehensive care plan
- It allows a primary care physician to know that his or her patient followed through on a behavioral health referral
- It minimizes potential adverse medication interactions for members who are being treated with psychotropic and non-psychotropic medication
- It allows for better management of treatment and follow-up for members with coexisting behavioral and medical disorders
- It promotes a safe and effective transition from one level of care to another
- It can reduce the risk of relapse

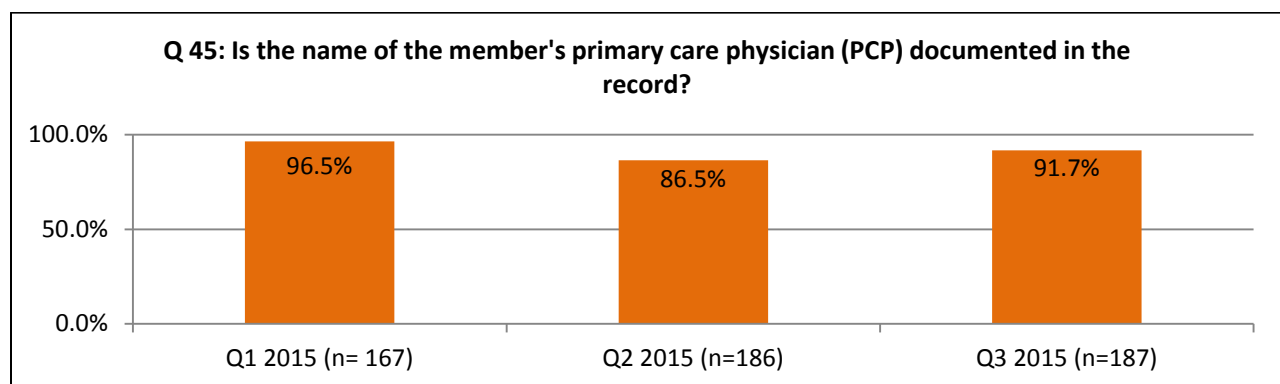
Some members may refuse to allow for release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. Optum, as well as accrediting organizations, expect providers to make a “good faith” effort at communicating with other behavioral health clinicians or facilities and any medical care professionals who are treating the member as part of an overall approach to coordinating care.

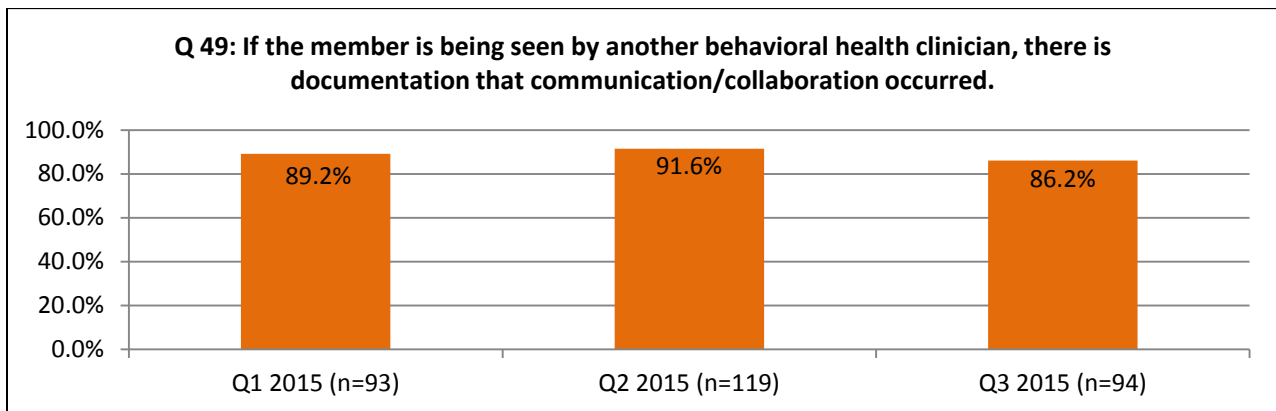
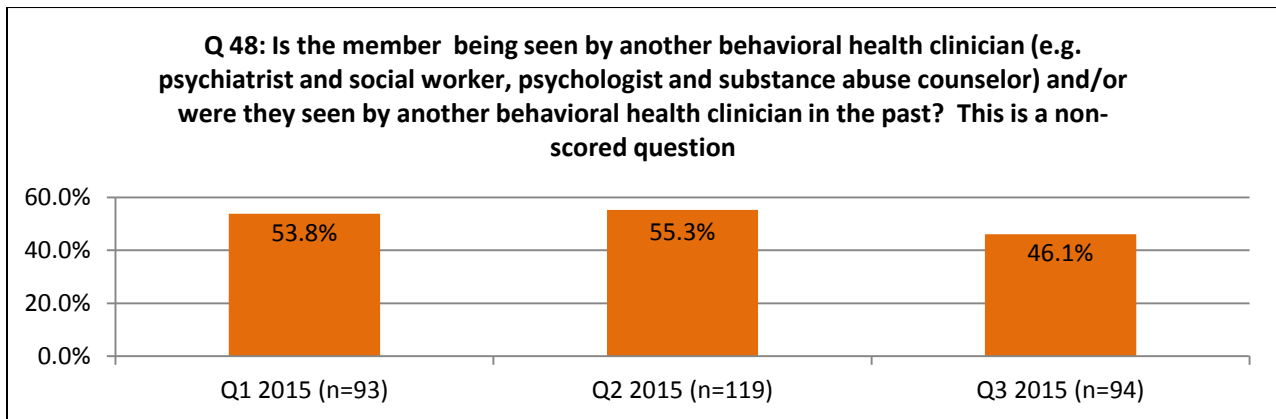
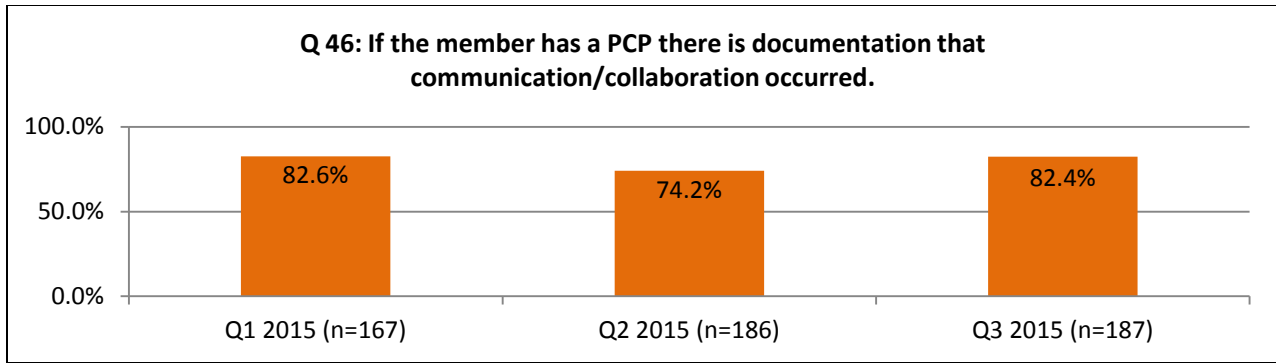
The Treatment Record Review Audit Tool includes questions related to Coordination of Care. These questions are completed during an audit by Optum Idaho Provider Quality Specialist (audit) staff. The results are tabulated in an internal Excel spreadsheet.

Quarterly Performance Results:

Coordination of Care	Performance Goal	Q1 2015	Q2 2015	Q3 2015
Q45: Is the name of the member's primary care physician (PCP) documented in the record?	NA	96.5 %	86.5%	91.7%
Q 46: If the Member has a PCP there is documentation that communication/collaboration occurred	NA	82.6%	74.2%	82.4%
Q48 Is the member being seen by another behavioral health clinician (e.g. psychiatrist and social worker, psychologist and substance abuse counselor) and/or were they seen by another behavioral health clinician in the past? This is a non-scored question.	NA	53.8%	55.3%	46.1%
Q49 If the member is being seen by another behavioral health clinician, there is documentation that communication/ collaboration occurred.	NA	89.2%	91.6%	86.2%

**Analysis:** Coordination of Care audits completed during Q3 revealed that 91.7% of member records reviewed had documentation of the name of the member's PCP. Of those, 82.4% indicated that Communication/Collaboration had occurred between the behavioral health provider and the member's PCP. The results also indicated that that 46.1% of the records indicated that the member was being seen (or had been seen in the past) by another behavioral health clinician (psychiatrist, social worker, psychologist, substance abuse counseling). Of those, 86.2% indicated that communication/collaboration had occurred.





**Barriers:** Based on the above analysis, no barriers were identified.

**Opportunities and Interventions:** No opportunities for improvement were identified.

### Provider Disputes

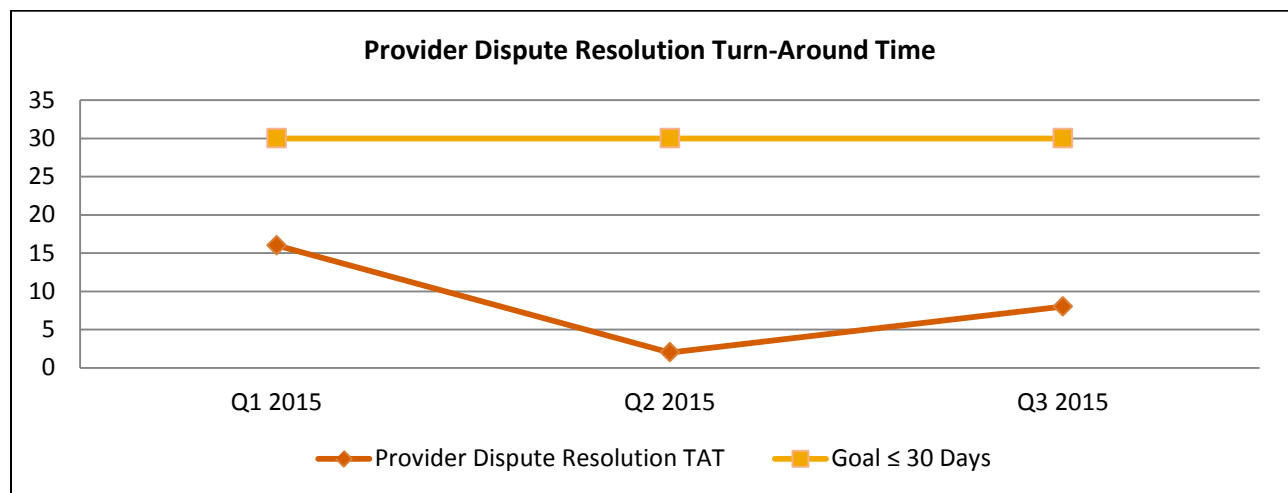
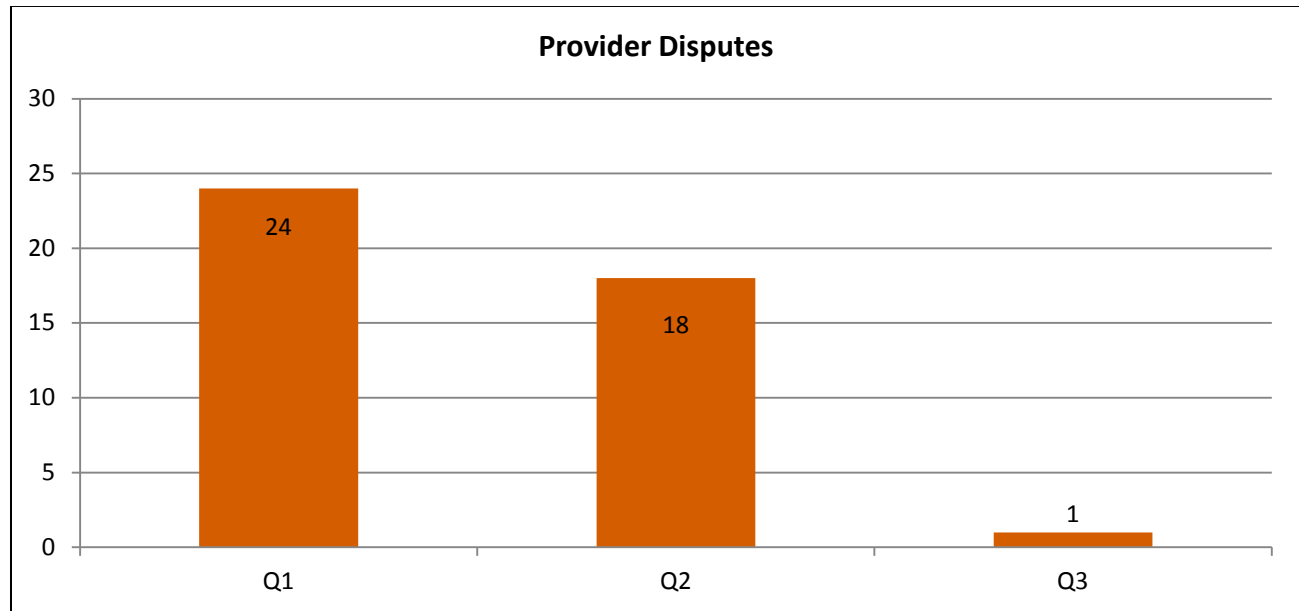
**Methodology:** Provider Disputes are requests by a practitioner for review of a non-coverage determination (claims-based denials) when a service has already been provided to the member, and includes a clearly expressed desire for reconsideration and indication as to why the non-coverage determination is believed to have been incorrectly issued. Provider disputes require that a written notice be sent within 30 days following the request for consideration.

Quarterly Performance Results:

Provider Disputes	Performance Goal	Q1 2015	Q2 2015	Q3 2015
# of Provider Disputes	NA	24	18	1
Average # of Days Provider Disputes Resolved	30 Days	16	2	8

**Analysis:** There was 1 provider dispute during Q3. It was resolved within the goal of  $\leq 30$  days.

**Note:** The Q1 – Q2 Quality report indicated that there were 17 provider disputes during Q1. The actual number was 24 provider disputes. This information has been updated in this Q3 report.





**Barriers:** Based on the above analysis, no barriers were identified.

**Opportunities and Interventions:** No opportunities for improvement were identified.

### Provider Satisfaction

Optum Idaho regularly conducts a provider satisfaction survey of providers delivering behavioral health services to IBHP members. This survey obtains data on provider satisfaction with Optum services including Care Advocacy, Network Services and Claims Administration. The results of the survey are analyzed for tracking and trending. Action plans are developed to address opportunities for improvement. Both the survey results and action plans are shared as necessary and appropriate. In 2014 Optum Idaho established a target for “Overall Provider Satisfaction” of 85%.

**Methodology:** Fact Finders, Inc., an independent health research company, conducts the Provider Satisfaction Survey for Optum. The questionnaire used to survey Optum providers has been developed to measure key indicators of satisfaction with Optum. These include:

<i>Overall Satisfaction</i>	<i>Customer Service Line</i>
<i>Authorizations</i>	<i>Peer Review</i>
<i>Field Care Coordinators</i>	<i>Alert Care Management</i>
<i>Claims</i>	<i>Optum Website</i>
<i>Training and Education</i>	<i>Electronic Health Records</i>
<i>Provider Monitoring Audits</i>	<i>Complaint Process</i>
<i>Suggestions for Improvement</i>	

Fact Finders, Inc., places an initial call to the provider agency to introduce the research and schedule an appointment for the interview. Provider agencies are then called by an interviewer at the appointed date and time. Providers are given the option of calling Fact Finders’ toll-free telephone number to complete the interview at their convenience, as well. Providers may also request to complete the survey via fax.

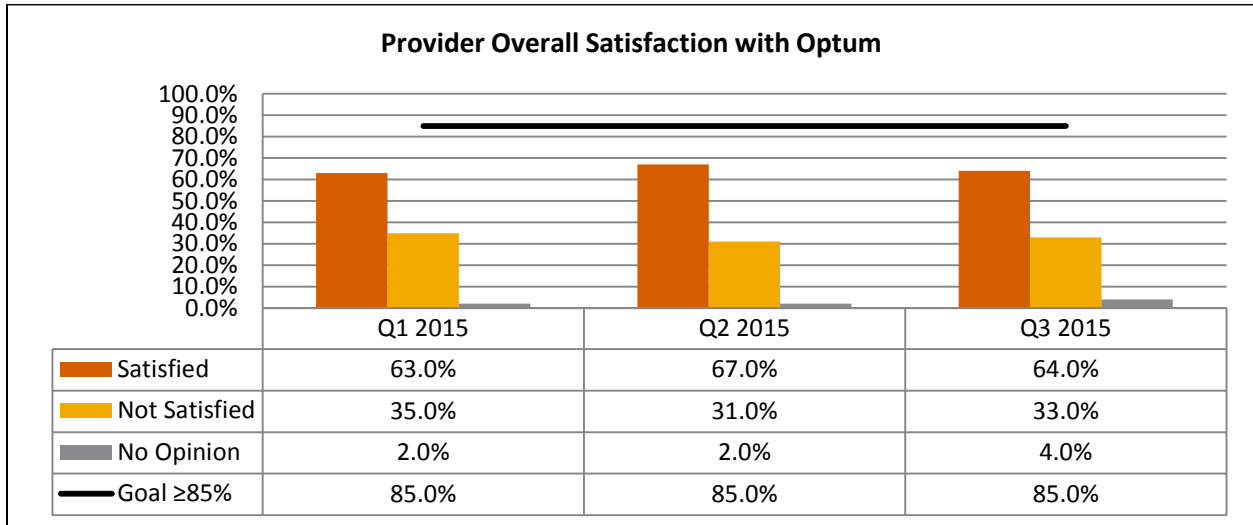
#### Quarterly Performance Results:

Provider Satisfaction Survey	Performance Goal	Q1 2015	Q2 2015	Q3 2015
Satisfied	≥85%	63.0%	67.0%	64.0%
Not Satisfied	NA	35.0%	31.0%	33.0%
No Opinion	NA	2.0%	2.0%	4.0%

**Analysis:** Overall Provider satisfaction continues to fall below the performance goal of ≥85%. Several Improvement Action Plans were initiated in Q1, 2015 to monitor and address Provider Satisfaction. These include:

- Provider Overall Satisfaction with Optum
- Provider Satisfaction with Peer Review Process

- Provider Satisfaction-Customer Service



**Barriers:** Optum Idaho is working with network providers to determine if they are dissatisfied with the Peer Review Process or the outcome of the Peer Review decision.

**Opportunities and Interventions:** We will continue to monitor this measure in 2015 and promote initiatives to improve the network experience with Optum. The following project initiatives highlight key accomplishments during Q3:

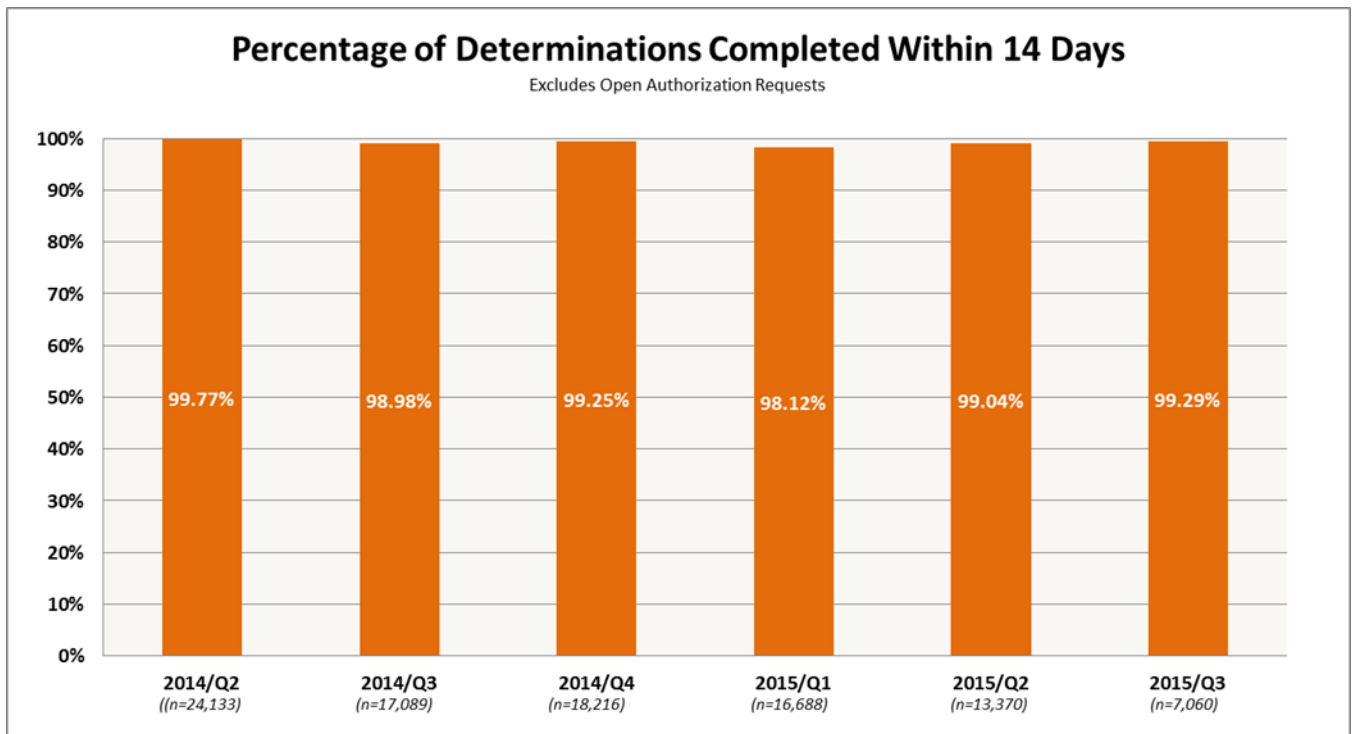
2015 Improvement Action Plan	Date Initiated	Quality Committee Oversight	Status	Key Accomplishments
Provider Overall Satisfaction with Optum (Provider Survey Results)	1/23/2015	Provider Advisory Committee Quality Assurance Performance Improvement	Open	•Training Deck updated to include EPSDT definitions and requirements
Provider Satisfaction-Customer Service	1/30/2015	Quality Assurance Performance Improvement	Open	•QAPI confirmed performance improvement as reflected in Provider Satisfaction Survey
Provider Satisfaction with Peer Review Process	2/6/2015	Clinical and Services Advisory Committee	Open	•Creation of survey to clarify provider dissatisfaction •Creation of provider denial notification and peer review scripts currently under review •Implemented use/training of internal medical directors for peer reviews

## Utilization Management Care Coordination

### Service Authorization Requests

**Methodology:** Optum Idaho has formal systems and workflows designed to process pre-service, concurrent and post service requests for benefit coverage of services, for both in-network and out-of-network (OON) providers and agencies. Optum Idaho adheres to a 14-day turnaround time for processing requests for non-urgent pre-service requests that results in a denial or limited authorization of a requested service; termination, suspension, or reduction of a previously authorized service, the denial in whole or in part of a payment for service; or the failure to act upon a request for services in a timely manner.

**Analysis:** During Q3, the performance measure of processing authorizations within 14-days fell slightly below our goal of 100% at 99.29%.



**Barriers:** Since the 14-day turnaround time was not being met on a consistent basis, Optum Idaho implemented an Improvement Action Plan, Clinical Model 2.1, with the primary objective of establishing process improvement in meeting this metric.

**Opportunities and Interventions:** We will continue to monitor this measure and promote initiatives to improve it. The following project initiative highlights key accomplishments during Q3:

2015 Improvement Action Plan	Date Initiated	Quality Committee Oversight	Status	Key Accomplishments
Clinical Model 2.1	1/15/2015	Clinical and Services Advisory Committee	Open	<ul style="list-style-type: none"> <li>•Met with National and Local Reporting Team to identify metrics and required specifications for Linx and portal database reporting</li> <li>•Alert Peer Review Project results in lessons learned, FAQs and CA reference guide</li> </ul>

### Discharge Coordination: Post Discharge Follow-up

**Methodology:** To promote transitions from hospitalization to outpatient behavioral health services, Optum Idaho conducts discharge coordination activities. These activities are designed to make sure our members have an outpatient appointment for follow-up care with an appropriately licensed outpatient provider within seven (7) days of discharge from the hospital. Data is tracked internally by Discharge Coordination team.

Appointments Kept w/in 7 days of Hospital Discharge	Q2 2015
Number of Inpatient Discharges Reported to Discharge Coordinators	626
Number of Members with Kept Appointment w/in 7 days	336
Percentage of Members with Appointments Kept w/in 7 days	53.7%

**Analysis:** During Q2, 53.7% of members who were discharged from an inpatient hospital stay kept an appointment within 7 days of being discharged.

**Barriers:** An IAP is currently in place to continue to monitor this measure.

**Opportunities and Interventions:** The changes implemented from the IAP will result in improved data accuracy and reporting in line with national reporting standards.

### Field Care Coordination

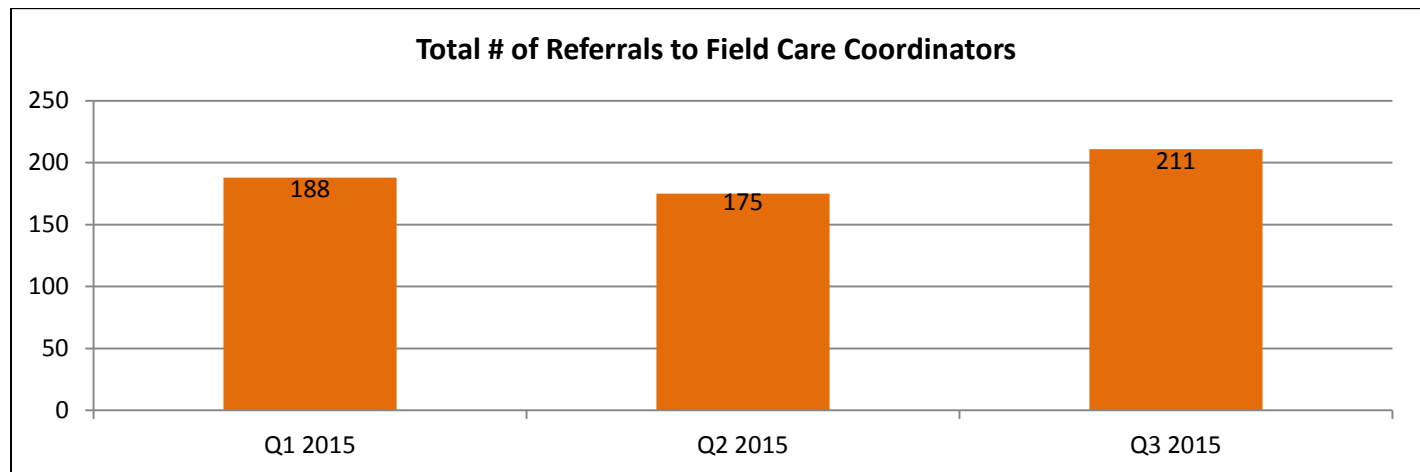
**Methodology:** The Field Care Coordination (FCC) program includes regionally based clinicians across the state of Idaho. They provide locally based care coordination and discharge planning support. Field Care Coordinators work with the provider to help members. The FCC team focuses on member wellness, recovery, resiliency, and an increase in overall functioning. They do this through:

- Focusing on consumers and families who are at greatest clinical risk
- Focusing on consumer’s wellness and the consumer’s responsibility for his/her own health and well-being.
- Improved care coordination for consumers moving between services, especially those being discharged from 24-hour care settings.

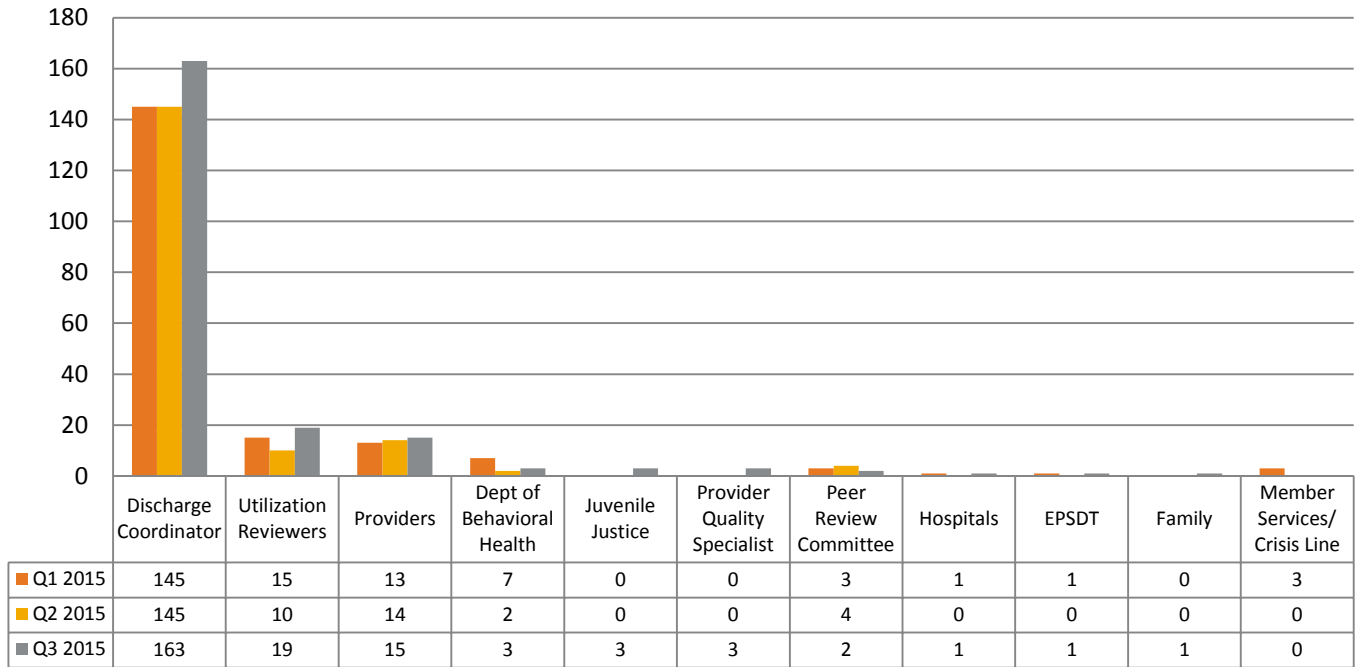
The Field Care Coordinators receive referrals from different sources. The below table identifies the referral sources and the number of referrals made to FCC staff during Q1 through Q3.

Referral Sources	Q1 2015	Q2 2015	Q3 2015
Discharge Coordinator	145	145	163
Utilization Reviewers	15	10	19
Providers	13	14	15
Dept of Behavioral Health	7	2	3
Juvenile Justice	0	0	3
Provider Quality Specialist	0	0	3
Peer Review Committee	3	4	2
Hospitals	1	0	1
EPSDT	1	0	1
Family	0	0	1
Member Services/Crisis Line	3	0	0
<b>Total</b>	<b>188</b>	<b>175</b>	<b>211</b>

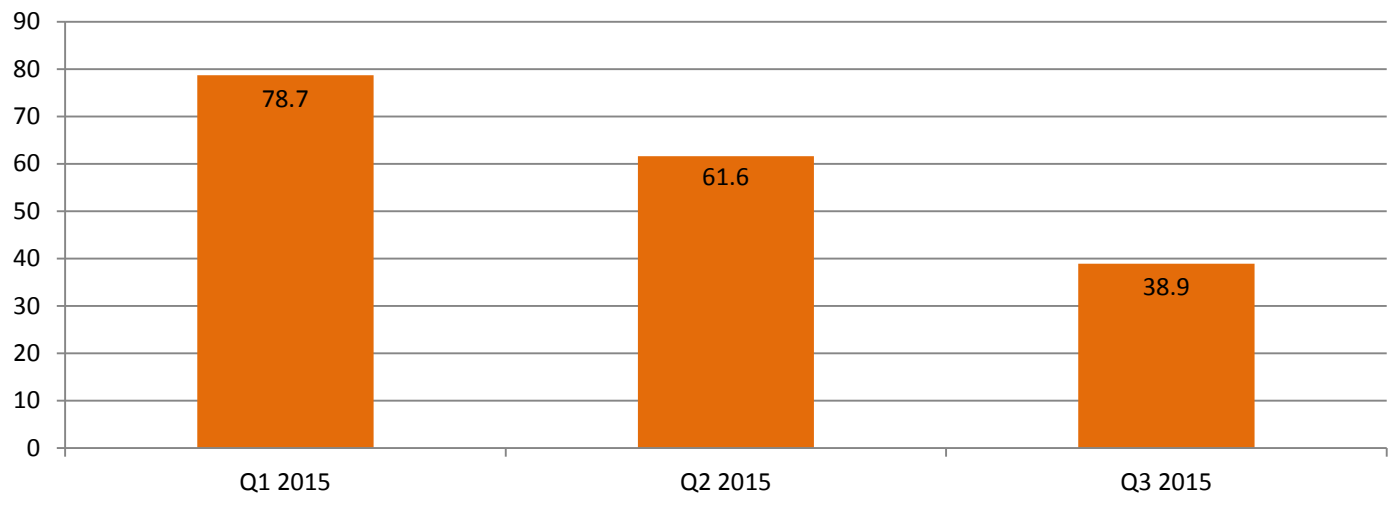
**Analysis:** During Q3, Field Care Coordinators received 211 referrals which was an increase from 175 referrals in Q2. Of the 211 referrals, 163 referrals were made by the Discharge Coordinator staff. The average length of FCC engagement was 38.9 days.



### Field Care Coordinator Referral Sources



### Average Length of FCC Engagement/Days



**Barriers:** Based on the above analysis, no barriers were identified.

**Opportunities and Interventions:** No opportunities for improvement were identified.

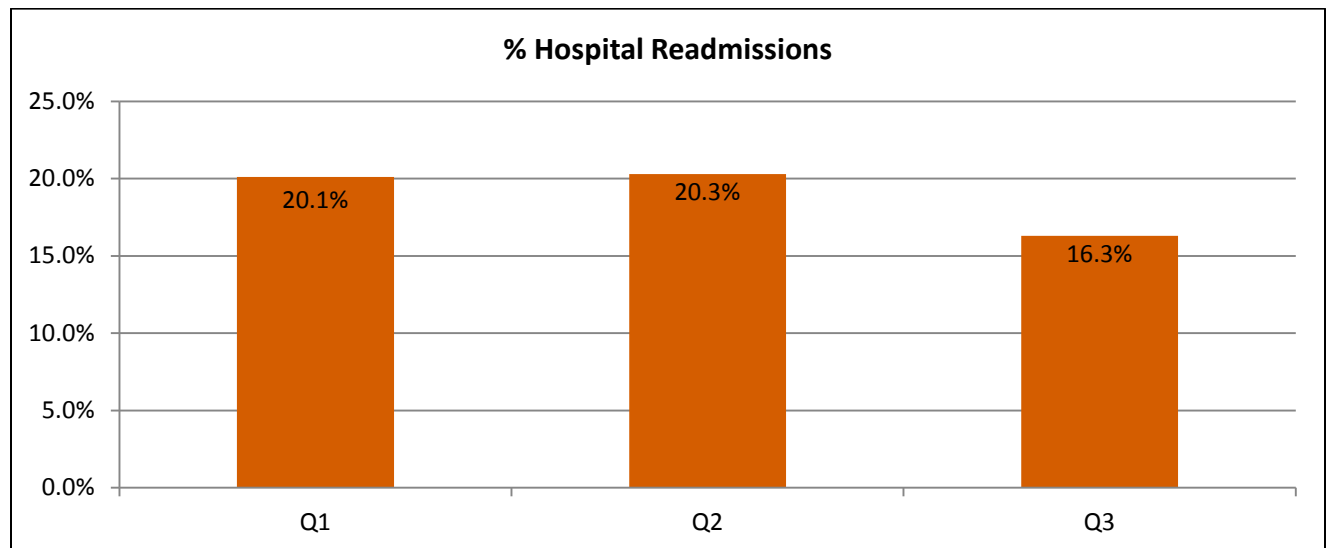
### Readmissions

**Methodology:** Optum Idaho monitors readmission rates according to NCQA 30-day readmission standards. Despite the IBHP being an outpatient only behavioral health plan,

Optum Idaho monitors readmission rates as part of our collaboration with IDHW. This collaboration is to promote a more integrated approach to the service delivery system in Idaho.

Month	Number of Member Inpatient Discharges	Number of Members Rehospitalized w/in 30 days of Discharge	% Readmitted
January	249	59	23.7%
February	324	49	15.1%
March	266	61	22.9%
<b>Q1</b>	<b>839</b>	<b>169</b>	<b>20.1%</b>
April	307	69	22.5%
May	285	48	16.8%
June	256	55	21.5%
<b>Q2</b>	<b>848</b>	<b>172</b>	<b>20.3%</b>
July	249	45	18.1%
August	262	46	17.6%
September	278	38	13.7%
<b>Q3</b>	<b>789</b>	<b>129</b>	<b>16.3%</b>

**Analysis:** During Q3 the readmission rate decreased from 20.3% in Q2 to 16.3% in Q3, a roughly 20% decrease in readmissions rate, which is the lowest rate since Optum Idaho started benefit services in 2013. Q3 also saw the lowest amount of member inpatient discharges and total number of member readmissions since Optum Idaho began operations.



**Barriers:** Based on the above analysis, no barriers were identified.

**Opportunities and Interventions:** No opportunities for improvement were identified.

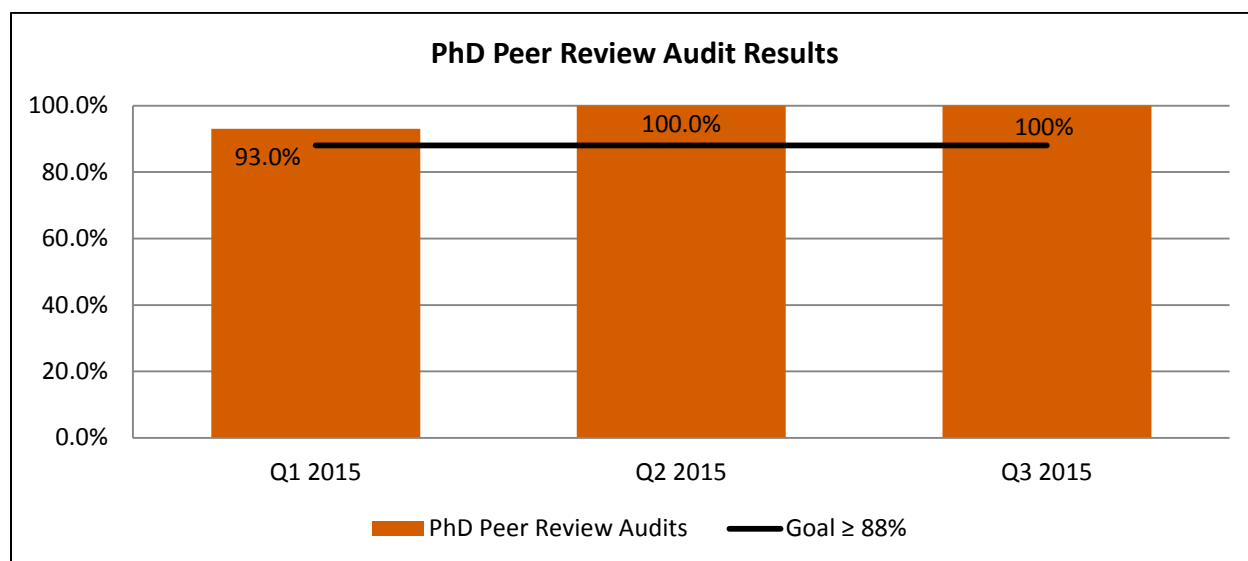
### Inter-rater Reliability

Optum evaluates and promotes the consistent application of the Level of Care Guidelines and the Coverage Determination Guidelines by clinical personnel by providing orientation and training, by routinely reviewing documentation of clinical transactions in member records, by providing ongoing supervision and consultation and by administering an annual assessment of inter-rater reliability. Inter-rater Reliability testing is completed annually and has been deferred until Q1 2016 due to the role out of Clinical Model 2.1 in August, 2015.

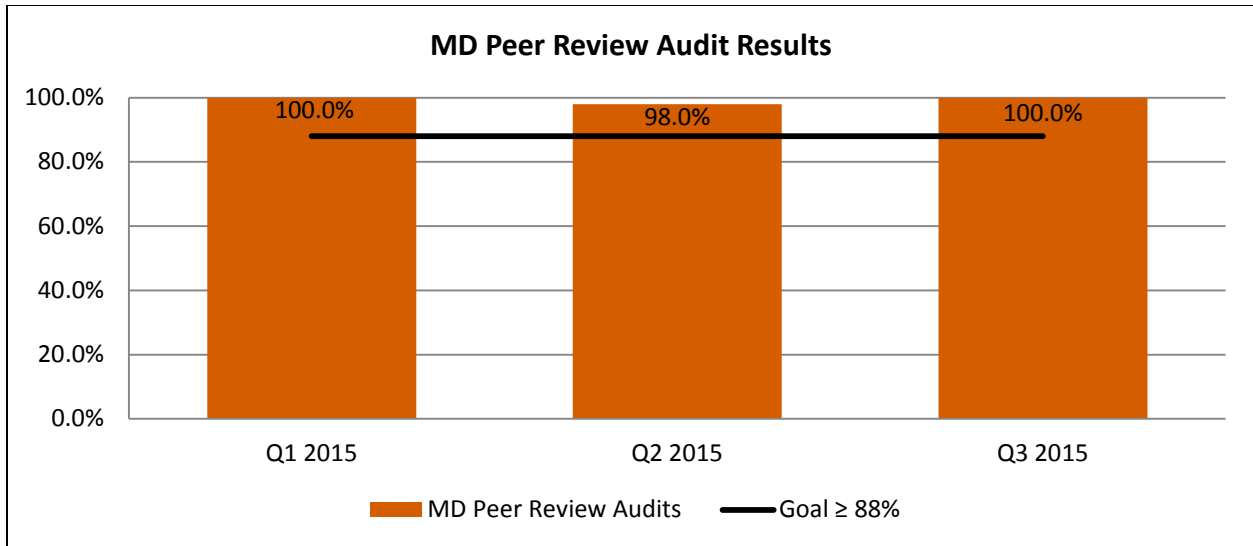
### Peer Review Audits

**Methodology:** Optum Idaho promotes a process for review and evaluation of the clinical documentation of non-coverage determinations and appeal reviews by Optum physicians and doctoral-level psychologists in their role as Peer Reviewers, for completeness, quality and consistency in the use of medical necessity criteria, coverage determination guidelines and adherence to standard Care Advocacy policies. Any pattern of deficiency incurred by an individual Peer Reviewer may result in clinical supervision, as needed. Optum Idaho's established target score for Peer Reviewer audits is  $\geq 88\%$ .

**Analysis:** Based on the performance goal of  $\geq 88\%$ , audit results indicate that PhD and MD Peer Review Audits received passing scores during Q3.







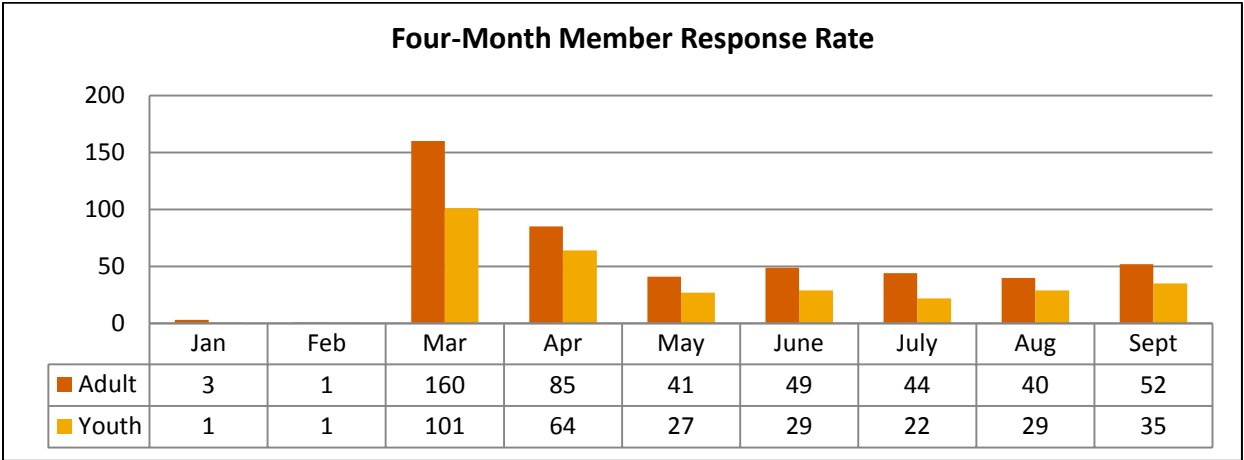
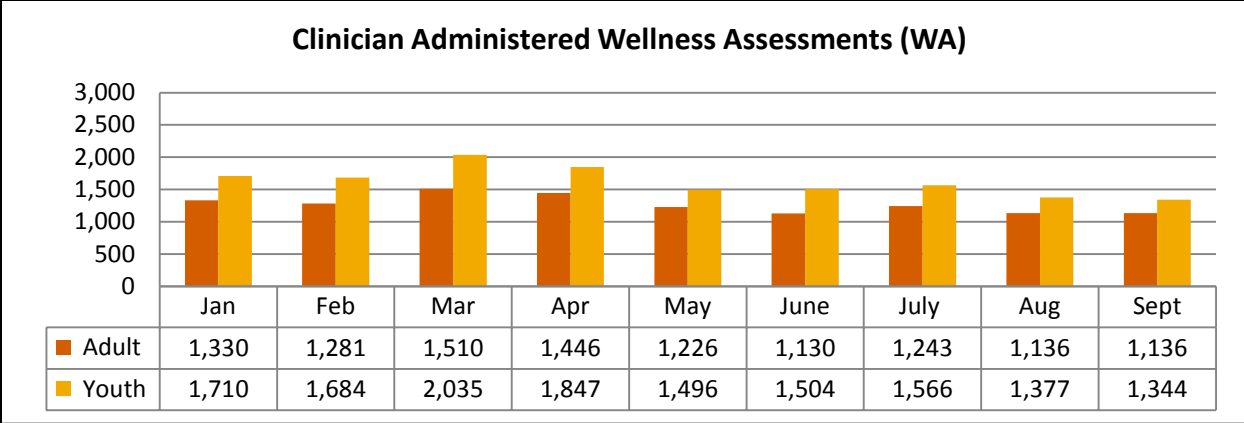
**Barriers:** Based on the above analysis, no barriers were identified.

**Opportunities and Interventions:** No opportunities for improvement were identified.

### Wellness Assessment Utilization and Follow-up

**Methodology:** One of the primary ways Optum Idaho measures treatment outcomes is through the use of our proprietary Algorithms for Effective Reporting and Treatment (ALERT®) an outcomes and outlier management system that utilizes member self-reports (Wellness Assessments) of symptom severity and impairment. The Wellness Assessment, in combination with claims, identifies members who may be at-risk or who may be over or under utilizing outpatient services. It provides decision support for the authorizations of outpatient services. It also generates provider profiles that enable quality improvement and clinical staff to take action when trends are identified.

**Analysis:** During Q3, our network administered 7802 ALERT® Wellness Assessments to our members. Of the total assessments, 3515 were administered to adults and 4,287 were administered to youth. A total of 222 members responded to the 4-month follow-up assessment (Youth – 86; Adult – 136). We will continue to monitor these rates.



**Barriers:** Based on the above analysis, no barriers were identified.

**Opportunities and Interventions:** No opportunities for improvement were identified.

## Outcomes

### **Adverse Symptom and Behavioral Outcomes**

**Methodology:** Optum’s proprietary Algorithms for Effective Reporting and Treatment (ALERT®) outpatient management program quantifiably measures the effectiveness of services provided to individual patients, to identify potential clinical risk and "alert" practitioners to that risk, track utilization patterns for psychotherapeutic services, and measure improvement of Member well-being. ALERT Online is an interactive dashboard that is available to network providers.

Information from the Idaho Standardized Assessments completed by the provider's patients is available in ALERT Online both as a provider group summary and also individual Member

detail. The Idaho Standardized Assessment is a key component of the Idaho ALERT program and for that reason providers are required to ask Members to complete the Assessment at the initiation of treatment and to monitor treatment progress whenever the provider requests authorization to continue treatment.

To determine change in clinical outcomes over time, Optum Idaho has prepared a before-and-after comparison of key clinical measures. The concept is to compare the status of members between baseline Wellness Assessment measures and a follow up 4-months after the baseline study. Data is reviewed bi-annually. Four (4)-month responses were compared to the baseline response to measure outcomes in the following 4 domains:

- Global Distress
- Caregiver Strain (youth only)
- Workplace Impairment
- Health (adult only)

### Change in Global Distress at 4-Months (Overall)

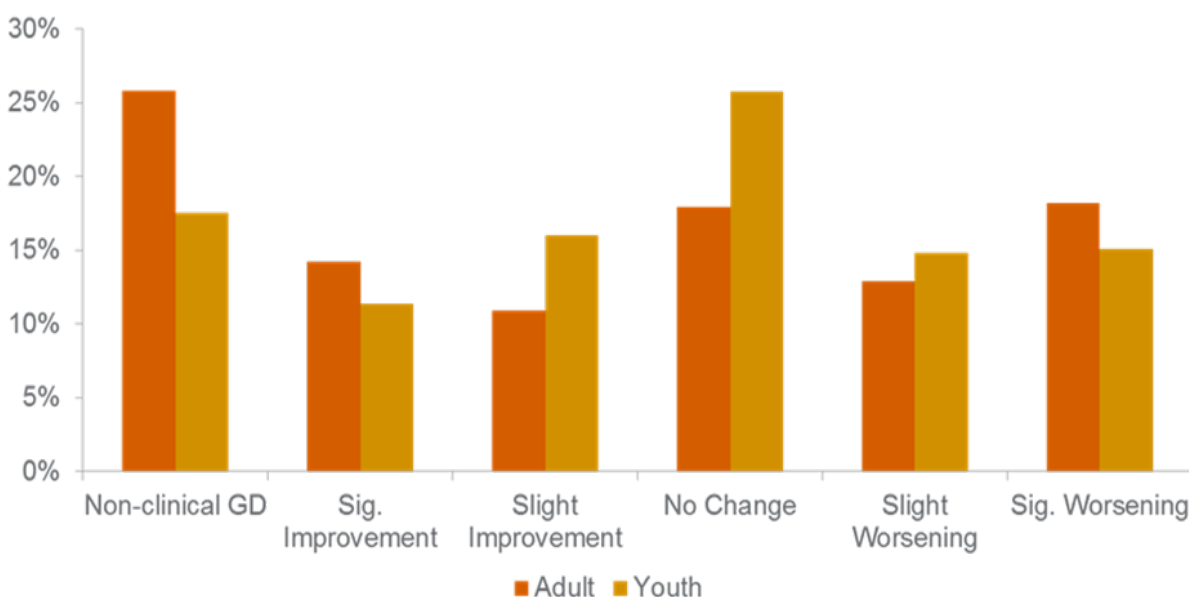


Fig. 1. Graph displays percentage of adults and youth who displayed improvement scores in different outcome categories.

**Analysis:** For 2015, Optum Idaho has gathered baseline and 4-month Wellness Assessment outcomes for comparison. The key measures selected to study included Global Clinical Distress, Caregiver Strain, Workplace Impairment, and Medical Behavioral Comorbidity. The study period began January 1, 2015 and ended June 30, 2015. There were 1,805 respondents to the 4-month Wellness Assessment, including 150 Adults in Q1-2015 and 155 Adults in Q2-2015 as well as 57 Youth in Q1-2015 and 68 Youth in Q2-2015. Overall, there were 305 adults

and 125 youth included. Only responses using the same respondent on the baseline and 4-month scores were used.

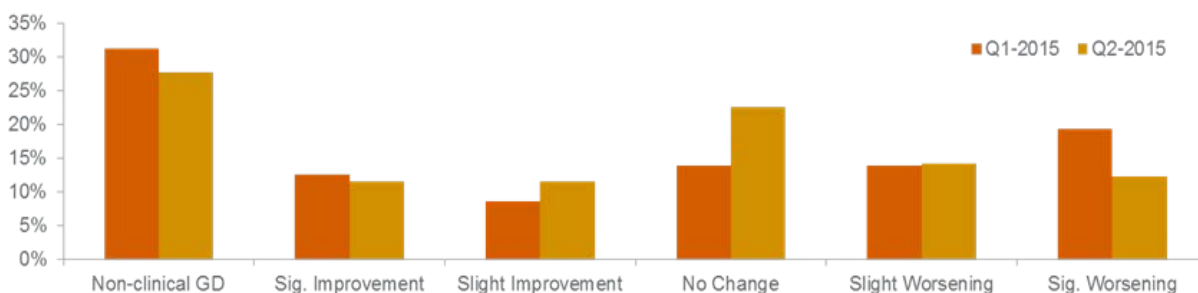
For comparison, responses to a national sample of Optum Idaho outcomes were compared to responses received from the national sample Medicaid members, excluding Optum Idaho, during the same measurement period. The national sample was comprised of 560 respondents to the Adult WA and 183 respondents to the Youth WA.

The outcomes results most commonly resulted in over 25% of adults achieving a “non-significant clinical global distress” score at the end of 4 months. The two next most common outcomes were “significant worsening,” and “no change” with slightly fewer adults in this category, with very similar outcomes. Overall, approximately half of adults had a positive outcome.

Among youth, the most common outcome was “no change” at month 4, with the next most common category being “non-significant clinical global distress.” Fewer than half of youth displayed a positive outcome.

### Change in Global Distress at 4-Months by Quarter

#### Adult Respondents



#### Youth Respondents

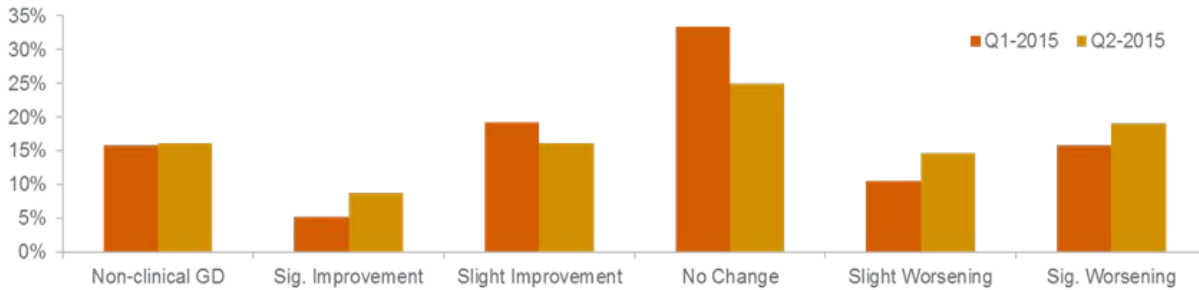


Fig. 2. Examination of changes in Global Distress Scores by adults and youth (0-17) by quarter

For both adults (18+ years) and youth (0-17 years), the percentage of members endorsing non-clinical levels of global distress were similar for Q1 and Q2 2015. For adults, Q2 percentages showing significant worsening improved over Q1 levels. The percentages of adults showing no change or slight improvement were higher in Q2 than in Q1. For youth, the pattern tended to show the reverse, with a greater percentage of youths showing slight or significant worsening in Q2 compared to Q1. The percentage showing no change decreased in the second quarter.

### Change in Mean Global Distress Scores (Overall)

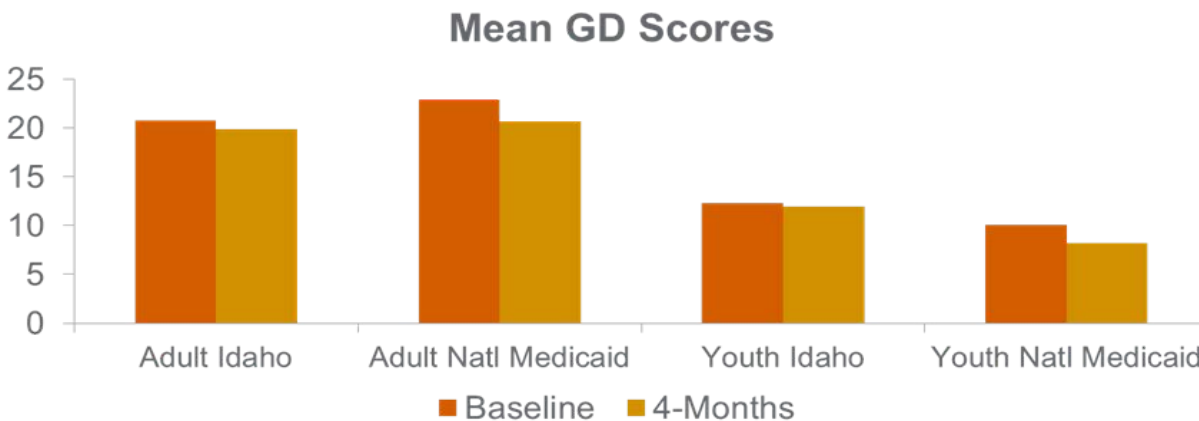


Fig. 3. Comparison of Global Distress Scores from Baseline to 4-months for Adults and Youth.

Both adults and youth showed a decrease in Global Distress at 4 months in both the Idaho and the national Medicaid sample. There was a numerically greater improvement for both adults and youth in the national sample than for Idaho.

The mean Global Distress score for adult respondents declined 4% and youth scores declined 3%. Change in adult cohorts was statistically significant ( $p < .01$ ). Idaho adult respondents report comparable rates of Global Distress to the national Medicaid sample, but the Idaho youth have higher levels of Global Distress at baseline and 4-months.

**Caregiver Strain (Youth Only)**

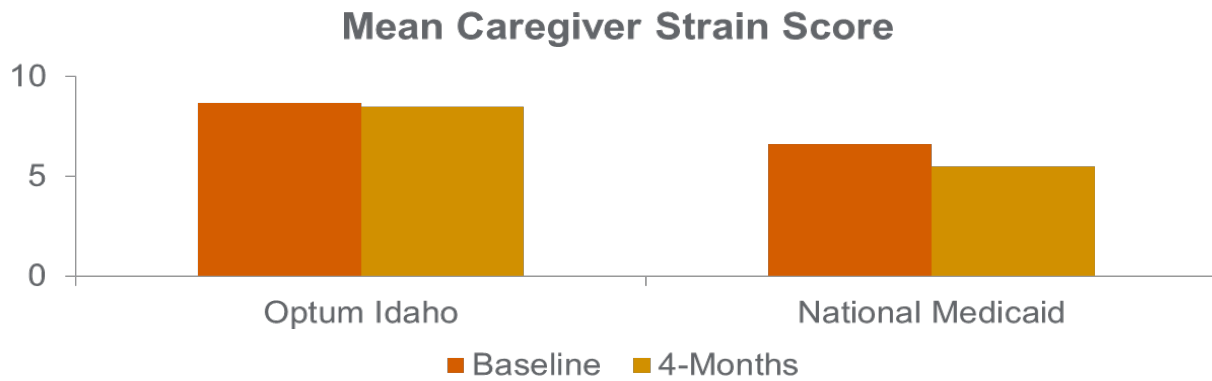


Fig. 4. Mean caregiver strain scores at baseline and at 4 months for both Optum Idaho and National Medicaid samples.

Caregiver Strain scores tended to correlate with Global Distress scales among youth.

There was no significant reduction in caregiver strain at 4-months among families of Optum Idaho youths in treatment overall or quarter over quarter. There were no caregiver strain values for adults.

There was no statistical significant reduction in caregiver strain among Idaho families at 4-months, overall or during Q1-2015 through Q2-2015. However, the reduction was significant in the national sample, overall ( $p < .01$ ).

Levels of caregiver strain in Idaho were higher than reported in the national Medicaid sample. The mean Caregiver Strain score for Optum Idaho respondents at 4-months was higher than the mean *baseline* score for the national Medicaid sample.

**Change in Caregiver Strain by Participation in Family Therapy**

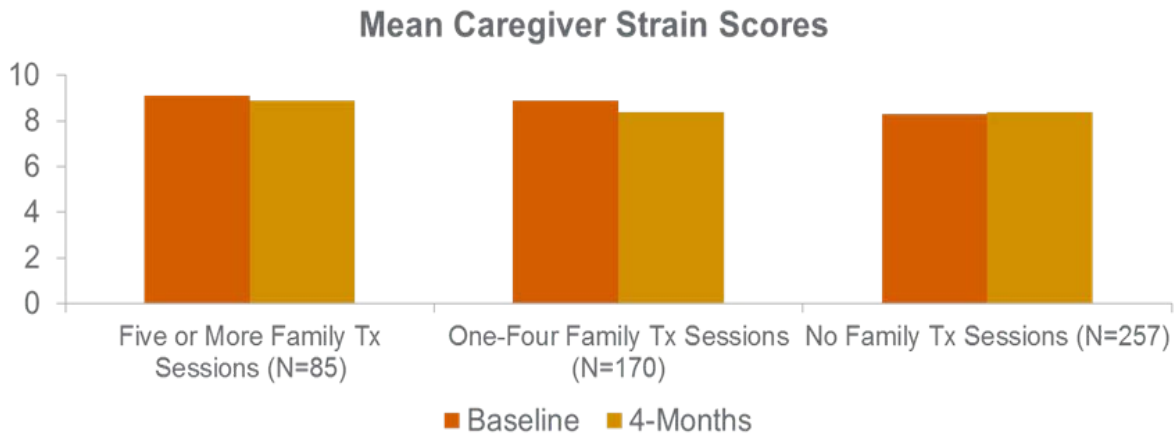
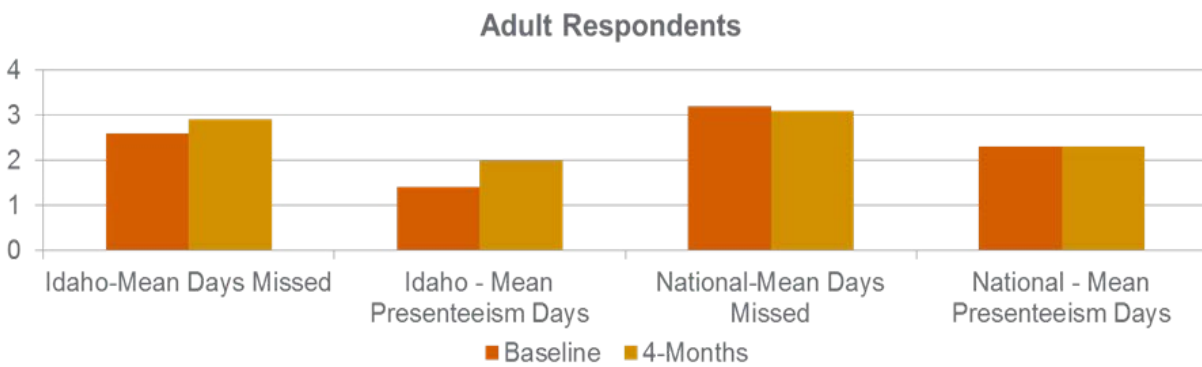


Fig. 5. Baseline and 4 month Caregiver Strain scores over study period Q1 2015 to Q2 2015. Participation in Family Therapy defined by claims for CPT codes 90846 and 90847. 50% (N = 255) of Idaho families responding to the Youth WA Caregiver Strain participated in family treatment\*. The mean number of family therapy sessions was 4.7 (median = 3.0).

Idaho families who participated in five or more family therapy sessions experienced a 3% reduction in mean caregiver strain scores. Those that had 1-4 sessions experienced a 5% reduction in mean caregiver strain scores. Those who did not experience family therapy had no change in mean caregiver strain scores. No changes were statistically significant.

### Workplace Impairment



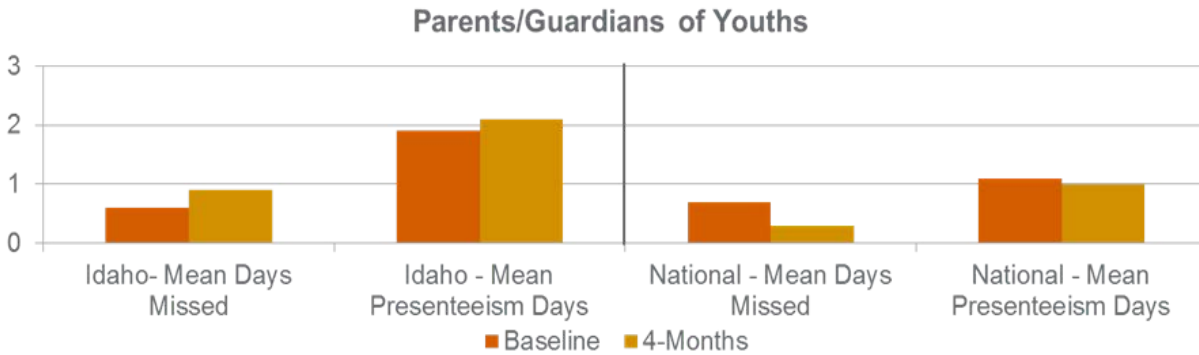


Fig. 6. Graphs taken from the most recent Idaho 4-month Outcomes report

WA respondents are asked to report the number of workdays missed in the past 30 days (absenteeism) and the number of workdays in which they were able to work but got less work done because of mental or physical health problems (presenteeism).

Respondents who are not employed outside the home are instructed to skip these items. Data reflects respondents who endorsed the items on baseline and 4-months (Adult N=167, Parents of Youth N = 204)

Although there was a trend towards increased workplace impairment at 4-months, the change was not statistically significant. This was also found to be the case during Q1-2015 and Q2-2015.

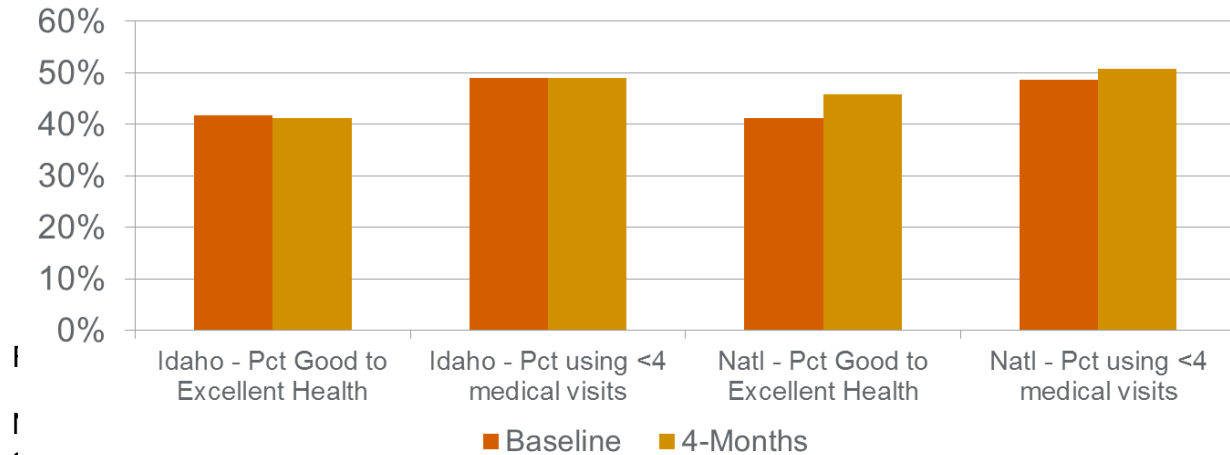
For the national sample, there was also not a significant decrease found for absenteeism or presenteeism for either adults or youth.

### **Health (Adult only)**

Comparison of Optum Idaho and national Medicaid adults found that Idaho adults had more health concerns at baseline, with 87% reporting a health concern compared to 78% in the national sample. In Idaho 79% of adults reported medical comorbidity compared to 69% nationally. Also 51% in Idaho reported fair or poor health compared to 46% nationally. The percentage of adults in Optum Idaho who had 4 or more medical services in the prior 6 months was 45% compared to 40% nationally.



## Health Status – Adults with Health Concerns



Q2-2015. Similar non-significant results were evident in the national sample.

### Outcomes Summary

Overall, based on the 4-month Wellness Assessment study, improvement was seen for both adults and youth for Global Distress scores. Less improvement in Global Distress and Caregiver Strain was seen in Idaho than in the comparable national Medicaid population. No signal appeared in Idaho for change in Caregiver Strain Scores, Workplace Impairment, or Medical Comorbidity. Levels of Caregiver Strain Scores were higher in Idaho at 4 months than in the national sample at baseline. Improvement was not significant for Workplace Impairment or Medical Comorbidity in either Idaho or the national sample.

More improvement in Caregiver Strain occurred among those members who underwent Family Therapy than for those who received none. There was slightly more improvement for those who had 1 to 4 Family Therapy sessions over the 4-month period than for those who had 5 or more sessions. The average number of Family Therapy sessions, 6.9 during Q1 and 4.7 during Q2, was much below the expected frequency of Family Therapy sessions expected for a positive effect to be seen. A therapeutic dosing of Family Therapy closer to weekly (average of 16) would be expected to have a stronger therapeutic effect. Optum Idaho has been encouraging providers to increase the frequency of Family Therapy sessions to strengthen the effect on Caregiver Strain. These efforts have occurred through treatment recommendations associated with Adverse Benefit Determination notices, peer reviewer consultations, formal provider training, and Field Care Coordination activities.

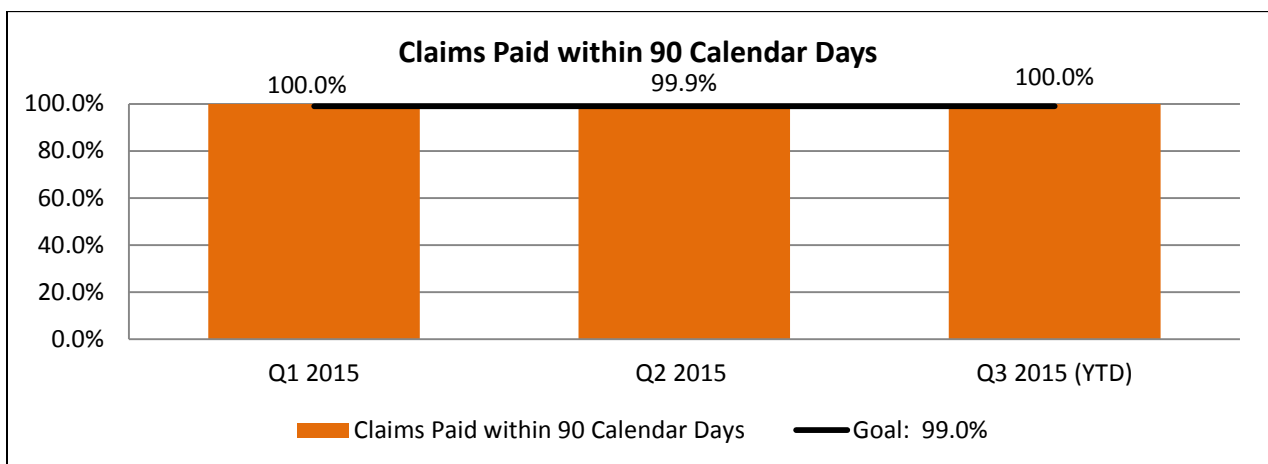
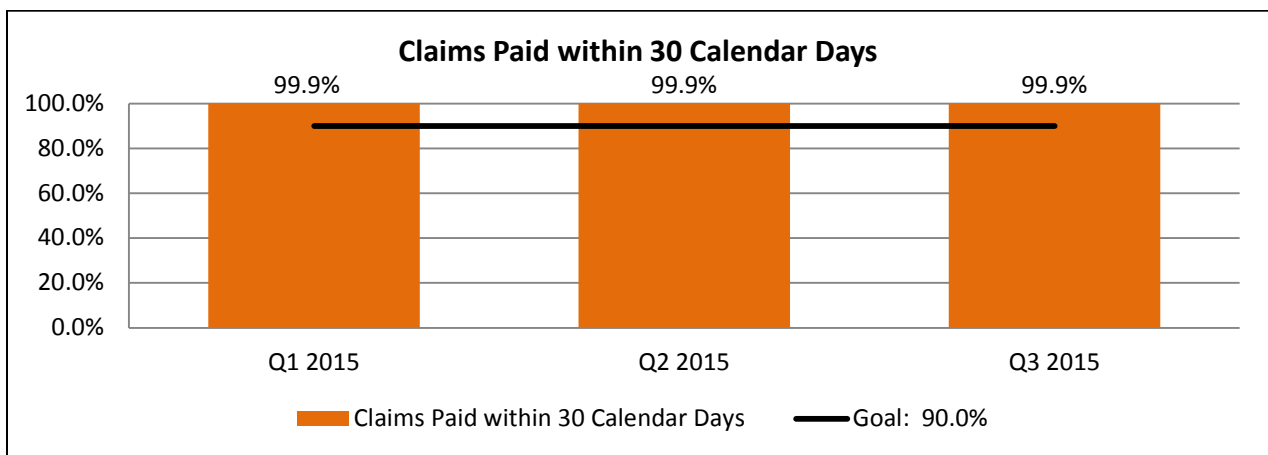
### Claims

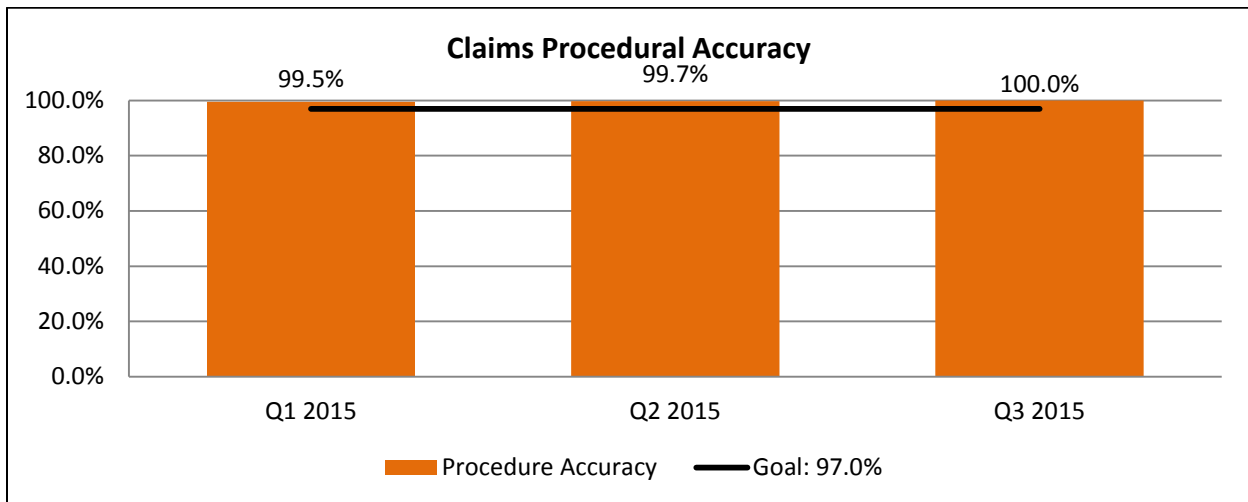
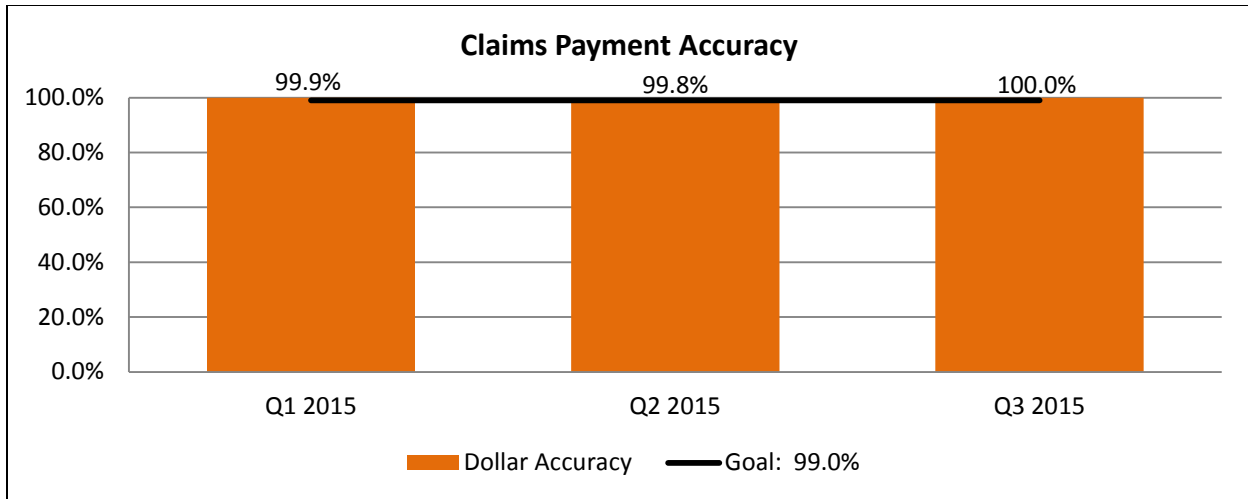
**Methodology:** The data source for claims is Cosmos via Webtrax.

Quarterly Performance Results:

Claims	Performance Goal	Q1 2015	Q2 2015	Q3 2015 (based on the Sept. OR54 report)
Paid within 30 days	90%	99.9%	99.9%	99.9%
Paid within 90 days	99%	100.0%	99.9%	100.0%
Dollar Accuracy	99%	99.9%	99.8%	100.0%
Procedural Accuracy	97%	99.5%	99.7%	100.0%

**Analysis:** The data shows that all performance goals have been met calendar year to date.





**Barriers:** Based on the above analysis, no barriers were identified.

**Opportunities and Interventions:** No opportunities for improvement were identified.

### 2015 Performance Improvement Initiatives

A continuous quality improvement (CQI) process is embedded within the structure of Optum Idaho QI program. The CQI process provides the mechanism by which improvement projects and initiatives are developed where barriers to delivering optimal behavioral health care and services can be identified, opportunities prioritized, and interventions implemented and evaluated for their effectiveness in improving performance. The following improvement activities or Improvement Action Plans were initiated and are currently open. The Optum Idaho quality committee structure will routinely oversee and monitor these activities until completion or closure.

Optum Idaho staff implemented initiatives related to the following Improvement Actions Plans and were able to close them during Q3.

Improvement Action Plan	Status
Primary Care Provider Interface	Closed
Authorizations: Calls to Optum – information from first call	Closed
Authorizations: Ease of Process to Authorize	Closed
E2E Review of Compliance Turn Around Times	Closed

The following is a list of the open Improvement Action Plans which highlights the Key Accomplishments related to each one.

2015 Improvement Action Plan	Date Initiated	Quality Committee Oversight	Status	Key Accomplishments
Special Programming for Pre-Adults Facing Transition to Adulthood	6/2/2014	Clinical and Services Advisory Committee	Open	<ul style="list-style-type: none"> <li>•Drafted Alert letters for members and providers submitted for internal vetting</li> <li>•Recovery and Resiliency training in October</li> </ul>
Provider Overall Satisfaction with Optum (Provider Survey Results)	1/23/2015	Provider Advisory Committee Quality Assurance Performance Improvement	Open	<ul style="list-style-type: none"> <li>•Training Deck updated to include EPSDT definitions and requirements</li> </ul>
Provider Satisfaction with Peer Review Process	2/6/2015	Clinical and Services Advisory Committee	Open	<ul style="list-style-type: none"> <li>•Creation of survey to clarify provider dissatisfaction</li> <li>•Creation of provider denial notification and peer review scripts currently under review</li> <li>•Implemented use/training of internal medical directors for peer reviews</li> </ul>
Provider Website	1/22/2014	Provider Advisory Committee	Open	<ul style="list-style-type: none"> <li>•Continuation of bi-weekly workgroup meetings for migration to new platform</li> <li>•Mock website received by IDHW 10/9/15 for review</li> </ul>
Provider Satisfaction-Customer Service	1/30/2015	Quality Assurance Performance Improvement	Open	<ul style="list-style-type: none"> <li>•QAPI confirmed performance improvement as reflected in Provider Satisfaction Survey</li> </ul>
Clinical Model 2.1	1/15/2015	Clinical and Services Advisory Committee	Open	<ul style="list-style-type: none"> <li>•Met with National and Local Reporting Team to identify metrics and required specifications for Linx and portal database reporting</li> <li>•Alert Peer Review Project results in lessons learned, FAQs and CA reference guide</li> </ul>
Complaint Acknowledgement	1/27/2015	Quality Assurance Performance Improvement	Open	<ul style="list-style-type: none"> <li>•Planned interventions completed including provider fax blast and Optum All Staff Training</li> <li>•Satisfaction rose from 57%-67%</li> </ul>
Authorizations: Resolution of Questions	2/2/2015	Provider Advisory Committee	Open	<ul style="list-style-type: none"> <li>•Increased to 80% approval in Q2</li> </ul>

7 Day Post-Discharge Monitoring	5/13/2015	Clinical and Services Advisory Committee	Open	<ul style="list-style-type: none"> <li>•Submitted modified report with change request to IDHW</li> <li>•Optum Idaho Leadership currently reviewing additional modifications presented by IDHW</li> </ul>
ALERT Peer Review	10/2/2015	Quality Assurance Performance Improvement Committee and Clinical and Services Advisory Committee	Open	<ul style="list-style-type: none"> <li>•Committees reviewed in late October</li> <li>•Working with ALERT team to develop review process of overutilization of Category 2 services</li> </ul>