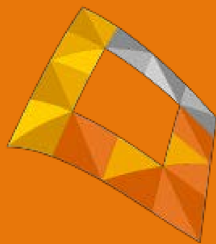
IDAHO BEHAVIORAL HEALTH PLAN QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT QUARTERLY REPORT



OPTUM™

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 4, 2015, for Medicaid outpatient mental health and substance use disorder services managed by IBHP in the state of Idaho.

October - December, 2015

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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*.

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

- ALERT outcomes
- Utilization Rates
- Member Satisfaction
- Provider Satisfaction
- Accessibility and Availability of Care and Services
- Geographic Availability of Providers
- Member Protections and Safety
- Provider Monitoring and Relations
- Utilization Management and Care Coordination
- 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 4 (October 1 – December 31) and provides comparative performance from previous quarters.

Overall Effectiveness and Highlights

Optum Idaho monitors performance measures as part of our Outcomes Management and Quality Improvement Work Plan. An Outcomes Analysis, a new section included in this report, highlights member outcomes. In Quarter 4, 2015, thirty (30) 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 27 (90%) 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.

Highlights of Optum's effectiveness in Quarter 4 include the following measures that exceeded their established target for performance in Quarter 4, 2015.

- Member Satisfaction (≥85%)
    - Optum Idaho continued to meet member satisfaction as indicated in the scores received in the most recent member satisfaction survey (Q2 2015). Member's rating of their overall experience has consistently exceeded the performance target of ≥85% since Q3, 2014 results -at 85.4%, to the latest results of 94.2%.
    - Member's experience with counseling or treatment increased from 91.9% during Q1, 2015, to 96.7% during Q2, 2015, a 5% increase.

- Member Services Call Standards
    - Optum Idaho again exceeded established performance call standards for member service calls during quarter 4.
        - The percent of calls answered within 30 seconds was met at 92.4% (goal: ≥80% of calls answered in 30 seconds).
        - The average speed of answer was met at 12.2 seconds (goal: ≤30 seconds).
        - Call abandonment rate was met at 1.3% (goal ≤3.5%).

- Customer Service (Provider) Call Standards
    - Optum Idaho again exceeded established performance call standards for customer service (provider) calls during quarter 4.
        - The percent of calls answered within 30 seconds was met at 98.9% (goal: ≥80% of calls answered in 30 seconds).
        - The average speed of answer was met at 1.4 seconds (goal: ≤30 seconds).
        - Call abandonment rate was met at 0.31% (goal ≤3.5%).

- Complaint Resolution Timeframes (Quality of Service 100% resolved within 10 days; Quality of Care 100% resolved within 30 days)
    - Complaint resolution turnaround time has been met for both quality of service and quality of care complaints during 2015.
        - Quality of Service Complaints again met resolution turnaround time at 100% during quarter 4.
        - Quality of Care complaints again met resolution turnaround time at 100% during quarter 4.

- Member Grievances (30 days to resolution)
    - During Q4, Optum Idaho received the fewest number of grievances for 2015. Optum continued to exceed the 30 day turnaround time for resolutions. Q4 resolution turnaround time improved from an average of 17 days in Q3 to an average of 10 days.

- Network Monitoring Audits (Overall audit score ≥85%)
    - A total of 287 audits were completed during 2015, which is an increase from 206 audits completed during 2014. During quarter 4, overall audit scores

were above the goal:

- Overall Initial Credentialing audit score was 95.1%
- Overall Recredentialing audit score was 98.4%
- Overall Ongoing Monitoring audit score was 88.5%
- Overall Quality of Care audit score was 94.7%

- Peer Review Audit Results – MD and PhD (≥88%)
  - Average peer review audit score for MD was 100.0% during Q4.
  - Average peer review audit score for PhD was 95.6% during Q4.

- Geographic Availability of Providers (100%)
  - Geographic availability of providers met performance standards at 99.9% in Area 1 (requires one provider within 30 miles for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties) and 99.8% in Area 2 (requires one provider within 45 miles for the remaining 41 counties not included in Area 1 – thirty-seven (37) remaining within the state of Idaho and 4 neighboring state counties)
  - Network Services reported that Tele psychiatry services have increased from 3 providers attesting to offering tele psychiatry services in 2014 to 33 providers who attested in 2015.

While Optum Idaho met goals in 27 key performance areas, the following 3 areas did not meet performance expectations:

- Written notification of Adverse Benefit Determination (100% sent within 1 business day)
  - Performance for this measure reached 97.9%, slightly below the goal of 100% sent within 1 business day.

- Service Authorization Requests completed within 14 days (100%)
  - Performance for this measure reached 99.0%, slightly below the goal of 100% completed within 14 days.

- Overall Provider Satisfaction (≥85.0%)
  - Overall provider satisfaction reached 65.0% which was an increase from 64.0% in Q3 but still well below the goal of ≥85.0%. Optum Idaho will continue to monitor and address the barriers to provider satisfaction and promote initiatives to improve the provider network experience.

In addition to the performance highlights above, Optum Idaho continues in its efforts to further community awareness of the behavioral health system and our work throughout Idaho.

In collaboration with the Division of Behavioral Health, the Treasure Valley YMCA and one of our participating network providers, Lifeways Inc., we developed a three-part holiday mental health awareness series that aired on KTVB-TV in November. The series highlighted potential holiday stressors and tips in managing through activities and celebrations common with the holidays.

Optum Idaho also partnered with several community-based organizations in Quarter 4 including Tom's Turkey Drive in North Idaho and KTVB's Seven Care Days that contributed to ten local

and regional charities. As part of this effort, we partnered with one of our network provider agencies in Southern Idaho, ProActive Behavioral Health, on a food drive for local residents. Additionally, when the staff at Optum Idaho's Meridian Office was made aware of possible NAMI funding shortfalls in North Idaho, they were compelled to act. A local Optum staff member and gardener put his garden harvest surplus to good use by establishing an intra-office farmers market. The farmers market caught on with the local staff and even outside community members, raising $540 in which Optum matched in so we could assist both NAMI Far North and NAMI Coeur d'Alene.

At Optum, we take pride in our commitment to engage in a meaningful way within the communities where we live and work. Throughout the year – but particularly during the holiday season – we are keenly aware of the needs of our neighbors. Together, with community partners, we strive to make our communities better; one person, one family, one community at a time. Every individual and every family has a unique road to wellness, health, and hope; just as every community has its own ways to support and assist the people who live there.

2015 Quality Performance Measures and Outcomes

Measure	Goal	January - March 2015	April - June 2015	July - September 2015	October - December 2015	Q4 Performance Status*
Member Satisfaction Survey Results						
Experience with Optum Idaho Staff and Referral Process	≥85.0%	**85.5%**	**85.8%**	Based on the Member Satisfaction Survey sampling methodology, Q3 & Q4 data is not yet available.		**met goal**
Experience with the Behavioral Health Provider Network	≥85.0%	**91.0%**	**91.6%**			**met goal**
Experience with Counseling or Treatment	≥85.0%	**91.9%**	**96.7%**			**met goal**
Overall Experience	≥85.0%	**92.2%**	**94.2%**			**met goal**
Provider Satisfaction Survey Results						
Overall Provider Satisfaction	≥85.0%	**63.0%**	**67.0%**	**64.0%**	**65.0%**	**did not meet goal**
Accessibility & Availability						
Idaho Behavioral Healthplan Membership						
Membership Numbers	NA	**282,058**	**286,394**	**287,120**	Due to claims lag, this data is not yet available.	**NA**
Utilizers (number of Medicaid members who used Idaho	NA	**28,632**	**28,870**	**27,928**		**NA**
Member Services Call Standards						
Total Number of Calls	NA	**1,206**	**1,122**	**1,094**	**1,416**	**NA**
Percent Answered within 30 seconds	≥80.0%	**92.4%**	**90.6%**	**88.5%**	**92.4%**	**met goal**
Average Speed of Answer (seconds)	≤30 Seconds	**12.1**	**12.0**	**14.1**	**12.2**	**met goal**
Abandonment Rate	≤3.5%	**1.8%**	**2.2%**	**2.2%**	**1.3%**	**met goal**
Customer Service (Provider						
Total Number of Calls	NA	**3,577**	**4,138**	**3,315**	**3,175**	**NA**
Percent Answered within 30	≥80.0%	**97.1%**	**94.6%**	**97.3%**	**98.9%**	**met goal**
Average Speed of Answer (seconds)	≤30 Seconds	**5**	**10**	**5.5**	**1.4**	**met goal**
Abandonment Rate	≤3.5%	**0.65%**	**1.11%**	**0.71%**	**0.31%**	**met goal**
Urgent and Non-Urgent Access Standards						
Urgent Appointment Wait Time (hours)	48 hours	**11.7**	**35.5**	**23.1**	**20.9**	**met goal**
Non-Urgent Appointment Wait Time (days)	10 days	**5.8**	**5.4**	**3.1**	**4.3**	**met goal**
Geographic Availability of Providers						
Area 1 - requires one provider within 30 miles for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties.	100.0%	**99.8%**	**99.7%**	**99.8%**	**99.9%**	**met goal**
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)	100.0%	**99.9%**	**99.9%**	**99.8%**	**99.8%**	**met goal**

Measure	Goal	January - March 2015	April - June 2015	July - September 2015	October - December 2015	Q4 Performance Status*
Member Protections and Safety						
Notification of Adverse Benefit Determinations						
Number of Adverse Benefit Determinations	NA	**417**	**523**	**462**	**477**	**NA**
Initial Verbal Notification on Same Day	100.0%	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**met goal**
Written Notification Sent within 1 Business Day	100.0%	**97.6%**	**98.6%**	**99.6%**	**97.9%**	**did not meet goal**
Grievances (appeal of adverse determination)						
Number of Grievances	NA	**26**	**29**	**21**	**16**	**NA**
Member Grievance Turnaround time	≤30 days	**9**	**10**	**17**	**10**	**met goal**
Complaint Resolution and Tracking						
Number of Quality of Service Complaints	NA	**35**	**40**	**21**	**26**	**NA**
Percent Quality of Service Resolved within Turnaround time	100% within ≤10 days	**97.0%**	**100.0%**	**100.0%**	**100.0%**	**met goal**
Number of Quality of Care Complaints	NA	**2**	**2**	**5**	**2**	**NA**
Percent Quality of Care Resolved within Turnaround time	≤30 days	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**met goal**
Critical Incidents						
Number of Critical Incidents Received	NA	**12**	**16**	**15**	**23**	**NA**
Percent Ad Hoc Reviews Completed within 5 business days from notification of incident	100.0%	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**met goal**
Response to Written Inquiries						
Percent Acknowledged ≤2 business days	100.0%	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**met goal**
Provider Monitoring and Relations						
Provider Quality Monitoring						
Number of Audits	NA	**66**	**69**	**76**	**76**	**NA**
Credentialing Audit (Percent overall score)	≥ 85.0%	**97.0%**	**97.3%**	**97.0%**	**95.1%**	**NA**
Recredentialing Audit (Percent overall score)	≥ 85.0%	**97.0%**	**95.3%**	**95.2%**	**98.4%**	**NA**
Ongoing Monitoring (Percent overall score)	≥ 85.0%	**91.0%**	**89.9%**	**91.0%**	**88.5%**	**NA**
Quality of Care (Percent overall score)	≥ 85.0%	**96.0%**	**90.5%**	**94.5%**	**94.7%**	**NA**
Percent of Audits that Required a Corrective Action Plan	NA	**12.1%**	**13.0%**	**22.4%**	**22.4%**	**NA**

Measure	Goal	January - March 2015	April - June 2015	July - September 2015	October - December 2015	Q4 Performance Status*
Coordination of Care Between Behavioral Health Provider and Primary Care Provider (PCP)						
Percent PCP is documented in member record	NA	**96.5%**	**86.5%**	**91.7%**	**97.0%**	**NA**
Percent documentation in member record that communication/ collaboration occurred betweem behavioral health provider and primary care provider	NA	**82.6%**	**74.2%**	**82.4%**	**78.7%**	**NA**
Provider Disputes						
Number of Provider Disputes	NA	**24**	**18**	**1**	**14**	**NA**
Average Number of Days to Resolve Provider Disputes	≤30 days	**16**	**2**	**8**	**7**	**met goal**
Utilization Management and Care Coordination						
Service Authorization Requests						
Percentage Determination Completed within 14 days	100%	**98.1%**	**99.1%**	**99.3%**	**99.0%**	**did not meet goal**
Field Care Coordination						
Total Referrals to FCCs	NA	**188**	**175**	**211**	**200**	**NA**
Average Number of Days Case Open to FCC	NA	**78.7**	**61.6**	**38.9**	**72.6**	**NA**
Peer-Review Audits						
PhD Peer Review Audit Results	≥ 88.0%	**93.0%**	**100.0%**	**100.0%**	**95.6%**	**met goal**
MD Peer Review Audit Results	≥ 88.0%	**100.0%**	**98.0%**	**100.0%**	**100.0%**	**met goal**
Inter-Rater Reliability						
Inter-Rater Reliabililty testing has been deferred until Q1 2016 due to role out of Clinical Model 2.1 in August, 2015.	NA	Completed Annually				**NA**
Claims						
Claims Paid within 30 Calendar Days	90.0%	**99.9%**	**99.9%**	**99.9%**	**99.9%**	**met goal**
Claims Paid within 90 Calendar Days	99.0%	**100.0%**	**99.9%**	**100.0%**	**100.0%**	**met goal**
Dollar Accuracy	99.0%	**99.9%**	**99.8%**	**100.0%**	**99.9%**	**met goal**
Procedural Accuracy	97.0%	**99.5%**	**99.7%**	**100.0%**	**99.7%**	**met goal**

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

Outcomes Analysis

There are multiple outcomes that Optum follows to assess the extent to which the IBHP benefits its members. These include measures of clinical symptoms and functional impairments, appropriateness of service delivery and fidelity to evidence-based practices, impact on hospital admissions/discharges and hospital readmissions, use of emergency room visits to address behavioral health needs, and timeliness to outpatient behavioral health care following hospital discharges.

ALERT 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)

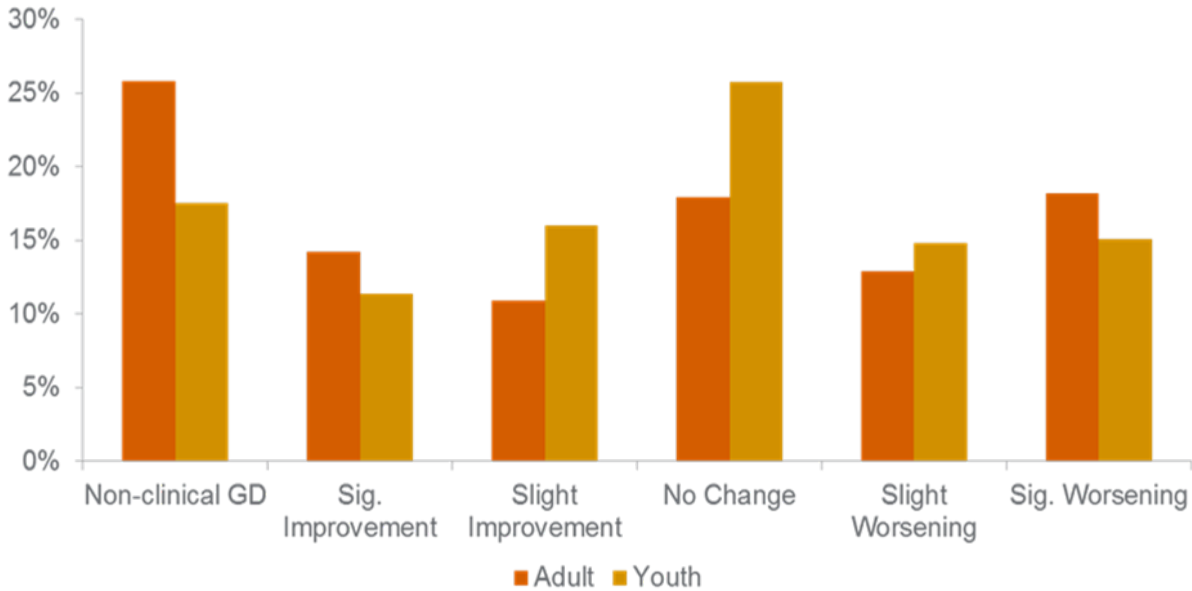


Fig. 1. Graph displays percentage of adults and youth who displayed improvement scores in different outcome categories.

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.

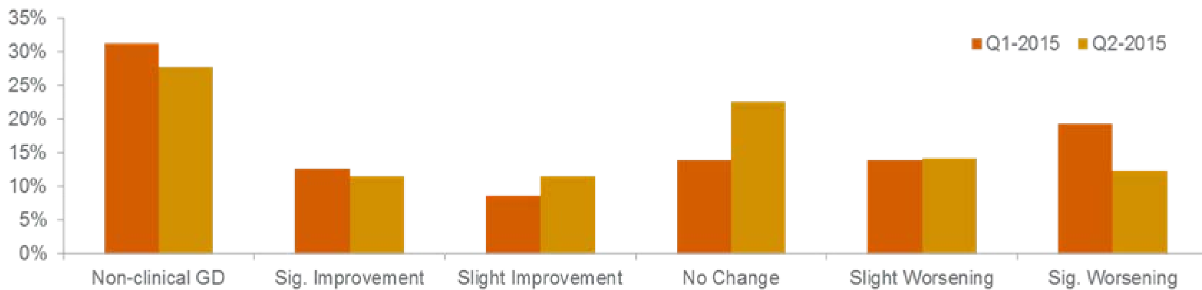
For comparison, responses to a national sample of Optum Idaho outcomes were compared to responses received from the national sample Medicaid members, excluding Optum Idaho, during the same measurement period. The national sample was comprised of 560 respondents to the Adult WA and 183 respondents to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

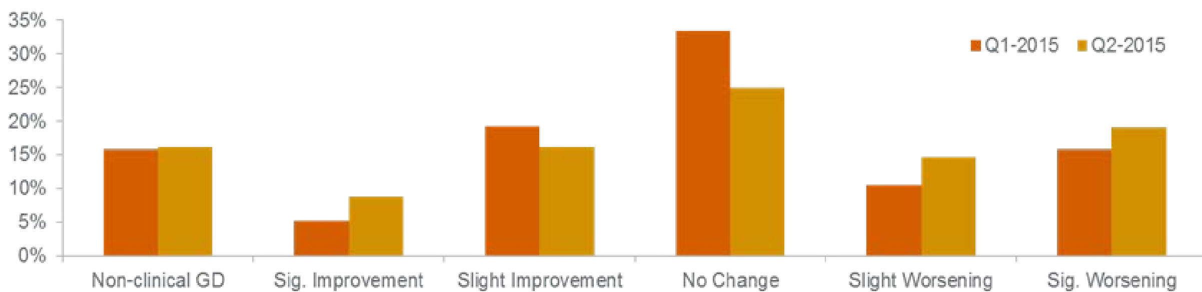


Fig. 2. Examination of changes in Global Distress Scores by adults and youth (0-17) by quarter

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)

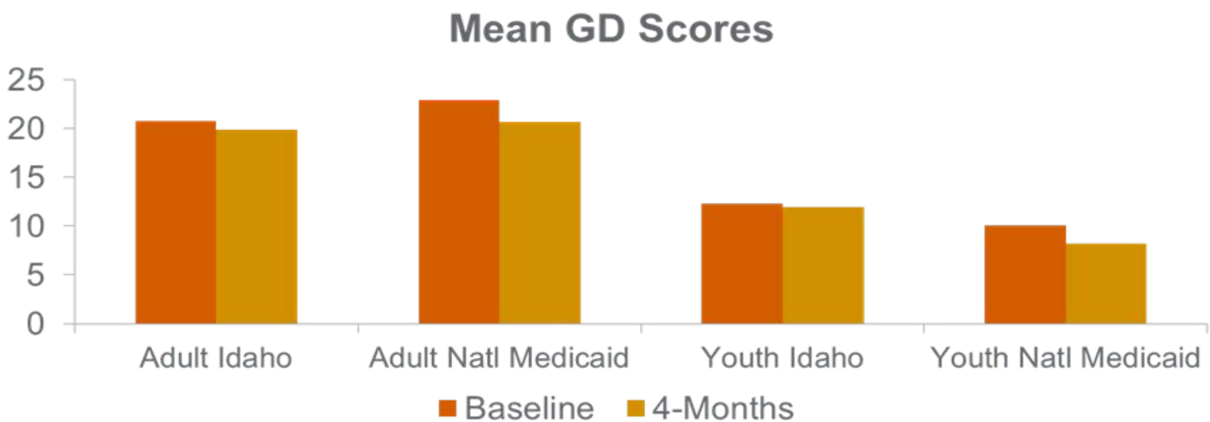


Fig. 3. Comparison of Global Distress Scores from Baseline to 4-months for Adults and Youth.

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 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.

Change in Mean Global Distress Scores by Quarter

	Adult			Youth		
	N	Baseline	4-Month	N	Baseline	4-Month
Q1 2014	**166**	**23.1**	**21.4**	75	12.2	13.1
Q2 2014	340	20.8	20.2	**167**	**12.6**	**11.3**
Q3 2014	227	20.4	19.4	103	11.8	11.4
Q4 2014	121	19.0	18.4	65	12.7	12.7
Q1 2015	150	19.3	19.2	57	12.3	12.2
Q2 2015	155	21.6	20.4	68	12.3	12.6

When further analyzed by quarter between Q1 2014 and Q2 2015, comparisons of baseline and 4-month scores show no significant change except for Q1 2014 for adults and Q2 2014 for children/youth. When seen, change was in the direction of less distress.

Caregiver Strain (Youth Only)

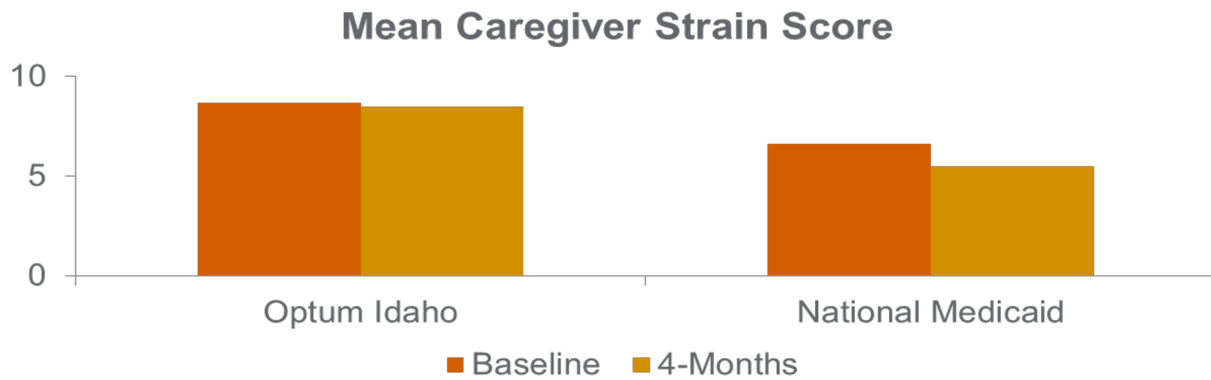


Fig. 4. Mean caregiver strain scores at baseline and at 4 months for both Optum Idaho and National Medicaid samples.

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

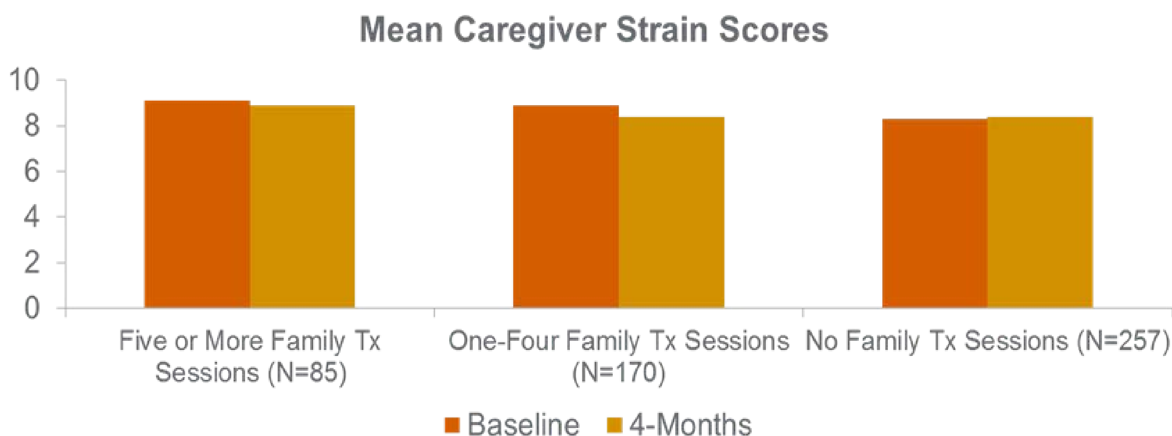


Fig. 5. Baseline and 4 month Caregiver Strain scores over study period Q1 2015 to Q2 2015.

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

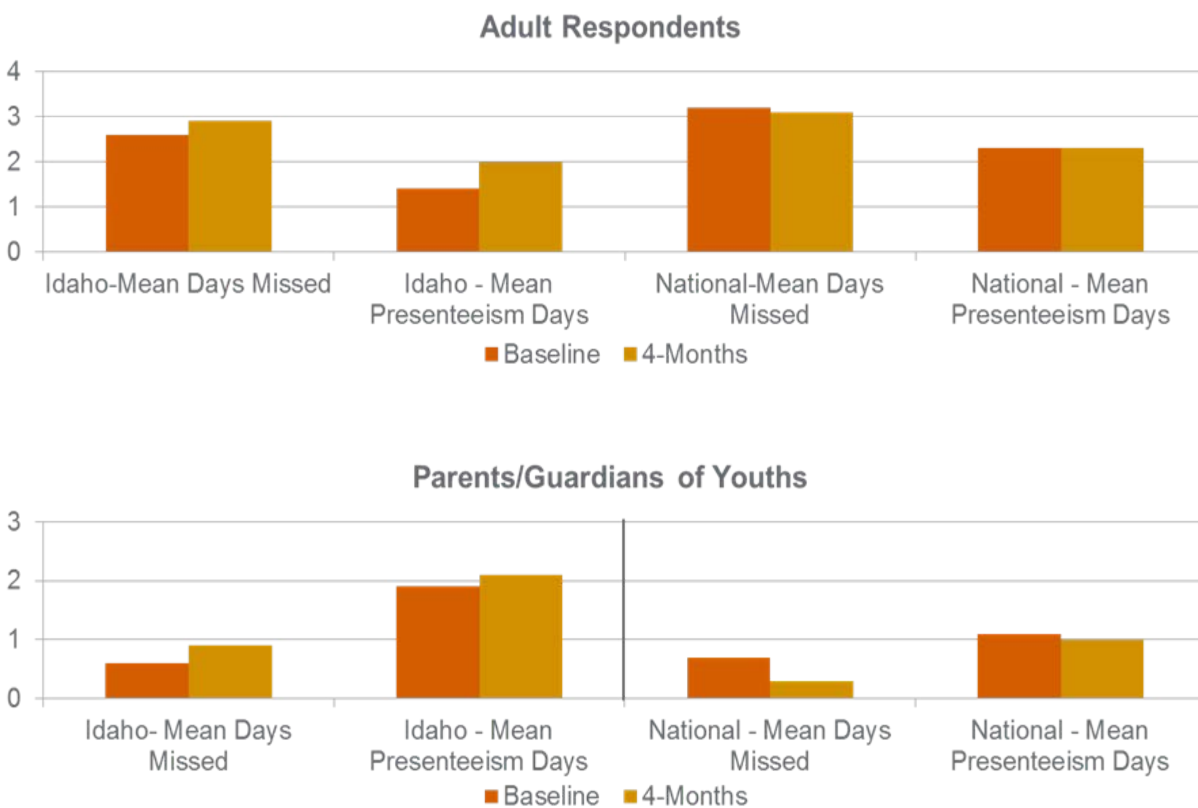


Fig. 6. Graphs taken from the most recent Idaho 4-month Outcomes report

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.

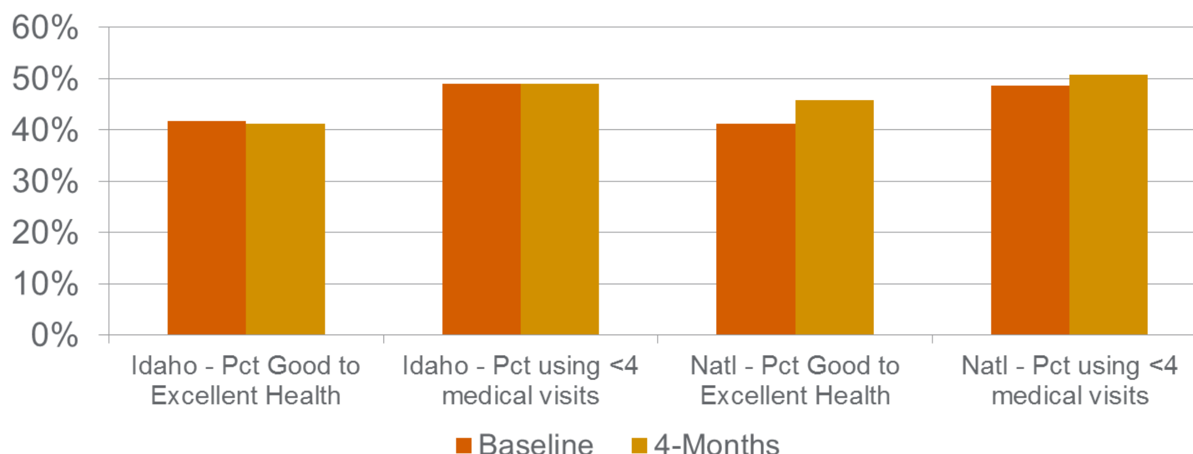


Fig. 7. Change in percentage of adults with health concerns between baseline and 4 months.

No significant change in health status or use of medical services was reported in 4-months by adult Idaho respondents with health concerns. This was also the case from Q1-2015 through Q2-2015. Similar non-significant results were evident in the national sample.

Barriers: Historical lack of knowledge about evidence-based treatments on part of members, family members, and some providers has resulted in poorer outcomes than expected or seen at other national Medicaid sites.

Opportunities and Interventions: Overall, there is a tendency for members in Idaho to have higher baseline scores for Global Distress and Caregiver Strain than is seen in similar Medicaid sites nationally. There is also a tendency to see less improvement than what is seen nationally. Both Global Distress and Caregiver Strain scores tend to show some improvement or no improvement but do not worsen for both adults and children/youth. Workplace impairment

scores worsen for both adults and children/youths, in contrast to the national pattern of improvement.

There are multiple possible reasons for the difference between Idaho's performance and that of similar national Medicaid sites. Due the long historical predominance of use of CBRS (psychosocial rehabilitation), the provider network may be behind national providers in accuracy of diagnoses, knowledge of national guidelines for clinical practice, differential application of appropriate evidence-based interventions corresponding to those diagnoses, and knowledge of what is entailed to deliver high-fidelity versions of evidence-based treatment in terms of both proper technique and frequency of sessions. There may also be underuse of medication options for both cultural reasons and limited knowledge of the value of medication for some diagnoses. Without additional information, specification of the relative role of any of these factors is hard to come by.

Opportunities for improvement lie in areas promoted by outcomes-driven care management. This approach focuses on members who are deteriorating or not improving as much as expected, applying more focus and care coordination/management activities on those cases. Examination of the clinical outcomes data for Global Distress finds a tendency for members who do not change to either worsen or improve. Those members who improve may not need additional resources to assist them. The match of member and provider is effective. For those members who are not improving or who are deteriorating, care coordination and care management to assist providers to achieve better outcomes is Optum's main strategic approach. Optum's use of Field Care Coordinators, Care Advocates, and Peer Reviewers (Medical Directors) are all methods for supporting providers to modify treatment plans in search of better clinical results.

Training of providers to improve diagnostic practices, including use of psychological testing and psychiatric evaluation, is one opportunity. Another opportunity is to educate providers and members/family members about appropriate evidence-based practices recommended in national guidelines for clinical practice, including those from the American Psychiatric Association and the American Association of Child and Adolescent Psychiatrists. Optum has selected these guidelines due to both organizations being well respected national organizations representing providers who treat both adults and children, both maintaining robust, standardized processing incorporating reviews of the literature and expert consensus, both being recognized in the national guideline clearinghouse of the federal Agency for Healthcare Research and Quality, and both periodically updating their guidelines. Numerous studies have supported the use of evidence-based practice has producing superior outcomes compared to treatment as usual.

There are also issues that need further attention about the types of services being delivered. Historically, Idaho's Medicaid system has favored the use of CBRS (PSR) for treating both adults and children/youth with behavioral health issues. Optum's benefit structure has been designed to promote more frequent use of psychotherapeutic and substance use disorder services consistent with national guidelines for best practices. Providers are encouraged to offer evidence-based practices such as Individual Therapy, Family Therapy, and Group Therapy in quantities needed to meet the needs of members. Furthermore, members are allowed to use combinations of these therapies as long as they are medically necessary and appropriate for the diagnostic picture and clinical situation. In the section below, this report will examine the types of services utilized to see their appropriateness for the age-related groups who use them.

Another dimension includes the adequacy of the frequency of visits. Psychotherapy, particularly in the acute phase during which active symptoms and negative behaviors are brought under control, typically requires at least weekly attendance to be effective. Historically, before Optum, the benefit structure in Idaho supported limited visits independent of medical necessity. Both providers and members/family members face a learning curve to change their expectations of how often they need to participate in therapeutic services to expect a positive outcome.

There is also the issue of fidelity of therapeutic techniques that are appropriate for the specific clinical needs of members. As an example, one technique for Individual Therapy, Cognitive Behavioral Therapy, has been shown to be very effective for treatment of anxiety and depression, but for some disorders such as Post-traumatic Stress Disorder, the subtype of Individual Therapy called Trauma-Focused psychotherapy has been shown to be effective. Receiving Cognitive Behavioral Therapy that is not trauma-focused is not expected to work. For children and youth, disruptive behavior disorders require Family Therapy, but the type of Family Therapy most core to addressing those disorders is Parenting Skills Training. Use of other types of Family Therapy is not expected to show the same good results as can be obtained through Parenting Skills Training. Furthermore, performing Parenting Skills Training with fidelity to the standards of good technique is essential.

Finally, outcomes should be better the more widespread the practice becomes for Providers to encourage members and families to make use of the Wellness Assessment to provide feedback about how treatment is going and then making changes in treatment plan according to the result. Knowing that treatment is not going well can lead to early and potentially helpful changes in treatment. Knowing that treatment is going well can help providers, members, and families stay the course towards recovery.

Therefore, assisting providers to move practice toward sound diagnostics, correct matching of type of service to diagnosis, correct selection of evidence-based techniques for each service type, and providing sufficient amounts and frequency of therapies corresponding to the standards for proper implementation all can move clinical outcomes in a more positive direction.

Wellness Assessments

Methodology: An important part of population profiling when engaging in population health is to monitor the severity of symptoms and functional problems among those being treated. Over time, members become utilizers and others leave treatment. One concept for understanding population health as an outcome is to see whether utilizers as a group are getting healthier or sicker.

Use of the Wellness Assessment can provide useful information about the Idaho Behavioral Health Plan's member composition over time. Although all providers are required to ask members and families to complete a Wellness Assessment as Optum Idaho's primary clinical outcomes measure, not all members submit the completed instrument.

The following analysis looks at the averaged baseline Wellness Assessment scores at all Wellness Assessments completed during the first and/or second visits during a quarter. It then follows up by looking at the averaged Wellness Assessment scores for all instruments submitted for subsequent visits during that quarter. The "follow-up assessments" may or may not include

scores from the same members who completed the initial assessments in a quarter. Therefore, the following data should not be interpreted as showing before-and-after comparisons for individual members. There can be scores included for initial values that do not have corresponding follow-up scores. These are comparisons of average severity values for the population submitting Wellness Assessments during the first 2 weeks of service and those members who submit them at subsequent visits that occur during the specified quarter.

Fig 1. Analysis: For adults, initial assessments display a flat curve over the 6 quarters from Q3 2014 through Q4 2015. That is, as a whole the level of Global Distress among IBHP utilizers remains approximately the same over time. Of note, there is a consistent reduction in follow-up adult Global Distress scores compared to initial scores for the population in treatment, with scores remains within the Moderate severity range.

ADULT global distress scores are described as follows:

Total Score	Severity Level	Description
0-11	Low	Low level of distress (*below clinical cut-off score of 12*).
12-24	Moderate	The most common range of scores for clients initiating standard outpatient psychotherapy.
25-38	Severe	Approximately one in four clients has scores in this elevated range of distress.
39+	Very Severe	This level represents extremely high distress. Only 2% of clients typically present with scores in this range.

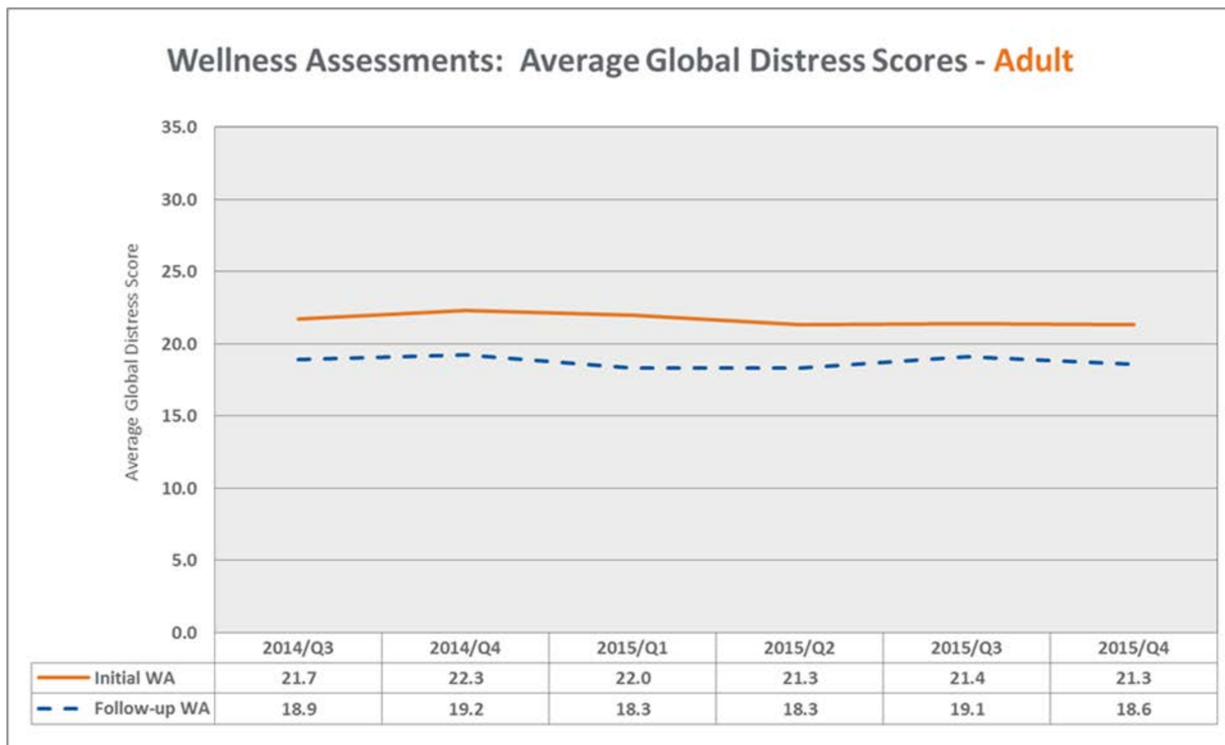


Fig. 1.

Fig. 2 Analysis: For children and youth, between Q3 2014 and Q4 2015, Global Distress scores have remained flat across time. When follow-up scores in the population are compared to initial scores, there is a barely discernible difference that may not be clinically significant.

YOUTH global distress scores are described as follows:

Total Score	Severity Level	Description
0-6	Low	Low level of distress *(below clinical cut-off score of 7)*
7-12	Moderate	The most common range of scores for clients initiating standard outpatient psychotherapy.
13-20	Severe	Approximately one in four clients has an initial score in this elevated range of distress.
21+	Very Severe	This level represents extremely high distress. Only 2% of clients typically present with scores in this range.

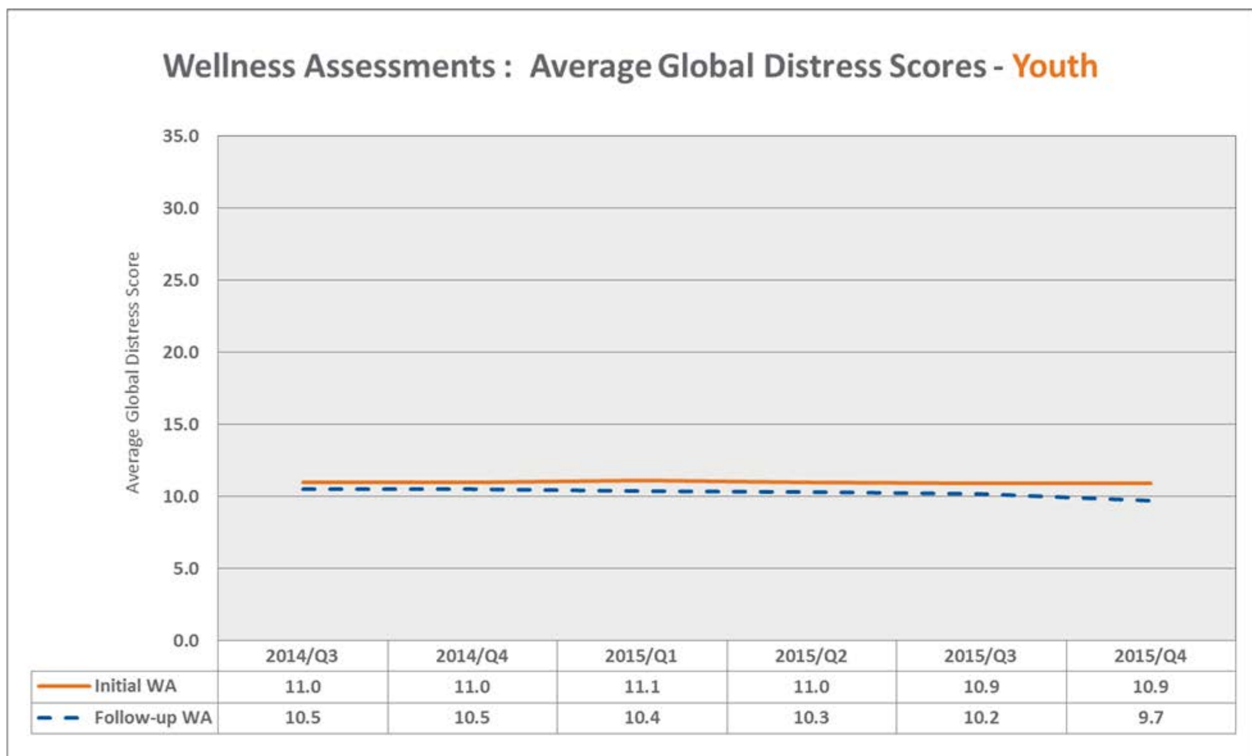


Fig. 2

Fig. 3 Analysis: For children and youth, between Q3 2014 and Q4 2015 average initial Caregiver Strain scores have decreased 5.7% over time. When follow-up scores in the population are compared to initial scores, over time the difference between initial and follow-up scores increased from 0.37 to 0.88, in favor of reduced severity. Of note, the greater reduction in child/youth caregiver strain score coincides with an increase in delivery of Family Therapy in the network. Notwithstanding the reduction in follow-up scores, severity levels remained in the moderate range through the study period.

Caregiver Strain Level Descriptions:

Score	Severity Level	Description
0-4	Low	No or mild strain *(below clinical cut-off score of 4.7)*
5-14	Moderate	The most common range of scores for caregivers with a child initiating outpatient psychotherapy.
15+	Severe	This level represents serious caregiver strain. Fewer than 10% of caregivers of children initiating outpatient psychotherapy report this level of strain.

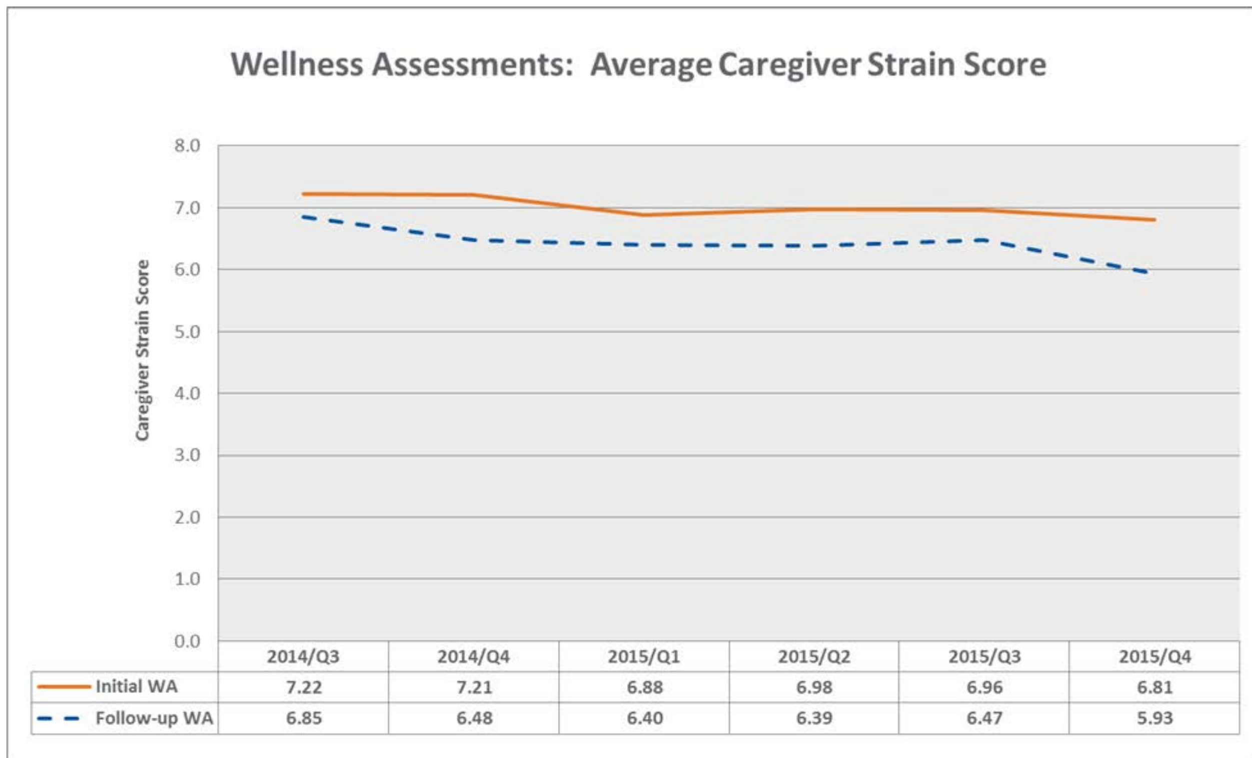
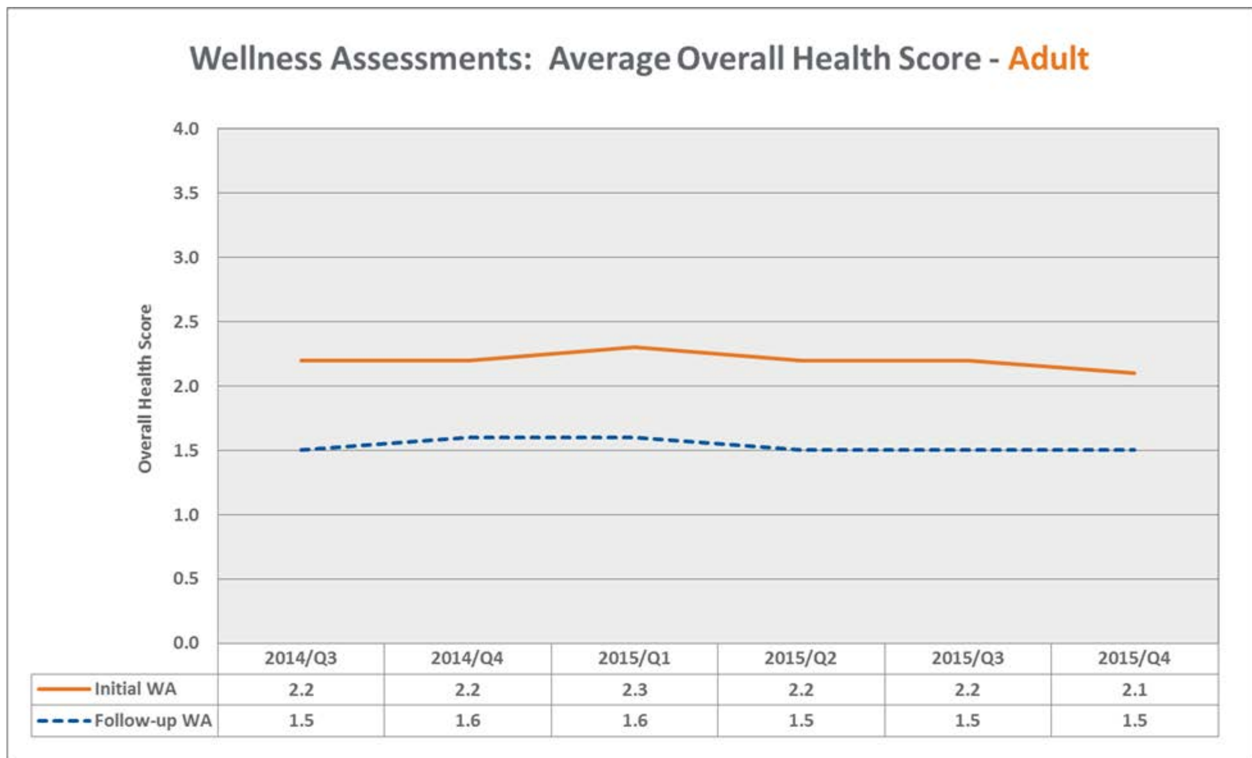


Fig. 3

Fig. 4 Analysis: Adult Physical Health score values are as follows: 0 = Excellent 1 = Very Good 2 = Good 3 = Fair 4 = Poor

Overall physical health status is an important predictor of risk. Outcomes for persons at higher risk due to coexisting physical health issues along with behavioral health problems tend to be worse. Between Q3 2014 and Q4 2015, adults at baseline on initial assessment showed a flat occurrence of physical health issues that varied between “fair” and “good.” On follow-up assessment for the same period, adults showed lower scores in the range between “good” and “very good.” These lower scores for the population remained in the same approximate range throughout the study period.

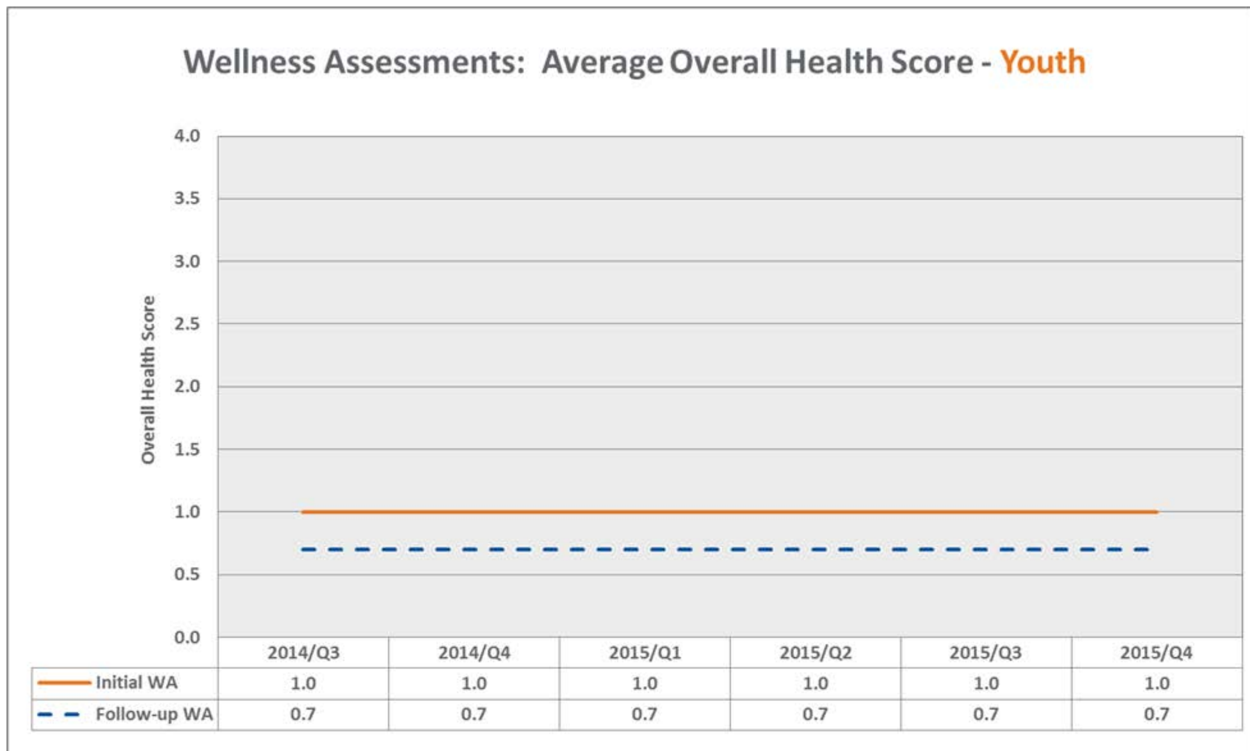


	2014/Q3	2014/Q4	2015/Q1	2015/Q2	2015/Q3	2015/Q4
Initial WA	2.2	2.2	2.3	2.2	2.2	2.1
Follow-up WA	1.5	1.6	1.6	1.5	1.5	1.5

Fig. 4

Fig. 5 Analysis: Child and Youth Physical Health score values are as follows: 0 = Excellent 1 = Very Good 2 = Good 3 = Fair 4 = Poor

Between Q3 2014 and Q4 2015, children and youth at baseline on initial assessment showed a flat occurrence of physical health issues that averaged “very good.” On follow-up assessment for the same period, children and youth showed lower scores in the range between “very good” and “excellent.” These lower scores for the population remained in the same approximate range throughout the study period.



	2014/Q3	2014/Q4	2015/Q1	2015/Q2	2015/Q3	2015/Q4
Initial WA	1.0	1.0	1.0	1.0	1.0	1.0
Follow-up WA	0.7	0.7	0.7	0.7	0.7	0.7

Fig. 5

Inpatient Utilization

Methodology: Data is obtained from IDHW and other community resources using hospital discharge data. A hospital stay is considered a readmission if the admission date occurred within 30-days of discharge from another hospital stay. This data displayed indicates the rate of hospital discharges per quarter. To control for an increase in IBHP members over this time frame, the data has been standardized by displaying the numbers per 1,000 members. This allows the rates in each quarter to be meaningfully compared.

Analysis: In general, a well performing outpatient behavioral health system is expected to keep members out of facility-based care such as psychiatric hospitals. Furthermore, when managing

a health population, managed care organizations need to monitor for possible negative unintended consequences. The need to monitor unintended consequences leads to knowing whether managed care initiatives result in increases in hospital admissions, readmissions, and emergency room visits. Worsening could theoretically be attributable to decreased authorization of CBRS, a service that has been popular despite lacking medical necessity (appropriateness) for childhood disorders. The following data tracks the actual rates of these events, as a type of outcome measure for the plan's operation as a whole.

Fig. 1: The overall rate of discharges (and correspondingly admissions, since without an admission there is no discharge), has decreased from 3.37 per 1,000 members to 2.97 per 1,000 members. This change represents an 11.9% decrease in hospitalizations.
Within age groups, for adults 21+, there has been a 14.4% decrease in hospital discharges, most of which occurred between Q3 and Q4 2014. Since Q4 2014, the hospitalization rate for adults has remained stable. For children and youth 0-17 years, there has been fluctuation in hospitalization rates, with a rise in Q4 2014 and Q1 2015 and a progressive decrease since. Between Q3 2014 and Q4 2015, there has been an 8% decrease in discharges for children and youth. For transitioning youth 18-20 years, hospital discharges have remained stable, with a decrease of 16% between the start and the end of the study's period. In summary, no age group has shown an increase in hospital discharges during the study period.

Fig. 2: During the study period from Q3 2014 through Q4 2015, discharges from the state hospitals remained stable. Discharges from community hospitals decreased 12.5%.

Fig. 3: From Q3 2014 to Q4 2015, based on information reported to Optum Idaho from hospitals, the overall average length of stay increased from 11.2 to 11.7 days, a 5% increase. When examined by age group, average lengths of stay for both children and youth and for adults 21+ remained fairly stable (increase of 3.9% for each) while there was an unexplained 28% increase in length of stay in Q2 2015 for the transitioning youth, 18-20.

Fig. 4: When average length of stay was examined by hospital type, state hospitals showed a decrease of 14.3%, predominantly between Q3 and Q4 2015. Community hospitals showed a gradual 14.9% increase during the study period.

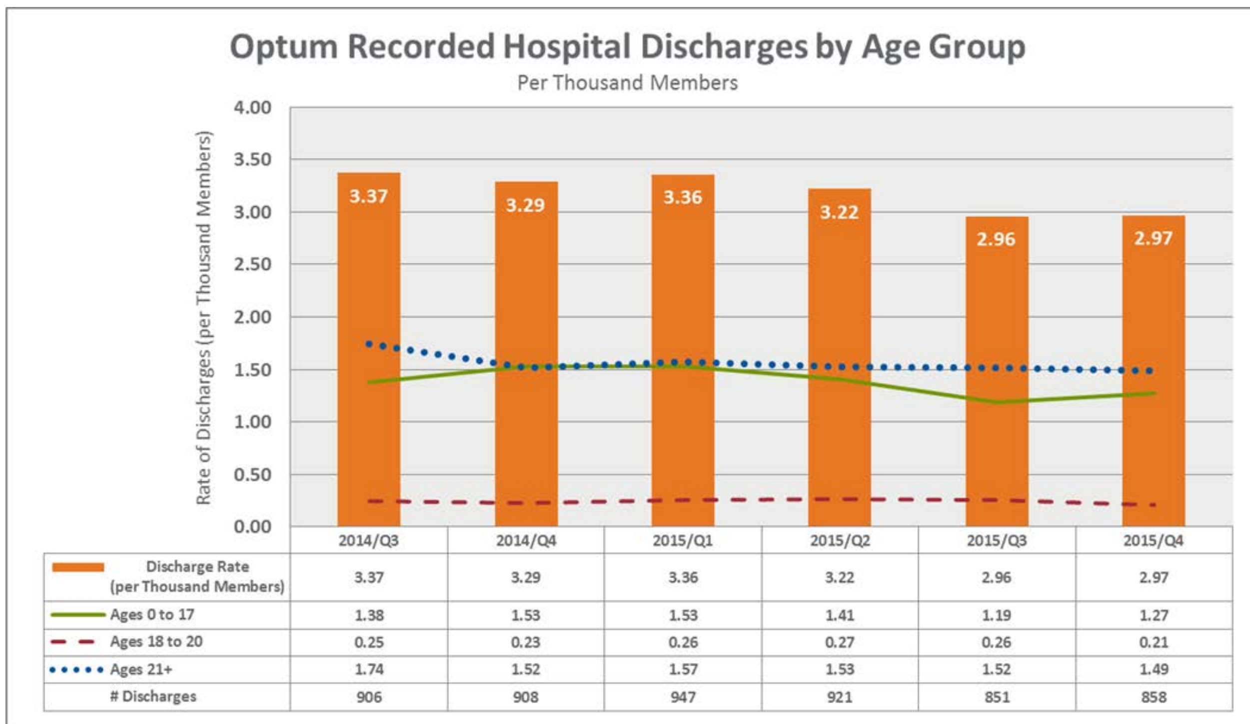
Fig. 5: According to HEDIS definition, a readmission to a hospital is counted for all persons aged 6 years and over and excludes transfers between hospitals. Overall psychiatric hospital readmissions within 30 days of discharge fluctuated by quarter. Starting at 11.6% in Q3 2014, the rate increased to a maximum of 13.1% in Q1 2015 and a nadir of 8.7% in Q4 2015. For overall readmissions during the study period, there was a reduction in readmissions of 25% between Q3 2014 and Q4 2015.

Because of possible seasonal fluctuations in hospital readmissions, the year-over-year changes between Q3 2014 and Q3 2015 and between Q4 2014 and Q4 2015 were examined. For Q3, readmission rates decreased 13.8% between 2014 and 2015. For Q4, readmission rates decreased 13.9% respectively. The overall finding is that for Q3 and Q4 2015, year-over-year hospital readmission rates decreased nearly 14% compared to prior year rates.

Within age groups, a similar pattern was seen for all groups, with readmission rates for 0-17, 18-20, and 21+ years reducing 21.5%, 20.0%, and 26.6% respectively between Q3 2014 and Q4 2015.

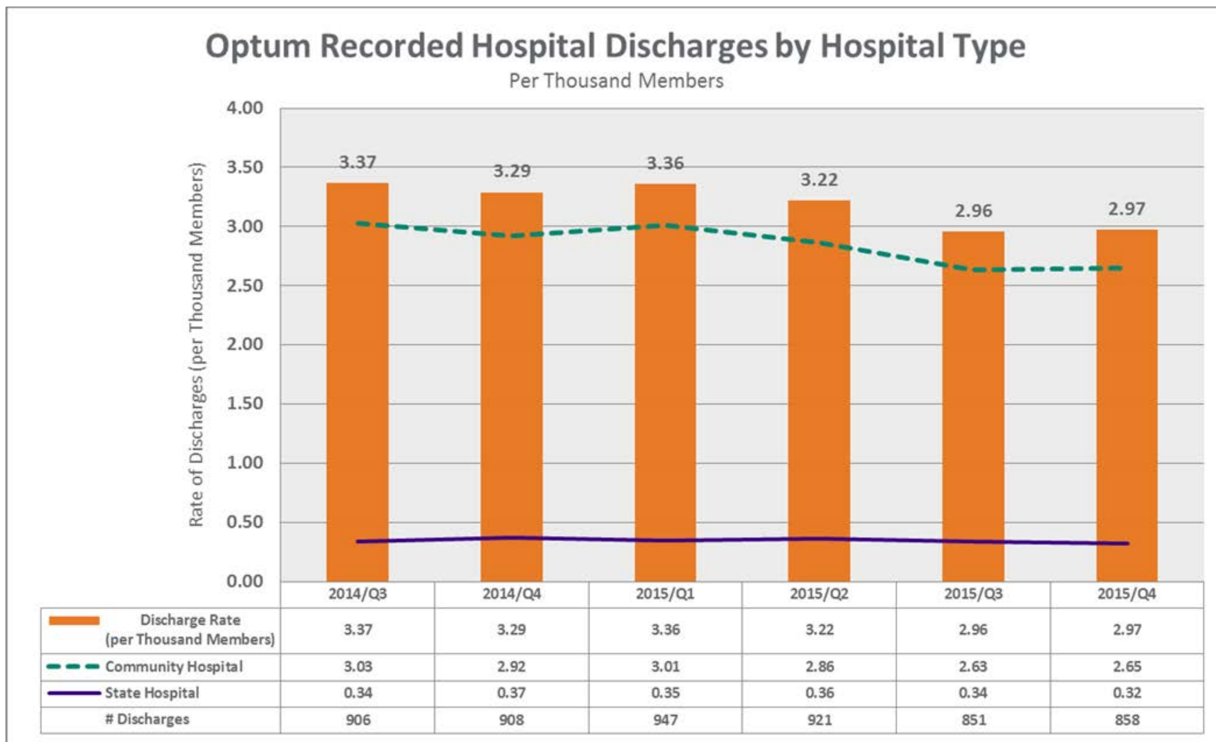
Fig. 6: When broken out by hospital type, the fluctuations in readmission rates per quarter can be accounted for by activity by the community hospitals. The mean readmission rate for the state hospitals amounted to 1.2% (range 1.1 to 1.3%) for the study period. The mean readmission rate for community hospitals was 9.7% (range 7.6 to 11.9%). Between Q3 2014 and Q4 2015, there was a reduction of 26% in community hospital readmission rates compared to 7% for state hospitals.

Fig. 7: One of the goals for care coordination that Optum Idaho promotes is improvement in the transition of members from inpatient to outpatient care, to support improved continuity of care. One of the measures for this is a HEDIS measure that examines the percentage of discharged members who are seen for an outpatient behavioral health visit within 7 days. Examination of 30 day outpatient visit attendance rates is also common. Examining attendance rates as percentages instead of raw numbers of appointments helps control for fluctuations in discharge rates from quarter to quarter. Between Q3 2014 and Q3 2015, the most recent quarter for which there is outpatient claims data outside the 90-day claims lag allowed for claims to be filed, there was an 8.4% reduction in visits occurring within 7days of discharge. There was a 4.1% reduction in visits occurring within the first 30 days after discharge. During the interim, no 7-day visit rate exceeded that seen in Q3 2014. The 30-day visit rate in Q1 2015 slightly exceeded the Q3 2014 rate. Notwithstanding addition in July 2014 of Field Care Coordinators and Community Transition Support Services to assist with the members at highest risk, no consistent positive impact appeared for post-stabilization visit rates.



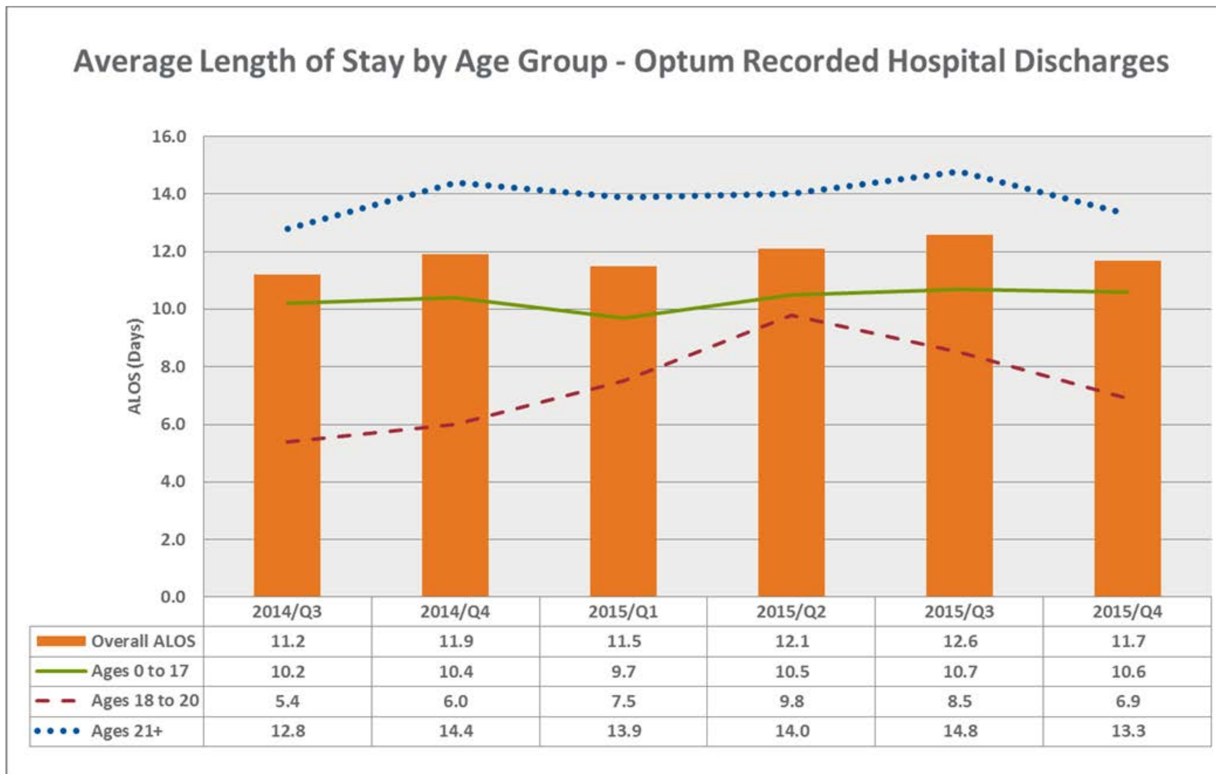
	2014/Q3	2014/Q4	2015/Q1	2015/Q2	2015/Q3	2015/Q4
Discharge Rate (per Thousand Members)	3.37	3.29	3.36	3.22	2.96	2.97
Ages 0 to 17	1.38	1.53	1.53	1.41	1.19	1.27
Ages 18 to 20	0.25	0.23	0.26	0.27	0.26	0.21
Ages 21+	1.74	1.52	1.57	1.53	1.52	1.49
# Discharges	906	908	947	921	851	858

Fig. 1



	2014/Q3	2014/Q4	2015/Q1	2015/Q2	2015/Q3	2015/Q4
Discharge Rate (per Thousand Members)	3.37	3.29	3.36	3.22	2.96	2.97
Community Hospital	3.03	2.92	3.01	2.86	2.63	2.65
State Hospital	0.34	0.37	0.35	0.36	0.34	0.32
# Discharges	906	908	947	921	851	858

Fig. 2



	2014/Q3	2014/Q4	2015/Q1	2015/Q2	2015/Q3	2015/Q4
Overall ALOS	11.2	11.9	11.5	12.1	12.6	11.7
Ages 0 to 17	10.2	10.4	9.7	10.5	10.7	10.6
Ages 18 to 20	5.4	6.0	7.5	9.8	8.5	6.9
Ages 21+	12.8	14.4	13.9	14.0	14.8	13.3

Fig. 3

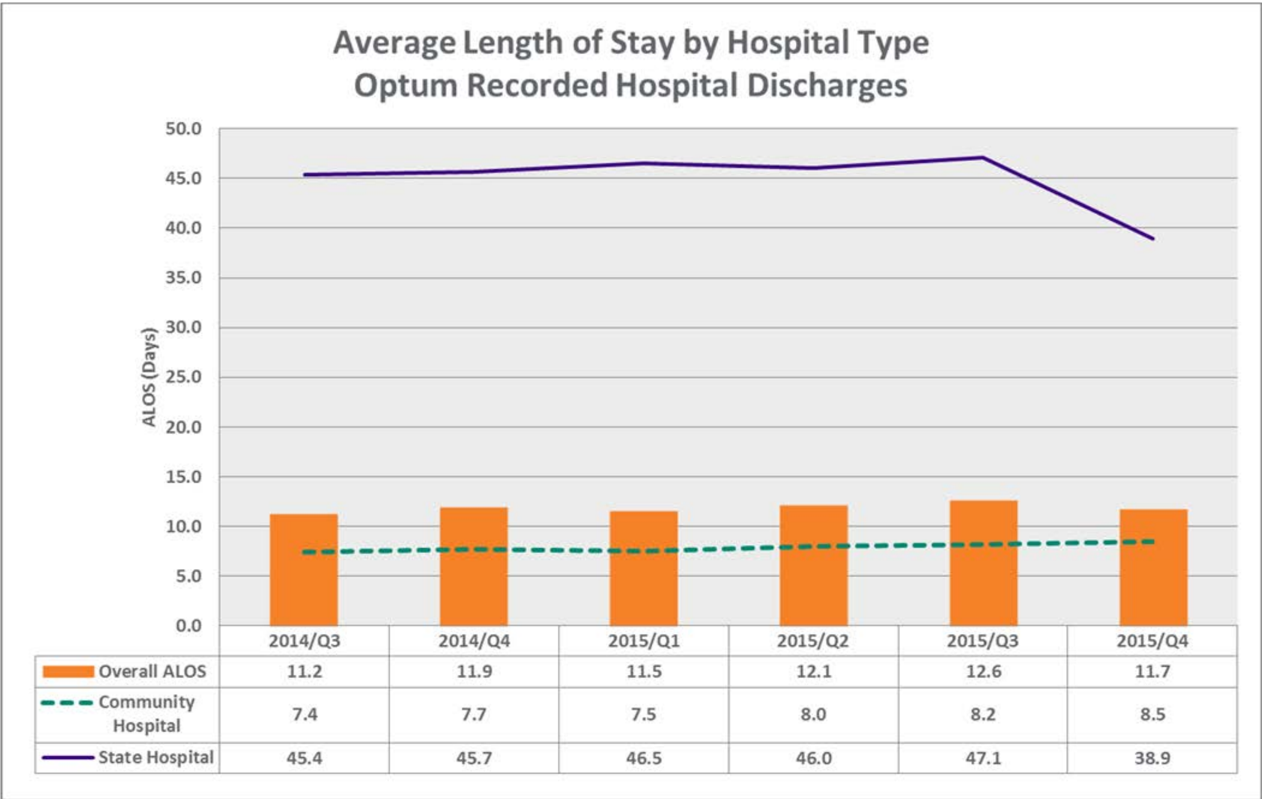
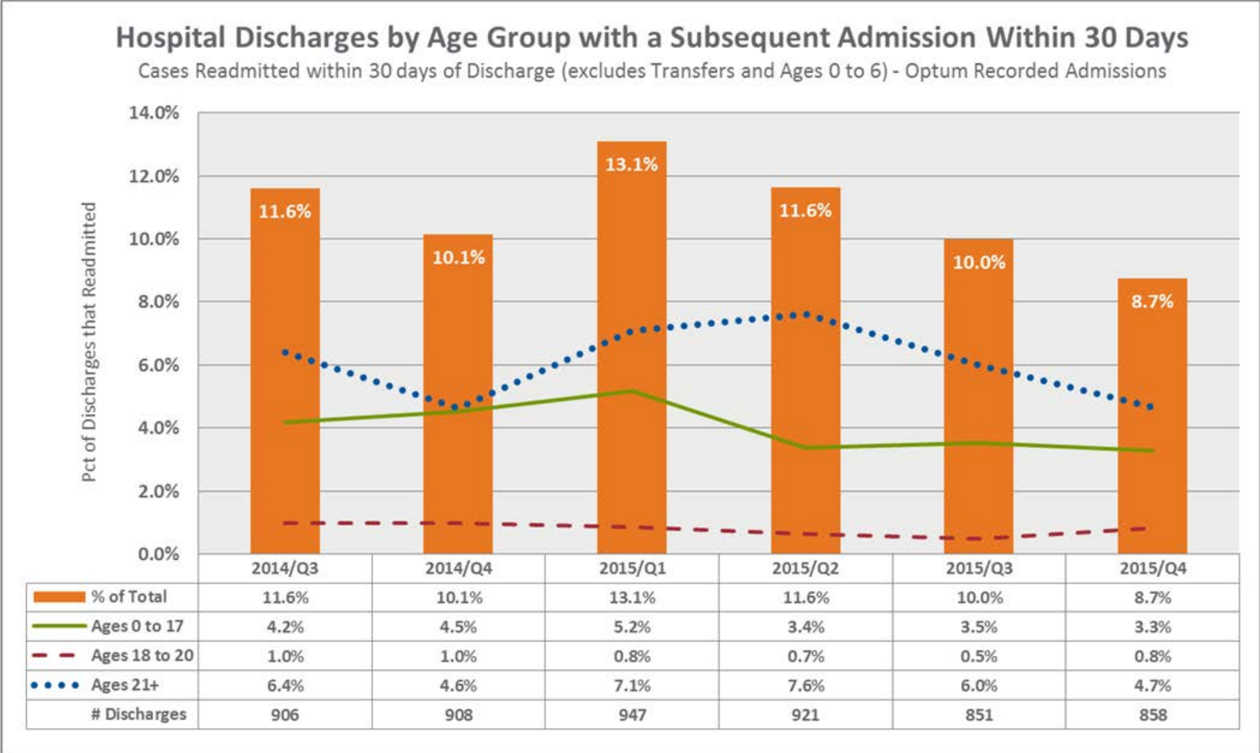
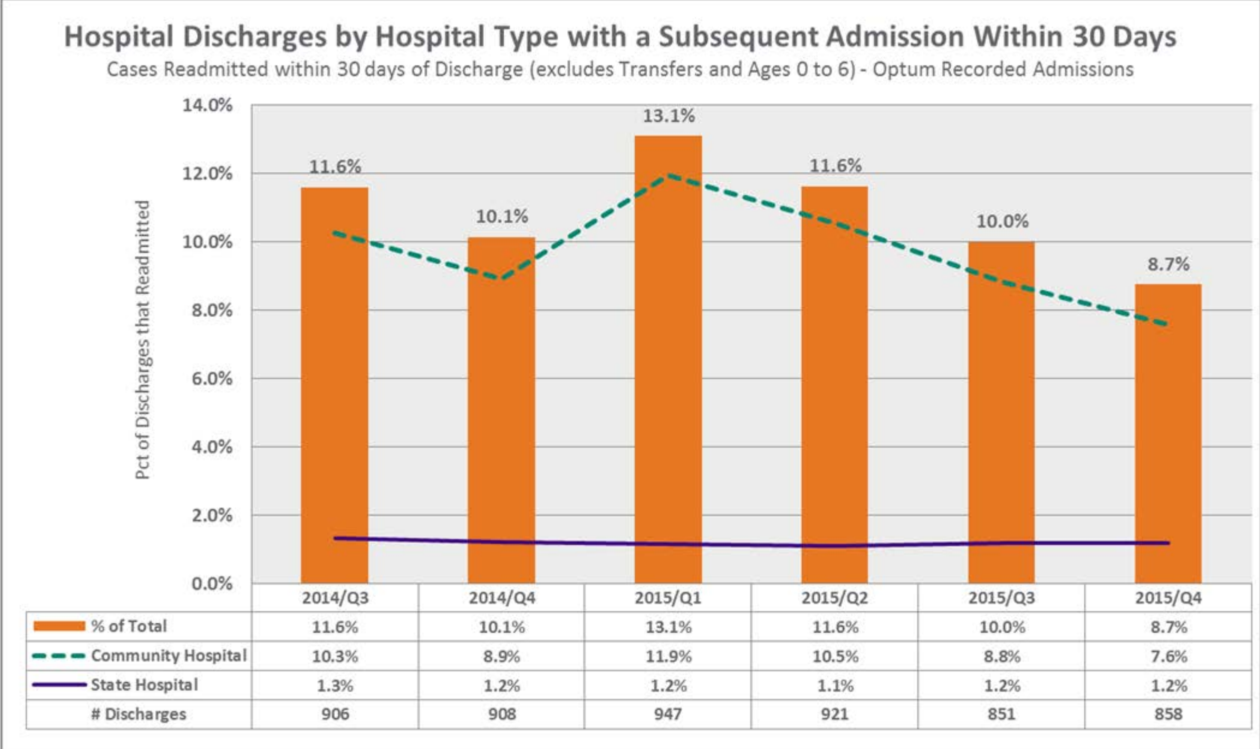


Fig. 4



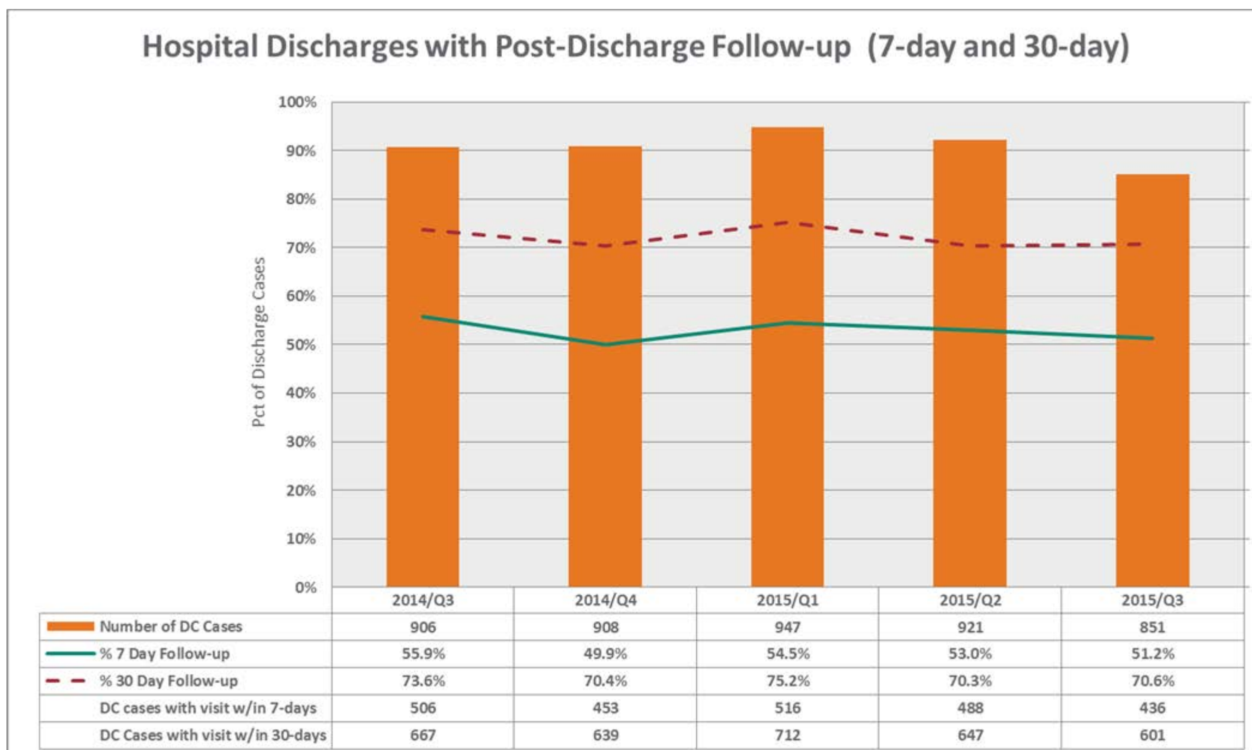
	2014/Q3	2014/Q4	2015/Q1	2015/Q2	2015/Q3	2015/Q4
% of Total	11.6%	10.1%	13.1%	11.6%	10.0%	8.7%
Ages 0 to 17	4.2%	4.5%	5.2%	3.4%	3.5%	3.3%
Ages 18 to 20	1.0%	1.0%	0.8%	0.7%	0.5%	0.8%
Ages 21+	6.4%	4.6%	7.1%	7.6%	6.0%	4.7%
# Discharges	906	908	947	921	851	858

Fig. 5



	2014/Q3	2014/Q4	2015/Q1	2015/Q2	2015/Q3	2015/Q4
% of Total	11.6%	10.1%	13.1%	11.6%	10.0%	8.7%
Community Hospital	10.3%	8.9%	11.9%	10.5%	8.8%	7.6%
State Hospital	1.3%	1.2%	1.2%	1.1%	1.2%	1.2%
# Discharges	906	908	947	921	851	858

Fig. 6



	2014/Q3	2014/Q4	2015/Q1	2015/Q2	2015/Q3
Number of DC Cases	906	908	947	921	851
% 7 Day Follow-up	55.9%	49.9%	54.5%	53.0%	51.2%
% 30 Day Follow-up	73.6%	70.4%	75.2%	70.3%	70.6%
DC cases with visit w/in 7-days	506	453	516	488	436
DC Cases with visit w/in 30-days	667	639	712	647	601

Fig. 7
Note: DC is an abbreviation for discharge.

Barriers: The historical responsibility for arranging post-discharge outpatient appointments for behavioral health services has rested with hospital discharge planners. Optum has an outpatient-only contract that results in our not managing hospitals or their staff or discharge planning. Hospital practices such as having the follow-up appointment "to be arranged by parent" or releasing patients after a very brief stay without an appointment set the stage for failed transfers of care.

Within the Optum Idaho care coordination system, discharge coordinators check to see whether a member has kept scheduled appointments but do not ensure and often are unable to ensure that there are scheduled appointments to keep due to hospitals' not releasing discharge information in a timely way.

Very few members have accepted Community Transition Support Services when offered. The practice of asking members whether they want a Peer Support Specialist to work with their Provider and themselves has not been fruitful. The target population for Community Transition Support Services is those members who have demonstrated difficulty following up with outpatient services when discharged from hospitals in the past. This target population is particularly difficult to serve due to the symptoms of the members' behavioral health disorders often interfering with willingness to receive services.

Opportunities and Interventions: Overall, there were favorable outcomes for hospital discharge rates and readmission rates for all age groups. Average lengths of stay decreased at the state hospitals but increased for community hospitals. Optum Idaho does not manage

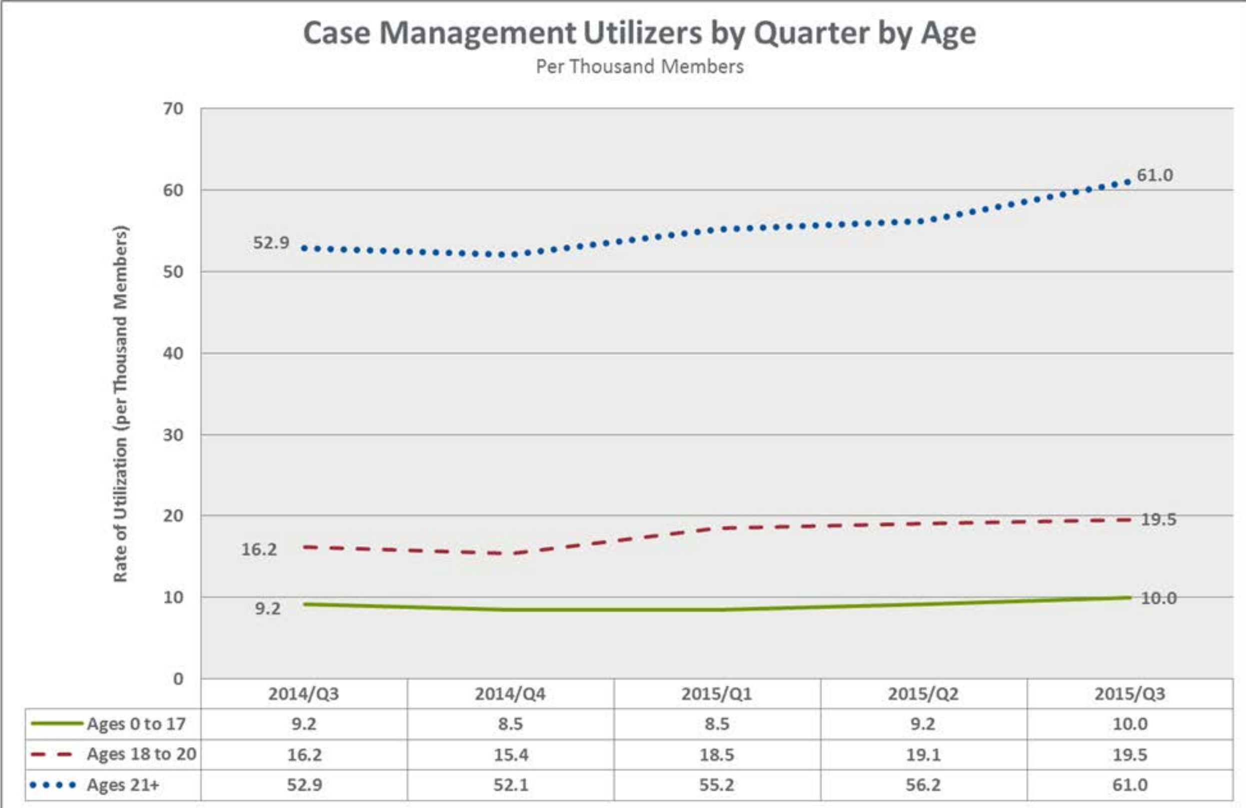
inpatient care, so the ability of outpatient services to better serve members and allow them to leave the hospital earlier is the only path available for reducing duration of inpatient stays. As outpatient services improve, the severity of illness of those who enter the hospital might worsen, making longer stays necessary. Desired improvement in timeliness of post-stabilization visits rates was not consistently seen for either 7-day or 30-day visits.
There are two main opportunities for further change remains to strengthen the capacity of outpatient services to keep members in community-based care. The first is an on-going pilot program first with the state hospitals and then community hospitals to use an Appointment Reminder Program for members and families. In this program, the hospital will enter information about scheduled aftercare appointments that Optum will use to electronically notify members or their families of an upcoming appointment visit. The second is a resetting of the Community Transition Support Service to help with post-discharge timeliness and overall treatment adherence.

Case Management Utilization Rates

Methodology: Utilization rates are based on claims data, thereby limiting the number of quarters that can be displayed. Reliable data requires waiting for the 90-day claims lag allowed providers to file claims.

The rate of utilization is calculated as follows:
Numerator is the number of unique utilizers of case management services for a specific quarter. Denominator is the total number of IBHP members for the same quarter, in thousands. The rate is derived by dividing the numerator by the denominator.

Analysis: Between Q3 2014 and Q3 2015, the last quarter for which reliable claims data is available, utilization rate of Case Management Services increased 16%. When broken out by age groups, the 0-17, 18-20, and 21+ year groups showed an increase of 9%, 20%, and 15%. Overall and independent of age, case management service utilization increased during the study period.



	2014/Q3	2014/Q4	2015/Q1	2015/Q2	2015/Q3
Ages 0 to 17	9.2	8.5	8.5	9.2	10.0
Ages 18 to 20	16.2	15.4	18.5	19.1	19.5
Ages 21+	52.9	52.1	55.2	56.2	61.0

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

Opportunities and Interventions: Although Case Management Services were changed in mid-August 2015 to a status that allows a predetermined number of case management hours before requiring clinical review, an increase in utilization of case management occurred prior to that change. As expected, case management utilization increased most for transitioning youth, who frequently need more assistance making arrangements for care and social services as their service needs increase approaching adulthood. Transitioning youth also need more education in how to locate and access services, as they approach adulthood. Children, who often have parents to make arrangements for medical and social services, as expected have needed fewer increases in case management utilization. No further changes are seen as needed for these groups and this service.

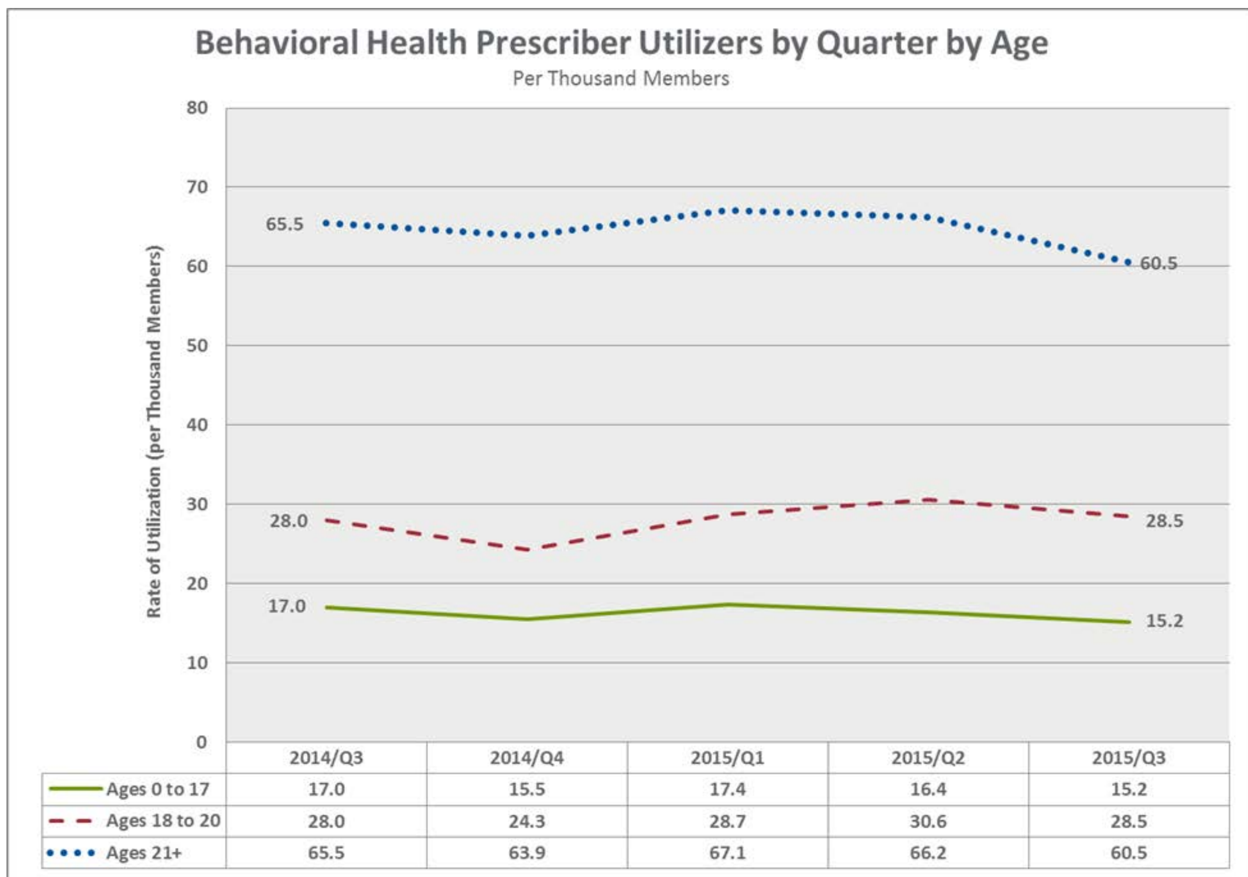
Prescriber Visit Utilization Rates

Methodology: Utilization rates are based on claims data, thereby limiting the number of quarters that can be displayed, since reliable data requires waiting for the 90-day claims lag allowed providers to file claims. Rate of utilization is calculated as follows:

Numerator is the number of unique utilizers of prescriber visits, i.e. medication management, to a behavioral health prescriber for a specific quarter.
Denominator is the total number of IBHP members for the same quarter, in thousands. The rate is derived by dividing the numerator by the denominator.

Analysis: Overall, the utilization rate for behavioral health prescription visits reduced by 5% between Q3 2014 and Q3 2015. Within age groups, 0-17, 18-20, and 21+ years, prescription visit rates decreased 5% for 0-17 year olds and 8% for 21+ years and over; rates increased by 1.8% for those 18-20 years old. From a high level perspective, the use of behavioral health prescribers changed little during the study period.

Utilization of prescriber visits is much greater for adults than for children. This pattern is appropriate in view of disability being a common eligibility requirement for adults to receive Medicaid in Idaho. The severity of their behavioral health conditions often requires medication management.



	2014/Q3	2014/Q4	2015/Q1	2015/Q2	2015/Q3
Ages 0 to 17	17.0	15.5	17.4	16.4	15.2
Ages 18 to 20	28.0	24.3	28.7	30.6	28.5
Ages 21+	65.5	63.9	67.1	66.2	60.5

Barriers: Members have a right to choose which prescriber to use among a wide choice of psychiatrists, psychiatric nurse practitioners, physician assistants, primary care providers, pediatricians, family nurse practitioners, and family physician assistants. At present, only data

for prescribers enrolled as network providers with the Idaho Behavioral Health Plan is available for analysis. The actual number of members receiving prescriptions from non-network providers may be substantial.

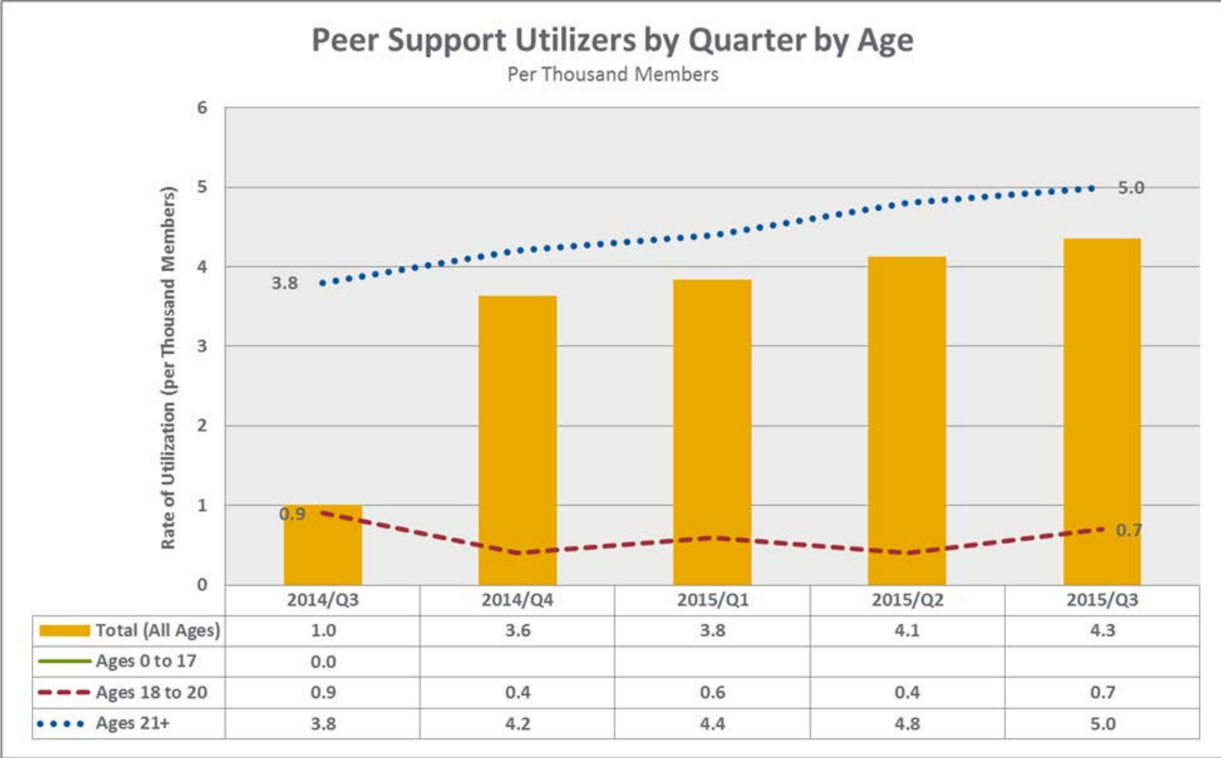
Opportunities and Interventions:
Further analysis is needed to clarify the penetration of prescription services for the utilizer population, including non-network prescribers with data from non-Optum sources. The issue of appropriateness of utilization would need further analysis by diagnostic groupings to see if those members with diagnoses that national guidelines for clinical practice indicate medication management is appropriate are receiving medication and prescriber visits.
Planning further system interventions will require more information.

Peer Support Utilization Rates

Methodology: Utilization rates are based on claims data, thereby limiting the number of quarters that can be displayed, since reliable data requires waiting for the 90-day claims lag allowed providers to file claims.

The rate of utilization is calculated as follows:
Numerator is the number of unique utilizers of Peer Support visits for a specific quarter.
Denominator is the total number of members 18 and over for the same quarter, in thousands.
The rate is derived by dividing the numerator by the denominator.

Analysis: Per Optum Idaho's Level of Care Guidelines, only members 18 years and over meet criteria for Peer Support Services. Overall, there has been limited change in utilization rates for Peer Support Services. When all members 18 and over are examined, the utilization rate for Peer Support has increased by 21% between Q3 2014 and Q3 2015. This increase can be attributed to the 21+ years group, since a 22% decrease has occurred for the 18-20 years group. The 21+ group has increased its utilization rate by 32%.



	2014/Q3	2014/Q4	2015/Q1	2015/Q2	2015/Q3
Total (All Ages)	1.0	3.6	3.8	4.1	4.3
Ages 0 to 17	0.0				
Ages 18 to 20	0.9	0.4	0.6	0.4	0.7
Ages 21+	3.8	4.2	4.4	4.8	5.0

Barriers: The chief barrier to utilization of peer support specialists has been the limited number certified by the State of Idaho. A separate barrier has been variation of provider agencies across the state in willingness to offer this service. There is also a very limited supply of Peer Support Specialists. Through Q3 2015, claims for 40 unique provider agencies have been filed. The lack of extensive historical experience with Peer Support for providers in the State of Idaho is also a likely interfering factor, since the benefits of using Peer Support are unfamiliar to many providers.

Opportunities and Interventions: Peer support is an evidence-based intervention that has demonstrated benefit for reducing hospital readmissions for persons with Serious Mental Illness and for reducing depressive symptoms. Optum Idaho favors increased utilization of this service, particularly in those groups for which the medical literature describes medical necessity, specifically members with Serious Mental Illness who have been hospitalized and those with depression who underutilization outpatient services.

Optum Idaho does not control the number of Peer Support Specialists who are trained and certified. Our span of control is limited to advising provider agencies how to use those certified specialists.

Optum Idaho has already made changes in the utilization management program to make authorization of Peer Support Services easier for providers. The reimbursement rate structure has, since go-live, been more attractive for providers than is case management and CBRS. Providers have received training about Peer Support Services and Recovery and Resiliency benefits through use of Peer Support. Continued efforts in these directions are being pursued.

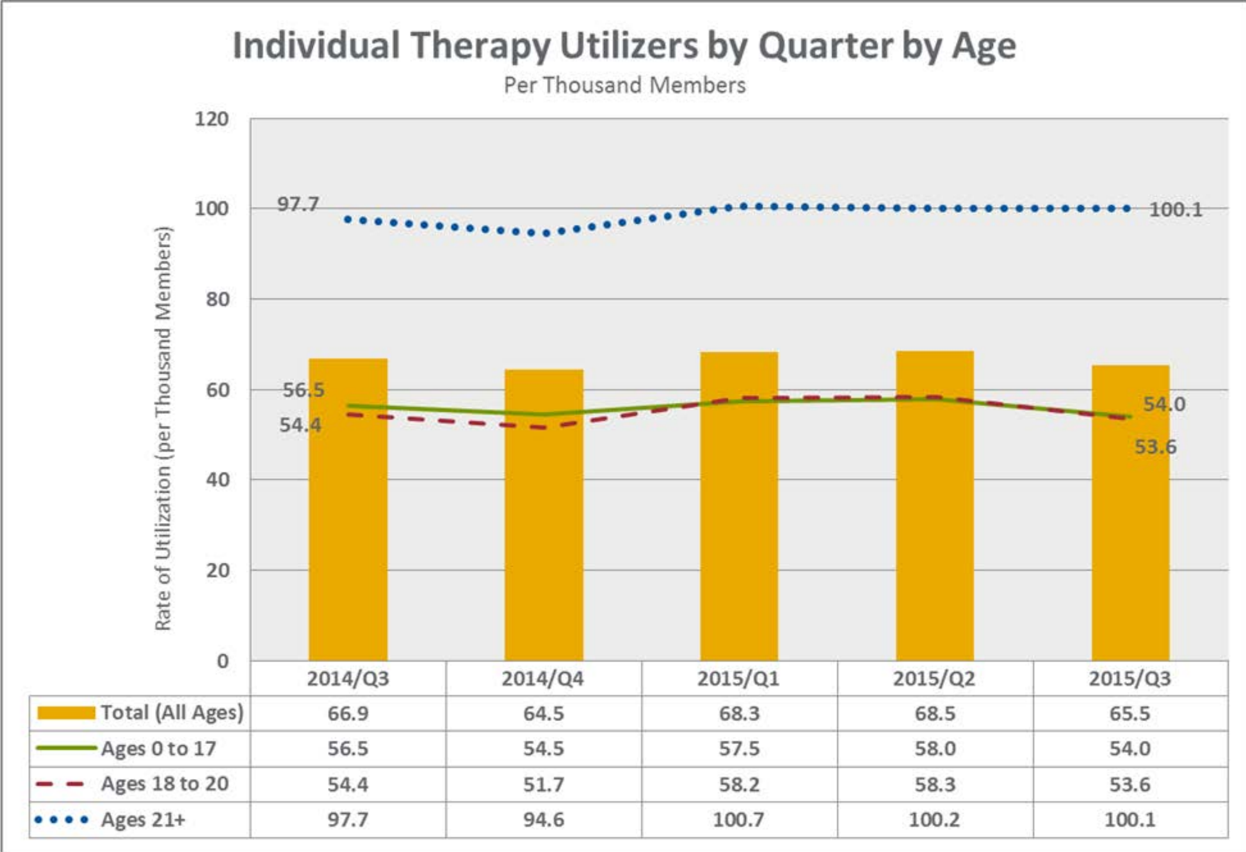
Individual Therapy Utilization Rates

Methodology: Utilization rates are based on claims data, thereby limiting the number of quarters that can be displayed. Reliable data requires waiting for the 90-day claims lag allowed providers to file claims.

The rate of utilization is calculated as follows:
Numerator is the number of unique utilizers of Individual and Extended Therapy visits for a specific quarter. Individual and Extended Therapy are combined due to both being one-to-one therapies of different duration.
Denominator is the total number of IBHP members for the same quarter, in thousands. The rate is derived by dividing the numerator by the denominator.

Analysis: Individual Therapy is important for many behavioral health disorders. Its appropriateness, however, can vary depending on the developmental age of a member. In general, according to the Treatment Guidelines of the American Psychiatric Association, Individual Therapy is an expected, evidence-based practice for adult mental disorders except for dementia. According to the Practice Parameters of the American Academy of Child and Adolescent Psychiatry, Individual Therapy is a central part of treatment in only some disorders, such as Post-Traumatic Stress Disorder, and in limited respects for others. For some disorders, for instance, Individual Therapy is limited to Problem-Solving Skills Training only for children of school age. In contrast to adults, family-based interventions are the most important and the most commonly expected for children and youth. As youth mature, their developmental capacity to use services comes to resemble the capacities of adults. It is expected, therefore, that there should be more adult utilizers of Individual Therapy than what would be seen with children, and that youth especially in the transitioning group aged 18-20 years should be intermediate.

Examination of the curves for the age groups 0-17 years, 18-20 years, and 21+ years, shows a clear predominance of utilizers of Individual Therapy in the adult group and many fewer for children and transitioning youth. In contrast to the expectation of more Individual Therapy for the transitioning youth group, it was found to nearly overlap child rates. In terms of utilizer rates, transitioning youth seem to be treated as though they are still children, at least with respect to use of Individual Therapy. Over the study period, there was very little change in utilizer rates for all age groups.

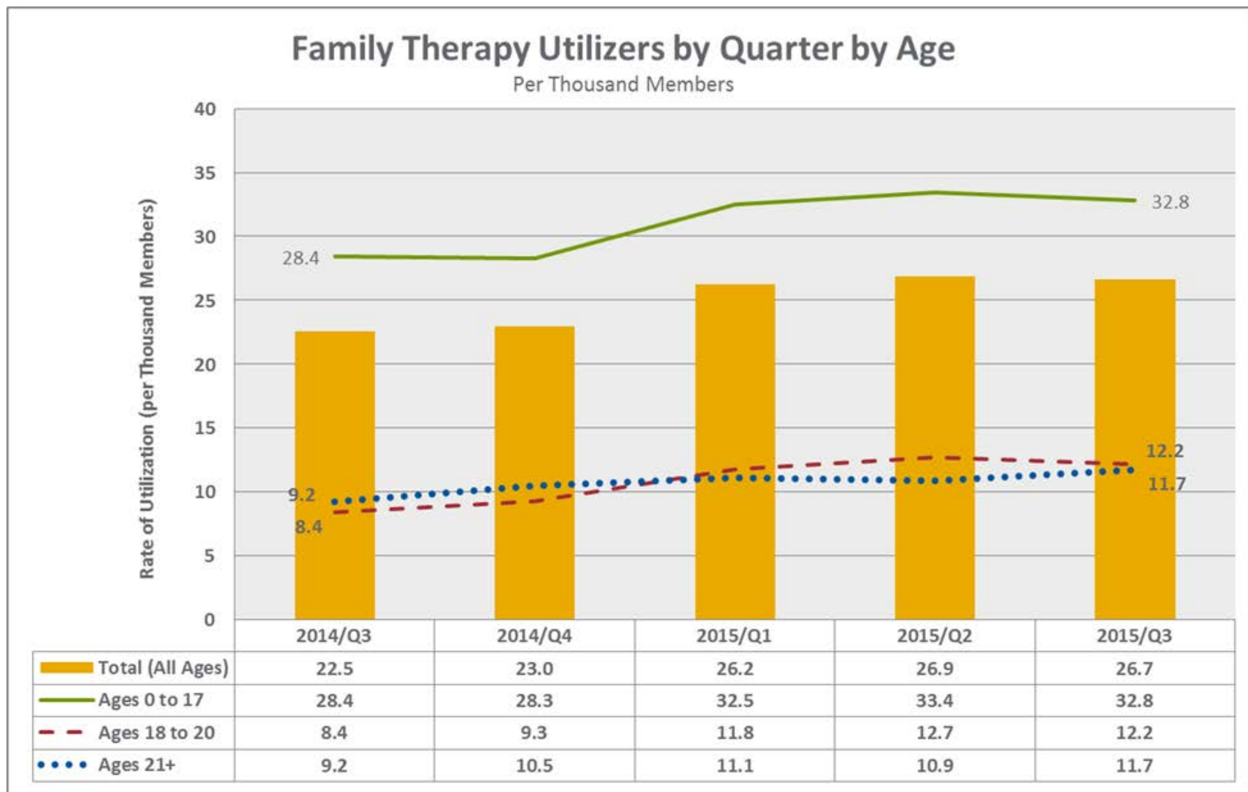


	2014/Q3	2014/Q4	2015/Q1	2015/Q2	2015/Q3
Total (All Ages)	66.9	64.5	68.3	68.5	65.5
Ages 0 to 17	56.5	54.5	57.5	58.0	54.0
Ages 18 to 20	54.4	51.7	58.2	58.3	53.6
Ages 21+	97.7	94.6	100.7	100.2	100.1

Family Therapy Utilization Rates

Methodology: Utilization rates are based on claims data, thereby limiting the number of quarters that can be displayed. Reliable data requires waiting for the 90-day claims lag allowed providers to file claims.
The rate of utilization is calculated as follows:
Numerator is the number of unique utilizers of Family Therapy visits for a specific quarter.
Denominator is the total number of IBHP members for the same quarter, in thousands. The rate is derived by dividing the numerator by the denominator.

Analysis: Over the past 5 quarters beginning Q3 2014 for which there are reliable claims data, there is an increase in the utilizer rates for Family Therapy for all age groups studies. The 0-17 year group increased 15.5%, the 18-20 year group 45.2%, and the adult 21+ year group 27.1%. As expected, despite the relatively large increase in utilizers of Family Therapy among 18-20 year-old members, an increase due to the low baseline level of utilizers in Q3 2014, there are for Q3 2015 approximately 2.75 times as many child utilizers as adult or transitioning youth utilizers. These findings suggest that the provider network is using Family Therapy predominantly for the appropriate age group.



	2014/Q3	2014/Q4	2015/Q1	2015/Q2	2015/Q3
Total (All Ages)	22.5	23.0	26.2	26.9	26.7
Ages 0 to 17	28.4	28.3	32.5	33.4	32.8
Ages 18 to 20	8.4	9.3	11.8	12.7	12.2
Ages 21+	9.2	10.5	11.1	10.9	11.7

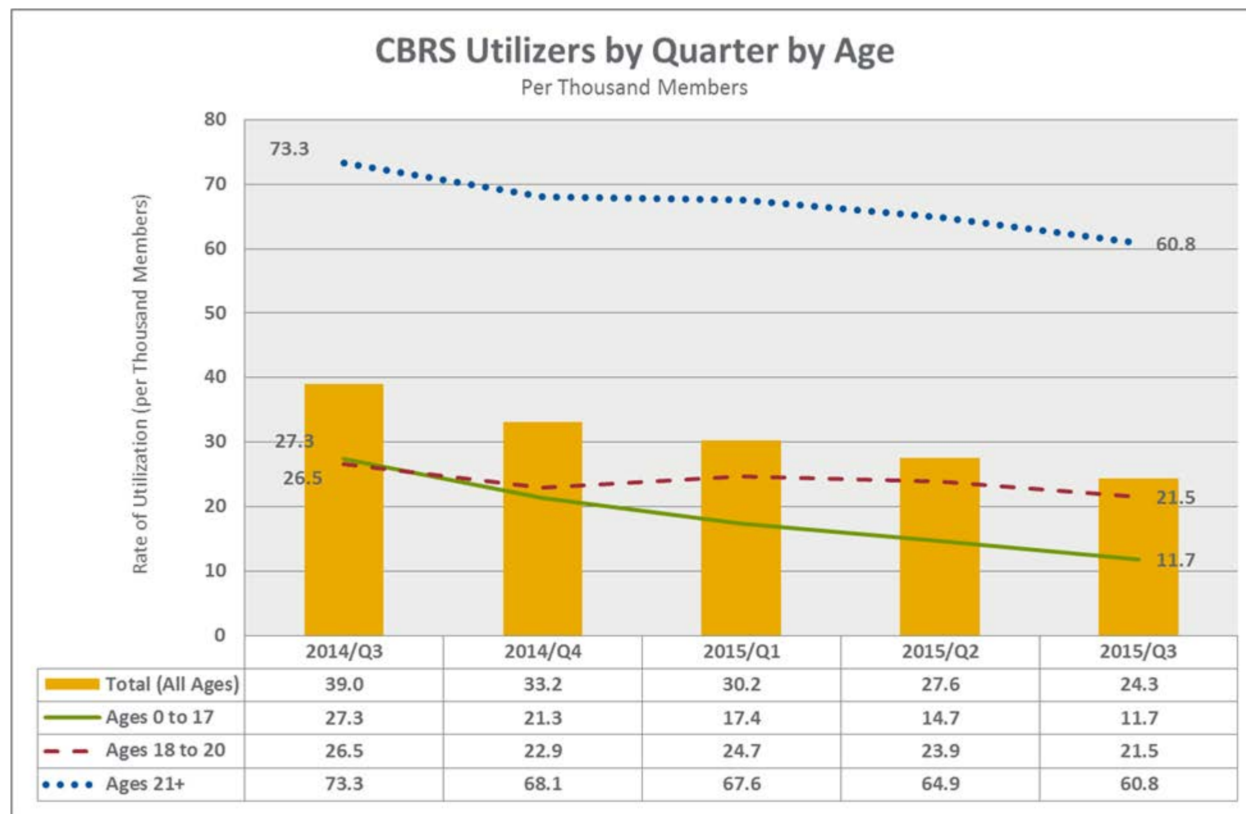
CBRS Utilization Rates

Methodology: Utilization rates are based on claims data, thereby limiting the number of quarters that can be displayed. Reliable data requires waiting for the 90-day claims lag allowed providers to file claims.
The rate of utilization is calculated as follows:
Numerator is the number of unique utilizers of CBRS visits for a specific quarter.

Analysis: CBRS, the IBHP's name for psychosocial rehabilitation services, is a set of rehabilitation services originally developed to better meet the functional needs of adults with schizophrenia and severe and persistent bipolar disorder. The only two diagnostic groupings that the Treatment Guidelines of the American Psychiatric Association recognize psychosocial rehabilitation as appropriate are those two diagnoses. The extension of use of techniques developed for adults with usually psychotic chronic conditions to children with very different conditions historically appeared in Idaho to the extent that CBRS was being used more with children/youth than with adults. Because the age of onset of schizophrenia and bipolar disorder has a modal distribution around the 18-20 year group, the use of more CBRS for transitioning youth would be expected than for children 0-17.

Between Q3 2014 and Q3 2015, one year's duration, the year-over-year reduction in CBRS for all age groups combined was 37.7%. All three age groups demonstrated a reduction in utilizer rates, with the 0-17 year group, the 18-20 year group, and the 21+ year group showing reductions of 57.1%, 18.9%, and 17.1% respectively. Although the study period began with a slight predominance of child over transitioning youth utilizers of CBRS, by the end of study period, adult utilizers predominated 5.2 times over child utilizers, and transitioning youth utilizers

predominating 1.8 times over child utilizers. These changes have resulted in a more appropriate use of CBRS for different age groups.



	2014/Q3	2014/Q4	2015/Q1	2015/Q2	2015/Q3
Total (All Ages)	39.0	33.2	30.2	27.6	24.3
Ages 0 to 17	27.3	21.3	17.4	14.7	11.7
Ages 18 to 20	26.5	22.9	24.7	23.9	21.5
Ages 21+	73.3	68.1	67.6	64.9	60.8

CBRS, Family Therapy, and Individual/Extended Therapy Utilization Rates

Methodology: Utilization rates are based on claims data, thereby limiting the number of quarters that can be displayed. Reliable data requires waiting for the 90-day claims lag allowed providers to file claims.

The rate of utilization is calculated as follows:

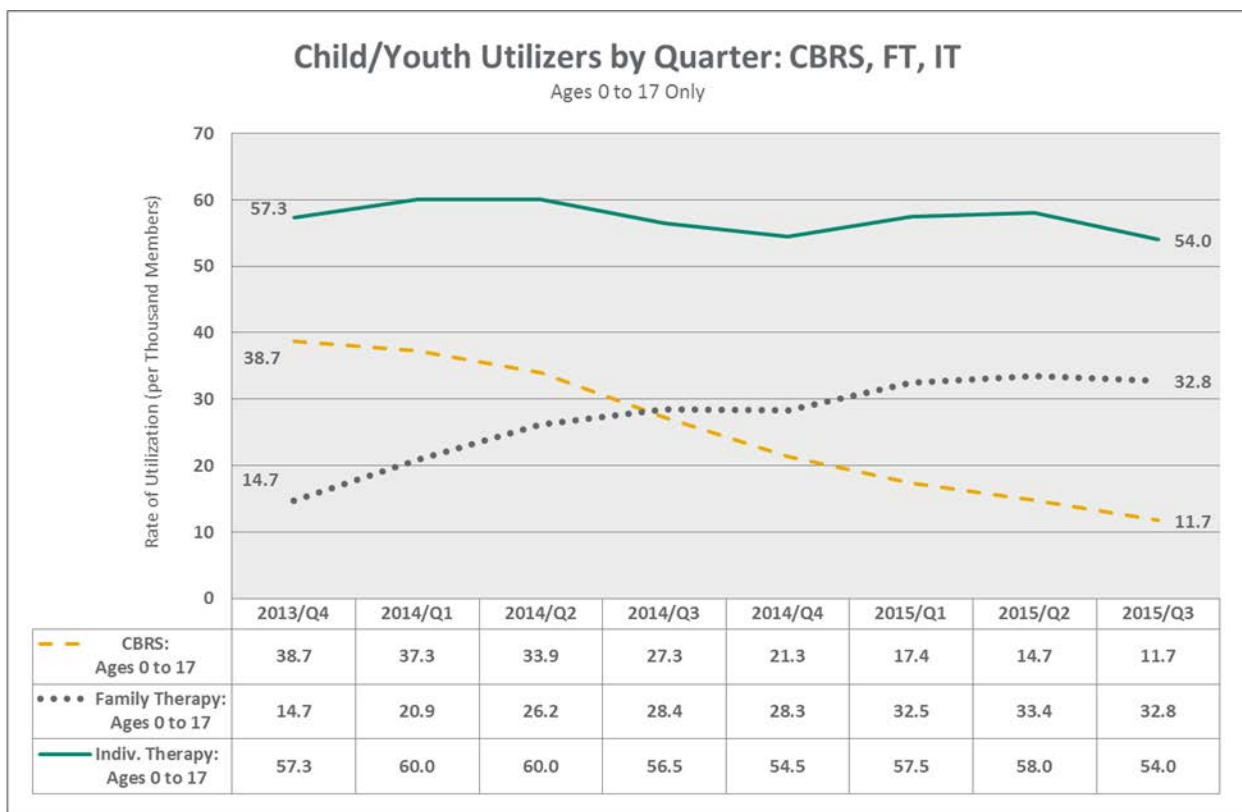
Numerator is the number of unique utilizers of CBRS, Family Therapy, or Individual/Extended Therapy for a specific quarter. For simplification, the utilizers of Individual and Extended Therapy, both 1-to-1 therapies, are combined under the name "IT" (Individual Therapies).

Denominator is the total number of IBHP members for the same quarter, in thousands. The rate is derived by dividing the numerator by the denominator.

Analysis: This graph combines the findings about utilizer rates for CBRS, Family Therapy, and the Individual Therapies in one graph. It begins in the first quarter in which Optum Idaho initiated utilization review, Q4 2013 and runs through Q3 2015, the most recent quarter in which reliable claims data is available. The wider scope of the study period for this representation is included to give the most informative overview over the changes in utilizer patterns for the past two years. Without this widened time scope, the true picture of system transformation in utilization cannot be properly appreciated. Future iterations of this report will not include this graph showing the entire change picture; it will only include on-going updates. For the child group 0-17 years, there is a reduction in utilizers of Individual Therapies of 5.8%. CBRS utilizer

rates have reduced 70.0%. And Family Therapy utilizer rates have increased 123%, or an increase of 2.23 times as in Q4 2013.

Viewed over the long term, utilizer rates for Family Therapy and CBRS have nearly switched places. Appropriate treatment planning for childhood disorders would display a greater use of Family Therapy than Individual Therapies, since Individual Therapy is expected to be an add-on treatment for most disorders, and Family Therapy the core treatment modality. The current pattern does not conform with this expected rate. The use of Individual Therapies still far exceeds the use of Family Therapy. There has been improvement over time. The ratio of Individual Therapies to Family Therapy (IT/FT) for Q4 2013 had been 3.9. For Q3 2015 the ratio was 1.6, a 59% reduction.

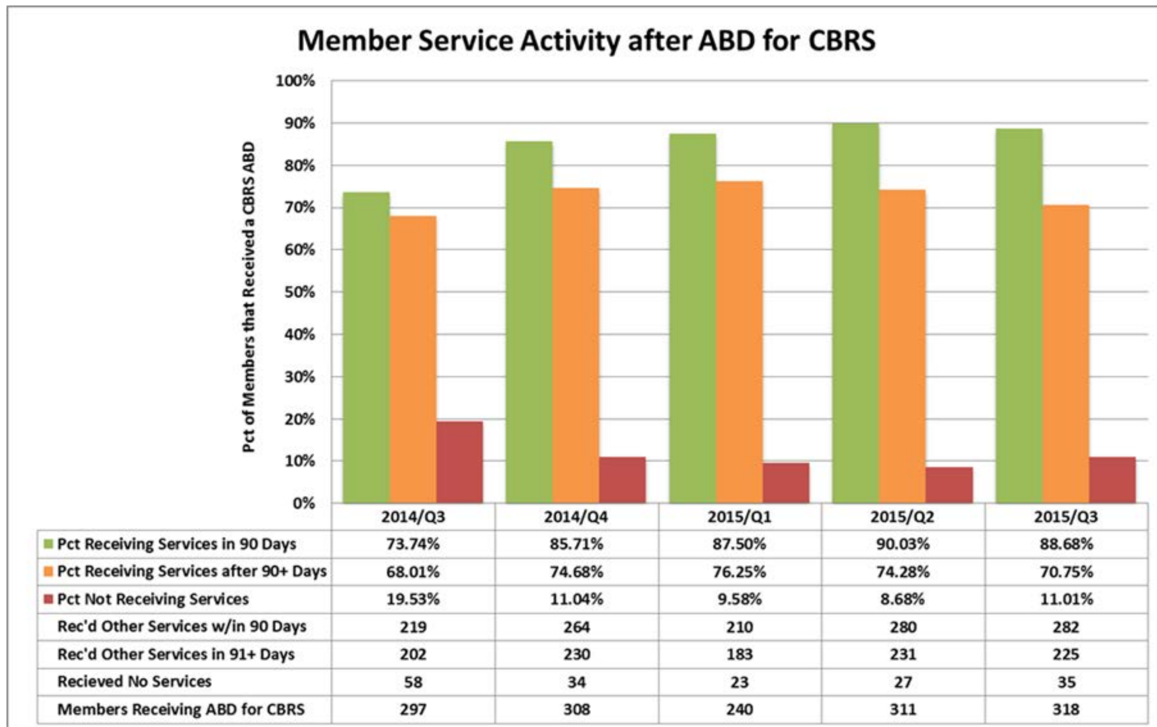


	2013/Q4	2014/Q1	2014/Q2	2014/Q3	2014/Q4	2015/Q1	2015/Q2	2015/Q3
CBRS: Ages 0 to 17	38.7	37.3	33.9	27.3	21.3	17.4	14.7	11.7
Family Therapy: Ages 0 to 17	14.7	20.9	26.2	28.4	28.3	32.5	33.4	32.8
Indiv. Therapy: Ages 0 to 17	57.3	60.0	60.0	56.5	54.5	57.5	58.0	54.0

Services Received Post CBRS Adverse Benefit Determination

Methodology: Based on Adverse Benefit Determination and Claims data. The design was to identify the final (or last) ABDs entered for requests for CBRS issued within a quarter between Q3 2014 and Q3 2015, the last quarter for which reliable claims data is available. Claims paid for treatment services (that is, medication management or psychotherapy) were then recorded as positive for both the period within 90 days of the ABD and then any following the 90-day period, to allow time for providers and members/families to shift into medically necessary care.

Analysis: Between Q3 2014 and Q3 2015, use of medically necessary services has increased following denials of authorization for CBRS. In Q3 2014, nearly 20% of members who had had CBRS authorization denied did not follow up with therapeutic services. Since Q4 2014, approximately 10% of members have not included therapeutic services in place of CBRS, a 50% reduction in under-utilizers. Since the first quarter of this study, in the first 90 days following the ABD, approximately 85-90% of members have received therapeutic services. Treatment continuation has been present in approximately 70-75% of members who have received ABDs. The overall pattern has been one of openness to acceptance of alternative services to CBRS, with an increasing acceptance over the study period. An unknown percentage of these members receiving “no services” may in fact be receiving medication from non-network prescribers that would not be reportable from Optum’s claims database.



	2014/Q3	2014/Q4	2015/Q1	2015/Q2	2015/Q3
Pct Receiving Services in 90 Days	73.74%	85.71%	87.50%	90.03%	88.68%
Pct Receiving Services after 90+ Days	68.01%	74.68%	76.25%	74.28%	70.75%
Pct Not Receiving Services	19.53%	11.04%	9.58%	8.68%	11.01%
Rec'd Other Services w/in 90 Days	219	264	210	280	282
Rec'd Other Services in 91+ Days	202	230	183	231	225
Recieved No Services	58	34	23	27	35
Members Receiving ABD for CBRS	297	308	240	311	318

Barriers: Historically, the Idaho Medicaid benefit before Optum limited access to all psychotherapies. Consequently, patterns of practice evolved that adapted to the benefit structure by favoring psychosocial rehabilitation over psychotherapy. And within the psychotherapies, Individual Therapy became favored, even though it was not the most important psychotherapy for most childhood disorders. Although progressively changing, limited provider familiarity with evidence-based therapies for children has constrained patterns of clinical practice consistent with national guidelines.

Opportunities and Interventions: The key to provider adoption of clinical practices consistent with national guidelines has been education and repeated work with providers to encourage trying new practices. Provider trainings on medical necessity, promotion of use of national guidelines form the American Psychiatric Association and American Academy of Child and Adolescent Psychiatry, care management contacts by Care Advocates, Field Care

Coordinators, and Medical Directors, and the Utilization Management program that informs providers when a requested service is not consistent with national guidelines and makes recommendations for more appropriate care have all shown a positive effect. Optum's use of its ACE program (Achievement in Clinical Excellence) also rewards providers who adopt use of treatments recommended in national clinical guidelines and use of the Wellness Assessment through the ALERT program. Providers recognized as high excellence in the ACE program receive a bonus for excellent performance and stars on the Provider Locator Tool to direct members and families to their agencies.

Optum Idaho continues to look at rectification of the service mix delivered to children and youth in the State. Over time, as utilization of medically appropriate services for these age groups matures, we look for further reduction in CBRS and enhancement of Family Therapy with eventual use of more Family Therapy for children than Individual Therapies. We also look to increased utilization of Individual Therapies in the transitioning youth group, 18-20 years. We also desire an increase in Peer Support Services in adults and transitioning youth. With Family Support Services becoming available in Spring 2016, we also look towards use of those value-added, Recovery and Resiliency services being used for the benefit of children and their families.

In addition to provider education improving utilization of appropriate services through recommendations on the supply side, we plan to continue member and family education to promote knowledge of medically necessary treatment in order to improve utilization from the demand side.

Member Satisfaction Survey Results

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). 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:

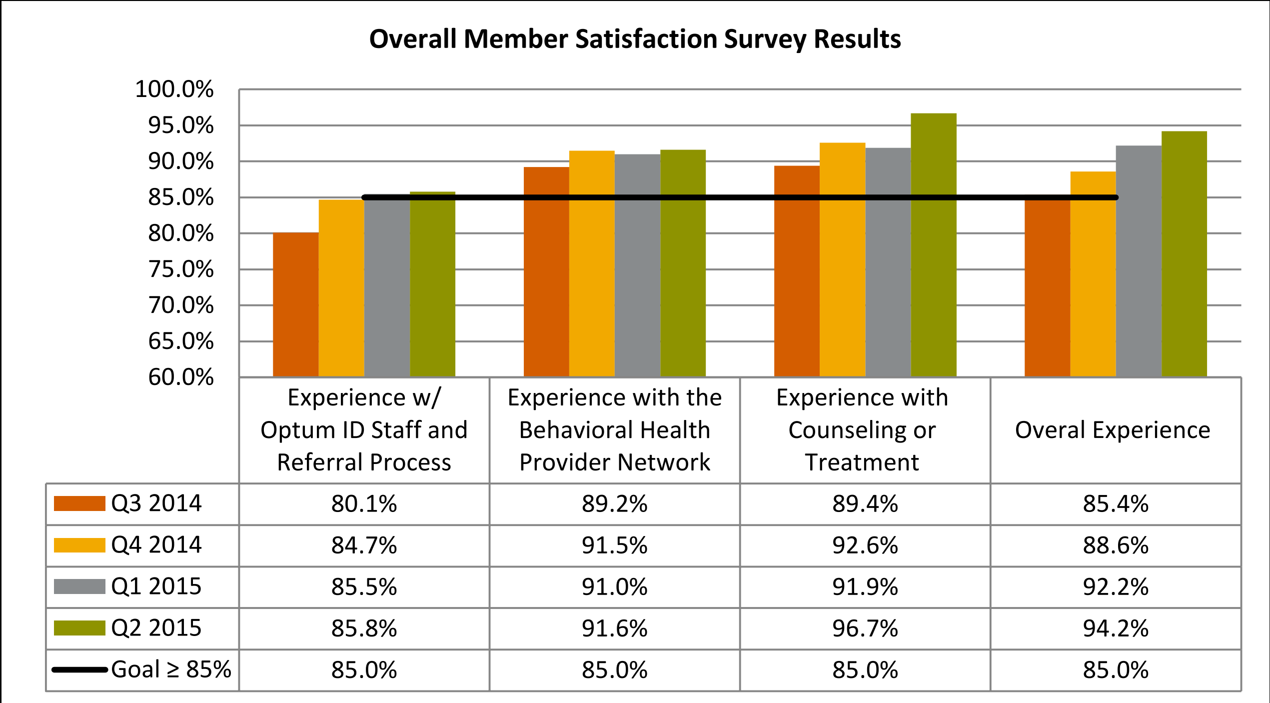
Member Overall Satisfaction Survey	Performance Goal	Q3 2014	Q4 2014	Q1 2015	Q2 2015*
Experience w/Optum ID Staff and Referral Process	≥85.0%	80.1%	84.7%	85.5%	85.8%
Experience with the Behavioral Health Provider Network	≥85.0%	89.2%	91.5%	91.0%	91.6%
Experience with Counseling or Treatment	≥85.0%	89.4%	92.6%	91.9%	96.7%
Overall Experience	≥85.0%	85.4%	88.6%	92.2%	94.2%

*Based on the Member Satisfaction Survey sampling methodology, Q2, 2015 data is the most recent results available.

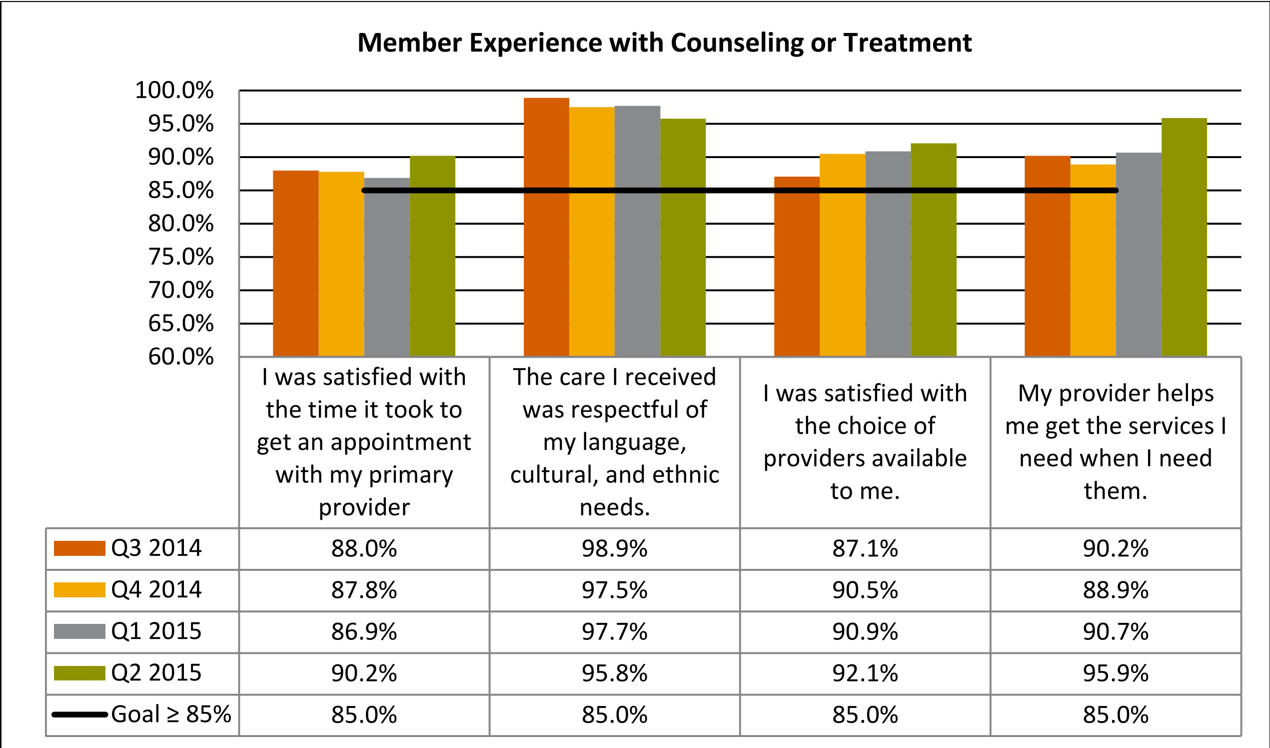
Analysis: All measures in this category saw an increase from Q1 results. The rate of member's Overall Experience with Behavioral Health services was at 94.2%, an increase from 92.2% during Q1, 2015. This measure has consistently increased since Q3, 2014. Member's experience with Optum ID Staff and Referral Process saw a slight increase from 85.5% during Q1 to 85.8% during Q2. The Member's experience with the Behavioral Health Provider Network increased slightly during Q2 to 91.6% from 91.0% during Q1. Member's experience with counseling and treatment saw an increase from 91.9% during Q1 to 96.7% during Q2. Performance goal of ≥85% was met.

In addition, the Member Satisfaction Survey includes specific questions related to the member's experiences with counseling and treatment:

- "I was satisfied with the time it took to get an appointment with my primary provider." Q2 result was 90.2% which was an increase from 86.9% during Q1.
- "The care I received was respectful of my language, cultural, and ethnic needs." Q2 result was 95.8% well above the goal of ≥85%.
- "I was satisfied with the choice of providers available to me." Q2 result was 92.1% which was an increase from 90.9% during Q1.
- "My provider helps me get the services I need when I need them." Q2 result was 95.9%, an increase from 90.7% during Q1.



	Experience w/ Optum ID Staff and Referral Process	Experience with the Behavioral Health Provider Network	Experience with Counseling or Treatment	Overal Experience
Q3 2014	80.1%	89.2%	89.4%	85.4%
Q4 2014	84.7%	91.5%	92.6%	88.6%
Q1 2015	85.5%	91.0%	91.9%	92.2%
Q2 2015	85.8%	91.6%	96.7%	94.2%
Goal ≥ 85%	85.0%	85.0%	85.0%	85.0%



	I was satisfied with the time it took to get an appointment with my primary provider	The care I received was respectful of my language, cultural, and ethnic needs.	I was satisfied with the choice of providers available to me.	My provider helps me get the services I need when I need them.
Q3 2014	88.0%	98.9%	87.1%	90.2%
Q4 2014	87.8%	97.5%	90.5%	88.9%
Q1 2015	86.9%	97.7%	90.9%	90.7%
Q2 2015	90.2%	95.8%	92.1%	95.9%
Goal ≥ 85%	85.0%	85.0%	85.0%	85.0%

Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

Provider Satisfaction Survey Results

Optum Idaho regularly conducts a provider satisfaction survey of providers delivering behavioral health services to IBHP members. This survey addresses 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. 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:

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

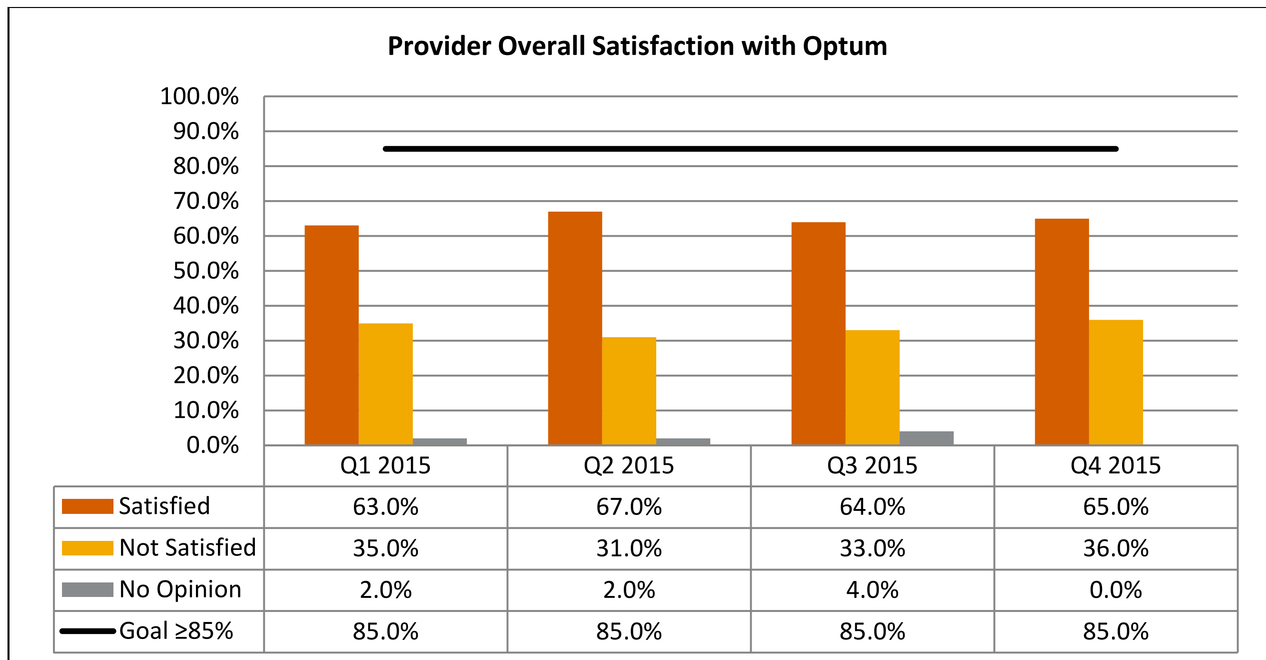
Surveys are conducted over the phone between providers and a representative from Fact Finders, Inc. The representative from Fact Finders, Inc., places an initial call to the provider agency to introduce the research and schedule an appointment to conduct the survey. Provider agencies are then called 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	Q4 2015
Satisfied	≥85.0%	63.0%	67.0%	64.0%	65.0%
Not Satisfied	NA	35.0%	31.0%	33.0%	36.0%
No Opinion	NA	2.0%	2.0%	4.0%	0.0%

Analysis: Overall Provider satisfaction continued to fall below the performance goal of ≥85%. Several Improvement Action Plans were initiated in Q1 and Q2, 2015 to monitor and address Provider Satisfaction. These Improvement Action Plans address:

- Provider Overall Satisfaction with Optum
- Provider Satisfaction with Peer Review Process
- Provider Satisfaction-Customer Service
- Provider Website



	Q1 2015	Q2 2015	Q3 2015	Q4 2015
Satisfied	63.0%	67.0%	64.0%	65.0%
Not Satisfied	35.0%	31.0%	33.0%	36.0%
No Opinion	2.0%	2.0%	4.0%	0.0%
Goal ≥85%	85.0%	85.0%	85.0%	85.0%

Barriers: Optum Idaho continues to monitor and address the barriers to provider satisfaction and to work 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 2016 and promote initiatives to improve the network experience with Optum. The following project initiatives highlight key accomplishments during Q4:

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	•Provider survey edits being reviewed by PAC to determine validity.
Provider Satisfaction-Customer Service	1/30/2015	Quality Assurance Performance Improvement	Open	•Continuing to monitor
Provider Website	1/29/2015	Provider Advisory Committee	Open	•Website launched •Executive Director reviewing IAP Closure report. Will be presented to QAPI for oversight review.
Provider Satisfaction with Peer Review Process	2/1/2015	Clinical and Services Advisory Committee	Open	•Creation of survey to clarify provider dissatisfaction •Training of second Medical Director to complete Peer Reviews •Scripts developed for Care Advocates to inform providers of new expectations

				•Script for Linx documentation developed

Performance Improvement

A continuous quality improvement (CQI) process is embedded within the structure of Optum Idaho's QI program. The CQI process provides the mechanism by which improvement projects and initiatives are developed so that 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 routinely oversees and monitors these Improvement Action Plans until completion or closure.

The following is a list of the open improvement action plans and key accomplishments during Q4. There were no Improvement Action Plans closed during this quarter.

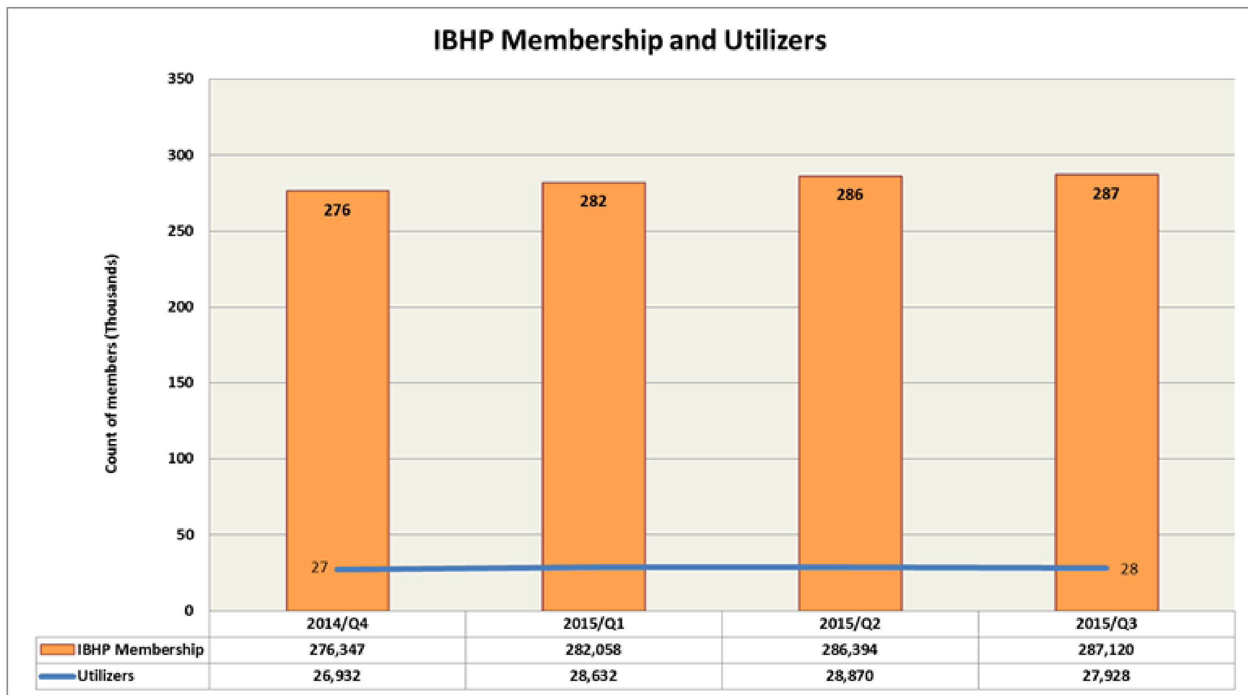
2015 Improvement Action Plan	Date Initiated	Quality Committee Oversight	Status	Key Accomplishments
Special Programming for Pre-Adults Facing Transition to Adulthood	4/26/2014	Clinical and Services Advisory Committee	Open	•Introduced notification letter process to providers •Notification letters to be sent starting1/20/16 •Statewide training in Youth in Recovery •Recovery and Resiliency training conducted in October
Provider Overall Satisfaction with Optum (Provider Survey Results)	1/23/2015	Provider Advisory Committee Quality Assurance Performance Improvement	Open	•Provider survey edits being reviewed by PAC to determine validity.
Provider Satisfaction with Peer Review Process	2/1/2015	Clinical and Services Advisory Committee	Open	•Creation of survey to clarify provider dissatisfaction •Training of second Medical Director to complete Peer Reviews •Scripts developed for Care Advocates to inform providers of new expectations •Script for Linx documentation developed
Provider Website	1/29/2015	Provider Advisory Committee	Open	•Website launched •Executive Director reviewing IAP Closure report. Will be presented to QAPI for oversight review.
Provider Satisfaction-Customer Service	1/30/2015	Quality Assurance Performance Improvement	Open	•Continuing to monitor
Clinical Model 2.1	2/19/2015	Clinical and Services Advisory Committee	Open	•Meetings established with the reporting team on a bi-weekly basis. •Reviewed Provider Express portal and demonstrated used

				for reporting team •Reviewed clinical elements of scorecard and data sources for Key Performance Indicators •Timeline of completion reviewed
Complaint Acknowledgement	1/27/2015	Quality Assurance Performance Improvement	Open	•No additional actions taken. Waiting for Q4 survey results to determine next steps
7 Day Post-Discharge Monitoring	4/8/2015	Clinical and Services Advisory Committee	Open	•Submitted modified report with change request to IDHW – IDHW agreed to the changes. •Ad Hoc report change submitted
ALERT Peer Review	10/2/2015	Quality Assurance Performance Improvement Committee and Clinical and Services Advisory Committee	Open	•Standard Operating Procedures (SOP) completed
Authorizations: Provider Service Line-Ease of Getting Through	9/4/2015	Provider Advisory Committee	Open	•PAC will evaluate survey question as feedback received indicates confusion from providers on how question is worded
Authorizations: Resolution of Questions	2/2/2015	Provider Advisory Committee	Open	•Continue to work with PAC regarding validity of questions.

Accessibility & Availability

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.



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

Member Services 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.

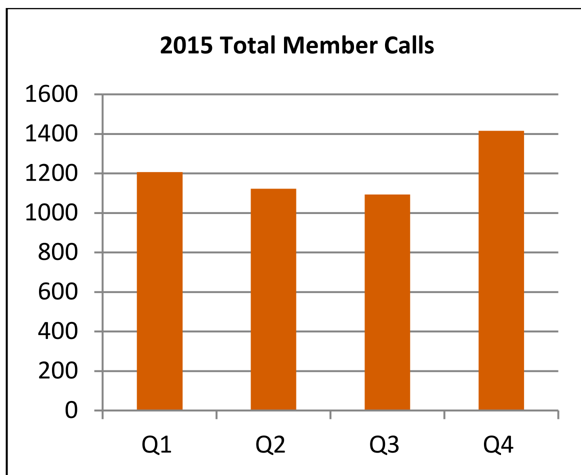
To ensure we meet our member's needs in a timely and efficient manner, Optum Idaho established performance targets that exceeded IBHP contractual targets for average speed to answer (120 seconds) and call abandoned rate (≤7%). Data source is Avaya's Communication system (ProtoCall).

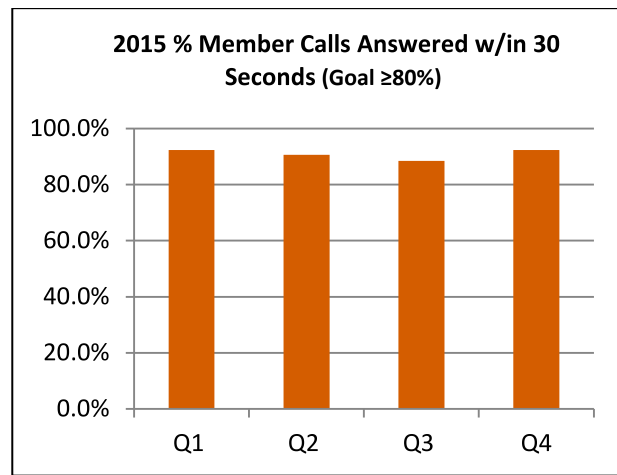
Quarterly Performance Results:

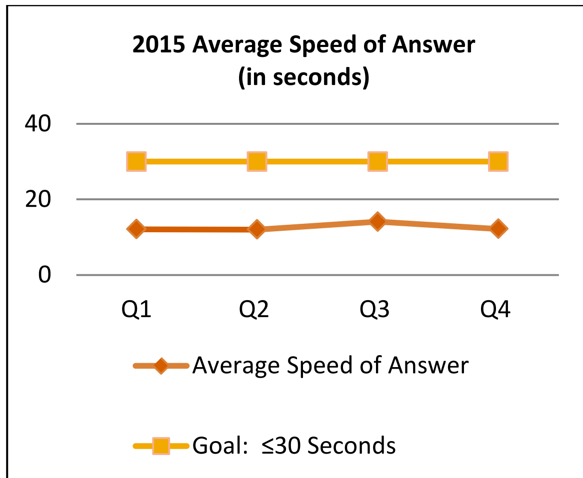
Member Service Line	Optum Idaho Standards	IBHP Contract Standards	Q1 2015	Q2 2015	Q3 2015	Q4 2015
Total Number of Calls	NA	NA	1,206	1,122	1,094	1,416
Percent of Calls Answered Within 30 Sec	≥80.0%	None	92.4%	90.6%	88.5%	92.4%

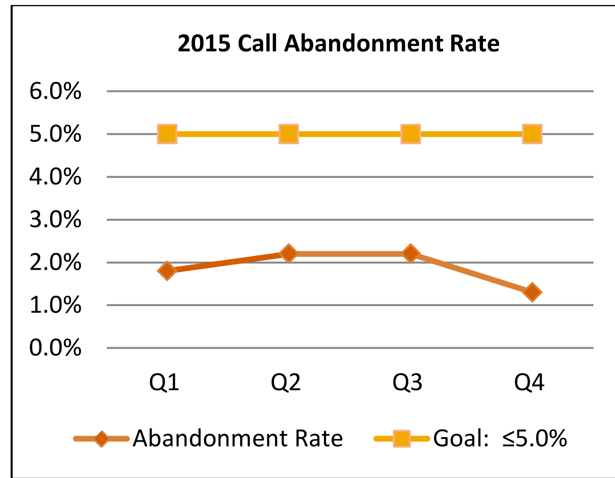
Average Speed of Answer	≤30 Seconds	120 seconds (2 minutes)	12.1 sec	12.0 sec	14.1 sec	12.2 sec
Abandonment Rate	≤3.5%	≤7%	1.8%	2.2%	2.2%	1.3%

Analysis: During Q4, the Member Services and Crisis Line received a total of 1,416 calls. Optum Idaho exceeded established performance call standards in each quarter of the 2015 calendar year. In Q4, 92.4% of calls were answered within 30 seconds (goal ≥80%), which was an increase from 88.5% in Q3. The average speed to answer of 12.2 seconds (goal ≤30 seconds) during Q4, was also an improvement from 14.1 seconds during Q3. The abandoned rate of 1.3% during Q4 met both the Optum Idaho Standards goal of ≤3.5% and the IBHP Contractual Standards goal of ≤7.0%.









Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified

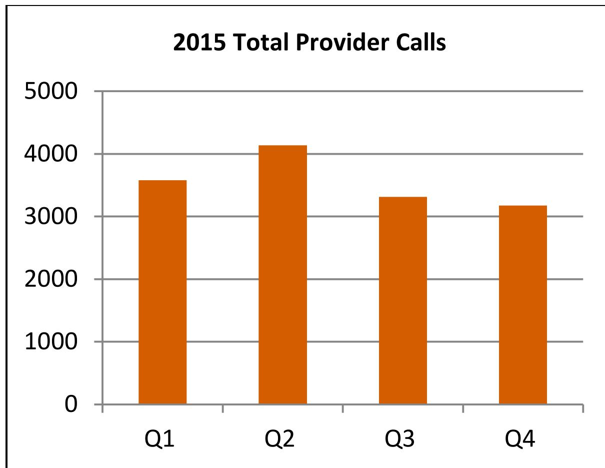
Customer Service (Provider Calls) Standards

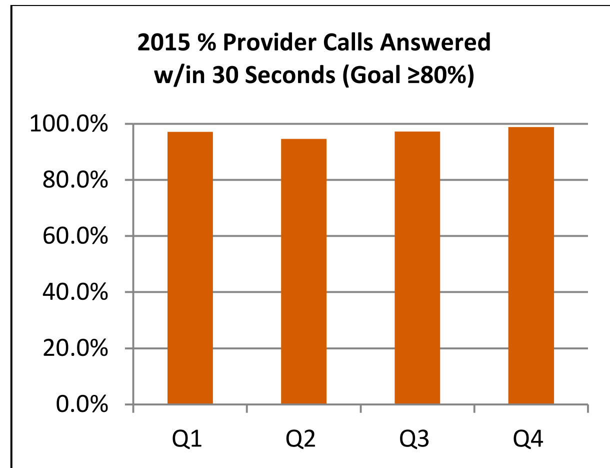
Methodology: The Customer Service Line is primarily used by providers, IDHW personnel and any other stakeholders to contact Optum Idaho. To ensure the needs of our providers and stakeholders are met in a timely and efficient manner, Optum established performance targets that exceeded IBHP contractual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

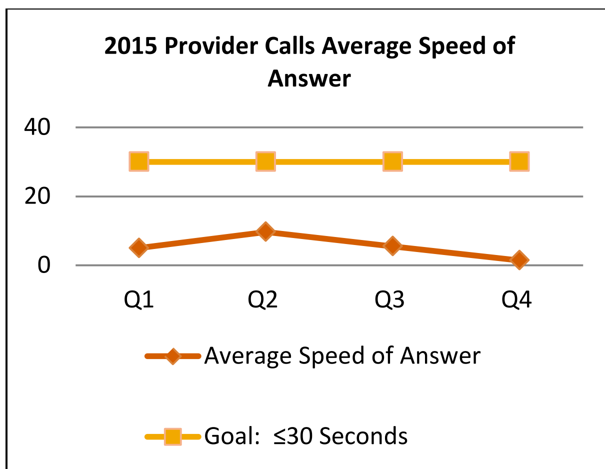
Quarterly Performance Results:

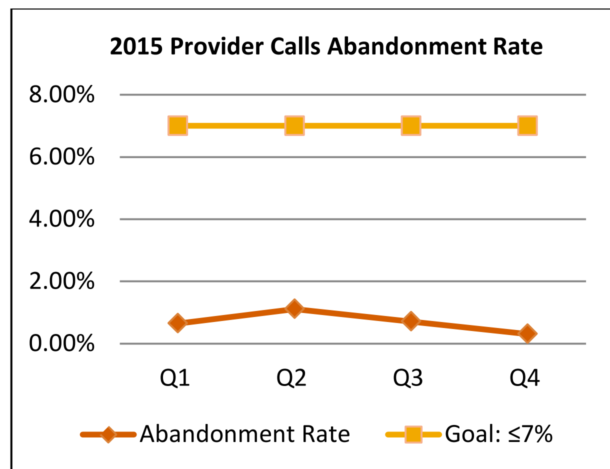
Customer Service Line	Optum Idaho Standards	IBHP Contract Standards	Q1 2015	Q2 2015	Q3 2015	Q4 2015
Total Number of Calls	NA	NA	3,577	4,138	3,315	3,175
Percent of Calls Answered Within 30 Sec	≥80.0%	None	97.1%	94.6%	97.3%	98.9%
Average Speed of Answer	≤30 Seconds	120 seconds (2 minutes)	5 sec	10 sec	5.5 sec	1.4 sec
Abandonment Rate	≤3.5%	≤7%	0.65%	1.11%	0.71%	0.31%

Analysis: Q4 performance in customer service call standards outperformed all other 2015 quarters for all three customer service line measures. The percent of calls answered within 30 seconds was at 98.9%, an increase from Q3 (97.3%) remaining above our goal of ≥80%. The average speed of answer was at 1.4 seconds during Q4, an improvement from 5.5 seconds in Q3, and again meeting our goal of ≤30 seconds. The call abandonment rate during Q4 was 0.31% continuing to meet both the Optum Idaho internal goal of ≤3.5% and the IBHP Contract Standard of ≤ 7%. The total number of provider calls during Q4 was 3,175. This was a decrease from 3,315 calls during Q3.









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

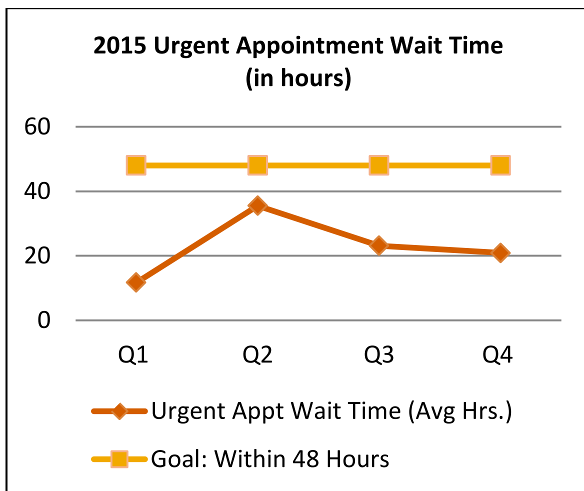
Methodology: As part of our Quality Improvement Program, and to ensure that all members have access to appropriate treatment as needed, we develop, maintain, and monitor a network with adequate numbers and types of clinicians and outpatient programs. We require that the network providers adhere to specific 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.

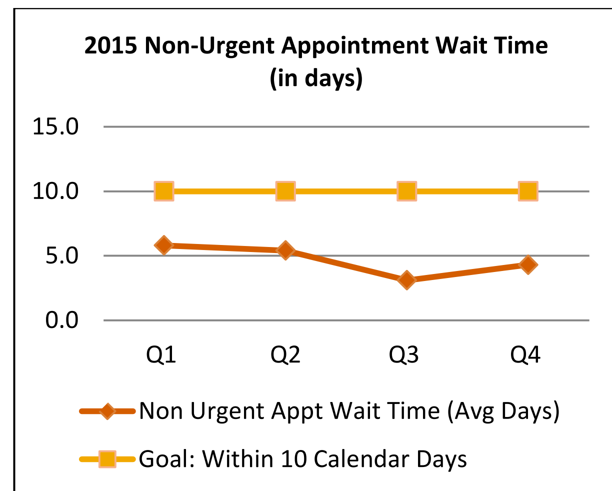
Quarterly Performance Results:

Urgent/Non-Urgent Appointment Wait Time	Performance Goal	Q1 2015	Q2 2015	Q3 2015	Q4 2015

Urgent Appointment Wait Time	Within 48 hours from request	11.7 hours	35.5 hours	23.1 hours	20.9 hours
Non-Urgent Appointment Wait Time	Within 10 days from request	5.8 days	5.4 days	3.1 days	4.3 days

Analysis: The performance goal for Urgent Appointment wait time is 48 hours. During Q4, the Urgent Appointment Wait time decreased from 23.1hours in Q3 to 20.9 hours during Q4, 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 Q4 at 4.3 days.





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	Q4 2015
Area 1	(within 30 miles)	100.0%	99.8%	99.7%	99.8%	99.9%
Area 2	(within 45 miles)	100.0%	99.9%	99.9%	99.8%	99.8%

Analysis: Optum Idaho continues to meet contract availability standards. During Q4, Area 1 availability standards were met at 99.9% 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 December 2015, the IBHP had 5,309 providers practicing in 619 locations, which consist of individually credentialed and roster clinicians and agencies. Along with continued recruitment of new providers to the network, the network manager staff encouraged existing providers to expand service offerings including TeleHealth services. Of note, the number of network providers who attest to offering TeleHealth services, which is reported annually, increased from 3 in 2014, to 33 in 2015.

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 the quality monitoring programs, are designed to help ensure the health, safety and appropriate treatment of Optum 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 Optum's ongoing assessment of the overall network, Optum evaluates, audits, and reviews the performance of existing contracted providers, programs, and facilities.

Notification of Adverse Benefit Determination

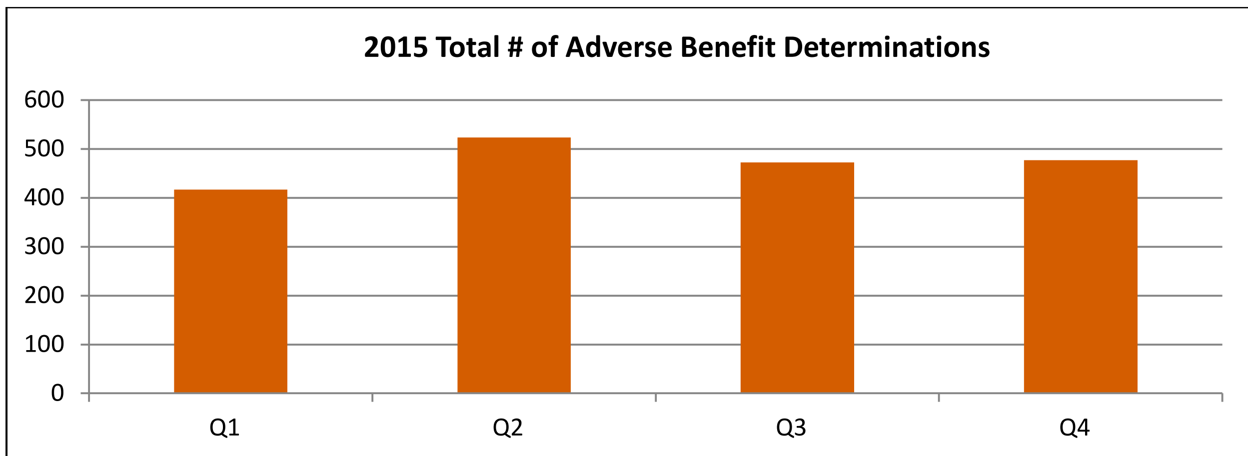
Methodology: Adverse Benefit Determinations (ABD's) are maintained in the ARTT (Appeals Reporting Tracking Tool) database. When a request for services is received, Optum has 14 days to review the case and make a determination to authorize services or deny services in total or in part. Once a determination is made to deny or reduce services, Optum has 1 day following the verbal notification of the decision to mail a written notice informing the member and provider of the denial.

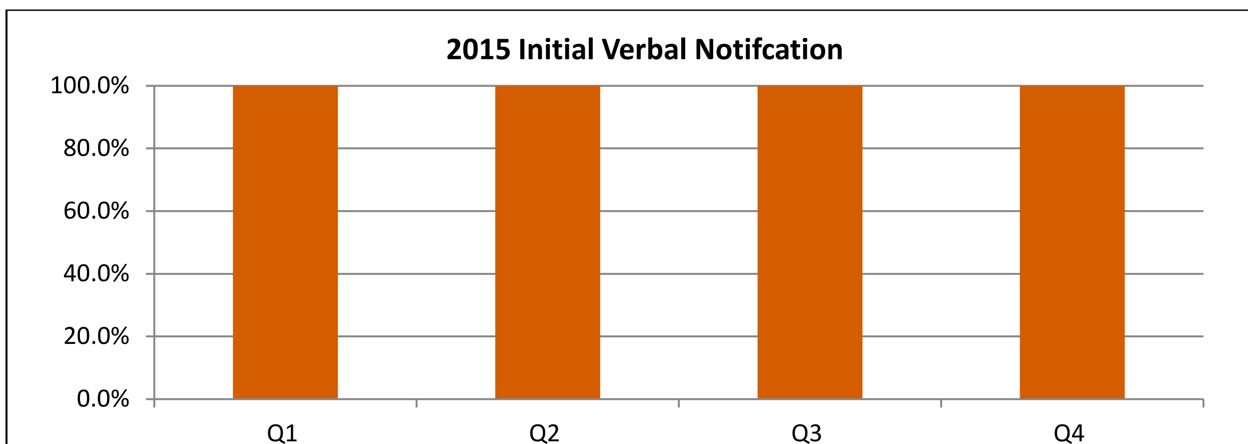
Quarterly Performance Results:

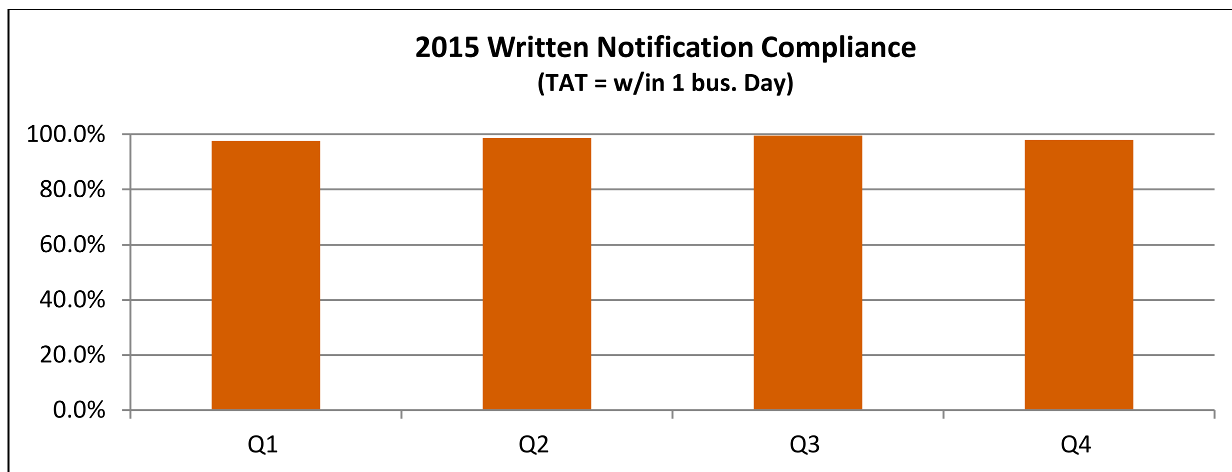
Notification of ABD	Performance Goal	Target	Q1 2015	Q2 2015	Q3 2015	Q4 2015
Total # ABD's	NA	NA	417	523	462	477
Initial Verbal Notification to Provider	Verbal notice of decision is provided the same day of determination	100.0%	100.0%	100.0%	100.0%	100.0%
Written Notification	Written notice is sent within 1 business day following verbal notification	100.0%	97.6%* (407/417)	98.6%* (516/523)	99.6% (460/462)	97.9% (467/477)

*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.

Analysis: During Q4, there were 477 ABD's which was an increase from 462 during Q3. Initial Verbal Notification performance (verbal notice of decision being provided on the same day of determination) was met at 100%. Written notification performance was at 97.9% (467/477) for Q4.







Barriers: System limitations do not allow for automated messages when an adverse benefit determination is made. Notification of ABD's relies on communication between multiple teams which increases the possibility of error.

Opportunities and Interventions: Beginning in January, 2016, ABDs will no longer be maintained in Appeals Reporting Tracking Tool (ARTT). ABDs will be processed and maintained in Linx. This will allow for increased efficiency and better auditing mechanisms to limit ABD's falling outside of the performance goal. It will also provide a better method of communication between teams decreasing the possibility of error.

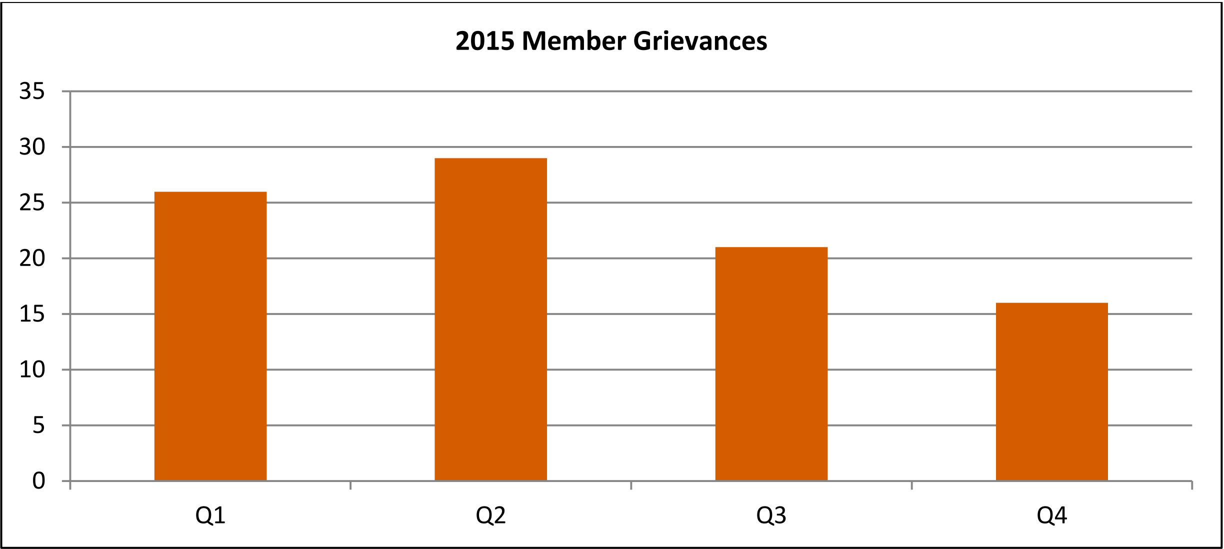
Grievances

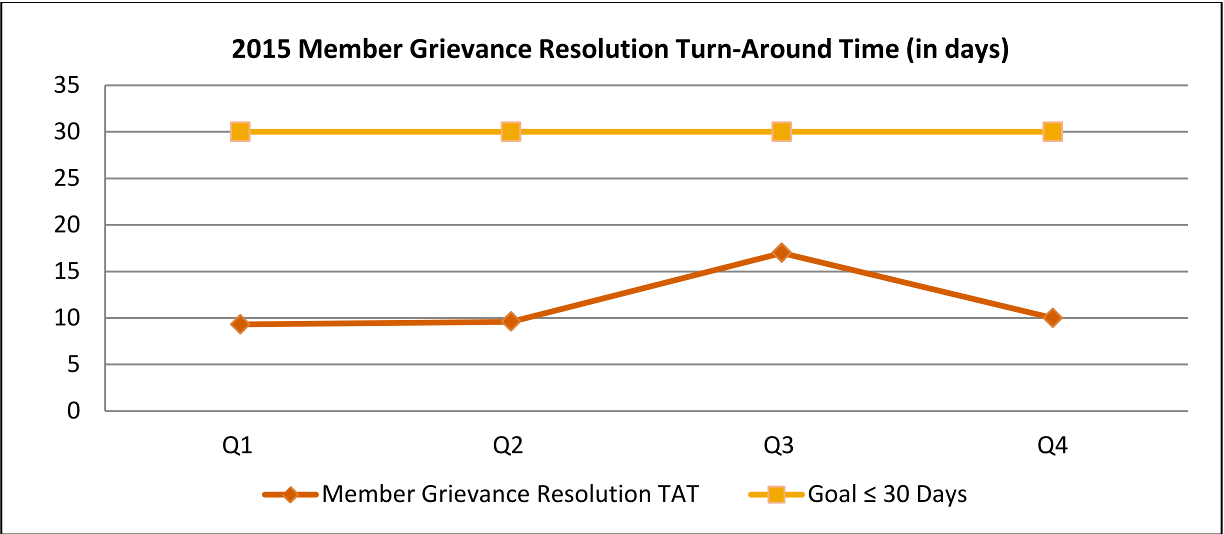
Methodology: Optum Idaho recognizes the right of a member, authorized representative or provider or agency, acting on behalf of a member, to appeal an adverse action that resulted in member financial liability or denied service, which is referred to within Optum as filing a grievance. All grievances are required to be reviewed and resolved within 30 days.

Quarterly Performance Results:

Grievances	Performance Goal	Q1 2015	Q2 2015	Q3 2015	Q4 2015
Number of Member Grievances	NA	26	29	21	16
Average Number of Days to Resolution	30 Days	9	10	17	10

Analysis: During Q4, Optum ID received the fewest number of grievances for 2015. Optum continued to exceed the 30 day turnaround time for resolutions. Q4 resolution turnaround time improved from an average of 17 days in Q3 to an average of 10 days.





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 broad categories: Benefit, Service (and Attitude), Access (and Availability), Billing & Financial, Quality of Care, Privacy Incident, and Quality of Practitioner Office Site.

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:

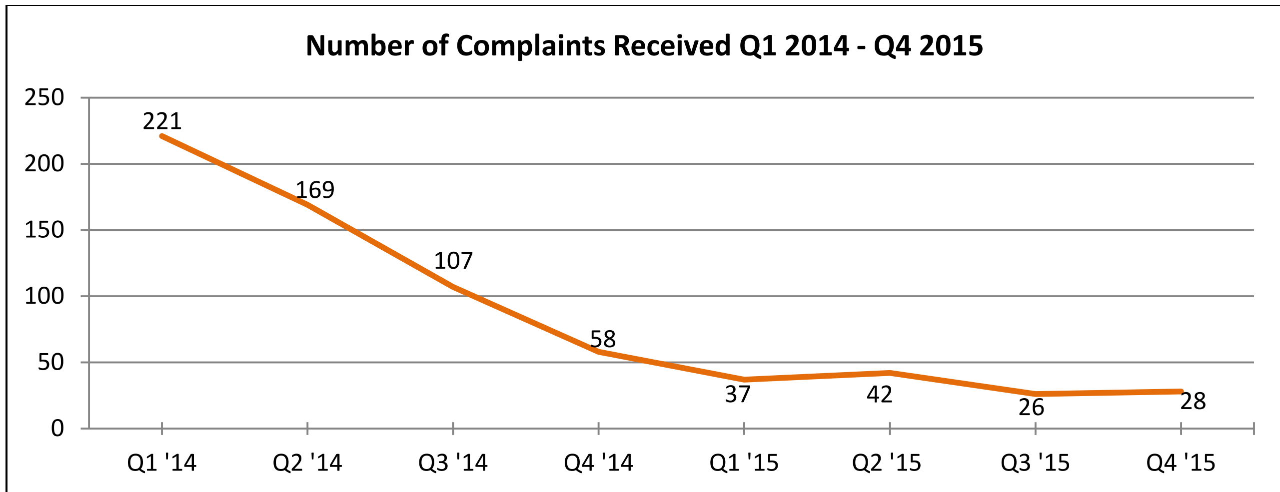
Complaint Resolution and Tracking Timeframes	Acknowledged	Resolved
Quality of Service (QOS) Complaints	5 Business Days	10 Business Days
Quality of Care (QOC) Concerns	5 Business Days	30 Calendar Days

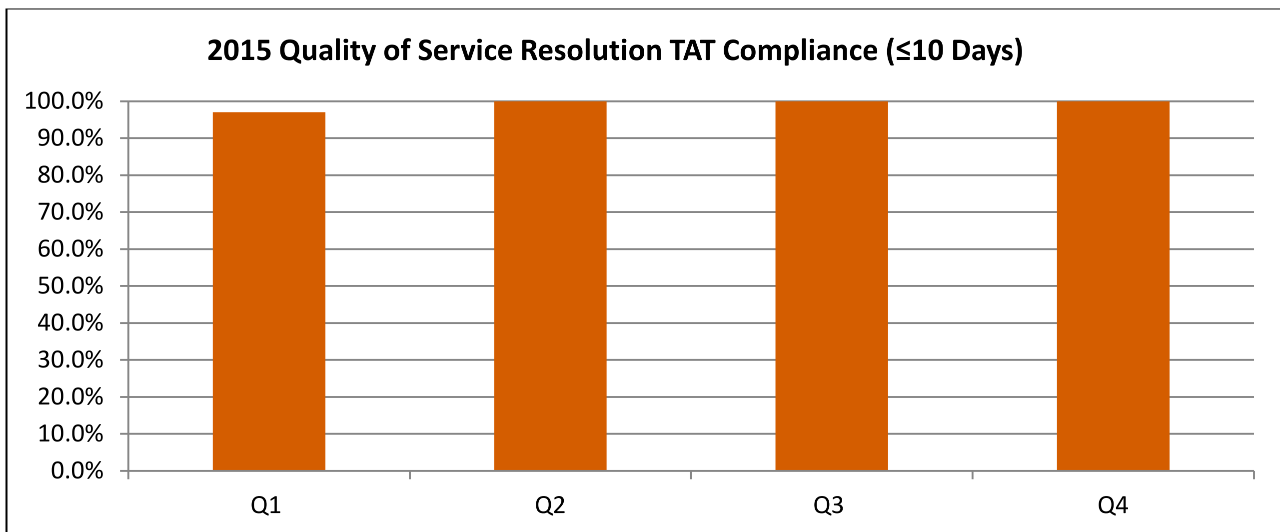
Quarterly Performance Results:

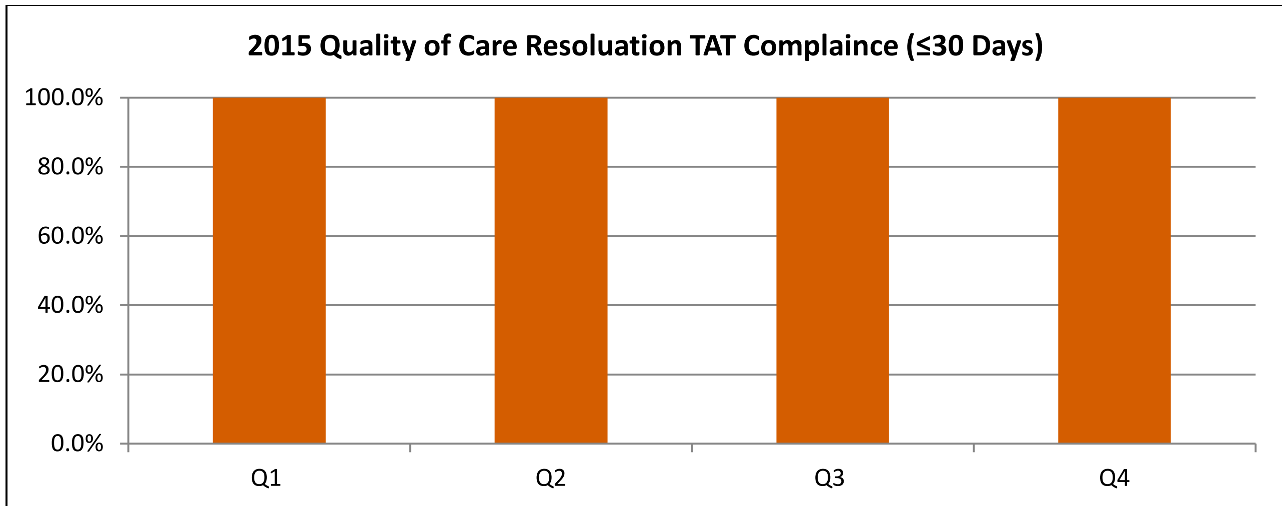
Complaints	Performance Goal	Q1 2015	Q2 2015	Q3 2015	Q4 2015
Number of Quality of Service (QOS) Complaints Received	NA	35	40	21	26
Percent QOS Complaints Resolved w/in TAT	10 Days	97.0%	100.0%	100.0%	100.0%
Number of Quality of Care Complaints (QOC) Received	NA	2	2	5	2
Percent QOC Complaints Resolved w/in TAT	30 Days	100.0%	100.0%	100.0%	100.0%

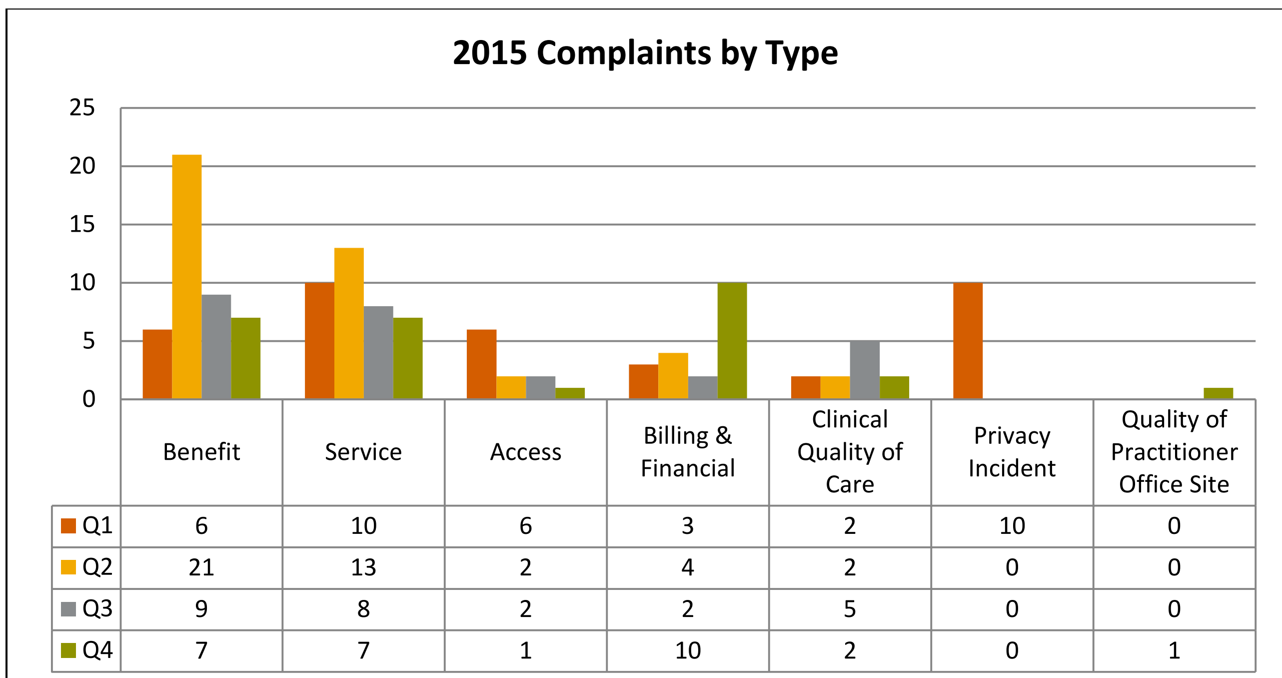
Analysis: Of the total complaints logged in Q4, twenty-six (26) were identified as Quality of Service and 2 were Quality of Care. Optum met the goal of 100% for resolution timeframes for both QOS complaints (10 business days) and QOC concerns (30 days).

The total number of complaints increased slightly from 26 during Q3 to 28 during Q4. The data showed a noticeable increase in the number of complaints in the category of Billing & Financial, although no trends were identified in the nature of these complaints. We will continue to monitor this category. Other categories remained consistent.


Number of Complaints Received Q1 2014 - Q4 2015
250
200
150
100
50
0
221
169
107
58
37
42
26
28
Q1 '14
Q2 '14
Q3 '14
Q4 '14
Q1 '15
Q2 '15
Q3 '15
Q4 '15


2015 Quality of Service Resolution TAT Compliance (≤10 Days)
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Q1
Q2
Q3
Q4





	Benefit	Service	Access	Billing & Financial	Clinical Quality of Care	Privacy Incident	Quality of Practitioner Office Site
Q1	6	10	6	3	2	10	0
Q2	21	13	2	4	2	0	0
Q3	9	8	2	2	5	0	0
Q4	7	7	1	10	2	0	1

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 (also defined as a sentinel event).
- 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 (also defined as a sentinel event).
- 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 (also defined as a sentinel event).
- High profile incidents identified by the IDHW as warranting investigation.

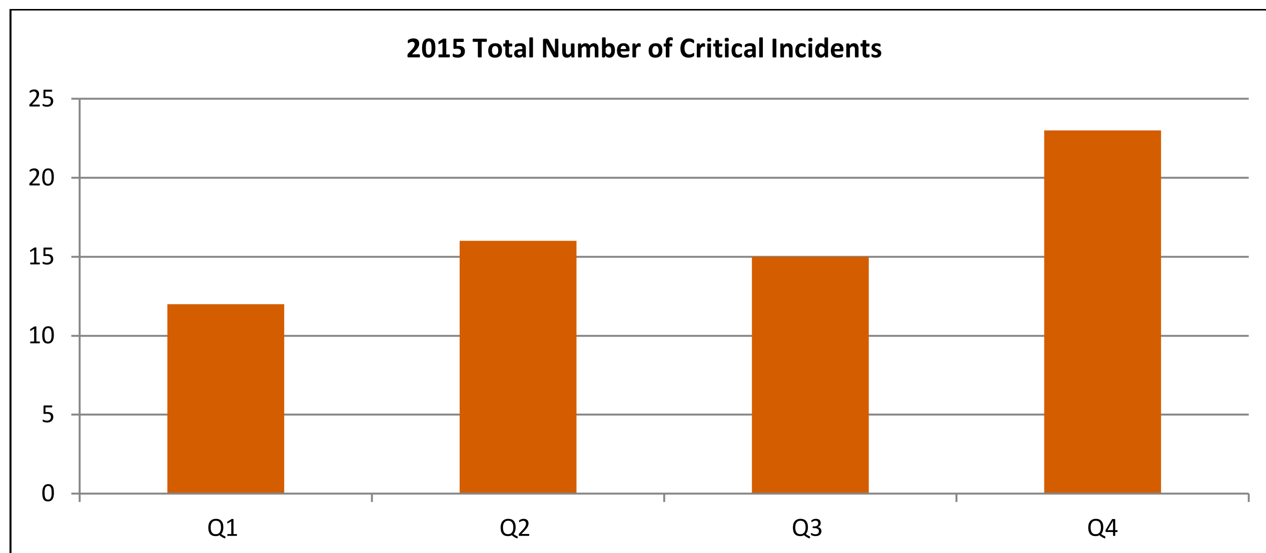
Optum has a Sentinel Events Committee (SEC) to review Critical Incidents that meet Optum's definition of sentinel events. Optum Idaho has a Peer Review Committee (PRC) to review Critical Incidents that do not meet Optum's definition of sentinel event. The SEC and PRC make recommendations for improving 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.

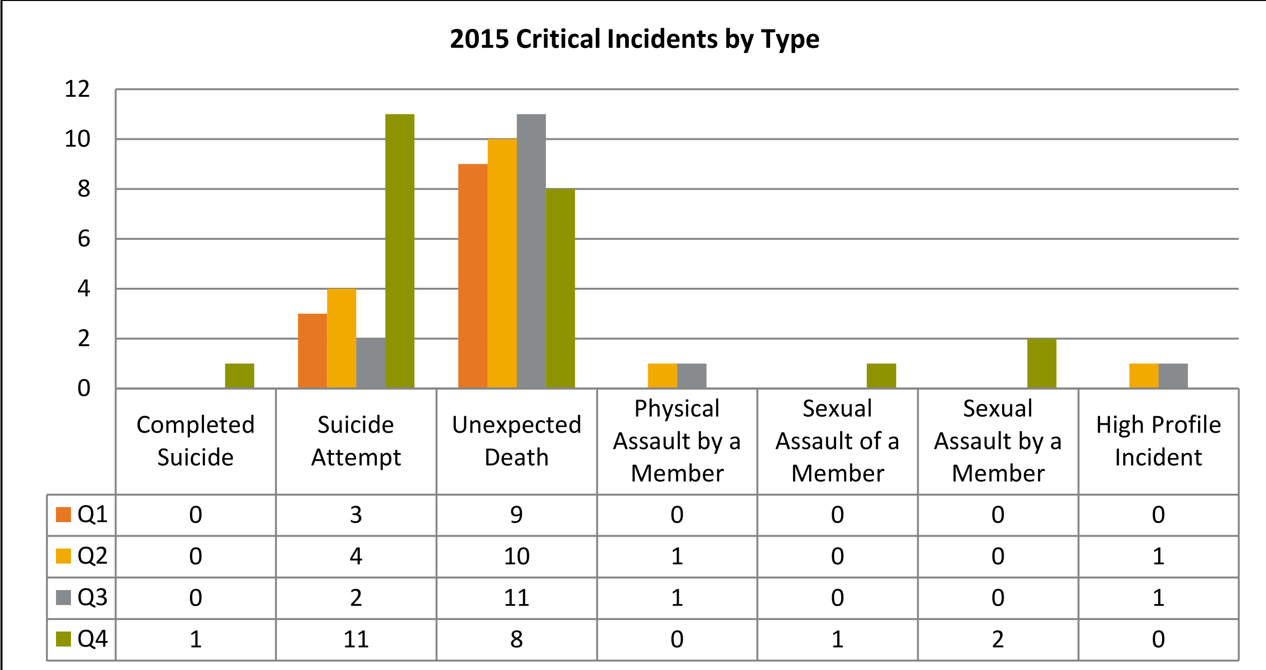
Quarterly Performance Results:

Critical Incidents	Performance Goal	Q1 2015	Q2 2015	Q3 2015	Q4 2015
Number of CI's Received	NA	12	16	15	23
CI Ad-hoc Review: % completed within 5 business days from notification of incident	100%	100.0%	100.0%	100.0%	100.0%

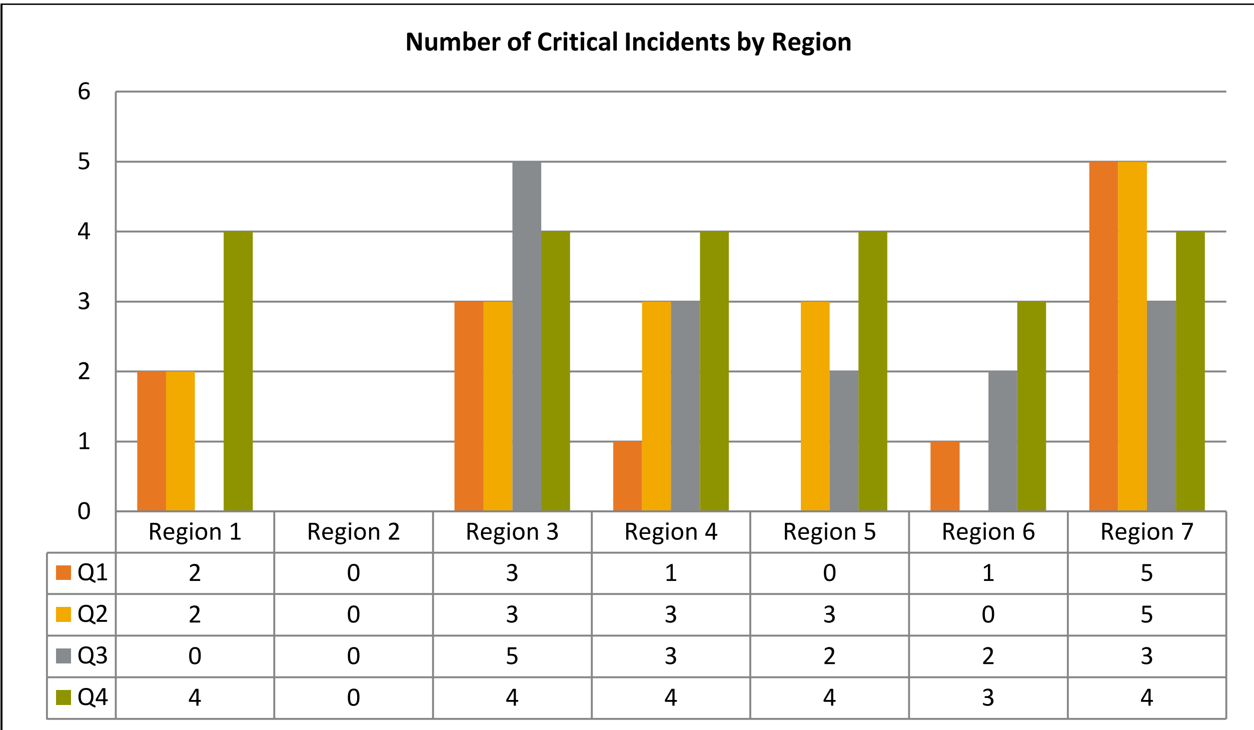
Analysis: There were 23 Critical Incidents reported during Q4. The turnaround time for Ad-Hoc Committee review within 5 business days from notification of incident was met. Of the 23 Critical Incidents reported, 8 were from unexpected deaths, 1 was from a completed suicide, 11 were from suicide attempts, 1 from a sexual assault of a member, and 2 from a sexual assault by a member.

69.6% of Critical Incidents reported during Q4 indicated there was coordination of care between the behavioral health provider and the Primary Care Provider (PCP). Of the Co-morbid health conditions, 30.4% were male and 30.4% were female members. Eighty-seven percent (87%) of the cases reported in Q3 were adults (18+) and 13% were children/adolescents (17 and below). Further analysis shows that the average age for males was 39 and females 38. Of Critical Incidents reported during Q4, 47.8% were males and 52.2% were females. No providers were put on unavailable status due to a Critical Incident.

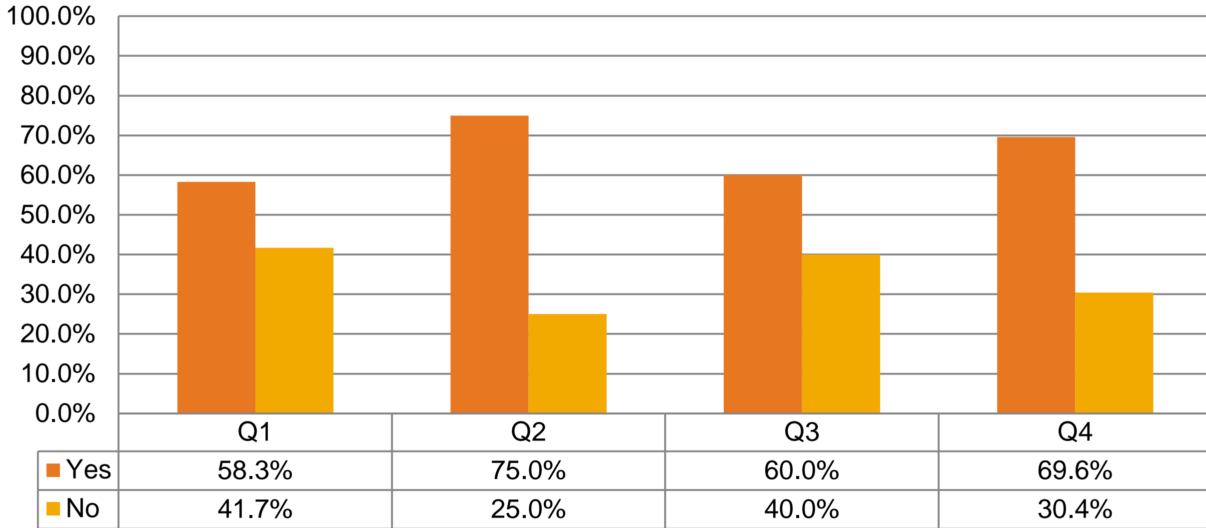




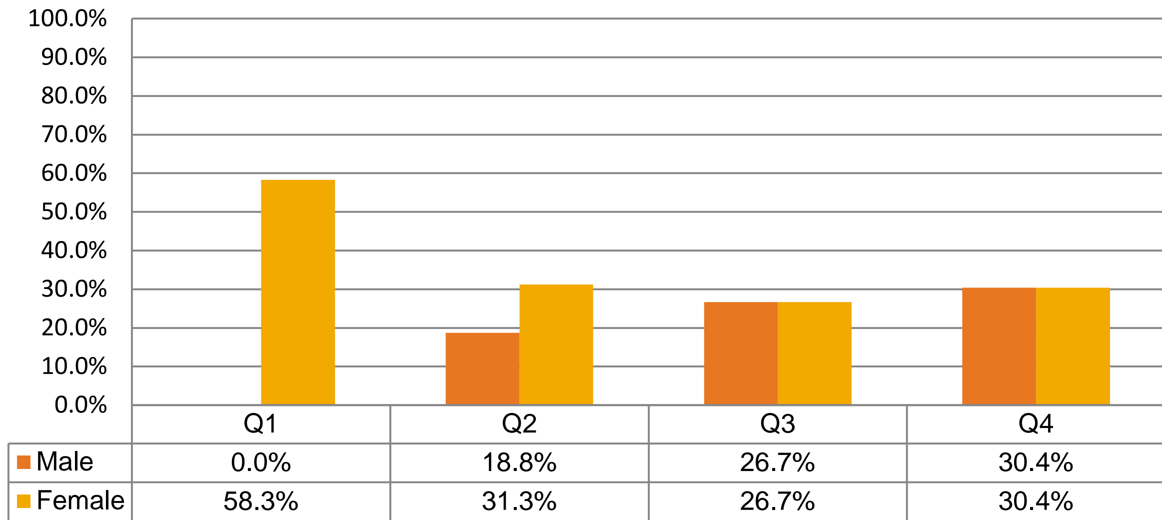
	Completed Suicide	Suicide Attempt	Unexpected Death	Physical Assault by a Member	Sexual Assault of a Member	Sexual Assault by a Member	High Profile Incident
Q1	0	3	9	0	0	0	0
Q2	0	4	10	1	0	0	1
Q3	0	2	11	1	0	0	1
Q4	1	11	8	0	1	2	0



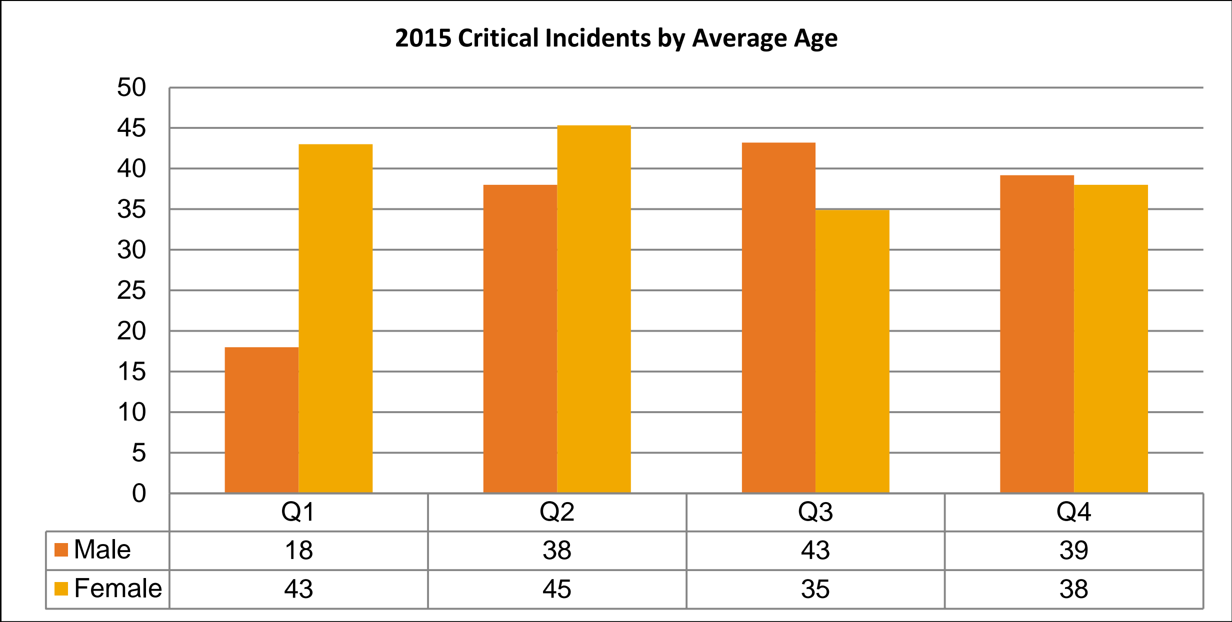
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Q1	2	0	3	1	0	1	5
Q2	2	0	3	3	3	0	5
Q3	0	0	5	3	2	2	3
Q4	4	0	4	4	4	3	4



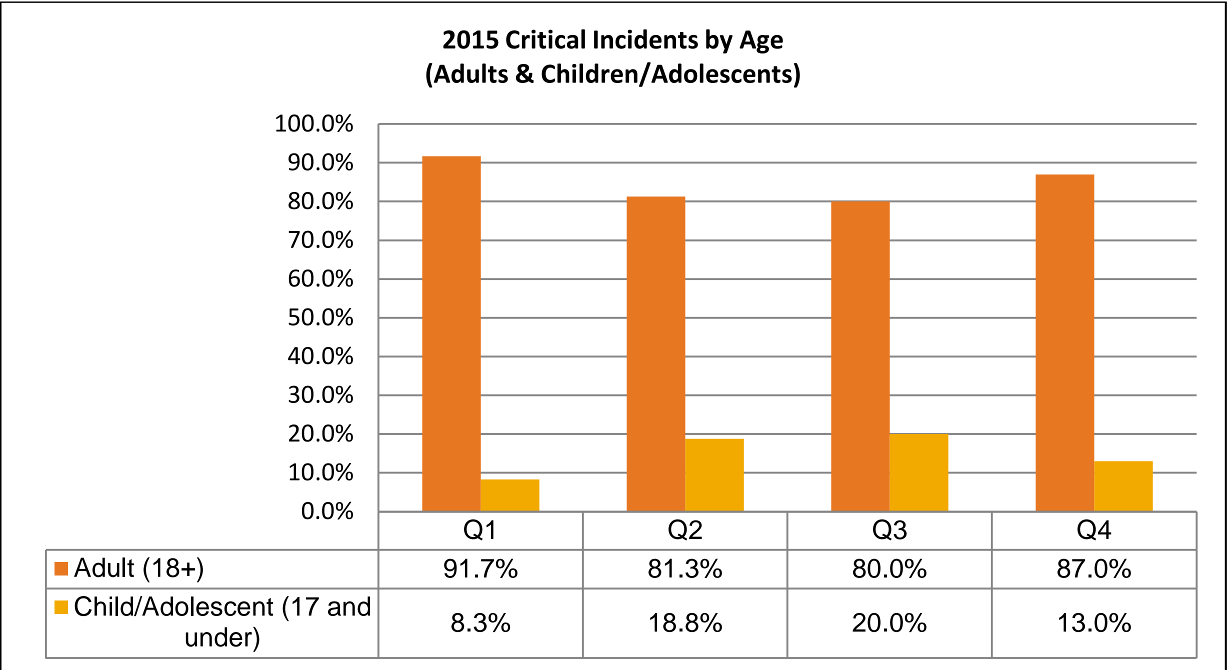
	Q1	Q2	Q3	Q4
Yes	58.3%	75.0%	60.0%	69.6%
No	41.7%	25.0%	40.0%	30.4%



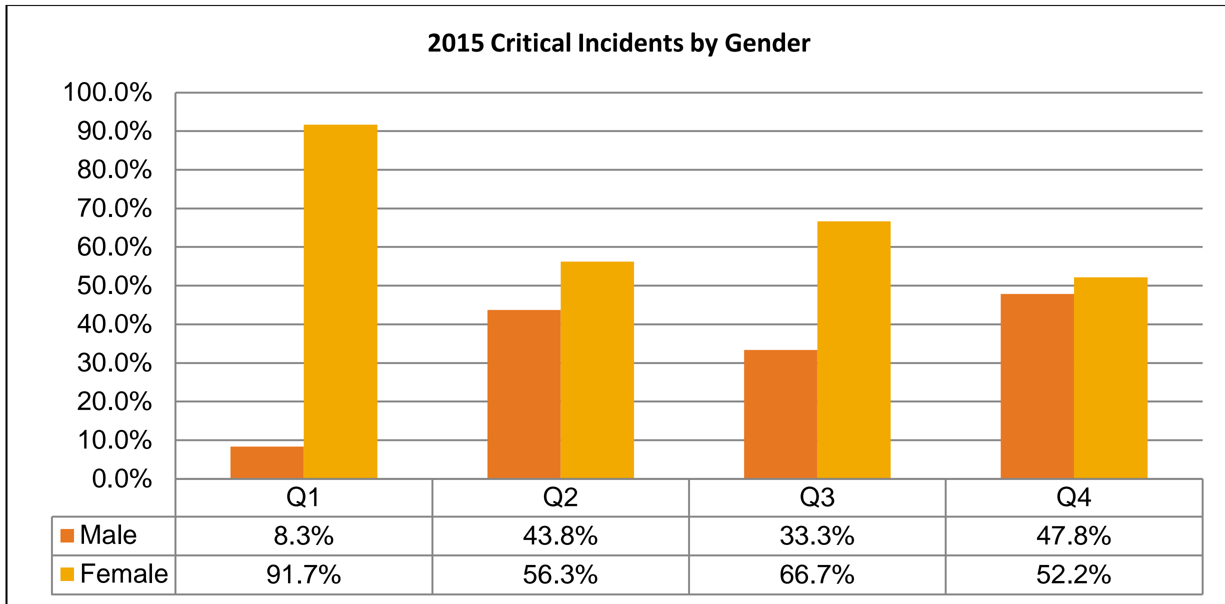
	Q1	Q2	Q3	Q4
Male	0.0%	18.8%	26.7%	30.4%
Female	58.3%	31.3%	26.7%	30.4%



	Q1	Q2	Q3	Q4
Male	18	38	43	39
Female	43	45	35	38



	Q1	Q2	Q3	Q4
Adult (18+)	91.7%	81.3%	80.0%	87.0%
Child/Adolescent (17 and under)	8.3%	18.8%	20.0%	13.0%



Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

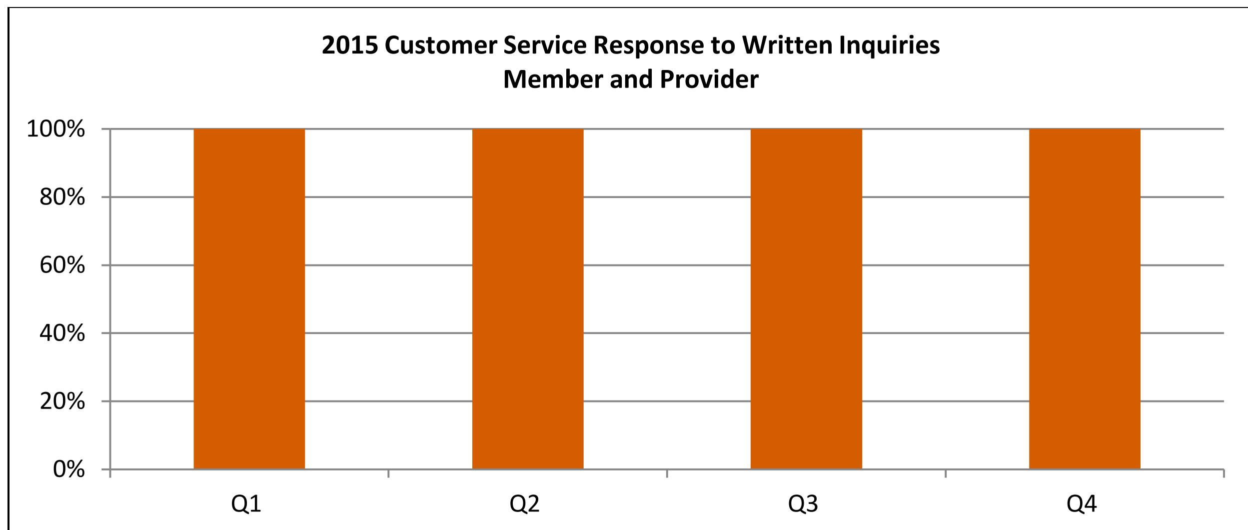
Response to Written Inquiries

Methodology: Optum Idaho's policy is to respond to all phone calls, voice mail and email/written inquiries within two (2) business days. This data is maintained and tracked in an internal database by Optum's Customer Service Department.

Quarterly Performance Results:

Customer Service Response to Written Inquiries	Performance Goal	Q1 2015	Q2 2015	Q3 2015	Q4 2015
Percent Acknowledged ≤ 2 business days	100.0%	100.0%	100.0%	100.0%	100.0%

Analysis: The data summarizes Optum Idaho Customer Service responsiveness to written inquiries to both members and providers. The data indicated that the standard of 100% acknowledged within 2 business days was again met during Q4, consistently being met throughout 2015.



Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

Provider Monitoring and Relations

Provider Quality Monitoring

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

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.

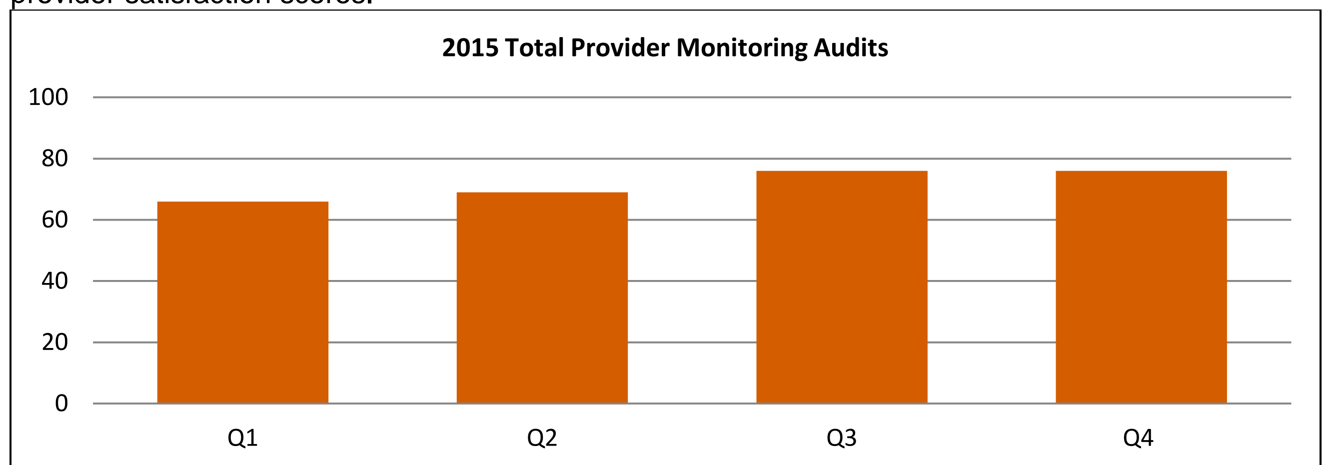
Quarterly Performance Results:

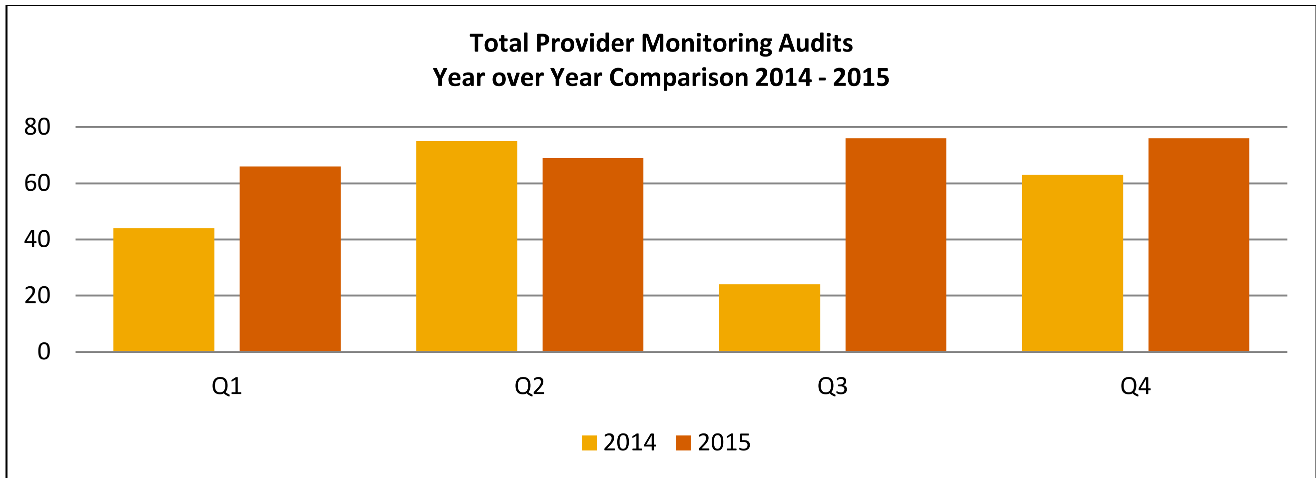
Treatment Record Audit	Performance Goal	Q1 2015	Q2 2015	Q3 2015	Q4 2015
Number of Audits Conducted	NA	66	69	76	76
Credentialing Audit (Average overall score)	85.0%	97.0%	97.3%	97.0%	95.1%
Recredentialing Audit (Average overall score)	85.0%	97.0%	95.3%	95.2%	98.4%
Ongoing Monitoring (Average overall score)	85.0%	91.0%	89.9%	91.0%	88.5%
Quality of Care (Average overall score)	85.0%	96.0%	90.5%	94.5%	94.7%
Percent of Audits Requiring a Corrective Action Plan	NA	12.1%	13.0%	22.4%	22.4%

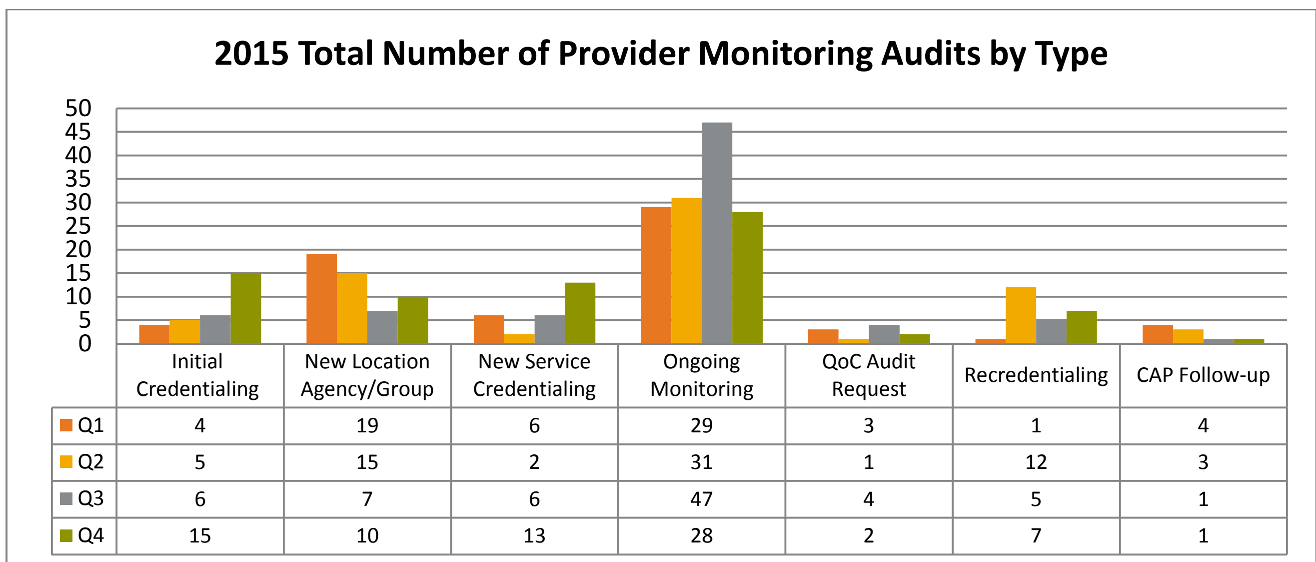
Analysis: During Q4, 76 Provider Monitoring Audits were completed. A total of 287 audits during 2015, which is an increase from 206 audits completed during 2014. During Q4, 77.6% of audits received a passing score. Corrective action plans were implemented for 22.4% of the audits that were completed during Q4.

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 – Q4, 2015, in the areas of Provider Satisfaction with Quality Monitoring Audit Process and Satisfaction with Auditors. Overall, Providers have stated that they have been satisfied with the audit process and with the auditors

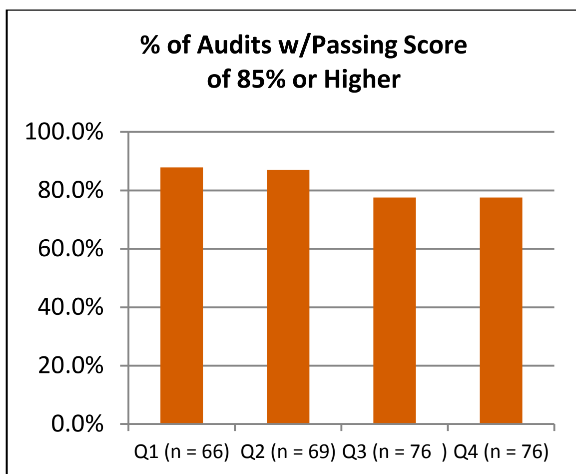
Overall audit scores per region and per audit type are reflected in graphs below, along with provider satisfaction scores.

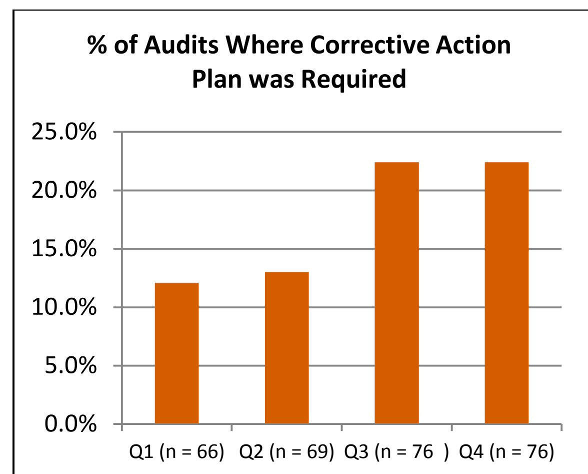


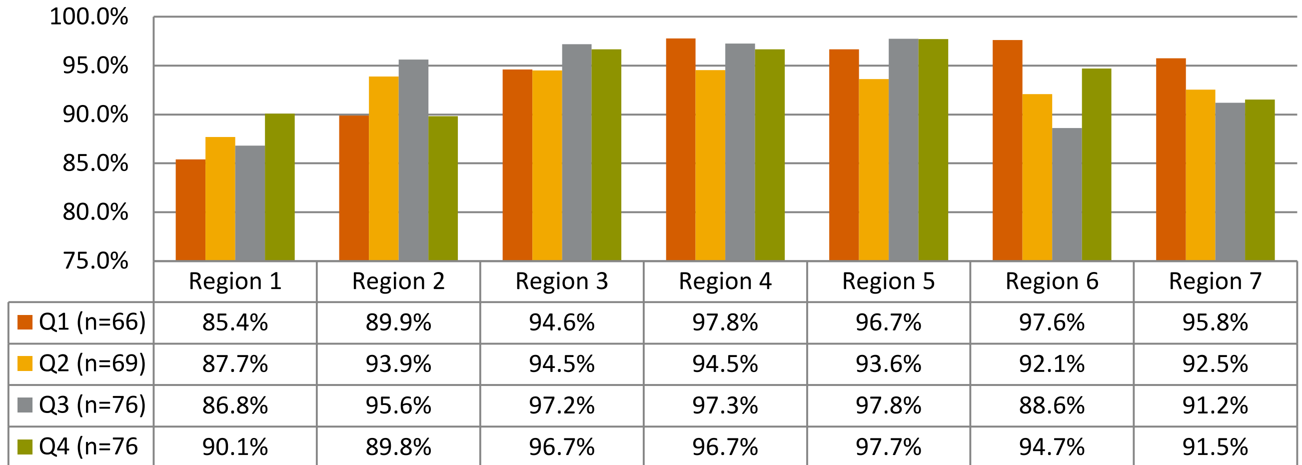




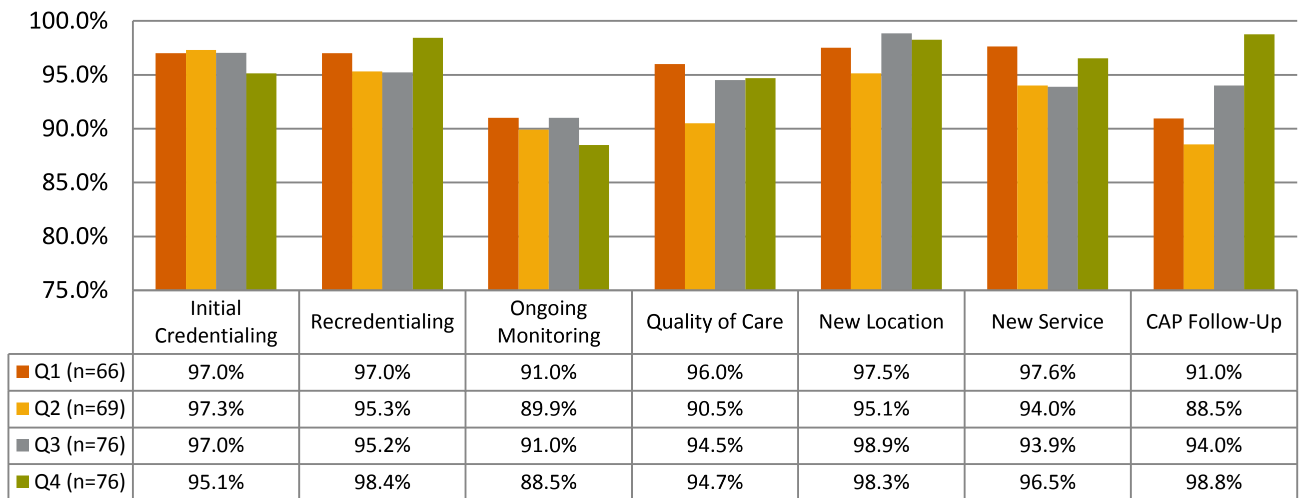
	Initial Credentialing	New Location Agency/Group	New Service Credentialing	Ongoing Monitoring	QoC Audit Request	Recredentialing	CAP Follow-up
Q1	4	19	6	29	3	1	4
Q2	5	15	2	31	1	12	3
Q3	6	7	6	47	4	5	1
Q4	15	10	13	28	2	7	1



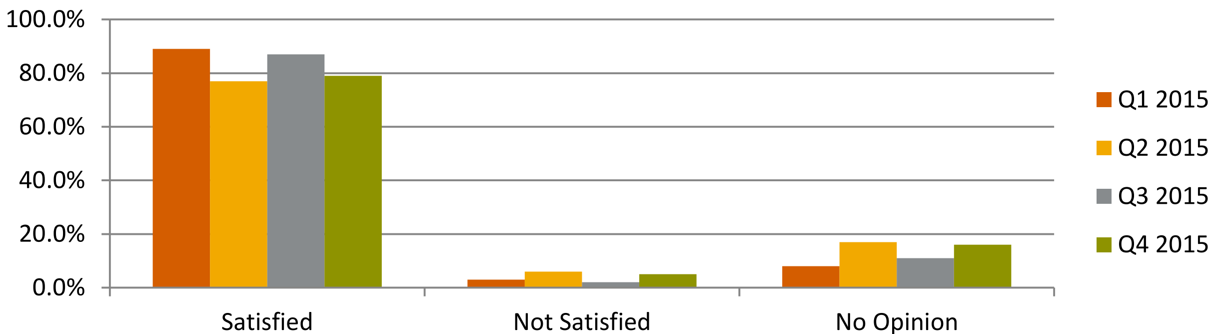


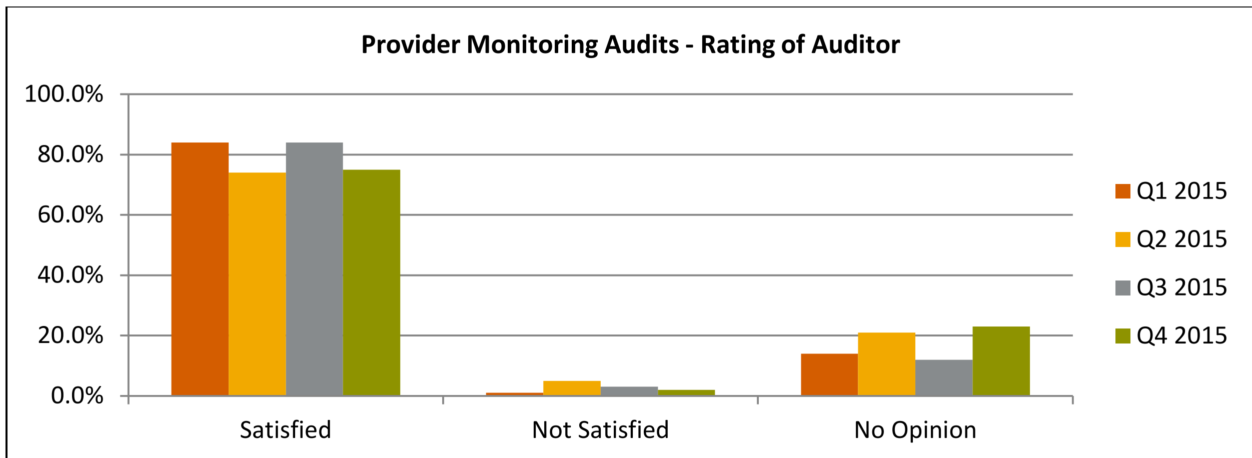


	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Q1 (n=66)	85.4%	89.9%	94.6%	97.8%	96.7%	97.6%	95.8%
Q2 (n=69)	87.7%	93.9%	94.5%	94.5%	93.6%	92.1%	92.5%
Q3 (n=76)	86.8%	95.6%	97.2%	97.3%	97.8%	88.6%	91.2%
Q4 (n=76	90.1%	89.8%	96.7%	96.7%	97.7%	94.7%	91.5%



	Initial Credentialing	Recredentialing	Ongoing Monitoring	Quality of Care	New Location	New Service	CAP Follow-Up
Q1 (n=66)	97.0%	97.0%	91.0%	96.0%	97.5%	97.6%	91.0%
Q2 (n=69)	97.3%	95.3%	89.9%	90.5%	95.1%	94.0%	88.5%
Q3 (n=76)	97.0%	95.2%	91.0%	94.5%	98.9%	93.9%	94.0%
Q4 (n=76)	95.1%	98.4%	88.5%	94.7%	98.3%	96.5%	98.8%





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

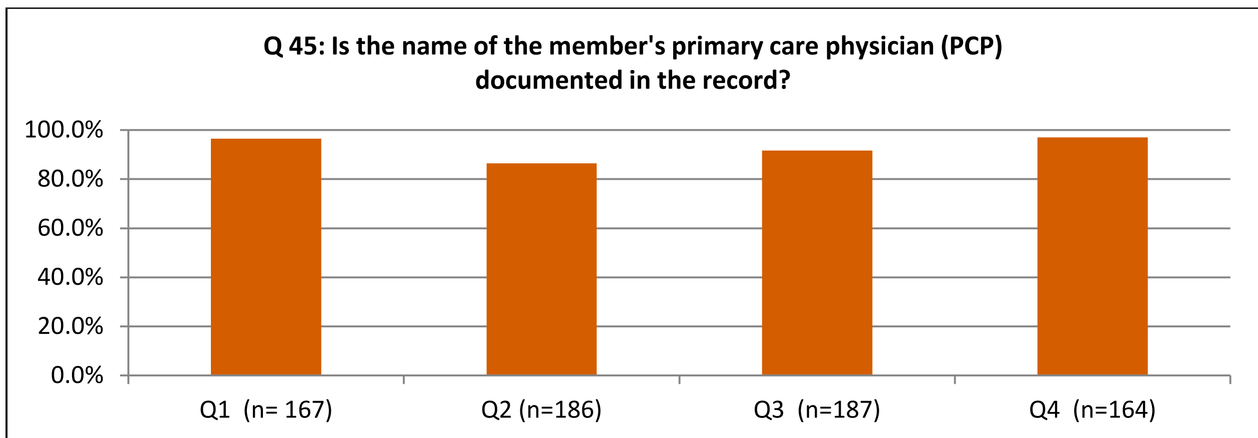
Some members may refuse to allow for release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. Optum, as well as accrediting organizations, expect providers to make a "good faith" effort at communicating with other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

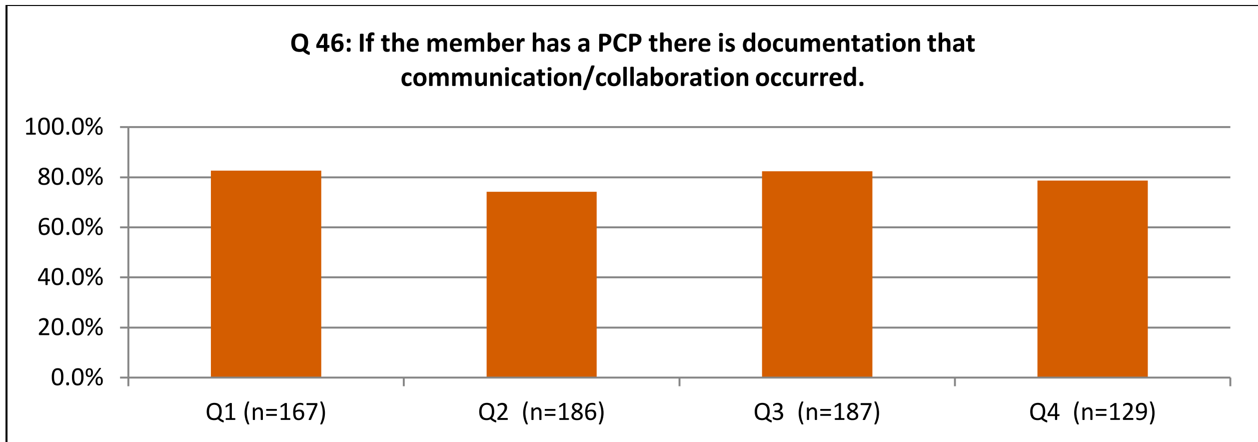
The Treatment Record Review Audit Tool includes questions related to Coordination of Care. These questions are completed during an audit by Optum Idaho Provider Quality Specialist (audit) staff. The results are tabulated in an internal Excel spreadsheet.

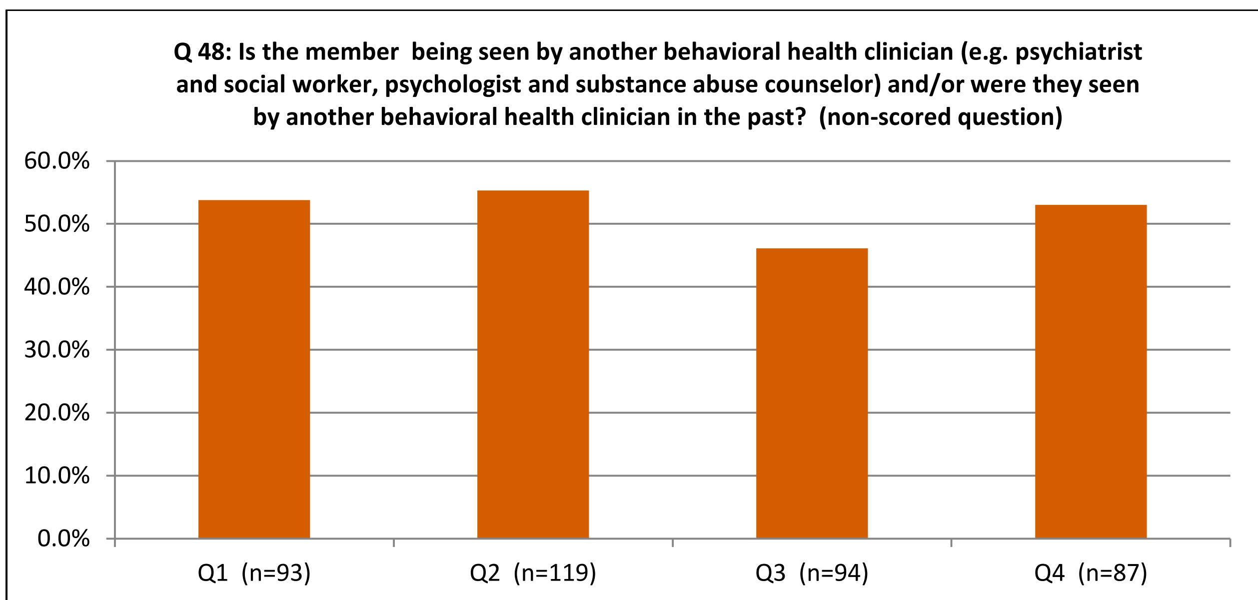
Quarterly Performance Results:

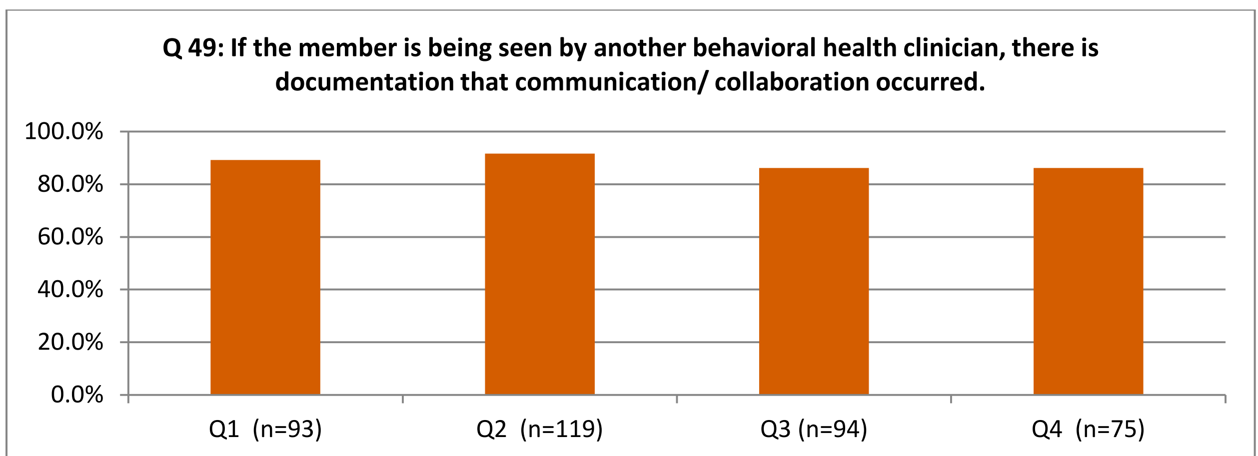
Coordination of Care (% answered in the affirmative)	**Performance Goal**	**Q1 2015**	**Q2 2015**	**Q3 2015**	**Q4 2015**
Q45: Is the name of the member's primary care physician (PCP) documented in the record?	NA	96.5 %	86.5%	91.7%	97.0%
Q 46: If the Member has a PCP there is documentation that communication/collaboration occurred	NA	82.6%	74.2%	82.4%	78.7%
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%	53.0%
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%	86.2%

Analysis: Coordination of Care audits completed during Q4 revealed that 97.0% of member records reviewed had documentation of the name of the member's PCP. Of those, 78.7% indicated that Communication/Collaboration had occurred between the behavioral health provider and the member's PCP. The results also indicated that that 53.0% 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.

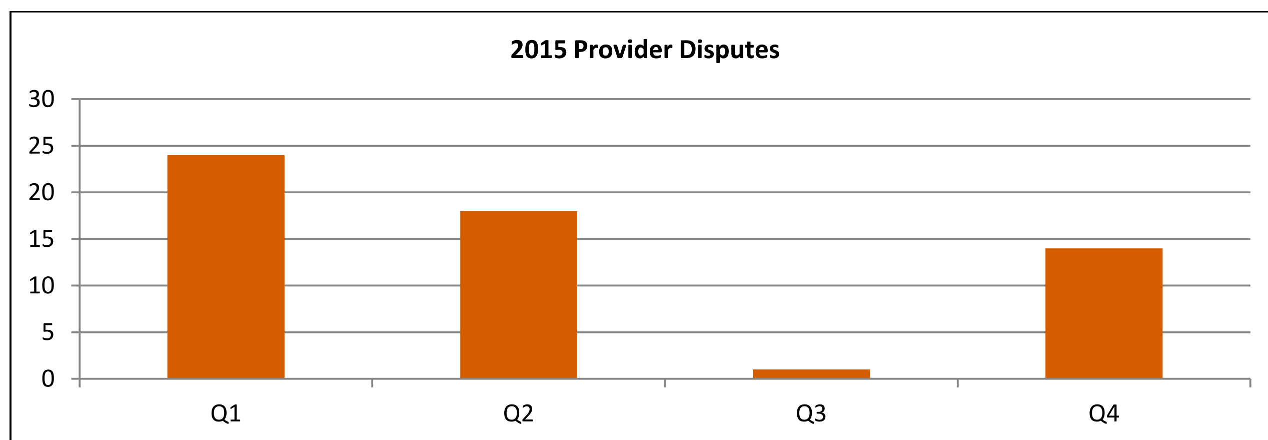
Provider Disputes

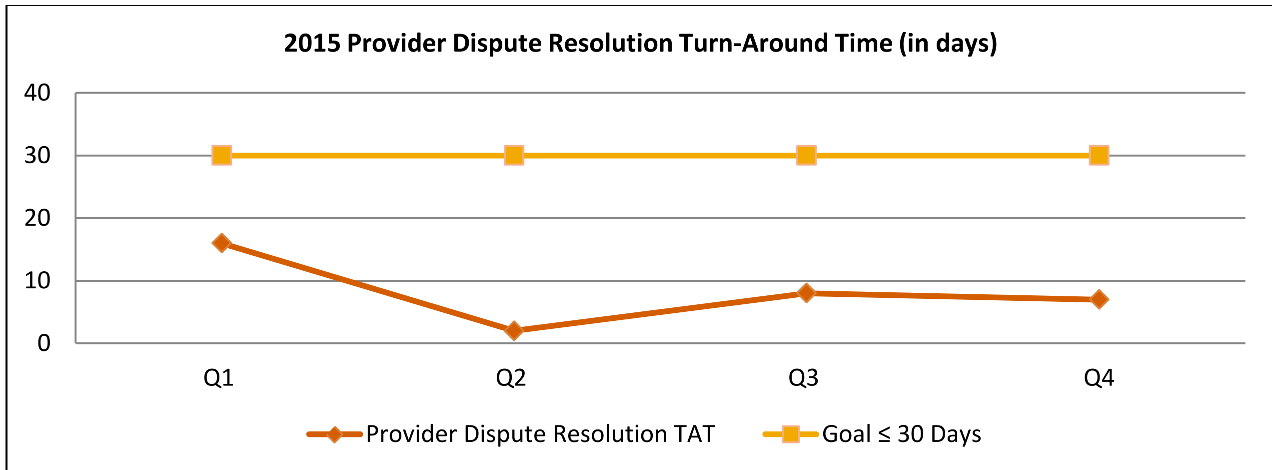
Methodology: Provider Disputes are requests by a practitioner for review of a non-coverage determination (claims-based denials) when a service has already been provided to the member, and includes a clearly expressed desire for reconsideration and indication as to why the non-coverage determination is 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	Q4 2015
Number of Provider Disputes	NA	24	18	1	14
Average # of Days Provider Disputes Resolved	30 Days	16	2	8	7

Analysis: There were 14 provider disputes during Q4. All were resolved within the goal of ≤30 days, with an average resolution of 7 days for Q4.





Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

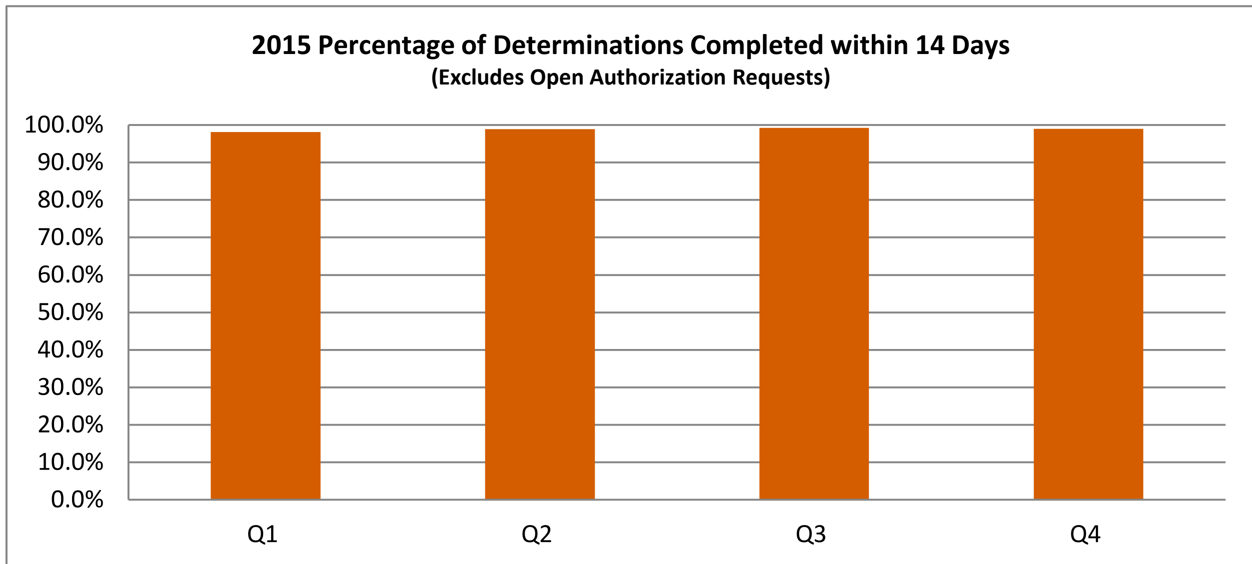
Utilization Management and Care Coordination

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.

Service Authorization Requests	Performance Goal	Q1 2015	Q2 2015	Q3 2015	Q4 2015
Number of Service Authorization Requests	NA	16,624	13,307	7,041	6,313
Percent Determinations Completed within 14 days	100.0%	98.1%	98.9%	99.2%	99.0%

Analysis: During Q4, the performance measure of processing authorizations within 14-days fell slightly below our goal of 100% at 99.0%.



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 Q4:

2015 Improvement Action Plan	Date Initiated	Quality Committee Oversight	Status	Key Accomplishments
Clinical Model 2.1	2/19/2015	Clinical and Services Advisory Committee	Open	•Meetings established with the reporting team on a bi-weekly basis. •Reviewed Provider Express portal and demonstrated use for reporting team •Reviewed clinical elements of scorecard and data sources for Key Performance Indicators •Timeline of completion reviewed

Field Care Coordination

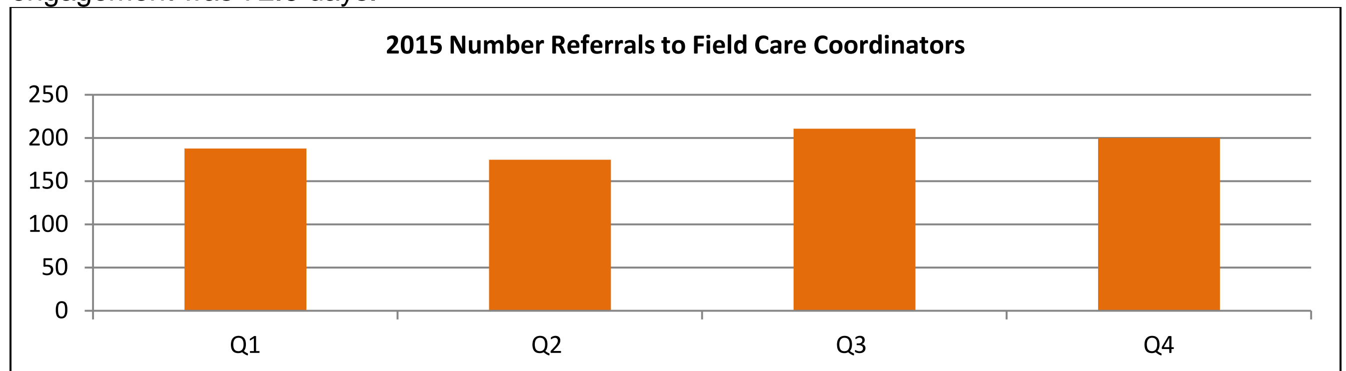
Methodology: The Field Care Coordination (FCC) program includes regionally based clinicians across the state of Idaho. They provide locally based care coordination and discharge planning support. Field Care Coordinators work with the provider to help members. The FCC team focuses on member wellness,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

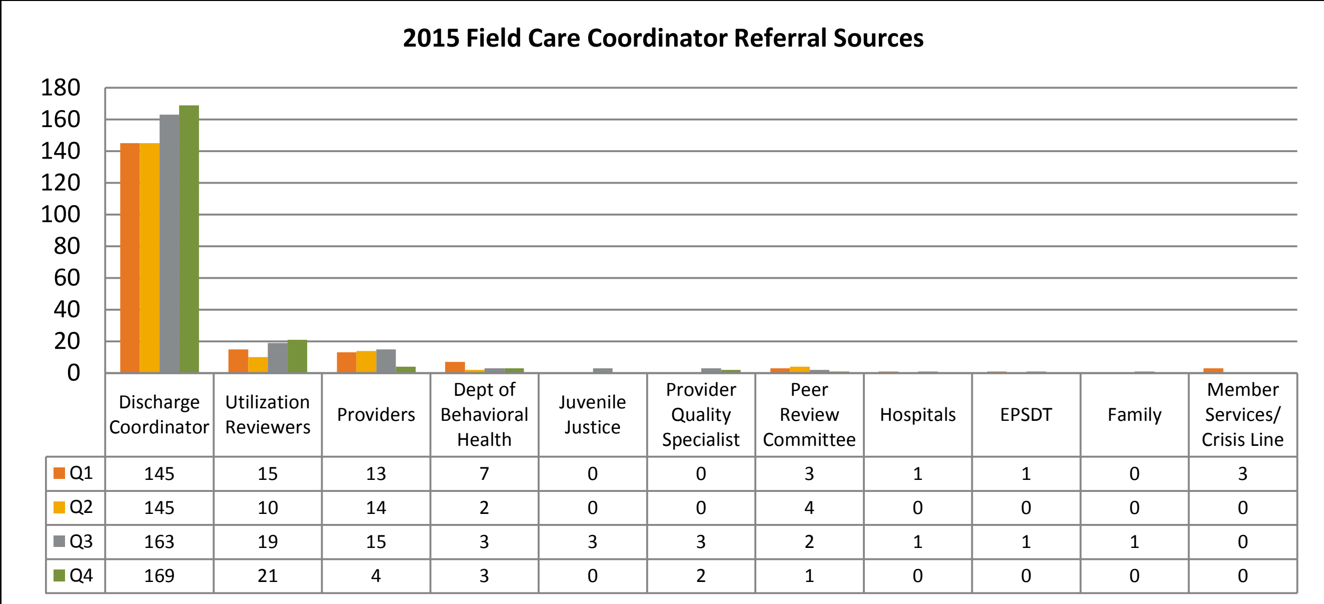
- Focusing on consumers and families who are at greatest clinical risk
- Focusing on consumer's wellness and the consumer's responsibility for his/her own health and well-being.
- Improved care coordination for consumers moving between services, especially those being discharged from 24-hour care settings.

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 Q4.

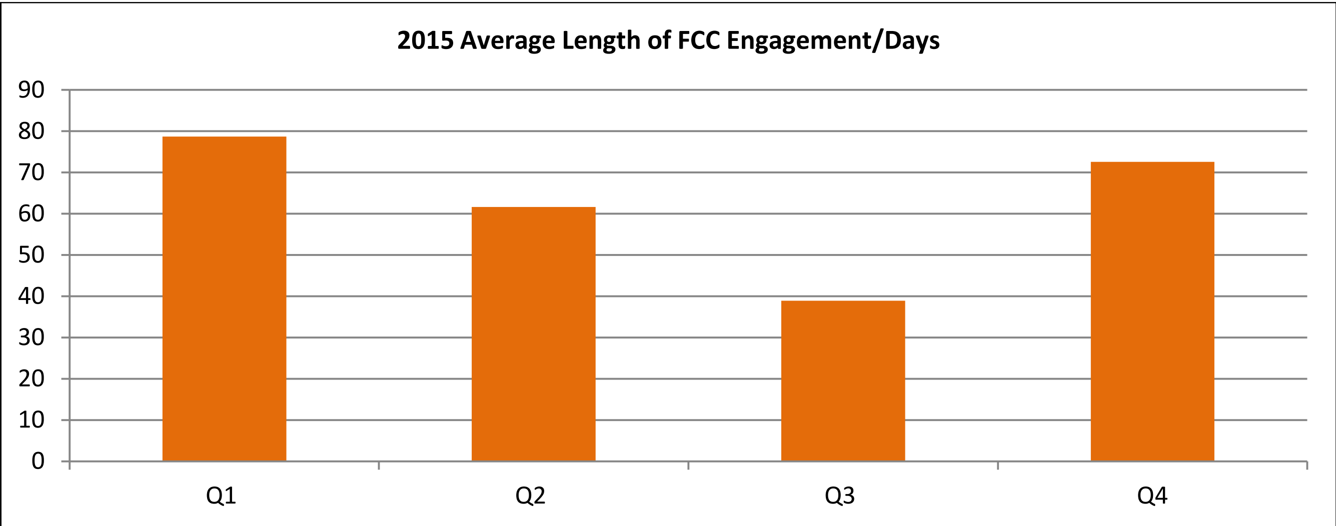
Referral Sources	Q1 2015	Q2 2015	Q3 2015	Q4 2015
Discharge Coordinator	145	145	163	169
Utilization Reviewers	15	10	19	21
Providers	13	14	15	4
Dept of Behavioral Health	7	2	3	3
Juvenile Justice	0	0	3	0
Provider Quality Specialist	0	0	3	2
Peer Review Committee	3	4	2	1
Hospitals	1	0	1	0
EPSDT	1	0	1	0
Family	0	0	1	0
Member Services/Crisis Line	3	0	0	0
Total	188	175	211	200

Analysis: During Q4, Field Care Coordinators received 200 referrals. Of the 200 referrals, 169 referrals were made by the Discharge Coordinator staff. The average length of FCC engagement was 72.6 days.





	Discharge Coordinator	Utilization Reviewers	Providers	Dept of Behavioral Health	Juvenile Justice	Provider Quality Specialist	Peer Review Committee	Hospitals	EPSDT	Family	Member Services/ Crisis Line
Q1	145	15	13	7	0	0	3	1	1	0	3
Q2	145	10	14	2	0	0	4	0	0	0	0
Q3	163	19	15	3	3	3	2	1	1	1	0
Q4	169	21	4	3	0	2	1	0	0	0	0

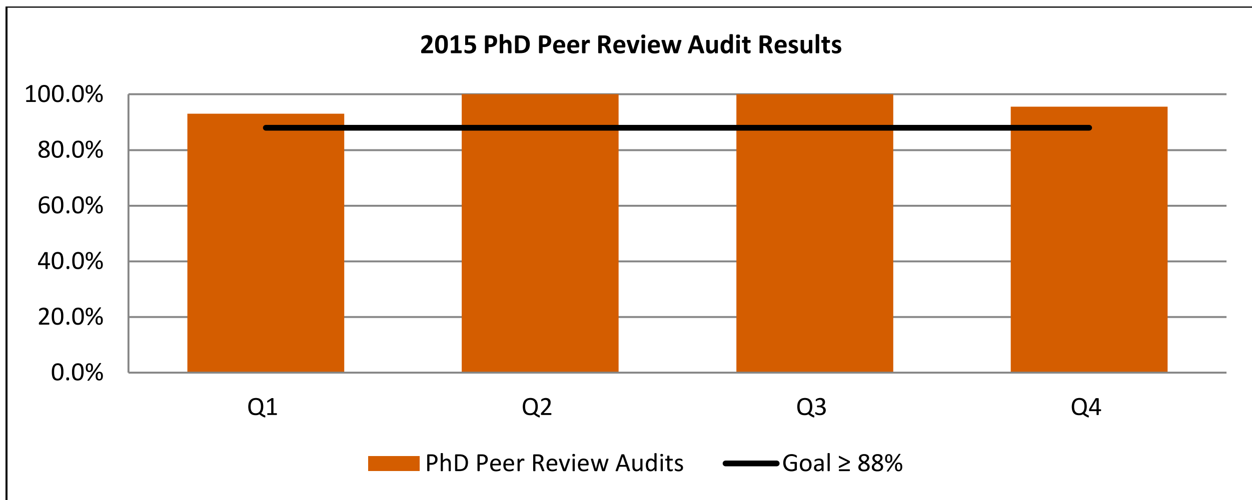


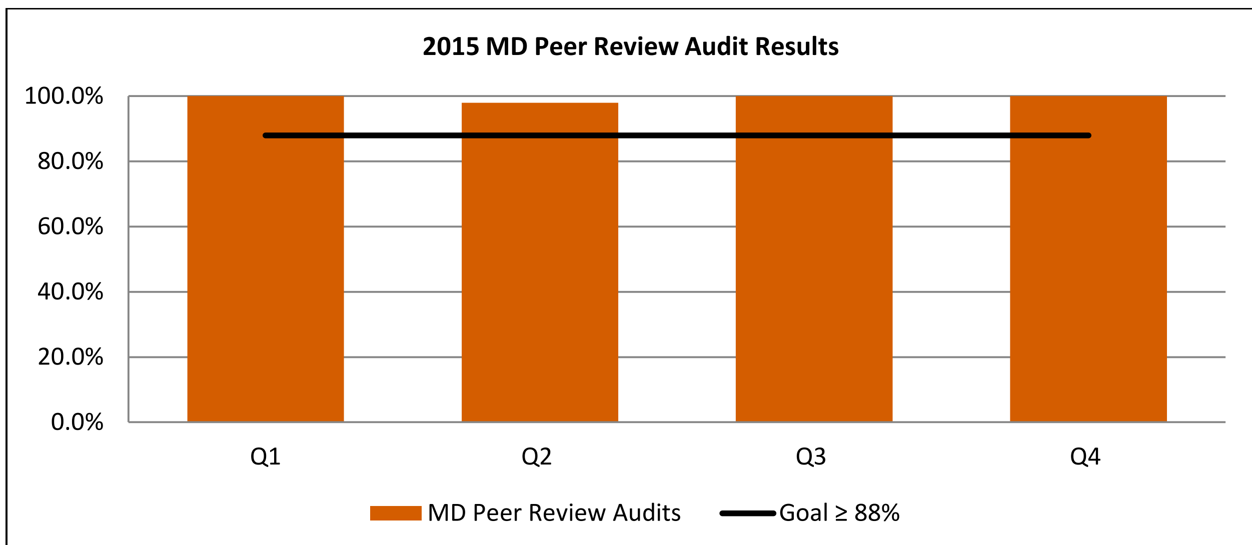
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

Peer Reviewer 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 ≥ 88%.

Analysis: Based on the performance goal of ≥ 88%, audit results indicate that PhD and MD Peer Review Audits received passing scores during Q4.





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, routinely reviewing documentation of clinical transactions in member records, providing ongoing supervision and consultation and 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.

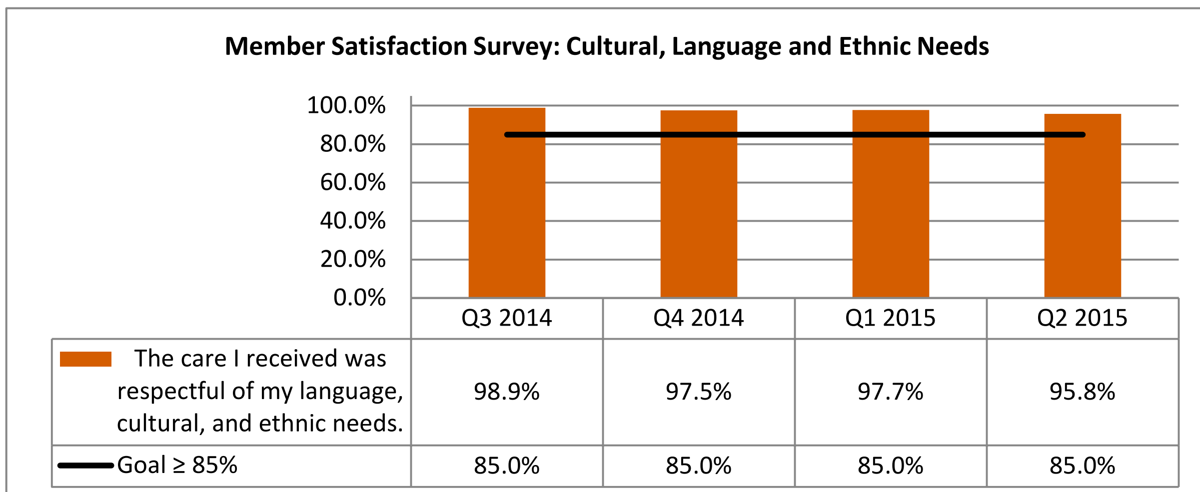
Population Analysis

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 gage 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 95.8% of members believe the care they received was respectful of their language, cultural, and ethnic needs. Based on the Member Satisfaction Survey sampling methodology, Q2 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.

Analysis: due to reporting lag, this information will be presented in the Q1, 2016 report.

Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

Claims

Methodology: The data source for claims is Cosmos via Webtrax. Data extraction is the number of "clean" claims paid within 30 and 90 calendar days. A clean claim excludes adjustments (Adjustments are any transaction that modifies (increase/decrease) the original claims payment; the original payment must have dollars applied to the deductible/ copay/ payment to provider or member) and/or resubmissions (A resubmission is correction to an original claim that was denied by Optum) A claim will be considered processed when the claim has been completely reviewed and a payment determination has been made; this is measured from the received date to the paid date (check), plus two days for mail time. Company holidays are included.

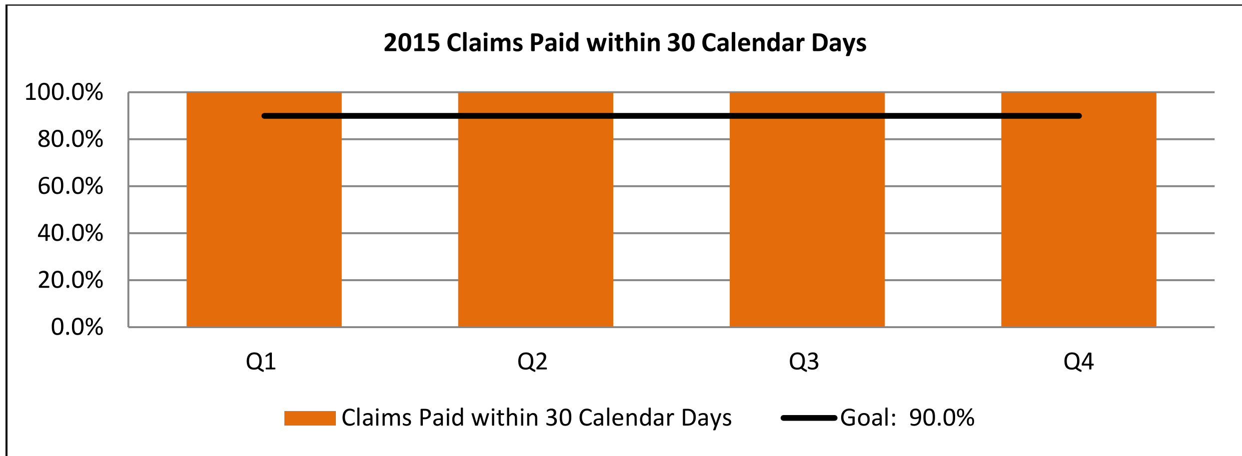
Dollar Accuracy Rate (DAR) is measured by collecting a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claim dollars paid correctly out of the total claim dollars paid. It is the percent of paid dollars processed correctly (total paid dollars minus overpayments and underpayments divided by the total paid dollars).

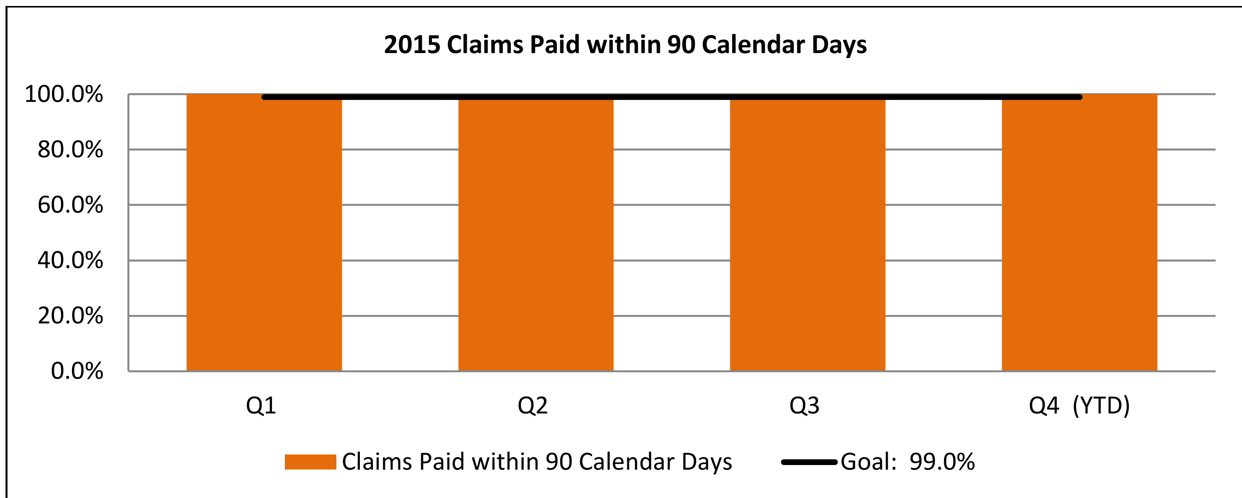
Procedural Accuracy Rate (PAR) is measured by collection a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claims processed without procedural (i.e. non-financial) errors. It is the percentage of claims processed without non-financial errors (total number of claims audited minus the number of claims with non-financial errors divided by the total claims audited).

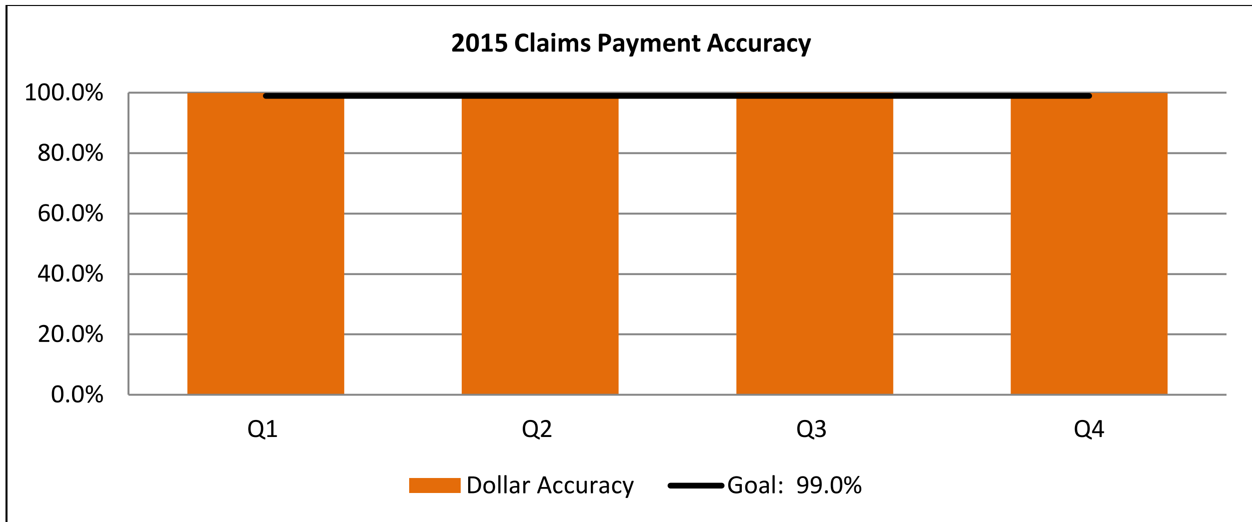
Quarterly Performance Results:

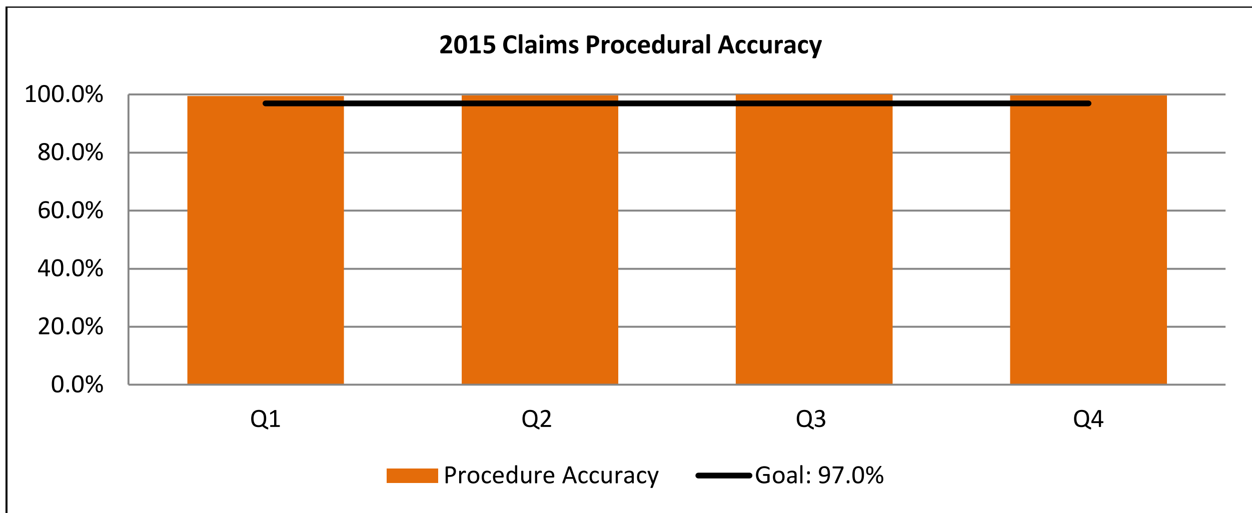
Claims	Performance Goal	Q1 2015	Q2 2015	Q3 2015	Q4 2015 (based on the Dec. OR54 report)
Paid within 30 days	90%	99.9%	99.9%	99.9%	99.9%
Paid within 90 days	99%	100.0%	99.9%	100.0%	100.0%
Dollar Accuracy	99%	99.9%	99.8%	100.0%	99.9%
Procedural Accuracy	97%	99.5%	99.7%	100.0%	99.7%

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.