# OPTUM™

Behavioral Solutions

# Idaho Behavioral Health Plan Quality Management and Improvement Quarterly Report

# Q1 and Q2
# 2015

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## Performance Summary

The Idaho Behavioral Health Plan Quality Management and Improvement (QMI) quarterly report summarizes Optum Idaho's Quality Management and Utilization Management (QMUM) Program for Quarter 1 and Quarter 2, 2015. It provides an overview of outcomes data for Medicaid outpatient mental health and substance use disorder services managed by the Idaho Behavioral Health Plan (IBHP) in the State of Idaho.

The following mission statement was written and distributed by the Idaho Department of Health and Welfare (IDHW) and serves as a guiding document for the IBHP QMI program:

- *Our mission is to promote and protect the health and safety of Idahoans.*
- *Improve the quality of care provided to all behavioral health Members;*
- *Improve behavioral health Member satisfaction with services received; and*
- *Improve health outcomes for all behavioral health Members.*

This mission is actualized in the strategic goals developed by the Optum Idaho Leadership Team and monitored through the *Outcomes Management & Quality Improvement Work Plan.*

During Quarter 1 and Quarter 2, Optum Idaho met performance goals in 23 of the 25 measurement areas which include the following:
- Geographic Availability of Providers
  - Area 1
  - Area 2
- Member Call Standards:
  - % of Calls Answered within 30 seconds
  - Average Speed of Answer
  - Call Abandonment Rate
- Urgent Appointment Access Standards
- Non-Urgent Appointment Access Standards
- Initial Notification of Adverse Benefit Determinations
- Grievance Resolution Turnaround Time
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- Quality of Care Complaint Resolution Turnaround time
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- Critical Incident Ad-Hoc Review Turnaround time
- Customer Service Response to Written Inquiries
- Customer Service Line:
  - % of Calls Answered within 30 seconds
  - Average Speed of Answer
  - Call Abandonment Rate
- Provider Dispute Resolution Turnaround time
- Portal Authorizations Processed in 14 calendar Days
- PhD Peer Review Audit Scores
- MD Peer Review Audit Scores
- Claims Paid within 30 days

- Claims Paid within 90 days
- Claims Dollar Accuracy
- Claims Procedural Accuracy

Optum Idaho did not meet the performance goal in the following 2 areas:

- Adverse Benefit Determination – Written notification w/in 1 business day
- Provider Overall Satisfaction

The results of Optum Idaho's efforts in Quarter 1 and Quarter 2, 2015, have proven to be positive in achieving the right care, at the right time for our members.

## Q1 & Q2 Performance Analysis by Category:

**Quality Assurance Core Documents and Policy Review**

*Analysis:* The Quality Assurance Performance Improvement (QAPI) Committee, as part of the annual review of all Quality Improvement Core Documents and Policies and Procedures, reviews the documents at monthly meetings. The following documents were reviewed during Q1 and Q2:

**These Core Documents were reviewed during Q1.**
- 2015 Quality Improvement Plan
- Outcomes Management Work Plan

**The following is a tracking of the Annual Review of the Optum Idaho Policies & Procedures:**

| Annual Review of Optum Idaho Quality Assurance Policies - 2015 | | | |
|---|---|---|---|
| **Optum Idaho Policy Name** | **Initial Development Date** | **Previous QAPI Review Date** | **2015 Review Date** (*Sent to National Policy Committee) |
| 1. Optum Idaho Monitoring Important Aspects of Care and Services | August 2013 | 6/17/14 | 5/19/15* |
| 2. Optum Idaho Performance Improvement Projects | August 2013 | 6/17/14 | 6/16/15* |
| 3. Optum Idaho QAPI Program Evaluation | August 2013 | 6/17/14 | 6/16/15* |
| 4. Optum Idaho Quality Improvement Plan | August 2013 | 6/17/14 | 6/16/15* |
| 5. Optum Idaho Treatment Record Documentation | August 2013 | 7/15/14 | 7/21/15* |
| 6. Optum Idaho Quality of Care Audits | August 2013 | 7/15/14 | 7/21/15* |
| 7. Optum Idaho Provider Monitoring Plan | August 2013 | 7/15/14 | 7/21/15* |
| 8. Optum Idaho Supervisory Protocol | December 2013 | 7/15/14 | May* (Monika Mikkelsen) |
| 9. Optum Idaho QAPI Committee Structure | August 2013 | 7/15/14 | 7/21/15* |
| 10. Optum Idaho Outcomes Management and Quality Improvement Work Plan | August 2013 | 7/15/14 | 7/21/15* |

| | | | |
|---|---|---|---|
| 11. Optum Idaho External Audits | August 2013 | 7/15/14 | 5/19/15* |
| 12. Optum Idaho Provider Site Audits | September 2013 | 8/19/14 | 7/21/15* |
| 13. Optum Idaho QOS Complaints and QOC Concerns | August 2013 | 8/19/14 | 1/20/15* |
| 14. Optum Idaho Critical Incidents | January 2015* (NEW) | NA | NA |
| 15. Optum Idaho Member Grievances and Appeals of Adverse Actions | August 2013 | 8/17/14 | Internal Dept. Review |

## Availability of Providers

## Language and Culture

Optum uses U. S. Census results to estimate the ethnic, racial, and cultural distribution of our membership. Descriptive data on our network are also included in this section. Gaps were identified when the rate between U. S. Census results and our network data was greater than ten percentage points.

| 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% |

## Optum Network Results for Ethnicity/Race

Network Self-report of Race and Ethnicity

| Total Network | Hispanic or Latino | White Alone | Black or African American Alone | Native Indian & Alaska Native Alone | Asian Alone | Native Hawaiian or Pacific Islander Alone | Some other race Alone |
|---|---|---|---|---|---|---|---|
| 1727 | 0.6% | 28.3% | 0.2% | 0.1% | 0.2% | 0.1% | 0.5% |

The IBHP offers services to a total membership of approximately 258,113 eligible participants. The table below indicates percentages of males to females for the varying age groups of our eligible members; 48% female to 52% male for all age groups except 18 and over which shows a 65% female to 35% male ratio.

**TOTAL MEMBERSHIP BY GENDER AND AGE CATEGORY**
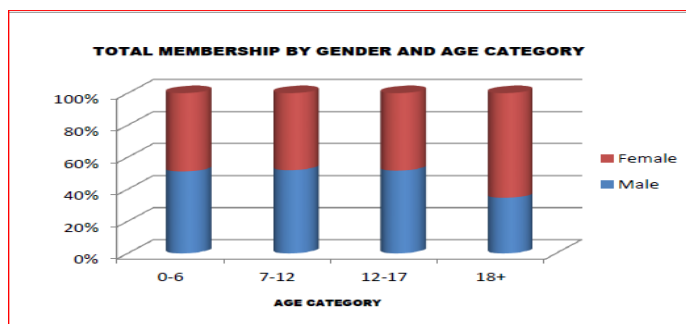
Among this membership, Optum has also noted ethnicities and primary languages spoken as reported by the member. There are six ethnic categories represented as White, Native American, Pacific Islander, Hispanic, Black, and Asian Pacific American with 98% of the membership reporting as White. Additionally, there are 13 different primary languages reported as Arabic, Chinese, English, French, German, Hindi, Kurdish, Portuguese, Romanian, Serbian, Spanish, Tai, and Vietnamese with 96% reporting English as a primary language.

## Results for Language and Culture

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. During Q1 and Q2, we have responded to one (1) request for language assistance as follows:

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

*Analysis:*

*Language*

As illustrated in the data on language spoken at home, English is the primary language spoken in the home for more than 96% of the total population. Spanish is the second largest language spoken in the majority of states.

Spanish was also the top secondary language spoken by network practitioners. Other services offered to our Spanish-speaking membership include bi-lingual enrollee educational materials available to practitioners on providerexpress.com, the MenteSano-CuerpoSano.com website for Spanish-speaking enrollees and AT&T Language Line services for translation assistance. This analysis did not identify a need for additional providers based on language spoken.

*Culture*

Overall, comparison of membership and network data suggests that we maintain a sufficiently diverse network to serve the cultural and ethnic needs of the membership in Idaho. Because providers report information on their linguistic and cultural characteristics on a voluntary basis, it is likely that diversity of the network is under-reported in our network data.

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

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

## Geographic Availability of Providers

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

**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.

**Analysis:** Optum currently meets contract availability standards for Area 1 at 99.8% during Q1 and 99.7% during Q2.  Area 2 availability standards were met at 99.9% during both Q1 and Q2.

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

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

## Member Accessibility to Care and Services

### Member Enrollment

| IBHP Member Enrollment Results | Q1 2015 | Q2 2015 |
|---|---|---|
| Dual Eligible Enrollment | 69,194 | 69,594 |
| Non-Dual Eligible Enrollment | 743,115 | 752,912 |

**Methodology:** IDHW sends eligibility data to Optum on a monthly basis. Dual Eligible members are enrolled in Medicare and Medicaid. Non Dual Eligible members are enrolled in Medicaid only.

**Analysis:** Dual Eligible Enrollment was at 69,594 during Q2, 2015, which is an increase from 69,194 during Q1. Non-Dual Eligible Enrollment was at 752,912 during Q2, 2015, which is an increase from 743,115 during Q1.

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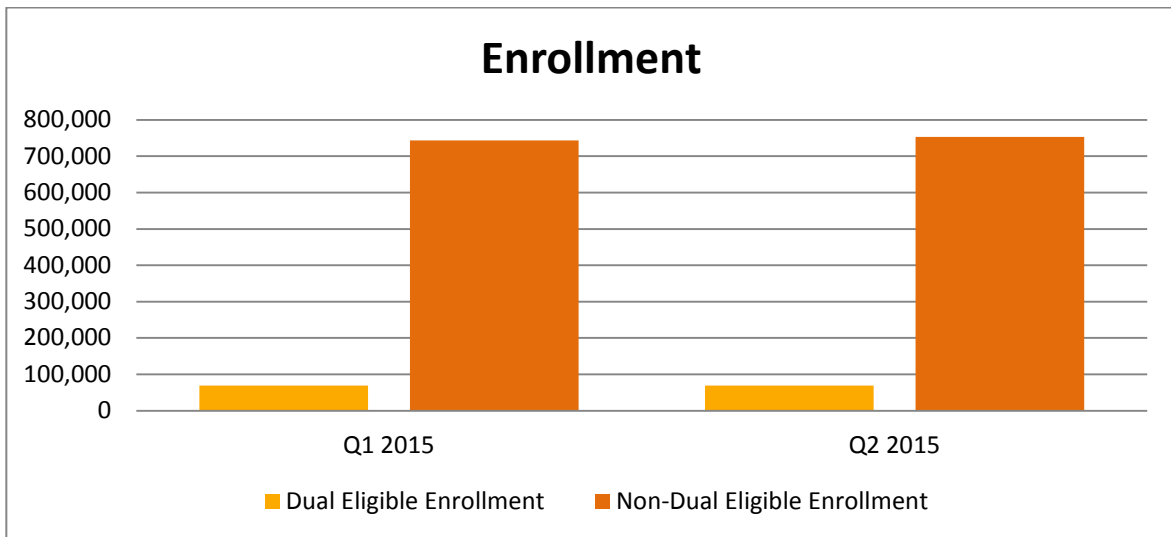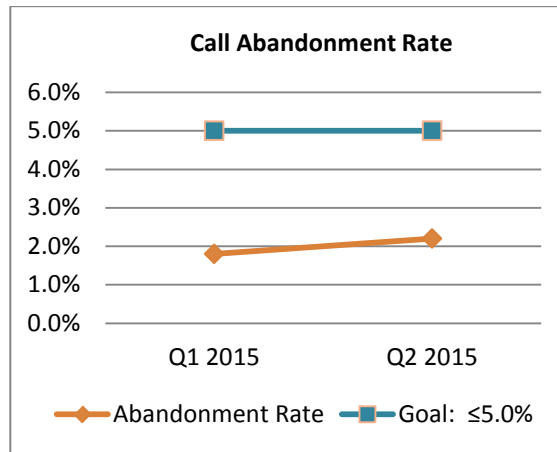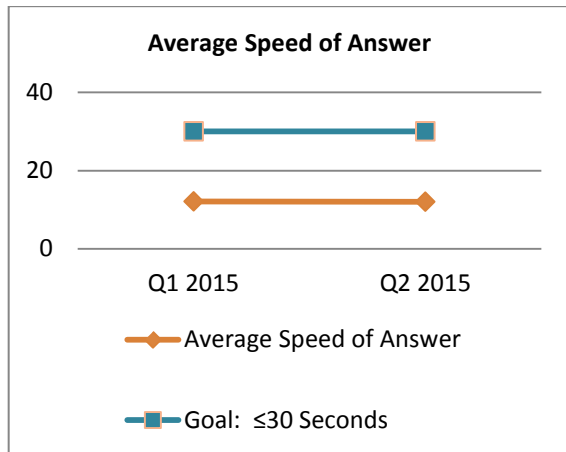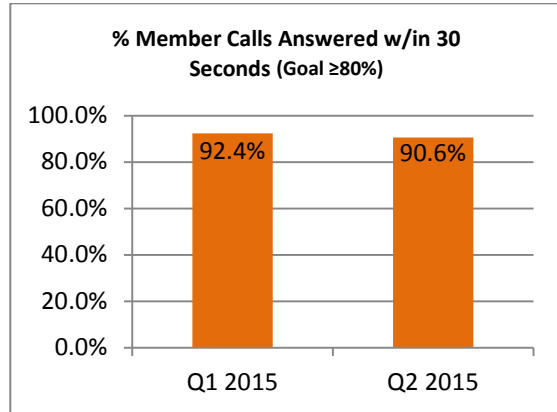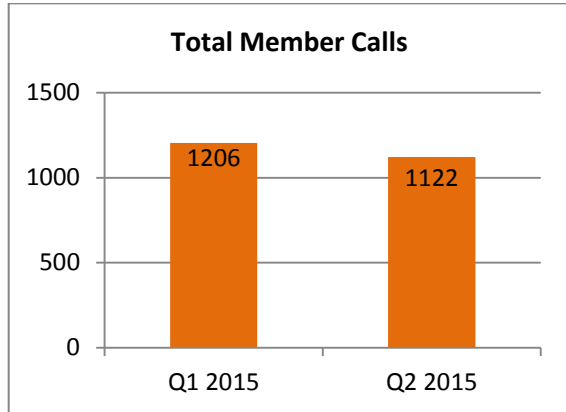
## Call Standards

| Member Service Line Results | Optum Idaho Standards | IBHP Contract Standards | Q1 2015 | Q2 2015 |
|---|---|---|---|---|
| Total Number of Calls | NA | NA | 1206 | 1122 |
| Percent of Calls Answered Within 30 Sec | ≥80% | None | 92.4% | 90.6% |
| Average Speed of Answer | ≤30 Seconds | 120 seconds (2 minutes) | 12.1 sec | 12.0 sec |
| Abandonment Rate | ≤3.5% | ≤7% | 1.8% | 2.2% |

**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 met our member's needs in a timely and efficient manner, Optum Idaho established  performance targets that exceeded IBHP contractual targets for average speed to answer (120 seconds) and call abandoned rate (≤7%) as shown in the grid above.
Data source is ProtoCall's Avaya's Communication system, and Optum/United's Avaya's Communication System.  The data shows the volume and response metrics.

**Analysis:**  The total number of member calls was 1122 in Q2.  This is a decrease from 1206 during Q1.  The percent of calls answered within 30 seconds was above the goal of ≥80% during both quarters (Q1 – 92.4% and Q2 – 90.6%).  The goal of ≤30 seconds for average speed of answer was also met during both quarters (Q1 – 12.1 seconds and Q2 – 12.0 seconds).   The call abandonment rate was at 1.8% during Q1 and 2.2% during Q2, both meeting the goal of ≤3.5%.

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

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

**Total Member Calls**



**% Member Calls Answered w/in 30 Seconds (Goal ≥80%)**



**Average Speed of Answer**



**Call Abandonment Rate**

## Urgent and Non-urgent Access Standards

| Urgent/Non-Urgent Appointment Wait Time Results | Performance Goal | Q1 2015 | Q2 2015 |
|---|---|---|---|
| Urgent Appointment Wait Time | **Appointment within 48 hours** | 11.7 hours | 35.5 hours |
| Non-Urgent Appointment Wait Time | **Appointment within 10 days** | 5.8 days | 5.4 days |

*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. Access to Treatment data is pulled from ProtoCall, Linx, and an internal Excel tracking spreadsheet. The report captures the data of existing members and new members receiving behavioral health services, the average time taken to receive authorization for services, and the average time until an appointment with a

provider.

*Analysis:* The performance goal for Urgent Appointment wait time is 48 hours.  While there was a significant increase in wait time during Q2, the goal was met during both quarters.  The increase in wait time is attributed to a provider agency and delays in establishing appointment based upon their scheduling process.  The performance goal for non-urgent appointment wait time is an appointment within 10 days.  This goal was met during Q1 and Q2.

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

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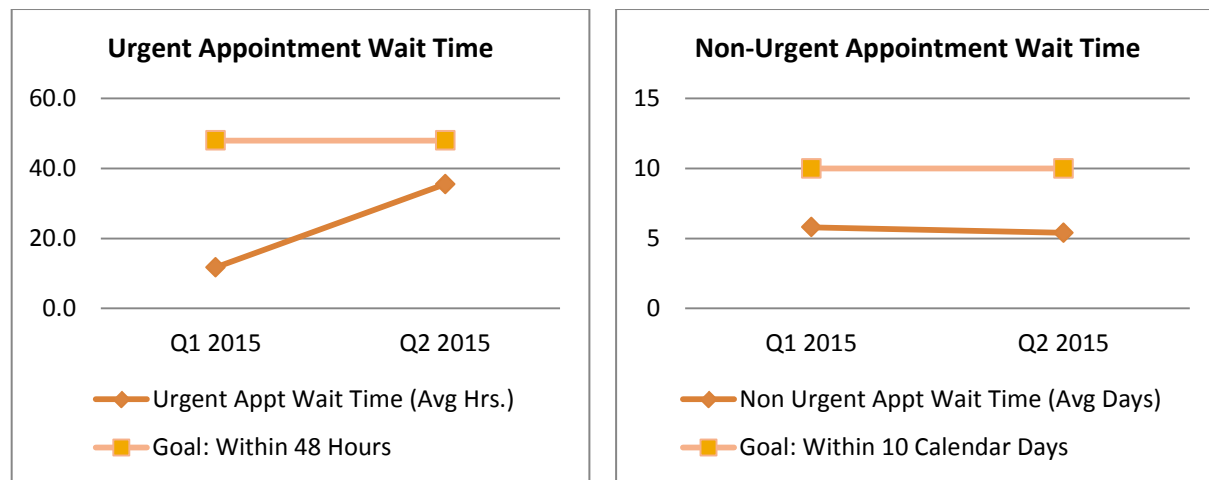


## Member Experience

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

To be eligible for the survey, the members must have a valid mailing address on record with permission for Optum to mail to their address on record. Adults 18 years of age and older and parents of children aged 15 years or younger are eligible for the survey. 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.

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 network provider* (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')

Based on the sampling method used for this survey, the data for Q1 & Q2 was not available for this quarterly report.  Q1 Member Satisfaction data should be available for the 3rd Q report.

# Member Protections and Safety

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

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

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

## Adverse Benefit Determination (ABD) and Notification:

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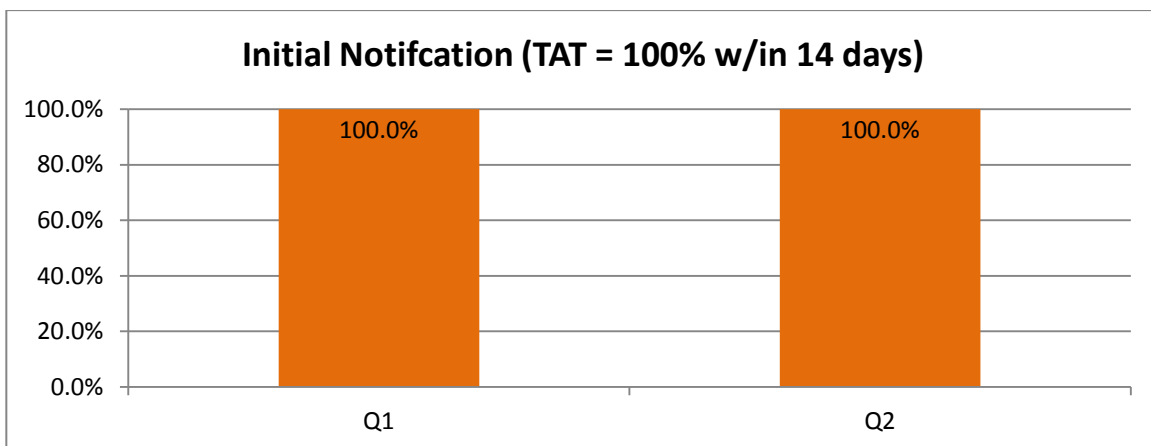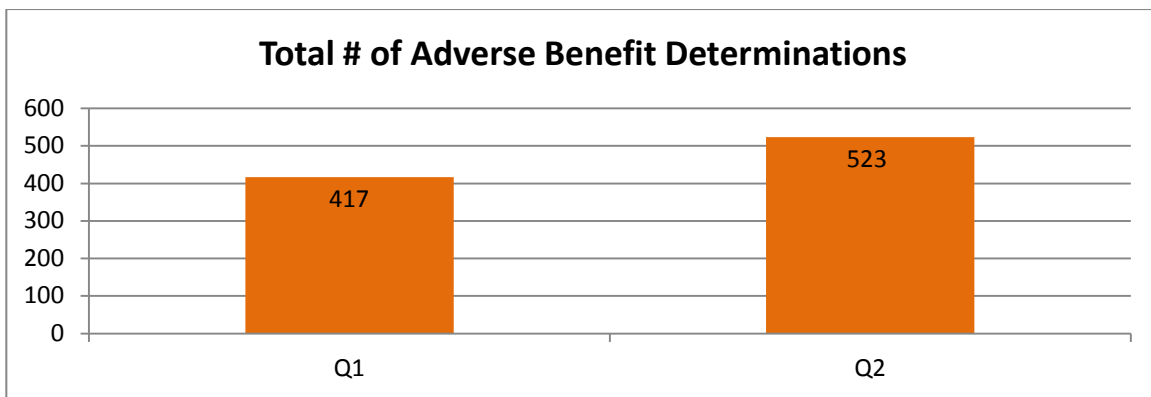| Notification of ABD Results | Performance Goal | Target | Q1 2015 | Q2 2015 |
|---|---|---|---|---|
| Total # ABD's | NA | NA | 417 | 523 |
| Adverse Determination Decision | Decision is made within 14 days from request | 100% | 99% (413) | 99.8% (522) |
| Initial Verbal Notification to Provider | Verbal notice of decision is provided the same day of determination | 100% | 100.0% | 100.0% |
| Written Notification | Written notice is sent within 1 business day following verbal notification | 100% | 96.2% (401) | 95.6% (500) |

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

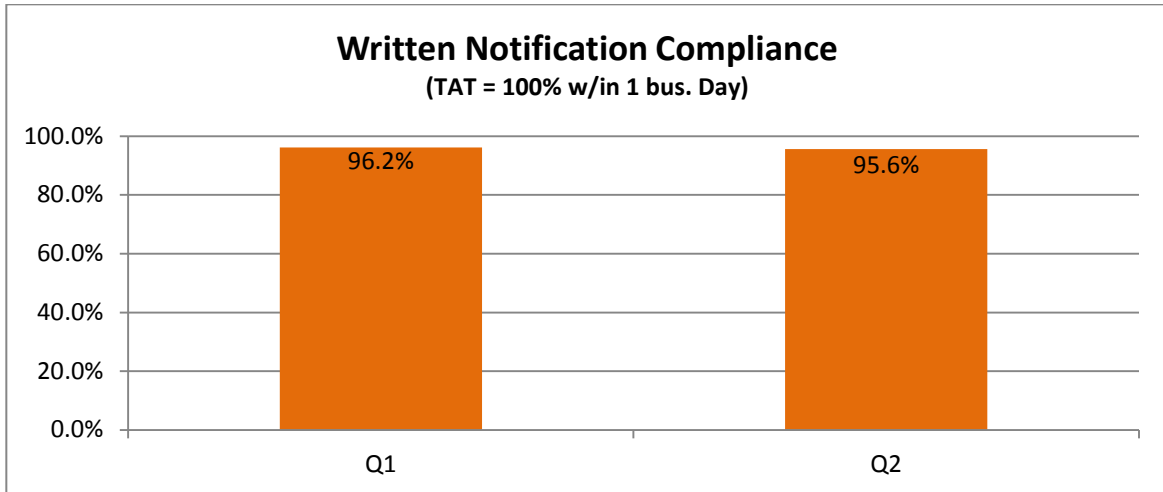**Analysis:** There were 417 ABD's during Q1 and 523 during Q2. When a request for services is received, Optum has 14 days to review the case and make a determination to authorize services or deny services in total or in part. This TAT was not met at a 100% during both Q1 (99%) and Q1 (99.8%), due to a combined total of 5 out of 940 requests not having determination made within the 14 day timeframe.

Once a determination is made to deny or reduce services, Optum has 1 day following the decision to mail a notice of action to member and provider. Optum was slightly below the goal of 100% at 96.2% during Q1 and 95.6% during Q2. Optum's Quality Operations has reviewed each case that did not meet the written notification timeframe and was unable to link cases to any systems defects.

*Barriers:* Most of the cases were clerical errors due to training issues and recent changes in operational practices between Care Advocacy and Quality Operations.

*Opportunities and Interventions:* Each case not meeting the established turnaround time will continue to be reviewed to identify gaps and need for improvement.

**Total # of Adverse Benefit Determinations**

Q1: 417
Q2: 523

**Initial Notifcation (TAT = 100% w/in 14 days)**

Q1: 100.0%
Q2: 100.0%

## Written Notification Compliance
### (TAT = 100% w/in 1 bus. Day)



## Grievances

**Methodology:** Optum Idaho recognizes the right of a member, authorized representative or provider or agency, acting on behalf of a member, to request that Optum Idaho conduct a review of an adverse action that resulted in member financial liability or denied service, which is called a grievance.

Optum has two grievance review types; urgent and non-urgent. For an urgent grievance review, Optum Idaho makes an expedited decision and provides notice as expeditiously as the participant's health condition requires and no later than three (3) business days after receipt of the request. For a non-urgent grievance review, Optum Idaho makes a decision and provided notice within 30 calendar days from receipt.

**Analysis:** During first and second quarters of 2015, there were a total of 53 member grievances (24 during Q1 and 29 during Q2). This is comparable to first and second quarters of 2014 with a total of 57. The 30 day turnaround time was met during both quarters.

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

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

## Member Grievances



## Member Grievance Resolution Turn-Around Time
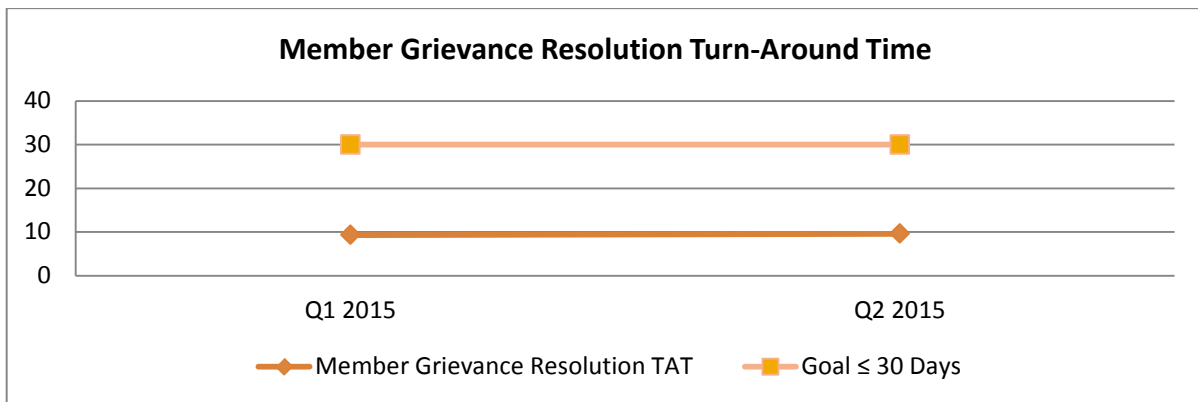


## Complaint Resolution and Tracking:

| Complaints – Quality of Service and Quality of Care Results | Performance Goal | Q1 2015 | Q2 2015 |
|---|---|---|---|
| Number of Complaints Received | NA | 37 | 42 |
| % Complaints Acknowledged w/in TAT Goal: 5 Days | **5 Days** | 100% | 100% |

| Year to Year Comparison | Q1 2014 | Q1 2015 | Q2 2014 | Q2 2015 |
|---|---|---|---|---|
| Total Number of Complaints | 221 | 37 | 169 | 42 |

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

Complaints are collected and grouped into the following six (6) broad categories: Clinical (Potential Quality of Care), Access (and Availability), Service (and Attitude), Benefit, Billing and Financial, and Quality of Practitioner Office Site. Complaints are analyzed by category and resolution status (substantiated/ unsubstantiated).
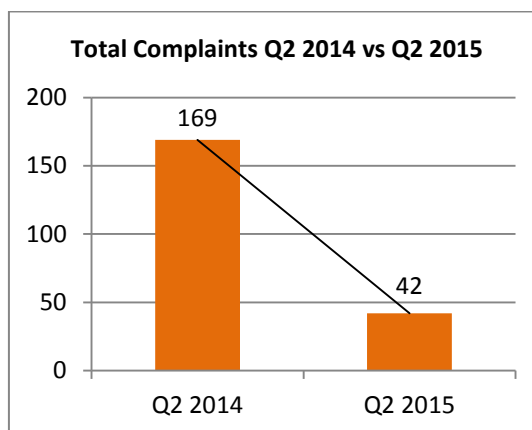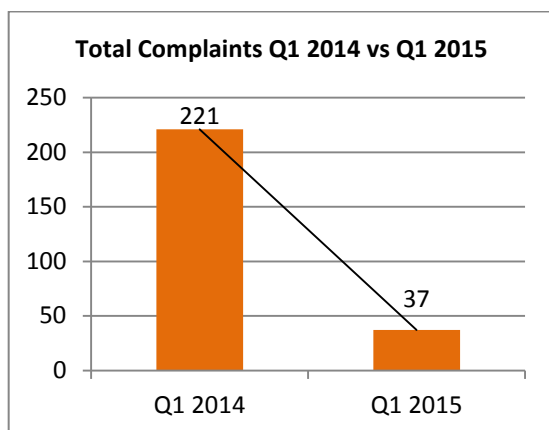
Optum Idaho maintains a process for recording and triaging Quality of Care (QOC) Concerns and Quality of Service (QOS) complaints, to ensure timely response and resolution in a manner that is consistent with contractual and operational standards. The timeframes for acknowledgement and resolution for complaints are as follows:
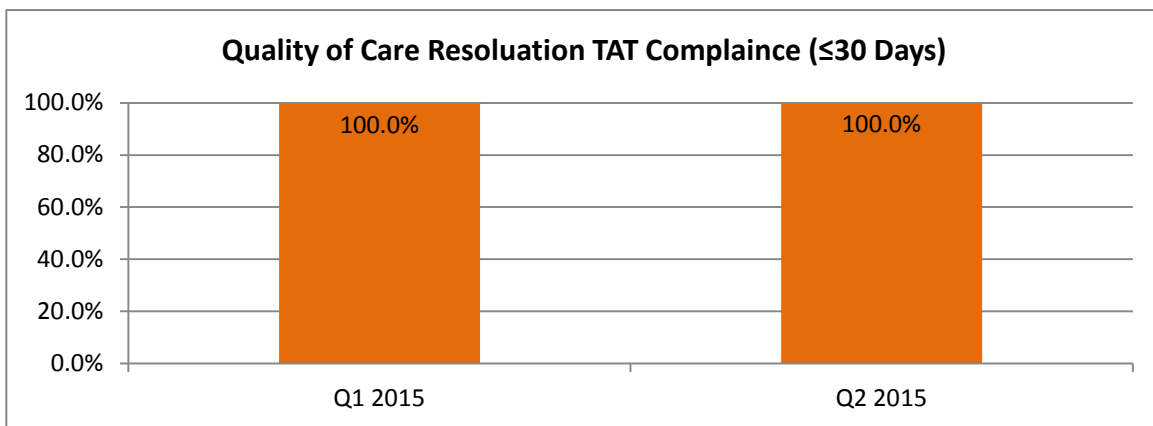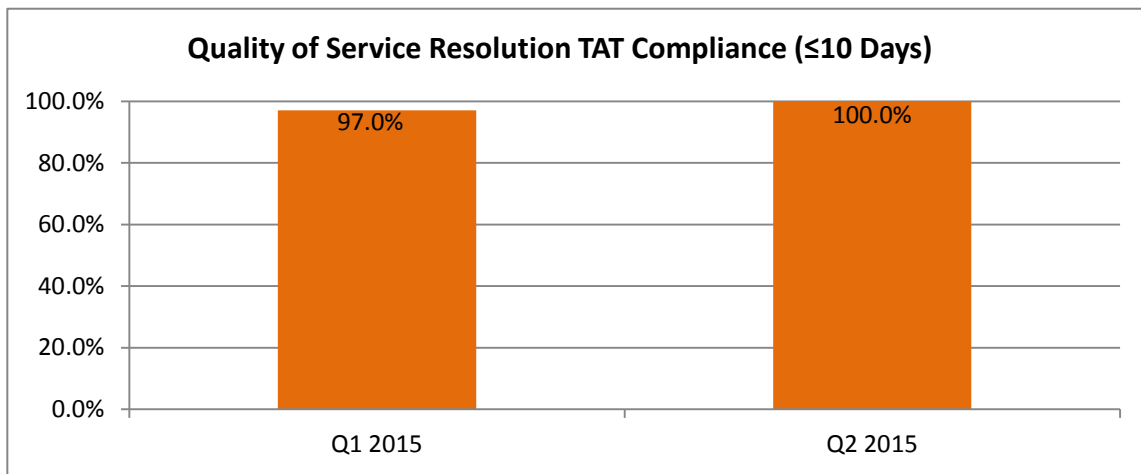
| Complaint Resolution and Tracking Timeframes | Acknowledged | Resolved |
|---|---|---|
| Quality of Service (QOS) Complaints | 5 Business Days | 10 Business Days |
| Quality of Care (QOC) Concerns | 5 Business Days | 30 Days |

**Analysis:**  There were a total of 79 complaints during Q1 (37) and Q2 (42).  This is a significant decrease in the number of complaints from 390 complaints during first and second quarters of 2014.  Of the total complaints during Q1 and Q2 2015, seventy-five (75) were Quality of Service and 4 were Quality of Care.  Quality of Care Resolution TAT was met during both quarters.  Quality of Service TAT was slightly below performance at 97.0% during Q1 but increased to 100.0% during Q2.

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



**Total Complaints Q1 2014 vs Q1 2015**



**Total Complaints Q2 2014 vs Q2 2015**

## Total Complaints

Q1 2015: 37
Q2 2015: 42

## Total Quality of Service and Quality of Care Complaints

| | Q1 2015 | Q2 2015 |
|---|---|---|
| Quality of Service | 35 | 40 |
| Quality of Care | 2 | 2 |

## Quality of Service Resolution TAT Compliance (≤10 Days)

Q1 2015: 97.0%
Q2 2015: 100.0%

## Quality of Care Resoluation TAT Complaince (≤30 Days)

Q1 2015: 100.0%
Q2 2015: 100.0%
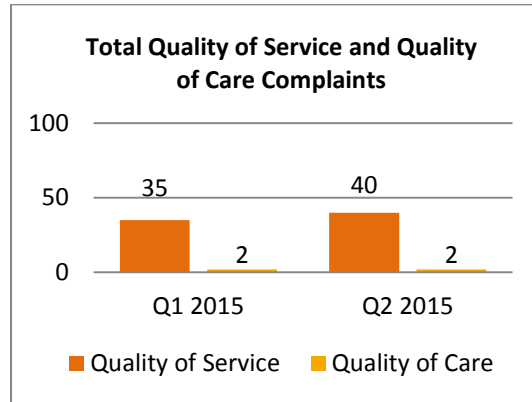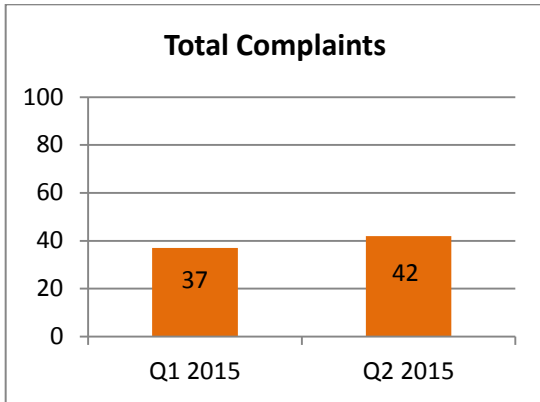
## Critical Incidents

| Critical Incident Tracking Results | Performance Goal | Q1 2015 | Q2 2015 |
|---|---|---|---|
| # of  CI's Received | NA | 12 | 16 |
| CI Ad-hoc Review: % completed within 5 business day from notification of incident | **100%** | 100% | 100% |

*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. Providers are required to report potential Critical Incidents to Optum Idaho within 24 hours of being made aware of the occurrence.  A Critical Incident is a serious, unexpected occurrence involving a member that is believed to represent a possible Quality of Care Concern on the part of the provider or agency providing services, which has, or may have, detrimental effects on the member, including death or serious disability, that occurs during the course of a member receiving behavioral health treatment. Optum Idaho classifies a Critical Incident as being any of the following events:
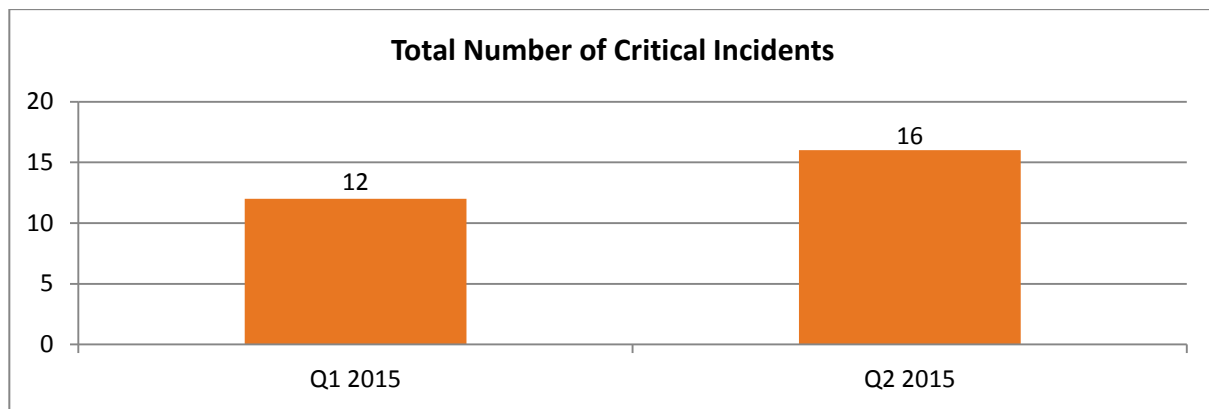
- A completed suicide by a member who was engaged in treatment at any level of care at the time of the death, or within the previous 60 calendar days.
- A serious suicide attempt by a member, requiring an overnight admission to a hospital medical unit that occurred while the member was receiving treatment services.
- An unexpected death of a member that occurred while the member was receiving agency based treatment or within 12 months of a member having received MH/SA treatment.
- A serious injury requiring an overnight admission to a hospital medical unit of a member occurring on an agency's premises while the member was receiving agency-based treatment.
- A report of a serious physical assault **of a member** occurring on an agency's premises while in agency-based treatment.
- A report of a sexual assault **of a member** occurring on an agency's premises while in agency-based treatment.
- A report of a serious physical assault **by a member** occurring on an agency's premises while the member was receiving agency-based treatment.
- A report of sexual assault **by a member** occurring on an agency's premises while the member was receiving agency-based treatment.
- A homicide that is attributed to a member who was engaged in treatment at any level of care at the time of the homicide, or within the previous 60 calendar days.
- A report of an abduction of a member occurring on an agency's premises while the member was receiving agency-based treatment.
- An instance of care ordered or provided for a member by someone impersonating a physician, nurse or other health care professional.
- High profile incidents identified by the IDHW as warranting investigation.

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

*Analysis:*  There were 12 Critical Incidents during Q1 and 16 during Q2.  In both quarters, the TAT for Ad-Hoc Committee review within 5 business day from notification of incident was met. The majority of Critical Incidents during both quarters were Unexpected Deaths.   No providers were put on unavailable status due to the Critical Incident.

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

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

**Total Number of Critical Incidents**

## Critical Incident by Type

| | Suicide Attempt | Unexpected Death | Physical Assault by a Member | High Profile Incident |
|---|---|---|---|---|
| Q1 | 25.0% | 75.0% | 0.0% | 0.0% |
| Q2 | 25.0% | 62.5% | 6.3% | 6.3% |
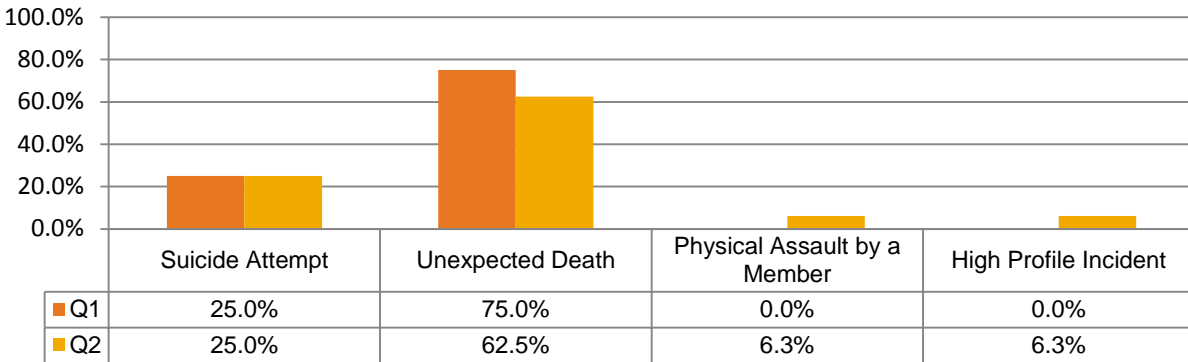
## Critical Incident by Region

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|
| Q1 | 16.7% | 0.0% | 25.0% | 8.3% | 0.0% | 8.3% | 41.7% |
| Q2 | 12.5% | 0.0% | 18.8% | 18.8% | 18.8% | 0.0% | 31.3% |
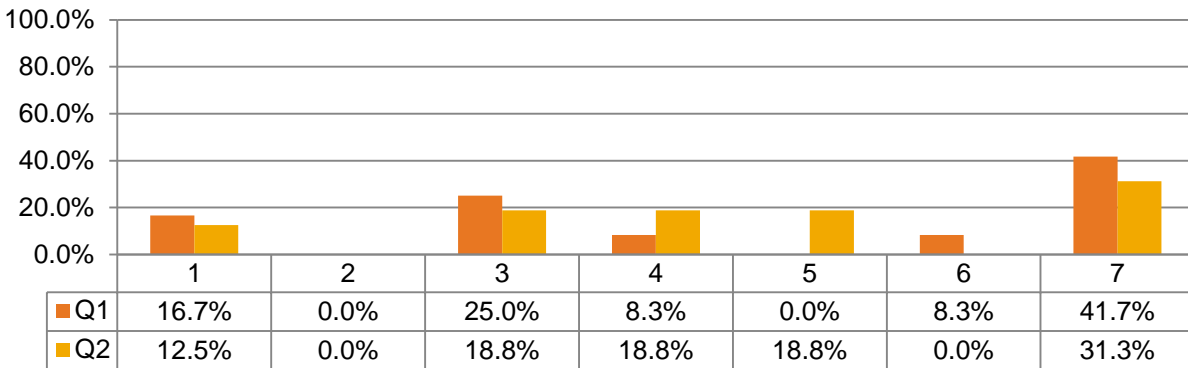
## Critical Incident- Coordination of Care Occurred

| | Q1 | Q2 |
|---|---|---|
| Yes | 58.3% | 75.0% |
| No | 41.7% | 25.0% |
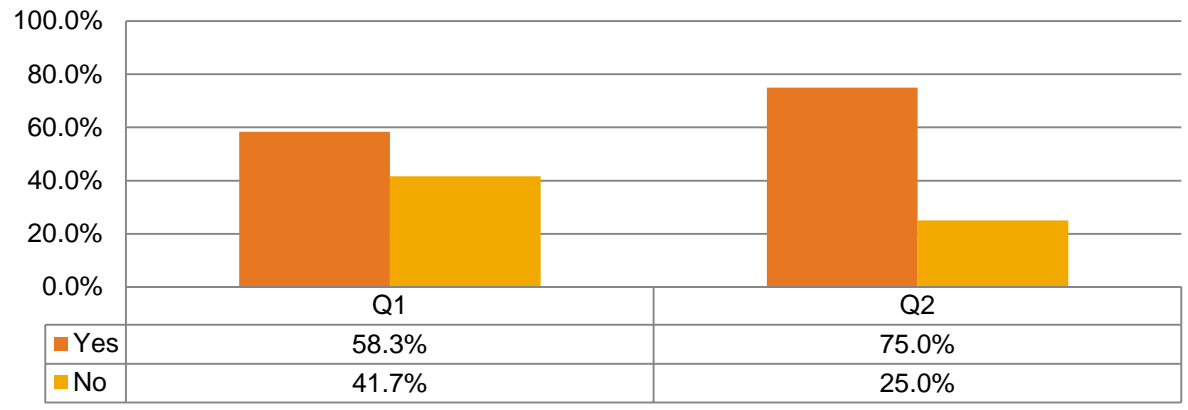
## Critical Incident-
## Co-Morbid Health Conditions Present (by gender)

| | Q1 | Q2 |
|---|---|---|
| Male | 0.0% | 18.8% |
| Female | 58.3% | 31.3% |
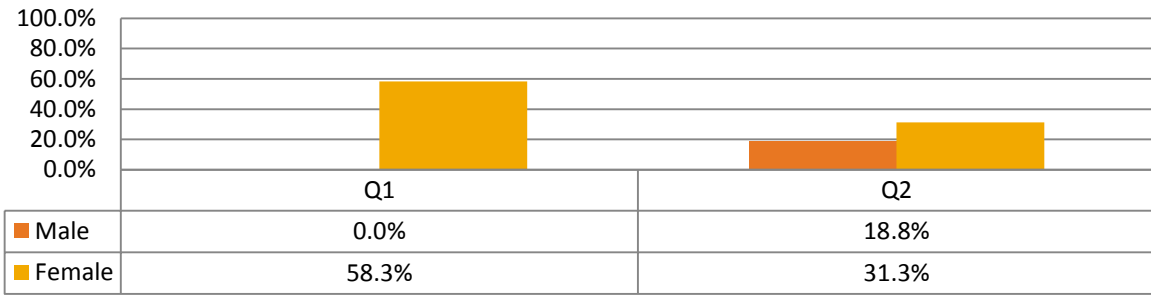
## Critical Incident by Age
## (Adults & Children/Adolescents)

| | Q1 | Q2 |
|---|---|---|
| Adult (18+) | 91.7% | 81.3% |
| Child/Adolescent (17 and under) | 8.3% | 18.8% |
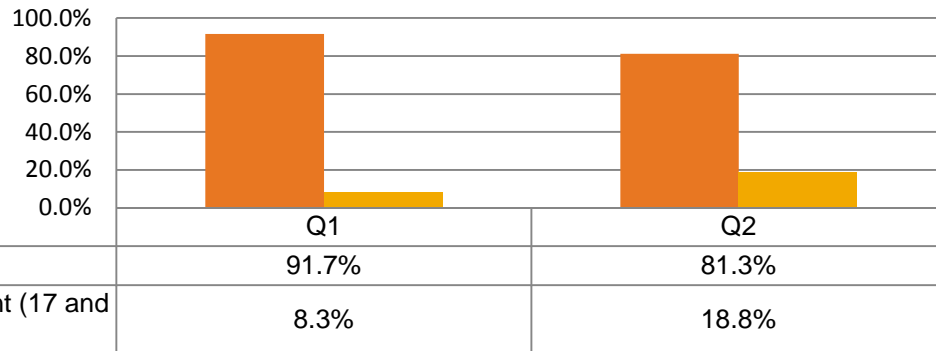
## Critical Incident by Average Age

| | Q1 | Q2 |
|---|---|---|
| Male | 18 | 38 |
| Female | 43 | 45 |

## Critical Incident by Gender

| | Q1 | Q2 |
|---|---|---|
| Male | 8.3% | 43.8% |
| Female | 91.7% | 56.3% |
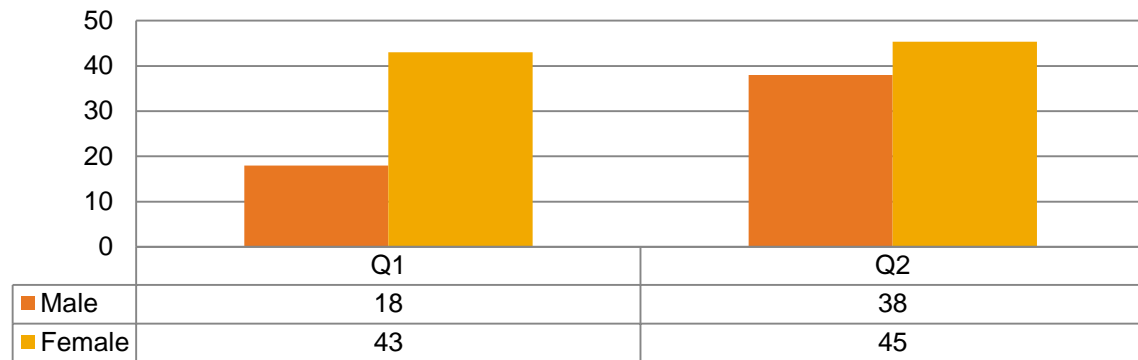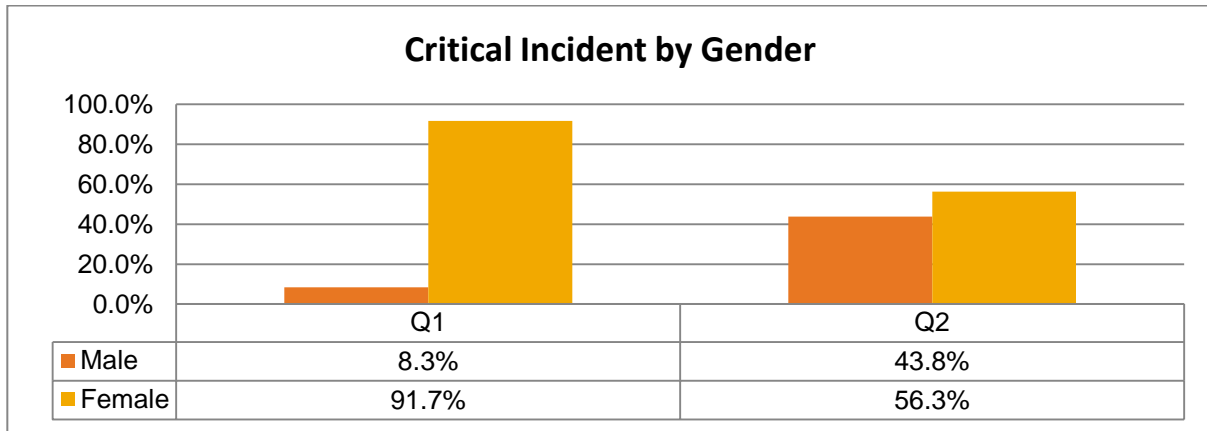
**Response to Written Inquiries:**

| Customer Service Response to Written Inquiries Results | Performance Goal | Q1 2015 | Q2 2015 |
|---|---|---|---|
| Percentage Acknowledged ≤ 2 business days | **100%** | 100% | 100% |

*Methodology:* This data is maintained and tracked in an internal database.

*Analysis:* The data summarizes Optum Idaho Customer Service responsiveness to written inquiries to both members and providers. The data indicates that the standard of 100% acknowledged within 2 business days was met during Q1 and Q2.

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

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

## Provider Monitoring and Relations

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

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

## Customer Service Line

| Customer Service Line Results | Optum Idaho Standards | IBHP Contract Standards | Q1 2015 | Q2 2015 |
|---|---|---|---|---|
| Total Number of Calls | NA | NA | 3577 | 4138 |
| Percent of Calls Answered Within 30 Sec | ≥80% | None | 97.1% | 94.6% |
| Average Speed of Answer | ≤30 Seconds | 120 seconds (2 minutes) | 5 sec | 10 sec |
| Abandonment Rate | ≤3.5% | ≤7% | 0.65% | 1.11% |

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

**Analysis:** The total number of provider calls was 4138 during Q2, 2015. This is an increase from 3577 in Q1, 2015. The percent of calls answered within 30 seconds was at 97.1% during Q1 and 94.6% during Q2, both above our goal of ≥80%. The average speed of answer was at 5 seconds during Q1 and 10 seconds during Q2, meeting our goal of ≤ 30 seconds. The call abandonment rate during Q1 was 0.65% and 1.11% during Q2, indicating that the goal of ≤ 7% was met during both quarters.

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

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

**Total Provider Calls**



**% Provider Calls Answered w/in 30 Seconds (Goal ≥80%)**



**Average Speed of Answer**



**Call Abandonment Rate**
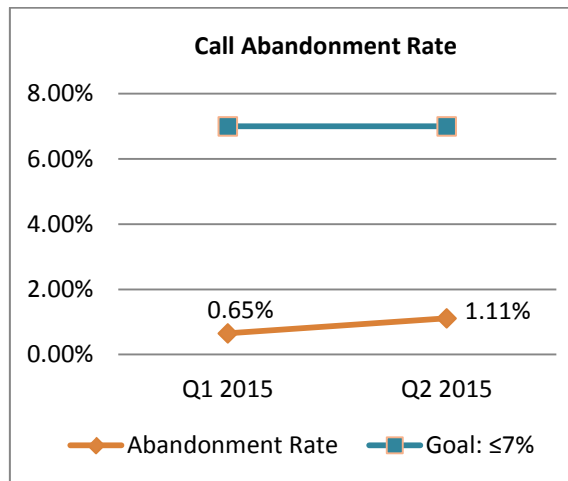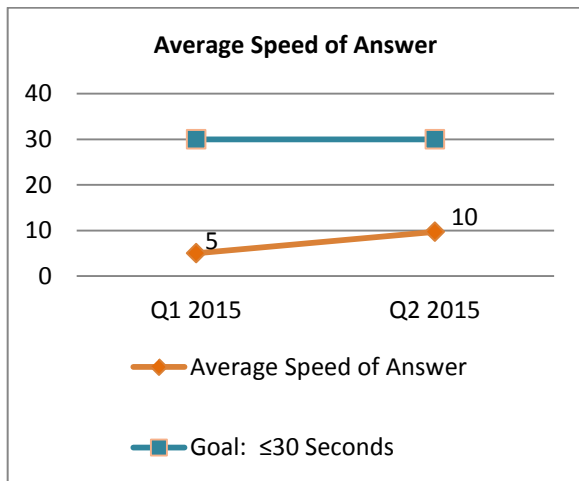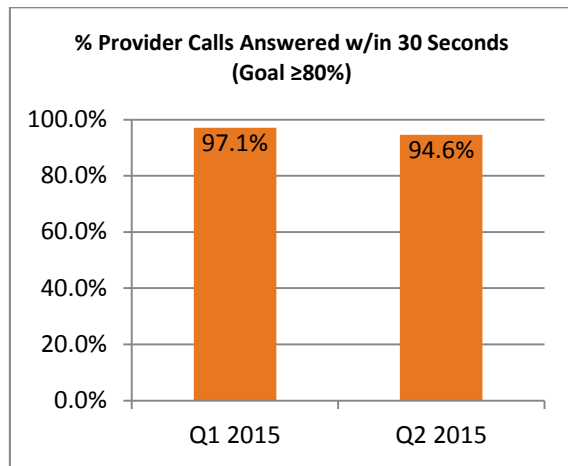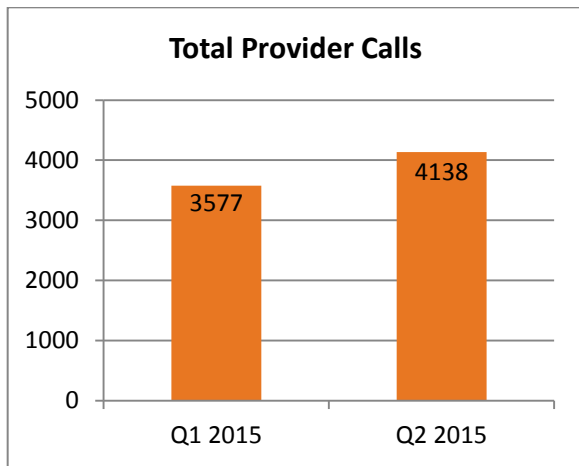


## Network Treatment Record Reviews

The Optum QI Team 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.

| Treatment Record Audit Results | Performance Goal | Q1 2015 | Q2 2015 |
|---|---|---|---|
| # of Audits Conducted | NA | 66 | 68 |
| Credentialing Audit (% overall score) | 85% | 97.0% | 97.3% |
| Recredentialing Audit (% overall score) | 85% | 97.0% | 95.3% |
| Ongong Monitoring (% overall score) | 85% | 91.0% | 89.9% |

| | | | |
|---|---|---|---|
| Quality of Care (% overall score) | 85% | 96.0% | 90.5% |
| % of Corrective Action Plans (CAP) | NA | 12.1% | 13.2% |

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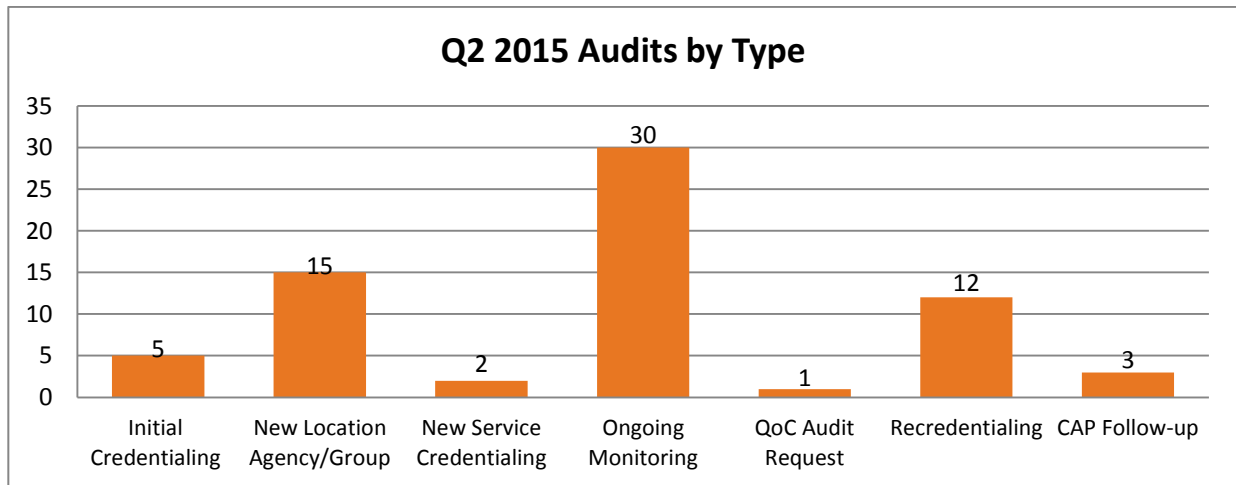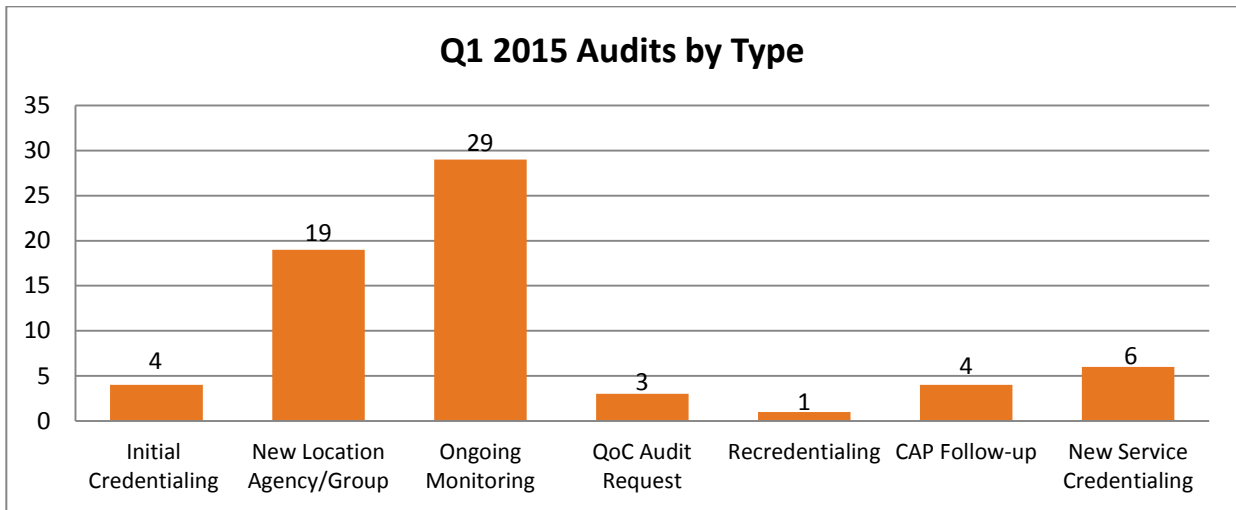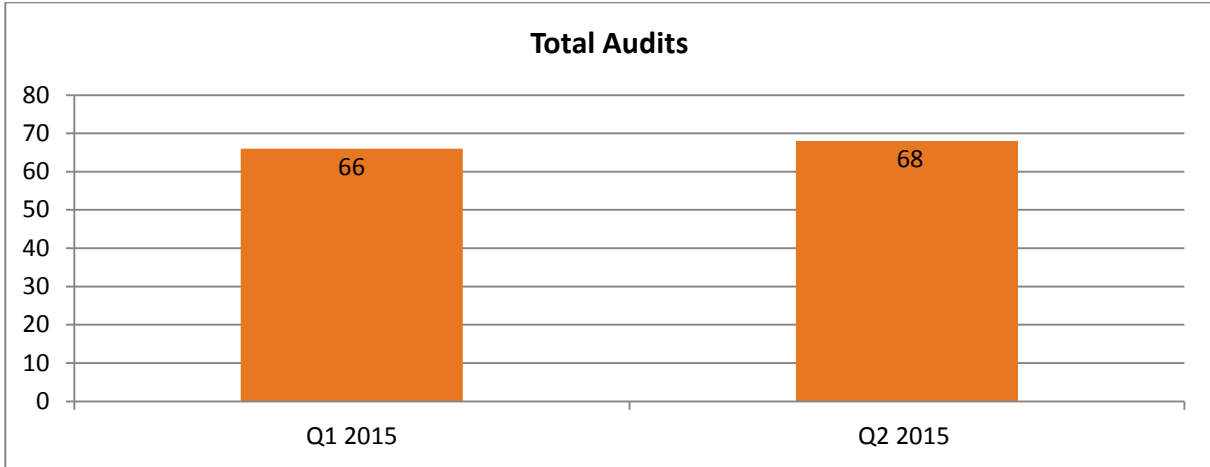
The provider will receive verbal feedback at the conclusion of the site visit and written feedback within 30 days of the site visit. Scores above 85% are considered passing. A score between 80-84% requires submission of a corrective action plan. A score of 79% or below requires submission of a corrective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

**Analysis:** During Q2, 68 audits were completed as compared to 66 during Q1. During first and second quarters, the majority of audits completed were Ongoing Monitoring Audits (Q1 = 29 and Q2 = 30), followed by New Location Audits (Q1 = 19 and Q2 = 15). Further analysis shows that the majority of providers are passing the audits with scores of 85% or above. During Q1, 87.8% of audits received a passing score, while 86.7% received a passing score during Q2. Corrective action plan audits were required for 12.1% of audits during Q1 and 13.2% of audits during Q2. Overall audits scores per region and per audit type are reflected in graphs below.

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 and Q2, 2015, in the areas of Provider Satisfaction with Quality Monitoring Audit Process and satisfaction with auditors. In both first and second quarters, Providers stated they were satisfied with the process and with the auditors.

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

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

## Total Audits

| | Q1 2015 | Q2 2015 |
|---|---|---|
| Total Audits | 66 | 68 |

## Q1 2015 Audits by Type

| Type | Count |
|---|---|
| Initial Credentialing | 4 |
| New Location Agency/Group | 19 |
| Ongoing Monitoring | 29 |
| QoC Audit Request | 3 |
| Recredentialing | 1 |
| CAP Follow-up | 4 |
| New Service Credentialing | 6 |

## Q2 2015 Audits by Type

| Type | Count |
|---|---|
| Initial Credentialing | 5 |
| New Location Agency/Group | 15 |
| New Service Credentialing | 2 |
| Ongoing Monitoring | 30 |
| QoC Audit Request | 1 |
| Recredentialing | 12 |
| CAP Follow-up | 3 |

## Percent of Audits with Passing Score of 85% or Higher

| | Q1 2015 (n =66) | Q2 2015 (n = 68) |
|---|---|---|
| Passing Score | 87.8% | 86.7% |

## Corrective Action Plans Required

| | Q1 2015 (n = 66) | Q2 2015 (n = 68) |
|---|---|---|
| CAP Required | 12.1% | 13.2% |

## Overall Audit Score Per Region

| | Region 1 | Region 2 | Region 3 | Region 4 | Region 5 | Region 6 | Region 7 |
|---|---|---|---|---|---|---|---|
| Q1 2015 | 85.4% | 89.9% | 94.6% | 97.8% | 96.7% | 97.6% | 95.8% |
| Q2 2015 | 87.7% | 93.9% | 94.5% | 94.5% | 93.6% | 92.1% | 92.4% |

## Overall Audit Score by Type

| | Initial Credentialing | Recredentialing | Ongoing Monitoring | Quality of Care | New Location | New Service | CAP Follow-Up |
|---|---|---|---|---|---|---|---|
| Q1 2015 | 97.0% | 97.0% | 91.0% | 96.0% | 98.0% | 98.0% | 91.0% |
| Q2 2015 | 97.3% | 95.3% | 89.9% | 90.5% | 95.1% | 94.0% | 88.5% |

## Provider Monitoring Audits - Rating of Process



| | Satisfied | Not Satisfied | No Opinion |
|---|---|---|---|
| Q1 2015 | 89.0% | 3.0% | 8.0% |
| Q2 2015 | 77.0% | 6.0% | 17.0% |

## Provider Monitoring Audits - Rating of Auditor



| | Satisfied | Not Satisfied | No Opinion |
|---|---|---|---|
| Q1 2015 | 84.0% | 1.0% | 14.0% |
| Q2 2015 | 74.0% | 5.0% | 21.0% |

## 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.

**Analysis:**  There were 17 provider disputes during Q1 and 18 during Q2.  All disputes were resolved within the goal of ≤ 30 days.

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

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

## Provider Disputes



## Provider Dispute Resolution Turn-Around Time
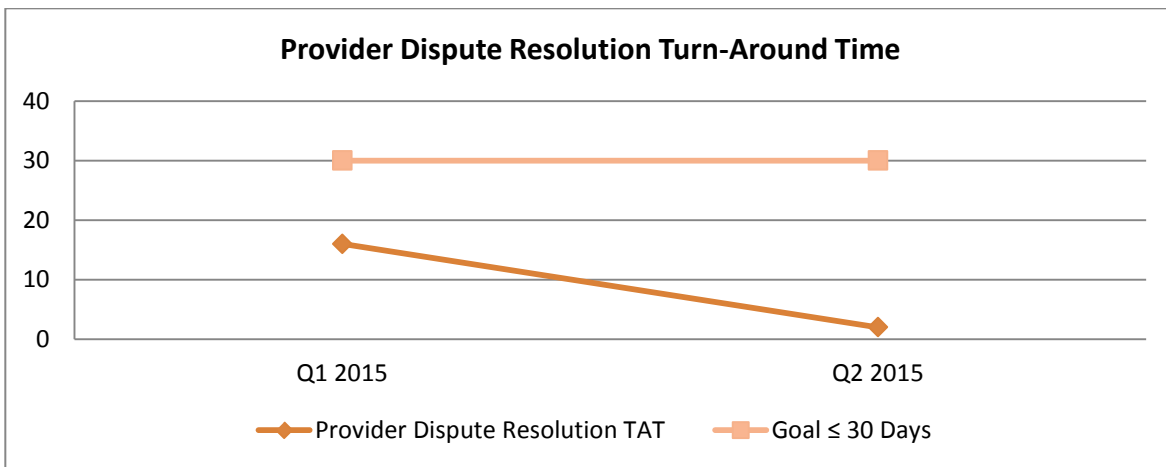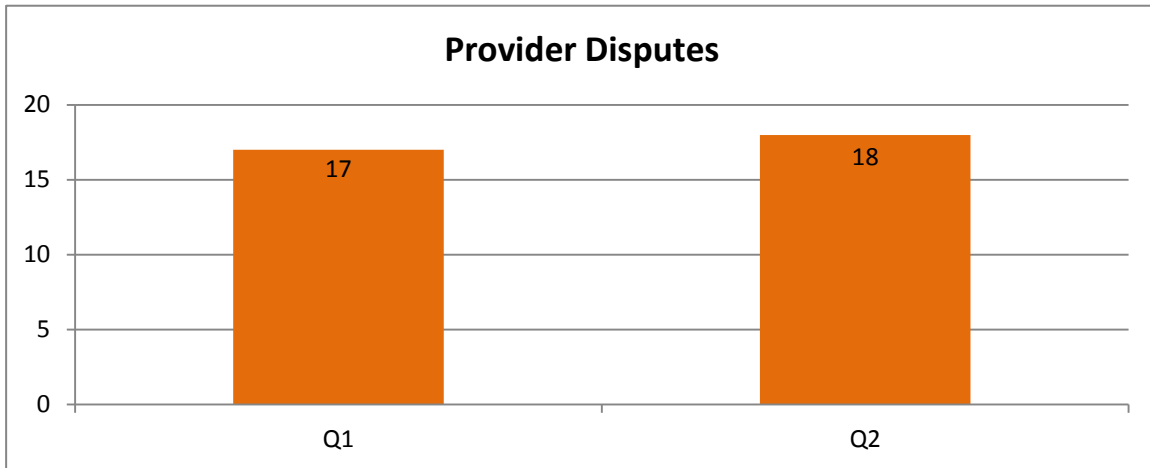


**Provider Satisfaction**

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

| Provider Satisfaction Survey Results | Performance Goal | Q1 2015 | Q2 2015 |
|---|---|---|---|

| Satisfied | ≥85% | 63.0% | 67.0% |
|---|---|---|---|
| Dissatisfied | NA | 35.0% | 31.0% |
| No Opinion | NA | 2.0% | 2.0% |

**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 | |

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

**Analysis:**  Overall Provider satisfaction increased from 63.0% during Q1 to 67.0% during Q2. While there was an increase between Q1 and Q2, satisfaction is below the performance goal of ≥85%.  An Improvement Action Plan was implemented in January of 2015 to monitor and address Provider Satisfaction.

**Barriers:**  Barriers that have been identified include:  Early year (2014) claims issues and difficulties for providers calling in for authorizations.  Potential barriers still existed in Optum Idaho being proactive in engagement efforts, routinely distributing information quickly and assisting providers in the transition to managed care.

**Opportunities and Interventions:**  In 2015 we continue to promote initiatives to improve our network experience with Optum. We will continue to monitor this measure throughout 2015, while also promoting the following interventions of the *Provider Overall Satisfaction IAP:*
- Develop formal provider on-boarding orientation
- Develop new survey questions that adequately reflect process
- Increase number of face to face provider visits routinely conducted by Regional Network Managers from 2/monthly to 4 monthly

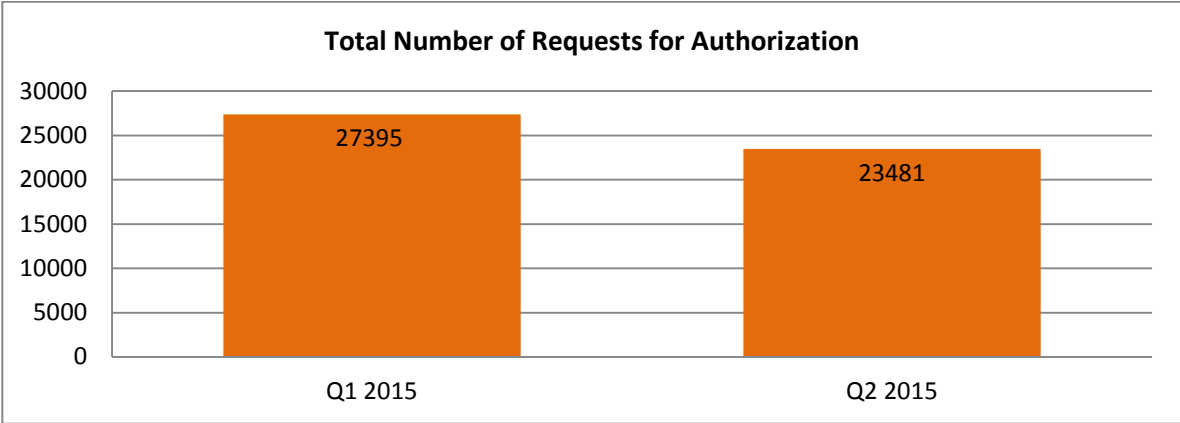## Overall Provider Satisfaction with Optum
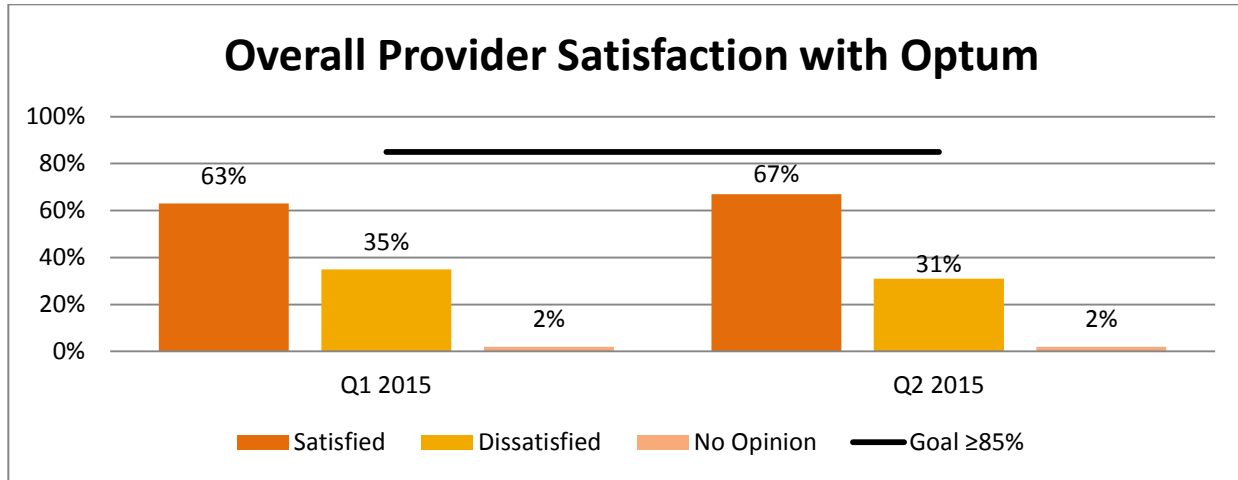


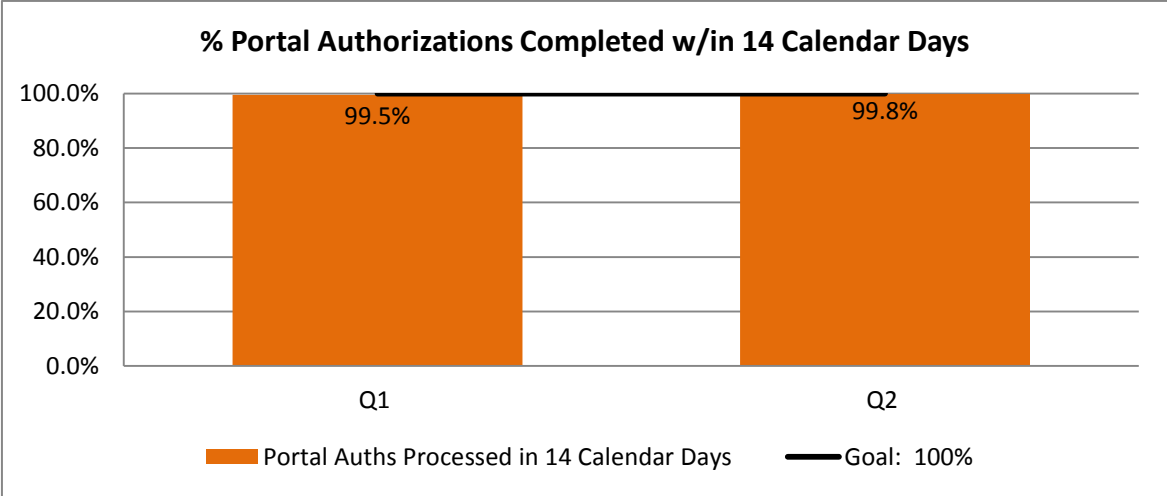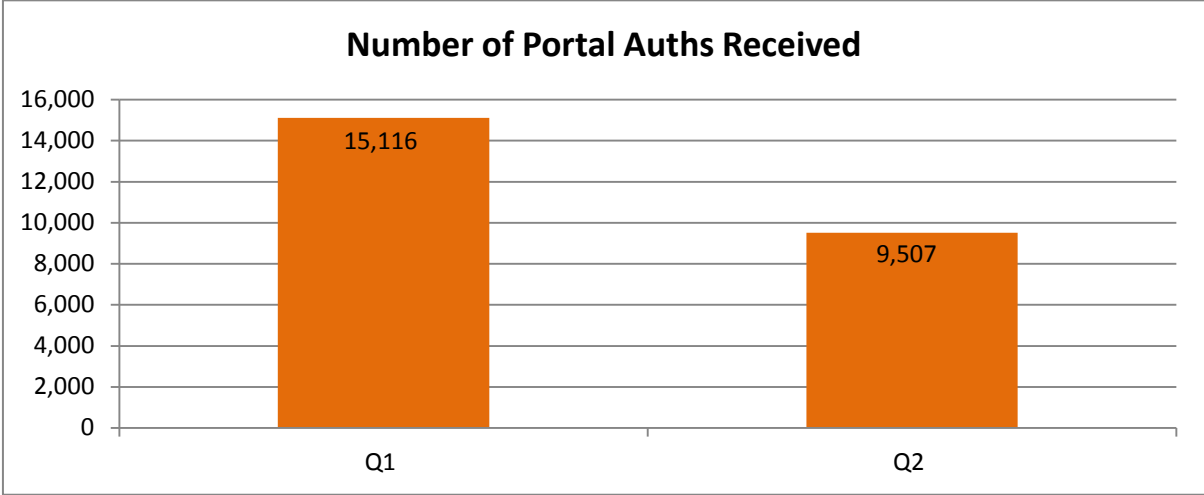# Utilization and Care Management
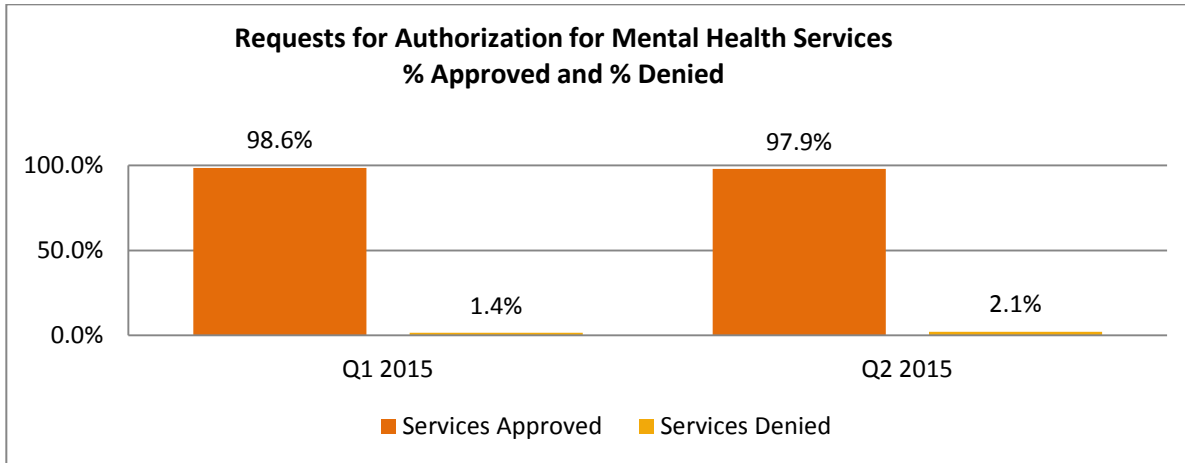
**Service Authorization Requests**

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

***Analysis:*** During Q1, a total of 15,116 portal authorization requests were received. During Q2, a total of 9,507 portal authorization requests were received. Portal authorization request numbers identify the total authorization received. The total number of services actually authorized during Q1 were 27,395 and during Q2 23,481. During Q1, 98.6% of requests for mental health service authorizations were approved and 1.4% denied. During Q2, 97.0% of requests for mental health service authorizations were approved and 2.1% denied. All substance abuse service authorization requests were approved.

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

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

## Number of Portal Auths Received

| Quarter | Value |
|---------|-------|
| Q1 | 15,116 |
| Q2 | 9,507 |

## % Portal Authorizations Completed w/in 14 Calendar Days

| Quarter | Value |
|---------|-------|
| Q1 | 99.5% |
| Q2 | 99.8% |

Legend: Portal Auths Processed in 14 Calendar Days — Goal: 100%

## Total Number of Requests for Authorization

| Quarter | Value |
|---------|-------|
| Q1 2015 | 27395 |
| Q2 2015 | 23481 |

**Requests for Authorization for Mental Health Services**
**% Approved and % Denied**



## Post Discharge Follow-up

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

***Analysis:*** At the time of this report, 7-day data was not available. An Improvement Action Plan was implemented 5/13/2015. Additional performance measures may be added to our current reporting and performance suite as a result of the discharge follow-up project.

***Barriers:*** The current report was generated based on an appointment within 10-days of inpatient discharge vs. an appointment within 7-days of discharge. The IAP was implemented to correct this.

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

## Readmissions

***Methodology:*** Optum Idaho monitors readmission rates according to NCQA 30-day readmission standards. Despite the IBHP being and outpatient only behavioral health plan, Optum Idaho reports and monitors readmission rates as part of our collaboration with IDHW. This collaboration is to promote a more integrated approach to the service delivery system in Idaho.

***Analysis:*** Data showed 20.1% readmissions within 30 days of hospital discharge during Q1 and 20.3% readmissions within 30 days of hospital discharge during Q2. We will continue to monitor this measure and establish baseline performance targets in which to trigger improvement efforts.

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

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

| Month | Total Number of Members Hospitalized | Total Number of Members Rehospitalized w/in 30 days of Discharge | % Readmitted |
|---|---|---|---|
| January | 249 | 59 | 23.7% |
| February | 324 | 49 | 15.1% |
| March | 266 | 61 | 22.9% |
| **Q1** | **839** | **169** | **20.1%** |
| April | 307 | 69 | 22.5% |
| May | 285 | 48 | 16.8% |
| June | 256 | 55 | 21.5% |
| **Q2** | **848** | **172** | **20.3%** |
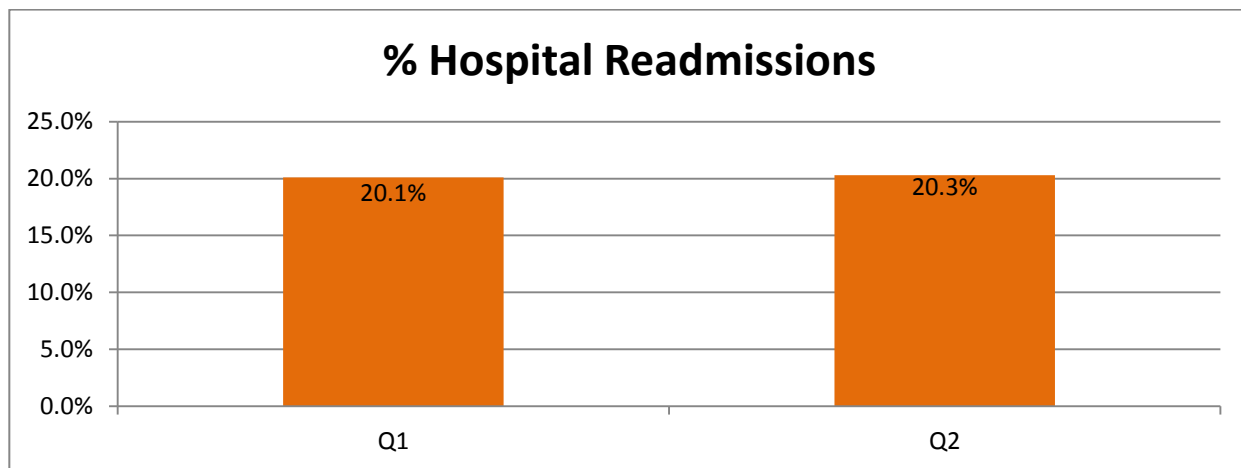


## Inter-rater Reliability

Inter-rater Reliability testing has been deferred until Q1 2016 due to the role out of Clinical Model 2.1 in August, 2015.
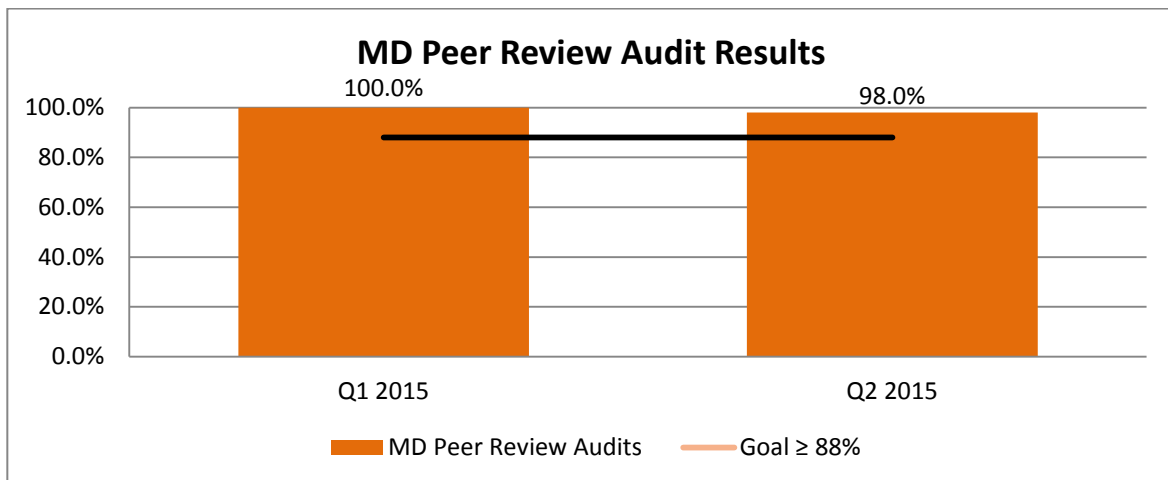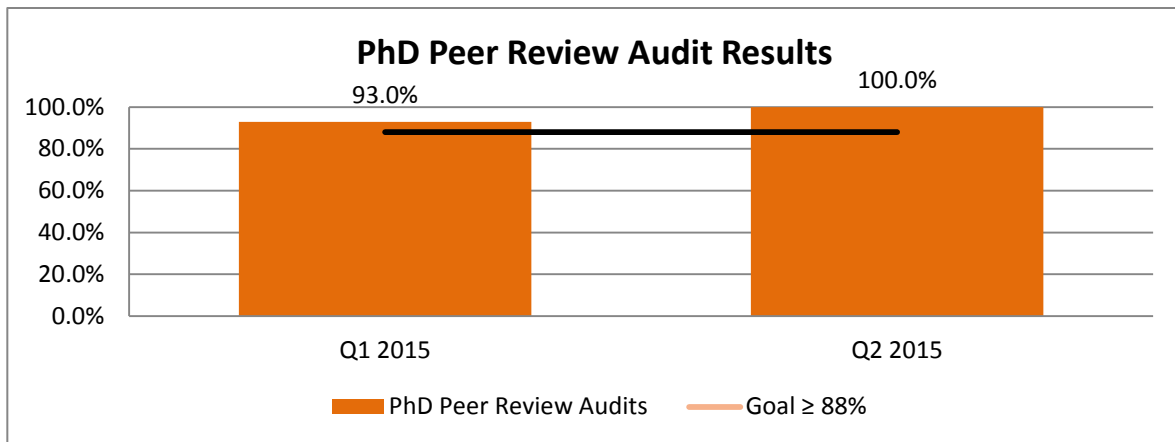
## Peer Reviewer Audits

***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 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 both PhD and MD Peer Review Audits received passing scores during Q1 and Q2.

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

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

**PhD Peer Review Audit Results**

Q1 2015: 93.0%
Q2 2015: 100.0%

Legend: PhD Peer Review Audits — Goal ≥ 88%

**MD Peer Review Audit Results**

Q1 2015: 100.0%
Q2 2015: 98.0%
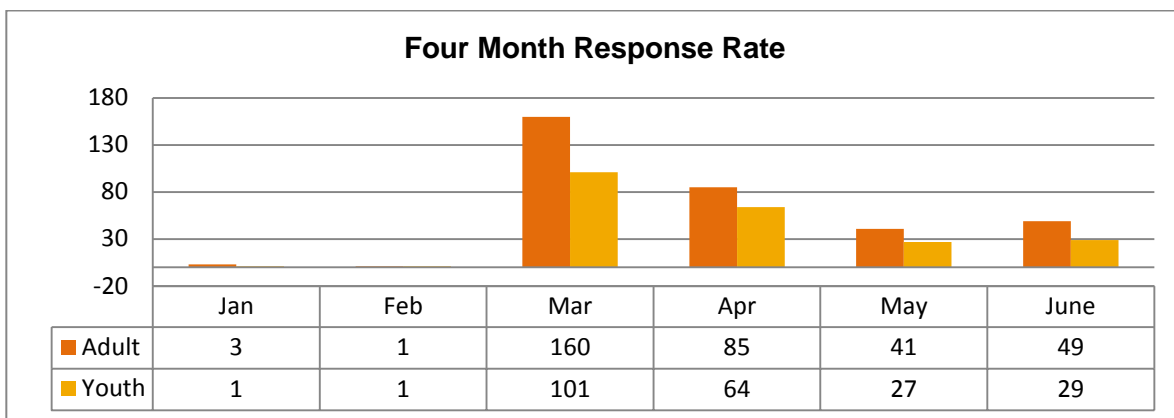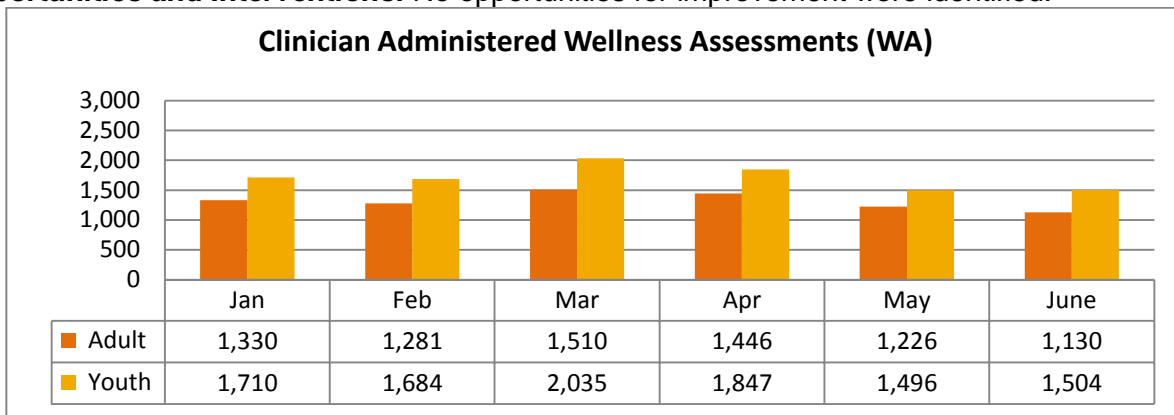
Legend: MD Peer Review Audits — Goal ≥ 88%

## Wellness Assessment Utilization and Follow-up

***Methodology:*** One of the primary ways Optum Idaho measures treatment outcomes is through the use of our proprietary Algorithms for Effective Reporting and Treatment (ALERT®) outpatient management program. We will use ALERT to regularly quantifiably measure the effectiveness of therapy for individual patients, identify potential clinical risk and "alert" providers to that risk, as well as to evaluate the potential over- and under-utilization of outpatient care and measure improvement of member wellbeing.

***Analysis:*** During Q1 and Q2, our network administered 18,199 ALERT Wellness Assessments to our members.  Of the total assessments, 7923 were administered to adults (Q1 – 4121 &    Q2 – 3802) and 10276 were administered to youth (Q1 – 5429 & Q2 – 4847).  A total of 562 members responded to the 4-month follow-up assessment (Youth – 223; Adult – 339).  We saw the highest response rate during March and the lowest response rates during January and February. We will continue to monitor these rates.

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

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

### Clinician Administered Wellness Assessments (WA)

|  | Jan | Feb | Mar | Apr | May | June |
|---|---|---|---|---|---|---|
| Adult | 1,330 | 1,281 | 1,510 | 1,446 | 1,226 | 1,130 |
| Youth | 1,710 | 1,684 | 2,035 | 1,847 | 1,496 | 1,504 |

### Four Month Response Rate

|  | Jan | Feb | Mar | Apr | May | June |
|---|---|---|---|---|---|---|
| Adult | 3 | 1 | 160 | 85 | 41 | 49 |
| Youth | 1 | 1 | 101 | 64 | 27 | 29 |

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

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

**Analysis:** The data shows that all performance goals were met during Q1 and Q2.

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

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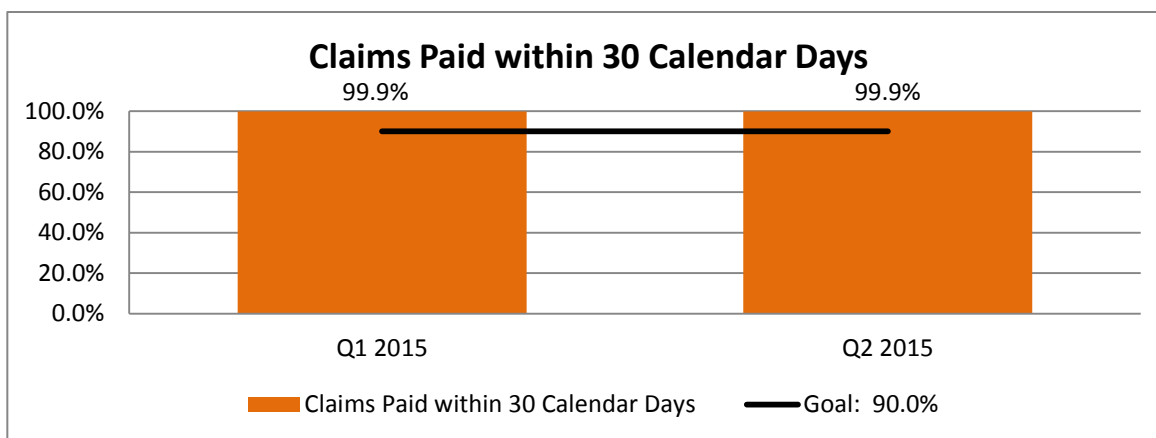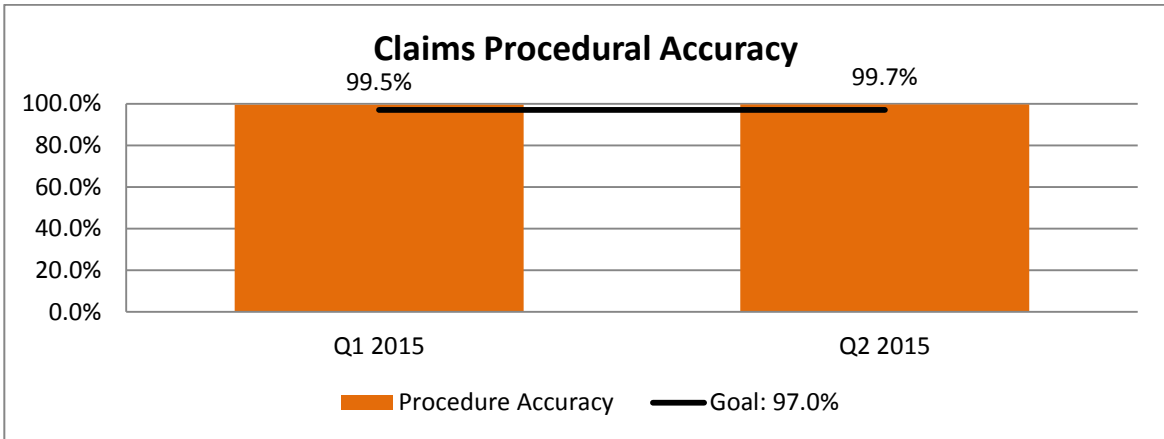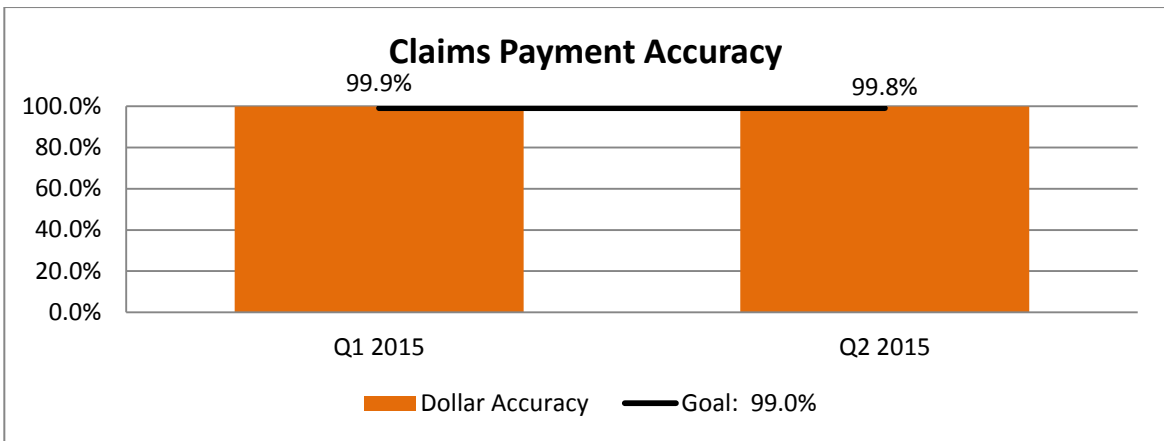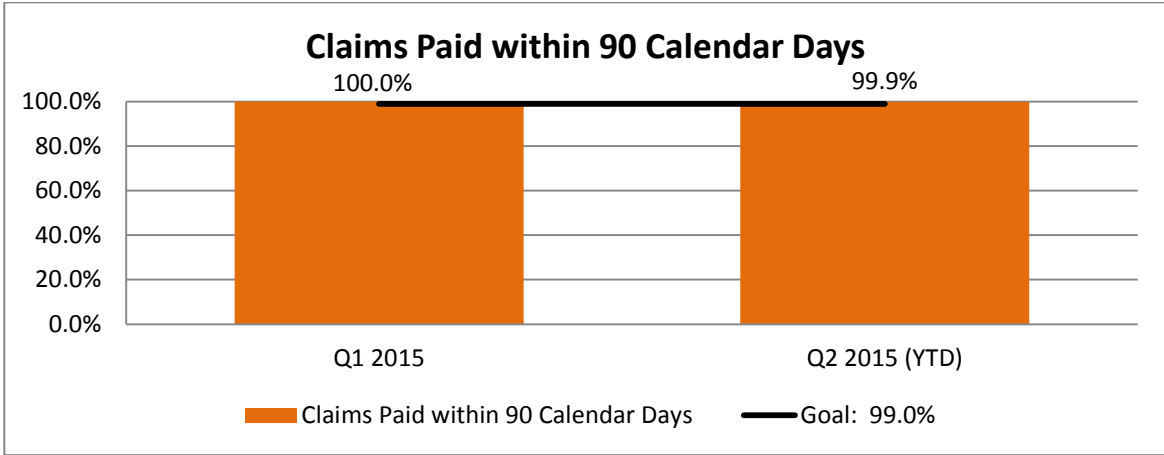


Claims Paid within 30 Calendar Days

## Claims Paid within 90 Calendar Days



Bar chart showing Claims Paid within 90 Calendar Days.
- Q1 2015: 100.0%
- Q2 2015 (YTD): 99.9%
- Goal: 99.0%

Legend: Claims Paid within 90 Calendar Days | Goal: 99.0%

## Claims Payment Accuracy



Bar chart showing Claims Payment Accuracy.
- Q1 2015: 99.9%
- Q2 2015: 99.8%
- Goal: 99.0%

Legend: Dollar Accuracy | Goal: 99.0%

## Claims Procedural Accuracy



Bar chart showing Claims Procedural Accuracy.
- Q1 2015: 99.5%
- Q2 2015: 99.7%
- Goal: 97.0%

Legend: Procedure Accuracy | Goal: 97.0%

# 2015 Performance Improvement Initiatives

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

**Open Improvement Action Plans**

| 2015 Improvement Action Plan | Date Initiated | Quality Committee Oversight | Status |
|---|---|---|---|
| Special Programming for Pre-Adults Facing Transition to Adulthood | 6/2/2014 | Clinical and Services Advisory Committee | Open |
| Primary Care Provider Interface | 7/25/2014 | Provider Advisory Committee Quality Assurance Performance Improvement | Open |
| Authorizations: Calls to Optum-Information from First Call | 2/2/2015 | Provider Advisory Committee | Open |
| Provider Overall Satisfaction with Optum:(Provider Survey Results) | 1/23/2015 | Provider Advisory Committee Quality Assurance Performance Improvement | Open |
| Provider satisfaction with peer review process and explanation | 2/6/2015 | Clinical and Services Advisory Committee | Open |
| Provider Website | 1/22/2014 | Provider Advisory Committee | Open |
| Provider Satisfaction-Customer Service | 1/30/2015 | Quality Assurance Performance Improvement | Open |
| Clinical Model 2.1 | 1/15/2015 | Clinical and Services Advisory Committee | Open |
| Authorizations: Ease of Process to Authorize | 1/26/2014 | Quality Assurance Performance Improvement | Open |
| Complaint Acknowledgement | 1/27/2015 | Quality Assurance Performance Improvement | Open |
| E2E Review of Compliance Turn Around Times | 7/7/2014 | Quality Assurance Performance Improvement | Open |
| Authorizations: Resolution of Questions | 5/11/2015 | Provider Advisory Committee | Open |
| 7 Day Post-Discharge Monitoring | 5/13/2015 | Clinical and Services Advisory Committee | Open |

**The following Improvement Actions Plans were closed during Q1 and Q2:**

| Improvement Action Plan | Status |
|---|---|

| | |
|---|---|
| Annual Provider Training Report | Closed |
| Notice of Adverse Actions-Member Grievances & Tracking System | Closed |

**Looking Ahead:**
Our 2015 performance to date demonstrates our hard work and efforts as a result of our 2014 findings. We look forward to further improvement and continued collaboration with IDHW, our members, providers, and stakeholders.