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Verity Annual Quality Report

Mental Health and Addiction Services Division

Multnomah County Department of County Human Services

2008 Annual Quality Report presented to:

Verity Quality Management Committee
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VERITY QUALITY IMPROVEMENT ANNUAL REPORT

DESCRIPTION OF PROGRESS TOWARD WORK PLAN OBJECTIVES AND INDICATORS

This report has three sections:

The Executive Summary gives a narrative review of overall program changes, customer satisfaction and utilization for the year.

The OHP Verity Dashboard provides a table comparing key performance indicators from fiscal year 2005 to fiscal year 2008.

Performance Analysis provides more detail and graphs about several key performance indicators from the OHP Verity Dashboard utilizing a Plan, Do, Study, Act (PDSA) format.

EXECUTIVE SUMMARY

Business Services

Verity's business model switch to a fee-for-service reimbursement method in 2006 continues to challenge some Verity providers. Verity is grateful for our provider network's ongoing efforts to modify infrastructure needed to support this payment method. These efforts were successful and resulted in an increase in capitation payments in 2009. In 2008 PH Tech, Verity's third party claims administrator, continued to provide intensive on-site technical assistance to providers to assure that agencies could accurately bill for services delivered. Training sessions with national experts occurred for all agencies in 2007 and 2008. After Verity hosted training sessions by M.T.M. Services, LLC, in 2008 several agencies have contracted with MTM to review their business systems. Verity providers are actively working to develop improved business systems that will increase access to services, improve documentation, increase staff productivity, and improve billing accuracy.

Despite the additional technical assistance, Verity's largest network provider was unable to sustain all their business locations. Cascadia Behavioral Healthcare transferred Bridgeview transitional housing program to Luke-Dorf Inc., their Gresham clinic to Lifeworks Northwest in August 2008, and their Portland Downtown clinic to Central City Concern in December. All agencies worked together with Verity closely to quickly transfer contracts and clients during the restructuring of Cascadia BHC.

Verity continues to refine the fee-for-service model. Annual revenue caps for services are stipulated in agency contracts. In 2008, Verity began to provide quarterly reviews to agencies to assist in planning and to keep with-in budget.

In Spring 2008, most of the children's providers were close to or over their annual revenue caps for outpatient care. Many of the children's agencies began a restructuring process during this time and access to care appeared to drop. Verity will be watching closely access indicators, complaints, and utilization information during 2009 to assure that the system comes into balance with available funding. Verity is developing processes to refine financial methodology for determining annual hard capitations based on utilization projections.

Clinical Model Changes

Verity continues to support Evidence Based Practices through incentives and contract requirements.

Initiation & Engagement

Verity uses the national performance indicators Initiation and Engagement to measure access to service. Any member experiencing a new episode of care should be seen two times in the first 14 days after intake and be seen a total of 4 times with 45 days. Adult providers exceeded Initiation goals in FY 08, seeing 51% of members with a new episode of care two times within 14 days, and came with 1% of meeting engagement goals by seeing 29% of new clients 4 times within 45 days.

Network providers for children achieved an initiation rate of 48%. Children's Initiation was on target to exceed the goal through the first three quarters of FY 08 with a fourth quarter decrease causing the year end rate to fall short of target by 2%. Engagement rates also decreased in the fourth quarter but child providers still saw 33% of new children and families 4 times within 45 days of intake.

ICTS Initiation and Engagement rates were over 83% for Initiation and 78% for Engagement. Though high, these services are authorized for the Intensive Service Array that should include 1 to 4+ appointments a week and Verity expects that these rates should be close to 95%+ given the nature of the authorization and needs of these children. Verity has shared this information with agencies and will continue to monitor rates for ICTS authorizations.

Adult Hospitalizations

Verity actively pursued interventions to reduce hospitalizations in 2008. The primary focus has been improving initial and concurrent utilization review in Verity member services, increasing diversion from hospitalization by dispatching Cascadia's mobile crisis Project Respond team to the emergency departments, and by providing intensive transitional services for members that have multiple hospitalizations without but do not follow-up with outpatient providers by implementation of the Critical Time Intervention Team.

Negotiating contract language with hospitals continues to be a priority.

These interventions are beginning to show a decrease of hospitalizations. Adult hospital discharges Per Thousand Members Per Month (PTMPM) went down slightly in FY 2008 from 2.8 to 2.4. The first six months of FY09 PTMPM rate is 2.2 and continues in a downward trend.

Outcomes

Verity requires all agencies to submit an outcomes instrument for approval. Children's programs are administering Child And Adolescent Needs And Strengths (CANS-MH) assessment to measure outcomes. Last year child providers all submitting CANS-MH outcomes data. A central database to compare the system as a whole has not been accomplished yet. This is a goal for 2009.

Adult system providers utilize several different assessment tools and Verity has not received data that can compare across the system. Verity will be entering into discussions with agencies to pick a standard tool and implement the tool in late 2009.

Customer Satisfaction

Mental Health Statistics Improvement Program Survey

Verity scores have remained stable between 2007 and 2008. Verity scores continue to be higher than overall Oregon State scores and comparable to national data. Due to differences in data collection method and the time frame the data were collected, comparisons with state and national data are general and not fully comparable.

Percent Agree for Verity, State & National[1]				
	Verity May 2007	**Verity May 2008**	**State of Oregon**	**National**
	(n=941)	(n=795)	(n=2,684)	(n=137,024)
Access	83%	81%	70%	85%
Quality	85%	88%	75%	87%
Satisfaction	87%	87%	57%	71%
Outcome	71%	71%	78%	88%

Youth Satisfaction Survey and Youth Satisfaction Survey – Family

Verity scores continue to be higher than state scores. With the exception of outcome scores, Verity scores are comparable to national data.

Percent Agree on YSSF for Verity, State & National[2]					
	Verity 2006 May and October	**Verity May 2007**	**Verity May 2008**	**Oregon Statewide 2006**	**National 2006**
	(n=535)	(n=348)	(n=361)	(n=2,143)	(n=63,054)
Access	79%	82%	79%	70%	83%
Appropriate	81%	82%	82%	64%	81%
Outcomes	61%	62%	64%	56%	73%
Participation	85%	87%	77%	74%	87%
Cultural Sensitivity	95%	94%	90%	88%	91%

Adult, Family and Youth Service Recipient Focus Groups

Adult Results

- Eighteen adults participated in two sessions (45% of confirmed participants).
- Most adults led the development of their treatment plan, citing trust of their counselor as a major component to their success.
- The location of services was very convenient for most adults.
- Adults appreciated learning from peers, and said that groups were helpful to their recovery.

[1] State and National data for 2006 Surveys obtained from http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/URS2006.asp

[2] National data for 2006 Surveys obtained from http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/URS2006.asp

- Adults said information on medications and training opportunities were most helpful in taking charge of their illness.
- Many adults felt they needed to advocate for themselves to get all the information they wanted.

Family Results

- Thirty-four family members participated in three sessions (56% of confirmed participants).
- Home visits, a good bond between the child and therapist, communication, and inclusion of the whole family were the most helpful components of children's treatment, along with consistency and reinforcement of expectations in all areas of the child's life.
- Many parents said their child was more successful after treatment
- Parents reported feeling supported unconditionally by therapists who supported the whole family, understanding the impact a child's mental health had on all family members.
- Most said the length of treatment was sufficient, although many children were still in treatment.
- Most families called their child's therapist in crisis, saying trust with the counselor before crisis improved success of the crisis response.
- Parents especially appreciated the therapist's identification of their family's strengths.

SMI Results

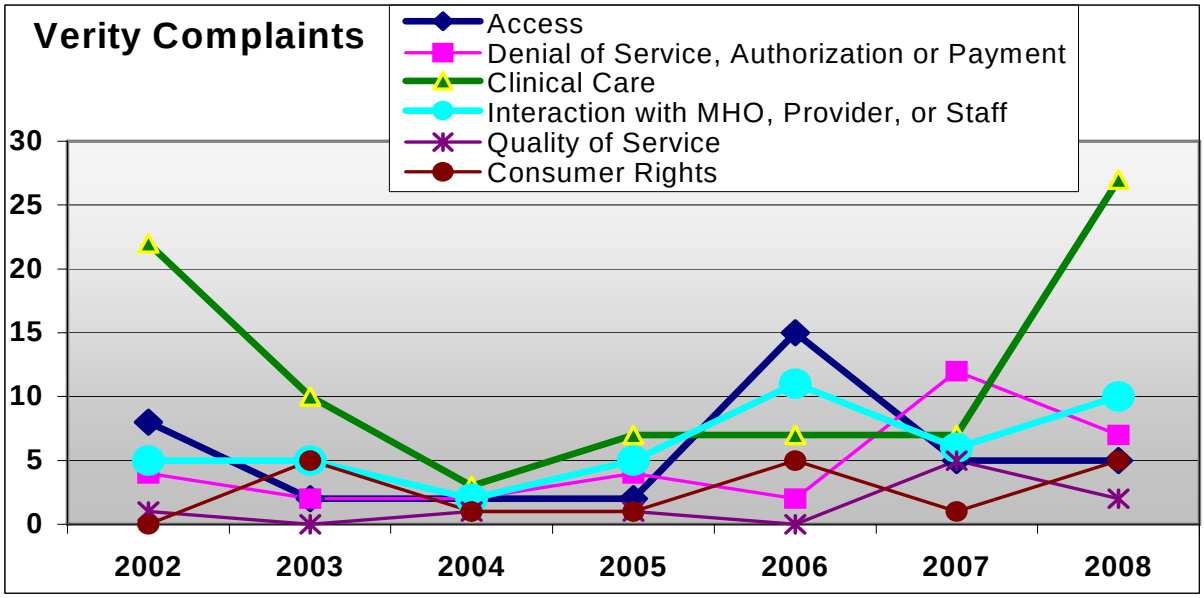
- Twenty-three seriously mentally ill (SMI) adults participated in two sessions (58% of confirmed participants).
- Most developed their treatment plan collaboratively with their counselor.
- SMI clients were pleased with the location of services.
- Groups and case management were the most-cited services that helped with recovery.
- Groups especially helped link adults to others with similar challenges, and provided a safe forum in which clients could learn from their peers.
- SMI clients reported that information on social activities such as employment, education, and groups helped them take charge of their illness.
- Ultimately, SMI clients wanted more opportunities to engage socially.
- Most received sufficient information on medications and side effects from their pharmacist or medical provider.

Youth Results

- Twenty youth ages 14 – 18 participated in two sessions (50% of confirmed participants).
- Youth recognized that they could not improve their mental health until they decided to try, and in the process felt supported by their counselor, caseworker, staff, mothers, friends, and family.
- Youth especially liked using a checklist or computer program with their counselor to develop their treatment goals, as it helped them focus and raise issues.
- More than half of youth said they believed in a higher power, but most did not discuss, nor want to discuss, these beliefs with their counselor.
- Most attended treatment weekly or bi-monthly, and were satisfied with this frequency.
- Youth said they would be encouraged to participate in treatment more if treatment was fun, out of the office, and included more interaction with the counselor.

Complaints

- Verity completed a public education campaign in March 2008 to educate our enrollees who were receiving services on how to generate a complaint and to help avoid misunderstandings in the process. New consumer friendly posters on the complaint process were distributed to every clinic and on the Multnomah County consumer web site. In May 2008, the Mental Health care in Multnomah County was featured in several local news articles and the restructuring of Cascadia BHS occurred. As a result of these two events Verity had an increase in complaints.
- Verity had 56 official complaints in 2008, a significant increase from 2007. The graph below demonstrates a rise in complaints each time there was a major system change implemented such as in 2002, 2006, and now in 2008.
- Trends indicate a dramatic increase in Clinical Care complaints. Access complaints remain below 2006 and the same as 2007. Denial of Service has gone down due to the separating out of appeals from the complaint data. In 2009 a more accurate picture of appeals will be added to this report.



Utilization

Verity served 6795 unique adults in FY08 and 4,100 unique children received mental health services. This was 28 more adults and 126 fewer children than served in FY07.

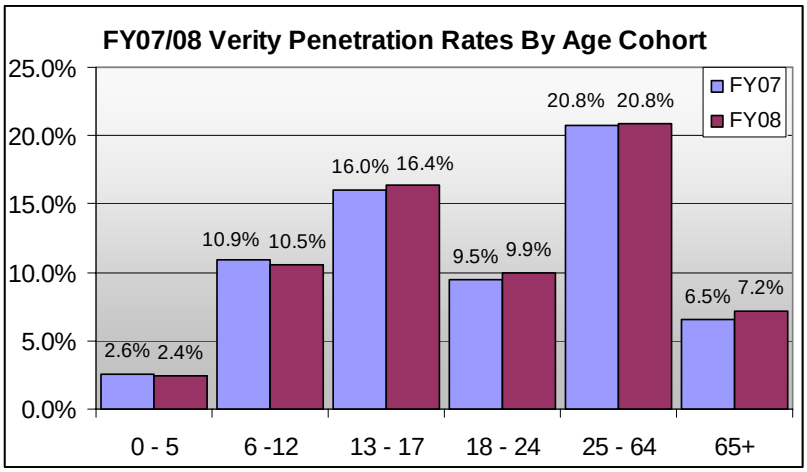
Verity has a high percentage of its members that suffer from diagnosis that are complicated, can be difficult to treat, and result in higher treatment costs. State data pulled on 12/24/08, for Unique Encounters - Served by Diagnostic Categories indicates that Verity has 21% of the state for encounters for Schizophrenia, 29% of Pervasive Developmental Disorders, and 19% of Bipolar Disorders.

Category FY 08 Verity	Total	Adults	Children
Total Enrolled	93,632	41,620	52012
Total Served	10,895	6,975	4,100
Percent of Members Served	11.6%	16.8%	7.9%
Total High Acuity Children and Severely Mentally Ill Adults Served	2,989	2,208	781
Percent of Members Served	3.2%	5.3%	1.5%
Percent of Served Members	27.4%	31.7%	19.0%

Three percent of total Verity members enrolled and 27% of total members served are receiving higher levels of care. The table above shows children and adult authorization types and numbers served with percentage of the population being served in these higher levels. The adult SMI population does not include ACT services since the billing streams are separated from Verity billing databases. When included there is an increase of 106 SMI individuals in Multnomah County.

Penetration rates

Verity MHO had a 12% penetration rate for FY08, over a .7% difference from the previous year. Jay M. Pomerantz, MD wrote in *Drug Benefit Trends®*, Volume 14, #9: "Excellent behavioral health networks have penetration rates of 8% to 10% or greater, whereas average ones will have a rate between 5% and 6%." This number is from the general population, not just Medicaid populations.



Verity has a good overall penetration rate both at a state level and in comparison with the general population. There was an increase for 65+ to 7.2% that approaches an excellent penetration rate. Both 0-5 yrs and 6-12 yrs rates went down slightly. It is not expected to have a high penetration rate for the 0-5 yrs age group and this is not a concern at this time. The 6-12 age group reduced by .4, a low decrease that will be monitored but not seen as a concern.

The categories for Penetration rates by specific ethnicity groups has been compromised by the lack of ability to get useful ethnicity data from the state eligibility databases at this time.

OHP Verity Dashboard

The next two pages reflect Verity's Dashboard measures, a quick look at critical measures.

★ - Optimal Performance ↑ - Better Than Targeted Performance √ - Performance On Track Towards Achieving Target ↓ - Worse Than Targeted Performance NR – Not Rated

CLINICAL						
Category	**FY 05**	**FY 06**	**FY 07**	**FY 08**	**Rank**	**Comments**
Total Member Months	799,862	799,170	774,793	793,979	**NR**	
Unique Adults Served	6,416	6,443	6,767	6,795	**NR**	
Unique Children Served	4,465	4,319	4,226	4,100	**NR**	
Adult Penetration	13.44%	14.92%	16.22%	16.3%	↑	This is outpatient only data that was recalculated. Unique served/Unique Enrollment
Child/Adolescent Penetration	9.07%	8.55%	8.20%	8%		Children % is from ages 0-17. 2008 children penetration rate is 13%
Adult Hospital Discharges Per Thousand Members Per Month (PTMPM)	2.2	2.2	2.4	2.1	√	Since April 2006 members served by a provider had fewer hospitalizations but more unaffiliated members are being hospitalized
Adult Inpatient Days PTMPM	15.3	15.2	15.9	14.6	√	Verity only Non-Medicare
Adult Hospital Average Length of Stay (ALOS) Days	6.8	6.9	6.6	6.9	√	Verity only Non-Medicare
Adult Hospital Readmissions in 30 Days (includes readmissions in 0-7 days)	28%	26%	21.9%	18.0%	↑	Verity and Medicare combined
Child/Adolescent Hospital Discharges PTMPM	.4	.3	.4	.3	★	
Child/Adolescent Inpatient Days PTMPM	3.0	2.6	2.6	2.3	★	
Child/Adolescent Hospital ALOS	7.6	7.7	6.8	7.5	↓	
Child/Adolescent Hospital Readmissions in 30 Days (includes readmissions 1-30 days)	16%	17%	9.4%	5.5%	↑	
Psychiatric Residential Treatment Services (PRTS) Admissions PTMPM	N/A	.15	.12	.10	↑	FY06 represents 6 months
Intensive Evaluation Services (IES) Admissions PTMPM	N/A	.21	.25	.23	√	FY06 represents 6 months
PRTS Days PTMPM	N/A	9.1	13.7	9.2	★	FY06 represents 6 months
IES Days PTMPM	N/A	6.5	7.1	4.8	★	FY06 represents 6 months

CLINICAL						
Category	**FY 05**	**FY 06**	**FY 07**	**FY 08**	**Rank**	**Comments**
PRTS average length of stay (days)	275 pilot	68.1	94.3	88.9	★	FY06 represents 6 months
IES average length of stay (days)	N/A	32.3	28.2	19.2	★	FY06 represents 6 months
Percent of Intensive Community-Based Treatment Services in home/community	N/A	ICTS 33%	ICTS 61.4%	SMI 28.4% ICTS 58.0%	↑	
Initiation: Clients who have a second outpatient visit within 14 days of the first visit	6-12 yrs: 51%	6-12 yrs: 49%	6-17 yrs: 48.1%	48.25%	√	1. The measures were collapsed in FY 07 for validity. The total number was very low in the broken out categories 2. The data from FY04-FY06 was based on agency and all types of outpatient procedure code groups were included. The measure in 2007 includes only standard outpatient procedure codes.
	13-17 yrs: 54%	13-17 yrs: 53%				
	18-64 yrs 56%	18-64 yrs 48%	18+ yrs 48.6%	51.2%	↑	
	65+ yrs 42%	65+ yrs 35%				
Engagement: Clients will have four visits within the first 44 days	6-12 yrs: 30%	6-12 yrs: 34%	6-17 yrs: 33.9%	33.11%	√	
	13-17 yrs: 33%	13-17 yrs: 34%				
	18-64 yrs 37%	18-64 yrs 28%	18+ yrs 28.2%	29.07%	√	
	65+ yrs 23%	65+ yrs 16%				
CLINICAL: CALL CENTER/CRISIS SERVICES						
Total Crisis Line calls received	55,215	66,420	63,811	64,247	√	Successful change in systems reduced average speed with a higher number of calls, and the abandonment rate is the lowest it has ever been with a much larger volume of calls.
Total Crisis Line calls answered	52,134	61,928	60,393	60,932	√	
Average speed of answer	12 seconds	18 seconds	15 seconds	15 seconds	√	
Abandonment rate	5.7%	7.2%	5.3%	5.1%	↑	
FINANCIAL						
Total State OHP payment	$29,438,119	$33,491,713	$34,878,339	$36,072,468	NR	The total payment includes over four million dollars shifted from the state to the MHO for children's intensive treatment services in FY06.
OHP Revenue PMPM	$36.80	$42.42	$45.56	$45.86	NR	Projected increase in expenses expected in FY08 due to slow build-up of the children's system of care will utilize excess revenues from FY07.
Total OHP Expense PMPM	$36.42	$40.78	$40.52	$41.41	NR	

Customer Satisfaction Adult Outcomes						
Category	**FY 05**	**FY 06**	**FY 07**	**FY 08**	**Rank**	**Comments**
Outcome Domain (outcome questions below)	67%	69%	70.6%	71.0%	√	502 responses in FY07 with one survey administered
Deal more effectively with daily problems.	75.5%	76.5%	77.7%	81.6%	↑	
Getting along better with my family.	70.4%	69%	72.8%	73.9%	√	
Better able to control my life.	74.7%	75.1%	77.3%	78.2%	√	
Better able to deal with crisis.	69%	72%	72.9%	75.8%	√	
I do better in social situations.	67.3%	68%	67.4%	68.9%	√	
My symptoms are not bothering me as much.	57.8%	59.9%	66.1%	64.2%	√	
My housing situation has improved.	60.5%	61.1%	62.5%	64.3%	√	
I do better in school and/or work.	54.7%	57.8%	63.4%	61.6%	√	
Access Domain	78%	78%	83%	81.0%	√	
Quality Domain	79%	83%	85%	88.0%	↑	
Satisfaction Domain	86%	85%	87%	87.0%	√	
Customer Satisfaction Child and Adolescent Outcomes (YSSF)						
Outcome Domain (outcome questions below)	53%	57%	62.5%	64.0%	√	Surveys changed to once a year.
I/my child are doing better in school and work.	57.3%	66.8%	62.9%	64.5%	√	251 answered surveys in FY04, 321 in FY05, 405 in FY 06 and 348 in FY 07.
I/my child get along better with friends and other people.	61.8%	66.5%	65.7%	66.3%	√	FY05 Survey was conducted in June 04 and reported without lag time.
I/my child are better at handling daily life.	63.5%	66.6%	66.5%	69.0%	↑	
I/my child get along better with my family.	59.9%	64.6%	63%	65.9%	↑	
I/my child are better able to cope when things go wrong.	58%	58.3%	61.3%	62.1%	√	
I/my child are satisfied with our family life right now.	55.1%	54.4%	55.3%	57.9%	√	
Access Domain	77%	77%	82%	79.0%	√	
Participation Domain	83%	85%	87%	77.0%	√	
Cultural Sensitivity Domain	94%	94%	94%	90.0%	√	
Appropriateness Domain	80%	80%	82%	82.0%	√	

Performance Analysis

Domain: Non Clinical PIP for Access

Program Area: All Outpatient

Plan: Access - Initiation and Engagement

Objectives

Improve the initiation and engagement in treatment services for Verity clients in order to prevent more serious illness

Questions/Predictions

Increasing initiation and engagement of clients will:

- Increase the likelihood that clients will actively engage in treatment services and successfully complete treatment
- Decrease utilization of hospital and residential beds by Verity clients engaged in outpatient services
- Reduce noncompliance for future appointments
- Resolve brief crisis episodes and intervene at an earlier point where successful resolution can occur before symptoms become chronic

Indicators

Initiation

Verity clients who have a second outpatient visit within 14 days of the first visit

Engagement

Verity clients who have met the initiation indicator and have two additional visits within the first 44 days

Performance Goal for Outpatient Services—Excluding ICTS Services

Initiation

Child Baseline: 6-17 years, 47.2%
Yearly Target: 50%
Adult Baseline: 18 +, 43.3%
Yearly Target: 48%
Long Term Target for both Children and Adults: 70% (2007 QM Committee Recommendation)

Engagement

Child Baseline: 6-17 years, 32%
Yearly Target: 35%
Adult Baseline: 18+, 23.6%
Yearly Target: 30%
Long Term Target for both Children and Adults: 50% (2007 QM Committee Recommendation)

Performance Goal for ICTS Services

Establish baseline and performance goal targets

Measurement Method

Initiation

Percent of Verity clients with a second outpatient visit within 14 days of the first visit

Engagement

Percent of Verity clients who have met the initiation indicator and have two additional visits within the first 44 days

Measurement Source

Verity OHP claim data

Do—Action Steps

- Have scheduled regular no show subcommittee meetings
- Encourage agencies to utilize schedule monitoring system as described in January 2008 training
- Develop accurate tracking system for no shows and implement best practices to reduce no shows
- Verity will provide agencies' data to ensure all encounters are captured
- Work with agencies to develop an improvement plan, if indicated, for initiation and engagement
- Review staff capacity from practitioner reports

Results

Initiation and engagement (I&E) is a new monitor in the mental health field, but already established as a HEDIS measure in the Addictions Field. There is additional research providing additional information and confirming the use of initiation and engagement as a proxy measure for utilization management that can indicate quality care. (Merrick, Elizabeth L, PhD, Et al 2008) Merrick, et al looked at the difference between an in-person evaluation and call center evaluation to authorize services between two divisions within one Managed Care system. Harvard Pilgrim Health Care (HPHC) is a private managed care organization located in New England, so the population is different than Verity, a managed care organization that has Medicaid enrollees. Nevertheless, the initiation and Engagement rates give us some benchmark information. Treatment initiation rates for a gate-keeping system that requires face-to-face evaluation by the organization's employees ranged from 42.13% to 43.50% over a four-year time period. The call-center authorization process increased initiation rates to a range from 46.46% to 50.23%. Engagement rates for the face-to-face modal ranged from 53.18-55.79 and from 56.25-58.19 in the call center model. There was no statistically significant difference between the two models, but having open access did increase both Initiation and Engagement rates overall.

Verity provides open access authorization directly to mental health providers in the community without utilization review by Verity staff, taking the open access model even one step further. One could assume that our rates should be slightly higher. However, our populations have higher acuity than a private managed care model, which could negate the increase in access. Verity does compare favorably with HPHC rates in Initiation, but Engagement numbers are significantly higher at HPHC. This could be due to a difference in how the percentage is calculated. Since the article did not give how this was calculated, I am unable to determine if their denominator is based on the overall number or just those that successfully initiated. Verity rates for engagement run from 28.39% to 34.07% in general outpatient programs compared to 54.05% to 56.90% rates for HPHC. ICTS was significantly higher than HPHC with an engagement rate of 78.54%.

Initiation	Goal	FY07	FY08	HPHC range (both adult and children)
Adult	**48%**	48.80%	51.20%	42.82-47.71
Children/ Adolescents	**50%**	48.15%	48.25%	
ICTS	**N/A**	83.59% (7/1/07-10/31/08)		
Engagement		FY07	FY08	HPHC
Adult	**30%**	28.39%	29.07%	54.05-56.90
Children/ Adolescents	**35%**	34.07%	33.11%	
ICTS	**N/A**	78.54% (7/1/07-10/31/08)		
Engagement w/o Initiation		FY07	FY08	
Adult	**N/A**	37.67%	57.20%	
Children/ Adolescents	**N/A**	38.80%	53.58%	
ICTS	**N/A**	82.85% (7/1/07-10/31/08)		

FY 08 percentage rates include the first quarter of FY 09 as there is not enough data to split the first quarter out yet. In all calculations, the first quarter of FY 09 dropped or remained the same. The result will be that when FY 08 is calculated alone the rate will go up slightly.

Adults exceeded Initiation goals in FY 08, and came with in 1% of meeting engagement goals. The Mental Health system suffered a major disruption in May 2008 with the financial crisis at Cascadia Behavioral Healthcare. However, Verity was pleased that the disruption did not decrease access as demonstrated in this measure. A lot of effort went into increasing capability to immediately serve new clients in other agencies, which appears to have successfully kept access to appointments open throughout the network.

Initiation rates fell short of the target goal by 2% for Children's Initiation. Children's Initiation was on target to exceed the goal through the first three quarters of FY 08, but dropped off during the 4th Quarter. Engagement rates also went down but were on target before the third quarter. In the third quarter, many agencies were at their maximum capitation and trimmed services, which had the negative effect of delaying access to treatment. Several of the agencies are going through a restructuring process based on the capitations and access was not restored during the first quarter. Much of the restructuring is now complete, and increased access should increase the Initiation rates in the children's system again. Initiation rates will be closely monitored quarterly this next year to assure that the system adequately recovers from changes at the agencies.

ICTS Initiation and Engagement rates were over 83% for Initiation and 78% for Engagement. Though high, these services are authorized for the Intensive Service Array that include 1 to 4+ appointments a week and Verity expects that these rates should be close to 95% given the nature of the authorization and needs of these children.

Domain: Quality/Appropriateness

Program Area: Adult Outpatient

Plan: Clinical Outcomes—Acute Inpatient Services

Objectives

To decrease utilization of acute inpatient hospital services

Questions/Predictions:

- If Verity engages clients in care before they have an acute episode and provides the level of services indicated by LOC, inappropriate utilization of acute inpatient beds will reduce
- Currently unaffiliated clients are defined as Verity member without an outpatient authorization. Will outreach and education of enrollees reduce unaffiliated acute episodes?
- Outpatient connections made while in the hospital and/or shortly afterwards will reduce readmissions
- Enrolled members who receive services at the appropriate level for their Locus score will be hospitalized less frequently

Indicators

Inpatient discharge per thousand members per month (PTMPM)

Inpatient days per thousand members per month

Performance Goal

Baseline: All Discharge PTMPM: 2.3

Target: All Discharge PTMPM: 2.0

Unaffiliated: Reduce rate of unaffiliated acute hospital services by 10%

Measurement Method

NUMERATOR: Hospital day/discharge by authorization type

DENOMINATOR: Total day/discharge count of open authorizations

Measurement Source

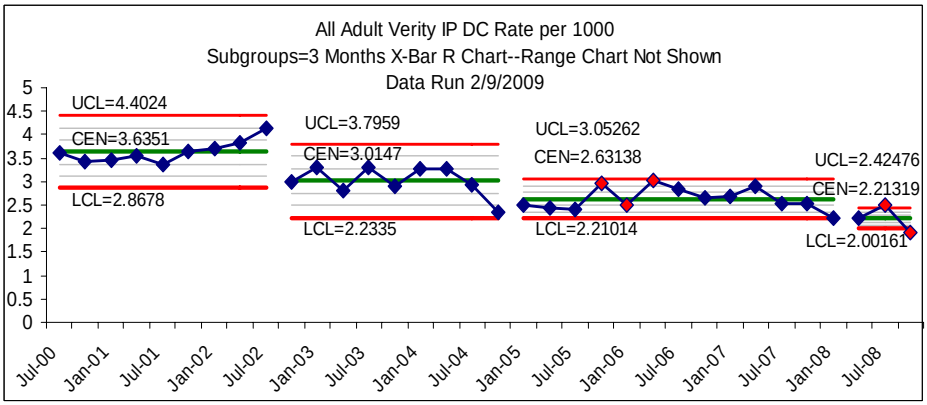
Verity authorization table

Do—Action Steps

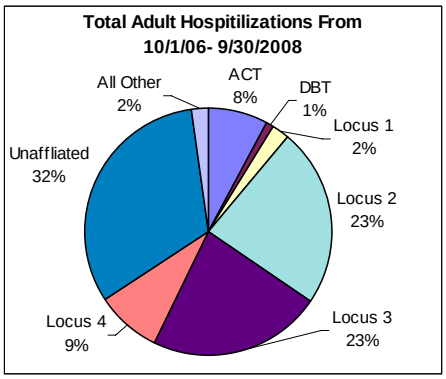
- Continue implementing clinical and business model changes.
- Provide assistance & training for FFS—currently providing Medicaid training with Scott Lloyd, MTM Consultants
- Conduct follow-up limited fidelity assessment of ACT program to measure changes in assertive engagement mechanisms and community involvement, and measure the development of internal dual diagnosis program. Monitor ACT clients' hospitalizations
- Monitor unaffiliated member hospitalization and post enrollment with OP provider
- Study rate of hospital admissions by LOC

- Develop outreach/transitional services targeted at nonaffiliated Verity members who have been hospitalized more than twice since April 2006. The goal is to engage these clients in outpatient services
- Develop mental health educational/marketing materials to place in all medical and dental offices where the majority of Verity enrollees get services, and all DHS offices. Do a limited mailing to targeted OHP enrollees based on demographic information
- Monitor utilization of services by LOC determination
- Hire one FTE call center utilization outreach staff to work with unaffiliated members while in the hospital.
- Implement Critical Time Intervention Program to provide transitional case management for up to 90 days for unaffiliated members being discharged to the community from a hospital or jail.

Results



Interventions to reduce hospitalizations continued to be actively pursued in 2008. The primary focus has been improving utilization review in Verity member services and the implementation of the Critical Time Intervention Team. Negotiating for hospital contracts continues to be a priority. These interventions are beginning to show a decrease in hospitalizations. Since July 2008, hospitalization PTMPM has decreased to 2.21 over the last four months; the hospitalization rate has been 2.04 and is expected to remain at this level.



Unaffiliated members remain a large proportion of total hospitalizations. Monitoring of this group is being refined, and interventions for high utilizers in this group have been implemented.

The Call Center Manager has worked closely with call center staff to clarify criteria and procedures for utilization review. Verity hired two FTE for the Critical Time Intervention Team. They are working with unaffiliated clients who have multiple hospitalizations, and provide case management until they are connected to an outpatient provider.

Both of these interventions are leading to improved services and clarification with hospitals on appropriate length of hospital stays.

All Levels of Care have seen a reduction in hospitalization PTMPM rates since 2007, including unaffiliated as seen in the table (right). Unaffiliated PTMPM appears very low due to having to use the total Verity enrollment to determine the rate and ACT is very high due to the small number of clients in the authorization type.

Verity will continue to review data for Locus 2 and 3 hospitalizations and work on an intervention plan for this group in 2009.

	FY 2007	FY2008	FY2009
ACT	60.20	47.18	42.59
Locus 1	4.69	1.55	3.28
Locus 2	6.76	5.13	5.42
Locus 3	13.37	12.54	11.34
Locus 4	0.40	0.17	0.18
Unaffiliated	1.16	1.06	1.02

Domain: Integration and Coordination: Collaborative PIP

Program Area: All Adult Verity Clients

Plan: Integration—Physical Health Care for SMI Clients

Place medical RN's into behavioral health clinics to provide screening, referral and education services

Objectives:

- Screen Verity clients in behavioral health clinics for medical problems
- Refer patients to primary care providers (PCP)

Questions/Predictions: Does the integration and coordination of medical and mental health services in the behavioral health setting establish an identified PCP, increase office visits and decrease emergency department use?

SMI patients have a 25-year difference in expected lifespan than those in the general population. Providing screening services in behavioral health clinics and connecting these patients to PCP services will increase life expectancy. Having regular health care access not only reduces ED use but also improves quality of life by preventing health problems.

Indicators:

1. Number of individuals enrolled in project
2. Number of PCP referrals that resulted in a client being paneled to a specific PCP
3. Number of clients who had an encounter with a PCP within 12 months
4. Number of visits per client who access ED services

Performance Goal: 90% of Verity clients will have an encounter with a PCP within 12 months or enrollment into the project

Measurement Method:

1. Number of individuals enrolled in project
2. Number of PCP referrals that resulted in a client being paneled to a specific PCP
3. Number of clients who had a non-emergent encounter with a PCP or doctor in a primary care clinic within 12 months
4. Number of visits per client who access ED or urgent services

Measurement Source: Agency screening tools, encounter data at MHO and FCHP

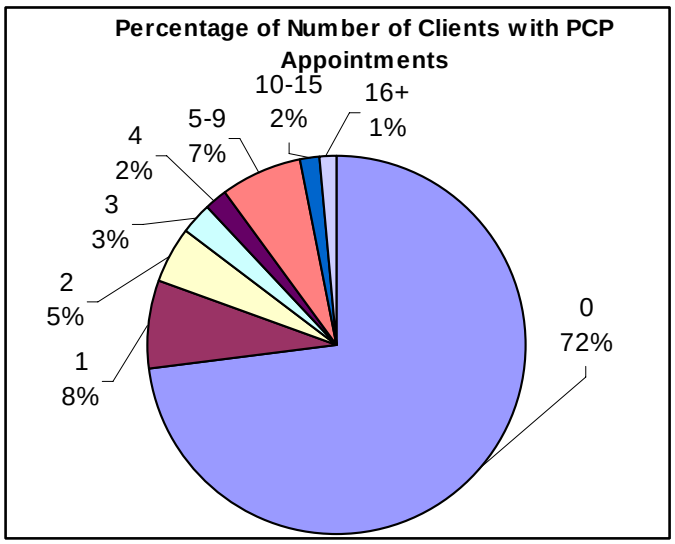
Do: Action Steps

- Run baseline data
- Nurse hired for Lifeworks site
- Communication tools developed
- Determine how to exchange data

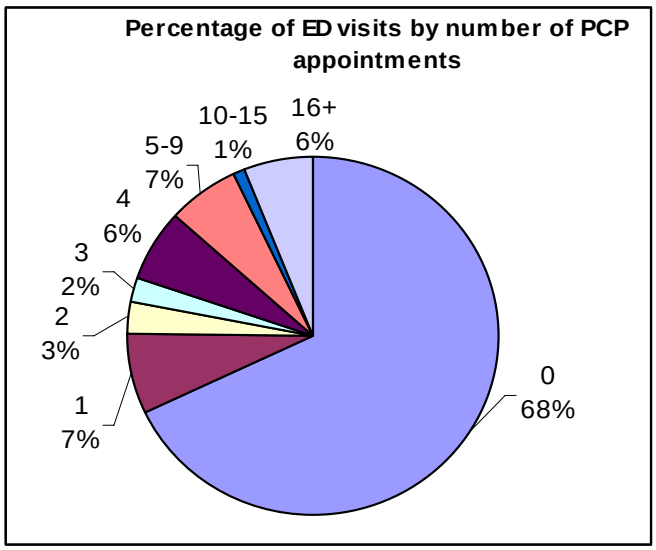
Results

Verity has entered into collaborative projects with two health plans, Care Oregon and Kaiser. The project was initially intended to be one project, but both projects were focused on the same question: did case management increase Primary Care Physician (PCP) visits and decreases urgent and emergency care for Serious and Persistent Mentally Ill individuals? Two models were simultaneously be implemented. Model A was a face-to-face venue within a behavioral health setting.

Care Oregon Data for Verity clients PCP encounters



Care Oregon Data for Verity clients ED encounters



Model B was a telephonic model with limited face-to-face contacts utilizing an Exceptional Needs Care Coordinator (ENCC). In Model A, a Registered Nurse (RN) who has experience in both medical and mental health will be place into a behavioral healthcare setting to screen and assist clients in establishing care with a PCP. This model is currently used by Care Oregon. Lifeworks Gresham clinic was chosen as the pilot study site. The nurse has been hired and has seen approximately 75 clients. Lifeworks has agreed to obtain a signature for all Gresham Lifeworks clients and release this data to Care Oregon. Care Oregon will run data for those clients and has released aggregate data to Verity. The measures will be PCP visits and ED use as indicated above. Care Oregon was provided a list of Names and OHP ID numbers for Verity/Care Oregon SMI clients. Care Oregon then looked at encounters for PCP and ED usage. Most clients (72%) have not seen a PCP in the last year. However, 68% have not had any ED use. To understand this more, a comparison of ED usage by the number of times seen by their PCP in the last year will give a better understanding of usage. Care Oregon is working on running the data in this way.

The same measures were going to be used for the Verity/Kaiser project. Model B is a telephonic model with limited face-to-face contacts utilizing an Exceptional Needs Care Coordinator (ENCC) who is also an RN. The nurses in both models will screen clients for physical health risks, which will include lack of an established Primary Care Physician (PCP), and/or identification of physical health care concerns. The nurses will help establish care with a PCP and coordinate care between the PCP and mental health care provider until the patient is fully established with a PCP and major concerns have been addressed.

When Kaiser ran the initial data for mutual clients, Kaiser found that all clients were assigned a PCP. However, 18% has not seen their PCP in the last year. There was little over-utilization of the emergency department (ED), and 53% did not use the ED in the last year. Twenty-seven individuals had 42 ED encounters.

Number of PCP VISITS	Number of clients	Sum of ED VISITS	Sum of UCC VISITS
0	10	8	0
1	13	7	10
2	10	8	4
3	6	6	2
4	5	9	7
5	5	5	1
6	3	3	0
7	2	29	17
8	2	1	1
9	1	0	0
Total	**57**	**76**	**42**

81% of the patients who used the ED had 1-3 visits, but only utilized 14% of the ED visits. Two individuals accounted for 8% of those who had ED visits, but utilized 76% of the total encounters. Since the number of individuals needing a PCP was low, and ED utilization was not considered high (with the exception of two individuals), the two health plans decided to collaborate in other areas of concern with this population.

Both plans agreed to measure communication between the agency and the health plan, metabolic rates, medication follow-up, and ED and UCC (Urgent Care) utilization. Presently, a communication tool has been developed, but not implemented. Regular meetings with agencies that have the majority of the Kaiser clients have been occurring to work out how the project is to be implemented, how the agencies will communicate with Kaiser, as well as how the data exchange between Verity and Kaiser will occur. The implementation phase should occur in March.

This collaboration will promote:

- Timely identification and assessment of the client's medical conditions
- Detection of co-morbid medical condition(s)
- Coordination in dialogue and joint treatment plan development between the behavioral and medical care teams

Domain: Clinical Outcomes

Program Area: All Verity Clients

Plan: Integration and Coordination—Community Encounters

Objectives

Increase the amount of mental health services provided in non-office settings

Reduce total days in PRTS and Day treatment and further develop indicators to ensure children and SMI adults are served at the appropriate level of care

Questions/Predictions

Agencies with increased non-office visits will increase number of successful discharges

Increased Community Based Services will reduce total days in higher levels of service

Clients who have non-office visits will remain in treatment and have improved outcomes

Indicators

Percent of service days in which members receive ICTS services

Percent of service days in which members receive PRTS services

Sum of total day treatment days

Performance Goal

Establish baselines and set performance goal targets

Measurement Method

Percent of total ICTS days

Percent of total PRTS days

Sum of total day treatment days

Measurement Source

Verity OHP claim data

Do—Action Steps

Continue the implementation of home and community based services for SMI adults and children in the ICTS program, and monitor data.

Identify additional programs that could benefit from the provision of home and community based services, and provide incentives to shift service locations.

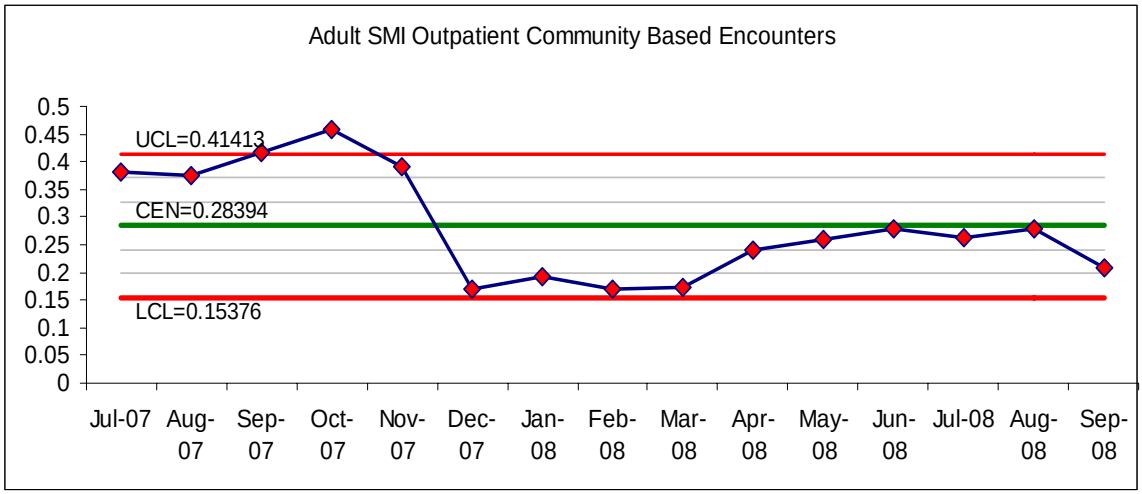
Provide technical assistance to agencies for Place of Service Codes (POS)

Results

Among adult SMI clients, between 40% and 50% of encounters occurred outside the office from July 2007 – November 2007. Between November and December, the rate dropped to 15% of encounters occurring in the community, a rate that slowly crept up to 28%. A drop in September 2008 showed

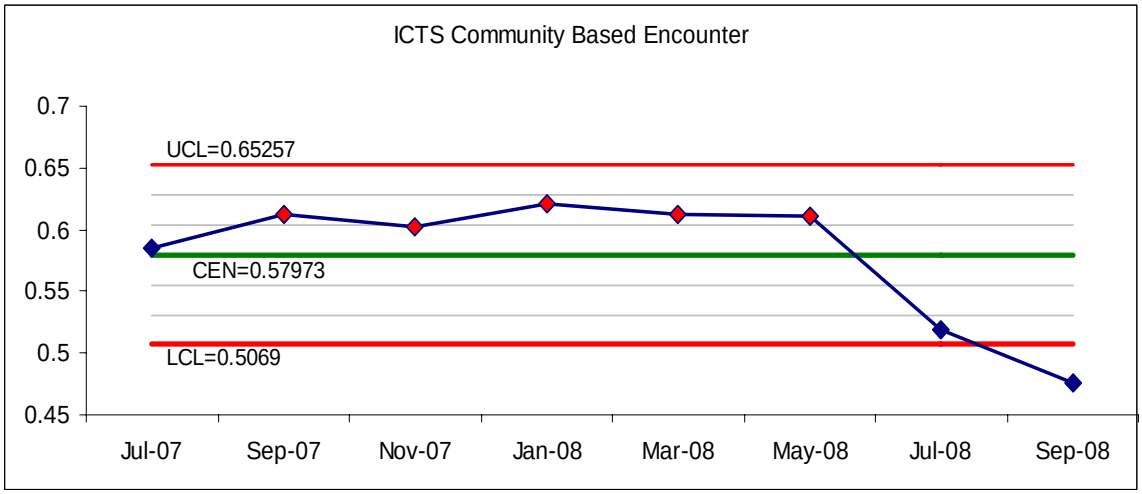
roughly 20% of SMI encounters were community based. The mean percent of community-based encounters among SMI was 28.4% (see Chart 1).

Chart 1



Among youth in ICTS programs, roughly 60% of encounters occurred out of the office from July 2007 through May 2008. There was a sharp decline between May and July 2008, continuing through September. That month, roughly 47% of ICTS encounters in the community. The mean percent of community-based encounters among ICTS youth was 58.0% (see Chart 2).

Chart 2



Concurrent to these trends, children in PRTS services saw a decline in community-based services in the spring of 2008. This was about the time that the Call Center took over Utilization Management and Utilization Review, which could have impacted community-based encounters, although we cannot confirm any causal relationships.

Domain: Delivery of Services/Integration and Coordination

Program Area: All Verity Clients

Plan: Integration and Coordination—Hospital Discharge Planning

Objectives

To increase the number of hospitalized Verity members whose outpatient provider was involved in the discharge planning prior to discharge and within one-week.

Questions/Predictions

- Clients with outpatient services during hospitalization will have reduced length of stay
- Those connected with an outpatient provider will have reduced hospital readmissions

Indicators

Outpatient provider involvement in discharge planning prior to discharge

Performance Goal

10% improvement in each stratification

In hospital: LOCUS 1, 2 Target 40% LOCUS 3, 4: 60% ACT/Waitlist: 98%

Within 7-days: LOCUS 1, 2 Target 80% LOCUS 3, 4: 90% ACT/Waitlist: 100%

Establish baseline for CASII 1-5 in 2008

Measurement Method

Percent of Verity clients with an open outpatient authorization who are hospitalized and who receive at least one outpatient encounter during inpatient admission

Percent of Verity clients with an open outpatient authorization who are hospitalized and who receive at least one outpatient encounter 7 days after discharge

Percent of Verity clients with no outpatient authorization who are hospitalized and who receive at least one outpatient encounter during inpatient admission

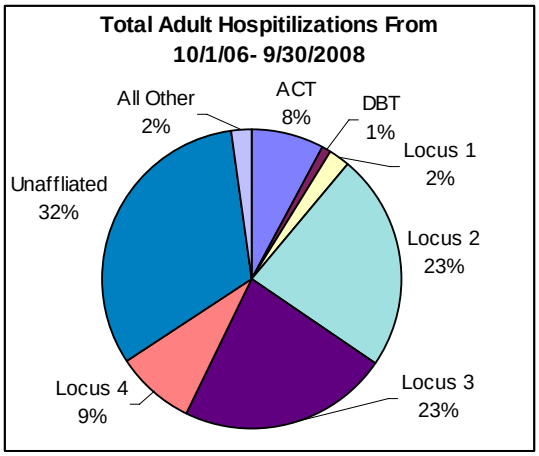
Percent of Verity clients with no outpatient authorization who are hospitalized and who receive at least one outpatient encounter 7 days after discharge

Measurement Source

Verity OHP claim data

Do—Action Steps

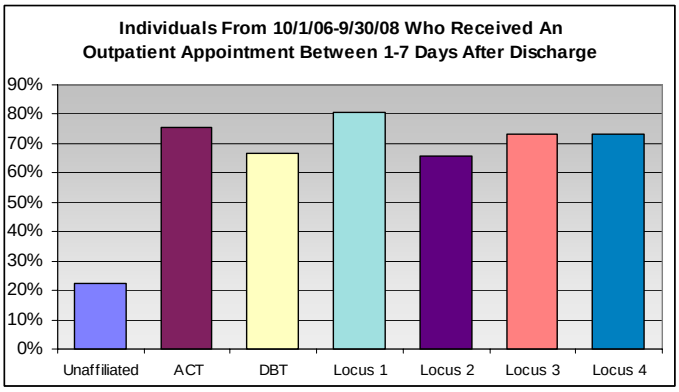
- Continue monitoring data
- Contract with hospitals will contain language for aftercare coordination



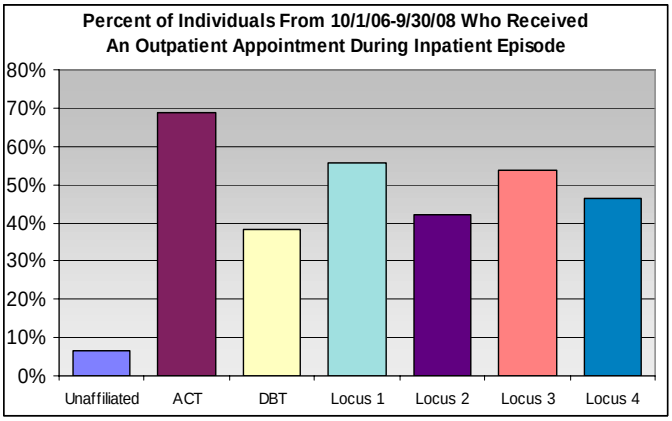
Results

Unaffiliated members account for 32% of total hospitalizations since October 1, 2006 to September 31, 2008. However, unaffiliated members are only seen by an outpatient provider

while in the hospital 7% of the time and have a follow up appointment within 7 days 22% of the time. The rate of outpatient encounters falls far below what Verity considers optimum coordination of care. Unaffiliated members comprised 22% of hospitalizations in the last year. 145 members remain unaffiliated with a current outpatient provider. Eighteen of those individuals had two hospitalizations in FY 08 and two had three hospitalizations. As a result, Verity hired two FTE to assist Verity members who have multiple hospitalizations, and are not connected with an outpatient provider. This team coordinates these members' follow-up services and helps them get connected with appropriate care.

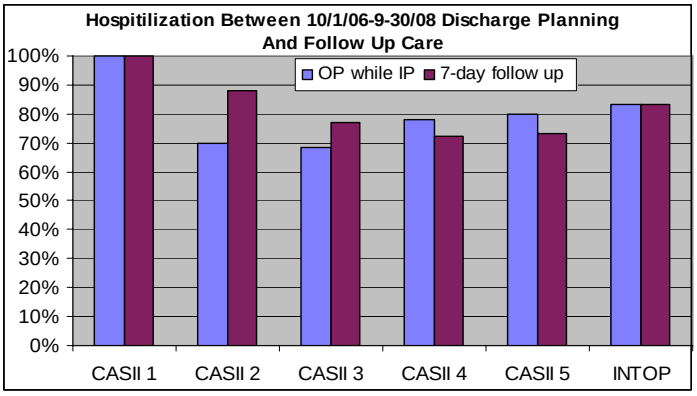


Goals were met or exceeded for Locus Level 1 for both outpatient appointment while inpatient (56%) and 7-day follow up (81%). 42% of Locus 2 individuals saw an outpatient provider while in the hospital. However, Locus 2 fell short of the goal of 80% for 7-day follow up appointments with 56% seeing an outpatient provider in the first seven days after hospitalization. DBT and Locus level 3 and 4 fell short for both goals. DBT had 67% with 7-day follow up. Locus level 3 and 4 had a 73% 7-day follow up appointment rate. Locus level 3 did slightly better (54%) for outpatient appointments while inpatient, Locus level 4 dropped to 46% and DBT had only 38% of clients being seen while inpatient. DBT only has 1% of the total hospitalizations so just a few negative appointments can affect the rate tremendously.



Authorization Types

Baseline levels for CASII and Individually Tailored Outpatient Services (INTOP) indicate that children's discharge planning (indicated by an outpatient encounter while in the inpatient) is higher than most adult levels. With the exception of CASII 3, children are being seen in the hospital by an outpatient provider at least 70% of the time. CASII 3 just barely missed this mark by 2%. CASII 1 is 100% for both outpatient while inpatient and 7-day follow up, however there were only two hospitalizations in this level. The 7-day follow up rate is overall 70%. However, the CASII levels 3, 4, and 5 are below 80%, so Verity is working to increase follow-up care rates.



Until Verity contracts with hospitals, effective interventions are constrained. Aftercare coordination has been added to those contracts, but until they are signed, the follow-up requirement is not binding. However, aftercare coordination is in all outpatient contracts, and Verity outpatient providers are given notice by Verity UR staff if a client is admitted to the hospital. Verity will continue to discuss follow up care and look at other ways to encourage higher follow-up care rates.

Domain: Quality/Appropriateness

Program Area: Day Treatment Services

Plan: Quality—Day Treatment Length Of Stay

Objectives

To reduce the average length of stay (ALOS) in day treatment

Questions/Predictions

Providing appropriate level outpatient services and supports for high-risk clients will reduce the length of stay in higher level treatment settings.

Indicators

Provide appropriate average length of stay in day treatment

Reduce number of day treatment monthly unduplicated authorizations

Performance Goal

Establish baseline and set performance goal targets

Measurement Method

Average Length of Stay

Measurement Source

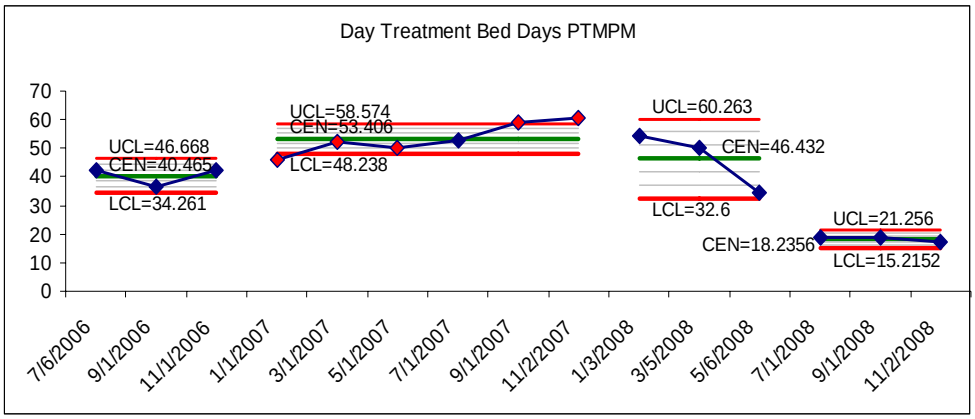
Verity OHP Authorization data

Do—Action Steps

- Continue to monitor data
- Do a chart review for the top 10% of the clients who are currently in day treatment who had the most lengthy stays to determine if the length of stay was avoidable or not.

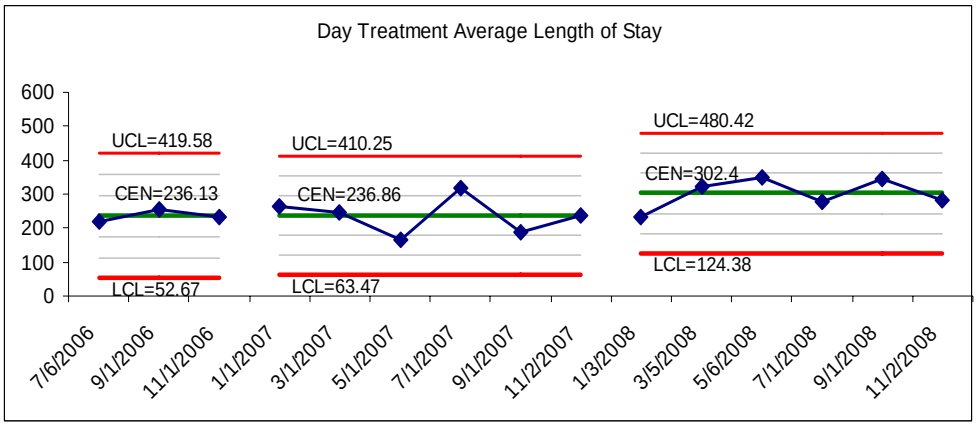
Results

After reviewing level of care appropriateness for enrollees, the children's system of care determined that many children did not need their current level of care. A review of the typical treatment revealed very few active discharge plans and very long lengths of stay. The first step to reduce the average length of stay was to decrease overall utilization. Overall, utilization began to reduce in early 2008, but still remained high. In June 2008, Verity member services took over utilization review for day treatment. There was a significant reduction in Day Treatment Bed Days per thousand members per month. The children that remain in this level of service need



intensive services in day treatment or a comparable level of care and need additional days to stabilize prior to moving to a lower level of care. The result of reducing utilization is that some agencies are closing their programs, causing fewer available openings.

A goal was set in 2007 for ALOS at nine months. However, the average length of stay for these high needs clients increased, and Verity believes that this will drop as agencies and the community identifies community supports for ongoing severe and persistent mental illness.



DOMAIN: QUALITY/CHILD AND FAMILY SATISFACTION

Program Area: Outpatient and PRTS Child and Adolescent Programs

Plan: Quality—Youth Satisfaction

Objectives

To increase the level of outcome satisfaction

Questions/Predictions

- Increase outcome ratings by focusing on items predictive of outcome

Indicators

Verity will primarily focus on increasing scores in the Outcome domain. Questions that are highly predictive of outcome satisfaction:

✓ "My family got as much help as we needed for my child" (Quality/Appropriateness)

✓ "My child had someone to talk to" (Quality/Appropriateness)

Performance Goal

Increase outcome domain score for clients who have been in treatment greater than 6 months or more than two weeks for residential

Measurement Method

NUMERATOR: Consumers included in the denominator who responded either "strongly agree" or "agree"

DENOMINATOR: Consumers who received a mental health service during a specified period of time and who have completed an YSS/F consumer survey

Measurement Source

Youth Services Satisfaction Survey (YSS)/ Youth Services Satisfaction Survey for Families (YSSF) administered to each adolescent and family at discharge from residential treatment and submitted to Verity OHP, or administered every May as a waiting room survey and submitted to Verity OHP

Fall Focus Groups

Do—Action Steps

- Verity will share each agency's scores with the other participating agencies. Verity will schedule a time to discuss interventions aimed at increasing satisfaction around the items most strongly relating to outcome at internal agency staff or quality management meetings.
- A full satisfaction report, with all statistical information, will be completed and available for any agency, quality management staff, or interested people.
- Consumer focus groups will be held. Consumers will be asked for examples of interventions that they would like the agencies to add or change. The focus of the session will be on the two questions listed under "Indicators".

Results

Verity developed a full satisfaction report for public dispersion and provided data specific to individual agencies. Children receiving mental health services and their guardians were surveyed using the Youth Satisfaction Survey (YSS) and Youth Satisfaction Survey for Families (YSS-F), www.mhsip.org. The YSS is filled out by 14-18 year- olds while family members of any aged child fill out the YSS-F. The survey was distributed and received in May 2008. Five focus groups were held with youth and three focus groups were held with families in October and November 2008. Important findings from the focus groups are in Appendix A.

Overall findings of interest:

- Verity scores continue to be higher than state and national scores, with the exception of outcome.
- Families in services for 1 year or more expressed more satisfaction than those in services 0-3 months for the domains of Satisfaction, Participation and Appropriateness.
- Parent/Guardians in May 2008 were significantly more satisfied for the domains of Appropriateness and Outcome when compared to past survey collection dates.
- Questions relating to Quality/Appropriateness of care best explain Outcome scores.

Survey Respondents

A total of 514 surveys were collected from consumers. Approximately 1 in 5 consumers responded to the survey. When compared to the overall Verity population, there was a higher proportion of White/Caucasian (3% more) and lower proportions of Hispanic/Latino, Asian/Pacific Islander, and Black/African American (8%, 6% & 8% less, respectively) survey respondents.

YSS-F Verity Compared to Oregon & the Nation:

Verity scores continue to be higher than Oregon state scores. With the exception of outcome scores, Verity scores are comparable to national data.

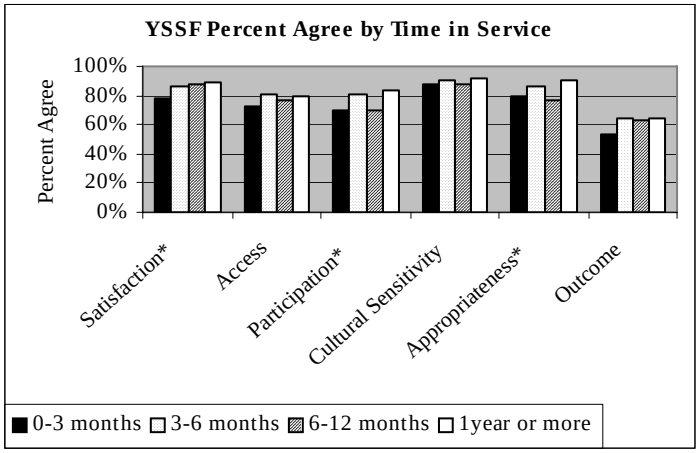
State and national data tend to be collected via mail from consumers who are no longer receiving services, thus differences in outcome scores with Verity data would be expected. Due to the differences in data collection method, comparisons with state and national data are very general.

Percent Agree on YSSF for Verity, State & National[3]					
	Verity 2006 May and October	**Verity May 2007**	**Verity May 2008**	**Oregon Statewide 2006**	**National 2006**
	(n=535)	(n=348)	(n=361)	(n=2,143)	(n=63,054)
Access	79%	82%	79%	70%	83%
Appropriate	81%	82%	82%	64%	81%
Outcomes	61%	62%	64%	56%	73%
Participation	85%	87%	77%	74%	87%
Cultural Sensitivity	95%	94%	90%	88%	91%

[3] National data for 2006 Surveys obtained from http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/URS2006.asp

Time in Service:

A question relating to the time a client has been receiving services was added to the survey. Respondents could select one of four time periods: 0-3 months, 3-6 months, 6-12 months and 1 year or more. There were significant differences by time in services for the domains of Satisfaction, Participation and Appropriateness. For each of the aforementioned domains, families who were in services 0-3 months were less satisfied than those in services 1 year or more.



Relationships to Outcome Scores:

Stepwise regression was used to determine the questions that best explain outcome scores. The questions, and their domain, that best explain outcome scores are as follows:

- My family got as much help as we needed for my child (Quality/Appropriateness)
- My child had someone to talk to (Quality/Appropriateness)

Only respondents in services 3 months or more were included in this analysis (n=238). R-squared scores ranged from .25 for the first question listed above to .28 when both questions were used to explain outcome scores. R-squared is a measure of the extent to which the predictor explains the outcome measure. For example, an R-squared of .28 for the two questions means that 28% of the variation in the outcome domain is due to those questions.

Conclusions

Key results from the satisfaction surveys include the following:

- Approximately 1 in 4 clients served by participating agencies returned a survey.
- When compared to the overall Verity population, there was a higher proportion of White/Caucasian and lower proportions of Hispanic/Latino, Asian/Pacific Islander, and Black/African American survey respondents.
- Verity scores continue to be higher than state scores and comparable to national scores (with the exception of the outcome domain).
- On the YSSF, respondents were significantly less satisfied in May 2005 for the domain of Satisfaction. For May 2008, respondents were significantly more satisfied for the domains of Appropriateness and Outcome when compared to October 2004.
- On the YSSF, questions connected to appropriateness/quality of care were related to outcome scores for children in services more than 3 months.
- Youth were significantly less satisfied in the domains of Satisfaction, Access, Participation, and Cultural Sensitivity when compared to family responses.

Domain: Quality/Satisfaction

Program Area: Adult Outpatient and SMI

Plan: Quality—Adult Satisfaction

Objectives

To increase the level of outcome satisfaction

Questions/Predictions:

- By focusing on items predictive of outcome, we will increase outcome ratings

Indicators

Verity will primarily focus on increasing scores in the Outcome domain. Questions that are highly predictive of outcome satisfaction:

- Staff told me what side effects to watch out for (Quality)
- I, not staff, decided my treatment goals (Quality)
- I was encouraged to use consumer run programs (Quality)
- The location of services was convenient (Access)

Performance Goal

Increase outcome domain for clients who have been in treatment greater than 6 months

Measurement Method

NUMERATOR: Consumers included in the denominator who responded either "strongly agree" or "agree

DENOMINATOR: Consumers who received a mental health service during a specified period of time and who have completed a MHSIP consumer survey

Measurement Source

MHSIP Satisfaction Survey administered to each SMI client receiving services during a two-week period each May and submitted to Verity. Findings supplemented by focus group results.

Do—Action Steps

- Verity will share each agency's scores with the other participating agencies. Verity will schedule a time to discuss interventions aimed at increasing satisfaction around the items most strongly relating to outcome at internal agency staff or quality management meetings.
- A full satisfaction report, with all statistical information, will be completed and available for any agency, quality management staff, or interested people.
- Consumer focus groups will be held. Consumers will be asked for examples of interventions that they would like the agencies to add or change. The focus of the session will be on the two questions listed in "Indicators."

Results

Verity developed a full satisfaction report for public dispersion and provided data specific to individual agencies. Four focus groups were held in October and November 2008. Focus group results are highlighted with youth results in Appendix A. Highlights of the satisfaction survey results include the following:

- Approximately 1 in 4 clients served by participating agencies returned a survey.
- Percent agree for Verity survey respondents in 2008 exceed all state domains and the Satisfaction domain for national data from 2006.
- Females are significantly more satisfied for the domains of Access, Quality and Satisfaction than males.
- The 18-29 year group is significantly less satisfied for the domains of Access and Satisfaction.
- Asian/Pacific Islanders express the most satisfaction for the domains of Access, Quality and Satisfaction. Respondents declining to provide race/ethnicity have the lowest satisfaction scores for the aforementioned domains.
- Questions relating to Quality and Access best explain Outcome scores.

When compared to the overall Verity population, there are fewer Hispanic and Black survey respondents. There are slightly more Asian survey respondents. At the present time, it is not possible to look at penetration rates by race ethnicity. This would be interesting to look at in the future to help in determining if the differences in representation are due to differences in responses for those utilizing services or those responding to the surveys.

Verity survey respondents in 2008 exceeded Oregon State and national scores in all domains. Although it is interesting to look at the differences between Verity, Oregon and national domain scores, these differences are difficult to interpret. This is because the state and national data are collected in a different manner than Verity. For example, people currently receiving services complete Verity surveys. State and national respondents may currently be in services or may have completed services. This difference in sampling is especially important when looking at the Outcome domain. The state and national responses are from 2006, while Verity data are from 2008.

As part of Verity's continuous improvement plan, agencies are being presented with their satisfaction survey data as it compares with overall Verity, state and national data. In addition, Verity has an interest in focusing on agency implementation of Evidence-Based Practices (EBP). This second focus is especially important in light of the questions related to outcome scores. Questions coming from the domain of Quality have consistently (2006, 2007, and 2008) been highly correlated with outcome scores. This is the first year that length of service has been taken into account when considering outcome scores. Clients in services fewer than 3 months were not included in this analysis. Questions such as "staff told me what side effects to watch out for," "I, not staff, decided my treatment goals," and "I was encouraged to use consumer run programs" are significantly related to outcome scores. These themes were developed further through the focus groups.

Comparisons & Analyses[4]

The MHSIP contains 28 questions with 5-point Likert ratings (1=Strongly Agree to 5=Strongly Disagree). The 28 questions were divided into 4 domains (Access, Quality, Satisfaction, and Outcome). Each domain was calculated by taking the average response score to questions within that

[4] Significant differences are reported at $p<0.05$. To account for multiple tests, post hoc analyses are done with bonferoni adjustment.

domain. For the purpose of analyses, responses were divided into 3 rating categories (1=Strongly Agree, 2=Agree, 3 = Not Agree).

Verity, State and National Comparisons:

Verity scores have remained stable between 2007 and 2008. Verity scores continue to be higher than overall Oregon State scores and comparable to national data. Due to differences in data collection method and the time frame the data were collected, comparisons with state and national data are general and not fully comparable.

Percent Agree for Verity, State & National[5]				
	Verity May 2007	**Verity May 2008**	**State of Oregon**	**National**
	(n=941)	(n=795)	(n=2,684)	(n=137,024)
Access	83%	81%	70%	85%
Quality	85%	88%	75%	87%
Satisfaction	87%	87%	57%	71%
Outcome	71%	71%	78%	88%

Differences by Gender & Age:

Females are significantly more satisfied than males for the domains of Access, Quality and Satisfaction. There are no differences between the genders for the domain of Outcome.

Percent Agree by Gender		
	Female	**Male**
Access *	86%	77%
Quality *	91%	85%
Satisfaction *	92%	85%
Outcome	71%	73%

There are significant differences between the age groups for the domains of Access, Quality and Satisfaction. Post hoc tests show that for Access, the youngest age group (18-29yr) is significantly less satisfied when compared to the two older groups (45-65yr and 66yr+). For Satisfaction, post hoc tests show that the youngest age group (18-29yr) is significantly less satisfied than the next age group (30-44yr). Post hoc tests did not reveal any specific differences within the domain of Quality.

Percent Agree by Age Category				
	18 -29yr	**30 -44yr**	**45 -65yr**	**66+yr**
Access *	77%	83%	86%	100%
Quality *	87%	92%	91%	97%
Satisfaction*	89%	94%	90%	100%
Outcome	71%	67%	75%	94%

[5] State and National data for 2006 Surveys obtained from http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/URS2006.asp

Time in Services Comparison:

A question relating to time a client has been receiving services was added to the survey. Respondents could select one of four time periods: 0-3 months, 3-6 months, 6-12 months and 1 year or more. There were no differences by time in service for any of the domains.

Domain: Prevention, Education, and Outreach

Program Area: All Outpatient Verity Clients

Plan: PEO—Suicide Prevention

Provide suicide prevention resources to all Verity clients

Objectives:

To implement suicide prevention activities

Questions/Predictions:

Access to and utilization of crisis intervention resources and preventative education will reduce suicide rates

Indicators:

Number of suicide prevention activities reported by Verity

Performance Goals:

100% of Verity clients will receive the suicide prevention handbook

Screen High School students for suicide risk

Measurement Method:

Total count of handbooks sent to Verity members

Total count of prevention/education/outreach (PEO) activities reported by Multnomah County Call center staff.

Measurement Source:

PEO Report

Do—Action Steps

Identify prevention activities taking place in the community

Disperse suicide prevention brochures in mental health, medical, and dental clinics that serve Verity clients

Results

Verity included a section for youth suicide prevention in the 2008 annual handbook. The information was based on “Recognizing Depression in Youth – A Key to Solving One of Oregon’s Most Serious Problems: Youth Suicide” by Kirk D. Wolfe, M.D. Plans were put on hold to develop a brochure for health clinics due to system changes. However, a website redesign was completed that included additional links for suicide prevention. Crisis posters were also redesigned to be more consumer friendly and laminated copies were distributed to all agencies’ clinic sites.

Verity did not implement the Columbia Teen Screen suicide risk tool due to the labor intensiveness, reaction to situational events, and lack of cultural competencies. The Spanish version was Puerto Rican/Cuban and not applicable in this geographical region. The C-4 committee is developing a new plan for suicide screening in high schools in 2010.

Domain: Medicaid Requirements—Fraud and Abuse Prevention

Program Area: All Verity Clients

Plan: Documentation Errors

Verity will improve documentation for billable services by using voluntary agency participation in internal audits

Objectives: Decrease documentation errors

Questions/Predictions: Documentation errors will decrease by assuring chart audits are regularly taking place at the agency level.

Indicators: Participating agencies will submit a chart audit tool to Verity for approval. They must contain the following indicators:

- Current consent for treatment
- Current MHA assessment completed and signed by a QMHP—1 yr updates signed by an LMP
- Treatment plan completed in the last 12 months
- At least one MH Goal addressing diagnosis on the assessment
- TX plan interventions have frequency and duration for specific intervention
- TX plan signed by a QMHP—1 yr updates signed by an LMP
- Progress notes clearly define what treatment goal and intervention are being addressed in session

Performance Goal:

- 50% of providers will participate quarterly participating
- Participating providers will reduce error rates to acceptable levels

Measurement Method: Agencies will complete chart audits at least quarterly and submit aggregate data of results. The following sample size will be used:

NUMERATOR: Number of missing or incomplete data for each indicator above

DENOMINATOR: Charts audited for each indicator above

Measurement Source:

Chart Audit reports by agency

Do: Action Steps

- Develop chart audit tool
- Develop Pay for Performance Parameters

Results

Verity was unsuccessful in obtaining agency utilization review templates for this project. Only one agency submitted a UR tool. As a result Verity will change the intervention in 2009 to increase participation.

Verity conducted a focused chart review of five Cascadia sites that serve Verity clients on September 5 and 8, 2008. The audit was performed to determine Cascadia's adult outpatient programs' compliance with applicable Oregon Administrative Rules (OAR) and the use of the H0036 billing code. This code is defined as Community Psychiatric Supportive Treatment, or Daily Structure and Support

(DSS). Division leadership requested a focused audit after a review of H0036 indicated a high number of billed claims for this service. The following findings resulted in requesting a corrective action plan with a pay-back requirement.

- Overall, 74% of charts contained a current Consent to Treatment form signed by the consumer. David's Harp had the highest compliance rate with 96% of charts complete, while Garlington had the lowest compliance rate with 17% of charts complete.
- Overall, 82% of charts contained a Mental Health Assessment or update completed in the last year, signed by a QMHP. David's Harp and Royal Palm had the highest compliance rates, with 88% of charts complete at each facility. Downtown and Bridgeview had the lowest compliance rate, with 67% of charts complete at each facility.
    - Of the charts containing a recent MHA or update, 98% were signed by an LMP.
- Overall, 82% of charts contained a treatment plan, updated in the past year and signed by a QMHP. Royal Palm had the highest compliance rate with 94% of charts complete, while Garlington had the lowest compliance rate with 67% of charts complete.
    - Of the charts containing a recent treatment plan or update, 94% were signed by an LMP, 95% specified at least one Mental Health goal, and 75% prescribed DSS. Of the charts with prescribed DSS, 82% specified frequency and duration.
- Overall, 89% of charts contained a progress note for the encounter being audited. Royal Palm had the highest compliance rate with 100% of charts complete, while Downtown had the lowest compliance rate with 78% of charts complete.
    - Of the charts containing a progress note for the encounter being audited, 93% were signed by a QMHP or QMHA and 87% reflected the number of units billed.
- Overall, 75% of charts contained documented services that described a therapeutic approach toward daily living, community integration, or interpersonal functioning. Garlington maintained the highest compliance rate with 100% of charts complete, while Downtown had the lowest compliance rate with 14% of charts complete.

For the twelve compliance items reviewed, those items falling below an 85% compliance threshold were given a finding with required Corrective Action. The CAP has just been approved and sent to Cascadia and the response time is later than this report.

APPENDIX A

Verity 2008 Satisfaction Focus Group Results

Treatment Plan

Adult: Felt engaged, responsible for progress if involved in writing

Family: Need input from child and family during plan development

SMI: Providing input increases ownership of own improvement

Youth: Felt empowered and respected if involved

Groups

Adult: Like learning from peers, benefit from consumer-run programs

SMI: Like the social interaction groups and consumer-run programs provide. Important to learn coping skills that work

All: Identified groups are best

Communication

Family: Need constant, consistent communication with everyone involved: a team approach. Child's communication improved over course of therapy

Youth: Want consistent message of expectations, to be held accountable

Checklist or Tool

Adult: Helped focus sessions

SMI: Focused treatment plan, therapy sessions

Youth: Provided prompts to direct therapy, include in TX plan

All: Want more focused therapy

Location

Adult: Easy access to services; <30 minutes on TriMet

Family: Home visits are invaluable

SMI: Easy access to services; <30 minutes on TriMet. Like all services in one place

Crisis

Family: Call therapist, police in crisis. Response time is critical; some agencies better than others.

All: Crisis response most effective when trust was built with responder before crisis. Want response plan in treatment plan

Time in Treatment

Family: Sufficient time in treatment, but poor transitions between counselors disrupts progress

Youth: Sessions should be more fun, out of the office, include more interaction with counselor, and not force topics

Information

Adult: Need to ask questions to get all information on medications

SMI: Appreciate information on education, jobs, and social engagement opportunities

All: Sufficient information on medications and side effects from prescriber or pharmacist

Spiritual Beliefs

Youth: Important personally to mental health improvement but should not be part of treatment unless counselor and youth share religious or spiritual beliefs. Interested in learning more about different religions

Support

Family: Felt supported in treatment when therapist identified family strengths, paid attention to all family members

SMI: Supported most by therapist, case manager; especially those available 24-7 by phone

Youth: Supported by therapist, case manager, family, and friends

Trust with Counselor

Adult: Treatment plan was more accurate, made better progress on goals with trust

SMI: Staff turnover makes trust hard, important for progress

Family: Imperative piece of child's success; family also needs to trust

Youth: Will talk if trust counselor; someone young with similar life experience

APPENDIX A

Verity 2008 Satisfaction Focus Group Recommendations

Take-Home Information

Provide standardized medical information to clients. Provide a list of questions about medications and their side-effects for clients to ask providers. *(information)*

Provide take-home information for clients at the end of each session, with lists of things to work on. *(information)*

Ensure psycho-education and process groups provide printed information to take home and homework assignments. *(groups)*

Checklist, or Computerized Tool

Incorporate a computer program, checklist, or quiz into treatment planning and therapy, taking necessary precautions to protect clients' privacy and information. *(treatment plan)*

Youth especially like using electronic means to communicate issues they are not comfortable talking about in person. *(trust with counselor)*

Providers and Verity will share tools with the QM committee.

Support

Ensure respite, skills training, home visits, and family inclusive therapy for youth clients *(support)*

Trust with Counselor

Ensure consistent counselor through course of treatment *(trust)*

Implement alliance questionnaire to evaluate and ensure trust, identify corrective action *(trust)*

Groups

Increase peer services; increase billing for peer services. *(groups)*

Develop a resource list of peer-run or community support groups; distribute list to provider and post online. *(information)*

Explore groups amenable to the dual diagnosis population, or those for whom AA or NA are not viable options. *(groups)*

Increase the availability of psycho-education and process groups, especially those that assign homework assignments or provide binders with information. *(groups)*

Specific structured groups are more helpful than others including anger management, seeking safety, and mindfulness. *(groups)*

Ensure clients are matched appropriately in groups; enable group transfers until client finds group most appropriate for specific needs. *(group)*

Fulfill social desire for groups in SMI population and knowledge exchange of coping techniques in Adult OP. *(groups)*

Ensure availability of parent support groups. *(groups)*

Location

Increase availability of out-of-office appointments for youth/families *(time in treatment)*

Maintain office locations in close proximity to clients' homes *(location)*

Communication

Ensure constant communication between all service providers, including school, counselor, and other agencies serving client. *(communication)*

Increase consistency through constant communication with client/family and partners. *(communication)*

Provide elements that enhance therapeutic communication. *(communication)*

Solicit communication outside regular appointments by phone or email with clients. *(comm.)*

Crisis

Include crisis response plan to clients' treatment plan. *(treatment plan)*

Primary counselor should be trained and available to respond immediately to crisis. *(crisis)*

ICTS providers guarantee 24-7 immediate response, not referral to police or other agency *(crisis)*

Spiritual Beliefs

Recognize the importance of youths' spiritual beliefs; provide resources for youth to explore further. *(spiritual beliefs)*

Time in Treatment

Ensure transitions are as seamless as possible for clients; smooth transitions between levels of care or between providers are critical to success. *(time in treatment)*