



Community Behavioral Health Summary of the Annual Evaluation of the Quality Improvement Program 2018

Community Behavioral Health (CBH) is a non-profit 501c(3) corporation contracted by the City of Philadelphia's Department of Behavioral Health and Intellectual disabilities (DBHIDS) to manage the delivery of the HealthChoices behavioral health program of the Commonwealth of Pennsylvania (Pennsylvania). This program covers mental health and substance use services for Medicaid recipients of Philadelphia County. In partnership with DBHIDS, services are delivered in accordance with HealthChoices, which is governed at the federal level by the Centers for Medicaid and Medicare Services (CMS) and administered at the state level through the Pennsylvania Department of Human Services (PA DHS) and the Office of Mental Health and Substance Abuse Services (OMHSAS).

CBH has slightly over 607,000 Medical Assistance eligible members. Our mission is that CBH will meet the behavioral needs of the Philadelphia community by assuring access, quality, and fiscal accountability through a high performing, efficient, and nimble organization driven by quality, performance, and outcomes.

CBH contracts with Medical Assistance enrolled and licensed providers with the requirement that they deliver effective and medically necessary services to covered members in the least restrictive, most developmentally appropriate, and culturally competent manner. In creating and maintaining this managed care system, CBH promotes maximum access, member and family participation, public accountability, and local control.

CBH authorizes services for a vast array of programs, including outpatient mental health and substance use, inpatient psychiatric and addictions treatment, residential rehabilitation, and family, school, and community-based programs.

Our Members

CBH's primary goal is to effectively address and support the overall health and wellness of Philadelphians across multiple domains, in partnership with other city agencies and physical health managed care organizations. CBH authorizes payment for a vast array of services, including outpatient mental health and substance use programs, inpatient psychiatric, residential rehabilitation, as well as family, school, and community-based programs.

Our Providers

CBH is committed to ensuring Philadelphians receive an array of quality, cost-effective, recovery-oriented, and evidence-based services. Targeted efforts include developing and expanding a wide array of community-based alternatives to restrictive settings, as well as developing specialized services for individuals with autism, youth involved in the child welfare system, and forensic-involved adults reentering the community.

Our Approach to Quality

The effectiveness of our services and strategies are evaluated in alignment with the DBHIDS Practice Guidelines, population health priorities, the triple aim, program requirements, and other dimensions of quality as described. Continuous quality improvement processes are used as a fundamental tool to support quality goals and priorities.

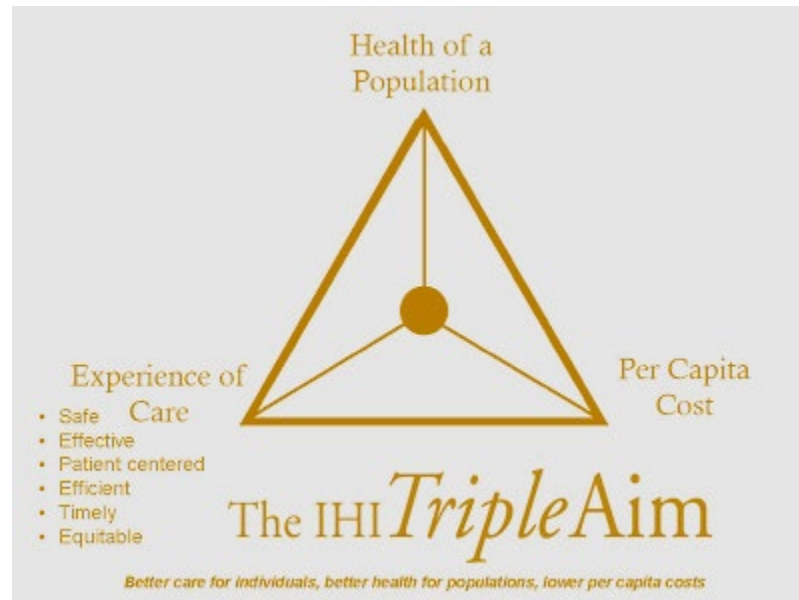
Population Health

Population health refers to the health of a community. Traditional approaches to health care center around individuals who are already experiencing a health-related condition. Population health approaches take a much broader view, seeking to improve the health status of everyone in a community, not just those who are sick. By providing excellent clinical care as well as community-level interventions and services, population health approaches help to create communities in which every member—not just those who seek out health services—can thrive. The essence of our population approach is to:

1. Attend to the whole population, not just to those seeking services. Population health approaches emphasize community-level outcomes, not just outcomes for individuals with particular diagnoses. A key benefit of a population health approach is its focus on keeping people well so that, over time, communities experience less illness and its associated consequences.
2. Promote health, wellness, and self-determination. Health is much more than the absence of illness or management of symptoms. There is a fundamental difference between providing targeted interventions to address illness versus promoting wellness and quality of life.
3. Provide early intervention and prevention. There will always be a need for access to high-quality clinical care, supports, and services. A population health approach provides such care and also works to screen for and prevent the onset or progression of conditions, which improves outcomes and better utilizes resources.
4. Address the social determinants of health. Poor health and health disparities do not result from medical causes alone. Chronic stress, toxic environments, limited access to nutritious foods, inadequate housing, social isolation, and numerous other nonmedical factors contribute to poor outcomes. A population health approach seeks to address these factors to reduce health disparities and safeguard everyone's right to optimum health and self-determination.
5. Empower individuals and communities to keep themselves healthy. Healthcare providers cannot shoulder the entire responsibility for healthy communities. A population health approach not only educates but also empowers and motivates people to take responsibility for promoting their own health and wellness.

The Triple Aim

Our goal is to help the people we serve by ensuring that our system is achieving the triple aim of better health, better care, and better costs.



Dimensions of Quality

1. **Safe:** avoiding injuries to consumers from care that is intended to help them.
2. **Effective:** providing services, based on scientific knowledge, to all who could benefit and refraining from providing services to those not likely to benefit (avoiding under use and overuse, respectively).
3. **Consumer-centered:** providing care that is respectful of and responsive to individual consumer preferences, needs and values, and ensuring that consumer values guide all clinical decisions.
4. **Timely:** reducing wait time and sometimes harmful delays for both those who receive and those who give care.
5. **Efficient:** avoiding waste, including waste of equipment, supplies, ideas, and energy.
6. **Equitable:** providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.

Continuous Quality Improvement

CBH utilizes the Deming Cycle (Plan-Do-Study-Act) in its approach to quality improvement. The Deming Cycle begins with the **Plan** step, which involves identifying a goal or purpose, formulating a theory, defining success metrics, and putting a plan into action. These activities are followed by the **Do** step, in which the components of the plan are implemented. Next is the **Study** step, where outcomes are monitored to test the validity of the plan for signs of progress and success, or problems and areas for improvement. The **Act** step closes the cycle, integrating the learning generated by the entire

process, which can be used to adjust the goal, change methods, or even reformulate a theory altogether. These four steps are repeated over and over as part of a never-ending cycle of continual improvement.

Quality Management (QM) Program Structure

Quality Management Staff

CBH has dedicated significant resources and staffing to meet the needs of the QM program. CBH's QM Program resources are organized as follows:

- **Core Staff** – these internal staff play a critical role in leading, managing, and executing the QM Program activities. These staff include:
 - Chief Medical Officer
 - Medical Director of Quality Management
 - Director of Quality Management
 - Assistant Director of Quality Management
 - Manager of Quality Reporting
 - Quality Management Supervisor
 - Complaints & Grievances Supervisor
 - Quality Review Specialists
 - Complaints & Grievances Specialists
 - Administrative Support
- **Expanded Staff** – these internal staff have other roles in the organization and a portion of their role is spent supporting the execution of QM program activities. These resources come from other key departments within the organization including, but not limited to, the following:
 - Clinical Care Management
 - Medical Affairs
 - Member Services
 - Information Technology

Quality Improvement Committee (QIC)

The QIC provides oversight of the Quality Management Program. The committee was chaired by the Medical Director of Quality Management and is composed of DBHIDS and CBH leadership, member representatives, practitioners from the provider network, and representatives from the PA DHS OMHSAS. The QIC provided critical feedback and guidance to the QM department on key initiatives. The Committee is also responsible for reviewing and approving all the key QM documents, such as the QM Program Description, Work Plan, Annual Evaluation, and Policies and Procedures, in a timely manner.

Evaluation of CBH's Performance

Below is a summary of CBH's performance on key QI activities.

Target Goal: Reduce inappropriate prescribing of opioids

CBH distributed the second Philadelphia Medicaid Prescriber Dashboard reports to approximately 1,400 prescribers in June 2018. This Initiative promotes appropriate prescribing practices among medical professionals in Philadelphia via data sharing. Specifically, it describes the prescribing patterns, including the healthcare provider's own prescribing history and how they rank against the 'average' prescriber of the same specialty, and it provides a summary or graphical representation of their prescribing history.

Target Goal: Expand access to Applied Behavior Analysis (ABA), an evidence-based treatment for those with Autism Spectrum Disorder (ASD).

- CBH has nine in-network ABA providers: MCC, SPIN, Epic, CGRC, Devereux, Silver Springs, Interact, NET, and CCTC plus five Out-of-Network ABA contractors: ABA Support Services, Lovaas, Behavior Interventions, ABA2Day and Laila Way Behavioral Services.
- Each ABA-Designated agency has at least one Board-Certified Behavior Analyst (BCBA) on staff, to serve as the ABA Program Supervisor.
- As of February 2019, eighty-six (86) Licensed Behavior Specialists are now working at ABA-Designated agencies and providing services under the direct supervision of a BCBA.
- Access to ABA through CBH increased several-fold to over 500+ children authorized for ABA assessment or treatment in 2018.
- Partnering with the School District of Philadelphia to improve collaboration around ABA services and clarify shared responsibility of Special Education and Behavioral Health systems to support high-quality ABA for all Philadelphia students.
- More children on the Autism spectrum are receiving access to high-quality ABA, while the number of children receiving traditional BHRS is decreasing.

Target Goal: Offer a choice of at least two providers to all CBH members requesting service.

The Member Services Department of CBH set a standard expectation that all Member Services Representatives must offer a choice of at three providers to members. Even when a member identifies a preferred provider from the onset, Member Services Representatives still offer a choice of three providers in the event that the member's preferred provider is unable to accept new referrals at the time of need. Members were offered a choice of two providers 100% of the time.

Target Goal: 100% of calls to Member Services are answered within 30 seconds.

100.0% of calls were answered within 20 seconds.

Target Goal: Call Abandonment rate is 5% or less.

The call abandonment rate for 2018 was 3.6%.

Target Goal: Achieve 100% resolution within 30 days for first level and second level grievances.

98.9% of first-level grievances and 90% of second-level grievances were resolved within 30 days. First and second level grievances that exceeded 30 days for resolution were due to CBH being closed for inclement weather or the member/parent requesting to exceed 30 days.

Target Goal: Receive no more than five complaints or grievances (NCQA appeals) per 1000 members per quarter.

The complaint rate was below the overall goal of 5/1000 members for all 4 quarters. The appeals rate declined steadily over the year, meeting the goal of 5/1000 members in Q4.

Target Goal: Obtain 80% satisfaction rate on all measures used to determine member satisfaction via the member experience survey.

For adult services, CBH met the goal on 24 of 25 measures. For children's services, CBH met the goal on 16 of 25 measures.

Target Goal: Conduct onsite reviews as a means of on-going evaluation of the provider network.

Network Improvement and Accountability Collaborative (NIAC) conducted 61 site visits in 2018. There were 58 providers, representing 205 programs, presented to the Credentialing Committee for credentialing status.

Target Goal: 90% of respondents to the annual provider satisfaction survey have an overall satisfaction score of at least 3 on a 5-point Likert scale.

In 2018, there were 97 respondents to the CBH Provider Satisfaction Survey. For Overall Provider Satisfaction with CBH, 98% of respondents ($n=56$) reported being "Always", "Usually", or "Sometimes" satisfied.

Target Goal: Obtain 80% agreement rate on Inter-Rater Reliability Studies

The primary purpose of an Inter-Rater Reliability (IRR) study is to determine the extent to which CBH clinical staff agree in their assessment of medical necessity in selecting the most appropriate level of care for CBH members. The overall percent agreement across all teams was 86%. This exceeds the target goal of 80%.

Target: Improve inpatient 30-day readmission rate for individuals with Persistent Serious Mental Illness (PSMI) by .5 percentage point.

The baseline rate for this measure (2015) was determined to be 21.79%. CBH's 2016 rate was 18.83%, an increase of 2.96 percentage points. CBH's 2017 rate (latest year available) was 17.10%, an improvement of 1.73 percentage points.

Target: Obtain 30- day readmission rates post discharge from mental health hospitalization of <= 15% for adults and <= 10% for children.

For 2017 (latest data available), CBH's 30-day readmission rate was 13.15%.

Target Goal: Achieve 7- and 30- day follow-up rates post discharge from mental health hospitalization of => 75%

The 7- day follow-up rate for measurement year 2017 (latest data available) was 30.31% and the 30-day follow-up rate was 45.64%

Target Goal: Increase medication adherence of individuals with a diagnosis of schizophrenia by a minimum of .5 percentage points.

The baseline rate for this measure (2015) was determined to be 66.33%. CBH's 2016 rate was 64.55%, a decline of 1.96 percentage points. CBH's 2017 rate (latest year available) was 64.30%, a decline of .25 percentage points.