As Washington’s Medicaid external quality review organization (EQRO), Qualis Health provides external quality review and supports quality improvement for enrollees of Washington Apple Health managed care programs and the managed mental healthcare services. Our work supports the Washington State Health Care Authority (HCA) and Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery.

This report has been produced in support of the DSHS Division of Behavioral Health and Recovery, documenting the results of external review of the State’s Regional Support Networks (RSNs). Our review was conducted by Ricci Rimpau, RN, BS, CPHQ, CHC, Operations Manager; Lisa Warren, Quality Program Specialist; Crystal Didier, M.Ed., Clinical Quality Specialist; Sharon Poch, MSW, Clinical Quality Specialist; and Joe Galvan, Project Coordinator.

Qualis Health is one of the nation’s leading population health management organizations, and a leader in improving care delivery and patient outcomes, working with clients throughout the public and private sectors to advance the quality, efficiency and value of healthcare for millions of Americans every day. We deliver solutions to ensure that our partners transform the care they provide, with a focus on process improvement, care management and effective use of health information technology.

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Seattle, Washington 98133-0400
Toll-Free: (800) 949-7536
Office: (206) 364-9700
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Introduction

This report presents the 2015 results of the external quality review of Greater Columbia Behavioral Health (GCBH), a mental health Regional Support Network (RSN) serving Washington Medicaid recipients.

In 2014, the Washington State Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery (DBHR) contracted with 11 RSNs throughout the State of Washington to provide comprehensive and culturally appropriate mental health services for adults, children and their families. DBHR currently contracts with the RSNs to deliver mental health services for Medicaid enrollees through managed care. The RSNs administer services by contracting with provider groups, including community mental health programs and private nonprofit agencies, to provide mental health treatment. The RSNs are accountable for ensuring that mental health services are delivered in a manner that complies with legal, contractual and regulatory standards for effective care.

Greater Columbia Behavioral Health RSN (GCBH) administers public mental health funds for Medicaid participants enrolled in managed care plans in Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman and Yakima counties. The RSN does not provide any direct client services; however, it provides financial and administrative oversight for the direct client services that are provided to enrollees through contracts with provider agencies in the ten-county area.

The Balanced Budget Act (BBA) of 1997 requires State Medicaid agencies that contract with managed care plans to conduct and report on specific external quality review (EQR) activities. As the external quality review organization (EQRO) for DBHR, Qualis Health has prepared this report to satisfy the Federal EQR requirements.

In this report, Qualis Health presents the results of the EQR to evaluate access, timeliness and quality of care for Medicaid enrollees delivered by health plans and their providers. The report also addresses the extent to which the RSN addressed the previous year’s EQR recommendations (see Appendix A).

EQR activities

EQR Federal regulations under 42 CFR §438.358 specify the mandatory and optional activities that the EQR must address in a manner consistent with protocols of the Centers for Medicare & Medicaid Services (CMS). This report is based on information collected from the RSN based on the CMS EQR protocols:

- **Compliance monitoring** through document review, clinical record reviews, on-site interviews at the RSN and telephonic interviews with provider agencies to determine whether the RSN met regulatory and contractual standards governing managed care
- **Encounter data validation (EDV)** conducted through data analysis and clinical record review
- **Validation of performance improvement projects (PIPs)** to determine whether the RSN met standards for conducting these required studies
- **Validation of performance measures** including an Information Systems Capabilities Assessment (ISCA)

Together, these activities answer the following questions:

1. Does the RSN meet CMS regulatory requirements?
2. Does the RSN meet the requirements of its contract with the State and the Washington State administrative codes?
3. Does the RSN monitor and oversee contracted providers in their performance of any delegated activities to ensure regulatory and contractual compliance?
4. Does the RSN conduct the two required PIPs, and are they valid?
5. Does the RSN produce accurate and complete encounter data?
6. Does the RSN's information technology infrastructure support the production and reporting of valid and reliable performance measures?
Executive Summary

In fulfillment of Federal requirements under 42 CFR §438.350, the Washington State Department of Social and Health Services (DHS) Division of Behavioral Health and Recovery (DBHR) contracts with Qualis Health to perform an annual external quality review (EQR) of the access, timeliness and quality of managed mental health services provided by Regional Support Networks (RSNs) to Medicaid enrollees.

In 2014, DBHR contracted with 11 RSNs throughout the State of Washington to provide comprehensive and culturally appropriate mental health services for adults, children and their families. This report summarizes the 2015 review of Greater Columbia Behavioral Health (GCBH).

Qualis Health’s EQR consisted of assessing and identifying strengths, opportunities for improvement and recommendations requiring corrective action plans to meet the RSN’s compliance with State and Federal requirements for quality measures. These measures include quality assessment and performance improvement, validating encounter data submitted to the State, completing an information system capability assessment and validating the RSN’s performance improvement projects.

The results are summarized below. For a complete, numbered list of all recommendations requiring corrective action plans (CAPs), refer to Appendix B.

<table>
<thead>
<tr>
<th>Scoring Icon Key</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Fully Met (pass)</td>
</tr>
<tr>
<td>○ Partially Met (pass)</td>
</tr>
<tr>
<td>● Not Met (fail)</td>
</tr>
<tr>
<td>● N/A (not applicable)</td>
</tr>
</tbody>
</table>

Compliance Review Results

This review assesses GCBH’s overall performance, identifies strengths and notes opportunities for improvement and recommendations requiring corrective action plans (CAPs) in areas where the RSN did not clearly or comprehensively meet Federal and/or State requirements. The accompanying recommendations offer guidance on how the RSN may achieve full compliance with State contractual and Federal CFR guidelines. The results are summarized below in Table A-1. Please refer to the Compliance Review section of this report for complete results.

### Table A-1: Summary Results of Compliance Monitoring Review, By Section

<table>
<thead>
<tr>
<th>CMS EQR Protocol</th>
<th>CFR Citation</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1.</td>
<td>438.206</td>
<td>○ Partially Met (pass)</td>
</tr>
<tr>
<td>Availability of Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 2.</td>
<td>438.208</td>
<td>○ Partially Met (pass)</td>
</tr>
<tr>
<td>Coordination and Continuity of Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 3.</td>
<td>438.210</td>
<td>● Fully Met (pass)</td>
</tr>
<tr>
<td>Coverage and Authorization of</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Performance Improvement Project (PIP) Validation Results

As a mandatory EQR activity, Qualis Health evaluated the RSN’s performance improvement projects (PIPs) to determine whether the projects are designed, conducted and reported in a methodologically sound manner. The projects must be designed to achieve, through ongoing measurements and intervention in clinical and non-clinical areas, significant improvement sustained over time that is expected to have a favorable effect on health outcomes and enrollee satisfaction. The results for the RSN’s PIPs are found in the following Table A-2. Further discussion can be found in the Performance Improvement Project section of this report.

Table A-2: Performance Improvement Project Validation Results

<table>
<thead>
<tr>
<th>Results</th>
<th>Validity and Reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Clinical/Children’s PIP:</strong> Lowered Inpatient Readmission Rates in a High-Risk Population Through the Development of Enhanced Communication with Inpatient Providers</td>
<td>● Fully Met (pass)</td>
</tr>
<tr>
<td><strong>Non-Clinical PIP:</strong> Increasing Inclusion of Healthcare Information and PCP Involvement Into Outpatient Mental Health Treatment Through Provider Training and Shared PRISM Health Information.</td>
<td>● Partially Met (pass)</td>
</tr>
</tbody>
</table>
Information System Capability Assessment (ISCA) Results

The RSN's information systems and data processing and reporting procedures were examined to determine the extent to which they supported the production of valid and reliable State performance measures and the capacity to manage care of RSN enrollees.

The ISCA procedures were based on the CMS protocol for this activity, as adapted for the Washington RSNs with DBHR's approval. For each of the seven ISCA review areas, the following methods were used to rate the RSN’s performance:

- information collected in the ISCA data collection tool
- responses to interview questions
- results of the claims/encounter analysis walkthroughs and security walkthroughs

The organization was then ranked as fully meeting, partially meeting or not meeting standards. Although not rated, the RSN's meaningful use of EHR systems for informational purposes was evaluated.

The results are summarized below in Table A-3. Please refer to the ISCA section of this report for complete results.

Table A-3: ISCA Review Results

<table>
<thead>
<tr>
<th>ISCA Section</th>
<th>Description</th>
<th>ISCA Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Information</td>
<td>This section assesses the RSN’s information systems for collecting, storing, analyzing and reporting medical, member, practitioner and vendor data.</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>Systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Hardware</td>
<td>This section assesses the RSN’s hardware systems and network infrastructure.</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>Systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Information</td>
<td>This section assesses the security of the RSN’s information systems.</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>Security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Medical Services</td>
<td>This section assesses the RSN’s ability to capture and report accurate medical services data.</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Enrollment Data</td>
<td>This section assesses the RSN’s ability to capture and report accurate Medicaid enrollment data.</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>F. Practitioner Data</td>
<td>This section assesses the RSN’s ability to capture and report accurate practitioner information.</td>
<td>Fully Met (pass)</td>
</tr>
</tbody>
</table>
**Executive Summary**

**Encounter Data Validation (EDV) Results**

EDV is a process used to validate encounter data submitted by RSNs to the State. Encounter data are electronic records of the services provided to Medicaid enrollees by providers under contract with an RSN. Encounter data is used by the RSNs and the State to assess and improve the quality of care and to monitor program integrity. Additionally, the State uses encounter data to determine capitation rates paid to the RSNs.

Qualis Health performed independent validation of the procedures used by the RSN to perform its own encounter data validation. The EDV requirements included in the RSN’s contract with DBHR were used as the standard for validation. Qualis Health obtained and reviewed each RSN’s encounter data validation report submitted to DBHR as a contract deliverable for calendar year 2014. The RSN’s encounter data validation methodology, encounter and enrollee sample size(s), selected encounter dates and fields selected for validation were reviewed for conformance with DBHR contract requirements. The RSN’s encounter and/or enrollee sampling procedures were reviewed to ensure conformance with accepted statistical methods for random selection. Table A-4 shows the results of the review of the RSN’s Encounter Data Validation processes. Please refer to the EDV section of this report for complete results.

<table>
<thead>
<tr>
<th>EDV Standard</th>
<th>Description</th>
<th>EDV Result</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sampling Procedure</strong></td>
<td>Sampling was conducted using an appropriate random selection process and was of adequate size.</td>
<td>Select the score:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Fully Met (pass)</td>
</tr>
<tr>
<td><strong>Review Tools</strong></td>
<td>Review and analysis tools are appropriate for the task and used correctly.</td>
<td>• Fully Met (pass)</td>
</tr>
<tr>
<td><strong>Methodology and Analytic Procedures</strong></td>
<td>The analytical and scoring methodologies are sound and all encounter data elements requiring review are examined.</td>
<td>• Not Met (fail)</td>
</tr>
</tbody>
</table>

Qualis Health conducted its own validation to assess the RSN’s capacity to produce accurate and complete encounter data, including a review of the most recent Information System Capabilities Assessment (ISCA). The encounter data submitted by the RSNs to the State was analyzed to determine the general magnitude of missing encounter data, types of potentially missing encounter data, overall data quality issues and any issues with the processes the RSNs have in compiling encounter data and
Executive Summary

submitting the data files to the State. Clinical record review of encounter data was performed to validate data sent to the State and confirm the findings of the analysis of the State-level data.

Table A-5 summarizes results of Qualis Health’s EDV. Please refer to the EDV section of this report for complete results.

**Table A-5: Results of Qualis Health Encounter Data Validation**

<table>
<thead>
<tr>
<th>EDV Standard</th>
<th>Description</th>
<th>EDV Result</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Electronic Data Checks</strong></td>
<td>Full review of encounter data submitted to the state indicates no (or minimal) logic problems or out-of-range values.</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td><strong>Onsite Clinical Record Review</strong></td>
<td>State encounter data are substantiated in audit of patient charts at individual provider locations. Audited fields include demographics (name, date of birth, ethnicity and language) and encounters (procedure codes, provider type, duration of service, service date and service location). A passing score is that 95% of the encounter data fields in the clinical records match.</td>
<td>Select the score: Not Met (fail)</td>
</tr>
</tbody>
</table>
Compliance with Regulatory and Contractual Standards

The 2015 compliance review addresses the RSN's compliance with Federal Medicaid managed care regulations and applicable elements of the contract between the RSN and the State. The applicable CFR sections and results for the 2015 compliance reviews are listed in Table B-1, below.

The CMS protocols for conducting the compliance review are available here: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Each section of the compliance review protocol contains elements corresponding to relevant sections of 42 CFR§438, DBHR's contract with the RSNs, the Washington Administrative Code and other State regulations where applicable. Qualis Health evaluated the RSN's performance on each element of the protocol by
- Reviewing and performing desk audits on documentation submitted by the RSNs
- Performing onsite record reviews/chart audits at the RSN's contracted provider agencies
- Conducting telephonic interviews with the RSN's contracted provider agencies
- Conducting onsite interviews with the RSN staff

Compliance Scoring

Qualis Health uses CMS's three-point scoring system in evaluating compliance. The three-point scale allows for credit when a requirement is partially met and the level of performance is determined to be acceptable. The three-point scoring system includes the following levels:

- **Fully Met** means all documentation listed under a regulatory provision, or component thereof, is present and RSN staff provides responses to reviewers that are consistent with each other and with the documentation.

- **Partially Met** means all documentation listed under a regulatory provision, or component thereof, is present, but RSN staff is unable to consistently articulate evidence of compliance, or RSN staff can describe and verify the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice.

- **Not Met** means no documentation is present and RSN staff have little to no knowledge of processes or issues that comply with regulatory provisions, or no documentation is present and RSN staff have little to no knowledge of processes or issues that comply with key components of a multi-component provision, regardless of compliance determinations for remaining, non-key components of the provision.

<table>
<thead>
<tr>
<th>Scoring Icon Key</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="pass" alt="Fully Met" /></td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td><img src="pass" alt="Partially Met" /></td>
<td>Partially Met (pass)</td>
</tr>
<tr>
<td><img src="fail" alt="Not Met" /></td>
<td>Not Met (fail)</td>
</tr>
<tr>
<td>![N/A](not applicable)</td>
<td>N/A (not applicable)</td>
</tr>
</tbody>
</table>
# Summary of Compliance Review Results

## Table B-1: Summary Results of Compliance Monitoring Review, By Section

<table>
<thead>
<tr>
<th>CMS EQR Protocol</th>
<th>CFR Citation</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability of Services</td>
<td>438.206</td>
<td>Partially Met (pass)</td>
</tr>
<tr>
<td>Section 2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordination and Continuity of Care</td>
<td>438.208</td>
<td>Partially Met (pass)</td>
</tr>
<tr>
<td>Section 3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage and Authorization of Services</td>
<td>438.210</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>Section 4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Selection</td>
<td>438.214</td>
<td>Partially Met (pass)</td>
</tr>
<tr>
<td>Section 5.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subcontractual Relationships and Delegation</td>
<td>438.230</td>
<td>Partially Met (pass)</td>
</tr>
<tr>
<td>Section 6.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice Guidelines</td>
<td>438.236</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>Section 7.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Assessment and Performance Improvement Program</td>
<td>438.240</td>
<td>Partially Met (pass)</td>
</tr>
<tr>
<td>Section 8.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Information Systems</td>
<td>438.242</td>
<td>Fully Met (pass)</td>
</tr>
</tbody>
</table>

This review assesses the RSN’s overall performance, identifies strengths and notes opportunities for improvement and recommendations requiring corrective action plans (CAPs) in areas where the RSN did not clearly or comprehensively meet Federal and/or State requirements. The accompanying recommendations offer guidance on how the RSN may achieve full compliance with State contractual and Federal CFR guidelines.

### Strengths

- GCBH has updated its second opinion policy and procedure to include formal tracking and monitoring of all second opinion requests.
- GCBH’s care coordinators maintain data on all requests for out-of-network services. The data are reported to the Quality Management Oversight Committee (QMOC), which analyzes the data to track any trends suggesting a potential need to make a particular service available within the GCBH delivery network.
- Also reported to the QMOC is information regarding the costs of out-of-network services GCBH has funded. This enables the RSN to assess the financial impact of such services and to facilitate assessment of network sufficiency.
- The RSN stated that its annual clinical record reviews include monitoring for timely access to care and services. Other methods for evaluating access include reviewing enrollee complaints and grievances, and performing enrollee surveys.
• To meet State standards for timely access to care and services, several provider agencies in population-dense counties offer walk-in services and, in rural counties, in-home services.

• For monitoring purposes, during the authorization process, GCBH documents and tracks the use of services delivered to enrollees with both limited English proficiency and diverse cultural and ethnic backgrounds.

• The RSN maintains documentation of any cultural competency training(s) and ensures this communication flows through its cultural competency committee.

• GCBH monitors network providers through onsite clinical record reviews to ensure that documentation of coordination activities is evident in the enrollee’s clinical record and that communication occurs within the scope of the consent and release(s) given by the enrollee.

• GCBH monitors treatment plans during the annual administrative and clinical review to ensure the treatment plans incorporate enrollees’ special healthcare needs.

• The RSN has documented policies and procedures for the consistent application of review criteria for the initial and continuing authorization of services.

• The RSN has mechanisms in place to ensure compliance with authorization timeframes and indicated it will be implementing an internal improvement process that will include notifying clinical directors of challenges with meeting timeframes.

• GCBH’s Quality Review Team (QRT) conducts consumer, provider and allied provider mental health surveys, which incorporate consumer and family voice.

Summary of Corrective Action Plans (CAPs) and Opportunities for Improvement, By Section

Section 1: Availability of Services

Opportunities for Improvement
During an interview with a contracted provider agency, the provider stated that it was not sure how the RSN handles second opinion requests.

• GCBH should continue to educate its provider network on its second opinions policy to ensure its providers understand the policy and procedure detailing how the RSN monitors and tracks second opinion requests.

Interviews with two contracted network providers indicated that with the implementation of the Affordable Care Act and the increase in enrollment of Medicaid clients, there have been challenges in meeting access to care standards as well as recruiting new staff to meet these access needs.

• GCBH should consider assisting its provider network with developing mechanisms to maintain staff and attract mental health providers to its network.

Section 2: Coordination of Care

Opportunity for Improvement
GCBH monitors treatment plans during the clinical review, but the clinical review tool is outdated.

• The RSN should update its clinical audit tool to reflect current Washington Administrative Code (WAC) requirements.
Section 3: Coverage and Authorization of Services

N/A

Section 4: Provider Selection

Recommendation Requiring CAP
GCBH has a policy and procedure in place that explains how the RSN and provider agencies will monitor for employees excluded from participating in Federal healthcare programs, but the policy does not include provisions for monitoring its members on the governing board. In reviewing the Office of the Inspector General (OIG) sample list at the RSN, it was revealed that the RSN is not monitoring, on a monthly basis, the governing board.

- GCBH needs to include, in its policy on excluded providers, monitoring the members of the board of directors.

Section 5: Subcontractual Relationships and Delegation

N/A

Section 6: Practice Guidelines

N/A

Section 7: Quality Assessment and Performance Improvement Program

Recommendations Requiring CAP
During the external quality review, it was noted that the RSN staff roles and responsibilities for the quality improvement program are not clearly defined and do not clearly identify who should be present to contribute at the various committee meetings such as the Clinical Director’s Committee, the Quality Management Oversight Committee, the Children’s Committee and the Management Information Systems Committee. This has impacted the quality management process and the development of integrated reports used to identify the needs of the enrollees.

- GCBH needs to address the roles and responsibilities of its RSN staff related to the quality improvement program and clearly define and identify who should be present to contribute at the various committee meetings such as the Clinical Director’s Committee, the Quality Management Oversight Committee, the Children’s Committee and the Management Information Systems Committee.

Although GCBH’s provider agencies are required by GCBH’s policy to maintain a quality management (QM) process and procedure, the RSN does not have a process in place to monitor its provider agencies to determine if the providers are maintaining and following a QM process, including monitoring and tracking the quality and appropriateness of care furnished to its enrollees.

- GCBH needs to develop a process to hold its provider network accountable for maintaining and following a QM process that includes monitoring and tracking the quality and appropriateness of care furnished to its enrollees.

Many of GCBH’s policies and procedures have not been reviewed, revised and updated as necessary or approved for many years.
• GCBH needs to implement a process to review, revise and update as necessary and approve its policies and procedures at least every two years.

Opportunities for Improvement
GCBH does not follow the State’s Quality Strategy Plan as the State has not implemented the Plan.
• As soon as DBHR adopts a State Quality Strategy plan, the RSN should review its quality strategy plan to make sure it aligns with DBHR’s.

GCBH conducted two non-clinical performance improvement projects (PIPs) in 2015. Both PIPs have been retired.
• GCBH will need to conduct at least one clinical PIP and one non-clinical PIP in 2016, one of which will need to be a children’s PIP.

Although GCBH collects and analyzes performance data for the State, it does not use the performance data to support its overall quality assessment and performance improvement program.
• GCBH should consider including its performance data into its overall quality assessment and performance improvement program.

Section 8: Health Information Systems

N/A

Section 1: Availability of Services

Table B-2: Summary of Compliance Review for Availability of Services

<table>
<thead>
<tr>
<th>Protocol Section</th>
<th>CFR</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Delivery Network</td>
<td>438.206 (b)(1)</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>2. Second Opinion</td>
<td>438.206 (b)(3)</td>
<td>Partially Met (pass)</td>
</tr>
<tr>
<td>3. Out-of-network</td>
<td>438.206 (b)(4)</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>5. Out-of-network Provider Credentials</td>
<td>438.206 (b)(6)</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>6. Furnishing of Services and Timely Access</td>
<td>438.206 (c)(1)</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>7. Furnishing of Services and Cultural Considerations</td>
<td>438.206 (c)(2)</td>
<td>Fully Met (pass)</td>
</tr>
</tbody>
</table>
### Overall Result for Section 1.

- Partially Met (pass)

## Delivery Network

### FEDERAL REGULATION SOURCE(S)

**§438.206 (b)(1): Availability of Services – Delivery Network**

The State must ensure, through its contracts, that each MCO, and each PIHP and PAHP consistent with the scope of the PIHP's or PAHP's contracted services, meets the following requirements:

1. Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each MCO, PIHP and PAHP must consider the following:
   - The anticipated Medicaid enrollment
   - The expected utilization of services, taking into consideration the characteristics and healthcare needs of specific Medicaid populations represented in the particular MCO, PIHP and PAHP
   - The numbers and types (in terms of training, experience and specialization) of providers required to furnish the contracted Medicaid services
   - The numbers of network providers who are not accepting new Medicaid patients
   - The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities

### STATE REGULATION / RSN AGREEMENT SOURCE(S)

**WAC 388-865-0230**

RSN Agreement Section(s) 4.4; 4.9

### SCORING CRITERIA

- The RSN maintains and monitors a network of appropriate providers that is supported by written agreements.
- The RSN’s provider network is sufficient to provide adequate access to all services covered under the contract.
- In establishing and maintaining the network, the RSN considers:
  - The anticipated Medicaid enrollment
  - The expected utilization of services, taking into consideration the characteristics and healthcare needs of specific Medicaid populations represented in the RSN.
  - The numbers and types (training, experience and specialization) of providers required to furnish the contracted Medicaid services
  - The numbers of network providers who are not accepting new Medicaid patients
  - Geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities
- The RSN has formal procedures in place to monitor its provider network to ensure adequacy.
Reviewer Determination
- Fully Met (pass)

Strengths
- GCBH maintains written agreements with its contracted providers, which specify the types of services its provider network will provide to enrollees.

Second Opinion

FEDERAL REGULATION SOURCE(S)
§438.206 (b)(3): Availability of Services – Delivery Network
3) Provides for a second opinion from a qualified healthcare professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388-865-0355
RSN Agreement Section(s) 9.10

SCORING CRITERIA
- The RSN provides for a second opinion from a qualified healthcare professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.
- The RSN maintains policies and procedures related to second opinions that meet the standards.
- The RSN provides literature or other materials available to enrollees to provide information about an enrollee’s right to a second opinion.
- RSN staff is knowledgeable about State and Federal requirements, as well as internal policies and procedures.
- The RSN has an effective process in place to monitor compliance with standards.

Reviewer Determination
- Partially Met (pass)

Strengths
- GCBH has updated its second opinion policy and procedure to include formal tracking and monitoring of all second opinion requests.
- The RSN’s policy and procedure indicates that enrollees may receive second opinions from qualified healthcare professionals within or outside the network, at no cost to the enrollee.

Opportunity for Improvement
During an interview with a contracted provider agency, the provider stated that it was not sure how the RSN handles second opinion requests.
• GCBH should continue to educate its provider network on its second opinions policy to ensure its providers understand the policy and procedure detailing how the RSN monitors and tracks second opinion requests.

**Out-of-Network**

**FEDERAL REGULATION SOURCE(S)**

§438.206 (b)(4): Availability of Services – Delivery Network

4) If the network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO, PIHP or PAHP must cover these services adequately and in a timely manner out of network for the enrollee, for as long as the MCO, PIHP or PAHP is unable to provide them.

**STATE REGULATION / RSN AGREEMENT SOURCE(S)**

RSN Agreement Section(s) 4.3;13.3

**SCORING CRITERIA**

• The RSN provides documentation of services that are covered adequately and in a timely manner for out-of-network enrollees when the network is unable to provide necessary services covered under the contract.
• The RSN provides up-to-date existing agreements and/or contracts with out-of-network providers.
• The RSN has a process to track out-of-network encounters and reviews this information for network planning.

**Reviewer Determination**

- Fully Met (pass)

**Strengths**

• GCBH's care coordinators maintain data on all requests for out-of-network services. The data are reported to the Quality Management Oversight Committee (QMOC), which analyzes the data to track any trends suggesting a potential need to make a particular service available within the GCBH delivery network.
• Also reported to the QMOC is information regarding the costs of out-of-network services GCBH has funded. This enables the RSN to assess the financial impact of such services and to facilitate assessment of network sufficiency.

**Coordination of Out-of-Network**

**FEDERAL REGULATION SOURCE(S)**

§438.206 (b)(5): Availability of Services – Delivery Network

(5) Requires out-of-network providers to coordinate with the MCO or PIHP with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.
### SCORING CRITERIA

- The RSN has a documented process of how out-of-network providers are paid.
- The RSN has a documented policy and process that requires out-of-network providers to coordinate with the RSN with respect to payment.
- The RSN ensures and has a documented policy and process that cost to the enrollee is not greater than it would be if the out-of-network services were furnished within the network.
- The RSN has a process on the action taken if the enrollee receives a bill for out-of-network services.

### Reviewer Determination

- Fully Met (pass)

**Strength**

- GCBH’s contracted provider agencies are required to coordinate with out-of-network providers with respect to payment and to ensure that cost to the enrollee is no greater than it would be if services were furnished within the network.

### Out-of-Network Provider Credentials

**FEDERAL REGULATION SOURCE(S)**

- §438.206 (b)(6): Availability of Services – Out-of-network Provider Credentials
  
  6) Demonstrates that out-of-area providers are credentialed as required by §438.214.

**STATE REGULATION / RSN AGREEMENT SOURCE(S)**

- WAC 388-865-0284
- RSN Agreement Section(s) 8.6

### SCORING CRITERIA

- The RSN has a process to ensure that out-of-network providers are credentialed.

### Reviewer Determination

- Fully Met (pass)

**Meets Criteria**

*Furnishing of Services and Timely Access*
§438.206 (c)(1): Availability of Services – Furnishing of Services and Timely Access

The State must ensure that each MCO, PIHP and PAHP contract complies with the requirements of this paragraph.

1) Timely Access. Each MCO, PIHP and PAHP must do the following:
   i) Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.
   ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.
   iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.
   iv) Establish mechanisms to ensure compliance by providers.
   v) Monitor providers regularly to determine compliance.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
RSN Agreement Section(s) 4.8

SCORING CRITERIA
• The RSN has documented policy and procedure for timely access.
• The RSN ensures its providers meet State standards for timely access to care and services, taking into account the urgency of the need for services.
• The RSN ensures that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.
• The RSN has established mechanisms to ensure services included in the contract are available 24 hours a day, 7 days a week, when medically necessary.
• The RSN takes corrective action and has documentation of such corrective action if providers fail to comply with access standards.
• The RSN has a documented policy and process to track and provide documentation of monitoring inappropriate use of emergency rooms by Medicaid enrollees.

Reviewer Determination

- Fully Met (pass)

Strengths
• The RSN stated that its annual clinical record reviews include monitoring for timely access to care and services. Other methods for evaluating access include reviewing enrollee complaints and grievances, and performing enrollee surveys.
• To meet State standards for timely access to care and services, several provider agencies in population-dense counties offer walk-in services and, in rural counties, in-home services.
• GCBH has a documented policy and procedure to track and monitor the inappropriate use of emergency room services by enrollees.
Opportunity for Improvement

Interviews with two contracted network providers indicated that with the implementation of the Affordable Care Act and the increase in enrollment of Medicaid clients, there have been challenges in meeting access to care standards as well as recruiting new staff to meet these access needs.

- GCBH should consider assisting its provider network with developing mechanisms to maintain staff and attract mental health providers to its network.

Furnishing of Services and Cultural Considerations

<table>
<thead>
<tr>
<th>FEDERAL REGULATION SOURCE(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>§438.206 Availability of services (c)(2): Furnishing of Services and Cultural Considerations</td>
</tr>
<tr>
<td>Each MCO, PIHP and PAHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STATE REGULATION / RSN AGREEMENT SOURCE(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>WAC 388-865-0200</td>
</tr>
<tr>
<td>RSN Agreement Section(s) 1.16; 4.4.2.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SCORING CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The RSN has a documented policy and procedure related to the delivery of services in a culturally competent manner for all enrollees. This includes enrollees with limited English proficiency and diverse cultural and ethnic backgrounds.</td>
</tr>
<tr>
<td>- The RSN monitors and documents through tracking of the use of services delivered to those with limited English proficiency and diverse cultural and ethnic backgrounds.</td>
</tr>
<tr>
<td>- The RSN maintains documentation of any cultural competency training(s).</td>
</tr>
</tbody>
</table>

Reviewer Determination

- Fully Met (pass)

Strengths

- The RSN has a documented policy and procedure related to the delivery of services in a culturally competent manner for all enrollees. This includes enrollees with limited English proficiency and diverse cultural and ethnic backgrounds.
- For monitoring purposes, during the authorization process, GCBH documents and tracks the use of services delivered to enrollees with both limited English proficiency and diverse cultural and ethnic backgrounds.
- The RSN maintains documentation of any cultural competency training(s) and ensures this communication flows through its cultural competency committee.
- GCBH’s contracted agencies have an adequate number of Spanish-speaking staff to provide needed services.
- The RSN considers consumer voice in the development of enrollee materials and the services it provides.
## Section 2: Coordination and Continuity of Care

### Table B-3: Summary of Compliance Review for Coordination and Continuity of Care

<table>
<thead>
<tr>
<th>Protocol Section</th>
<th>CFR</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordination and Continuity of Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care and Coordination of Healthcare Services</td>
<td>438.208 (b)</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>Additional Services for Enrollees with Special Healthcare Needs</td>
<td>438.208 (c)(1)(2)</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>Treatment Plans</td>
<td>438.208(c)(3)</td>
<td>Partially Met (pass)</td>
</tr>
<tr>
<td>Direct Access to Specialists</td>
<td>438.208 (c)(4)</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>Overall Result for Section 2.</td>
<td></td>
<td>Partially Met (pass)</td>
</tr>
</tbody>
</table>

### Primary Care and Coordination of Services

**FEDERAL REGULATION SOURCE(S)**

§438.208 (b): Coordination and Continuity of Care – Primary Care and Coordination of Healthcare Services for all RSN and Enrollees

(b) Primary care and coordination of healthcare services for all MCO, PIHP and PAHP enrollees. Each MCO, PIHP and PAHP must implement procedures to deliver primary care to and coordinate healthcare service for all MCO, PIHP and PAHP enrollees. These procedures must meet State requirements and must do the following:

1. Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the healthcare services furnished to the enrollee.

2. Coordinate the services the MCO, PIHP or PAHP furnishes to the enrollee with the services the enrollee receives from any other MCO, PIHP or PAHP.

3. Share with other MCOs, PIHPs and PAHPs serving the enrollee with special healthcare needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities.

4. Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR, parts 160 and 164, subparts A and E, to the extent that they are applicable.

**STATE REGULATION / RSN AGREEMENT SOURCE(S)**
SCORING CRITERIA

- The RSN has a policy and procedure to deliver care to, and coordinate healthcare services, for all enrollees.
- The RSN ensures that each enrollee has access to a primary healthcare provider.
- The RSN ensures providers coordinate with the RSN and with other health plans regarding the services it delivers.
- The RSN has a process in place to monitor care coordination.
- The RSN ensures that the enrollee’s privacy is protected in the process of coordinating care.

Reviewer Determination

- Fully Met (pass)

Strength

- GCBH monitors network providers through onsite clinical record reviews to ensure that documentation of coordination activities is evident in the enrollee’s clinical record and that communication occurs within the scope of the consent and release(s) given by the enrollee.

Additional Services for Enrollees with Special Healthcare Needs

FEDERAL REGULATION SOURCE(S)

§438.208 (c)(1),(2): Coordination and Continuity of Care – Additional Services for Enrollees with Special Health Care Needs

(1) Identification. The State must implement mechanisms to identify persons with special healthcare needs to MCOs, PIHPs and PAHPs, as those persons are defined by the State. These identification mechanisms—

(i) Must be specified in the State’s quality improvement strategy in §438.202; and

(ii) May use State staff, the State’s enrollment broker, or the State’s MCOs, PIHPs and PAHPs.

(2) Assessment. Each MCO, PIHP and PAHP must implement mechanisms to assess each Medicaid enrollee identified by the State (through the mechanism specified in paragraph [c] [1] of this section) and identified to the MCO, PIHP and PAHP by the State as having special healthcare needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate healthcare professionals.

STATE REGULATION / RSN AGREEMENT SOURCE(S)

WAC 388-865-0420
RSN Agreement Section(s) 13.3.16

SCORING CRITERIA

- The RSN has a documented mechanism for identifying persons with special healthcare needs.
- The RSN has a policy and procedure to assess each enrollee in order to identify any ongoing special conditions of the enrollee that require a special course of treatment or regular care monitoring.
- The RSN ensures enrollees with special healthcare needs are assessed by an appropriate mental health professional (MHP).
- The RSN has a process in place to monitor compliance with this requirement.

**Reviewer Determination**

- Fully Met (pass)

**Meets Criteria**

*Treatment Plans*

**FEDERAL REGULATION SOURCE(S)**

§438.208 (c)(3): Coordination and Continuity of Care – Treatment Plans

(3) Treatment plans. If the State requires MCOs, PIHPs and PAHPs to produce a treatment plan for enrollees with special healthcare needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be—

(i) Developed by the enrollee’s primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee;

(ii) Approved by the MCO, PIHP or PAHP in a timely manner, if this approval is required by the MCO, PIHP or PAHP; and

(iii) In accord with any applicable State quality assurance and utilization review standards.

**STATE REGULATION / RSN AGREEMENT SOURCE(S)**

WAC 388-865-0425
RSN Agreement Section(s) 8.8.2.1.4; 10.2

**SCORING CRITERIA**

- The RSN ensures that treatment plans for enrollees with special healthcare needs are developed with the enrollee’s participation, and in consultation with any specialists caring for the enrollee.
- The enrollee’s treatment plan incorporates the enrollee’s special healthcare needs.
- The RSN has a method to monitor treatment plans for enrollees with specialized needs.
- The RSN has a method to follow through on findings from monitoring the treatment plans.

**Reviewer Determination**

- Partially Met (pass)

**Strength**

- GCBH monitors treatment plans during the annual administrative and clinical review to ensure the treatment plans incorporate enrollees’ special healthcare needs.
Opportunity for Improvement
GCBH monitors treatment plans during the clinical review, but the clinical review tool is outdated.
- The RSN should update its clinical audit tool to reflect current Washington Administrative Code (WAC) requirements.

Direct Access

FEDERAL REGULATION SOURCE(S)
§438.208 (c)(4): Coordination and Continuity of Care – Direct Access to Specialists
(4) For enrollees with special healthcare needs determined through an assessment by appropriate healthcare professionals (consistent with §438.208 [c][2]) to need a course of treatment or regular care monitoring, each MCO, PIHP and PAHP must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388-865-0430
RSN Agreement Section(s) 8.8.2.1.4; 13.3.16

SCORING CRITERIA
- The RSN has policies and procedures regarding direct access to specialists for enrollees with special healthcare needs.
- The RSN must allow the enrollee direct access to a specialist as appropriate for the enrollee’s condition and identified needs.
- The RSN monitors the availability of direct access to specialists.

Reviewer Determination
- Fully Met (pass)

Meets Criteria

Section 3: Coverage and Authorization of Services

Table B-4: Summary of Compliance Review for Authorization of Services

<table>
<thead>
<tr>
<th>Protocol Section</th>
<th>CFR</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage and Authorization of Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Rule</td>
<td>438.210 (a)</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>Coverage and Authorization of Services</td>
<td>438.210 (b)</td>
<td>Fully Met (pass)</td>
</tr>
</tbody>
</table>
FEDERAL REGULATION SOURCE(S)
§438.210 (a): Coverage and Authorization of Services
(a) Coverage. Each contract with an MCO, PIHP or PAHP must do the following:

(1) Identify, define and specify the amount, duration and scope of each service that the MCO, PIHP or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration and scope that is no less than the amount, duration and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in § 440.230.

(3) Provide that the MCO, PIHP or PAHP—

(i) Must ensure that the services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness or condition of the beneficiary;

(iii) May place appropriate limits on a service—

(A) On the basis of criteria applied under the State plan, such as medical necessity; or

(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes “medically necessary services” in a manner that—

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP or PAHP is responsible for covering services related to the following:

(A) The prevention, diagnosis and treatment of health impairments.

(B) The ability to achieve age-appropriate growth and development.

(C) The ability to attain, maintain or regain functional capacity.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
SCORING CRITERIA

- The RSN ensures that services are provided in an amount, duration and scope sufficient to achieve the purpose for which they are provided.
- The RSN has a policy and procedure for not discriminating against difficult-to-serve enrollees.
- The RSN ensures difficult-to-serve enrollees are not discriminated against when provided services.
- The RSN applies the State’s standard for “medical necessity” when making authorization decisions.

Reviewer Determination

- Fully Met (pass)

Meets Criteria

Authorization of Services

FEDERAL REGULATION SOURCE(S)

§438.210(b): Coverage and Authorization of Services – Authorization of Services

(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require—

(1) That the MCO, PIHP or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP or PAHP—

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and

(ii) Consult with the requesting provider when appropriate.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, be made by a healthcare professional who has appropriate clinical expertise in treating the enrollee’s condition or disease.

STATE REGULATION / RSN AGREEMENT SOURCE(S)

WAC 388-865-0320
RSN Agreement Section(s) 5.2

SCORING CRITERIA

- The RSN has documented policies and procedures for the consistent application of review criteria for the initial and continuing authorization of services.
- The RSN has a mechanism in place to ensure consistent application of review criteria.
- The RSN consults with the requesting provider when appropriate.
- The RSN has a process to ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested is made by a mental health professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

**Reviewer Determination**

- Fully Met (pass)

### Strengths

- The RSN has documented policies and procedures for the consistent application of review criteria for the initial and continuing authorization of services.
- The RSN consults with the requesting provider when appropriate.

### Notice of Adverse Action

**FEDERAL REGULATION SOURCE(S)**

§438.210 (c): Coverage and Authorization of Services—Notice of Adverse Action

- Each contract must provide for the MCO, PIHP or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP or PAHP to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. For MCOs and PIHPs, the notice must meet the requirements of §438.404, except that the notice to the provider need not be in writing.

**STATE REGULATION / RSN AGREEMENT SOURCE(S)**

RSN Agreement Section(s) 6.3

### SCORING CRITERIA

- The RSN has a documented policy and procedure to notify the requesting provider, and give the enrollee written notice of any decision by the RSN to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested.
- The RSN ensures the notice meets the requirements of §438.404, except that the notice to the provider need not be in writing.

**Reviewer Determination**

- Fully Met (pass)

### Strengths

- GCBH has a documented policy and procedure to notify the requesting provider and give the enrollee written notice of any decision by the RSN to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested.
- GCBH provides a written copy of notice of action letters to the providers in its network.
**Timeframes for Decisions**

**FEDERAL REGULATION SOURCE(S)**

§438.210 (d): Coverage and Authorization of Services – Timeframes for Decisions

(1) Standard Procedures

(2) Expedited Authorizations

(d) Timeframe for decisions. Each MCO, PIHP or PAHP contract must provide for the following decisions and notices:

(1) Standard authorization decisions. For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—

(i) The enrollee or the provider requests extension; or

(ii) The MCO, PIHP or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(2) Expedited authorization decisions.

(i) For cases in which a provider indicates, or the MCO, PIHP or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function, the MCO, PIHP or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three working days after receipt of the request for service.

(ii) The MCO, PIHP or PAHP may extend the three working days' time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

**STATE REGULATION / RSN AGREEMENT SOURCE(S)**

RSN Agreement Section(s) 5.2

**SCORING CRITERIA**

- The RSN has a documented policy and procedure for coverage and authorization decisions, including expedited authorizations.
- The RSN has a process for tracking standard and expedited authorization decisions.
- The RSN has mechanisms in place to ensure compliance with authorization timeframes.

**Reviewer Determination**

- Fully Met (pass)

**Strengths**

- The RSN has a documented policy and procedure for coverage and authorization decisions, including expedited authorizations.
- The RSN has mechanisms in place to ensure compliance with authorization timeframes and indicated it will be implementing an internal improvement process that will include notifying clinical directors of challenges with meeting timeframes.
**Compensation for Utilization of Services**

**FEDERAL REGULATION SOURCE(S)**
§438.210(e): Coverage and Authorization of Services – Compensation for Utilization of Services
(e) Each contract must provide that, consistent with §438.6(h) and § 422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any enrollee.

**STATE REGULATION / RSN AGREEMENT SOURCE(S)**
WAC 388-865-0330
RSN Agreement Section(s) 5.4

**SCORING CRITERIA**
- The RSN has a documented policy and procedure specifying that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any enrollee.
- The RSN has mechanisms in place to ensure providers and/or utilization management contractors do not provide staff with incentives to deny, limit or discontinue medically necessary services.

**Reviewer Determination**
- Fully Met (pass)

Meets Criteria

**Emergency and Post-Stabilization Services**

**FEDERAL REGULATION SOURCE(S)**
§438.210 Coverage and Authorization of Services—§438.114 Emergency and Post-stabilization Services
(a) Definitions. As used in this section—

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
(2) Serious impairment to bodily functions.
(3) Serious dysfunction of any bodily organ or part.
Emergency services means covered inpatient and outpatient services that are as follows:

(1) Furnished by a provider that is qualified to furnish these services under this title.

(2) Needed to evaluate or stabilize an emergency medical condition.

Post-stabilization care services means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition or, under the circumstances described in paragraph (e) of this section, to improve or resolve the enrollee's condition.

(b) Coverage and payment: General rule. The following entities are responsible for coverage and payment of emergency services and post-stabilization care services.

(1) The MCO, PIHP or PAHP.

(2) The PCCM that has a risk contract that covers these services.

(3) The State, in the case of a PCCM that has a fee-for-service contract.

(c) Coverage and payment: Emergency services—

(1) The entities identified in paragraph (b) of this section—

(i) Must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO, PIHP, PAHP or PCCM; and

(ii) May not deny payment for treatment obtained under either of the following circumstances:

(A) An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (1), (2) and (3) of the definition of emergency medical condition in paragraph (a) of this section.

(B) A representative of the MCO, PIHP, PAHP or PCCM instructs the enrollee to seek emergency services.

(2) A PCCM must—

(i) Allow enrollees to obtain emergency services outside the primary care case management system regardless of whether the case manager referred the enrollee to the provider that furnishes the services; and

(ii) Pay for the services if the manager's contract is a risk contract that covers those services.

(d) Additional rules for emergency services.

(1) The entities specified in paragraph (b) of this section may not—

(i) Limit what constitutes an emergency medical condition with reference to paragraph (a) of this section, on the basis of lists of diagnoses or symptoms; and

(ii) Refuse to cover emergency services based on the emergency room provider, hospital or fiscal agent not notifying the enrollee's primary care provider, MCO, PIHP, PAHP or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.

(2) An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

(3) The attending emergency physician, or the provider actually treating the enrollee, is responsible for—

(e) Coverage and payment: Post-stabilization care services. Post-stabilization care services are covered and paid for in accordance with provisions set forth at §422.113(c) of this chapter. In applying those determinations determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment.
provisions, reference to “M C organization” must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section.

(f) Applicability to PIHPs and PAHPs. To the extent that services required to treat an emergency medical condition fall within the scope of the services for which the PIHP or PAHP is responsible, the rules under this section apply.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
RSN Agreement Section(s) 5.2

SCORING CRITERIA

- The RSN has written policies and procedures pertaining to crisis, stabilization and post-hospital follow-up services.
- The RSN pays for treatment of conditions defined in its policies as urgent or emergent conditions.
- The RSN tracks and monitors payment denials, to ensure that there is no denial for crisis services.
- The RSN tracks and monitors the use of crisis services for inappropriate or avoidable use related to access to routine care.

Reviewer Determination

- Fully Met (pass)

Strength

- The RSN has written policies and procedures pertaining to crisis, stabilization and post-hospital follow-up services.

Section 4: Provider Selection

Table B-5: Summary of Compliance Review for Provider Selection

<table>
<thead>
<tr>
<th>Protocol Section</th>
<th>CFR</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Selection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Rules, Credentialing, Re-credentialing</td>
<td>438.214 (a)(b)</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>Nondiscrimination</td>
<td>438.214 (c)</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>Excluded Providers</td>
<td>438.214 (d)</td>
<td>Partially Met (pass)</td>
</tr>
<tr>
<td>Overall Result for Section 4.</td>
<td></td>
<td>Partially Met (pass)</td>
</tr>
</tbody>
</table>
General Rules and Credentialing and Re-credentialing Requirements

FEDERAL REGULATION SOURCE(S)

§438.214: (a) General Rules (b) Provider Selection

(a) General rules. The State must ensure, through its contracts, that each MCO, PIHP or PAHP implements written policies and procedures for selection and retention of providers and that those policies and procedures include, at a minimum, the requirements of this section.

(b) Credentialing and re-credentialing requirements.

(1) Each State must establish a uniform credentialing and re-credentialing policy that each MCO, PIHP and PAHP must follow.

(2) Each MCO, PIHP and PAHP must follow a documented process for credentialing and re-credentialing of providers who have signed contracts or participation agreements with the MCO, PIHP or PAHP.

(e) State requirements. Each MCO, PIHP and PAHP must comply with any additional requirements established by the State.

STATE REGULATION / RSN AGREEMENT SOURCE(S)

WAC 388-865-028
RSN Agreement Section(s) 4.5; 8.6; 8.8.2.1.12

SCORING CRITERIA

- The RSN has a credentialing and re-credentialing policy and procedure for providers who have signed contracts or participation agreements.
- The RSN has a uniform documented process for credentialing.
- The RSN has a uniform documented process for re-credentialing.
- The RSN monitors the credentialing and re-credentialing process.
- The RSN ensures the provider agencies have in place credentialing and re-credentialing policies and processes.

Reviewer Determination

- Fully Met (pass)

Meets Criteria

Nondiscrimination

FEDERAL REGULATION SOURCE(S)

§438.214 (c): Provider Selection and Nondiscrimination

(c) Nondiscrimination. MCO, PIHP and PAHP provider selection policies and procedures, consistent with §438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

§438.12: Provider Selection and Nondiscrimination
(1) An MCO, PIHP and PAHP may not discriminate for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the MCO, PIHP or PAHP declines to include individuals or groups of providers in its network it must give the affected providers written notice of the reason for its decision.

(2) In all contracts with healthcare professionals, an MCO, PIHP and PAHP must comply with the requirements specified in §438.214.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388-865-028
RSN Agreement Section(s) 4.5; 8.6; 8.8.2.1.12

SCORING CRITERIA
- The RSN has policies and procedures for the selection and retention of providers that do not discriminate against providers who serve high-risk enrollees or specialize in conditions that require costly treatment.
- The RSN has policies and procedures in place that do not discriminate for participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification.
- The RSN has a process to notify individuals or groups of providers when not chosen for participation in the network.

Reviewer Determination
- Fully Met (pass)

Meets Criteria

Excluded Providers

FEDERAL REGULATION SOURCE(S)
§438.214 (d): Excluded Providers
(d) Excluded providers. MCOs, PIHPs and PAHPs may not employ or contract with providers excluded from participation in Federal healthcare programs under either section 1128 or section 1128A of the Act.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388-865-028
RSN Agreement Section(s) 4.5; 8.6; 8.8.2.1.12

SCORING CRITERIA
- The RSN has a policy and procedure to ensure the RSN does not employ or contract with providers excluded from participation in Federal healthcare programs.
- The RSN can demonstrate the process and the documentation to determine whether individuals or organizations are excluded providers.
• The RSN ensures that the RSN does not knowingly have on staff or on the governing board a person with beneficial ownership of more than 5% of the RSN's equity.

• The RSN's provider contracts include the provision that providers not knowingly have a director, officer, partner or person with a beneficial ownership of more than 5% of the agency's equity.

Reviewer Determination

• Partially Met (pass)

Recommendation Requiring CAP

GCBH has a policy and procedure in place that explains how the RSN and provider agencies will monitor for employees excluded from participating in Federal healthcare programs, but the policy does not include provisions for monitoring its members on the governing board. In reviewing the Office of the Inspector General (OIG) sample list at the RSN, it was revealed that the RSN is not monitoring, on a monthly basis, the governing board.

• GCBH needs to include, in its policy on excluded providers, monitoring the members of the board of directors.

Section 5: Subcontractual Relationships and Delegation

Table B-6: Summary of Compliance Review for Subcontractual Relationships and Delegation

<table>
<thead>
<tr>
<th>Protocol Section</th>
<th>CFR</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subcontractual Relationships and Delegation</td>
<td>438.230</td>
<td>⬤ Partially Met (pass)</td>
</tr>
</tbody>
</table>

General Rule

FEDERAL REGULATION SOURCE(S)

§438.230 Subcontractual Relationships and Delegation

(a) General rule. The State must ensure, through its contracts, that each MCO, PIHP and PAHP—

(1) Oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor; and

(2) Meets the conditions of paragraph (b) of this section.

(b) Specific conditions.

(1) Before any delegation, each MCO, PIHP and PAHP evaluates the prospective subcontractor's ability to perform the activities to be delegated.

(2) There is a written agreement that—

(i) Specifies the activities and report responsibilities delegated to the subcontractor; and

(ii) Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is
(3) The MCO, PIHP or PAHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations.

(4) If any MCO, PIHP or PAHP identifies deficiencies or areas for improvement, the MCO, PIHP or PAHP and the subcontractor take corrective action.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388--865-0284
RSN Agreement Section(s) 8

SCORING CRITERIA
- The RSN has policies and procedures for oversight and accountability for any functions and responsibilities that it delegates to any subcontractor/provider.
- The RSN performs pre-delegation assessments of contracted providers before delegation is granted on the subcontractor's ability to perform the activities to be delegated.
- The RSN has written contracts/agreements that address the specifics of what activities have been delegated to the subcontractor/provider.
- The RSN includes in the delegation contract/agreement that the RSN is responsible to monitor and review the subcontractor's/provider's performance on an ongoing basis and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
- The RSN initiates a corrective action if subcontractor/provider performance is inadequate.

Reviewer Determination
- Partially Met (pass)

Strength
- GCBH’s provider contracts specify the delegated responsibilities and provide for sanctions and/or revocation of delegated activities should provider performance prove inadequate.

Section 6: Practice Guidelines

Table B-7: Summary of Compliance Review for Practice Guidelines

<table>
<thead>
<tr>
<th>Protocol Section</th>
<th>CFR</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Guidelines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Evidence and Adoption</td>
<td>438.236(a-b)</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>Dissemination</td>
<td>438.236 (c)</td>
<td>Fully Met (pass)</td>
</tr>
</tbody>
</table>
### FEDERAL REGULATION SOURCE(S)

§438.236 (a),(b): Practice Guidelines– Basic Rule

(a) Basic rule. The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP, meets the requirements of this section.

(b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP, adopts practice guidelines that meet the following requirements:

1. Are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field.
2. Consider the needs of the MCO, PIHP or PAHP's enrollees.
3. Are adopted in consultation with contracting healthcare professionals.
4. Are reviewed and updated periodically as appropriate.

### STATE REGULATION / RSN AGREEMENT SOURCE(S)

RSN Agreement Section(s) 7.7.3

### SCORING CRITERIA

- The RSN has documented policies and procedures related to adoption of practice guidelines including consultation with contracting healthcare professionals.
- The RSN’s guidelines are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field.
- The RSN has documentation of the needs of the enrollees and how the guidelines fit those needs.
- The RSN has documentation that the guidelines are reviewed and updated periodically as appropriate.
- The RSN has a documented policy and procedure of how affiliated providers are consulted as guidelines are adopted and re-evaluated.

### Reviewer Determination

- Fully Met (pass)

### Strengths

- The RSN has documented policies and procedures related to adoption of practice guidelines, including consultation with contracting healthcare professionals.
- GCRBH met with stakeholders who recommended the RSN develop a guideline on recovery; in response, GCBH developed the guideline “Recovery-Oriented Assessment.”
**Dissemination of Guidelines**

**FEDERAL REGULATION SOURCE(S)**

§438.236 (c): Practice Guidelines

(c) Dissemination of guidelines. Each MCO, PIHP and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

**STATE REGULATION / RSN AGREEMENT SOURCE(S)**

RSN Agreement Section(s) 7.7.3.4; 7.7.3.5

**SCORING CRITERIA**

- The RSN has a policy and procedure on how to disseminate practice guidelines to all providers and, upon request, to enrollees and potential enrollees.
- The RSN can demonstrate it has disseminated the practice guidelines to all providers and to enrollees upon request.

**Reviewer Determination**

- Fully Met (pass)

**Application of Guidelines**

**FEDERAL REGULATION SOURCE(S)**

§438.236 (d): Practice Guidelines

(d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services and other areas to which the guidelines apply are consistent with the guidelines.

**STATE REGULATION / RSN AGREEMENT SOURCE(S)**

RSN Agreement Section(s) 7.7.3.4; 7.7.3.5

**SCORING CRITERIA**

- The RSN has documented policy and procedures as well as documented meeting minutes regarding decisions for utilization management, enrollee education, coverage of services and other areas to which the guidelines apply are consistent with the guidelines.
- The RSN had documentation of the interface between the QA/PI program and the practice guidelines adoption process.

**Reviewer Determination**

- Fully Met (pass)
Section 7: Quality Assessment and Performance Improvement Program

Table B-8: Summary of Compliance Review for QAPI General Rules and Basic Elements

<table>
<thead>
<tr>
<th>Protocol Section</th>
<th>CFR</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Assessment and Performance Improvement Program</td>
<td>438.240 (a)(b)(d)(e)</td>
<td>Partially Met (pass)</td>
</tr>
<tr>
<td>Rules, Evaluation, Measurement, Improvement, Program Review by State</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submit Performance Measurement Data</td>
<td>438.240 (b)(c)</td>
<td>Partially Met (pass)</td>
</tr>
<tr>
<td>Mechanisms to Detect Over- and Underutilization of Services</td>
<td>438.240 (b)(3)</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>Quality and Appropriateness of Care Furnished to Enrollees With Special Healthcare Needs</td>
<td>438.240 (b)(4)</td>
<td>Partially Met (pass)</td>
</tr>
<tr>
<td>Overall Result for Section 7.</td>
<td></td>
<td>Partially Met (pass)</td>
</tr>
</tbody>
</table>

General Rules

FEDERAL REGULATION SOURCE(S)

§438.240 (a),(b),(d),(e): Quality Assessment and Performance Improvement Program.

(a) General rules.

(1) The State must require, through its contracts, that each MCO and PIHP have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees.

(b) Basic elements of MCO and PIHP quality assessment and performance improvement programs. At a minimum, the State must require that each MCO and PIHP comply with the following requirements:

(1) Conduct performance improvement projects as described in paragraph (d) of this section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

(d) Performance improvement projects.

(1) MCOs and PIHPs must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas, and that involve the following:

(i) Measurement of performance using objective quality indicators.

(ii) Implementation of system interventions to achieve improvement in quality.

(iii) Evaluation of the effectiveness of the interventions.
(iv) Planning and initiation of activities for increasing or sustaining improvement.

(2) Each MCO and PIHP must report the status and results of each project to the State as requested, including those that incorporate the requirements of §438.240(a) (2). Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

(e) Program review by the State.

(1) The State must review, at least annually, the impact and effectiveness of each MCO’s and PIHP’s quality assessment and performance improvement program. The review must include—

(i) The MCO’s and PIHP’s performance on the standard measures on which it is required to report; and

(ii) The results of each MCO’s and PIHP’s performance improvement projects.

(2) The State may require that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program.

**STATE REGULATION / RSN AGREEMENT SOURCE(S)**

WAC 388-865-0280; 388-865-0320  
RSN Agreement Section(s) 7.9; 7.10

**SCORING CRITERIA**

- The RSN has an ongoing quality assessment and performance improvement program (QAPI) for the services it furnishes to its enrollees.
- The RSN has a QA and PI process to evaluate the QAPI program and provides for an annual report to DBHR.
- The RSN collects, analyzes and uses performance data to support its quality assessment and performance improvement program.
- The RSN has a Quality Management Committee that meets regularly, reviews results of performance data and reports to the governing board.
- The RSN has effective mechanisms to assess the quality and appropriateness of care furnished to enrollees.
- The RSN conducts one clinical performance improvement project and one non-clinical performance improvement project each year.
- The RSN ensures its compliance with the State Quality Strategy plan.

**Reviewer Determination**

- Partially Met (pass)

**Strength**

- GCBH performs an annual review of its QAPI program.

**Opportunities for Improvement**

GCBH does not follow the State’s Quality Strategy Plan as the State has not implemented the Plan.

- As soon as DBHR adopts a State Quality Strategy plan, the RSN should review its quality strategy plan to make sure it aligns with DBHR’s.
GCBH conducted two non-clinical performance improvement projects (PIPs) in 2015. Both PIPs have been retired.

- GCBH will need to conduct at least one clinical PIP and one non-clinical PIP in 2016, one of which will need to be a children’s PIP.

**Recommendation Requiring CAP**

During the external quality review, it was noted that the RSN staff roles and responsibilities for the quality improvement program are not clearly defined and do not clearly identify who should be present to contribute at the various committee meetings such as the Clinical Directors Committee, the Quality Management Oversight Committee, the Children’s Committee and the Management Information Systems Committee. This has impacted the quality management process and the development of integrated reports used to identify the needs of the enrollees.

- GCBH needs to address the roles and responsibilities of its RSN staff related to the quality improvement program and clearly define and identify who should be present to contribute at the various committee meetings such as the Clinical Directors Committee, the Quality Management Oversight Committee, the Children’s Committee and the Management Information Systems Committee.

**Basic Elements**

**FEDERAL REGULATION SOURCE(S)**

§438.240 (b),(c): Quality Assessment and Performance Improvement Program

(b) Basic elements of MCO and PIHP quality assessment and performance improvement programs. At a minimum, the State must require that each MCO and PIHP comply with the following requirements:

(2) Submit performance measurement data as described in paragraph (c) of this section.

(c) Performance measurement. Annually each MCO and PIHP must—

(1) Measure and report to the State its performance, using standard measures required by the State including those that incorporate the requirements of §438.204(c) and §438.240(a)(2)(listed below);

(2) Submit to the State, data specified by the State, that enables the State to measure the MCO’s or PIHP’s performance; or

(3) Perform a combination of the activities described in paragraphs (c) (1) and (c) (2) of this section.

(a) General rules.

§438.204(c): For MCOs and PIHPs, any national performance measures and levels that may be identified and developed by CMS in consultation with State and other relevant stakeholders.

§438.240(a)(2): CMS, in consultation with States and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by States in their contracts with MCOs and PIHPs.

**STATE REGULATION / RSN AGREEMENT SOURCE(S)**

WAC 388-865-0280; 388-865-0320

RSN Agreement Section(s) 7.9; 7.10

**SCORING CRITERIA**
Compliance

- The RSN collects, analyzes and uses performance data to support its quality assessment and performance improvement program.
- The RSN reports performance data to the State every year.

Reviewer Determination

- Partially Met (pass)

Strength

- The RSN reports performance data to the State every year.

Opportunity for Improvement

Although GCBH collects and analyzes performance data for the State, it does not use the performance data to support its overall quality assessment and performance improvement program.

- GCBH should consider including its performance data into its overall quality assessment and performance improvement program.

Mechanisms to Detect Under- and Overutilization of Services

FEDERAL REGULATION SOURCE(S)

§438.240 (b)(3): Quality Assessment and Performance Improvement Program

(b) Basic elements of MCO and PIHP quality assessment and performance improvement programs. At a minimum, the State must require that each MCO and PIHP comply with the following requirements:

(3) Have in effect mechanisms to detect both underutilization and overutilization of services.

STATE REGULATION / RSN AGREEMENT SOURCE(S)

WAC 388-865-0280; 388-865-0320
RSN Agreement Section(s) 7.9; 7.10

SCORING CRITERIA

- The RSN has a documented policy and procedure regarding the detection of both underutilization and overutilization of services.
- The RSN has consistent criteria for identifying underutilization and overutilization.
- The RSN has processes for routine monitoring for underutilization and overutilization.
- The RSN has processes for taking corrective action to address underutilization and overutilization.

- Fully Met (pass)

Meets Criteria
Mechanism to Assess the Quality and Appropriateness of Care

FEDERAL REGULATION SOURCE(S)
§438.240 (b)(4): Quality Assessment and Performance Improvement Program

(b) Basic elements of MCO and PIHP quality assessment and performance improvement programs. At a minimum, the State must require that each MCO and PIHP comply with the following requirements:

(4) Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special healthcare needs.

STATE REGULATION / RSN AGREEMENT SOURCE(S)
WAC 388-865-0280; 388-865-0320
RSN Agreement Section(s) 7.9; 7.10

SCORING CRITERIA

- The RSN has a process in place to assess the quality and appropriateness of care furnished to enrollees.
- The RSN monitors and tracks the quality and appropriateness of care furnished to enrollees.
- The RSN has processes to take action when quality and appropriateness of care issues are identified.

Reviewer Determination

- Partially Met (pass)

Strengths

- GCBH’s Quality Review Team (QRT) conducts consumer, provider and allied provider mental health surveys, which incorporate consumer and family voice.
- GCBH conducts annual administrative and clinical audits of its provider network.

Recommendations Requiring CAP

Although GCBH’s provider agencies are required by GCBH’s policy to maintain a quality management (QM) process and procedure, the RSN does not have a process in place to monitor its provider agencies to determine if the providers are maintaining and following a QM process, including monitoring and tracking the quality and appropriateness of care furnished to its enrollees.

- GCBH needs to develop a process to hold its provider network accountable for maintaining and following a QM process that includes monitoring and tracking the quality and appropriateness of care furnished to its enrollees.

Many of GCBH’s policies and procedures have not been reviewed, revised and updated as necessary or approved for many years.

- GCBH needs to implement a process to review, revise and update as necessary and approve its policies and procedures at least every two years.
### Section 8: Health Information Systems

Table B-9: Summary of Compliance Review for Health Information Systems, General Rules and Basic Elements

<table>
<thead>
<tr>
<th>Protocol Section</th>
<th>CFR</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collect, Analyze, Integrate and Report Data</td>
<td>438.242 (a)</td>
<td>● Fully Met (pass)</td>
</tr>
<tr>
<td>Data Accuracy, Timeliness, Completeness</td>
<td>438.242 (b)</td>
<td>● Fully Met (pass)</td>
</tr>
<tr>
<td><strong>Overall Result for Section 8.</strong></td>
<td></td>
<td>● Fully Met (pass)</td>
</tr>
</tbody>
</table>

**General Rule**

**FEDERAL REGULATION SOURCE(S)**

§438.242 (a): Health Information Systems

(a) General rule. The State must ensure, through its contracts that each MCO and PIHP maintains a health information system that collects, analyzes, integrates and reports data and can achieve the objectives of this subpart. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and dis-enrollments for other than loss of Medicaid eligibility.

**STATE REGULATION / RSN AGREEMENT SOURCE(S)**

WAC 388-865-0275  
RSN Agreement Section(s) 11

**SCORING CRITERIA**

- The RSN has a health information system that collects, analyzes, integrates and reports data on utilization, dis-enrollments and requests to change providers, grievances and appeals.
- The RSN utilizes reports from health information data to make informed management decisions.
- The RSN analyzes the health information data to identify services needed for enrollees.

**Reviewer Determination**

● Fully Met (pass)

**Strength**

- GCBH has a health information system that collects, analyzes, integrates and reports data on dis-enrollments, requests to change providers, and grievances and appeals.
### FEDERAL REGULATION SOURCE(S)

§438.242 (b): Health Information Systems

(b) Basic elements of a health information system. The State must require, at a minimum, that each MCO and PIHP comply with the following:

1. Collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the State.
2. Ensure that data received from providers is accurate and complete by—
   1. Verifying the accuracy and timeliness of reported data;
   2. Screening the data for completeness, logic and consistency; and
   3. Collecting service information in standardized formats to the extent feasible and appropriate.
3. Make all collected data available to the State and upon request to CMS, as required in this subpart.

### STATE REGULATION / RSN AGREEMENT SOURCE(S)

WAC 388-865-0275
RSN Agreement Section(s) 11

### SCORING CRITERIA

- The RSN collects data on service encounters and on all provider and enrollee characteristics included in the Consumer Information System (CIS) Data Dictionary.
- The RSN ensures that data received from providers is accurate and complete by collecting data in standardized formats and reviewing the data for accuracy, timeliness, completeness, logic and consistency.
- The RSN makes all collected data available to the State and, upon request, to CMS.

### Reviewer Determination

- Fully Met (pass)

Meets Criteria
Performance Improvement Project Validation

PIP Review Procedures

Performance improvement projects (PIPs) are designed to assess and improve the processes and outcomes of the healthcare system. They represent a focused effort to address a particular problem identified by an organization. As Prepaid Inpatient Health Plans (PIHPs), Regional Support Networks (RSNs) are required to have an ongoing program of PIPs that focus on clinical and non-clinical areas that involve

- Measurement of performance using objective quality indicators
- Implementation of systems interventions to achieve improvement in quality
- Evaluation of the effectiveness of the interventions
- Planning and initiation of activities for increasing or sustaining improvement

As a mandatory EQR activity, Qualis Health evaluates the RSNs’ PIPs to determine whether they are designed, conducted and reported in a methodologically sound manner. The PIPs must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. In evaluating PIPs, Qualis Health determines whether

- The study topic was appropriately selected
- The study question is clear, simple and answerable
- The study population is appropriate and clearly defined
- The study indicator is clearly defined and is adequate to answer the study question
- The PIP’s sampling methods are appropriate and valid
- The procedures the RSN used to collect the data to be analyzed for the PIP measurement(s) are valid
- The RSN’s plan for analyzing and interpreting PIP results is accurate
- The RSN’s strategy for achieving real, sustained improvement(s) is appropriate
- It is likely that the results of the PIP are accurate and that improvement is “real”
- Improvement is sustained over time

Following PIP evaluations, RSNs are offered technical assistance to assist them with improving their PIP study methodology and outcomes. RSNs may resubmit their PIPs up to two weeks following the initial evaluation. PIPs are assigned a final score following the final submission.

PIP Scoring

Qualis Health assessed the RSNs’ PIPs using the current CMS EQR protocol available here: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Qualis Health assigns a score of Met or Not Met to each element that is applicable to the PIP being evaluated. Elements may be Not Applicable if the PIP is at an early stage of design or implementation. If a PIP has advanced only to the first measurement of the study indicator (baseline), elements 1–6 are
reviewed. If a PIP has advanced to the first re-measurement, elements 1–9 are reviewed. Elements 1–10 are reviewed for PIPs that have advanced to repeated re-measurement.

If all reviewed elements are assigned a score of Met, the overall score is Met. If any reviewed element is assigned a score of Not Met the overall score is Not Met.

Table C-1: Performance Improvement Project Validation Scoring

<table>
<thead>
<tr>
<th>Scoring Icon Key</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Fully Met (pass)</td>
</tr>
<tr>
<td>● Partially Met (pass)</td>
</tr>
<tr>
<td>● Not Met (fail)</td>
</tr>
<tr>
<td>● N/A (not applicable)</td>
</tr>
</tbody>
</table>

**PIP Validity and Reliability**

Qualis Health assesses the overall validity and reliability of the reported results for all PIPs. Because determining potential issues with the validity and reliability of the PIP is sometimes a judgment call, Qualis Health reports a level of confidence in the study findings based on a global assessment of study design, development and implementation. Levels of confidence and their definitions are included in Table C-2.

Table C-2: Performance Improvement Project Validity and Reliability Confidence Levels

<table>
<thead>
<tr>
<th>Confidence Level</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Confidence in Reported Results</strong></td>
<td>The study results are based on high-quality study design and data collection and analysis procedures. The study results are clearly valid and reliable.</td>
</tr>
<tr>
<td><strong>Moderate Confidence in Reported Results</strong></td>
<td>The study design and data collection and analysis procedures are not sufficient to warrant a higher level of confidence. Study weaknesses (e.g., threats to internal or external validity, barriers to implementation, questionable study methodology) are identified that may impact the validity and reliability or reported results.</td>
</tr>
<tr>
<td><strong>Low Confidence in Reported Results</strong></td>
<td>The study design and/or data collection and analysis procedures are unlikely to result in valid and reliable study results.</td>
</tr>
<tr>
<td><strong>Not Enough Time Has Elapsed to Assess Meaningful Change</strong></td>
<td>The PIP has not advanced to at least the first re-measurement of the study indicator.</td>
</tr>
</tbody>
</table>
Note: At the time of this review, Greater Columbia Behavioral Health’s (GCBH) performance improvement projects (PIPs) had not been reviewed or approved by the Division of Behavioral Health and Recovery. GCBH reported to the external quality review team that it was given permission to have two non-clinical PIPs.

**PIP Validation Results: Non-Clinical/Children’s PIP**

**Lowered Inpatient Readmission Rates in a High-Risk Population through the Development of Enhanced Communication with Inpatient Providers**

Greater Columbia Behavioral Health (GCBH) RSN believes that inpatient services should not be utilized if there are viable alternatives that can address an enrollee’s needs without hospitalization. In 2007, the Stabilization and Wellness in Families Together (SWIFT) program was developed by the Department of Human Services for Benton and Franklin counties in a partnership with Lutheran Community Services in Kennewick. The goal of the program was to keep children stabilized in their homes using Wraparound techniques. During the same time period, Lutheran Community Services expanded its already-existing 3 Rivers Wrap program. This program works on the principles of child- and family-led strength-based treatment that addresses immediate needs and coordinates community supports. Approximately six months after the opening of the SWIFT program, the hospitalization rate for Benton and Franklin counties dropped from an average of six admissions per month to two per month. In July 2009, Lourdes Counseling Center closed its ten-bed children’s inpatient unit, citing low census due to youth receiving services from mental health providers in their offices or at home rather than being admitted to a psychiatric hospital. As a next step, in 2010, GCBH ceased delegating its authorization process to a contracted entity and brought the process in house in an effort to improve the continuity of enrollee care and access a full spectrum of community resources. The year prior to the change in the authorization process, there was a 51% psychiatric hospitalization readmission rate among youth ages 21 and younger. The year following the change, the readmission rate dropped to 28%.

Readmission to inpatient psychiatric care within 30 and 180 days post discharge is a clinical outcome indicator often used to measure the quality of services an individual received during a hospitalization. GCBH sought to continue to lower readmission rates with a target below 15%, a rate often observed in other states. GCBH is a large, ten-county RSN with areas of concern related to its children’s inpatient population, particularly in large rural areas with limited or difficult-to-reach outpatient services. These regions have faced challenges finding less restrictive alternatives to inpatient care within their home communities. The role of staff in the authorization center relates primarily to determining whether criteria for admission to or continuation of inpatient care have been met. The nature of the authorization staff’s relationships with the inpatient providers and the scope of their knowledge of resources regarding youth place them in a position to facilitate the process of discharge planning for care continuity and needed outpatient services. The implementation of the children’s questionnaire, which would explore such gaps and concerns, would allow for greater exploration with providers about whether various services that might support the enrollee after hospitalization are available and/or have been explored. This Healthcare Effectiveness Data Information Set (HEDIS)-supported strategy has been found to reduce the risk for readmissions.

This study topic was brought to GCBH stakeholders, who agreed that focus on recovery, family voice and utilization management are essential components in addressing recidivism. Stakeholders include the GCBH Regional Advisory Board (RAB), 51% of whose members are enrollee and enrollee family
members. Others are the GCBH Children’s Committee and GCBH Clinical Directors Committee. All have voiced concerns about readmissions and its relationship to quality of care following inpatient treatment.

The study question is “Does enhanced communication with inpatient providers, via the use of a child inpatient admission questionnaire by GCBH authorization center staff at the time of authorization/admission, decrease the rate of children readmissions to community inpatient services within ninety days of his/her inpatient discharge?”

First re-measurement: October 1, 2013, to September 30, 2014
Extended re-measurement: October 1, 2013 to March 31, 2015

Table C-3: Clinical PIP Validation Results

<table>
<thead>
<tr>
<th>Study Design</th>
<th>Activity</th>
<th>Narrative</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Design</td>
<td>1</td>
<td>Appropriate study topic</td>
<td>The process for choosing this PIP was based on a review of RSN data and HEDIS-supported strategies. GCBH also sought input from a wide variety of stakeholders including the GCBH Regional Advisory Board (RAB), the GCBH Children’s Committee and the GCBH Clinical Directors Committee. This PIP includes a high-risk, high-needs population whose members have limited resources and ability to advocate for themselves. The intent of the PIP is to enhance communication, empower youth and their families, build on strengths and identify resources previously unused or not considered within the community.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Clearly defined, answerable study question</td>
<td>The study question, Does enhanced communication with inpatient providers, via the use of a child inpatient admission questionnaire by GCBH authorization center staff at the time of authorization/admission, decrease the rate of children readmissions?, is clear, simple and answerable.</td>
</tr>
</tbody>
</table>
### Correctly identified study population

The study population is defined as Medicaid-eligible/enrolled children under the age of 21 who were discharged from inpatient care in a community setting during a given measurement period.  

- **Fully Met (pass)**

### Correctly identified study indicator

The indicator for the study is the change in inpatient readmission rates for youth 21 and younger. The indicator numerator is defined as the number of readmissions to a community inpatient setting between the second and 90th calendar day following discharge from a prior episode of inpatient care. The indicator denominator is the number of discharged youth under the age of 21 within a given measurement period from inpatient care in a community setting who were Medicaid eligible at the time the inpatient care episode began.

- **Fully Met (pass)**

### Reviewer Comments:

GCBH has chosen an appropriate study topic that was designed with input from stakeholders and is consistent with the enrollee population. The PIP question is clearly defined and capable of being answered. The indicator is a valid gauge of enrollee outcomes.

### Implementation

#### Valid sampling technique

GCBH reported that a convenience sample was used; however, it also reported that the entire population was included in the study and that all enrollees who fit the criteria of the study population were included in the sample.

- **N/A**

#### Accurate/complete data collection

The study design clearly specifies the data to be collected. The data were collected through the GCBH consumer information system (CIS) database using SQL queries. GCBH programmers used SQL queries to extract data as applicable. Queries were re-run to check for errors. The data analysis plan called for a test to measure the change in pre- and post-intervention readmission rates.

- **Fully Met (pass)**
Data were collected 90 days after the final day of the intervention period and was duplicated with the additional six-month intervention time and 90 days after the final day of the intervention. The data analysis plan for the indicator includes a chi-square test calculation with a p-value less than or equal to .05 to determine statistical significance.

<table>
<thead>
<tr>
<th>7</th>
<th>Appropriate data analysis/interpretation of study results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some inconsistencies were noted in the data during the first re-measurement period, due to a lack of fidelity to the intervention protocol. The re-measurement period was extended six months to allow for re-engagement of proper implementation of the questionnaire protocol. Data were analyzed as planned using chi-square and ( p \leq .05 ) significance level and noted that for the baseline period of October 1, 2012, to September 30, 2013, the readmission rate was 14%; for the first re-measurement period from October 1, 2013, to September 30, 2014, the readmission rate was 13%; and with the six-month extension included in the re-measurement period, October 1, 2013, to March 1, 2015, the readmission rate was 11%. While this did show slight improvement, the improvement was not statistically significant.</td>
<td>Partially Met (pass)</td>
</tr>
</tbody>
</table>

**Reviewer Comments:**
GCBH did not use any sampling techniques for this PIP. Accurate and complete data collection was conducted through an SQL query of the CIS database. There were some issues related to data collection and analysis that were corrected through retraining and an extended re-measurement period.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>8</th>
<th>Appropriate improvement strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCBH did not report the completion of gap or barrier analysis but did note the</td>
<td>Partially Met (pass)</td>
<td></td>
</tr>
</tbody>
</table>
children’s questionnaire used in this PIP has provided data that can be analyzed to identify issues related to available resources and ongoing needs. GCBH reported anecdotally that the intervention has facilitated the identification of gaps and root causes that can be used by the GCBH Quality Management Oversight Committee (QMOC) for further program or system enhancement.

GCBH noted calculation errors in the data collection strategies for the baseline PIP calculation that impacted the logic for the strategic intervention. Initially the readmission rate at the end of the first year after having moved to an in-house authorization center was calculated at 28%, but the correct calculation was 14%.

Due to irregularities in the data that were observed for a four-to-six-week period during the re-measurement period, a breach in the adherence to the intervention protocol was caught and corrected. An additional six months was added to the re-measurement intervention period.

Several threats to validity were noted, including differences in perception related to severity of qualifying symptoms among mental health professionals, lack of knowledge of less restrictive alternatives, and differences in cultural and ethnic perspectives in some of the counties. The implementation of the
Performance Improvement Project Validation

Wraparound with Intensive Services (WISe) model may also have impacted validity.

9. Real improvement achieved

Statistically significant improvement was not achieved, but slight improvement was indicated. This cannot be attributed to the intervention, but the PIP was carried out as planned.

10. Sustained improvement achieved

GCBH measured the baseline with one re-measurement period and an extended re-measurement period.

• Partially Met (pass)

Overall Score

• Fully Met (pass)

Reviewer Comments

Strength(s):

GCBH has created a well-thought-out PIP. The study question is clear, as is the study population, the study indicator and the intervention.

Recommendation(s):

GCBH needs to consider ending this PIP or changing the study question and study topic to address an issue that is in need of true improvement. GCBH should aggregate and analyze the data it has collected from its current intervention and use the information to inform the selection of its new PIP.

Confidence Level:

High confidence in reported results

Standard 1: Selected Study Topic Is Relevant and Prioritized

Table C-4: Validation of PIP Selected Study Topic

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>The study topic was selected through data collection and analysis of comprehensive aspects of specific enrollee needs, care and services.</td>
<td>• Fully Met (pass)</td>
</tr>
<tr>
<td>1.2</td>
<td>The PIP is consistent with the demographics and epidemiology of the enrollees.</td>
<td>• Fully Met (pass)</td>
</tr>
<tr>
<td>1.3</td>
<td>The PIP considered input from enrollees with special healthcare needs.</td>
<td>• Fully Met (pass)</td>
</tr>
</tbody>
</table>
1.4 The PIP addresses a broad spectrum of key aspects of enrollee care and services.  

1.5 The PIP, over time, included all enrolled populations.

**Reviewer Comments:**
GCBH has chosen to address the reduction of readmission rates to community inpatient facilities through the implementation of an improved discharge planning process. An extended analysis of program utilization was conducted in relation to services that address enrollees’ needs within the community instead of inpatient hospitalization. The development of several less restrictive alternative treatment programs for youth were noted as well as the closure of one ten-bed inpatient program. In 2010, GCBH brought the authorization for mental health services in house and noted that in one year (July 2010–June 2011), there were 180 enrollee inpatient discharges for youth 21 and younger. There were 93 readmissions or 51% within 90 days of discharge. One year later the readmission rate had dropped to 28%; however, GCBH noted that the rate often observed in most states is below 15%.

GCBH sought input from multiple stakeholders regarding the focus of the PIP. One of the stakeholder groups is the GCBH RAB, 51% of whose participants are enrollees and enrollee family members.

GCBH chose this PIP as a means to facilitate a process that goes beyond presenting problems and determining the medical necessity for care. The intervention also includes the identification of psychosocial, cultural and environmental factors.

The PIP includes all enrollees who fit the criteria for the study.

**Meets Criteria**

---

**Standard 2: Study Question Is Clearly Defined**

Table C-5: Validation of PIP Study Question

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>The study question(s) is clear, concise and answerable.</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>2.2</td>
<td>The study question identifies the focus of the PIP and sets the framework for data collection, analysis and interpretation.</td>
<td>Fully Met (pass)</td>
</tr>
</tbody>
</table>

**Reviewer Comments:**
The study question is “Does enhanced communication with inpatient providers, via the use of a child inpatient admission questionnaire by GCBH Authorization Center staff at the time of authorization/admission, decrease the rate of children readmissions to community inpatient services within ninety days of his/her inpatient discharge?” The question is clear, simple and answerable. The question establishes the framework for data collection, analysis and interpretation.

**Meets Criteria**
Standard 3: Study Population Is Clearly Defined, and, if a Sample Is Used, Appropriate Methodology Is Used

Table C-6: Validation of PIP Study Population

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>The enrollee population to whom the study question and indicator is relevant is clearly defined.</td>
<td>● Fully Met (pass)</td>
</tr>
<tr>
<td>3.2</td>
<td>The data collection approach captures all enrollees to whom the study question applied.</td>
<td>● Fully Met (pass)</td>
</tr>
<tr>
<td>3.3</td>
<td>Appropriate data sources and evaluation methods were used to identify the study population.</td>
<td>● Fully Met (pass)</td>
</tr>
</tbody>
</table>

Reviewer Comments:
The enrollee population is defined as the number of youth discharges within a given measurement period from inpatient care authorized by GCBH staff, in a community setting, who were Medicaid eligible and under the age of 21 when the inpatient episode of care commenced. The data are captured through an SQL query of the GCBH in-house authorization and CIS databases.

Meets Criteria

Standard 4: Study Indicator Is Objective and Measureable

Table C-7: Validation of PIP Study Indicator

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>The study uses objective, clearly defined, measurable indicators.</td>
<td>● Fully Met (pass)</td>
</tr>
<tr>
<td>4.2</td>
<td>The indicators track performance over a specified period of time.</td>
<td>● Fully Met (pass)</td>
</tr>
<tr>
<td>4.3</td>
<td>The number of indicators is adequate to answer the study question, appropriate for the level of complexity of applicable clinical practice guidelines, and appropriate to the availability of and resources to collect necessary data.</td>
<td>● Fully Met (pass)</td>
</tr>
</tbody>
</table>

Reviewer Comments:
The indicator numerator is defined as the number of enrollee readmissions to a community inpatient setting between the second and 90th calendar day following discharge from a prior episode of inpatient hospitalization. The enrollee is an individual who is under the age of 21 at the time of readmission and is
Medicaid enrolled. The indicator denominator is the number of discharges of youth under 21 within a given measurement period from an inpatient community setting, authorized by GCBH staff and who are Medicaid eligible at the time the inpatient hospitalization episode was initiated.

Baseline data were collected from October 1, 2012, to September 30, 2013; the first re-measurement period was October 1, 2013, to September 30, 2014, with an additional extended re-measurement period of October 1, 2014, to March 31, 2015, due to fidelity issues related to adherence to the intervention protocol.

This indicator is adequate to answer the study the question.

Table C-8: Validation of PIP Sampling Methods

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>The sampling technique considered and specified the true (or estimated) frequency of occurrence of the event, the confidence interval to be used and the acceptable margin of error.</td>
<td>N/A</td>
</tr>
<tr>
<td>5.2</td>
<td>Valid sampling techniques were employed that protected against bias.</td>
<td>N/A</td>
</tr>
<tr>
<td>5.3</td>
<td>The sample contained a sufficient number of enrollees.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Reviewer Comments:
GCBH reported that a convenience sample was used; however, it also reported that the entire population was included in the study and that all enrollees who fit the criteria of the study population were included in the sample. If the whole study population is included, no sampling techniques were used.

Table C-9: Validation of PIP Data Collection Procedures

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>The study design clearly specifies the data to be collected.</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>6.2</td>
<td>The study design clearly specifies the sources of data.</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>6.3</td>
<td>The study design specifies a systematic method of collecting valid and reliable data that represents the entire population to which the</td>
<td>Fully Met (pass)</td>
</tr>
</tbody>
</table>
The instruments for data collection provide for consistent and accurate data collection over the time periods studied.  

The study design prospectively specifies a data analysis plan.  

Qualified staff and personnel were used to collect the data.  

Reviewer Comments:
The data collected were the number of enrollee readmissions to a community inpatient setting between the second and 90th calendar day after a discharge from a previous episode of inpatient care. Enrollees are ages 21 or younger at the time of the readmission and eligible for services and enrolled in Medicaid in the GCBH RSN. Also collected were the total number of discharges of youth ages 21 and under within a given measurement period. The data were collected through the GCBH CIS database using SQL queries.

Queries were re-run to check for errors. The data analysis plan called for a test to measure the change in pre- and post-intervention readmission rates. Data were collected 90 days after the final day of the intervention period and were duplicated with the additional six-month intervention time and 90 days after the final day of the intervention.

GCBH authorization staff is master's level clinicians; the quality manager is a PhD-level clinician with experience in research and study designs. The GCBH programmer and IS staff are well versed in data collection and reporting processes, as well as report design. The questionnaire used for the intervention was designed by the GCBH psychiatrist, who is experienced in the use of HEDIS measures for utilization management processes.

Meets Criteria

Standard 7: Data Analysis and Interpretation of Study Results

Table C-10: Validation of PIP Data Analysis and Interpretation

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>An analysis of the findings was performed according to the data analysis plan.</td>
<td>Partially Met (pass)</td>
</tr>
<tr>
<td>7.2</td>
<td>Numerical PIP results and findings were accurately and clearly presented.</td>
<td>Partially Met (pass)</td>
</tr>
<tr>
<td>7.3</td>
<td>The data analysis methodology was appropriate to the study question and data types.</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>7.4</td>
<td>The analysis identified initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external</td>
<td>Partially Met (pass)</td>
</tr>
</tbody>
</table>
The analysis of study data included an interpretation of the extent to which the PIP was successful, as well as follow-up activities. • Partially Met (pass)

**Reviewer Comments:**
Analysis of findings was performed according to the data analysis plan. There was an issue regarding fidelity to adherence to the implementation of the intervention protocol in which one member of the authorization team was not completing the questionnaires in real time. The implementation period was extended for an additional six months to allow for re-engagement to the proper intervention protocol.

Several calculation and data collection logic errors were discovered that impacted the baseline calculation for the strategic intervention. Initially, the readmission rate for the 12-month period following the creation of the GCBH in-house authorization center was calculated to be 28%, but the correct rate was 14%. GCBH had used the incorrect 28% to create a goal by which to decrease the readmission rate to 15%; however, that goal was higher than the actual readmission rate of 14%.

The data analysis plan of using a chi-square with a significance level of \( p \leq .05 \) was followed.

For the baseline period of October 1, 2012 to September 30, 2013 the readmission rate was 14%, for the first re-measurement period from October 1, 2013 to September 30, 2014 the readmission was 13% and with the six month extension included in the re-measurement period October 1, 2013 to March 1, 2015 the readmission rate was 11%. While this did show minimal improvement, it was not statistically significant.

GCBH reported that it has obtained data from over 500 questionnaires, but no analysis has been done.

**Opportunities for Improvement:**
If GCBH is interested in continuing with this PIP or the study topic, an analysis of the questionnaire data should be done and relevant data should inform the direction of the PIP. GCBH should not continue this PIP in its current state as there has been no statistically significant improvement in readmission rates and rates were already below the desired 15% threshold at baseline.

---

**Standard 8: Appropriate Improvement Strategies**

**Table C-11: Validation of PIP Improvement Strategies**

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1</td>
<td>A continuous cycle of measurement and performance analysis was conducted.</td>
<td>• Fully Met (pass)</td>
</tr>
<tr>
<td>8.2</td>
<td>Reasonable interventions were undertaken to address causes/barriers identified through data analysis and QI processes.</td>
<td>• Partially Met (pass)</td>
</tr>
<tr>
<td>8.3</td>
<td>The interventions are/were sufficient to be expected to improve processes or outcomes.</td>
<td>• Partially Met (pass)</td>
</tr>
</tbody>
</table>
The interventions are/were culturally and linguistically appropriate. ● Fully Met (pass)

Reviewer Comments:
A continuous cycle of measurement and performance analysis was conducted.

The use of the Children’s Questionnaire has provided GCBH with data that has the potential to provide information that can identify gaps and barriers related to available resources and ongoing needs. GCBH noted that there is enhanced communication between authorization staff and inpatient providers and this helps to build a team approach for effective strategies that work to keep youth in their homes.

The questionnaire explores cultural and linguistic issues that may need to be addressed when working with youth and their families.

Opportunities for Improvement:
GCBH has collected a wealth of information that could be used to identify causes and barriers and subsequently address them. GCBH should analyze the data to identify gaps and root causes for readmissions and other noted trends. GCBH should bring this data to its QMOC and RAB committees for discussion to generate possible future PIP topics. GCBH’s PIP, in its current state, should be retired and/or built upon into another PIP that can improve performance in a statistically significant way.

Standard 9: Assess Whether Improvement Is “Real” Improvement

Table C-12: Validation of PIP Improvement Assessment

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1</td>
<td>The same methodology as the baseline measurement was used when measurement was repeated.</td>
<td>● Fully Met (pass)</td>
</tr>
<tr>
<td>9.2</td>
<td>There was documented, quantitative improvement in processes or outcomes of care.</td>
<td>● Fully Met (pass)</td>
</tr>
<tr>
<td>9.3</td>
<td>The reported improvement in performance appears to be the result of the planned quality improvement intervention.</td>
<td>● Partially Met (pass)</td>
</tr>
<tr>
<td>9.4</td>
<td>There is statistical evidence that any observed performance improvement is true improvement.</td>
<td>● Partially Met (pass)</td>
</tr>
</tbody>
</table>

Reviewer Comments:
The same methodology was used at baseline, the re-measurement and the extended re-measurement. The chi-square calculation did not indicate statistically significant improvement in readmission rates between baseline and the 12- and 18-month re-measurement periods following the intervention. Though there was a slight drop in readmission rates, it was not significant and cannot be clearly attributed to the intervention.

Opportunities for Improvement:
GCBH should consider discontinuing or altering this PIP. The PIP, with its current study question and
Performance Improvement Project Validation

Standard 10: The RSN Has Sustained the Documented Improvement

Table C-13: Validation of PIP Sustained Improvement

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1</td>
<td>Sustained improvement was demonstrated through repeated measurements over comparable time periods.</td>
<td>● Partially Met (pass)</td>
</tr>
</tbody>
</table>

Reviewer Comments:
Improvement remained comparable over the re-measurement periods. The re-measurement periods overlapped and improvement was not statistically significant. The slight decrease in readmissions cannot be clearly linked to the intervention.

Opportunities for Improvement:
GCBH needs to consider discontinuing or modifying this PIP.

PIP Validation Results: Non-Clinical PIP

Increasing Inclusion of Healthcare Information and PCP Involvement Into Outpatient Mental Health Treatment Through Provider Training and Shared PRISM Health Information.

The integration of physical and mental healthcare is well underway in Washington State. GCBH has recognized the opportunity to follow the lead of local and regional planning in moving toward the goal of healthcare integration. GCBH reported that during clinical audits of provider agency records, in 2012 and 2013, an average of only 35% of outpatient enrollee service plans addressed medical concerns. During meetings between GCBH staff and administrative staff from Eastern State Hospital (ESH), GCBH reported that staff from ESH described poor outcomes for discharged clients who seemed to be negatively impacted by the lack of a primary care physician (PCP) involved in the patient’s aftercare. Adults with serious mental illness have statistically higher mortality rates and shorter life expectancies than those without such a diagnosis, even when suicide is removed as a cause of death. By including physical healthcare concerns and involving a PCP in an enrollee’s treatment, health issues can be addressed in a timely manner that empowers the enrollee.

GCBH sought input and approval for this PIP from the GCBH Regional Advisory Board (RAB), the Clinical Directors Committee, the Quality Committee and the GCBH consumer advocate. The foundation for this PIP was initiated 2013. At the onset of the PIP, the focus was to lower the Predictive Risk Intelligence System (PRISM) scores of high-risk psychiatric enrollees. The intent was to raise awareness and impact PRISM scores. Following the initial provider training and measurement period, it was discovered that overall provider participation for this PIP was low. After receiving some feedback on the training and study design, changes were made in an attempt to strengthen it. Multiple providers chose not to participate in
the PIP, a new training was developed, and two indicators were created. GCBH believed that the trainings and partnerships with the participating providers would facilitate an improved result.

The study questions are:
1. “Will the training of outpatient providers, the provision of PRISM summary report, and the integration of physical healthcare information into mental health records increase the inclusion of healthcare issues into treatment planning for a high-risk Medicaid-enrolled adult psychiatric population?”
2. “Will the training of outpatient providers and the encouragement of PCP contact increase the involvement of PCPs into mental health treatment planning for a high-risk Medicaid-enrolled adult psychiatric population?”

Table C-14: Clinical PIP Validation Results

<table>
<thead>
<tr>
<th>Study Design</th>
<th>Activity</th>
<th>Narrative</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Design</td>
<td>1. Appropriate study topic</td>
<td>The study topic was chosen based on data and trends, with the input of stakeholders. The study topic is the integration of primary care and mental health services by increasing the inclusion of PRISM summary information in the clinical record and PCP involvement in outpatient mental health treatment planning.</td>
<td>Fully Met (pass)</td>
</tr>
</tbody>
</table>
|              | 2. Clearly defined, answerable study question | GCBH created two study questions:
1. Will the training of outpatient providers, the provision of PRISM summary report, and the integration of physical healthcare information into mental health records increase the inclusion of healthcare issues into treatment planning for a high-risk Medicaid enrolled adult psychiatric population?
2. Will the training of outpatient providers and the encouragement of PCP contact increase the involvement of PCPs into mental health treatment planning for a high-risk Medicaid enrolled adult psychiatric population? | Fully Met (pass)       |
|              | 3. Correctly identified study population | Initially, the study population was defined as enrollees ages 18 and older at the time of admission who | Fully Met (pass)       |
had a PRISM score of 0.5 or higher, were authorized by GCBH staff for inpatient hospitalization and discharged to an outpatient provider facility. For the re-measurement period the PRISM score criteria was removed.

| 4 Correctly identified study indicator | There are two study indicators for this PIP. For the first indicator, the numerator includes adults 18 years or older with active Medicaid coverage who had a current PRISM summary report, were GCBH authorized for inpatient admission, and were discharged into a GCBH network outpatient mental health setting. These enrollees also have at least one routine service for which healthcare information was included in the outpatient record as demonstrated by chart review. For the second indicator the numerator is defined as adults ages 18 and older with active Medicaid coverage who had a PRISM summary report, were GCBH authorized for inpatient admission, and were discharged into a GCBH network outpatient mental health setting. These enrollees also had an intake and at least one routine service for which the PCP was contacted about the enrollee’s health needs as evidenced by a chart review. For both numerators, the denominator is defined as adults 18 years or older, with active Medicaid coverage at the time of GCBH inpatient authorization and a current PRISM summary report, who were discharged into the GCBH network outpatient provider aftercare. | Fully Met (pass) |

**Reviewer Comments:**
GCBH has chosen an appropriate study topic, with two clear, specific and measurable study questions. The study population was changed, but was identified correctly in conjunction with the two study
### Implementation

<table>
<thead>
<tr>
<th>Score</th>
<th>Indicator Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Valid sampling technique</td>
<td>There were no samples used in this study. N/A</td>
</tr>
<tr>
<td>6</td>
<td>Accurate/complete data collection</td>
<td>The study design specifies the data to be collected. The charts are reviewed for the two indicators, one being documentation that the enrollee’s health information from their PRISM summary sheet has been integrated into their treatment plan and the second being that there is documentation that the provider involved the PCP in the enrollee’s care. The GCBH quality manager conducted chart reviews to verify the presence of the documentation. GCBH provided no explanation for how the list of charts to be reviewed is generated. Partially Met (pass)</td>
</tr>
</tbody>
</table>

#### Reviewer Comments:

Sampling techniques were not used for this PIP. The study design defines the data to be collected but does not clearly outline how the list of eligible enrollees will be created. Data is collected by a single individual with no system to check for data accuracy.

### Outcomes

<table>
<thead>
<tr>
<th>Score</th>
<th>Indicator Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Appropriate improvement strategies</td>
<td>GCBH discovered some shortcomings in the PIP study design and implemented appropriate improvement strategies related to provider training for the intervention. Not all threats to validity were assessed and addressed. Partially Met (pass)</td>
</tr>
<tr>
<td>9</td>
<td>Real improvement achieved</td>
<td>GCBH reported quantitative improvement in both indicators; however, there was not statistically significant change in the second indicator. GCBH Partially Met (pass)</td>
</tr>
</tbody>
</table>
Performance Improvement Project Validation reports that it cannot conclude that changes in direction or significance are the result of the study intervention.

| 10  | Sustained improvement achieved | There appeared to be quantitative improvement through repeated measurements over comparable periods of time. The second indicator lacked statistical significance, and there was no baseline measurement. | Partially Met (pass) |

Overall Score | Partially Met (pass)

Reviewer Comments

Strength(s):
GCBH has chosen a study topic that is quite fitting in light of the national, state and regional trends toward physical and mental health integration. The study questions are clear and answerable and data collection and analysis are appropriate.

Recommendation(s):
If GCBH chooses to continue using this study topic, it should consider looking at alternative study questions and indicators that are less closely tied to current WAC and contract requirements. While this PIP does seek additional documentation related to enrollees’ healthcare and linkages with their primary care, it is difficult to discern if the proposed interventions are the true cause for any changes in the indicator or if the requirements impact the outcomes. GCBH will need to seek a PIP that has indicators of success with a strong causal relationship to the intervention and fewer threats to validity.

Confidence Level:
Moderate confidence in reported results

Standard 1: Selected Study Topic Is Relevant and Prioritized

Table C-15: Validation of PIP Selected Study Topic

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>The study topic was selected through data collection and analysis of comprehensive aspects of specific enrollee needs, care and services.</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>1.2</td>
<td>The PIP is consistent with the demographics and epidemiology of the enrollees.</td>
<td>Fully Met (pass)</td>
</tr>
</tbody>
</table>
1.3 The PIP considered input from enrollees with special healthcare needs. | Fully Met (pass)
1.4 The PIP addresses a broad spectrum of key aspects of enrollee care and services. | Fully Met (pass)
1.5 The PIP, over time, included all enrolled populations. | Partially Met (pass)

Reviewer Comments:
The process for choosing this PIP was based on data collected through audit reviews, as well as the enhancement of WAC and contract requirements. The integration of mental health and physical healthcare needs is also a top priority at national, state and local levels. The PIP is consistent with demographics and epidemiology of enrollees; adults with serious mental illness have statistically higher mortality rates and shorter life expectancy than individuals without a mental health diagnosis, even when suicide is excluded.

The GCBH RAB, which is composed of 51% enrollees and their families, and the GCBH consumer advocate were involved in the creation of this PIP and endorsed the provision of education to the RSN’s providers to begin a process leading to enrollees’ involvement in their healthcare and partnering with a PCP in treatment planning.

Healthcare integration addresses a broad spectrum of key aspects of enrollee care and services.

Initially GCBH attempted to include all of its providers in this PIP and conducted training to facilitate the process. Overall provider participation was not successful, and ultimately only four provider agencies committed to participate in the PIP.

Opportunities for Improvement:
GCBH reported that this PIP is a small-scale pilot PIP that would be used to assess the viability of creating system changes that would lead to the overall integration of healthcare into mental health treatment. If GCBH intends to continue to consider this study topic for a PIP it needs to consider making appropriate provider participation a requirement and expanding the scope of the PIP.

Standard 2: Study Question Is Clearly Defined

Table C-16: Validation of PIP Study Question

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>The study question(s) is clear, concise and answerable.</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>2.2</td>
<td>The study question identifies the focus of the PIP and sets the framework for data collection, analysis and interpretation.</td>
<td>Fully Met (pass)</td>
</tr>
</tbody>
</table>

Reviewer Comments:
GCBH created two study questions:

1. Will the training of outpatient providers, the provision of PRISM summary report, and the integration of physical healthcare information into mental health records increase the inclusion of healthcare issues into treatment planning for a high risk Medicaid enrolled adult psychiatric population?

2. Will the training of outpatient providers and the encouragement of PCP contact increase the involvement of PCPs into mental health treatment planning for a high risk Medicaid enrolled adult psychiatric population?

Both questions are directly linked to the study topic. The questions are clear, concise and answerable. The questions set the initial framework for data collection, analysis and interpretation.

**Meets Criteria**

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### Standard 3: Study Population Is Clearly Defined, and, if a Sample is Used, Appropriate Methodology Is Used

#### Table C-17: Validation of PIP Study Population

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>The enrollee population to whom the study question and indicator is relevant is clearly defined.</td>
<td>✔ Fully Met (pass)</td>
</tr>
<tr>
<td>3.2</td>
<td>The data collection approach captures all enrollees to whom the study question applied.</td>
<td>● Partially Met (pass)</td>
</tr>
<tr>
<td>3.3</td>
<td>Appropriate data sources and evaluation methods were used to identify the study population.</td>
<td>✔ Fully Met (pass)</td>
</tr>
</tbody>
</table>

**Reviewer Comments:**

For the first study period, January 1, 2014, to June 15, 2014, GCBH chose to identify the study population as GCBH-authorized inpatient individuals, 18 years of age and older, whose PRISM scores were 0.5 or higher. For the second study period with PRISM summary reports, enrollees with any score were used. This was a strategy to include a larger number of enrollees in the study.

Data were captured by GCBH authorization staff. PRISM summary PDFs were placed in a file by the authorization staff or entered by name on an excel spreadsheet.

Data were collected through password-protected emails and authorization drive systems. The quality manager accessed an electronic folder containing PRISM summaries that had been obtained by authorizing staff members. Once the discharge outpatient facility was chosen, the PRISM report was sent through the GCBH portal to the designated provider. Data collection during the first study period included the use of a log to check provider charts, at their locations, for the presence of physical health information and the inclusion of PCP involvement. During the second measurement period, data collection was simplified to decrease the possibility of error and to increase the involvement of GCBH’s quality manager.
and authorization staff. The quality manager monitored the names of eligible participants who were on the spreadsheet and checked for discharge dates and outpatient referral information. Facilities received PRISM summary reports via secure fax from the quality manager.

**Opportunities for Improvement:**
GCBH needs to fully explain how all eligible enrollees’ PRISM summaries are extracted/obtained from the PRISM database.

---

**Standard 4: Study Indicator Is Objective and Measureable**

**Table C-18: Validation of PIP Study Indicator**

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>The study uses objective, clearly defined, measurable indicators.</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>4.2</td>
<td>The indicators track performance over a specified period of time.</td>
<td>Partially Met (pass)</td>
</tr>
<tr>
<td>4.3</td>
<td>The number of indicators is adequate to answer the study question, appropriate for the level of complexity of applicable clinical practice guidelines, and appropriate to the availability of and resources to collect necessary data.</td>
<td>Fully Met (pass)</td>
</tr>
</tbody>
</table>

**Reviewer Comments:**
There are two indicators for this PIP. In the first indicator, the numerator includes adults 18 years or older with active Medicaid coverage who had a current PRISM summary report, were GCBH authorized for inpatient admission, and were discharged into a GCBH network outpatient mental health setting. These enrollees also have at least one routine service for which their healthcare information was included in the outpatient record as demonstrated by chart review. The denominator is defined as adults 18 years or older, with active Medicaid coverage at the time of GCBH inpatient authorization and a current PRISM summary report, who were discharged into the GCBH network outpatient provider aftercare.

For the second indicator, the numerator is defined as adults ages 18 and older with active Medicaid coverage who had a PRISM summary report, were GCBH authorized for inpatient admission, and were discharged into a GCBH network outpatient mental health setting. These enrollees also had an intake and at least one routine service for which their PCP was contacted about the enrollee’s health needs as evidenced by a chart review. The denominator is defined as adults 18 years or older, with active Medicaid coverage at the time of GCBH inpatient authorization and a current PRISM summary report, who were discharged into the GCBH network outpatient provider aftercare.

The number of indicators is adequate to answer the study questions.

**Opportunities for Improvement:**
Throughout the 2015 PIP DBHR RSN response form, GCBH refers to three different sets of dates for the study period. Under Dates of the Study Period, in section 4.2 and section 7.4, the timeframes vary. GCBH needs to clarify the dates of the study period and be sure dates are consistent throughout reports. If
there is a reason for varying dates, GCBH should provide an explanation.

**Standard 5: Sampling Method**

**Table C-19: Validation of PIP Sampling Methods**

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>The sampling technique considered and specified the true (or estimated) frequency of occurrence of the event, the confidence interval to be used and the acceptable margin of error.</td>
<td>N/A</td>
</tr>
<tr>
<td>5.2</td>
<td>Valid sampling techniques were employed that protected against bias.</td>
<td>N/A</td>
</tr>
<tr>
<td>5.3</td>
<td>The sample contained a sufficient number of enrollees.</td>
<td>Partially Met (pass)</td>
</tr>
</tbody>
</table>

**Reviewer Comments:**
This PIP did not use samples. The entire study population was included in the indicator.

**Opportunities for Improvement:**
A significant number of providers chose not to participate in this PIP. GCBH should consider making provider participation in its PIP mandatory, when appropriate.

**Standard 6: Data Collection Procedure**

**Table C-20: Validation of PIP Data Collection Procedures**

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>The study design clearly specifies the data to be collected.</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>6.2</td>
<td>The study design clearly specifies the sources of data.</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>6.3</td>
<td>The study design specifies a systematic method of collecting valid and reliable data that represents the entire population to which the study’s indicators apply.</td>
<td>Partially Met (pass)</td>
</tr>
<tr>
<td>6.4</td>
<td>The instruments for data collection provide for consistent and accurate data collection over the time periods studied.</td>
<td>Partially Met (pass)</td>
</tr>
<tr>
<td>6.5</td>
<td>The study design prospectively specifies a data analysis plan.</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>6.6</td>
<td>Qualified staff and personnel were used to collect the data.</td>
<td>Fully Met (pass)</td>
</tr>
</tbody>
</table>
Reviewer Comments:
The study design specifies that the data is collected through chart reviews conducted by the GCBH quality manager. The quality manager goes to the provider agencies to review the charts and look for documentation of the two indicators. One is that there is documentation that the outpatient provider has integrated health information from the PRISM summary sheet into the enrollee’s treatment plan; the other is documentation that the provider involved the PCP in care. Each indicator is collected in a Yes/No format along with the client identification number on a tally sheet.

A chi-square calculation was performed to determine if there was a significant difference in protocol adherence with additional training and education for providers. Significance level chosen was $p \leq .05$.

The authorization staff is master’s-level clinicians. The staff are responsible for entering the enrollees’ names, ProviderOne numbers, dates of admission, dates of discharge and outpatient facility or other disposition onto an Excel spreadsheet. The GCBH quality manager is a PhD-licensed mental health counselor. The quality manager monitored the spreadsheet and conducted chart reviews to collect data following the intervention period.

Opportunities for Improvement:
It is not clearly detailed how the list of enrollees in the eligible study population is obtained. GCBH needs to fully explain what data sources are used and how the data is extracted to create the list of eligible enrollees.

GCBH should consider a data collection process for the indicators that is not solely based on the review of one individual. GCBH should consider a process in which the data collected can be verified to ensure correct clients, correct charts and correct details have been matched.

Standard 7: Data Analysis and Interpretation of Study Results

Table C-21: Validation of PIP Data Analysis and Interpretation

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>An analysis of the findings was performed according to the data analysis plan.</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>7.2</td>
<td>Numerical PIP results and findings were accurately and clearly presented.</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>7.3</td>
<td>The data analysis methodology was appropriate to the study question and data types.</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>7.4</td>
<td>The analysis identified initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity.</td>
<td>Partially Met (pass)</td>
</tr>
<tr>
<td>7.5</td>
<td>The analysis of study data included an interpretation of the extent to which the PIP was successful, as well as follow-up activities.</td>
<td>Partially Met (pass)</td>
</tr>
</tbody>
</table>
Reviewer Comments:
GCBH used chi-square calculations according to its data analysis plan. Once the final number of enrollees was determined for the first and second measurements, data were gathered for the indicators. The percent of records that included PRISM information increased 25% during the first measurement period and 62% at the second measurement period. The percentage of PCP involvement in the first measurement period was 18% and increased to 38% in the second measurement period. Chi-square calculations were then provided for the two study periods for the indicators. Chi-square calculation for the first indicator showed a significant difference in the inclusion of PRISM health information into enrollee records. Chi-square calculation for the second indicator showed no significant difference in PCP involvement.

Some threats to validity noted by GCBH included higher-than-anticipated rates of enrollees who chose not to enter outpatient services, as well as some enrollees who may not have wanted their health issues integrated into their treatment plans or PCP involvement. Additionally, staff turnover could have impacted outcomes, as well as overall provider commitment to the PIP.

One noted observation was that many of the enrollees who did not attend their first outpatient appointments were individuals with a history of substance use disorder (SUD) or were currently involved in substance use.

Opportunities for Improvement:
If GCBH chooses to continue with this PIP topic in the future, turning the focus toward SUD would be a way to keep the PIP relevant and current with the upcoming integration of mental health and substance use disorder treatment in 2016.

Standard 8: Appropriate Improvement Strategies

Table C-22: Validation of PIP Improvement Strategies

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1</td>
<td>A continuous cycle of measurement and performance analysis was conducted.</td>
<td>Fully Met (pass)</td>
</tr>
<tr>
<td>8.2</td>
<td>Reasonable interventions were undertaken to address causes/barriers identified through data analysis and QI processes.</td>
<td>Partially Met (pass)</td>
</tr>
<tr>
<td>8.3</td>
<td>The interventions are/were sufficient to be expected to improve processes or outcomes.</td>
<td>Partially Met (pass)</td>
</tr>
<tr>
<td>8.4</td>
<td>The interventions are/were culturally and linguistically appropriate.</td>
<td>Fully Met (pass)</td>
</tr>
</tbody>
</table>

Reviewer Comments:
GCBH detected some shortcomings in the study design after the end of the first measurement period. Many issues were related to intervention training. Definitions were not made clear and some were left to be interpreted by individual providers. The GCBH quality manager did not follow up with providers during the initial study period and was not aware that several providers were not participating. Providers were
retrained through mutual collaboration between GCBH and providers.

Members of the seriously mentally ill population are statistically less likely to seek out or share information with a PCP and are less likely to advocate for themselves. This PIP helps to target these issues. Providers with Spanish-speaking enrollees provide Spanish-speaking staff to work with those enrollees. Other language needs are addressed through translation services, when necessary.

**Opportunities for Improvement:**
If this PIP topic is continued, GCBH needs to carefully consider how it plans to move forward with threats to validity. Other noted threats include the requirements of WAC 388-877-0610: "Each agency licensed by the department to provide any behavioral health service is responsible for an individual’s initial assessment. The initial assessment must include and document the individual’s medical provider’s name or medical providers’ names; medical concerns; medications currently taken,” as well as the DBHR RSN contract requirements related to coordination of care, which state that the contractor must ensure that for enrollees who have a suspected or identified physical healthcare problem that appropriate referrals are made to a physical healthcare provider and the individualized service plan identifies medical concerns and plans to address them.

**Standard 9: Assess Whether Improvement Is “Real” Improvement**

**Table C-23: Validation of PIP Improvement Assessment**

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1</td>
<td>The same methodology as the baseline measurement was used when measurement was repeated.</td>
<td>★ Partially Met (pass)</td>
</tr>
<tr>
<td>9.2</td>
<td>There was documented, quantitative improvement in processes or outcomes of care.</td>
<td>★ Partially Met (pass)</td>
</tr>
<tr>
<td>9.3</td>
<td>The reported improvement in performance appears to be the result of the planned quality improvement intervention.</td>
<td>★ Partially Met (pass)</td>
</tr>
<tr>
<td>9.4</td>
<td>There is statistical evidence that any observed performance improvement is true improvement.</td>
<td>★ Partially Met (pass)</td>
</tr>
</tbody>
</table>

**Reviewer Comments:**
The same methodology was used at the first and second measurement; no baseline measurement was documented.

There was quantitative improvement noted in both indicators; however, there was not statistically significant change in the second indicator. GCBH reports that it cannot conclude that changes in direction or significance are the result of the study intervention.

GCBH noted that systemic changes have occurred among its providers to integrate health information and involve PCPs in treatment.
Opportunities for Improvement:
It is difficult to fully assess any causal relationship to improvement, as there are noted WAC and contractual requirements closely related to these outcomes. GCBH needs to evaluate whether it is feasible to continue this PIP in a way that can clearly determine if the use of a specific intervention impacts outcome data, particularly since there are such strong similarities between the WAC and contract requirements and the PIP outcomes. Additionally, without baseline data collected prior to the implementation of the intervention, it is not possible to truly assess if there is a causal relationship between the specific intervention and any change in outcomes.

Standard 10: The RSN Has Sustained the Documented Improvement

Table C-24: Validation of PIP Sustained Improvement

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1</td>
<td>Sustained improvement was demonstrated through repeated measurements over comparable time periods.</td>
<td>● Partially Met (pass)</td>
</tr>
</tbody>
</table>

Reviewer Comments:
There appeared to be quantitative improvement through repeated measurements over comparable periods of time. The second indicator lacked statistical significance, and there was no baseline measurement.

Opportunities for Improvement:
GCBH needs to decide if continuing this PIP is a viable option. If GCBH chooses not to retire this study topic, the PIP needs to be recrafted so that its results are clearly discernable from WAC and contract expectations.
Information Systems Capabilities Assessment (ISCA)

Qualis Health’s subcontractor, Healthy People, examined GCBH’s information systems and data processing and reporting procedures to determine the extent to which they supported the production of valid and reliable State performance measures and the capacity to manage care of RSN enrollees.

ISCA Methodology

The ISCA procedures were based on the CMS protocol for this activity, as adapted for the Washington RSNs with DBHR’s approval. For each ISCA review area, Healthy People used the information collected in the ISCA data collection tool, responses to interview questions, and results of the claims/encounter walkthroughs and security walkthroughs to rate the RSN’s performance for seven review areas. Rankings are based on the following: fully meeting, partially meeting or not meeting standards. Although not rated, the RSN’s meaningful use of EHR systems was also evaluated.

The ISCA review process consists of four phases:

**Phase 1: Standard information about RSN’s information systems is collected.** The RSN and two of its delegated provider agencies complete the ISCA data collection tool before the onsite review.

**Phase 2: The completed ISCA data collection tools and accompanying documents are reviewed.** Submitted ISCA tools are thoroughly reviewed. Wherever an answer seems incomplete or indicates an inadequate process, it is marked for follow-up. If the desktop review indicates that further accompanying documents are needed, those documents are requested.

**Phase 3: Onsite visits and walkthroughs with the RSN and two delegated provider agencies are conducted.** Claims/encounter walkthroughs and data center security walkthroughs are conducted. In-depth interviews with knowledgeable RSN staff and delegated provider agency staff are conducted. Additional documents are requested if needed, based upon interviews and walkthroughs completed at the RSN and at two delegated provider agencies.

**Phase 4: Analysis of the findings from the RSN’s information system onsite review commences.** In this phase, the material and findings from the first three phases are reviewed and in cooperation with the RSN and selected delegate provider agencies to close out any open review questions. The RSN-specific ISCA evaluation report is then finalized.

The following sections discuss the specific criteria for assessing compliance for each of the eight ISCA review areas.

**Section A: Information Systems**

This section assesses the RSN’s information systems for collecting, storing, analyzing and reporting medical data by member, practitioner and vendor. Information systems that facilitate valid and reliable performance measurement have the following characteristics:

- flexible data structures
• no degradation of processing with increased data volume
• adequate programming staff
• reasonable processing and coding time
• ease of interoperability with other database systems
• data security via user authentication and permission levels
• data locking capability
• proactive response to changes in encounter and enrollment criteria
• adherence to the Federally required format for electronic submission of claims/encounter data

To ensure accurate and complete performance measure calculation, appropriate practices in computer programming should include
• good documentation
• clear, continuous communication between the client and the programmers on client information needs
• a quality assurance process version control
• continuous professional development of programming staff

Section B: Hardware Systems

This section assesses the RSN’s hardware systems and network infrastructure. Appropriate protocol for sustaining quality hardware systems include
• infrastructural support that includes maintenance and timely replacement of computer equipment and software, disaster recovery procedures, adequate training of support staff and a secure computing environment
• redundancy or duplication of critical components of a hardware system with the intention of increasing reliability of the system, usually in the case of a backup or fail-safe

Section C: Information Security

This section assesses the security of the RSN’s information systems. Appropriate practices for securing data include
• Maintaining a well-run security management program that includes IT governance, risk assessment, policy development, and policy dissemination and monitoring. Each of these activities should flow into the next to ensure that policies remain current and that important risks are addressed.
• Protecting computer systems and terminals from unauthorized access through use of a password system and security screens. Passwords should be changed frequently and reset whenever an employee terminates.
• Securing paper-based claims and encounters in locked storage facilities when not in use. Data transferred between systems/locations should be encrypted.
• Utilizing a comprehensive backup plan that includes scheduling, rotation, verification, retention and storage of backups to provide additional security in the event of a system crash or compromised integrity of the data. Managers responsible for processing claims and encounter data must be knowledgeable of their backup schedules and of retention of backups to ensure data integrity.
• Verifying integrity of backups periodically by performing a “restore” and comparing the results. Ideally, annual backups would be kept for seven years or more in an offsite climate-controlled facility.
• Ensuring databases and database updates include transaction management, commits and rollbacks. Transaction management is useful when making multiple changes in the database to ensure that all changes work without errors before finalizing the changes. A database commit is a command for committing a permanent change or update to the database. A rollback is a method for tracking changes before they have been physically committed to disk. This prevents corruption of the database during a sudden crash or some other unintentional intervention.
• Employing formal controls in the form of batch control sheets or assignment of a batch control number to ensure a full accounting of all claims received.

Section 11.2 of DBHR’s RSN contract presents requirements related to Business Continuity and Disaster Recovery (BC/DR). The contractor must certify annually that a BC/DR plan is in place for both the contractor and subcontractors. The certification must indicate that the plans are up to date and that the system and data backup and recovery procedures have been tested. The plan must address these criteria:
• a mission or scope statement
• an appointed IS disaster recovery staff
• provisions for backup of key personnel, identified emergency procedures and visibly listed emergency telephone numbers
• procedures for allowing effective communication with hardware and software vendors
• confirmation of updated system and operations documentation, as well as process for frequent backup of systems and data
• offsite storage of system and data backups, ability to recover data and systems from backup files, and designated recovery options that may include use of a hot or cold site
• evidence that disaster recovery tests or drills have been performed

Exhibit C of the RSN contract presents detailed requirements for data security, including
• data protection during electronic transport, including via email and the public Internet
• safeguarding access to data stored on hard media (hard disk drives, network server disks and optical discs), on paper or on portable devices or media, and access to data used interactively over the State Governmental Network
• segregation of DSHS data from non-DSHS data to ensure that all DSHS data can be identified for return or destruction, and to aid in determining whether DSHS data has or may have been compromised in the event of a security breach
• data disposition (return to DSHS or destruction) when the contracted work has been completed or when data is no longer needed
• notification of DSHS in the event of compromise or potential compromise of DSHS shared data
• sharing of DSHS data with subcontractors

Section D: Medical Services Data

This section assesses the RSN’s ability to capture and report accurate medical services data. To ensure the validity and timeliness of the encounter and claims data used in calculating performance measures, it is important to have documented standards, a formal quality assurance of input data sources and transactional systems, and readily available historical data.
Appropriate practices include

- Automated edit and validity checks of procedure and diagnosis code fields, timely filing, eligibility verification, authorization, referral management and a process to remove duplicate claims and encounters.
- A documented formal procedure for rectifying encounter data submitted with one or more required fields missing, incomplete or invalid; ideally, the data processor would not alter the data until receiving written notification via a paper claim or from the provider.
- Periodic audits of randomly selected records conducted internally and externally by an outside vendor to ensure data integrity and validity. Audits are critical after major system upgrades or code changes.
- Multiple diagnosis codes and procedure codes for each encounter record, distinguishing clearly between primary and secondary diagnoses.
- Efficient data transfer (frequent batch processing) to minimize processing lags that can affect data completeness.

Section E: Enrollment Data

This section assesses the RSN’s ability to capture and report accurate Medicaid enrollment data. Timely and accurate eligibility data are paramount in providing high-quality care and for monitoring services reported in utilization reports.

Appropriate enrollment data management practices include

- Access to up-to-date eligibility data should be easy and fast. Enrollment data should be updated daily or in real time.
- The enrollment system should be capable of tracking an enrollee’s entire history with the RSN, further enhancing the accuracy of the data.

Section F: Practitioner Data

This section assesses the RSN’s ability to capture and report accurate practitioner information. RSNs need to ensure accuracy in capturing rendering practitioner type as well as practitioner service location. RSNs also need to be able to uniquely identify each of their practitioners. RSNs must also present accurate practitioner information within the RSN provider directory.

Section G: Vendor Data

This section assesses the quality and completeness of the vendor data captured by the RSN. The majority of each RSN’s claims/encounter data is contracted provider agency data. RSNs must perform encounter data validation audits at least annually for each of their contracted provider agencies. RSNs must also evaluate the timeliness of the claims/encounter data submitted to their agency by their vendors.

Section H: Meaningful Use of Electronic Health Records (EHR)
This section assesses how the RSN and its contracted providers use electronic health records (EHRs). This section is not rated. This review section evaluates the following:

- any planning and/or development efforts the RSN has taken toward adopting and using a certified EHR system
- number of providers in the RSN network currently using EHRs
- whether any EHR technology in use by the RSN has been verified as certified by the appropriate Federal body
- any training, education or outreach the RSN has delivered to network providers on the meaningful use of certified EHR technology
- whether the RSN uses data from EHRs as part of its quality improvement program (i.e., to improve the quality of services delivered or to develop PIPs)
- strategies or policies the RSN has developed to encourage the adoption of EHR by providers

**Scoring Criteria**

For each ISCA review area, the information collected in the ISCA data collection tool, responses to interview questions and results of the claims/encounter walkthroughs, as well as security walkthroughs were used to rate the RSN’s performance. The rating was applied to the review areas specified in this chapter below and ranked as fully meeting, partially meeting or not meeting standards. The RSN’s meaningful use of Electronic Health Records (EHR) systems was reviewed but is not rated. The table below presents the scoring key for the ISCA standards.

<table>
<thead>
<tr>
<th>Scoring Icon Key</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>🟢 Fully Met (pass)</td>
<td></td>
</tr>
<tr>
<td>🟡 Partially Met (pass)</td>
<td></td>
</tr>
<tr>
<td>🔴 Not Met (fail)</td>
<td></td>
</tr>
<tr>
<td>⚫ N/A (not applicable)</td>
<td></td>
</tr>
</tbody>
</table>

**Summary of Results**

Healthy People examined GCBH’s information systems and data processing and reporting procedures to determine the extent to which they supported the production of valid and reliable State performance measures and the capacity to manage care of RSN enrollees.

GCBH *fully met* the Federal standards related to information systems capabilities. Table D-2 presents GCBH’s ratings for the eight separate ISCA review areas.

<table>
<thead>
<tr>
<th>ISCA Section</th>
<th>Description</th>
<th>ISCA Result</th>
</tr>
</thead>
</table>

Table D-2: ISCA Scores by Section
During the review year (January–December 2014), GCBH used a Microsoft SQL database management system to process encounter data. The RSN’s contracted provider agencies used various practice management systems to collect, process and submit encounter data to GCBH.

The detailed GCBH ISCA review findings for each of the eight ISCA review areas will be presented in the following sections of this report.

**ISCA Section A: Information Systems**

**Table D-3: Information Systems**

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Information Systems</td>
<td>This section assesses the RSN’s information systems for collecting, storing, analyzing and reporting medical, member, practitioner and vendor data.</td>
<td>✅ Fully Met (pass)</td>
</tr>
<tr>
<td>B. Hardware Systems</td>
<td>This section assesses the RSN’s hardware systems and network infrastructure.</td>
<td>✅ Fully Met (pass)</td>
</tr>
<tr>
<td>C. Information Security</td>
<td>This section assesses the security of the RSN’s information systems.</td>
<td>✅ Fully Met (pass)</td>
</tr>
<tr>
<td>D. Medical Services Data</td>
<td>This section assesses the RSN’s ability to capture and report accurate medical services data.</td>
<td>✅ Fully Met (pass)</td>
</tr>
<tr>
<td>E. Enrollment Data</td>
<td>This section assesses the RSN’s ability to capture and report accurate Medicaid enrollment data.</td>
<td>✅ Fully Met (pass)</td>
</tr>
<tr>
<td>F. Practitioner Data</td>
<td>This section assesses the RSN’s ability to capture and report accurate practitioner information.</td>
<td>✅ Fully Met (pass)</td>
</tr>
<tr>
<td>G. Vendor Data</td>
<td>This section assesses the quality and completeness of the vendor data captured by the RSN.</td>
<td>✅ Fully Met (pass)</td>
</tr>
<tr>
<td>H. Meaningful Use of EHR</td>
<td>This section assesses how the RSN and its contracted providers use electronic health records (EHRs). This section is not scored.</td>
<td>❌ N/A</td>
</tr>
</tbody>
</table>
During the review year (January–December 2014), GCBH used a Microsoft SQL database management system to process encounter data. The RSN’s contracted provider agencies used various practice management systems to collect, process and submit encounter data.

Provider agencies submit data to GCBH via GCBH’s provider portal. Native files and 837 files are uploaded by the provider agencies to the provider portal. GCBH’s auto importer imports the uploaded files into a raw records table on an SQL Server. The auto processor launches stored procedures on the SQL server, which validates the unprocessed records and either accepts or rejects each encounter. Potential duplicate encounters are then analyzed and merged as appropriate. Provider agencies receive a batch error detail report for each submitted encounter batch. The provider agencies also receive a monthly encounter data error rate report, which lists all errors by category.

GCBH has a database maintenance specialist trained to process the data stored in MS SQL via a Microsoft Access tool. The GCBH Information Services (IS) manager is also available to process information.

GCBH’s authorization center processes all provider agency authorization requests. GCBH does not link authorization data to encounters. However, beginning in 2015, GCBH will, during both encounter data validation audits and clinical audits of the contracted provider agencies, generate a summary report validating the authorization status of all individuals selected within the audit sets.

Meets Criteria

ISCA Section B: Hardware Systems

Table D-4: Hardware Systems

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section B</td>
<td>This section assesses the RSN’s hardware systems and network infrastructure.</td>
<td>Fully Met (pass)</td>
</tr>
</tbody>
</table>

Since June 2015, GCBH has operated Dell servers using MS Windows Server 2012 R2 standard operating systems. The servers have a ProSupport hardware service warranty. Backup Exec is used to back up the data. GCBH’s provider portal is HIPAA compliant. GCBH has separate production, test and development environments.

Meets Criteria

ISCA Section C: Information Security

Table D-5: Information Security
Information Systems Capabilities Assessment

### Section C

This section assesses the security of the RSN’s information systems.

- **Result**: Fully Met (pass)

GCBH has multiple policies and procedures related to information security. All policies and procedures are fully compliant. A list of the policies and procedures are provided below:

- IS705: Business Continuity/Disaster Recovery Plan
- IS702: Network Security
- PS606: Computer and Information Security
- PS619: Sanctions
- PS624: Privacy and Security
- IS703: Establishing or Removing GCBH Data Dictionary Elements
- IS706: Data Importing Procedure
- IS707: Data Integrity Procedure
- IS709: Data Exporting Procedure
- PS601: Designated Record Set
- PS602: Administrative Requirements for Implementation of HIPAA
- PS603: Administrative Requirements—Documentation Retention
- PS623: HIPAA Definitions
- PS608: Workstation and Portable Computer Procedure
- PS609: Remote Access Procedure
- PS610: Password Protection Procedure
- PS626: Removal of PHI from Office
- PS611: Consumer Protected Health Information Rights
- PS612: Confidentiality, Use and Disclosure of PHI
- PS615: HIPAA Compliant
- PS618: HIPAA Officer Responsibilities
- PS620: HIPAA Training
- PS621: Staff Training for Privacy and Security
- PS622: Virus Protection
- PS623: HIPAA Definitions 05.13.14
- PS627: PHI Data Transmission Policy

GCBH performs sufficient data backups on an appropriate schedule. All backups are encrypted and are either stored onsite or offsite based upon the rotation schedule. Backup data is stored securely at GCBH’s office location as well as at a local commercial bank.

In the summer of 2014, GCBH completed a full restore of its web server, going back to a clean backup that was performed in early 2012. In the spring of 2015, GCBH implemented a new and complete server environment that mirrored all the current integrated services. This environment was created in parallel to the current system so that service disruptions would be minimized. GCBH was able to completely save, export (from old environment), import (to new environment) and restore full access and functionality for all data to all users in the new environment within four days. GCBH has also successfully performed several individual file and folder restores based on ad hoc user requests.
In 2014, GCBH Information Systems staff performed onsite audits at each of the RSN’s 11 contracted provider agencies. The audits evaluated compliance with HIPAA and GCBH Information Systems contractual requirements. The audits found that three contracted provider agencies were not encrypting their backup data, as required by DBHR and GCBH. GCBH worked with the three agencies, and all three provider agencies are now meeting DBHR data encryption requirements.

Meets Criteria

ISCA Section D: Medical Services Data

Table D-6: Medical Services Data

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section D</td>
<td>This section assesses the RSN’s ability to capture and report accurate medical services data.</td>
<td>Fully Met (pass)</td>
</tr>
</tbody>
</table>

GCBH’s formal procedures for reporting encounter data submitted with one or more required fields missing, incomplete or invalid are adhered to and well documented. During processing, encounter data submissions are run through an automated, rules-based edit system to screen the data, identify potential input errors and ensure compliance with the State’s Data Dictionary and Service Encounter Reporting Instructions (SERI). GCBH performs further edits and validity checks of procedure and diagnosis code fields, eligibility verification, service authorization and detection of duplicate encounter claims. Screened encounter data submissions are then converted into a HIPAA-compliant 837 format before being transmitted to DBHR. As required by DBHR, GCBH verifies and certifies batched encounter data for accuracy and completeness before transmitting the data.

GCBH uses SQL to store and provide reports for all service and encounter data. Microsoft Access is used to analyze data and to process reports; Microsoft Excel is also periodically used by staff to analyze data and prepare reports. GCBH Quality Management (QM) and IS staff use SQL to run reports and conduct analyses.

Per DBHR instructions, GCBH submits outpatient service data to DBHR via 837P transaction files and inpatient service data to DBHR via 837I transaction files. DBHR’s Service Encounter Reporting Instructions v.201411.2 indicates the following for reporting outpatient service diagnosis codes:

- For all intake evaluation modality encounters that are complete and a diagnosis has been determined, report that diagnosis.
- For all encounters that occur after an intake has been completed and authorized, use the approved/authorized diagnosis in the HI01-2 field in the 837P HIPAA transaction.
- DBHR will only use the HI01-2 field when looking at diagnosis. Other diagnosis codes do not need to be reported.

It is not best practice to only capture the intake evaluation diagnosis. However, it is not out of compliance with DBHR requirements to only capture the intake evaluation diagnosis.

Meets Criteria
ISCA Section E: Enrollment Data

Table D-7: Enrollment Data

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section E</td>
<td>This section assesses the RSN’s ability to capture and report accurate Medicaid enrollment data.</td>
<td>Fully Met (pass)</td>
</tr>
</tbody>
</table>

DBHR provides member enrollment data to GCBH. GCBH receives 834 and 820/821 enrollment data files from DBHR. Medicaid eligibility verification takes place at several points.

GCBH does not cross-check 834s to 837s before submitting 837s to remove services for members who weren’t Medicaid eligible at the time of the encounter, as this is not a State requirement. Instead, GCBH follows DBHR’s SERI v.201411.2, which specifies that all services that meet the following criteria should be reported to the State:

- State plan services provided to Medicaid-eligible individuals
- Non-covered/non-State plan services to Medicaid-eligible individuals (i.e., IMD facilities, State-only or Federal block grant).
- All services to non-Medicaid individuals who are funded in whole or part by the RSN.

Meets Criteria

ISCA Section F: Practitioner Data

Table D-8: Practitioner Data

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section F</td>
<td>This section assesses the RSN’s ability to capture and report accurate practitioner information.</td>
<td>Fully Met (pass)</td>
</tr>
</tbody>
</table>

GCBH claims/encounter reporting is accurate regarding both rendering practitioner type and practitioner service location. GCBH also has accurate practitioner information within the RSN provider directory. GCBH maintains up-to-date provider profile information in an accessible repository that enables the RSN’s member services staff to help Medicaid enrollees make informed decisions about access to providers that can meet their special care needs, such as non-English languages or clinical specialties.

GCBH’s subcontracted provider agencies deliver current practitioner rosters to GCBH on a periodic basis.

Meets Criteria
ISCA Section G: Vendor Data

Table D-9: Vendor Data

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section G</td>
<td>This section assesses the quality and completeness of the vendor data captured by the RSN.</td>
<td>Fully Met (pass)</td>
</tr>
</tbody>
</table>

GCBH’s claims/encounter data is contracted provider agency data; GCBH does not provide any direct client care. Ten of the 11 GCBH provider agencies met the acceptable standard of 95% match rate for encounter data validation. The provider agency that did not meet the 95% match rate standard evidenced problems with coding for language as English and for sexual orientation due to a new provider agency EHR system. GCBH issued a corrective action plan to the provider agency. The agency’s problems coding for language as English and for sexual orientation have already been successfully resolved.

Meets Criteria

ISCA Section H: Meaningful Use of Electronic Health Records (EHR)

Table D-10: Meaningful Use of EHR

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section H</td>
<td>This section assesses how the RSN and its contracted providers use electronic health records (EHRs). This section is not rated.</td>
<td>Not Rated</td>
</tr>
</tbody>
</table>

GCBH has developed policies and procedures for contracted provider agency EHR implementation, specifying the RSN’s role in EHR adoption, expectations during implementation, and plans for transition periods when data may not be available. GCBH has a process for testing with provider data systems during provider agency EHR implementation. GCBH is monitoring data for quality, completeness and accuracy throughout EHR implementation, including a post-implementation review. GCBH also provides technical assistance to each of its contracted agencies for EHR implementation.

Meets Criteria
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Encounter Data Validation (EDV)

Encounter data validation (EDV) is a process used to validate encounter data submitted by Regional Support Networks (RSNs) to Washington State (the State). Encounter data are electronic records of the services provided to Medicaid enrollees by providers under contract with an RSN. Encounter data are used by RSNs and the State to assess and improve the quality of care and to monitor program integrity. Additionally, the State uses encounter data to determine capitation rates paid to the RSNs.

Prior to performing the data validation for encounters, Qualis Health reviewed the State’s standards for collecting, processing and submitting encounter data to develop an understanding of State encounter data processes and standards. Documentation reviewed included

- Service Encounter Reporting Instructions (SERI) in effect for the date range of encounters reviewed
- The Consumer Information System (CIS) Data Dictionary for RSNs
- Health Care Authority Encounter Data Reporting Guide for Managed Care Organizations, Qualified Health Home Lead Entities, Regional Support Networks
- Prior year’s EQR report(s) on validating encounter data

After reviewing the State’s data processes and standards, Qualis Health reviewed the RSN’s capacity to produce accurate and complete encounter data, including a review of the most recent Information System Capabilities Assessment (ISCA) performed by an external quality review organization (EQRO).

Following the standards review and ISCA, Qualis Health performed three additional activities supporting a complete encounter data validation. First, Qualis Health performed a validation of encounter data received by the State from the RSNs. Second, Qualis Health conducted a review of the procedures and results of each RSN’s internal EDV required under each RSN’s contract with the State. Finally, Qualis Health conducted an independent validation of State encounter data matched against provider-level clinical record documentation to confirm the findings of the RSN’s internal EDV.

State-level Encounter Data Validation

Qualis Health analyzed encounter data submitted by the RSNs to the State to determine the general magnitude of missing encounter data, types of potentially missing encounter data, overall data quality issues and any issues with the processes the RSNs have in compiling encounter data and submitting the data files to the State. Specific tasks included

- A review of standard edit checks performed by the State on encounter data received by the RSNs and how Washington’s Medicaid Management Information System (MMIS) treats data that fail an edit check

Encounter Data Validation
• A basic integrity check on the encounter data files to determine whether expected data exist, whether the encounter data fit with expectations and whether the data are of sufficient quality to proceed with more complex analysis

• Application of consistency checks, including verification that critical fields contain values in the correct format and that the values are consistent across fields

• Inspection of data fields for general validity

• Analyzing and interpreting data on submitted fields, the volume and consistency of encounter data and utilization rates, in aggregate and by time dimensions, including service date and encounter processing data, provider type, service type and diagnostic codes

Validating RSN EDV Procedures

Qualis Health performed independent validation of the procedures used by the RSNs to perform encounter data validation. The EDV requirements included in the RSNs’ contract with Division of Behavioral Health and Recovery (DBHR) were the standards for validation.

Qualis Health obtained and reviewed each RSN’s encounter data validation report submitted to DBHR as a contract deliverable for calendar year 2014. The RSN’s encounter data validation methodology, encounter and enrollee sample size(s), selected encounter dates and fields selected for validation were reviewed for conformance with DBHR contract requirements. The RSN’s encounter and/or enrollee sampling procedures were reviewed to ensure conformance with accepted statistical methods for random selection.

Each RSN submitted a copy of the data system (spreadsheet, database or other application) used to conduct encounter data validation, along with any supporting documentation, policies, procedures or user guides, to Qualis Health for review. Qualis Health’s analytics staff then evaluated the data system to determine whether its functionality was adequate for the intended program.

Additionally, each RSN submitted documentation of its data analysis methods from which summary statistics of the encounter data validation results were drawn. The data analysis methods were then reviewed by Qualis Health analytics staff to determine validity.

Clinical Record Reviews

Qualis Health performed clinical record reviews onsite at provider agencies that had contracts with the RSNs. The process included the following:

• Selecting a statistically valid sample of encounters from the file provided by the State

• Loading data from the encounter sample into a custom database to record the scores for each encounter data field

• Providing the RSN with a list of the enrollees whose clinical charts were selected for review for coordination with contracted provider agencies pursuant to the onsite review
Qualis Health staff reviewed encounter documentation included in the clinical record to validate data submitted to the State and to confirm the findings of the analysis of State-level data.

Upon completion of the clinical record reviews, Qualis Health calculated error rates for each encounter field. The error rates were then compared to error rates reported by the RSN to DBHR for encounters for which dates of service fell within the same time period.

**Scoring Criteria**

**Table E-1: Scoring Scheme for Encounter Data Validation Standards**

<table>
<thead>
<tr>
<th>Scoring Icon Key</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Fully Met (pass)</td>
</tr>
<tr>
<td>○ Partially Met (pass)</td>
</tr>
<tr>
<td>● Not Met (fail)</td>
</tr>
<tr>
<td>● N/A (not applicable)</td>
</tr>
</tbody>
</table>

**GCBH RSN Encounter Data Validation**

Greater Columbia Behavioral Health (GCBH) contracts with 15 providers for Medicaid-funded services. The EDV process for GCBH covered the period of encounters occurring between January 1, 2013–December 31, 2013. The GCBH EDV was based on a sample encompassing 1,276 encounters and 222 consumer charts.

**Table E-2: Scores and Ratings on GCBH’s Encounter Data Validation**

<table>
<thead>
<tr>
<th>EDV Standard</th>
<th>Description</th>
<th>EDV Result</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sampling Procedure</strong></td>
<td>Sampling was conducted using an appropriate random selection process and was of adequate size.</td>
<td>Select the score: ● Fully Met (pass)</td>
</tr>
<tr>
<td><strong>Review Tools</strong></td>
<td>Review and analysis tools are appropriate for the task and used correctly.</td>
<td>● Fully Met (pass)</td>
</tr>
<tr>
<td><strong>Methodology and Analytic Procedures</strong></td>
<td>The analytical and scoring methodologies are sound and all encounter data elements requiring review are examined.</td>
<td>● Not Met (fail)</td>
</tr>
</tbody>
</table>

**Opportunities for Improvement**

GCBH should use the recommended October through September period for defining the encounter sample frame.

The RSN should also provide a more thorough description of the EDV, including the dates during which it occurred, the number and credentials of reviewers, steps taken to ensure inter-rater reliability, a table
Encounter Data Validation
detailing the sample frame and number sampled for each community mental health agency (CMHA),
and the percentages of matches for each data element.
Qualis Health recommends GCBH compare the data in enrollee charts with data processed by
ProviderOne. Doing so can help the RSN ensure that its encounter data are received and processed as
expected, enabling the RSN to address any data errors in a timely manner.
The RSN should not limit the selection of enrollees to individuals that have had three or more
encounters. In doing so, the RSN fails to validate enrollees who have only had a request for service.

Sampling Procedure

Qualis Health reviewed the sampling procedure and overall sample size to evaluate Greater Columbia
Behavioral Health’s adherence to the contractually required sampling methodology.

GCBH reviewed 15 providers using Medicaid-funded encounters occurring within the period from January
1, 2013, to December 31, 2013. No reason was given for why the sample frame period differed from the
recommended October to September period. The date of the EDV was not given, although the RSN’s
EDV report was dated December 2014. An overall sample size of 1,276 encounters was selected,
exceeding the contract minimum of 822 encounters. The encounters were drawn from 222 client charts,
exceeding the contract minimum of 200 unique client charts.

The data source for the sample was an extract from the RSN’s encounter database. Qualis Health
recommends that all RSNs use data received by the State, after loading it into ProviderOne, to ensure
that encounter data are received and processed as expected and any errors can be promptly detected
and corrected.

The sample frame consisted only of clients with three or more encounters. It is unclear why clients with
two or fewer encounters were excluded. A stratified sample of clients was drawn based on the proportion
of clients served by each provider and the age distribution for each provider, using the counts of unique
recipients during the six months prior to the sample frame period. The chart sample and, in turn, the
encounter sample, were both drawn using a Microsoft Access-based audit tool loaded with a pre-
programmed sampling script (an example of the sample selection SQL queries were attached to the
RSN’s EDV report).

Given the resulting mix of encounters selected across the agency and age group strata, GCBH’s
sampling procedure appears to have been adequate for providing an unbiased and representative
sample, with the exception of setting the minimum of three encounters for defining the sample frame.

Review Tools

Reviews were conducted at the agencies in onsite reviews. GCBH used an Access database tool to
collect results for each reviewed encounter and chart. The audit tool was designed to enable the reviewer
to mark any data element for a given encounter record that did not match information noted in the clinical
record. The tool prompts the reviewer through a series of screens and provides fields in which to record
results. The tool also allows the user to create notes related to specific findings.

Methodology and Analytic Procedures
The reviewer(s) conducting the EDV used a laptop into which encrypted files containing an Access-based audit tool had been loaded. Prior to each review, the quality manager imported records related to the selected encounters into the audit tool. All data generated during the reviews were loaded into an Excel-based tool for analysis. All counts from which scores were calculated were generated from the raw data using formulas or the Excel Pivot Table function. These formulas/tables were included in the Excel file.

The DBHR contract calls for the following minimum set of encounter data fields to be validated:

- Date of service
- Name of service provider
- Procedure code
- Minutes of service
- Service location
- Provider type
- Service code agrees with treatment described

GCBH did not review the date of service. It was not clear how many reviewers participated in the work or what steps they took to assess or promote inter-rater reliability.

Validation results for GCBH’s EDV indicated that the overall match rate (99.4%) was above the contracted limit of 95%.

GCBH’s descriptions of the review tool and methodology were nominally sufficient for assessing the accuracy and completeness of the RSN’s EDV data; however, the Date of Service encounter data element was not reviewed, so the requirements for the analytical procedures cannot be considered as being met. The RSN could improve its description by providing the time period during which the review occurred, the number and credentials of the reviewers, the RSN’s strategy for ensuring inter-rater reliability, a table detailing the sample frame and numbers sampled for each CMHA, and a more user-friendly presentation of results, including match rates for each required data element (in addition to the overall match rate, which was included).

Qualis Health Encounter Data Validation

Results are presented here for each of the EDV activities performed, including electronic data checks of demographic and encounter data provided by DBHR, onsite reviews comparing electronic data to data included in the clinical record, and a comparison of Qualis Health’s EDV findings to the internal findings reported by the RSN to DBHR for the same encounter date range.

Table E-3: Scores and Ratings on Qualis Health Encounter Data Validation

<table>
<thead>
<tr>
<th>EDV Standard</th>
<th>Description</th>
<th>EDV Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Data Checks</td>
<td>Full review of encounter data submitted to the state indicates no (or minimal) logic problems or out-of-range values.</td>
<td>✅ Fully Met (pass)</td>
</tr>
<tr>
<td>Onsite Clinical Record</td>
<td>State encounter data are substantiated in audit of patient charts at individual provider</td>
<td>⚫ Not Met (fail)</td>
</tr>
</tbody>
</table>
Encounter data did not meet the 95% standard for compliance.

- To ensure encounter data are substantiated and in compliance, the RSN needs to
  - Provide training on the Service Encounter Reporting Instructions (SERI): on coding, on what is included and excluded in each modality, and on the general encounter reporting instructions
  - Provide training on what services can be encountered and what services cannot
  - Provide training on who can provide services that are encountered
  - Provide training on medical necessity to ensure that services provided and encountered are medically necessary and cannot be provided by some other means
  - Provide training on standards of documentation
  - Monitor encounters more closely to ensure that the encounters submitted are accurate and well documented

### Electronic Data Checks

Qualis Health analysts reviewed all demographic details and encounters for GCBH from ProviderOne for the October 2013 through September 2014 reporting period, comprising 20,663 patients and 358,765 encounters. Fields for each encounter were checked for completeness and to determine if the values were within expected ranges. Results of the electronic data checks are provided in Table E-4.

While nearly all demographic fields passed logic and consistency checks, Qualis Health observed the following results:

- All language data was present, but 12.3% was coded as unknown, which is high.
- All sexual orientation data was present, but 55.1% of the values were “Unknown, patient refused.”

GCBH’s demographic and encounter data error rates were minimal. Other than Social Security Number (an optional field), all fields were 100% accurate when checked for logical consistency and completeness.

### Table E-4: Results of Qualis Health’s Encounter Data Validation

<table>
<thead>
<tr>
<th>Measure</th>
<th>State Standard</th>
<th>RSN Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographic Data</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RSN ID</td>
<td>100% complete, all values in range</td>
<td>100%</td>
</tr>
<tr>
<td>Consumer ID</td>
<td>100% complete</td>
<td>100%</td>
</tr>
<tr>
<td>First Name</td>
<td>100% complete</td>
<td>100%</td>
</tr>
<tr>
<td>Last Name</td>
<td>100% complete</td>
<td>100%</td>
</tr>
</tbody>
</table>
### Clinical Record Review

Qualis Health reviewed 481 encounters submitted by Greater Columbia Behavioral Health to ProviderOne with a service date between October 1, 2013, and September 30, 2014, as well as demographic records associated with the 137 individuals whose encounters were included in the sample. Reviewers compared data from database extracts provided by DBHR to data included in the clinical records. Qualis Health reviewed encounter data fields required for review in the RSN contract with DBHR, including:

- Date of service
- Name of service provider
- Procedure code
- Service units/duration
- Service location
- Provider type
- Verification that the service code agrees with the treatment described in the encounter documentation

Qualis Health reviewed all demographic fields delineated in the CIS Consumer Demographics native transaction as described in the most current CIS Data Dictionary, including:

- First name
- Last name
- Gender
- Date of birth
- Ethnicity/Race
- Hispanic origin
- Preferred language
Site Visit Results

Results of the comparison of demographic data included in the clinical record to demographic data extracted from the DBHR CIS system are shown in Table E-5.

Results of the comparison of encounter data included in the clinical record to encounter data extracted from the ProviderOne database are shown in Table E-6.

The highest rates of mismatch were seen for procedure code and clinical note. Qualis Health reviewers found several issues contributing to the no-match rate. Some of the observed discrepancies are

- Discovery of activities entered as encounters that do not qualify as encounters
- Lack of clinical documentation for services
- Location not matching for almost all encounters

The comparison of the encounter field match rates from the Qualis Health review to the match rates from the GCBH internal EDV is shown in Table E-8. For several fields, the Qualis Health review was substantially below GCBH’s result. The exceptions were for the encounter fields described above. Variance in the results may be partially explained by the following:

- A difference in Qualis Health and GCBH encounter review. Qualis Health encounter review not only included whether the encounter data points matched, but also whether the encounter met the SERI or Washington Administrative Code (WAC) requirements and whether the encounter was a service that could be encountered.
- A lack of training and knowledge of encounter review elements, encounter submissions and documentation standards.
- The different sample sets reviewed. Qualis Health did not review the same sample encounters as GCBH.

Table E-5: Demographic Data Validation

<table>
<thead>
<tr>
<th>Field</th>
<th>Match</th>
<th>No Match – Erroneous</th>
<th>No Match – Missing</th>
<th>No Match – Unsubstantiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>94.89%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>5.11%</td>
</tr>
<tr>
<td>First Name</td>
<td>94.89%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>5.11%</td>
</tr>
<tr>
<td>Gender</td>
<td>91.97%</td>
<td>1.46%</td>
<td>0.00%</td>
<td>6.57%</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>90.51%</td>
<td>1.46%</td>
<td>0.73%</td>
<td>7.30%</td>
</tr>
<tr>
<td>Ethnicity/Race</td>
<td>75.91%</td>
<td>12.41%</td>
<td>1.46%</td>
<td>10.22%</td>
</tr>
<tr>
<td>Hispanic Origin</td>
<td>42.34%</td>
<td>35.04%</td>
<td>0.73%</td>
<td>21.90%</td>
</tr>
<tr>
<td>Preferred Language</td>
<td>68.61%</td>
<td>26.28%</td>
<td>0.00%</td>
<td>5.11%</td>
</tr>
<tr>
<td>Social Security Number</td>
<td>34.31%</td>
<td>0.73%</td>
<td>36.50%</td>
<td>28.47%</td>
</tr>
</tbody>
</table>
Sexual Orientation | 67.15% | 16.79% | 1.46% | 14.60%

Table E-6: Encounter Data Validation

<table>
<thead>
<tr>
<th>Field</th>
<th>Match</th>
<th>No Match – Erroneous</th>
<th>No Match – Missing</th>
<th>No Match – Unsubstantiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure Code</td>
<td>48.86%</td>
<td>42.83%</td>
<td>0.00%</td>
<td>8.32%</td>
</tr>
<tr>
<td>Date of Service</td>
<td>87.53%</td>
<td>8.32%</td>
<td>0.00%</td>
<td>4.16%</td>
</tr>
<tr>
<td>Service Location</td>
<td>1.25%</td>
<td>88.77%</td>
<td>0.00%</td>
<td>9.98%</td>
</tr>
<tr>
<td>Service Duration</td>
<td>75.05%</td>
<td>19.33%</td>
<td>0.00%</td>
<td>5.61%</td>
</tr>
<tr>
<td>Provider Agency</td>
<td>87.73%</td>
<td>7.90%</td>
<td>0.00%</td>
<td>4.37%</td>
</tr>
<tr>
<td>Provider Type</td>
<td>73.39%</td>
<td>21.41%</td>
<td>0.00%</td>
<td>5.20%</td>
</tr>
</tbody>
</table>

Table E-7: Comparison of Qualis Health and RSN Demographic Data Validation Results

<table>
<thead>
<tr>
<th>Field</th>
<th>Qualis Health Match</th>
<th>RSN Match</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>94.89%</td>
<td>--</td>
<td>N/A</td>
</tr>
<tr>
<td>First Name</td>
<td>94.89%</td>
<td>--</td>
<td>N/A</td>
</tr>
<tr>
<td>Gender</td>
<td>91.97%</td>
<td>100.00%</td>
<td>-8.03%</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>90.51%</td>
<td>100.00%</td>
<td>-9.49%</td>
</tr>
<tr>
<td>Ethnicity/Race</td>
<td>75.91%</td>
<td>100.00%</td>
<td>-24.09%</td>
</tr>
<tr>
<td>Hispanic Origin</td>
<td>42.34%</td>
<td>99.92%</td>
<td>-57.59%</td>
</tr>
<tr>
<td>Preferred Language</td>
<td>68.61%</td>
<td>--</td>
<td>N/A</td>
</tr>
<tr>
<td>Social Security Number</td>
<td>34.31%</td>
<td>--</td>
<td>N/A</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>67.15%</td>
<td>99.69%</td>
<td>-32.53%</td>
</tr>
</tbody>
</table>

Table E-8: Comparison of Qualis Health and RSN Encounter Data Validation Results

<table>
<thead>
<tr>
<th>Field</th>
<th>Qualis Health Match</th>
<th>RSN Match</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure Code</td>
<td>48.86%</td>
<td>99.76%</td>
<td>-50.91%</td>
</tr>
<tr>
<td>Date of Service</td>
<td>87.53%</td>
<td>--</td>
<td>N/A</td>
</tr>
<tr>
<td>Service Location</td>
<td>1.25%</td>
<td>96.63%</td>
<td>-95.38%</td>
</tr>
<tr>
<td>Service Duration</td>
<td>75.05%</td>
<td>97.73%</td>
<td>-22.68%</td>
</tr>
<tr>
<td>Provider Agency</td>
<td>87.73%</td>
<td>99.76%</td>
<td>-12.03%</td>
</tr>
<tr>
<td>Provider Type</td>
<td>73.39%</td>
<td>99.76%</td>
<td>-26.38%</td>
</tr>
</tbody>
</table>

Discussion

For several encounter fields, Qualis Health found a substantial level of disagreement between encounter data extracted from ProviderOne and data included in the clinical record. These discrepancies between the clinical records of providers and encounter data in ProviderOne are substantially higher than what
GCBH found through its internal EDV reviews. Discrepancies for the difference in GCBH’s internal review and Qualis Health’s review could have multiple factors contributing. One factor is the different sample sets reviewed. Qualis Health did not review the same encounters as GCBH. Another factor that potentially could have contributed to the variance is the process by which GCBH conducts the encounter review compared to that of Qualis Health. Within Qualis Health’s review, data elements may have matched the encounter while elements of the encounter did not follow the State’s SERI or WAC requirements, contained documentation that did not match the code that was submitted, or did not reflect a service that should have been submitted. Examples include the following:

- Submitting encounters to the State as location 11–office, while progress notes and other documentation reflect 53–community mental health agency, 12–home, 3–school and 99–all others
- Submitting encounters for internal consultation with the prescriber
- Submitting E&M codes with multiple units
- Encountering E&M by time without documentation containing evidence that counseling and coordination took greater than 50% of the encounter duration
- Submitting E&M with psychotherapy add-on although psychotherapy was not significant and separately identifiable
- Submitting family therapy without documentation supporting family therapy
- Submitting codes that have been discontinued since July 2013—H0001 and H0002
- Providing services when client did not meet access to care
- Submitting psychotherapy when documentation supports medication management
- Submitting requests for service with provider type 8 regardless of the credentials of who was providing the service
- Submitting requests for service with clinical staff provider type when the staff person was part of administrative staff
- Documenting requests for service without required encounter elements such as location, provider type, duration and procedure code
- Shredding requests for service documentation after 12 months if the individual did not show up for an intake assessment
- Submitting encounters for nonencounterable services such as playing games, leaving a message, transportation, going to the park, going to the library, rescheduling or scheduling an appointment, scheduling a meeting, shopping at the mall, email, texting, paperwork and refilling prescriptions
- Submitting psychotherapy when documentation supports that the client is receiving occupational therapy at the same time
- Submitting medical encounters without all required encounter elements such as location and procedure code
- Submitting a per diem for phone calls under 10 minutes as the only service provided for the day
- Submitting a per diem code prior to the intake
- Coding a medical intake as a non-medical intake
- Non-licensed MHP’s submitting intakes using 90791 instead of H0031
- Encountering rehabilitation case management when the client is not in a 24/7 facility
- Intake being submitted by an MHP but signed by a bachelor’s-level clinician
- Submitting an intake for watching a collaborative problem-solving video
- Submitting encounters that are incorrectly bundled
- Encountering nursing assessments at the same time as an E&M encounter
• Submitting outpatient codes when the client was in a 24/7 facility
• Submitting an encounter when the client no showed or cancelled.

Recommendation Requiring CAP
Encounter data did not meet the 95% standard for compliance.
• To ensure encounter data are substantiated and in compliance, the RSN needs to
  o Provide training on the Service Encounter Reporting Instructions (SERI): on coding, on what is included and excluded in each modality and on the general encounter reporting instructions
  o Provide training on what services can be encountered and what services cannot
  o Provide training on who can provide services that are encountered
  o Provide training on medical necessity to ensure that services provided and encountered are medically necessary and cannot be provided by some other means
  o Provide training on standards of documentation
  o Monitor encounters more closely to ensure that the encounters submitted are accurate and well documented
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### Appendix A: Previous-Year Findings and Recommendations

<table>
<thead>
<tr>
<th>CFR</th>
<th>Prior-Year Findings, Recommendations, Opportunities</th>
<th>RSN Activity Since the Prior Year</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollee rights&lt;br&gt;General rule—§438.100(a)</td>
<td>GCBH needs to continue to work with its provider agencies to recruit enough practitioners to ensure timely access to care and services.</td>
<td>The RSN is still working to resolve this issue.</td>
<td>Recommendation stands</td>
</tr>
<tr>
<td>Enrollee rights&lt;br&gt;General rule—§438.100(a)</td>
<td>To ensure that information in the enrollee handbook is current, GCBH should consider changing its existing policy to require the handbook to be reviewed at least every two years and updated as needed.</td>
<td>The RSN indicated it hasn’t updated its existing policy but it will review the handbook to make changes when it signs the BHO contract.</td>
<td>Recommendation stands</td>
</tr>
<tr>
<td>Information requirements—§438.100(b); §438.10(b)–(d)</td>
<td>Although the contracted provider agencies submit interpreter service logs listing the languages that are requested by enrollees, GCBH’s own customer service log does not record this information. To make certain the RSN is aware of all languages requested for interpreter services; GCBH needs to record the requested languages in its own customer service logs.</td>
<td>The RSN is working to implement recording the requested languages in its own customer service logs.</td>
<td>Recommendation stands</td>
</tr>
<tr>
<td>Information requirements—§438.100(b); §438.10(b)–(d)</td>
<td>Although GCBH has a large Spanish-speaking enrollee population, many of GCBH’s provider agencies do not have Spanish-speaking receptionists available to handle enrollees’ calls. GCBH needs to monitor the contracted agencies’ abilities to adequately handle all calls and ensure that all callers are treated with respect and dignity.</td>
<td>The RSN reported there has been an increase in bilingual staff at its contracted agencies.</td>
<td>Resolved</td>
</tr>
<tr>
<td>Handling of grievances and appeals—§438.406(a)–(b)</td>
<td>Although GCBH’s customer service representative stated that other RSN staff would be available to process grievances and appeals in her absence, the RSN has no written policy to address how the RSN will handle grievances and appeals in that circumstance. GCBH should consider developing a policy and procedure on how the RSN will handle grievances and appeals in the absence of the customer service representative.</td>
<td>The RSN still needs to create a policy and procedure on how the RSN will handle grievances and appeals in the absence of the customer service representative.</td>
<td>Recommendation stands</td>
</tr>
<tr>
<td>Health information systems—§438.242(a)–(b)</td>
<td>GCBH should begin planning for a system with more granular access control and monitoring capabilities.</td>
<td>GCBH provided no update on the status of this recommendation.</td>
<td>Recommendation stands</td>
</tr>
<tr>
<td>Health information systems—§438.242(a)–(b)</td>
<td>GCBH should formally define its process for updating provider directories, including steps for adding providers, approval of credentialing, and updates to the CIS to identify that providers are authorized to serve enrollees.</td>
<td>GCBH provided no update on the status of this recommendation.</td>
<td>Recommendation stands</td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Children’s PIP §438.240(d)</strong></td>
<td>GCBH needs to conduct the appropriate statistical tests, report and interpret the results, and report the results of its tracking of trends and gaps revealed by the questionnaires, inpatient providers’ compliance with authorization center facilitation, and outpatient providers’ compliance with the discharge plan. The RSN reported that statistical analysis and interpretation was conducted for its first re-measurement period. GCBH has collected over 500 questionnaires but has not followed through on the recommendation to analyze the data to review gaps and trends, or adherence to discharge planning. <strong>Partially resolved; recommendation stands to revise or retire the PIP</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nonclinical PIP §438.240(d)</strong></td>
<td>GCBH needs to address gaps in documentation of the study indicator, population and data analysis plan. In particular, GCBH needs to refine the study indicator definitions further to make the indicators specific, measurable and consistent, and clarify the measurement periods in the data analysis plan. After collecting first measurement and first re-measurement data for both indicators, GCBH needs to report the results according to the data analysis plan and conduct the appropriate statistical tests. GCBH clarified its study indicator definitions. GCBH also reported on its statistical analysis of the data collected for the first measurement and first re-measurement periods. GCBH did not refine the measurement periods in the data analysis plan. <strong>Partially resolved; recommendation stands to clarify the measurement periods in the data analysis plan and/or retire this PIP</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EDV</strong></td>
<td>While GCBH uses an adequate procedure for choosing an EDV sample, the sample size is too small to meet DBHR contract requirements. GCBH’s record review procedure is partially adequate for assessing accuracy and completeness of the EDV data. The RSN review in 2015 had an adequate sample size. <strong>Resolved</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDV</td>
<td>GCBH’s EDV procedure compares data expected to be sent to the State against the data in enrollee charts. The RSN is encouraged to compare the chart data with data processed by ProviderOne. Doing so can help the RSN ensure that its encounter data are received and processed as expected, and will enable the RSN to address any data errors in a timely manner.</td>
<td>The RSN didn’t address the recommendation to use ProviderOne data.</td>
<td>Recommendation stands</td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>EDV</td>
<td>GCBH’s review and the previous EQRO’s review was generally close, except in comparing procedure code, service location and service duration, where discrepancies ranged between 22.6% and 34.2%. Some discrepancies may be due to the difference in comparison data, as the previous EQRO compared data in the charts with data processed by ProviderOne, whereas the RSN compared the chart data with data submitted by the RSN.</td>
<td>The review year 2015 EDV report indicates that the review was not generally close in comparing procedure codes, service location and service duration.</td>
<td>Recommendation stands</td>
</tr>
<tr>
<td>WISe</td>
<td>Documentation of the CFT meetings was sparse, with only about half of the charts documenting agreement and progress toward goals, and none indicating that minutes were provided to the team within a week. Among team members identified in the cross-system care plan, meeting attendance ranged from 77% by the family/youth partner to less than 50% by allied providers.</td>
<td>In progress.</td>
<td>Recommendation stands</td>
</tr>
<tr>
<td>Standards</td>
<td>Description</td>
<td>Status</td>
<td>Resolution</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td>--------</td>
<td>------------</td>
</tr>
<tr>
<td><strong>WISe</strong></td>
<td>As GCBH progresses in implementing the Wraparound with Intensive Services (WISe) program, it will be necessary to provide ongoing training on the details of the WISe manual and CFT coding to ensure that providers meet all requirements. GCBH will need to facilitate ongoing coordination of care between its mental health providers and the agency selected to implement Wraparound CFT services.</td>
<td>In progress.</td>
<td>Recommendation stands</td>
</tr>
<tr>
<td><strong>WISe</strong></td>
<td>The clinical records demonstrated that many of the young enrollees in high-intensity services were involved with other child-serving agencies, including those in DSHS, schools and the juvenile justice system. GCBH will need to continue to work with these allied agencies to include youth voice and presence in CFT meetings.</td>
<td>In progress.</td>
<td>Recommendation stands</td>
</tr>
<tr>
<td><strong>ISCA</strong></td>
<td>GCBH needs to implement a formal, written QA process for encounter data processing, analysis and reporting. GCBH hired a new IT staff person in summer 2014 to help address this issue.</td>
<td></td>
<td>Resolved</td>
</tr>
<tr>
<td><strong>ISCA</strong></td>
<td>GCBH needs to develop a formal process for monitoring of outsourced IT services. GCBH needs to designate a backup administrator who could keep the customized database running if the current consultant became unavailable. GCBH is training the new IT staff person to back up the RSN's current IT consultant.</td>
<td></td>
<td>Resolved</td>
</tr>
<tr>
<td>ISCA</td>
<td>GCBH should consider implementing a formal version control process for its reporting and archiving process. GCBH stated that it has an informal process and would submit documentation, but did not submit it.</td>
<td>Resolved</td>
<td></td>
</tr>
<tr>
<td>ISCA</td>
<td>GCBH should consider using version control software to enable a more robust, quick and efficient process that is less prone to error. GCBH stated that it has an informal process and would submit documentation, but did not submit it.</td>
<td>Resolved</td>
<td></td>
</tr>
<tr>
<td>ISCA</td>
<td>GCBH needs to continue to align its BC/DR plan with current contractual requirements. GCBH reported that it had updated and tested its BC/DR plan in 2014. However, the current plan does not describe the testing process or results. GCBH should work to include more detail on testing and enough guidance for a skilled IT person to back up systems and recover data.</td>
<td>Resolved</td>
<td></td>
</tr>
<tr>
<td>ISCA</td>
<td>GCBH needs to establish annual testing of its BC/DR plan to meet DBHR contract requirements. GCBH reported that it had updated and tested its BC/DR plan in 2014. However, the current plan does not describe the testing process or results. GCBH should work to include more detail on testing and enough guidance for a skilled IT person to back up systems and recover data.</td>
<td>Resolved</td>
<td></td>
</tr>
<tr>
<td>ISCA</td>
<td>GCBH transports backup tapes containing protected health information to an offsite location in a private vehicle. Although the tapes are encrypted, this transportation method is not an industry best practice. GCBH reported that it began transporting backups in agency vehicles as of August 2014. The RSN needs to continue to monitor this practice and update its policies accordingly.</td>
<td>Resolved</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B: All Recommendations Requiring Corrective Action Plans (CAPs)

Compliance with Regulatory and Contractual Standards

Section 1: Availability of Services

N/A

Section 2: Coordination of Care

N/A

Section 3: Coverage and Authorization of Services

N/A

Section 4: Provider Selection

Recommendation Requiring CAP
GCBH has a policy and procedure in place that explains how the RSN and provider agencies will monitor for employees excluded from participating in Federal healthcare programs, but the policy does not include provisions for monitoring its members on the governing board. In reviewing the Office of the Inspector General (OIG) sample list at the RSN, it was revealed that the RSN is not monitoring, on a monthly basis, the governing board.

1. GCBH needs to include, in its policy on excluded providers, monitoring the members of the board of directors.

Section 5: Subcontractual Relationships and Delegation

N/A

Section 6: Practice Guidelines

N/A

Section 7: Quality Assessment and Performance Improvement Program

Recommendation Requiring CAP
During the external quality review, it was noted that the RSN staff roles and responsibilities for the quality improvement program are not clearly defined and do not clearly identify who should be present to contribute at the various committee meetings such as the Clinical Directors Committee, the Quality Management Oversight Committee, the Children’s Committee and the Management Information Systems Committee. This has impacted the quality management process and the development of integrated reports used to identify the needs of the enrollees.
2. GCBH needs to address the roles and responsibilities of its RSN staff related to the quality improvement program and clearly define and identify who should be present to contribute at the various committee meetings such as the Clinical Directors Committee, the Quality Management Oversight Committee, the Children’s Committee and the Management Information Systems Committee.

Recommendation Requiring CAP
Although GCBH’s provider agencies are required by GCBH’s policy to maintain a quality management (QM) process and procedure, the RSN does not have a process in place to monitor its provider agencies to determine if the providers are maintaining and following a QM process, including monitoring and tracking the quality and appropriateness of care furnished to its enrollees.

3. GCBH needs to develop a process to hold its provider network accountable for maintaining and following a QM process that includes monitoring and tracking the quality and appropriateness of care furnished to its enrollees.

Recommendation Requiring CAP
Many of GCBH’s policies and procedures have not been reviewed, revised and updated as necessary or approved for many years.

4. GCBH needs to implement a process to review, revise and update as necessary and approve its policies and procedures at least every two years.

Section 8: Health Information Systems

N/A

Performance Improvement Project (PIP) Validation

There were no Recommendations Requiring CAP for Performance Improvement Project (PIP) Validation.

Information Systems Capabilities Assessment (ISCA)

There were no Recommendations Requiring CAP for the Information Systems Capabilities Assessment (ISCA).

Encounter Data Validation (EDV)

Recommendation Requiring CAP
Encounter data did not meet the 95% standard for compliance.

5. To ensure encounter data are substantiated and in compliance, the RSN needs to:
   o Provide training on the Service Encounter Reporting Instructions (SERI): on coding, on what is included and excluded in each modality and on the general encounter reporting instructions
   o Provide training on what services can be encountered and what services cannot
   o Provide training on who can provide services that are encountered
- Provide training on medical necessity to ensure that services provided and encountered are medically necessary and cannot be provided by some other means
- Provide training on standards of documentation
- Monitor encounters more closely to ensure that the encounters submitted are accurate and well documented
## Appendix C: Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>BC/DR</td>
<td>Business Continuity and Disaster Recovery</td>
</tr>
<tr>
<td>CAP</td>
<td>Corrective Action Plan</td>
</tr>
<tr>
<td>CFR</td>
<td>Code of Federal Regulations</td>
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<tr>
<td>CIS</td>
<td>Consumer Information System</td>
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<tr>
<td>CMHA</td>
<td>Community Mental Health Agency</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<tr>
<td>CPT</td>
<td>Current Procedural Terminology</td>
</tr>
<tr>
<td>DBHR</td>
<td>Department of Social and Health Services, Division of Behavioral Health and Recovery</td>
</tr>
<tr>
<td>EDI</td>
<td>Electronic Data Interchange</td>
</tr>
<tr>
<td>EDV</td>
<td>Encounter Data Validation</td>
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<tr>
<td>EHR</td>
<td>Electronic Health Record</td>
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<tr>
<td>EQR</td>
<td>External Quality Review</td>
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<tr>
<td>EQRO</td>
<td>External Quality Review Organization</td>
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<tr>
<td>HCA</td>
<td>Health Care Authority</td>
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<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedural Coding System</td>
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<tr>
<td>HEDIS</td>
<td>Healthcare Effectiveness Data Information Set</td>
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<tr>
<td>HIPAA</td>
<td>Health Insurance Accountability and Portability Act</td>
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<tr>
<td>ISCA</td>
<td>Information System Capability Assessment</td>
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<tr>
<td>MCO</td>
<td>Managed Care Organization</td>
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<tr>
<td>MMIS</td>
<td>Medicaid Management Information System</td>
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<td>OIG</td>
<td>Office of the Inspector General</td>
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<tr>
<td>PAHP</td>
<td>Prepaid Ambulatory Health Plans</td>
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<tr>
<td>PCP</td>
<td>Primary Care Physician</td>
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<tr>
<td>PIHP</td>
<td>Prepaid Inpatient Health Plan</td>
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<tr>
<td>PIP</td>
<td>Performance Improvement Project</td>
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<tr>
<td>PRISM</td>
<td>Predictive Risk Intelligence System</td>
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<tr>
<td>QM</td>
<td>Quality Management</td>
</tr>
<tr>
<td>QAPI</td>
<td>Quality Assessment and Performance Improvement</td>
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<tr>
<td>QMOC</td>
<td>Quality Management Oversight Committee</td>
</tr>
<tr>
<td>QRT</td>
<td>Quality Review Team</td>
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<tr>
<td>RAB</td>
<td>Regional Advisory Board</td>
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<tr>
<td>RSN</td>
<td>Regional Support Network</td>
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<tr>
<td>SERI</td>
<td>Service Encounter Reporting Instructions</td>
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<tr>
<td>SUD</td>
<td>Substance Use Disorder</td>
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<tr>
<td>SWIFT</td>
<td>Stabilization and Wellness in Families Together</td>
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<tr>
<td>WAC</td>
<td>Washington Administrative Code</td>
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<tr>
<td>WISe</td>
<td>Wraparound with Intensive Services</td>
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</table>