Appendix A. RSN Profiles

The profiles in this appendix summarize each RSN's overall performance in measures of access, timeliness, and quality, and in meeting regulatory and contractual standards, including those for PIPs. Components of the access, timeliness, and quality measures were abstracted from individual EQR reports delivered to DBHR throughout the year.

RSN scores, strengths, and opportunities for improvement were based on Acumentra Health's compliance review of each RSN.

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Chelan-Douglas Regional Support Network (CDRSN)

Activity	
Regulatory and Contractual Standards	
The 2009 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2010, Acumentra Health reviewed CDRSN's response to the specific 2009 EQR findings for which DBHR required corrective action. The review found that CDRSN had complied fully with each of the three required corrective actions, in the areas of Provider Selection, Practice Guidelines, and QAPI Program.	
Performance Improvement Projects (PIPs)	
Strengths	**Opportunities for Improvement**
Clinical—Metabolic Syndrome Screening and Intervention: Partially Met (50 out of 80)	
After conducting a barrier analysis, CDRSN refocused its PIP on increasing the number of completed laboratory screenings for enrollees at risk for metabolic syndrome. CDRSN did a good job of documenting the technical aspects of Standards 1–5.	At the time of the PIP review, CDRSN had not completed baseline or remeasurement data collection. The RSN needs to explain how the study intervention is expected to improve the study indicator.
Nonclinical—Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization: Minimally Met (38 out of 80)	
CDRSN provided a complete rationale for the selection and prioritization of the study topic, and presented a solid study question and study indicator.	At the time of the PIP review, CDRSN had not implemented a specific intervention aimed at improving the study indicator. The RSN reported follow-up data for an unspecified period, indicating some improvement, but without linking the results to an intervention.
Information Systems Capabilities Assessment (ISCA)	
The 2009 ISCA resulted in two corrective actions and four recommendations for improvement in the areas of information systems, security, and provider data. By the time of the 2010 follow-up review, CDRSN had completed the two corrective actions and implemented two recommendations, and was in the process of implementing the two remaining recommendations.	
CDRSN, headquartered in East Wenatchee, contracts with providers to deliver managed mental health services to enrollees throughout Chelan and Douglas counties. The RSN's governing board, comprising six local elected officials, makes recommendations to the Douglas County Board of Commissioners, which acts as the legal authority. In calendar year 2009, CDRSN had about 25,100 enrollees in its service area.	
Data source: Chelan-Douglas RSN 2010 External Quality Review Report (Acumentra Health).	

Chelan-Douglas Regional Support Network (continued)

Activity			
Encounter Data Completeness and Accuracy (n=43,969)			
Completeness—Number of fields with data 100% complete			
Outpatient encounter data	9 out of 10 fields	Demographic data	8 out of 11 fields
Inpatient encounter data	5 out of 6 fields	Consumer periodic data	9 out of 12 fields
Accuracy—Percentage of chart data matching electronic data			
Procedure code (n=449)	67.7%	SSN* (n=103)	99.0%
Provider type (n=449)	90.9%	Hispanic origin (n=103)	92.2%
Minutes of service (n=449))	67.9%	Preferred language (n=103)	94.2%
Service location (n=449)	63.5%	Primary diagnosis (n=103)	97.1%
First name (n=103)	98.1%	GAF/CGAS score (n=103)	78.6%
Last name (n=103)	100.0%	Grade* (n=103)	80.6%
Date of birth* (n=103)	99.0%	Employment* (n=103)	94.2%
Gender* (n=103)	100.0%	Education* (n=103)	95.1%
Ethnicity (n=103)	91.3%	** Optional fields*	
Clinical Record Review (n=100)			
Least restrictive environment—Percentage of charts with crisis plans (n=70)			
Describe symptoms/events that precede a crisis	100.0%	Document safe place the enrollee prefers to go when in crisis	61.4%
List family, friends, etc. from whom the enrollee prefers to receive support during a crisis episode	87.1%	List a backup safe place the enrollee would prefer to go when in crisis	8.6%
List backup persons who may be able to provide support if primary support person is unable to respond	64.3%		
Least restrictive environment—Percentage of charts for enrollees with a crisis plan in place who had crisis service encounters			
Enrollee's crisis plan implemented (n=33)	15.2%	Least restrictive environments considered (n=6)	83.3%
Recovery and resiliency—Percentage of enrollees with needs and strengths assessed, by domain (n=103)			
	Needs		**Strengths**
Activities of daily living	65.0%		44.7%
Medical needs	88.4%		80.6%
Physical limitations	78.6%		40.8%
Transportation needs	7.8%		4.8%
Housing needs	92.2%		79.6%
Vocational needs	84.5%		63.1%
Financial needs	72.8%		54.4%
Social needs	97.1%		91.3%
Recovery and resiliency—Percentage of identified needs addressed in treatment plan, by domain			
Activities of daily living (n=65)	81.5%	Housing needs (n=28)	46.4%
Medical needs (n=25)	36.0%	Vocational needs (n=60)	46.7%
Physical limitations (n=11)	27.3%	Financial needs (n=24)	29.2%
Transportation needs (n=9)	44.4%	Social needs (n=84)	83.3%

Clark County Regional Support Network (CCRSN)

Activity	
Regulatory and Contractual Standards	
The 2009 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2010, Acumentra Health reviewed CCRSN's response to the specific 2009 EQR findings for which DBHR required corrective action. The review found that CCRSN had complied fully with all five of the required corrective actions, in the areas of Delivery Network, Coverage and Authorization of Services, and Provider Selection.	
Performance Improvement Projects (PIPs)	
Strengths	**Opportunities for Improvement**
Clinical—Employment Outcomes for Adult Consumers: Fully Met (87 out of 100)	
Remeasurement data in the second quarter showed that employment rose from 8.5 percent to a peak of 10 percent. Although the change was not statistically significant, CCRSN concluded it had achieved clinical improvement. CCRSN has done an excellent job of documenting sound study methodology, and a thorough barrier analysis has enabled the RSN to identify obstacles to improvement and to modify its interventions to address those obstacles.	CCRSN needs to elaborate on its conclusion that the PIP achieved clinical improvement in spite of statistically nonsignificant results. CCRSN should also document any plans to modify its intervention or other aspects of the PIP on the basis of barriers identified or lessons learned.
Nonclinical—Timeliness of Access to Outpatient Services: Fully Met (85 out of 100)	
After remeasurement data in 2009 showed that the percentage of enrollees offered timely intake actually fell after the network-wide notification and referral process was implemented, CCRSN identified barriers to improvement and revised its intervention strategy for 2010. CCRSN has improved its PIP documentation substantially since 2008, fully meeting the criteria for Standards 1–9 in 2010.	CCRSN needs to recalculate its baseline data and collect remeasurement data to determine the success of the 2010 intervention.
Information Systems Capabilities Assessment (ISCA)	
The 2009 ISCA resulted in two recommendations for improvement. At the time of the 2010 follow-up review, Netsmart Technologies, the county's application service provider, was in the process of addressing the recommendation regarding adoption of an IT control framework. CCRSN demonstrated that it has a process in place to address the other recommendation, regarding data reporting.	
CCRSN coordinates public mental health services in Clark County and has operated as a prepaid mental health plan since 1995, under governance of the Board of Clark County Commissioners. An appointed Mental Health Advisory Board, including consumer and family representatives, meets regularly and advises the commissioners on policy matters related to mental health issues. In CY 2009, CCRSN provided outpatient services to 6,203 of its 79,388 Medicaid enrollees (7.8%).	
Data source: Clark County RSN 2010 External Quality Review Report (Acumentra Health).	

Clark County Regional Support Network (continued)

Activity			
Encounter Data Completeness and Accuracy (n=161,025)			
Completeness—Number of fields with data 100% complete			
Outpatient encounter data	10 out of 10 fields	Demographic data	8 out of 11 fields
Inpatient encounter data	5 out of 6 fields	Consumer periodic data	9 out of 12 fields
Accuracy—Percentage of chart data matching electronic data			
Procedure code (n=336)	92.6%	SSN* (n=100)	90.0%
Provider type (n=336)	90.8%	Hispanic origin (n=100)	93.0%
Minutes of service (n=336)	93.8%	Preferred language (n=100)	99.0%
Service location (n=336)	81.3%	Primary diagnosis (n=100)	94.0%
First name (n=100)	100.0%	GAF/CGAS score (n=100)	60.0%
Last name (n=100)	100.0%	Grade* (n=100)	88.0%
Date of birth* (n=100)	100.0%	Employment* (n=100)	94.0%
Gender* (n=100)	100.0%	Education* (n=100)	98.0%
Ethnicity (n=100)	98.0%	** Optional fields*	
Clinical Record Review (n=105)			
Least restrictive environment—Percentage of charts with crisis plans (n=65)			
Describe symptoms/events that precede a crisis	95.4%	Document safe place the enrollee prefers to go when in crisis	41.5%
List family, friends, etc. from whom the enrollee prefers to receive support during a crisis episode	84.6%	List a backup safe place the enrollee would prefer to go when in crisis	9.2%
List backup persons who may be able to provide support if primary support person is unable to respond	63.1%		
Least restrictive environment—Percentage of charts for enrollees with a crisis plan in place who had crisis service encounters (n=11)			
Enrollee's crisis plan implemented	72.7%	Least restrictive environments considered	54.6%
Recovery and resiliency—Percentage of enrollees with needs and strengths assessed, by domain (n=105)			
	Needs	**Strengths**	
Activities of daily living	85.7%	36.2%	
Medical needs	81.9%	40.0%	
Physical limitations	71.5%	39.1%	
Transportation needs	78.1%	40.0%	
Housing needs	97.1%	64.8%	
Vocational needs	76.2%	46.7%	
Financial needs	54.3%	48.6%	
Social needs	95.2%	60.9%	
Recovery and resiliency—Percentage of identified needs addressed in treatment plan, by domain			
Activities of daily living (n=37)	27.0%	Housing needs (n=49)	69.4%
Medical needs (n=60)	66.7%	Vocational needs (n=81)	77.8%
Physical limitations (n=12)	16.7%	Financial needs (n=45)	64.4%
Transportation needs (n=30)	30.0%	Social needs (n=93)	79.6%

Grays Harbor Regional Support Network (GHRSN)

Activity	
Regulatory and Contractual Standards	
The 2009 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2010, Acumentra Health reviewed GHRSN's response to the specific 2009 EQR findings for which DBHR required corrective action. The review found that GHRSN had complied fully with eight of the nine required corrective actions, and the remaining corrective action was in progress.	
Performance Improvement Projects (PIPs)	
Strengths	**Opportunities for Improvement**
Clinical—Improving Treatment Outcomes for Adults Diagnosed with a New Episode of Major Depressive Disorder: Fully Met (76 out of 80)	
GHRSN found that nearly all enrollees were administered a questionnaire to measure depressive symptomatology at intake into treatment, but that administration dropped below 50 percent after six weeks. GHRSN noted a statistically significant reduction in symptomatology during the second measurement period and discussed factors that may have contributed to the success of the intervention, as well as confounding factors that could negate its clinical impact. GHRSN fully or substantially met the criteria for all eight standards.	Although the clinical PIP achieved statistical and clinical improvement during the second remeasurement period, GHRSN will need to control for a potential confounding factor in future iterations of the PIP.
Nonclinical—Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization: Fully Met (89 out of 100)	
GHRSN achieved a significant improvement at the first remeasurement, but performance declined during the second remeasurement period. GHRSN has done an excellent job of explaining the selection and prioritization of the study topic, designing the study question, and defining indicators to measure the success of the intervention.	GHRSN needs to document additional details regarding the study population, data collection, analysis procedures, and the intervention itself. The RSN identified several barriers that may have affected the overall study results, and plans to address those barriers in the next year of the PIP.
Information Systems Capabilities Assessment (ISCA)	
The 2009 ISCA resulted in three corrective actions and seven recommendations for improvement. At the time of the 2010 follow-up review, GHRSN had completed the three corrective actions, related to oversight of its contractor for hospital authorizations. The RSN was in the process of implementing three recommendations, leaving four recommendations unaddressed.	
GHRSN, headquartered in Aberdeen, authorizes all Medicaid-funded mental health services provided in Grays Harbor County. The RSN contracts with two regional providers—Seattle-based Sea Mar Community Health Center and Olympia-based Behavioral Health Resources (BHR)—to provide outpatient mental health services. BHR operates a crisis clinic in Hoquiam. During fiscal 2008, GHRSN served approximately 17,200 enrollees.	
Data source: Grays Harbor RSN 2010 External Quality Review Report (Acumentra Health).	

Grays Harbor Regional Support Network (continued)

Activity			
Encounter Data Completeness and Accuracy (n=31,215)			
Completeness—Number of fields with data 100% complete			
Outpatient encounter data	9 out of 10 fields	Demographic data	8 out of 11 fields
Inpatient encounter data	5 out of 6 fields	Consumer periodic data	9 out of 12 fields
Accuracy—Percentage of chart data matching electronic data			
Procedure code (n=427)	90.4%	SSN* (n=102)	97.1%
Provider type (n=427)	84.5%	Hispanic origin (n=102)	92.2%
Minutes of service (n=427)	93.4%	Preferred language (n=102)	99.0%
Service location (n=427)	84.5%	Primary diagnosis (n=102)	94.0%
First name (n=102)	100.0%	GAF/CGAS score (n=102)	80.4%
Last name (n=102)	100.0%	Grade* (n=102)	80.4%
Date of birth* (n=102)	100.0%	Employment* (n=102)	93.1%
Gender* (n=102)	98.0%	Education* (n=102)	93.1%
Ethnicity (n=102)	90.2%	** Optional fields*	
Clinical Record Review (n=102)			
Least restrictive environment—Percentage of charts with crisis plans (n=94)			
Describe symptoms/events that precede a crisis	100.0%	Document safe place the enrollee prefers to go when in crisis	90.4%
List family, friends, etc. from whom the enrollee prefers to receive support during a crisis episode	98.9%	List a backup safe place the enrollee would prefer to go when in crisis	68.1%
List backup persons who may be able to provide support if primary support person is unable to respond	79.8%		
Least restrictive environment—Percentage of charts for enrollees with a crisis plan in place who had crisis service encounters (n=29)			
Enrollee's crisis plan implemented	27.6%	Least restrictive environments considered	34.5%
Recovery and resiliency—Percentage of enrollees with needs and strengths assessed, by domain (n=102)			
	Needs	**Strengths**	
Activities of daily living	79.5%	41.2%	
Medical needs	90.2%	63.7%	
Physical limitations	83.3%	44.1%	
Transportation needs	75.5%	55.9%	
Housing needs	93.2%	78.4%	
Vocational needs	89.3%	51.0%	
Financial needs	85.3%	59.8%	
Social needs	95.1%	58.8%	
Recovery and resiliency—Percentage of identified needs addressed in treatment plan, by domain			
Activities of daily living (n=39)	51.3%	Housing needs (n=38)	44.7%
Medical needs (n=50)	38.0%	Vocational needs (n=55)	29.1%
Physical limitations (n=15)	13.3%	Financial needs (n=35)	22.9%
Transportation needs (n=24)	29.2%	Social needs (n=77)	87.0%

Greater Columbia Behavioral Health (GCBH)

Activity	
Regulatory and Contractual Standards	
The 2009 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2010, Acumentra Health reviewed GCBH's response to the specific 2009 EQR findings for which DBHR required corrective action. The review found that GCBH had complied fully with each of the nine required corrective actions, related to the Delivery Network, Provider Selection, and QAPI Program.	
Performance Improvement Projects (PIPs)	
Strengths	**Opportunities for Improvement**
Clinical—Impact of Implementing the PACT Model on the Use of Inpatient Treatment: Fully Met (76 out of 80)	
GCBH has thoroughly documented the steps leading to its first remeasurement, which showed encouraging results. The RSN fully met six of the individual standards and substantially met the other two standards.	GCBH needs to demonstrate more explicitly how its intervention was responsible for improving the study indicator, and describe any lessons learned at this stage. The RSN noted some concerns related to data availability and the PACT enrollment rate that may make it necessary to retire this PIP.
Nonclinical—Improving Early Engagement In Outpatient Services: Minimally Met (25 out of 80)	
GCBH provided state and local data to support the selection of its topic and its relevance to the local Medicaid population. The RSN developed the study indicator it will use to measure improvement and provided sufficient justification selecting it.	GCBH needs to define its study question more precisely and supply greater detail about the nature of the encounters measured, the composition of the study population, data collection and analysis methods, and the intervention(s) by which the RSN expects to improve early engagement in treatment.
Information Systems Capabilities Assessment (ISCA)	
The 2009 ISCA resulted in two corrective actions and nine recommendations for improvement in the areas of information systems, staffing, security, and administrative data. At the time of the 2010 follow-up review, GCBH had completed one corrective action and was working to complete the other action. The RSN had implemented four recommendations and was working to implement an additional four recommendations, leaving one recommendation unaddressed.	
GCBH, headquartered in Kennewick, is a 12-member government consortium providing public mental health services for 11 counties and the Yakama Nation in south central Washington. A citizen's advisory board advises the GCBH board of directors, reviews and provides comments and/or recommendations on plans and policies, and serves on workgroups and committees of GCBH. In calendar year 2009, GCBH had about 181,300 enrollees in its service area.	
Data source: Greater Columbia Behavioral Health 2010 External Quality Review Report (Acumentra Health).	

Greater Columbia Behavioral Health (continued)

Activity			
Encounter Data Completeness and Accuracy (n=293,322)			
Completeness—Number of fields with data 100% complete			
Outpatient encounter data	9 out of 10 fields	Demographic data	9 out of 11 fields
Inpatient encounter data	5 out of 6 fields	Consumer periodic data	10 out of 12 fields
Accuracy—Percentage of chart data matching electronic data			
Procedure code (n=474)	93.7%	SSN* (n=106)	97.2%
Provider type (n=474)	95.8%	Hispanic origin (n=106)	97.2%
Minutes of service (n=474)	95.8%	Preferred language (n=106)	93.4%
Service location (n=474)	90.1%	Primary diagnosis (n=106)	99.1%
First name (n=106)	100.0%	GAF/CGAS score (n=106)	91.5%
Last name (n=106)	100.0%	Grade* (n=106)	96.2%
Date of birth* (n=106)	91.5%	Employment* (n=106)	99.1%
Gender* (n=106)	100.0%	Education* (n=106)	96.2%
Ethnicity (n=106)	96.2%	** Optional fields*	
Clinical Record Review (n=104)			
Least restrictive environment—Charts with crisis plans (n=45)			
Describe symptoms/events that precede a crisis	62.2%	Document safe place the enrollee prefers to go when in crisis	24.4%
List family, friends, etc. from whom the enrollee prefers to receive support during a crisis episode	97.8%	List a backup safe place the enrollee would prefer to go when in crisis	0.0%
List backup persons who may be able to provide support if primary support person is unable to respond	80.0%		
Least restrictive environment—Percentage of charts for enrollees with a crisis plan in place who had crisis service encounters			
Enrollee's crisis plan implemented (n=24)	33.3%	Least restrictive environments considered (n=8)	100.0%
Recovery and resiliency- Number of charts of enrollees with needs and strengths assessed, by domain (n=104)			
	Needs	**Strengths**	
Activities of daily living	84.6%	69.2%	
Medical needs	96.1%	88.5%	
Physical limitations	67.3%	53.8%	
Transportation needs	45.2%	34.6%	
Housing needs	95.2%	93.3%	
Vocational needs	91.3%	80.8%	
Financial needs	76.9%	73.1%	
Social needs	95.2%	91.4%	
Recovery and resiliency—Percentage of identified needs addressed in treatment plan, by domain			
Activities of daily living (n=57)	86.0%	Housing needs (n=30)	33.3%
Medical needs (n=47)	29.8%	Vocational needs (n=60)	58.3%
Physical limitations (n=16)	50.0%	Financial needs (n=33)	39.4%
Transportation needs (n=14)	35.7%	Social needs (n=88)	80.7%

King County Regional Support Network (KCRSN)

Activity	
Regulatory and Contractual Standards	
The 2009 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2010, Acumentra Health reviewed KCRSN's response to the specific 2009 EQR findings for which DBHR required corrective action. The review found that KCRSN had complied fully with each of the two corrective actions required, related to ensuring timely access to care and services and ensuring that providers consistently screen their employees for exclusion from federal health care programs.	
Performance Improvement Projects (PIPs)	
Strengths	**Opportunities for Improvement**
Clinical—Metabolic Syndrome Screening and Intervention: Fully Met (78 out of 80)	
Although results indicate a drop in the ratio of enrollees receiving screening for metabolic syndrome over those who did not, the RSN thoroughly documented its PIP with only minor gaps in its documentation related to data verification. KCRSN fully met six of the eight individual standards.	KCRSN needs to address minor gaps in its documentation related to data verification.
Nonclinical—Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization: Substantially Met (59 out of 80)	
To improve the timeliness of follow-up, KCRSN formed a Cross-System Diversion Team to review discharge planning, identify needed resources, and ensure continuity of care between inpatient and outpatient services. KCRSN has done a good job of documenting the technical aspects of its nonclinical PIP and the intervention begun this year.	KCRSN needs to assemble and analyze its baseline and remeasurement data, test any changes for statistical significance, and determine whether the intervention succeeds in improving the timeliness of follow-up care.
Information Systems Capabilities Assessment (ISCA)	
The 2009 ISCA resulted in three recommendations for improvement, including a recommendation for King County. By the time of the 2010 follow-up review, KCRSN had implemented two recommendations regarding administrative data and provider data. The county had taken no action on the recommendation to adopt an IT control framework.	
KCRSN, managed by the county's Mental Health, Chemical Abuse and Dependency Services Division, provides services and supports for adults with chronic mental illness and for severely emotionally disturbed children living in the county. The RSN administers services provided by a certified vendor pool of community mental health centers. A citizen's advisory board provides policy direction, prioritizes and advocates for service needs, and oversees evaluation of services. In calendar year 2009, KCRSN averaged about 252,900 enrollees.	
Data source: King County RSN 2010 External Quality Review Report (Acumentra Health).	

King County Regional Support Network (continued)

Activity			
Encounter Data Reviewed (n=1,066,317)			
Completeness—Number of fields with data 100% complete			
Outpatient encounter data	10 out of 10 fields	Demographic data	8 out of 11 fields
Inpatient encounter data	5 out of 6 fields	Consumer periodic data	10 out of 12 fields
Accuracy—Percentage of chart data matching electronic data			
Procedure code (n=456)	87.3%	SSN* (n=106)	99.1%
Provider type (n=456)	79.0%	Hispanic origin (n=106)	96.2%
Minutes of service (n=456)	94.3%	Preferred language (n=106)	98.1%
Service location (n=456)	88.2%	Primary diagnosis (n=106)	97.2%
First name (n=106)	100.0%	GAF/CGAS score (n=106)	88.7%
Last name (n=106)	100.0%	Grade* (n=106)	93.4%
Date of birth* (n=106)	100.0%	Employment* (n=106)	98.1%
Gender* (n=106)	100.0%	Education* (n=106)	97.2%
Ethnicity (n=106)	95.3%	** Optional fields*	
Clinical Record Review (n=107)			
Least restrictive environment—Percentage of charts with crisis plans (n=75)			
Describe symptoms/events that precede a crisis	92.0%	Document safe place the enrollee prefers to go when in crisis	26.7%
List family, friends, etc. from whom the enrollee prefers to receive support during a crisis episode	33.3%	List a backup safe place the enrollee would prefer to go when in crisis	1.3%
List backup persons who may be able to provide support if primary support person is unable to respond	18.7%		
Least restrictive environment—Percentage of charts for enrollees with a crisis plan in place who had crisis service encounters			
Enrollee's crisis plan implemented (n=13)	15.4%	Least restrictive environments considered (n=2)	100.0%
Recovery and resiliency—Percentage of enrollees with needs and strengths assessed, by domain (n=107)			
	Needs	**Strengths**	
Activities of daily living	88.8%	70.1%	
Medical needs	86.9%	73.8%	
Physical limitations	85.0%	40.2%	
Transportation needs	45.8%	35.5%	
Housing needs	96.3%	81.3%	
Vocational needs	88.8%	71.0%	
Financial needs	55.1%	44.9%	
Social needs	96.3%	79.4%	
Recovery and resiliency—Percentage of identified needs addressed in treatment plan, by domain			
Activities of daily living (n=66)	86.4%	Housing needs (n=36)	80.6%
Medical needs (n=52)	71.2%	Vocational needs (n=81)	87.6%
Physical limitations (n=13)	23.1%	Financial needs (n=28)	75.0%
Transportation needs (n=22)	59.1%	Social needs (n=90)	95.6%

North Central Washington Regional Support Network (NCWRSN)

Activity	
Regulatory and Contractual Standards	
The 2009 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2010, Acumentra Health reviewed NCWRSN's response to the 2009 EQR findings for which DBHR required corrective action. The follow-up review found that NCWRSN had partially complied with the required corrective actions, and needed to follow through with certain corrective measures.	
Performance Improvement Projects (PIPs)	
Strengths	**Opportunities for Improvement**
Clinical—Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization: Not Met (21 out of 80)	
Baseline data showed NCWRSN performing well above the statewide average for the timeliness of follow-up appointments. NCWRSN documented a solid study question to provide a framework for the PIP.	NCWRSN did not address the 2009 EQRO recommendations, describe a specific intervention aimed at improving timeliness, or present a formal data analysis. The RSN did not demonstrate that this topic represents a quality issue for its Medicaid enrollees, in view of the reported baseline performance.
Nonclinical—Improved Access to Services: Intakes Provided Within 14 Days of a Service Request: Not Met (14 out of 80)	
According to state data, during 2008, 86 percent of NCWRSN's Medicaid enrollees were seen within 14 days of a service request.	It is not clear that timely access to routine care represents a significant quality issue in NCWRSN's service area. The RSN has not proposed a study question or described a specific intervention to address the topic.
Information Systems Capabilities Assessment (ISCA)	
The 2009 ISCA resulted in 4 corrective actions and 18 recommendations for improvement. As of the 2010 follow-up, NCWRSN had completed 3 of the 4 corrective actions and was working to complete the remaining action. The RSN had implemented 8 of the 18 recommendations and was working to implement an additional 6 recommendations, leaving 4 recommendations unaddressed.	
NCWRSN administers local mental health systems in Adams, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, and Stevens counties. NCWRSN's mission is to ensure that people of all ages with mental illness can better manage their illness, achieve their personal goals, and live, work, and participate in their community. During 2008, NCWRSN had approximately 62,600 enrollees in its service area.	
Data source: North Central Washington RSN 2010 External Quality Review Report (Acumentra Health).	

North Central Washington Regional Support Network (continued)

Activity			
Encounter Data Completeness and Accuracy (n=58,039)			
Completeness—Number of fields with data 100% complete			
Outpatient encounter data	10 out of 10 fields	Demographic data	9 out of 11 fields
Inpatient encounter data	5 out of 6 fields	Consumer periodic data	7 out of 12 fields
Accuracy—Percentage of chart data matching electronic data			
Procedure code (n=448)	96.4%	SSN* (n=104)	99.0%
Provider type (n=448)	85.9%	Hispanic origin (n=104)	86.5%
Minutes of service (n=448)	96.4%	Preferred language (n=104)	99.0%
Service location (n=448)	92.2%	Primary diagnosis (n=104)	91.4%
First name (n=104)	99.0%	GAF/CGAS score (n=104)	32.7%
Last name (n=104)	99.0%	Grade* (n=104)	56.7%
Date of birth* (n=104)	100.0%	Employment* (n=104)	84.6%
Gender* (n=104)	100.0%	Education* (n=104)	51.9%
Ethnicity (n=104)	74.0%	* *Optional fields*	
Clinical Record Review (n=104)			
Least restrictive environment—Percentage of charts with crisis plans (n=26)			
Describe symptoms/events that precede a crisis	100.0%	Document safe place the enrollee prefers to go when in crisis	46.1%
List family, friends, etc. from whom the enrollee prefers to receive support during a crisis episode	65.4%	List a backup safe place the enrollee would prefer to go when in crisis	23.1%
List backup persons who may be able to provide support if primary support person is unable to respond	38.5%		
Least restrictive environment—Percentage of charts for enrollees with a crisis plan in place who had crisis service encounters (n=12)			
Enrollee's crisis plan implemented	91.7%	Least restrictive environments considered	75.0%
Recovery and resiliency—Percentage of enrollees with needs and strengths assessed, by domain (n=104)			
	Needs	**Strengths**	
Activities of daily living	89.4%	62.5%	
Medical needs	94.2%	80.8%	
Physical limitations	65.4%	45,2%	
Transportation needs	84.6%	50.0%	
Housing needs	95.2%	80.8%	
Vocational needs	95.2%	81.7%	
Financial needs	94.2%	59.6%	
Social needs	99.0%	83.6%	
Recovery and resiliency—Percentage of identified needs addressed in treatment plan, by domain			
Activities of daily living (n=59)	78.0%	Housing needs (n=38)	60.5%
Medical needs (n=45)	48.9%	Vocational needs (n=59)	61.0%
Physical limitations (n=19)	26.3%	Financial needs (n=38)	44.7%
Transportation needs (n=21)	28.6%	Social needs (n=88)	89.8%

North Sound Mental Health Administration (NSMHA)

Activity	
Regulatory and Contractual Standards	
The 2009 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2010, Acumentra Health reviewed NSMHA's response to the specific 2009 EQR findings for which DBHR required corrective action. The review found that NSMHA had complied fully with each of the two required corrective actions, related to provider credentialing/ recredentialing and screening of employees for exclusion from participation in federal healthcare programs.	
Performance Improvement Projects (PIPs)	
Strengths	**Opportunities for Improvement**
Clinical— Decrease in the Days to First Prescriber Appointment After Request for Service: Substantially Met (62 out of 80)	
NSMHA's PIP documentation reflects a sound study design and close attention to technical details.	NSMHA needs to complete its intervention, collect remeasurement data, and report the results of the intervention, identifying any barriers to improvement and/or lessons learned.
Nonclinical—Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization: Fully Met (98 out of 100)	
NSMHA has done an excellent job of documenting the design and implementation of this PIP, including thorough barrier analysis conducted after each phase of the study. NSMHA's study methods and documentation establish high confidence in the validity and reliability of the PIP findings.	According to NSMHA's analysis, although the overall follow-up rate has improved from 50 to 55 percent, neither intervention was responsible for the observed improvement. A few minor gaps remain in the PIP documentation related to the identification of the study population and tracking of the intervention.
Information Systems Capabilities Assessment (ISCA)	
The 2009 ISCA resulted in 11 recommendations for improvement in the areas of information systems, hardware systems, security, administrative data, enrollment systems, and provider data. By the time of the 2010 follow-up review, NSMHA had implemented 4 recommendations and had begun implementing an additional recommendation, leaving 6 recommendations unaddressed.	
NSMHA, headquartered in Mount Vernon, serves public mental health enrollees in Island, San Juan, Skagit, Snohomish, and Whatcom counties. A nine-member board of directors drawn from each county's executive and legislative branches of government sets the RSN's policy direction, and a citizen advisory board provides independent advice to the board and feedback to local jurisdictions and service providers. During calendar 2009, NSMHA had about 173,000 enrollees in its service area.	
Data source: North Sound Mental Health Administration 2010 External Quality Review Report (Acumentra Health).	

North Sound Mental Health Administration (continued)

Activity			
Encounter Data Completeness and Accuracy (n=391,133)			
Completeness—Number of fields with data 100% complete			
Outpatient encounter data	10 out of 10 fields	Demographic data	9 out of 11 fields
Inpatient encounter data	5 out of 6 fields	Consumer periodic data	11 out of 12 fields
Accuracy—Percentage of chart data matching electronic data			
Procedure code (n=480)	95.0%	SSN* (n=109)	95.4%
Provider type (n=480)	94.0%	Hispanic origin (n=109)	89.9%
Minutes of service (n=480)	92.3%	Preferred language (n=109)	99.1%
Service location (n=480)	96.2%	Primary diagnosis (n=109)	94.5%
First name (n=109)	100.0%	GAF/CGAS score (n=109)	73.4%
Last name (n=109)	100.0%	Grade* (n=109)	78.0%
Date of birth* (n=109)	100.0%	Employment* (n=109)	89.0%
Gender* (n=109)	100.0%	Education* (n=109)	91.7%
Ethnicity (n=109)	91.7%	** Optional fields*	
Clinical Record Review (n=105)			
Least restrictive environment—Percentage of charts with crisis plans (n=38)			
Describe symptoms/events that precede a crisis	89.5%	Document safe place the enrollee prefers to go when in crisis	44.7%
List family, friends, etc. from whom the enrollee prefers to receive support during a crisis episode	84.2%	List a backup safe place the enrollee would prefer to go when in crisis	26.3%
List backup persons who may be able to provide support if primary support person is unable to respond	57.9%		
Least restrictive environment—Percentage of charts for enrollees with a crisis plan in place who had crisis service encounters			
Enrollee's crisis plan implemented (n=11)	9.1%	Least restrictive environments considered (n=1)	100.0%
Recovery and resiliency—Percentage of enrollees with needs and strengths assessed, by domain (n= 105)			
	Needs	**Strengths**	
Activities of daily living	98.1%	93.3%	
Medical needs	97.1%	95.2%	
Physical limitations	90.5%	86.7%	
Transportation needs	95.2%	91.4%	
Housing needs	99.1%	95.2%	
Vocational needs	98.1%	91.4%	
Financial needs	99.1%	96.2%	
Social needs	99.1%	96.2%	
Recovery and resiliency—Percentage of identified needs addressed in treatment plan, by domain			
Activities of daily living (n=39)	71.8%	Housing needs (n=32)	59.4%
Medical needs (n=44)	47.7%	Vocational needs (n=54)	61.1%
Physical limitations (n=12)	25.0%	Financial needs (n=32)	40.6%
Transportation needs (n=18)	33.3%	Social needs (n=83)	90.4%

OptumHealth Pierce Regional Support Network (OPRSN)

Activity	
Performance Improvement Projects (PIPs)	
Strengths	**Opportunities for Improvement**
Clinical—Consumer Partnership in Treatment Planning: Minimally Met (32 out of 80)	
OPRSN has done a good job of documenting the relevance and prioritization of its PIP topic, and of defining the study question and indicator.	OPRSN needs to document its data collection and verification procedures in greater detail; develop an analysis plan; and select an intervention strategy to improve the study indicators.
Nonclinical—Increasing Consumer Employment: Minimally Met (28 out of 80)	
OPRSN has done a good job of documenting the relevance and prioritization of its PIP topic, and of defining the study indicators.	This PIP currently focuses on improving data availability and quality, an administrative activity not directly related to enrollee outcomes. OPRSN must refocus the PIP on improving enrollee employment or on another topic related to enrollee outcomes.
Information Systems Capabilities Assessment (ISCA)	
Information Systems—Fully Met (2.8 out of 3)	
OPRSN effectively monitors the activities of NetSmart, the RSN's application service provider. NetSmart's product suite is secure, robust, and scalable, and staff members are highly trained.	Some providers use homegrown applications to transmit encounter data to their Avatar database. The providers' IT systems represent potential single points of failure for encounter data submission.
Staffing—Fully Met (2.6 out of 3)	
OPRSN and NetSmart provide effective training for staff engaged in data processing, maintenance, and programming.	The high turnover rate for OPRSN's care managers could lead to inconsistencies in implementing RSN policies and procedures.
Hardware Systems—Fully Met (2.8 out of 3)	
OPRSN's and NetSmart's data center facilities and hardware systems are well designed and maintained. The organizations maintain premium-level hardware and software.	At least one provider agency was not following its policy to replace server hardware every three years. Several providers' server rooms had insufficient heating and cooling systems in place.
Security—Fully Met (2.7 out of 3)	
OPRSN and NetSmart use many effective security procedures. For example, data tapes are backed up regularly and stored in secure offsite locations.	Server rooms at several provider agencies exhibited poor control of physical access. Several providers' server rooms had no access logs to indicate who entered and exited the room.
Administrative Data (Encounter data)—Fully Met (2.8 out of 3)	
Encounter data submitted electronically passes through a stringent screening process to verify data accuracy and validity. OPRSN performs regular audits of encounter claims.	OPRSN does not routinely audit completed authorizations. As a result, the RSN cannot ensure that authorization policies and procedures are being followed accurately.
Enrollment Systems (Medicaid eligibility)—Fully Met (3 out of 3)	
OPRSN frequently audits DBHR's eligibility enrollment files to ensure that they are free of anomalies. OPRSN provides timely determination of enrollee eligibility to provider agencies.	
Vendor Data Integrity—n.a.	
Provider Data (Compensation and profiles)—Fully Met (3 out of 3)	
OPRSN demonstrated that providers' encounter claims are processed accurately and within the state's required time frame. The RSN maintains up-to-date provider profile information.	
OptumHealth, a subsidiary of UnitedHealth Group, began operating the Pierce County RSN in 2009, headquartered in Tacoma. A Mental Health Advisory Board, approved by the seven-member Governing Board, meets monthly to review issues of concern and relevance to mental health consumers and their families. OPRSN has more than 5 million public-sector members nationwide, including about 144,500 in Pierce County at the end of 2009.	
Data source: OptumHealth Pierce RSN 2010 External Quality Review Report (Acumentra Health).	

OptumHealth Pierce Regional Support Network (continued)

Activity			
Encounter Data Completeness and Accuracy (n=179,371)			
Completeness—Number of fields with data 100% complete			
Outpatient encounter data	10 out of 10 fields	Demographic data	9 out of 11 fields
Inpatient encounter data	5 out of 6 fields	Consumer periodic data	9 out of 12 fields
Accuracy—Percentage of chart data matching electronic data			
Procedure code (n=478)	95.8%	SSN* (n=108)	98.2%
Provider type (n=478)	93.1%	Hispanic origin (n=108)	93.5%
Minutes of service (n=478	95.0%	Preferred language (n=108)	98.2%
Service location (n=478)	91.8%	Primary diagnosis (n=108)	94.4%
First name (n=108)	99.1%	GAF/CGAS score (n=108)	47.2%
Last name (n=108)	100.0%	Grade* (n=108)	51.8%
Date of birth* (n=108)	100.0%	Employment* (n=108)	46.3%
Gender* (n=108)	100.0%	Education* (n=108)	50.9%
Ethnicity (n=108)	88.9%	* *Optional fields*	
Clinical Record Review (n=108)			
Least restrictive environment—Percentage of charts with crisis plans (n=58)			
Describe symptoms/events that precede a crisis	93.1%	Document safe place the enrollee prefers to go when in crisis	46.6%
List family, friends, etc. from whom the enrollee prefers to receive support during a crisis episode	70.7%	List a backup safe place the enrollee would prefer to go when in crisis	10.3%
List backup persons who may be able to provide support if primary support person is unable to respond	37.9%		
Least restrictive environment—Charts for enrollees with a crisis plan in place who had crisis service encounters			
Enrollee's crisis plan implemented (n=12)	50.0%	Least restrictive environments considered (n=7)	85.7%
Recovery and resiliency—Number of charts reviewed with needs and strengths assessed, by domain (n=108)			
	Needs	**Strengths**	
Activities of daily living	91.7%	70.4%	
Medical needs	86.1%	77.8%	
Physical limitations	71.3%	59.3%	
Transportation needs	39.8%	33.3%	
Housing needs	88.0%	82.4%	
Vocational needs	84.3%	67.6%	
Financial needs	57.4%	51.8%	
Social needs	97.2%	93.5%	
Recovery and resiliency—Percentage of identified needs addressed in treatment plan, by domain			
Activities of daily living (n=69)	63.8%	Housing needs (n=35)	77.1%
Medical needs (n=35)	42.9%	Vocational needs (n=65)	49.2%
Physical limitations (n=14)	42.9%	Financial needs (n=24)	33.3%
Transportation needs (n=22)	36.4%	Social needs (n=98)	85.7%

Peninsula Regional Support Network (PRSN)

Activity	
Regulatory and Contractual Standards	
The 2009 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2010, Acumentra Health reviewed PRSN's response to the specific 2009 EQR findings for which DBHR required corrective action. The review found that PRSN had complied fully with the two required corrective actions, in the areas of timely access to services and credentialing of RSN staff.	
Performance Improvement Projects (PIPs)	
Strengths	**Opportunities for Improvement**
Clinical—Metabolic Syndrome Screening and Intervention: Fully Met (77 out of 80)	
PRSN has improved its documentation since the 2009 review, fully meeting six of the eight individual standards. The RSN identified and discussed many barriers to improvement, as well as confounding factors that compromised the RSN's ability to draw clear conclusions about the effectiveness of the intervention.	The PIP has progressed to remeasurement, but the study results are difficult to interpret because PRSN's providers appear to have applied the intervention protocol inconsistently. PRSN needs to discuss this inconsistency and how it may have influenced the study results.
Nonclinical—Improved Delivery of Non-Crisis Outpatient Appointments After a Psychiatric Hospitalization: Substantially Met (64 out of 80)	
PRSN has strengthened its documentation since the 2009 review, fully meeting Standards 1–6.	Because PRSN has yet to report remeasurement results for this PIP, no real progress is evident since the 2009 review.
Information Systems Capabilities Assessment (ISCA)	
The 2009 ISCA resulted in one corrective action and five recommendations for PRSN, Kitsap County, and Kitsap Mental Health Services (KMHS), the RSN's information services subcontractor. By the time of the 2010 follow-up review, KMHS had completed the corrective action and had implemented two recommendations. No action had been taken on the three remaining recommendations in the areas of information systems, security, and provider data.	
PRSN, headquartered in Port Orchard, is a consortium of the mental health programs of Clallam, Jefferson, and Kitsap counties, administered by Kitsap County. The RSN's executive board, comprising nine county commissioners, sets policy and has oversight responsibilities. In calendar year 2009, PRSN had about 53,300 enrollees in its service area.	
Data source: Peninsula RSN 2010 External Quality Review Report (Acumentra Health).	

Peninsula Regional Support Network (continued)

Activity			
Encounter Data Completeness and Accuracy (n=124,863)			
Completeness—Number of fields with data 100% complete			
Outpatient encounter data	10 out of 10 fields	Demographic data	9 out of 11 fields
Inpatient encounter data	5 out of 6 fields	Consumer periodic data	9 out of 12 fields
Accuracy—Percentage of chart data matching electronic data			
Procedure code (n=436)	97.2%	SSN* (n=101)	100.0%
Provider type (n=436)	92.4%	Hispanic origin (n=101)	91.1%
Minutes of service (n=436)	92.9%	Preferred language (n=101)	95.0%
Service location (n=436)	88.5%	Primary diagnosis (n=101)	98.0%
First name (n=101)	100.0%	GAF/CGAS score (n=101)	97.0%
Last name (n=101)	100.0%	Grade* (n=101)	91.1%
Date of birth* (n=101)	100.0%	Employment* (n=101)	96.0%
Gender* (n=101)	100.0%	Education* (n=101)	95.0%
Ethnicity (n=101)	95.0%	* *Optional fields*	
Clinical Record Review (n=91)			
Least restrictive environment—Percentage of charts with crisis plans (n=38)			
Describe symptoms/events that precede a crisis	79.0%	Document safe place the enrollee prefers to go when in crisis	50.0%
List family, friends, etc. from whom the enrollee prefers to receive support during a crisis episode	76.3%	List a backup safe place the enrollee would prefer to go when in crisis	10.5%
List backup persons who may be able to provide support if primary support person is unable to respond	57.9%		
Least restrictive environment—Percentage of charts for enrollees with a crisis plan in place who had crisis service encounters			
Enrollee's crisis plan implemented (n=21)	9.5%	Least restrictive environments considered (n=8)	25.0%
Recovery and resiliency—Percentage of enrollees with needs and strengths assessed, by domain (n=91)			
	Needs	**Strengths**	
Activities of daily living	66.0%	44.0%	
Medical needs	78.0%	58.2%	
Physical limitations	53.9%	29.7%	
Transportation needs	16.5%	11.0%	
Housing needs	84.6%	65.9%	
Vocational needs	79.2%	60.4%	
Financial needs	42.9%	31.9%	
Social needs	94.5%	74.7%	
Recovery and resiliency—Percentage of identified needs addressed in treatment plan, by domain			
Activities of daily living (n=49)	71.4%	Housing needs (n=36)	75.0%
Medical needs (n=57)	66.7%	Vocational needs (n=50)	62.0%
Physical limitations (n=16)	43.8%	Financial needs (n=25)	36.0%
Transportation needs (n=19)	36.8%	Social needs (n=81)	82.7%

Southwest Regional Support Network (SWRSN)

Activity	
Regulatory and Contractual Standards	
The 2009 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2010, Acumentra Health reviewed SWRSN's response to the specific 2009 EQR findings for which DBHR required corrective action. The review found that SWRSN had complied fully with all three corrective actions required, in the areas of Provider Selection and Coordination and Continuity of Care.	
Performance Improvement Projects (PIPs)	
Strengths	**Opportunities for Improvement**
Clinical—Using Assertive Community Treatment to Decrease Consumer Hospital Utilization: Substantially Met (67 out of 100)	
SWRSN has done a good job of defining the study question and planning an appropriate intervention to achieve the desired improvement. SWRSN concluded that the PIP had achieved statistical and clinical improvement.	The evidence to support that the PIP achieved improvement is weak, as SWRSN did not report on providers' fidelity in implementing the PACT model, nor on confounding factors that may have influenced the results. SWRSN needs to report on fidelity to the PACT model, and periodically review barriers and lessons learned to identify ways to improve the intervention or other aspects of the study.
Nonclinical—Increased Incident Reporting Compliance: Partially Met (49 out of 80)	
SWRSN has done a good job of defining the study question and planning an appropriate intervention to achieve the desired improvement. The RSN substantially met Standards 2–6.	The documentation lacks sufficient explanation regarding the selection and prioritization of the study topic, and specifically in explaining how the quality problem is linked to enrollee outcomes. When selecting a study topic, the RSN needs to consider the number of enrollees potentially affected by the project, the magnitude of the project's impact, and the importance placed on the topic by multiple stakeholders.
Information Systems Capabilities Assessment (ISCA)	
The 2009 ISCA resulted in 12 recommendations for improvement. At the time of the 2010 follow-up review, SWRSN had implemented 9 recommendations and was working to implement another, leaving 2 recommendations unaddressed.	
SWRSN, based in Longview, is a division of the Cowlitz County Human Services Department. The RSN seeks to manage the provision of a consumer-driven network of individualized mental health services to reduce stigma and promote recovery and resiliency. A citizen advisory board appointed by the county board of commissioners reviews and provides recommendations on policies and programs. In fiscal 2008, SWRSN had about 22,800 enrollees in its service area.	
Data source: Southwest RSN 2010 External Quality Review Report (Acumentra Health).	

Southwest Regional Support Network (continued)

Activity			
Encounter Data Completeness and Accuracy (n=78,940)			
Completeness—Number of fields with data 100% complete			
Outpatient encounter data	10 out of 10 fields	Demographic data	8 out of 11 fields
Inpatient encounter data	5 out of 6 fields	Consumer periodic data	8 out of 12 fields
Accuracy—Percentage of chart data matching electronic data			
Procedure code (n=425)	92.7%	SSN* (n=104)	98.1%
Provider type (n=425)	74.1%	Hispanic origin (n=104)	92.3%
Minutes of service (n=425)	91.8%	Preferred language (n=104)	95.2%
Service location (n=425)	94.1%	Primary diagnosis (n=104)	94.2%
First name (n=104)	99.0%	GAF/CGAS score (n=104)	73.1%
Last name (n=104)	99.0%	Grade* (n=104)	87.5%
Date of birth* (n=104)	99.0%	Employment* (n=104)	94.2%
Gender* (n=104)	100.0%	Education* (n=104)	96.2%
Ethnicity (n=104)	96.1%	* *Optional fields*	
Clinical Record Review (n= 104)			
Least restrictive environment—Percentage of charts with crisis plans (n=46)			
Describe symptoms/events that precede a crisis	87.0%	Document safe place the enrollee prefers to go when in crisis	39.1%
List family, friends, etc. from whom the enrollee prefers to receive support during a crisis episode	63.0%	List a backup safe place the enrollee would prefer to go when in crisis	10.9%
List backup persons who may be able to provide support if primary support person is unable to respond	37.0%		
Least restrictive environment—Percentage of charts for enrollees with a crisis plan in place who had crisis service encounters (n=17)			
Enrollee's crisis plan implemented	76.5%	Least restrictive environments considered	76.5%
Recovery and resiliency—Percentage of enrollees with needs and strengths assessed, by domain (n=101)			
	Needs	**Strengths**	
Activities of daily living	83.2%	43.6%	
Medical needs	96.0%	60.4%	
Physical limitations	87.1%	35.6%	
Transportation needs	74.3%	31.7%	
Housing needs	85.1%	63.4%	
Vocational needs	71.3%	45.5%	
Financial needs	59.4%	41.6%	
Social needs	90.1%	57.4%	
Recovery and resiliency—Percentage of identified needs addressed in treatment plan, by domain			
Activities of daily living (n=55)	63.6%	Housing needs (n=33)	63.6%
Medical needs (n=50)	58.3%	Vocational needs (n=70)	47.1%
Physical limitations (n=24)	20.8%	Financial needs (n=39)	20.5%
Transportation needs (n=28)	17.9%	Social needs (n=75)	69.3%

Spokane County Regional Support Network (SCRSN)

Activity	
Regulatory and Contractual Standards	
The 2009 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2010, Acumentra Health reviewed SCRSN's response to the specific 2009 EQR findings for which DBHR required corrective action. The follow-up review found that SCRSN had complied fully with the two required corrective actions, related to ensuring providers' adherence to the RSN's adopted practice guidelines and developing an ongoing quality management plan.	
Performance Improvement Projects (PIPs)	
Strengths	**Opportunities for Improvement**
Clinical—Implementing an Evidence-Based Practice in a Regional Support Network: Partially Met (41 out of 80)	
SCRSN substantially met Standards 2 and 6, indicating that the RSN documented a solid study question and description of its intervention strategy.	SCRSN failed to connect the study topic, clinical competency in Motivational Interviewing (MI), with enrollee outcomes, and to explain how training a small percentage of its clinicians in MI will increase enrollees' feelings of respect and their involvement in treatment. It is unclear whether this PIP actually focuses on improving such outcomes, as distinct from simply implementing an evidence-based practice in the RSN system. The PIP does not follow the necessary steps to measure improvement relative to an identified quality problem.
Nonclinical—Reduced Errors in Service Encounter Reporting Through Consistent Interpretation of Reporting Guidelines: Not Met (0 out of 80)	
The 2009 EQR report cautioned that the PIP topic was not valid because SCRSN had not established a link between improved service reporting and better enrollee outcomes, and because one of the service modalities in question is not a Medicaid-funded service. SCRSN submitted the same PIP for 2010, but did not sufficiently address the drawbacks outlined above. Per federal regulations and the CMS protocol, all PIPs must have the potential to improve enrollee health, functional status, or satisfaction. As a result, this PIP was scored as Not Met.	The 2009 EQR report cautioned that the topic was not valid because SCRSN had not established a link between improved service reporting and better enrollee outcomes, and because Rehab Case Management, one of the service modalities in question, is not a Medicaid-funded service. SCRSN submitted the same nonclinical PIP for 2010, but did not sufficiently address the drawbacks outlined in the 2009 EQR report. Per federal regulations and the CMS protocol, all PIPs, whether clinical or nonclinical, must have the potential to improve enrollee health, functional status, or satisfaction.
Information Systems Capabilities Assessment (ISCA)	
The 2009 ISCA resulted in three corrective actions and five recommendations for improvement in the areas of information systems, hardware, and security. By the time of the 2010 follow-up review, SCRSN had completed the three corrective actions and had implemented one recommendation. The RSN had begun implementing the remaining four recommendations, including an assessment of its data facility by an external audit agency.	
SCRSN is housed within Spokane County's Community Services Division, which administers public mental health dollars for the county and reports to the Board of County Commissioners. SCRSN contracts with several dozen providers of community support, adult residential, and inpatient mental health services for Medicaid enrollees. During fiscal 2008, SCRSN had about 93,500 enrollees in its service area.	
Data source: Spokane County RSN 2010 External Quality Review Report (Acumentra Health).	

Spokane County Regional Support Network (continued)

Activity			
Encounter Data Completeness and Accuracy (n=252,380)			
Completeness—Number of fields with data 100% complete			
Outpatient encounter data	10 out of 10 fields	Demographic data	9 out of 11 fields
Inpatient encounter data	5 out of 6 fields	Consumer periodic data	10 out of 12 fields
Accuracy—Percentage of chart data matching electronic data			
Procedure code (n=428)	95.8%	SSN* (n=101)	95.1%
Provider type (n=428)	91.8%	Hispanic origin (n=101)	81.2%
Minutes of service (n=428)	95.8%	Preferred language (n=101)	92.0%
Service location (n=428)	97.7%	Primary diagnosis (n=101)	95.0%
First name (n=101)	100.0%	GAF/CGAS score (n=101)	88.1%
Last name (n=101)	100.0%	Grade* (n=101)	92.1%
Date of birth* (n=101)	100.0%	Employment* (n=101)	98.0%
Gender* (n=101)	100.0%	Education* (n=101)	96.0%
Ethnicity (n=101)	86.1%	** Optional fields*	
Clinical Record Review (n=99)			
Least restrictive environment—Percentage of charts with crisis plans (n=78)			
Describe symptoms/events that precede a crisis	89.7%	Document safe place the enrollee prefers to go when in crisis	59.0%
List family, friends, etc. from whom the enrollee prefers to receive support during a crisis episode	88.5%	List a backup safe place the enrollee would prefer to go when in crisis	32.1%
List backup persons who may be able to provide support if primary support person is unable to respond	52.6%		
Least restrictive environment—Percentage of charts for enrollees with a crisis plan in place who had crisis service encounters (n= 19)			
Enrollee's crisis plan implemented	79.0%	Least restrictive environments considered	68.4%
Recovery and resiliency—Percentage of enrollees with needs and strengths assessed, by domain (n=99)			
	Needs	**Strengths**	
Activities of daily living	78.8%	55.6%	
Medical needs	95.0%	72.7%	
Physical limitations	77.8%	38.4%	
Transportation needs	26.3%	16.2%	
Housing needs	87.9%	76.8%	
Vocational needs	88.9%	76.8%	
Financial needs	53.5%	37.4%	
Social needs	93.9%	82.8%	
Recovery and resiliency—Percentage of identified needs addressed in treatment plan, by domain			
Activities of daily living (n=48)	64.6%	Housing needs (n=38)	55.3%
Medical needs (n=46)	56.5%	Vocational needs (n=55)	49.1%
Physical limitations (n=21)	14.3%	Financial needs (n=28)	46.4%
Transportation needs (n=18)	22.2%	Social needs (n=77)	75.3%

Thurston-Mason Regional Support Network (TMRSN)

Activity	
Regulatory and Contractual Standards	
The 2009 compliance reviews addressed compliance with federal and state regulations governing managed care operations. In 2010, Acumentra Health reviewed TMRSN's response to the specific 2009 EQR findings for which DBHR required corrective action. The review found that TMRSN had complied fully with each of the two required corrective actions, related to coordination of care with medical providers and credentialing/recredentialing of RSN and provider staff.	
Performance Improvement Projects (PIPs)	
Strengths	**Opportunities for Improvement**
Clinical—Multisystemic Therapy: Fully Met (87 out of 100)	
TMRSN has improved its PIP documentation since the previous EQR evaluation, and has presented an additional year's worth of remeasurement data. The cumulative evidence indicates that the intervention has succeeded in improving enrollees' mental health outcomes.	To strengthen confidence in the reported results, TMRSN needs to present separate results for each remeasurement period compared to baseline results, and present an argument for sustained clinical improvement. TMRSN also needs to discuss whether it made any changes to the PIP process during the study as a result of data or barrier analysis.
Nonclinical—Increasing Percentage of Medicaid Clients Who Receive an Intake Service Within 14 Days of Service Request: Partially Met (50 out of 80)	
TMRSN has done a good job of prioritizing the study topic and defining its study question, indicators, and population.	TMRSN needs to define its intervention strategy in greater detail and describe how the RSN will track the effectiveness of implementing the intervention. Some gaps also remain in the documentation of the data collection and analysis plan.
Information Systems Capabilities Assessment (ISCA)	
The 2009 ISCA resulted in six recommendations for improvement in information systems, staffing, security, and provider data. As of the 2010 follow-up review, TMRSN had implemented one recommendation and had begun implementing four others. Thurston County has determined that it lacks the funding and resources to address the remaining recommendation, regarding adoption of an IT control framework.	
TMRSN, headquartered in Olympia, administers public mental health services for Thurston and Mason counties. The RSN contracts with Olympia-based Behavioral Health Resources (BHR) and Seattle-based Sea Mar Community Health Centers to provide outpatient, crisis, residential, and inpatient services, and with Providence St. Peter Hospital for geropsychiatric services. In 2008, TMRSN had about 45,300 enrollees in its service area.	
Data source: Thurston-Mason RSN 2010 External Quality Review Report (Acumentra Health).	

Thurston-Mason Regional Support Network (continued)

Activity			
Encounter Data Completeness and Accuracy (n=115,377)			
Completeness—Number of fields with data 100% complete			
Outpatient encounter data	10 out of 10 fields	Demographic data	10 out of 11 fields
Inpatient encounter data	5 out of 6 fields	Consumer periodic data	10 out of 12 fields
Accuracy—Percentage of chart data matching electronic data			
Procedure code (n=437)	95.4%	SSN* (n=105)	100.0%
Provider type (n=437)	90.4%	Hispanic origin (n=105)	86.7%
Minutes of service (n=437)	97.7%	Preferred language (n=105)	98.1%
Service location (n=437)	38.0%	Primary diagnosis (n=105)	96.2%
First name (n=105)	100.0%	GAF/CGAS score (n=105)	87.6%
Last name (n=105)	100.0%	Grade* (n=105)	86.7%
Date of birth* (n=105)	100.0%	Employment* (n=105)	97.1%
Gender* (n=105)	100.0%	Education* (n=105)	96.2%
Ethnicity (n=105)	93.3%	** Optional fields*	
Clinical Record Review (n=92)			
Least restrictive environment—Percentage of charts with crisis plans (n=90)			
Describe symptoms/events that precede a crisis	97.8%	Document safe place the enrollee prefers to go when in crisis	64.4%
List family, friends, etc. from whom the enrollee prefers to receive support during a crisis episode	97.8%	List a backup safe place the enrollee would prefer to go when in crisis	20.0%
List backup persons who may be able to provide support if primary support person is unable to respond	78.9%		
Least restrictive environment—Percentage of charts for enrollees with a crisis plan in place who had crisis service encounters			
Enrollee's crisis plan implemented (n=23)	26.1%	Least restrictive environments considered (n=7)	57.1%
Recovery and resiliency—Percentage of enrollees with needs and strengths assessed, by domain (n=92)			
	Needs	**Strengths**	
Activities of daily living	95.7%	81.5%	
Medical needs	79.4%	77.2%	
Physical limitations	76.1%	40.2%	
Transportation needs	77.2%	43.5%	
Housing needs	97.8%	81.5%	
Vocational needs	88.1%	67.4%	
Financial needs	71.8%	50.0%	
Social needs	100.0%	82.6%	
Recovery and resiliency—Percentage of identified needs addressed in treatment plan, by domain			
Activities of daily living (n=65)	67.7%	Housing needs (n=29)	65.5%
Medical needs (n=42)	66.7%	Vocational needs (n=53)	60.4%
Physical limitations (n=18)	44.4%	Financial needs (n=36)	44.4%
Transportation needs (n=29)	34.5%	Social needs (n=81)	87.6%

Timberlands Regional Support Network (TRSN)

Activity	
Regulatory and Contractual Standards	
The 2009 compliance reviews addressed TRSN's compliance with federal and state regulations governing managed care operations. In 2010, Acumentra Health reviewed TRSN's response to the specific 2009 EQR findings for which DBHR required the RSN to perform corrective action. The review found that TRSN had completed all 13 corrective actions required by DBHR.	
Performance Improvement Projects (PIPs)	
Strengths	**Opportunities for Improvement**
Clinical—Improving Treatment Outcomes for Adults Diagnosed With a New Episode of Major Depressive Disorder: Partially Met (44 out of 80)	
TRSN substantially met Standards 1, 2, 4, and 6, indicating that the RSN clearly documented the topic selection process, study question, population, and intervention.	At the time of review, TRSN had not yet finished collecting remeasurement data for the first study indicator and had not begun collecting data for the second study indicator. Some gaps remain in the PIP documentation relating to the description of the second study indicator and the data collection and analysis plan.
Nonclinical—Improving Coordination of Care and Outcomes: Partially Met (41 out of 80)	
TRSN has done a good job of describing the prioritization of the study topic and of defining the study question and indicator.	TRSN needs to describe in greater detail how it plans to collect and verify the accuracy of data used in computing the indicator, analyze the study data, and track the implementation of its interventions. The RSN needs to gather baseline data from a period that predates the intervention.
Information Systems Capabilities Assessment (ISCA)	
The 2009 ISCA resulted in three corrective actions and seven recommendations for improvement, including six items related to data security. By the time of the 2010 follow-up review, TRSN had completed the three corrective actions (including those related to data security) and had fully implemented all but one of the seven recommendations.	
TRSN, headquartered in Cathlamet, administers mental health services for Medicaid enrollees in Lewis, Pacific, and Wahkiakum counties. In calendar year 2009, TRSN had about 23,500 enrollees in its service area.	
Data source: Timberlands RSN 2010 External Quality Review Report (Acumentra Health).	

Timberlands Regional Support Network (continued)

Activity			
Encounter Data Completeness and Accuracy (n=46,762)			
Completeness—Number of fields with data 100% complete			
Outpatient encounter data	10 out of 10 fields	Demographic data	10 out of 11 fields
Inpatient encounter data	5 out of 6 fields	Consumer periodic data	9 out of 12 fields
Accuracy—Percentage of chart data matching electronic data			
Procedure code (n=416)	80.3%	SSN* (n=103)	98.1%
Provider type (n=416)	83.4%	Hispanic origin (n=103)	97.1%
Minutes of service (n=416)	90.9%	Preferred language (n=103)	43.7%
Service location (n=416)	91.6%	Primary diagnosis (n=103)	96.1%
First name (n=103)	100.0%	GAF/CGAS score (n=103)	91.3%
Last name (n=103)	100.0%	Grade* (n=103)	94.2%
Date of birth* (n=103)	100.0%	Employment* (n=103)	96.1%
Gender* (n=103)	91.3%	Education* (n=103)	98.1%
Ethnicity (n=103)	96.1%	* *Optional fields*	
Clinical Record Review (n=97)			
Least restrictive environment—Percentage of charts with crisis plans (n=31)			
Describe symptoms/events that precede a crisis	100.0%	Document safe place the enrollee prefers to go when in crisis	58.1%
List family, friends, etc. from whom the enrollee prefers to receive support during a crisis episode	100.0%	List a backup safe place the enrollee would prefer to go when in crisis	9.7%
List backup persons who may be able to provide support if primary support person is unable to respond	93.6%		
Least restrictive environment—Percentage of charts for enrollees with a crisis plan in place who had crisis service encounters (n=13)			
Enrollee's crisis plan implemented	61.5%	Least restrictive environments considered	84.6%
Recovery and resiliency—Percentage of enrollees with needs and strengths assessed, by domain (n=97)			
	Needs	**Strengths**	
Activities of daily living	98.0%	82.5%	
Medical needs	100.0%	90.7%	
Physical limitations	97.9%	68.0%	
Transportation needs	52.6%	19.6%	
Housing needs	96.9%	89.7%	
Vocational needs	95.9%	79.4%	
Financial needs	90.7%	79.4%	
Social needs	98.0%	84.5%	
Recovery and resiliency—Percentage of identified needs addressed in treatment plan, by domain			
Activities of daily living (n=52)	76.9%	Housing needs (n=18)	44.4%
Medical needs (n=44)	52.3%	Vocational needs (n=59)	52.5%
Physical limitations (n=24)	62.5%	Financial needs (n=36)	30.6%
Transportation needs (n=9)	11.1%	Social needs (n=82)	84.2%

Appendix B. MCO Profiles

The profiles in this appendix summarize each MCO's overall performance in measures of access, timeliness, and quality, and in meeting regulatory and contractual standards, including those for PIPs.

MCO scores for compliance with regulatory and contractual standards were calculated from ratings in the TEAMonitor reports, and strengths and opportunities for improvement were derived from the written TEAMonitor reviews. Scores and comments for the Access, Timeliness, and Quality measures were derived from the Performance Measure Comparative Analysis Report produced by Acumentra Health.

NOTE: TEAMonitor results for ANH's compliance with regulatory and contractual standards are combined with those of Regence BlueShield because the two plans share administrative functions and resources.

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Asuris Northwest Health (ANH)

Measure	Score	Measure	Score
Access to Care*			
Infant WCC Visits (6 visits)	—		
Child WCC Visits	48.5% ▼		
Adolescent WCC Visits	38.3%		
Timeliness of Care*			
Postpartum Care After 21–56 days	—		
Quality of Care*			
Childhood Immunizations (Combo 2)	—		
Childhood Immunizations (Combo 3)	—		
Diabetes Care (HbA1c test)	—		
Regulatory and Contractual Standards—Percent Met**			
Availability of Services	80%	Emergency and Post-stabilization Services	0%
Furnishing of Services (Timely Access)	50%	Enrollee Rights	69%
Program Integrity	100%	Enrollment and Disenrollment	100%
Claims Payment	0%	Grievance Systems	74%
Primary Care and Coordination	0%	Practice Guidelines	33%
Enrollees with Special Healthcare Needs	100%	Provider Selection (Credentialing)	100%
Patient Review and Coordination	88%	QAPI Program	40%
Coverage and Authorization of Services	25%	Subcontractual Relationships/Delegation	0%
Performance Improvement Projects (PIPs)**			
Clinical		**Nonclinical**	
Improving the Rate of Child Immunizations	Partially Met	Improving Employees' Understanding of Cultural Competency and Health Disparities	Partially Met
Well-Child Visits With a Disparity Aspect Involving the Hispanic Population	Partially Met		

— Sample size was smaller than the minimum required during the reporting year.

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
*Data source: 2010 Performance Measure Comparative Analysis Report.
**Data source: 2010 TEAMonitor report. Scores include results for Regence BlueShield.

Asuris Northwest Health, an "unbranded" subsidiary of Regence BlueShield, was licensed in 2002. ANH provides coverage for Medicaid clients in Spokane County, serving fewer than 1 percent of Healthy Options enrollees. ANH insures approximately 67,000 lives, about 4 percent of whom are Medicaid enrollees. Approximately 83 percent of Medicaid clients are 18 years of age or younger.

A list of plan **strengths** and **opportunities for improvement** appears on the reverse side. ⇨

Asuris Northwest Health (continued)

Strengths	Opportunities for improvement
Access to Care*	
Scored above the state average on Adolescent WCC Visits, but not significantly higher.	Scored significantly below the state average on Child WCC Visits.
Timeliness of Care*	
Quality of Care*	
Regulatory and Contractual Standards**	
Met 100% of elements for: • Program Integrity • Enrollees With Special Healthcare Needs • Enrollment/Disenrollment • Provider Selection Met 75–88% of elements for: • Availability of Services • Patient Review and Coordination	Met 50–74% of elements for: • Furnishing of Services • Enrollee Rights • Grievance Systems Met less than 50% of elements for: • Claims Payment • Primary Care and Coordination • Coverage and Authorization of Services • Emergency and Post-stabilization Services • Practice Guidelines • QAPI Program • Subcontractual Relationships/Delegation
Performance Improvement Projects (PIPs)**	
• TEAMonitor cited RBS/ANH's excellent use of data display (tables and charts) to report performance. Study rationales and study questions are well documented. • The nonclinical PIP topic is well chosen and could be very useful in reducing health disparities among the MCO's Medicaid enrollees.	• The child immunization PIP reported Combo 3 data, rather than Combo 2 data as required by contract. RBS/ANH needs to report Combo 2 data and the results of statistical significance tests, which likely would show significant improvement from baseline. • For the clinical PIPs, RBS/ANH needs to implement more active interventions to drive future improvement.

*Data source: 2010 Performance Measure Comparative Analysis Report.

**Data source: 2010 TEAMonitor report.

Columbia United Providers (CUP)

Measure	Score	Measure	Score
Access to Care*			
Infant WCC Visits (6 visits)	50.9%		
Child WCC Visits	59.4%		
Adolescent WCC Visits	33.3%		
Timeliness of Care*			
Postpartum Care After 21–56 days	58.2%		
Quality of Care*			
Childhood Immunizations (Combo 2)	70.1% ▼		
Childhood Immunizations (Combo 3)	62.5% ▼		
Diabetes Care (HbA1c test)	86.8%		
Regulatory and Contractual Standards—Percent Met**			
Availability of Services	40%	Emergency and Post-stabilization Services	0%
Furnishing of Services (Timely Access)	100%	Enrollee Rights	88%
Program Integrity	50%	Enrollment and Disenrollment	100%
Claims Payment	100%	Grievance Systems	89%
Primary Care and Coordination	0%	Practice Guidelines	33%
Enrollees with Special Healthcare Needs	100%	Provider Selection (Credentialing)	67%
Patient Review and Coordination	88%	QAPI Program	20%
Coverage and Authorization of Services	75%	Subcontractual Relationships/Delegation	75%
Performance Improvement Projects (PIPs)**			
Clinical		**Nonclinical**	
Improving Early Childhood Immunization Rates	Not Met	HEDIS Process Quality Improvement	Not Met
Improving Well-Child Visit Rates	Not Met		

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
*Data source: 2010 Performance Measure Comparative Analysis Report.
**Data source: 2010 TEAMonitor report.

Columbia United Providers was established in 1994 and began providing coverage for Medicaid enrollees in 1995. CUP serves approximately 6 percent of Healthy Options enrollees, including those with SCHIP and BH+ coverage, in Clark County in southwestern Washington. CUP insures 43,780 lives, 93 percent of whom are insured by Medicaid. About 84 percent of Medicaid clients are 19 years of age or younger.

A list of plan **strengths** and **opportunities for improvement** appears on the reverse side. ⇨

Columbia United Providers (continued)

Strengths	Opportunities for improvement
Access to Care*	
	Scored below the state average on Infant, Child, and Adolescent WCC Visits, but not significantly lower.
Timeliness of Care*	
	Scored below the state average on Postpartum Care, but not significantly lower.
Quality of Care*	
Scored above the state average on the Diabetes Care measure, but not significantly higher.	Scored significantly below the state average on Combo 2 and Combo 3 immunizations.
Regulatory and Contractual Standards**	
Met 100% of elements for: • Furnishing of Services • Claims Payment • Enrollees With Special Healthcare Needs • Enrollment/Disenrollment Met 75–89% of elements for: • Patient Review and Coordination • Coverage and Authorization of Services • Enrollee Rights • Grievance Systems • Subcontractual Relationships/Delegation	Met 50–74% of elements for: • Program Integrity • Provider Selection Met less than 50% of elements for: • Availability of Services • Primary Care and Coordination • Emergency and Post-stabilization Services • Practice Guidelines • QAPI Program
Performance Improvement Projects (PIPs)**	
• CUP clearly defined plans for conducting the clinical PIPs, including use of HEDIS measures to assess each PIP's impact.	• The clinical PIP documentation provided no baseline data and lacked specificity in many areas, including the description of interventions. CUP needs to submit baseline data and evidence of having implemented interventions. • As designed, the nonclinical PIP does not relate to improving processes that affect patient outcomes. • TEAMonitor recommended that CUP receive additional training or guidance on PIP selection and documentation.

*Data source: 2010 Performance Measure Comparative Analysis Report.
**Data source: 2010 TEAMonitor report.

Community Health Plan (CHP)

Measure	Score	Measure	Score
Access to Care*			
Infant WCC Visits (6 visits)	47.9%		
Child WCC Visits	66.4%		
Adolescent WCC Visits	32.6%		
Timeliness of Care*			
Postpartum Care After 21–56 days	60.1%		
Quality of Care*			
Childhood Immunizations (Combo 2)	78.1%		
Childhood Immunizations (Combo 3)	74.7%		
Diabetes Care (HbA1c test)	83.5%		
Regulatory and Contractual Standards—Percent Met**			
Availability of Services	100%	Emergency and Post-stabilization Services	50%
Furnishing of Services (Timely Access)	100%	Enrollee Rights	62%
Program Integrity	50%	Enrollment and Disenrollment	100%
Claims Payment	100%	Grievance Systems	74%
Primary Care and Coordination	0%	Practice Guidelines	67%
Enrollees with Special Healthcare Needs	80%	Provider Selection (Credentialing)	100%
Patient Review and Coordination	75%	QAPI Program	60%
Coverage and Authorization of Services	50%	Subcontractual Relationships/Delegation	100%
Performance Improvement Projects (PIPs)**			
Clinical		**Nonclinical**	
Well-Child Exams: Improving HEDIS Measurement Rates	Met	Improving Call Resolution Performance	Not Met

*Data source: 2010 Performance Measure Comparative Analysis Report.
**Data source: 2010TEAMonitor report.

Established in 1992, Community Health Plan is a network of community health centers and affiliate providers covering Medicaid enrollees in 33 counties across Washington. Members receive services from 1,600 primary care providers and 8,000 specialists at more than 300 primary care sites and more than 90 hospitals. CHP is the state's second-largest Medicaid provider, serving about 31 percent of Healthy Options enrollees, including those with S-CHIP and BH+ coverage. CHP insures more than 225,000 lives, 60 percent of whom are insured by Medicaid. About 85 percent of Medicaid clients are 18 years of age or younger.

A list of plan **strengths** and **opportunities for improvement** appears on the reverse side. ⇨

Community Health Plan (continued)

Strengths	Opportunities for improvement
Access to Care*	
Scored above the state average on Child WCC Visits, but not significantly higher.	Scored below the state average on Infant and Adolescent WCC Visits, but not significantly lower.
Timeliness of Care*	
	Scored below the state average on Postpartum Care, but not significantly lower.
Quality of Care*	
Scored above the state average on Combo 2 and Combo 3 immunizations and on the Diabetes Care measure, though not significantly higher.	
Regulatory and Contractual Standards**	
Met 100% of elements for: • Availability of Services • Furnishing of Services • Claims Payment • Enrollment/Disenrollment • Provider Selection • Subcontractual Relationships/Delegation Met 75–80% of elements for: • Enrollees with Special Healthcare Needs • Patient Review and Coordination	Met 50–74% of elements for: • Program Integrity • Coverage and Authorization of Services • Emergency and Post-stabilization Services • Enrollee Rights • Grievance Systems • Practice Guidelines • QAPI Program Met less than 50% of elements for: • Primary Care and Coordination
Performance Improvement Projects (PIPs)**	
• CHP's Quality Grant Program to support providers in developing interventions is a best practice. All 19 community health centers have developed interventions to increase WCC visit rates. CHP supports the interventions with quarterly reports, incentives, and technical assistance.	• For the clinical PIP, CHP performed statistical significance tests only from 2007 to 2008 rather than from baseline to current period or over three data points. CHP needs to complete significance testing through 2009 for each measure, which likely would demonstrate significant improvement. • For the nonclinical PIP, CHP needs to present more complete documentation, especially on the interventions, for the PIP to be evaluated. • The nonclinical PIP groups Medicaid enrollees with all other enrollees. CHP needs to collect performance data uniquely for Medicaid enrollees in order to measure specific benefits for this population.

*Data source: 2010 Performance Measure Comparative Analysis Report.
**Data source: 2010 TEAMonitor report.

Group Health Cooperative (GHC)

Measure	Score	Measure	Score
Access to Care*			
Infant WCC Visits (6 visits)	48.5%		
Child WCC Visits	59.3%		
Adolescent WCC Visits	37.4%		
Timeliness of Care*			
Postpartum Care After 21–56 days	67.9%		
Quality of Care*			
Childhood Immunizations (Combo 2)	75.5%		
Childhood Immunizations (Combo 3)	70.3%		
Diabetes Care (HbA1c test)	86.7%		
Regulatory and Contractual Standards—Percent Met**			
Availability of Services	80%	Emergency and Post-stabilization Services	50%
Furnishing of Services (Timely Access)	100%	Enrollee Rights	56%
Program Integrity	100%	Enrollment and Disenrollment	100%
Claims Payment	100%	Grievance Systems	53%
Primary Care and Coordination	0%	Practice Guidelines	100%
Enrollees with Special Healthcare Needs	80%	Provider Selection (Credentialing)	67%
Patient Review and Coordination	25%	QAPI Program	40%
Coverage and Authorization of Services	25%	Subcontractual Relationships/Delegation	100%
Performance Improvement Projects (PIPs)**			
Clinical		**Nonclinical**	
Improving Well-Child and Well-Adolescent Visit Rates	Met	Improving Practitioner Communication With Members	Not Met

*Data source: 2010 Performance Measure Comparative Analysis Report.
**Data source: 2010 TEAMonitor report.

Group Health Cooperative, a nonprofit health care system established in 1947, provides coverage for Medicaid clients in six counties in Washington, serving 4 percent of Healthy Options enrollees, including those with S-CHIP and BH+ coverage. More than 87 percent of GHC's clients receive care in GHC-owned medical facilities. GHC insures more than 612,000 lives, of whom 3.5 percent are insured by Medicaid. About 80 percent of Medicaid clients are 18 years of age or younger.

A list of plan **strengths** and **opportunities for improvement** appears on the reverse side. ⇨

Group Health Cooperative (continued)

Strengths	Opportunities for improvement
Access to Care*	
Scored above the state average on Adolescent WCC Visits, but not significantly higher.	Scored below the state average on Infant and Child WCC Visits, but not significantly lower.
Timeliness of Care*	
Scored above the state average on Postpartum Care, but not significantly higher.	
Quality of Care*	
Scored above the state average on the Diabetes Care measure, but not significantly higher.	Scored below the state average on Combo 2 and Combo 3 immunizations, but not significantly lower.
Regulatory and Contractual Standards**	
Met 100% of elements for: • Furnishing of Services • Program Integrity • Claims Payment • Enrollment/Disenrollment • Practice Guidelines • Subcontractual Relationships/Delegation Met 75–80% of elements for: • Availability of Services • Enrollees with Special Healthcare Needs	Met 50–67% of elements for: • Emergency and Post-stabilization Services • Enrollee Rights • Grievance Systems • Provider Selection Met less than 50% of elements for: • Primary Care and Coordination • Patient Review and Coordination • Coverage and Authorization of Services • QAPI Program
Performance Improvement Projects (PIPs)**	
• Both PIPs employed multiple additive interventions over time, with measures refreshed each year. • TEAMonitor cited physician leadership on GHC's clinical PIP as a best practice.	• GHC's sampling approach and study methods for the nonclinical PIP failed to consider the Medicaid population uniquely. It is unclear whether the sample adequately represents Medicaid enrollees. Additional data on Medicaid service utilization might help dispel this concern. • Survey response rates for Medicaid enrollees are low, possibly compromising the study conclusions. GHC may need to modify the study methods to improve response from this population.

*Data source: 2010 Performance Measure Comparative Analysis Report.
**Data source: 2010 TEAMonitor report.

Kaiser Permanente Northwest (KPNW)

Measure	Score	Measure	Score
Access to Care*			
Infant WCC Visits (6 visits)	—		
Child WCC Visits	74.8% ▲		
Adolescent WCC Visits	42.7%		
Timeliness of Care*			
Postpartum Care After 21–56 days	—		
Quality of Care*			
Childhood Immunizations (Combo 2)	—		
Childhood Immunizations (Combo 3)	—		
Diabetes Care (HbA1c test)	—		
Regulatory and Contractual Standards—Percent Met**			
Availability of Services	100%	Emergency and Post-stabilization Services	50%
Furnishing of Services (Timely Access)	100%	Enrollee Rights	88%
Program Integrity	100%	Enrollment and Disenrollment	100%
Claims Payment	100%	Grievance Systems	89%
Primary Care and Coordination	100%	Practice Guidelines	100%
Enrollees with Special Healthcare Needs	100%	Provider Selection (Credentialing)	100%
Patient Review and Coordination	100%	QAPI Program	100%
Coverage and Authorization of Services	75%	Subcontractual Relationships/Delegation	75%
Performance Improvement Projects (PIPs)**			
Clinical		**Nonclinical**	
Improving Well-Child Visit Rates	Met	Regional Appointment Center Call Answer Timeliness	Met

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
— Sample size was less than the minimum required during the reporting year.
*Data source: 2010 Performance Measure Comparative Analysis Report.
**Data source: 2010 TEAMonitor report.

Kaiser Permanente Northwest, a subsidiary of Kaiser Foundation Health Plan, Inc., was established in 1945 and began providing coverage for Medicaid enrollees in two counties in southwestern Washington in 1993. KPNW insures about 479,500 lives; fewer than 1 percent are insured by Washington Medicaid. About 94 percent of Medicaid clients are 18 years of age or younger. KPNW's commercial product line has been accredited by the National Committee for Quality Assurance since May 1995.

A list of plan **strengths** and **opportunities for improvement** appears on the reverse side. ⇨

Kaiser Permanente Northwest (continued)

Strengths	Opportunities for improvement
Access to Care*	
Scored significantly higher than the state average on Child WCC Visits. Scored above the state average on Adolescent WCC Visits, but not significantly higher.	
Timeliness of Care*	
Quality of Care*	
Regulatory and Contractual Standards**	
Met 100% of elements for: • Availability of Services • Furnishing of Services • Program Integrity • Claims Payment • Primary Care and Coordination • Enrollees with Special Healthcare Needs • Patient Review and Coordination • Enrollment/Disenrollment • Practice Guidelines • Provider Selection • QAPI Program Met 75–89% of elements for: • Coverage and Authorization of Services • Enrollee Rights • Grievance Systems • Subcontractual Relationships/Delegation	Met 50 of elements for: • Emergency and Post-stabilization Services
Performance Improvement Projects (PIPs)**	
• KPNW's interventions with providers for the clinical PIP are a best practice and include the web-based Panel Support Tool, which graphically displays "care gaps" on an intranet website. Bundled incentives for providers target improvement in pediatric WCC measures. • The nonclinical PIP is well designed and has implemented varied interventions over time in an effort to shorten call-wait times for enrollees, including increased staffing, targeted training, special interview techniques to identify employees most suited to the job, quality monitoring, and electronic messaging.	• Although the clinical PIP focuses on improving adolescent WCC visit rates, the PIP documentation does not make clear whether the incentive package includes care for adolescents. Visit rates for adolescents continue to show need for improvement.

*Data source: 2010 Performance Measure Comparative Analysis Report.
**Data source: 2010 TEAMonitor report.

Molina Healthcare of Washington (MHW)

Measure	Score	Measure	Score
Access to Care*			
Infant WCC Visits (6 visits)	60.0% ▲		
Child WCC Visits	67.4% ▲		
Adolescent WCC Visits	38.2%		
Timeliness of Care*			
Postpartum Care After 21–56 days	61.9%		
Quality of Care*			
Childhood Immunizations (Combo 2)	77.3%		
Childhood Immunizations (Combo 3)	73.6%		
Diabetes Care (HbA1c test)	82.1%		
Regulatory and Contractual Standards—Percent Met**			
Availability of Services	100%	Emergency and Post-stabilization Services	50%
Furnishing of Services (Timely Access)	100%	Enrollee Rights	69%
Program Integrity	50%	Enrollment and Disenrollment	100%
Claims Payment	100%	Grievance Systems	58%
Primary Care and Coordination	0%	Practice Guidelines	33%
Enrollees with Special Healthcare Needs	80%	Provider Selection (Credentialing)	100%
Patient Review and Coordination	0%	QAPI Program	80%
Coverage and Authorization of Services	75%	Subcontractual Relationships/Delegation	75%
Performance Improvement Projects (PIPs)**			
Clinical		**Nonclinical**	
Improving Well-Child Visit Rates	Met	Medicaid Pharmacy Authorization Turnaround Times	Met
Improving Childhood Immunization Rates	Met		

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
*Data source: 2010 Performance Measure Comparative Analysis Report.
**Data source: 2010 TEAMonitor report.

Established in 1995, Molina Healthcare of Washington provides coverage for Medicaid enrollees in 34 counties across Washington. MHW is the largest Medicaid provider, serving approximately 51 percent of Healthy Options enrollees, including those covered by S-CHIP and BH+. MHW insures approximately 352,000 lives, 95 percent of whom are covered by Medicaid. About 78 percent of Medicaid clients are 18 years of age or younger. MHW's Medicaid product lines are accredited by the National Committee for Quality Assurance.

A list of plan **strengths** and **opportunities for improvement** appears on the reverse side. ⇨

Molina Healthcare of Washington (continued)

Strengths	Opportunities for improvement
Access to Care*	
Scored significantly higher than the state average on Infant and Child WCC Visits. Scored above the state average on Adolescent WCC Visits, but not significantly higher.	
Timeliness of Care*	
	Scored below the state average on Postpartum Care, but not significantly lower.
Quality of Care*	
Scored above the state average on Combo 2 and Combo 3 immunizations, but not significantly higher.	Scored below the state average on the Diabetes Care measure, but not significantly lower.
Regulatory and Contractual Standards**	
Met 100% of elements for: • Availability of Services • Furnishing of Services • Claims Payment • Enrollment/Disenrollment • Provider Selection Met 75–80% of elements for: • Enrollees with Special Healthcare Needs • Coverage and Authorization of Services • QAPI Program • Subcontractual Relationships/Delegation	Met 50–69% of elements for: • Program Integrity • Emergency and Post-stabilization Services • Enrollee Rights • Grievance Systems Met less than 50% of elements for: • Primary Care and Coordination • Patient Review and Coordination • Practice Guidelines
Performance Improvement Projects (PIPs)**	
• MHW's use of tables linking the clinical PIP measures to key outcomes is a best practice. All PIPs list barriers and related interventions, and provide charts that describe key analytical elements, benchmarks and goals. • The childhood immunization PIP has demonstrated significant improvement from baseline. MHW refreshed its interventions in 2009 with a provider incentive as well as several more passive interventions. • The nonclinical PIP achieved significant improvement in pharmacy turnaround times in early stages, and appears to have sustained this improvement over the three-year investigation period.	• As performance on the WCC measures has plateaued, additional active interventions (e.g., provider incentives) are needed to improve and sustain performance. • MHW's PIP documentation did not clearly and succinctly provide information needed to evaluate the projects. TEAMonitor recommended that MHW provide staff training in this area.

*Data source: 2010 Performance Measure Comparative Analysis Report.
**Data source: 2010 TEAMonitor report.

Regence BlueShield (RBS)

Measure	Score	Measure	Score
Access to Care*			
Infant WCC Visits (6 visits)	55.5%		
Child WCC Visits	62.5%		
Adolescent WCC Visits	36.5%		
Timeliness of Care*			
Postpartum Care After 21–56 days	65.7%		
Quality of Care*			
Childhood Immunizations (Combo 2)	82.7% ▲		
Childhood Immunizations (Combo 3)	76.9% ▲		
Diabetes Care (HbA1c test)	84.5%		
Regulatory and Contractual Standards—Percent Met**			
Availability of Services	80%	Emergency and Post-stabilization Services	0%
Furnishing of Services (Timely Access)	50%	Enrollee Rights	69%
Program Integrity	100%	Enrollment and Disenrollment	100%
Claims Payment	0%	Grievance Systems	74%
Primary Care and Coordination	0%	Practice Guidelines	33%
Enrollees with Special Healthcare Needs	100%	Provider Selection (Credentialing)	100%
Patient Review and Coordination	88%	QAPI Program	40%
Coverage and Authorization of Services	25%	Subcontractual Relationships/Delegation	0%
Performance Improvement Projects (PIPs)**			
Clinical		**Nonclinical**	
Improving the Rate of Child Immunizations	Partially Met	Improving Employees' Understanding of Cultural Competency and Health Disparities	Partially Met
Well-Child Visits With a Disparity Aspect Involving the Hispanic Population	Partially Met		

▲▼ MCO percentage is significantly higher or lower than state average ($p<0.05$).
*Data source: 2010 Performance Measure Comparative Analysis Report.
**Data source: 2010 TEAMonitor report. Scores include results for Asuris Northwest Health.

Regence BlueShield, incorporated in 1997, provides coverage for Medicaid enrollees in nine counties in central and western Washington. RBS serves approximately 7 percent of Healthy Options enrollees, including those covered by S-CHIP. RBS insures approximately 896,000 lives, 4.5 percent of whom are insured by Medicaid. Approximately 80 percent of Medicaid clients are 18 years of age or younger.

A list of plan **strengths** and **opportunities for improvement** appears on the reverse side. ⇨

Regence BlueShield (continued)

Strengths	Opportunities for improvement
Access to Care*	
Scored above the state average on Infant and Child WCC Visits, though not significantly higher.	
Timeliness of Care*	
Scored above the state average on Postpartum Care, but not significantly higher.	
Quality of Care*	
Scored significantly higher than the state average on Combo 2 and Combo 3 immunizations. Scored above the state average on the Diabetes Care measure, but not significantly higher.	
Regulatory and Contractual Standards**	
Met 100% of elements for: • Program Integrity • Enrollees with Special Healthcare Needs • Enrollment/Disenrollment • Provider Selection Met 75–88% of elements for: • Availability of Services • Patient Review and Coordination	Met 50–74% of elements for: • Furnishing of Services • Enrollee Rights • Grievance Systems Met less than 50% of elements for: • Claims Payment • Primary Care and Coordination • Coverage and Authorization of Services • Emergency and Post-stabilization Services • Practice Guidelines • QAPI Program • Subcontractual Relationships/Delegation
Performance Improvement Projects (PIPs)**	
• TEAMonitor cited RBS/ANH's excellent use of data display (tables and charts) to report performance. Study rationales and study questions are well documented. • The nonclinical PIP topic is well chosen and could be very useful in reducing health disparities among the MCO's Medicaid enrollees.	• The child immunization PIP reported Combo 3 data, rather than Combo 2 data as required by contract. RBS/ANH needs to report Combo 2 data and the results of statistical significance tests, which likely would show significant improvement from baseline. • For the clinical PIPs, RBS/ANH needs to implement more active interventions to drive future improvement.

*Data source: 2010 Performance Measure Comparative Analysis Report.
**Data source: 2010 TEAMonitor report.

Appendix C: Elements of Regulatory and Contractual Standards

The interagency TEAMonitor group reviews MCOs' compliance with elements of access, quality, and timeliness required by federal managed care regulations and Healthy Options contract provisions. Acumentra Health reviews RSNs' compliance with a similar set of regulations and MHD contract provisions that apply to managed mental health care.

Table C-1 itemizes the relevant provisions in the Healthy Options and MHD contracts. Some of the listed provisions apply only to physical or to mental health care. Table C-2 lists the elements of each regulatory standard, with citations from the Code of Federal Regulations (CFR) and a summary description of each element.

Table C-1. Contract provisions related to access, timeliness, and quality.

Contract provisions	Healthy Options or *RSN* contract section(s)
Access to care	
The MCO/RSN must provide enough information to enable enrollees to make informed decisions about enrollment and to understand benefit coverage and how to obtain care. For physical health care, written information must discuss how to choose and change PCPs, identifying available PCPs by location, languages spoken, qualifications, and practice restrictions, and how to obtain emergency services, hospital care, and services outside the service area. The MCO must provide information on available specialists, informed consent guidelines, advance directives, grievance procedures, covered benefits, well-child care, translation and interpretation services, and how to obtain a second opinion. For mental health care, RSNs must use the MHD-published benefits booklet to notify enrollees of their benefits, rights, and responsibilities.	5.2.1; *5.1*
The MCO/RSN must ensure ***equal access*** for enrollees and potential enrollees with communication barriers. For oral communication, the MCO/RSN must provide free interpreter services for those with a primary language other than English. The MCO/RSN must ensure that written materials are available in a form that can be understood by each enrollee and potential enrollee, and must translate generally available written materials into prevalent non-English languages.	5.3; *5.1.1.4–5.1.1.5*
The MCO/RSN must maintain and monitor a ***provider network*** sufficient to serve enrollee needs, including out-of-network services as medically necessary. The MCO/RSN must consider factors such as the expected service utilization by the Medicaid population, the number and types of providers required, the geographic locations of providers and enrollees, and enrollees' cultural, ethnic, racial, and language needs.	7.2–7.3; *7.12*
The MCO/RSN's provider network must meet ***distance standards*** in each service area. For physical health care, two PCPs must be available within 10 miles for 90 percent of enrollees in an urban service area, and one PCP must be available within 10 miles in a rural service area. Similar standards exist for obstetrics, pediatric or family practice, and hospital and pharmacy services. For mental health care, service sites must be available within a 30-minute drive in rural areas, within a 90-minute drive in large rural geographic areas, and within a 90-minute public transportation trip in urban areas.	7.9; *7.13*
Each MCO must provide all medically necessary ***specialty care*** for enrollees in its service area, whether within or outside the provider network. The MCO must help providers obtain timely referrals to specialty care.	7.12
Timeliness of care	
The MCO/RSN must meet state standards for ***timely access***. For physical health care, designated services must be available 24 hours a day, seven days a week by telephone. Preventive care office visits must be available from the enrollee's PCP or another provider within 30 calendar days; routine care visits, within 10 calendar days; urgent, symptomatic visits within 48 hours; and emergency care, 24 hours a day, seven days a week. For mental health care, the RSN must offer a routine intake evaluation appointment within 10 business days of an enrollee's request. Emergent mental health care must occur within 2 hours of a request, and urgent care must occur within 24 hours of a request. The time period from request to first routine services appointment may not exceed 28 calendar days.	7.4–7.7; *7.6*

Contract provisions	Healthy Options or *RSN* contract section(s)
Quality of care	
"Quality" means "the degree to which a Contractor increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge (42 CFR 438.320)."	3.43
MCOs must cover ***medically necessary services*** related to preventing, diagnosing, and treating health impairments, achieving age-appropriate growth and development, and attaining, maintaining, or regaining functional ability. RSNs must provide a list of 18 specific services when they are medically necessary. The MCO/RSN must provide covered services in the amount, duration, and scope required by DSHS.	14.1; *13.5*
The MCO/RSN must adopt ***practice guidelines***, disseminate them to providers, and use them in decision making for utilization management, enrollee education, service coverage, and other areas. The guidelines must be evidence-based, consider enrollee needs, be adopted in consultation with contracting professionals, and be reviewed and updated regularly.	8.6; *7.11*
The MCO/RSN must guarantee ***enrollee rights***, including the right to be treated with respect and with consideration for dignity and privacy; to be informed of available treatment options and alternatives; to participate in decisions regarding their health care; to be free from unnecessary restraint or seclusion; and to request and receive copies of their medical records and ask that they be amended. RSN enrollees must have individual service plans, developed with the participation of enrollees and their families. Each RSN must provide an independent mental health ombuds to inform enrollees of their rights and help them resolve complaints and grievances.	11.1; *10.1–10.5*
The MCO/RSN must maintain written policies and procedures for ***advance directives*** that meet state and federal requirements and must provide for staff and community education concerning these policies.	11.3; *10.6*
For physical health care, the MCO must ensure that each enrollee has an ***appropriate source of primary care*** and must allow each new enrollee to choose a PCP, to the extent possible and appropriate. For mental health care, the RSN must offer each enrollee a choice of providers.	11.4; *7.14*
Each MCO must allow ***enrollees with special health care needs*** (SHCN) who use a specialist frequently to retain the specialist as a PCP or to be allowed direct access to specialists for needed care.	11.5
The MCO/RSN must have and maintain a ***utilization management program*** that includes mechanisms for detecting both underutilization and overutilization of services furnished to enrollees.	12.1; *7.10*
The MCO/RSN must meet state and federal requirements for ***service authorization***, including timely notification of providers and enrollees in the event that the contractor denies an authorization request. The notice must explain the reasons for denial and the procedures for filing an appeal or requesting expedited resolution.	12.2; *7.7–7.8*
MCO/RSN ***grievance systems*** must meet standards regarding procedures and time frames for grievances, appeals, and access to the hearing process.	13; *12.1–12.7*
Each MCO must provide female enrollees with ***direct access to a women's health specialist*** within the provider network as needed to provide routine and preventive care. The MCO must ensure that hospital delivery maternity care is provided in accordance with state law.	14.4–14.5

Contract provisions	Healthy Options or *RSN* contract section(s)
For physical health care, each MCO must ensure ***continuity of care*** for enrollees in an active course of treatment for a chronic or acute medical condition and must prevent the interruption of medically necessary care. For mental health care, the RSN must ensure coordination with other service delivery systems responsible for meeting needs identified in the enrollee's individual service plan, including primary medical care and services such as education, child welfare, drug and alcohol, developmental disabilities, aging and adult services, corrections, and juvenile justice.	14.6; *10.3.3*
Each MCO must ensure ***coordination of care*** for enrollees through their PCPs, including initiating and coordinating referrals for specialty care. The MCO must identify enrollees with SHCN and ensure that they receive individualized treatment plans that ensure integration of clinical and nonclinical disciplines and services. Each RSN must help to coordinate mental health care for enrollees admitted for psychiatric inpatient services; provide follow-up care for enrollees treated in an emergency room; facilitate communication between physical and mental health providers about Early Periodic Screening, Diagnosis, and Treatment for enrollees under age 21; and have a plan for coordinating services with chemical dependency and substance abuse, criminal justice, and other allied systems.	14.7; *13.8–13.11*
Each MCO must maintain a ***quality assessment and performance improvement*** program that meets federal regulatory requirements. The program must include a Quality Improvement Committee that oversees quality functions. an annual work plan, and an annual program evaluation. Each RSN's quality management program must include an annual review of community mental health agencies within the network.	8.1; *8.1–8.4*
The MCO/RSN must conduct ***performance improvement projects*** (PIPs) designed to achieve significant sustained improvement in areas expected to have a favorable effect on health outcomes and enrollee satisfaction. Each MCO/RSN must conduct and submit to DSHS at least one clinical and one nonclinical PIP. If any of the MCO's HEDIS rates for well-child care fall below 60 percent in 2008 or 2009, the MCO must implement a clinical PIP designed to increase the rates. If the MCO's HEDIS rates for Combo 2 childhood immunizations fall below 70 percent in 2008 or below 75 percent in 2009, the MCO must implement a clinical PIP. The MCO may be required to conduct a CAHPS-related nonclinical PIP and to participate in a yearly statewide PIP. The RSN's PIPs may address topics identified by MHD for statewide improvement or identified by the RSN for local improvement.	8.2; *8.2.5*
For physical health care, each MCO must report *HEDIS* ***performance measures*** according to NCQA specifications. The contract specifies measures to be submitted each year. Each RSN must show improvement on a set of performance measures specified and calculated by MHD. If the RSN does not meet MHD-defined improvement targets on any measure, the RSN must submit a performance improvement plan.	8.3; *8.3*
The MCO must meet state standards for placement of enrollees in the ***Patient Review and Coordination program***. This program is designed to determine and coordinate care for enrollees who have used medical services at a frequency or amount that is not medically necessary. Elements of the standards include guidelines, placement, appeals, and notification.	14.17

Table C-2. Elements of regulatory standards for managed care.

CFR section	Description
438.206 Availability of Services 438.206(b)(1)(i-v) Delivery network 438.206(b)(2) Direct access to a women's health specialist 438.206(b)(3) Provides for a second opinion 438.206(b)(4) Services out of network 438.206(b)(5) Out of network payment	Maintain and monitor a network of providers sufficient to provide adequate access to all services covered under the contract; provide female enrollees with direct access to women's health specialists; provide for second opinions; cover out-of-network services adequately and timely if necessary; meet contract standards.
438.206(c) Furnishing of Services 438.206(c)(1)(i) through (vi) Timely access 438.206(c)(2) Cultural considerations	Meet state standards for timely access to care and services; provide hours of operation for Medicaid enrollees that are no less than the hours for any other patient; make services available 24 hours a day, 7 days a week, when medically necessary; deliver services in a culturally competent manner to all enrollees.
447.46 Timely Claims Payment by MCOs 447.46 Timely claims payment	Meet standards requiring the contractor and any subcontractors to pay or deny 95% of all claims within 60 days of receipt and to pay 99% of "clean" claims within 90 days of receipt.
438.608 Program Integrity Requirements	Maintain administrative and management arrangements or procedures, including a mandatory compliance plan, designed to guard against fraud and abuse.
438.208 Primary Care and Coordination 438.208(b) Primary care and coordination of health care services	Ensure that each enrollee has an ongoing source of appropriate primary care and a person or entity responsible for coordinating healthcare services for the enrollee; ensure that medically necessary care for enrollees is not interrupted; facilitate orderly transfers when necessary; coordinate enrollees' healthcare services with community-based organizations.
438.208(c) Additional Services for Enrollees with Special Health Care Needs 438.208(c)(1) Identification 438.208(c)(2) Assessment 438.208(c)(3) Treatment plans 438.208(c)(4) Direct access to specialists	Implement mechanisms to identify and assess enrollees with special healthcare needs; develop individual treatment plans for these enrollees; provide direct access to specialists as necessary.
438.210 Coverage and Authorization of Services 438.210(b) Authorization of services 438.210(c) Notice of adverse action 438.210(d) Timeframe for decisions 438.210(e) Compensation for UM decisions	Meet requirements for a formal utilization management program, oversight of practitioners, written criteria for clinical decision making, and mechanisms to detect under- and overutilization of services.
438.114 Emergency and Post-stabilization Services	Establish policies and procedures for covering and paying for emergency and post-stabilization care services.

CFR section	Description
438.100 Enrollee Rights ***(a) General rule*** 438.100(a) General rule 438.10(b) Basic rule 438.10(c)(3) Language – non-English 438.10(c)(4) and (5) Language – oral interpretation 438.10(d)(1)(i) Format, easily understood 438.10(d)(1)(ii) and (2) Format, alternative formats 438.10(f) General information 438.10(g) Specific information 438.10(h) Basic rule 438.100(b)(2)(iii) Specific rights 438.100(b)(2)(iv) and (v) Specific rights 438.100(b)(3) Specific rights 438.100(d) Compliance with other federal/state laws	Federal regulations include comprehensive language governing enrollee rights; Healthy Options contract requirements address advance directives, enrollee choice of primary care provider, access to specialty care for enrollees with special healthcare needs, prohibition on charging enrollees for covered services, and affirmation of provider/enrollee right to communicate freely regarding needs and services.
438.226 Enrollment and Disenrollment 438.226 and 438.56(b)(1) - (3) Disenrollment requested by the MCO, PIHP 438.56(c) Disenrollment requested by the enrollee 438.56(d) Procedures for disenrollment 438.56(d)(5) MCO grievance procedures 438.56(e) Timeframe for disenrollment determinations	Establish policies, procedures, and mechanisms to ensure appropriate process for disenrollment.
438.228 Grievance Systems 438.228 Grievance systems 438.402(a) The grievance system 438.402(b)(1) Filing requirements - Authority to file 438.402(b)(2) Filing requirements - Timing 438.402(b)(3) Filing requirements - Procedures 438.404(a) Notice of action - Language and format 438.404(b) Notice of action - Content of notice 438.404(c) Notice of action - Timing of notice 438.406(a) Handling of grievances and appeals - General requirements 438.406(b) Handling of grievances and appeals - Special requirements for appeals 438.408(a) Resolution and notification: Grievances and appeals - Basic rule 438.408(b) and (c) Resolution and notification: Grievances and appeals - specific timeframes and extension of timeframes 438.408 (d) and (e) Resolution and notification: Grievances and appeals- Format of notice and Content of notice of appeal resolution 438.408(f) Resolution and notification: Grievances and appeals-Requirements for State fair hearings 438.410 Expedited resolution of appeals 438.414 Information about the grievance system to providers and subcontractors 438.416 Recordkeeping and reporting requirements 438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending 438.424 Effectuation of reversed appeal resolutions	Meet requirements regarding a defined grievance and appeal process for enrollees, including access to the state Fair Hearing system; policies, procedures, and standard notices to enrollees; acknowledgement of grievances and investigation and resolution of all relevant issues.

CFR section	Description
438.240 Performance Improvement Projects 438.240(b)(1) Basic elements of MCO and PIHP quality assessment and performance improvement programs 438.240(d) Performance improvement projects 438.240(e)(1)(ii) Program review by the state	Design PIPs to achieve, through ongoing measurement and interventions, significant improvement sustained over time, favorable effect on health outcomes and enrollee satisfaction.
438.236 Practice Guidelines 438.236(b)(1-4) Adoption of practice guidelines 438.236(c) Dissemination of [practice] guidelines 438.236(d) Application of [practice] guidelines	Promulgate and maintain practice guidelines based on reliable and valid clinical evidence, and use the guidelines to guide clinical decision making.
438.214 Provider Selection (Credentialing) 438.214(a) General Rules and 438.214(b) Credentialing and recredentialing requirements 438.214(c) and 438.12 Nondiscrimination and provider discrimination prohibited 438.214(d) Excluded providers 438.214(e) State requirements	Adhere to state policies and procedures based on NCQA credentialing standards.
438.240 Quality Assessment and Performance Improvement Program 438.240(a)(1) Quality assessment and performance improvement program - General rules 438.240(b)(2) and (c), and 438.204(c) Performance measurement 438.240(b)(3) Basic elements of MCO and PIHP quality assessment and performance improvement – detect both over and under utilization of services 438.240(b)(4) Basic elements of MCO and PIHP quality assessment and performance improvement – assess care furnished to enrollees with special health care needs 438.240(e) Basic elements of MCO and PIHP quality assessment and performance improvement – evaluating the program	Meet standards for QAPI program structure with written program descriptions, work plan, and evaluation.
438.230 Subcontractual Relationships and Delegation The MCO oversees functions delegated to subcontractor: 438.230 (a) and (b) Subcontractual relationships and delegation	Meet requirements for MCO oversight of delegated entities responsible for providing care and services; subcontract language regarding solvency, provider nondiscrimination, assigned responsibilities, and other provisions consistent with federal regulations in this area, such as reimbursement rates and procedures.

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Appendix D. PIP Review Procedures

TEAMonitor reviews the performance improvement projects (PIPs) conducted by the Healthy Options MCOs, while Acumentra Health reviews the PIPs conducted by RSNs. Although both sets of reviews are based on the federal protocol for validating PIPs, the review procedures differ somewhat (most notably in scoring methods), as outlined below.

TEAMonitor PIP Review Steps

ACTIVITY 1: Assess the Study Methodology
Step 1. Review the Selected Study Topic(s)
1.1. Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care and services?
1.2. Did the PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?
1.3. Did the PIPs, over time, include all enrolled populations; i.e., did not exclude certain enrollees such as those with special healthcare needs?
Step 2: Review the Study Question(s)
2.1. Was/were the study question(s) stated clearly in writing?
Step 3: Review Selected Study Indicator(s)
3.1. Did the study use objective, clearly defined, measurable indicators?
3.2. Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?
Step 4: Review the Identified Study Population
4.1. Did the plan clearly define all Medicaid enrollees to whom the study question and indicators are relevant?
4.2. If the plan studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?
Step 5: Review Sampling Methods
5.1. Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?
5.2. Did the sample contain a sufficient number of enrollees?
5.3. Did the plan employ valid sampling techniques that protected against bias?
Step 6: Review Data Collection Procedures
6.1. Did the study design clearly specify the data to be collected?
6.2. Did the study design clearly specify the sources of data?
6.3. Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?
6.4. Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?
6.5. Did the study design prospectively specify a data analysis plan?
6.6. Were qualified staff and personnel used to collect the data?
Step 7: Assess Improvement Strategies
7.1. Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?

Step 8: Review Data Analysis and Interpretation of Study Results
8.1. Was an analysis of the findings performed according to the data analysis plan?
8.2. Did the plan present numerical PIP results and findings accurately and clearly?
8.3. Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?
8.4. Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?
Step 9: Assess Whether Improvement Is "Real" Improvement
9.1. Was the same methodology as the baseline measurement used, when measurement was repeated?
9.2. Was there any documented, quantitative improvement in processes or outcomes of care?
9.3. Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?
9.4. Is there any statistical evidence that any observed performance improvement is true improvement?
Step 10: Assess Sustained Improvement
10.1. Was sustained improvement demonstrated through repeated measurements over comparable time periods?

ACTIVITY 2. Verify Study Findings (Optional)
1. Were the initial study findings verified upon repeat measurement?

ACTIVITY 3. Evaluate Overall Validity and Reliability of Study Results
Check one:
☐ High confidence in reported PIP results
☐ Confidence in reported PIP results
☐ Low confidence in reported PIP results
☐ Reported PIP results not credible
☐ Enough time has not elapsed to assess meaningful change

PIP scoring

TeaMonitor assigned each PIP a score of "Met," "Partially Met," or "Not Met" by using a checklist of elements deemed essential for meeting the standards specified by the Centers for Medicare and Medicaid Services. The checklist appears on the following page.

To achieve a "Met" the PIP must demonstrate <u>all of the following twelve (12) elements</u>:

- ☐ The topic of the PIP must reflect a problem or need for Medicaid enrollees.
- ☐ Study question(s) stated in writing.
- ☐ Relevant quantitative or qualitative measurable indicators documented.
- ☐ Description of the eligible population to whom the study questions and identified indicators apply.
- ☐ A sampling method documented and determined prior to data collection.
- ☐ The study design and data analysis plan proactively defined.
- ☐ Specific interventions undertaken to address causes/barriers identified through data analysis and QI processes (e.g., barrier analysis, focus groups, etc).
- ☐ Numerical results reported, e.g., numerator and denominator data.
- ☐ Interpretation and analysis of the results reported.
- ☐ Consistent measurement methods used over time or if changed, the rationale for the change is documented.
- ☐ Sustained improvement demonstrated through repeat measurements over time (baseline and at least two follow-up measurements required).
- ☐ Linkage or alignment between the following: data analysis documenting need for improvement; study question(s); selected clinical or non-clinical measures or indicators; and results.

To achieve a "Partially Met" the PIP must demonstrate <u>all of the following seven (7) elements</u>:

- ☐ The topic of the PIP must reflect a problem or need for Medicaid enrollees.
- ☐ Study question(s) stated in writing.
- ☐ Relevant quantitative or qualitative measurable indicators documented.
- ☐ A sampling method documented and determined prior to data collection.
- ☐ The study design and data analysis plan proactively defined.
- ☐ Numerical results reported, e.g., numerator and denominator data.
- ☐ Consistent measurement methods used over time or if changed the rationale for the change is documented.

A "Not Met" score results <u>from NOT demonstrating any one (1) of the following</u>:

- ☐ The topic of the PIP does not reflect a problem or need for Medicaid enrollees.
- ☐ Study question(s) not stated in writing.
- ☐ Relevant quantitative or qualitative measurable indicators not documented.
- ☐ A sampling method is not documented and determined prior to data collection.
- ☐ The study design and data analysis plan is not proactively defined.
- ☐ Numerical results, e.g., numerator and denominator data are not reported.
- ☐ Consistent measurement methods are not used over time and no rationale provided for change in measurement methods, as appropriate.

Acumentra Health PIP Review Steps

Acumentra Health's PIP validation procedure consists of the following activities:

Part 1: Assessing the methodology for conducting the PIPs
Part 2: Evaluating the validity and reliability of PIP results

Part 1: Assessing the methodology for conducting PIPs

Assessing the PIP methodology consists of the following 10 steps.

Step 1: Review the study topic
Step 2: Review the study question
Step 3: Review the selected study indicator(s)
Step 4: Review the identified study population and sampling methods
Step 5: Review the data collection procedures
Step 6: Assess the improvement strategy
Step 7: Review the data analysis and interpretation of study results
Step 8: Assess the likelihood that reported improvement is "real" improvement
Step 9: Assess whether the RSN has documented additional interventions or modifications
Step 10: Assess whether the RSN has sustained the documented improvement

Each step addresses the extent to which the PIP complies with a particular standard in the CMS protocol. The specific criteria for assessing compliance with each standard are listed on the following pages.

Step 1. Review the study topic

Criterion 1.1. The topic was based on relevant information.

The topic must reflect the demographics, prevalence of diagnoses, potential risks, or service needs of the RSN's Medicaid population. Examples of relevant information from which the topic may be selected include

- utilization patterns that reflect deficiencies in service
- enrollee or provider input
- data from surveys or from grievance or appeals processes that indicate underlying issues in care or services
- data comparing the RSN's performance in standardized measures with the performance of comparable organizations

Criterion 1.2. The topic was determined through a systematic selection and prioritization process.

The topic must aim to improve care and services for a large portion of the RSN's Medicaid population. Examples of evidence for a systematic selection and prioritization process include

- descriptions of data that support the topic selection
- documentation of opportunities for soliciting enrollee or provider input

Example—clinical: Developing an algorithm to standardize prescribing patterns for specific diagnoses

Example—nonclinical: Assessing and improving the accessibility of specific services; reducing disparities in services provided to minority enrollees as compared with non-minority enrollees; designing processes to improve care coordination

Step 2: Review the study question

Criterion 2.1. The RSN has clearly defined the question the study is designed to answer. The question

- is stated so as to create a framework for data collection, analysis, and interpretation
- can be answered quantitatively or qualitatively by the PIP study

Step 3: Review the selected study indicator(s)

Each project should use at least one quality indicator for tracking performance and improvement.

Criterion 3.1. The indicator is an objective, measurable, clearly defined, unambiguous statement of an aspect of quality to be measured. The indicator statement clearly identifies

- who—the eligible population
- what—the care or service being evaluated
- when—the specific care or service time frame

The indicator description includes

- *definition of the denominator:* the eligible population, identifying inclusions and exclusions (criteria used to determine the eligible population, such as age, gender, and diagnosis and enrollment status)
- *definition of the numerator:* the outcome achieved or service rendered to the eligible population
- dates of service, procedure codes for administrative data, or acceptable medical record data
- the basis for adopting the indicators (e.g., that they are generally used in the industry—these are preferred; or if the RSN developed its own indicators either at the outset of the study or as a means of narrowing the focus for the study, a description of how the indicator was developed)

Criterion 3.2. The indicator can measure enrollee outcomes, enrollee satisfaction, or processes of care strongly associated with improved enrollee outcomes.

- Indicators for clinical care should include at least some measure of change in mental health status or functional status or process-of-care proxies for these outcomes.
- Process measures may be used as proxies for outcomes only if validity has been established in the literature or by expert consensus.

Step 4: Review the identified study population and sampling methods

Criterion 4.1. The study population is clearly defined and includes all RSN enrollees who are eligible for the study. The study population

- represents the RSN's entire Medicaid population that fits the eligibility criteria described by the indicators
- is defined in terms of enrollment time frames

If the study population is an "at risk" subpopulation,

- the RSN has clearly defined the risk and the subpopulation
- the RSN has provided a rationale for selecting the subpopulation

The RSN may use a sample for the study. *If a sample is used,* the RSN must

- provide the rationale for using a sample
- explain the sampling methodology that produced a representative sample of sufficient size (see below)

Criterion 4.2. When the study includes the RSN's entire eligible population, the data collection approach captures all eligible enrollees.

Criterion 4.3. If a sample is used, the RSN has described the method for determining the sample size.

If a clinical or service condition is being studied for first time, the true prevalence or incidence is not likely to be known. Large samples would be needed to establish a valid baseline. The sampling methodology should include the

- rationale for the size of the sample based on the RSN's eligible population
- frequency of the occurrence being studied
- confidence interval and acceptable margin of error

Criterion 4.4. The sampling methodology is valid and protects against bias.

The description establishing validity and bias protection should include

- a description of the sampling type (e.g., probability or nonprobability; stratified random or convenience)
- the rationale for selecting the sampling type

Criterion 4.5. The sample is large enough to allow calculation of statistically meaningful measures.

Step 5: Review the data collection procedures

The data collection process must ensure that the data collected on the indicator(s) are valid and reliable. Validity indicates the accuracy of the data. Reliability indicates the repeatability or reproducibility of a measurement.

Criterion 5.1. The study design clearly specifies the data to be collected.

- Data elements are defined unambiguously.
- Descriptive terms (e.g., "high," "medium," "low") are defined numerically.

Criterion 5.2. The data sources are clearly identified.

- Examples of data sources include medical records, encounter and claim systems, or surveys.
- Time frames for collecting baseline and remeasurement data are specified.

Criterion 5.3. The study design describes a systematic method of collecting valid and reliable data on all enrollees to whom the indicator(s) apply.

- *For administrative data* (claims or encounter data), the data are complete and include all data submitted by providers. If data collection is automated, the RSN has provided the data specifications and algorithms used.
- *For medical record abstraction* or review of other primary sources, the RSN has documented the steps taken to ensure that the data were consistently extracted and recorded.

Criterion 5.4. *For manual data collection,* the data collection instrument produces consistent, accurate data that are appropriate for the study indicator(s) and that can be used over the study time period.

- The data abstraction process is documented, including a data collection instrument with clear guidelines and definitions.
- Reviewer training is documented, including guidelines, definitions, instructions on how to use the instrument, and instructions on how to handle situations not covered in the documentation.
- Methods of ensuring inter-rater reliability are provided.

Criterion 5.5. The study design includes a prospective data analysis plan that specifies

- whether qualitative or quantitative data or both are to be collected
- whether data are to be collected on the entire population or a sample
- whether measures are to be compared to previous results or similar studies; if comparing measures between two or more studies, the appropriate statistical test must be identified
- whether the PIP is to compare to the performance of different sites or clinics; if comparing performance of two or more entities, the statistical design and analysis must reflect the comparisons

Criterion 5.6. *For manual data collection,* the study design includes the rationale and staff qualifications for the data abstraction. The documentation

- indicates that staff received training on the use of the data collection instrument
- indicates the inter-rater reliability of the data collection instrument

Step 6: Assess the improvement strategy

An improvement strategy is defined as an intervention or set of interventions designed to change behavior at an institutional, practitioner, or enrollee level. The effectiveness of the interventions is determined by measuring a change in performance based on the quality indicator(s).

Criterion 6.1. The RSN has reported on at least one intervention undertaken to address causes or barriers identified through the quality improvement process. The interventions were

- systemic—i.e., designed to affect a wide range of participants through long-term system change
- timed to effect change after the baseline measurement and prior to remeasurement
- effective in improving the indicator for the population(s) studied
- reasonably expected to result in measured improvement
- free of major confounding variables that were likely to affect outcomes

Step 7: Review the data analysis and interpretation of study results

The RSN calculated its performance in the indicators by adhering to appropriate statistical analysis techniques as defined in a data analysis plan.

Criterion 7.1. The analysis of the findings adheres to a data analysis plan that used an appropriate statistical methodology.

Criterion 7.2. The study results, including numerical results and findings, are presented in a manner that provides accurate, clear, and easily understood information.

Criterion 7.3. The analysis identifies

- baseline and remeasurement data
- the statistical significance of any differences between these data sets
- any factors that influenced comparability
- any factors that threatened the validity of the findings

Criterion 7.4. The analysis is based on continuous quality improvement and focused on delivery system processes.

- The interpretation of the success of the PIPs included lessons learned and identified barriers to success or presented a hypothesis about less-than-optimal performance.
- Follow-up activities addressed the barriers identified.

Step 8: Assess the likelihood that reported improvement is "real" improvement

The reported improvement represents "real" change and is not due to a short-term event unrelated to the intervention or to chance.

Criterion 8.1. The RSN has used the same methodology for measuring the baseline as for conducting remeasurement, or the RSN has described and justified a change in measurement methodology.

Criterion 8.2. The analysis discussion includes documentation of

- quantitative improvement in processes related to the study question
- improvements in associated outcomes of care

Criterion 8.3. The analysis discussion describes clearly how the interventions relate to the improvement in performance.

Criterion 8.4. The analysis includes an appropriate calculation of statistical significance, with a discussion of the test used to calculate significance. (There is no required level of significance.)

Step 9: Assess whether the RSN has documented ongoing or additional interventions or modifications

The RSN has documented sustained improvement by remeasuring performance on the initial study indicator(s) at regular intervals. (*Note:* Interventions may be modified between remeasurement periods to address barriers or to take advantage of study findings.)

Criterion 9.1. The RSN has documented ongoing or additional interventions or modifications that are based on earlier data analyses.

Step 10: Assess whether the RSN has sustained the documented improvement

Criterion 10.1. Sustained improvement is demonstrated by additional remeasurements conducted over comparable time periods.

PIP scoring

Each compliance standard has a potential score of 100 points for full compliance, with lower scores for lower levels of compliance. The scores for each standard are weighted and combined to determine the overall PIP score, as shown in Table D-1.

Table D-1. Weighting of standard scores in overall PIP score.

Standard	Criterion number(s)	Scoring weight
Demonstrable Improvement		
1 Selected study topic is relevant and prioritized	1.1, 1.2	5%
2 Study question is clearly defined	2.1	5%
3 Study indicator is objective and measurable	3.1, 3.2	15%
4 Study population is clearly defined and, if sample is used, appropriate methodology is used	4.1, 4.2, 4.3, 4.4, 4.5	10%
5 Data collection process ensures that data are valid and reliable	5.1, 5.2, 5.3, 5.4, 5.5, 5.6	10%
6 Improvement strategy is designed to change performance based on the quality indicator	6.1	15%
7 Data are analyzed and results interpreted according to generally accepted methods	7.1, 7.2, 7.3, 7.4	10%
8 Reported improvement represents “real” change	8.1, 8.2, 8.3, 8.4	10%
	Demonstrable Improvement score	**80%**
Sustained Improvement		
9 RSN has documented additional or ongoing interventions or modifications	9.1	5%
10 RSN has sustained the documented improvement	10.1	15%
	Sustained Improvement score	**20%**
	Overall PIP score	**100%**

The overall score is weighted 80 percent for demonstrable improvement in the first year (Standards 1–8) and 20 percent for sustained improvement in later years (Standards 9–10). Thus, for a PIP that has completed one remeasurement, the maximum score is 80 points (80 percent x 100 points for full compliance). If the PIP has progressed to a second remeasurement, enabling reviewers to assess sustained improvement, the maximum score is 100 points. Table D-2 shows a scoring calculation for a PIP with both demonstrable and sustained improvement.

Table D-2. Example scoring worksheet.

Standard	Compliance rating	Assigned points	Weight	Points score
Demonstrable Improvement				
1	Fully met	100	5%	5.00
2	Fully met	100	5%	5.00
3	Partially met	50	15%	7.50
4	Partially met	50	10%	5.00
5	Fully met	100	10%	10.00
6	Minimally met	25	15%	3.75
7	Partially met	50	10%	5.00
8	Partially met	50	10%	5.00
		Demonstrable Improvement Score		**46.25**
Sustained Improvement				
9	Substantially met	75	5%	3.75
10	Partially met	50	15%	7.50
		Sustained Improvement Score		**11.25**
			Overall PIP Score	**57.50**

Part 2: Evaluating the validity and reliability of PIP results

This part of the PIP review aims to establish an overall level of confidence in the validity and reliability of the PIP findings. Levels of confidence are assigned one of the ratings shown below.

High confidence in reported RSN PIP results
Confidence in reported RSN PIP results
Low confidence in reported RSN PIP results
Reported RSN PIP **results not credible**.

This portion of the assessment evaluates whether the PIP used an appropriate study design to address the project's objectives and questions of interest. Since PIPs are observational studies, the influence of bias and confounding factors on the project results must be evaluated. Bias occurs when some systematic error is introduced during study design. Reviewers evaluate the presence of selection and observation biases to assess the accuracy of reported results, as well as the presence of any confounding factors.

The review also assesses *external validity*—the extent to which the study results can be generalized or applied to other populations—and *internal validity*—whether the study measured what it was intended to measure.