Colorado Medicaid
Community Mental Health Services Program

FY 2010-2011 Validation of Performance Measures

for

Access Behavioral Care

April 2011

This report was produced by Health Services Advisory Group, Inc. for the Colorado Department of Health Care Policy & Financing.

HSAG HEALTH SERVICES ADVISORY GROUP

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HSAG HEALTH SERVICES ADVISORY GROUP

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for **Access Behavioral Care**

Validation Overview

The Colorado State Medicaid agency, the Department of Health Care Policy & Financing (the Department), requires external quality review (EQR) activities as per the Balanced Budget Act of 1997 (BBA), 42 Code of Federal Regulations (CFR) §438.358. One of these activities is the validation of performance measures. The Department has contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to conduct the validation of performance measures for five Colorado behavioral health organizations (BHOs) for the measurement period of July 1, 2009, through June 30, 2010 (fiscal year [FY] 2009–2010). The BHOs provide mental health services to Medicaid-eligible recipients.

The Department identified the performance measures for validation. Some of these measures were calculated by the Department using data submitted by the BHOs; other measures were calculated by the BHOs. The measures came from a number of sources, including claims/encounter and enrollment/eligibility data. HSAG conducted the validation activities as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002 (CMS Performance Measure Validation Protocol). This report uses three sources—the BHO and Department versions of the Information Systems Capabilities Assessment Tool (ISCAT), site reviews, and source code—to tabulate findings for each BHO.

In addition, HSAG reviewed the Colorado Division of Behavioral Health's (DBH's) process for administering the Mental Health Statistics Improvement Program (MHSIP) and Youth Services Survey for Families (YSSF) consumer surveys, which were conducted in September 2010, as well as the process used to calculate the survey results. Because HSAG did not validate the process by which the survey participants were selected or how surveys were distributed, the MHSIP and YSSF measures were not included in the performance measure validation set and were not assigned a validation finding; however, audit findings and recommendations for the MHSIP and YSSF surveys are included in this report. The survey results are presented in Appendix E.

Access Behavioral Care Information

Information about **Access Behavioral Care** (**ABC**), a BHO in the southeast Metro Denver region of Colorado, appears in Table 1.

Table 1—Access Behavioral Care Information	
BHO Name:	Access Behavioral Care
BHO Location:	10065 E. Harvard Avenue, Suite 600 Denver, Colorado 80231
BHO Contact:	Dr. Robert Bremer, MA, PhD Executive Director
Contact Telephone Number:	720-744-5240
Contact E-Mail Address:	Robert.bremer@coaccess.com
Site Visit Date:	January 6, 2010

Performance Measures for Validation

HSAG validated a set of performance measures developed by the Department and BHOs as shown in Table 2. These measures represented HEDIS-like measures and measures developed by the Department. The performance measures were calculated on an annual basis. The domains derived from the MHSIP and YSSF surveys are presented in Table 3.

Table 2—List of Performance Measures for Access Behavioral Care	
1.	Inpatient Utilization
2.	Hospital Average Length of Stay
3.	Follow-up After Hospitalization for Mental Illness (7- and 30-day follow-up)
4.	Emergency Department Utilization
5.	Hospital Recidivism
6.	Overall Penetration Rates
7.	Penetration Rates by Service Category
8.	Penetration Rates by Age Category
9.	Penetration Rates by Medicaid Eligibility Category

Table 3—List of MHSIP and YSSF Survey Domains for Access Behavioral Care	
10.	Percentage of Medicaid adults surveyed who agreed with the domain score measuring consumer perceptions of access (Consumer Perception of Access). Source: MHSIP survey.
11.	Percentage of Medicaid adults surveyed who agreed with the domain score measuring consumer perceptions of quality/appropriateness (Consumer Perception of Quality/Appropriateness). Source: MHSIP survey.
12.	Percentage of Medicaid adults surveyed who agreed with the domain score measuring consumer perceptions of outcome/positive change (Consumer Perception of Outcome). Source: MHSIP survey.
13.	Percentage of Medicaid adults surveyed who agreed with the domain score measuring consumer perceptions of general satisfaction (Consumer Perception of Satisfaction). Source: MHSIP survey.
14.	Percentage of Medicaid adults surveyed who agreed with the domain score measuring consumer perceptions of treatment planning (Consumer Perception of Participation in Service/Treatment Planning). Source: MHSIP survey.
15.	Percentage of Medicaid adults surveyed who reported seeing a doctor or nurse face to face for a health checkup or illness (Consumer Link to Physical Health—Adults). Source: MHSIP survey.
16.	Percentage of parents/guardians surveyed on behalf of Medicaid children who agreed with the domain score measuring consumer perceptions of access (Consumers Perception of Access) Source: YSSF
17.	Percentage of parents/guardians surveyed on behalf of Medicaid children who agreed with the domain score measuring participation in treatment planning (Consumer Perception of Participation in Service/Treatment Planning) Source: YSSF
18.	Percentage of parents/guardians surveyed on behalf of Medicaid children who agreed with the domain score measuring consumer perceptions of cultural sensitivity (Consumer Perception of Cultural Sensitivity) Source: YSSF
19.	Percentage of parents/guardians surveyed on behalf of Medicaid children who agreed with the domain score measuring consumer perceptions of quality/appropriateness (Consumer Perception of the Appropriateness of Services) Source: YSSF
20.	Percentage of parents/guardians surveyed on behalf of Medicaid children who agreed with the domain score measuring consumer perceptions of outcome/positive change (Consumer Perception of Outcomes) Source: YSSF
21.	Percentage of parents/guardians surveyed on behalf of Medicaid children who reported the child seeing a doctor or nurse for a health checkup or illness (Consumer Link to Physical Health—Children) Source: YSSF

Description of Validation Activities

Preaudit Strategy

HSAG conducted the validation activities outlined in the CMS Performance Measure Validation Protocol. The Department provided the performance measure definitions for review by the HSAG validation team (Appendix A). The Department and BHOs worked together to develop this document, which was first used for performance measure validation purposes in FY 2007–2008. The Department and BHOs worked on additional improvements of these measures and the specification document in the Department's Behavioral Health Quality Improvement Committee meeting, and a revised specification document was used for FY 2009–2010 performance measure reporting purposes. Based on the measure definitions and reporting guidelines, HSAG developed the following:

a. Measure-specific worksheets based on Attachment I of the CMS Performance Measure Validation Protocol.

b. A documentation request, which consisted of the ISCAT or Appendix Z of the CMS Performance Measure Validation Protocol.

c. A customized ISCAT to collect the necessary data consistent with Colorado's mental health service delivery model. The ISCAT was forwarded to **ABC** with a timetable for completion and instructions for submission. HSAG responded to ISCAT-related questions directly from **ABC** during the pre-on-site phase. HSAG prepared an agenda describing all on-site visit activities and indicating the type of staff needed for each session. The agendas were forwarded to **ABC** approximately one month prior to the on-site visit. If requested, HSAG also conducted pre-on-site conference calls with **ABC** to discuss any outstanding ISCAT questions and on-site visit activities.

Validation Team

The HSAG performance measure validation team was assembled based on the full complement of skills required for the validation and requirements of this particular BHO. The team consisted of a lead auditor and validation team members, as described in Table 4.

Table 4—HSAG Validation Team

Name/Team Position	Skills and Expertise
Wendy Talbot, MPH, CHCA Lead Auditor	Performance measure and encounter data validation, statistics and analysis
Patience Hoag, RHIT, CHCA, CCS, CCS-P Secondary Auditor	Performance measure and encounter data validation, coding and auditing expertise, analysis
Margaret Ketterer, RN, BSN, CHCA Audit Director	Auditing expertise, compliance with performance measure specifications
Kelly Soto Project Coordinator	Project management and communications

The HSAG lead auditor and secondary auditor participated in the on-site review at the BHO. The remaining team members conducted their work at their respective HSAG offices.

Technical Methods of Data Collection and Analysis

The CMS Performance Measure Validation Protocol identifies key types of data that should be reviewed as part of the validation process. Below is a list of the types of data collected and how HSAG conducted an analysis of this data:

- *Information Systems Capabilities Assessment Tools (ISCATs)* were requested and received from each BHO and the Department. Upon receipt by HSAG, the ISCATs were reviewed to ensure that all sections were completed. The ISCATs were then forwarded to the validation team for review. The review identified issues or items that needed further follow-up.
- *Source code (programming language) for performance measures* was requested and was submitted by the Department and the BHOs. The validation team completed query review and observation of program logic flow to ensure compliance with performance measure definitions during the site visit. Areas of deviation were identified and shared with the lead auditor to evaluate the impact of the deviation on the measure and assess the degree of bias (if any).
- *Performance measure reports for FY 2009–2010* were reviewed by the validation team. The team also reviewed previous reports for trends and rate reasonability.
- *Supportive documentation* included any documentation that provided reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. All supportive documentation was reviewed by the validation team, with issues or clarifications flagged for further follow-up.

On-Site Activities

HSAG conducted a one-day on-site visit with both the Department and **ABC**. HSAG used several methods to collect information, including interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site visit activities are described below.

- **Opening meeting**—included introductions of the validation team and key **ABC** and Department staff involved in the performance measure activities. The review purpose, required documentation, basic meeting logistics, and queries to be performed were discussed.
- **Evaluation of system compliance**—included a review of the information systems assessment, focusing on the processing of claims, encounter, member, and provider data. Reviewers performed primary source verification on a random sample of members, validating enrollment and encounter data for a given date of service within both the membership and encounter data systems. Additionally, the review evaluated the processes used to collect and calculate performance measure data, including accurate numerator and denominator identification, and algorithmic compliance to determine if rate calculations were performed correctly.
- **Review of ISCAT and supportive documentation**—included a review of the processes used to collect, store, validate, and report performance measure data. This session was designed to be interactive with key **ABC** and Department staff. The goal of this session was to obtain a complete picture of the degree of compliance with written documentation. HSAG used interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that written policies and procedures were used and followed in daily practice.
- **Overview of data integration and control procedures**—included discussion and observation of source code logic and a review of how all data sources were combined. The data file used to report the selected performance measures was produced. HSAG performed primary source verification to further validate the output files, and reviewed backup documentation on data integration. HSAG also addressed data control and security procedures during this session.
- **Closing conference**—provided a summary of preliminary findings based on the review of the ISCAT and the on-site visit, and a review of the documentation requirements for any post-on-site visit activities.

HSAG conducted several interviews with key **ABC** and Department staff members involved with performance measure reporting. Table 5 lists the key interviewees for **ABC**.

Table 5—List of Access Behavioral Care Participants	
Name	**Title**
Robert Bremer	Executive Director
Julie McNamara	System Performance Director
Carrie Bandell	Director, Quality Management
Lance Carter	Information Technology
Jeni Sargent	Eligibility and Enrollment Manager
Rhiannon Longmore	Outcomes and Quality Coordinator
Ann Brunker	Senior Business Analyst/Analyst Manager
Julie Salazar	Senior Decision Support Analyst
Amanda Buie	Senior Decision Support Analyst
List of Department Observers	
Name	**Title**
Jerry Ware	Health Outcomes and Quality Management Unit Quality/Compliance Specialist
Marceil Case	Behavioral Health Specialist (telephonic participant)
List of Department Penetration Rate/Survey Calculation Staff	
Name	**Title**
Sally Langston	Statistical Analyst
Michael Sajovetz	Statistical Analyst
Bret Pittenger	Statistical Analyst

Data Integration, Data Control, and Performance Measure Documentation

The calculation of performance measures includes several crucial aspects: data integration, data control, and documentation of performance measure calculations. Each section below describes the validation processes used and the validation findings. For more detailed information, please see Appendix B.

Data Integration

Accurate data integration is essential to calculating valid performance measures. The steps used to combine various data sources, including encounter data and eligibility data, must be carefully controlled and validated. HSAG validated the data integration process used by the Department and the BHO. This validation included a comparison of source data to warehouse files and a review of file consolidations or extracts, data integration documentation, source code, production activity logs, and linking mechanisms. By evaluating linking mechanisms, HSAG was able to determine how different data sources (i.e., claims data and membership data) interacted with one another and how certain elements were consolidated readily and used efficiently. Overall, the data integration processes used by the Department and the BHO were determined by the audit team to be:

☒ Acceptable

☐ Not acceptable

Data Control

The organizational infrastructure of **ABC** must support all necessary information systems. Each quality assurance practice and backup procedure must be sound to ensure timely and accurate processing of data, as well as provide data protection in the event of a disaster. HSAG validated the data control processes used by **ABC**, which included a review of disaster recovery procedures, data backup protocols, and related policies and procedures. Overall, the data control processes in place at **ABC** were determined by the audit team to be:

☒ Acceptable

☐ Not acceptable

Performance Measure Documentation

Complete and sufficient documentation is necessary to support validation activities. While interviews and system demonstrations provided supplementary information, the majority of the validation review findings were based on documentation provided by **ABC** and the Department. HSAG reviewed all related documentation, which included the completed ISCAT, job logs, computer programming code, output files, work flow diagrams, narrative descriptions of performance measure calculations, and other related documentation. Overall, the documentation of performance measure data collection and calculations by **ABC** and the Department was determined by the audit team to be:

☒ Acceptable

☐ Not acceptable

Validation Findings

Through the validation process, the review team identified overall strengths and areas for improvement for **ABC**. In addition, the team evaluated **ABC**'s data systems for the processing of each type of data used for reporting the performance measures. General findings are indicated below.

Strengths

ABC followed recommendations from the previous year. **ABC** also transitioned to an automated process for generating the performance measures. This required staff members to take a closer look at the previous performance measure process, and they were able to identify areas where rates might have been under- or overreported. This new process was efficient and allowed tighter control of the reported rates. **ABC** also implemented a provider profile report. This report was used by **ABC** to track performance and to inform providers of their performance. **ABC** staff members were extremely knowledgeable regarding the performance measure specifications, and were fully involved in collaborating with the Department and other BHOs in updating the scope document.

Areas for Improvement

ABC should add language to the performance measure reporting process about auditing the performance measure data spreadsheet prior to submission to the State. **ABC** was performing this step, but it should be documented. **ABC** should continue to collaborate with the Department and the other BHOs regarding the scope document, addressing the challenges with formatting. The review of the performance measure programming code highlighted the fragmented nature of the document and the difficulty faced in ensuring that updates were uniformly integrated into the necessary sections. As new measures are added, the document will grow exponentially, making it difficult to work with and review for validation purposes. For these reasons, it was recommended that the BHOs and the Department reformat the document before the next performance measure validation cycle.

Eligibility Data System Findings

There were no concerns with the processing of State eligibility. Daily files were downloaded from the State's portal and processed before loading into PowerSTEPP, the plan's transactional system. All files were processed within 24 hours of receipt. There were a few occasions when the State's system was down and there were delays in receiving the files for a few days, but all files for the measurement year were processed and no backlog occurred. Each individual was assigned a unique ID for tracking and to avoid duplicate records. Eligibility data were loaded into **ABC**'s Web site for providers and clinics to retrieve. Providers could also verify eligibility at time of service through the State's web portal.

Claims/Encounter Data System Findings

There were no concerns with the processes in place at **ABC** for processing claims and encounter data. DST, the claims processing vendor, handled the processing of all paper and electronic claims. The use of the PowerSTEPP system for both claims and encounter data processing made the work flow consistent. **ABC**'s auto-adjudication rate was more than 83 percent, indicating that data received from the mental health centers and providers were clean. **ABC** had sufficient oversight of DST and performed quarterly audits. **ABC** was working diligently to prepare for the ICD-10 conversion and was in the process of moving all providers submitting through electronic data interchange to the 5010 model.

Actions Taken as a Result of the Previous Year's Recommendations

ABC followed the recommendations from last year's audit. **ABC** began running a provider profile report monthly for its highest-volume mental health center and quarterly for the other centers. The reports included metrics that assessed ongoing performance on selected key measures. **ABC** also began implementing its coding manual in April 2010. This process has been successful and was tightly monitored through data submission reviews for coding accuracy and errors. In addition, **ABC** continued its collaboration with the Department and the other BHOs in modifying and updating the scope document.

Performance Measure Specific Findings and Recommendations

Based on all validation activities, the HSAG team determined results for each performance measure. The CMS Performance Measure Validation Protocol identifies four separate validation results for each performance measure, which are defined in Table 6.

Table 6—Validation Results Definitions	
Fully Compliant (FC)	Indicates that the performance measure was fully compliant with Department specifications.
Substantially Compliant (SC)	Indicates that the performance measure was substantially compliant with Department specifications and had only minor deviations that did not significantly bias the reported rate.
Not Valid (NV)	Indicates that the performance measure deviated from Department specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.
Not Applicable (NA)	Indicates that the performance measure was not reported because the BHO did not have any Medicaid consumers who qualified for that denominator.

According to the protocol, the validation finding for each measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be *Not Met.* Consequently, it is possible that an error for a single audit element may result in a designation of NV because the impact of the error biased the reported performance measure by more than five percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, and the measure could be given a designation of SC.

As noted in the Validation Overview section, survey-based performance measures were not given a validation result. However, findings and recommendations based on HSAG's review of DBH's survey process are provided in Appendix E.

Table 7 through Table 17 below display the review findings and key recommendations for **ABC** for each validated performance measure. For more detailed information, please see Appendix D.

Table 7—Key Review Findings for Access Behavioral Care Performance Measure: Inpatient Utilization
Findings
ABC calculated this rate. A review of **ABC**'s programming code used for calculation of this rate identified no concerns. **ABC** used a manual process to populate the reporting template. Validation of data entry did occur; however, this process was not formally documented. Primary source verification performed on-site did not identify any concerns with **ABC**'s calculation of this measure.
Key Recommendations
◆ **ABC** should formally document its process for validation of data entry into the reporting template. ◆ **ABC** should continue close monitoring of the data used to calculate this measure.

Table 8—Key Review Findings for Access Behavioral Care Performance Measure: Hospital Average Length of Stay
Findings
ABC calculated this rate. A review of **ABC**'s programming code used for calculation of this rate identified no concerns. **ABC** used a manual process to populate the reporting template. Validation of data entry did occur; however, this process was not formally documented. Primary source verification performed on-site did not identify any concerns with **ABC**'s calculation of this measure.
Key Recommendations
◆ **ABC** should formally document its process for validation of data entry into the reporting template. ◆ **ABC** should continue close monitoring of the data used to calculate this measure.

Table 9—Key Review Findings for Access Behavioral Care Performance Measure: Follow-up After Hospitalization for Mental Illness (7- and 30-day follow-up)
Findings
ABC calculated this rate. A review of **ABC**'s programming code used for calculation of this rate identified no concerns, other than identifying one HCPCS code with transposed numbers. This programming was corrected, and due to the type of service it reflected, the code did not impact rates. **ABC** used a manual process to populate the reporting template. Validation of data entry did occur; however, this process was not formally documented. In reviewing the updated measure specification scope document, the description of this indicator had an incorrect reference to Attachment B for the Follow-Up After Hospitalization for Mental Illness (FUH) measure. The verbiage should have referred to Attachment C. This did not affect how the measure was calculated. Primary source verification performed on-site did not identify any concerns with **ABC**'s calculation of this measure.
Key Recommendations
◆ **ABC** should formally document its process for validation of data entry into the reporting template. ◆ **ABC** should continue to collaborate with the other BHOs and the Department to update the scope document for the FUH indicator, changing the incorrect reference from Attachment B to Attachment C. ◆ The BHOs and the Department should reformat the scope document so that specifications for this measure are in a single location rather than in two separate locations.

Table 10—Key Review Findings for Access Behavioral Care Performance Measure: Emergency Department Utilization
Findings
ABC calculated this rate. A review of **ABC**'s programming code used for calculation of this rate identified no concerns. **ABC** used a manual process to populate the reporting template. Validation of data entry did occur; however, this process was not formally documented. Primary source verification performed on-site did not identify any concerns with **ABC**'s calculation of this measure.
Key Recommendations
◆ **ABC** should formally document its process for validation of data entry into the reporting template. ◆ **ABC** should continue close monitoring of the data used to calculate this measure.

Table 11—Key Review Findings for Access Behavioral Care Performance Measure: Hospital Recidivism
Findings
ABC calculated this rate. A review of **ABC**'s programming code used for calculation of this rate identified no concerns. **ABC** used a manual process to populate the reporting template. Validation of data entry did occur; however, this process was not formally documented. Primary source verification performed on-site did not identify any concerns with **ABC**'s calculation of this measure.
Key Recommendations
◆ **ABC** should formally document its process for validation of data entry into the reporting template. ◆ **ABC** should continue close monitoring of the data used to calculate this measure.

Table 12—Key Review Findings for Access Behavioral Care Performance Measure: Overall Penetration Rates
Findings
The Department calculated this rate from **ABC** encounter data, which were submitted quarterly in a flat file format. **ABC** also submitted encounter data to the Department monthly in an 837 file format, but these data were not used for penetration rate calculation. HSAG conducted interviews with key Department and **ABC** staff members and reviewed the ISCAT. The processes in place to receive and collect claims/encounter data met standards. As noted in previous years, the specifications for the calculation of this measure remained in two separate areas of the scope document. One section of the scope document referenced FY 2007–2008 for the penetration rate calculation. At the Department level, a review of the programming code used by the Department for calculation of this rate identified no concerns.
Key Recommendations
◆ HSAG recommends that **ABC** continue to oversee and monitor the receipt of encounter data from the community mental health centers (CMHCs) as well as submissions of encounter data to the Department. ◆ HSAG recommends that the Department work with the BHOs to reformat the scope document as it relates to penetration rate calculation, incorporating all steps necessary for this calculation in a single area within the main document. In addition, the scope document should be modified to reference "measurement period" or "reporting period" rather than a specific date range. ◆ HSAG encourages the Department to continue to explore mechanisms to run the penetration rates based on the monthly 837 file submissions by **ABC** rather than the quarterly flat file submissions.

Table 13—Key Review Findings for Access Behavioral Care Performance Measure: Penetration Rates by Service Category
Findings
The Department calculated this rate from **ABC** encounter data, which were submitted quarterly in a flat file format. **ABC** also submitted encounter data to the Department monthly in an 837 file format, but these data were not used for penetration rate calculation. HSAG conducted interviews with key Department and **ABC** staff members and reviewed the ISCAT. The processes in place to receive and collect claims/encounter data met standards. As noted in previous years, the specifications for the calculation of this measure remained in two separate areas of the scope document. One section of the scope document referenced FY 2007–2008 for the penetration rate calculation. At the Department level, a review of the programming code used by the Department for calculation of this rate identified no concerns.
Key Recommendations
◆ HSAG recommends that **ABC** continue to oversee and monitor the receipt of encounter data from the CMHCs as well as submissions of encounter data to the Department. ◆ HSAG recommends that the Department work with the BHOs to reformat the scope document as it relates to penetration rate calculation, incorporating all steps necessary for this calculation in a single area within the main document. In addition, the scope document should be modified to reference "measurement period" or "reporting period" rather than a specific date range. ◆ HSAG encourages the Department to continue to explore mechanisms to run the penetration rates based on the monthly 837 file submissions by **ABC** rather than the quarterly flat file submissions.

Table 14—Key Review Findings for Access Behavioral Care Performance Measure: Penetration Rates by Age Category
Findings
The Department calculated this rate from **ABC** encounter data, which were submitted quarterly in a flat file format. **ABC** also submitted encounter data to the Department monthly in an 837 file format, but these data were not used for penetration rate calculation. HSAG conducted interviews with key Department and **ABC** staff members and reviewed the ISCAT. The processes in place to receive and collect claims/encounter data met standards. As noted in previous years, the specifications for the calculation of this measure remained in two separate areas of the scope document. One section of the scope document referenced FY 2007–2008 for the penetration rate calculation. At the Department level, a review of the programming code used by the Department for calculation of this rate identified no concerns.
Key Recommendations
◆ HSAG recommends that **ABC** continue to oversee and monitor the receipt of encounter data from the CMHCs as well as submissions of encounter data to the Department. ◆ HSAG recommends that the Department work with the BHOs to reformat the scope document as it relates to penetration rate calculation, incorporating all steps necessary for this calculation in a single area within the main document. In addition, the scope document should be modified to reference "measurement period" or "reporting period" rather than a specific date range. ◆ HSAG encourages the Department to continue to explore mechanisms to run the penetration rates based on the monthly 837 file submissions by **ABC** rather than the quarterly flat file submissions.

Table 15—Key Review Findings for Access Behavioral Care Performance Measure: Penetration Rates by Medicaid Eligibility Category
Findings
The Department calculated this rate from **ABC** encounter data, which were submitted quarterly in a flat file format. **ABC** also submitted encounter data to the Department monthly in an 837 file format, but these data were not used for penetration rate calculation. HSAG conducted interviews with key Department and **ABC** staff members and reviewed the ISCAT. The processes in place to receive and collect claims/encounter data met standards. As noted in previous years, the specifications for the calculation of this measure remained in two separate areas of the scope document. One section of the scope document referenced FY 2007–2008 for the penetration rate calculation. At the Department level, a review of the programming code used by the Department for calculation of this rate identified no concerns.
Key Recommendations
◆ HSAG recommends that **ABC** continue to oversee and monitor the receipt of encounter data from the CMHCs as well as submissions of encounter data to the Department. ◆ HSAG recommends that the Department work with the BHOs to reformat the scope document as it relates to penetration rate calculation, incorporating all steps necessary for this calculation in a single area within the main document. In addition, the scope document should be modified to reference "measurement period" or "reporting period" rather than a specific date range. ◆ HSAG encourages the Department to continue to explore mechanisms to run the penetration rates based on the monthly 837 file submissions by **ABC** rather than the quarterly flat file submissions.

Table 16—Key Review Findings for Access Behavioral Care MHSIP Survey Domains
Findings
The Division of Behavioral Health (DBH) administered the MHSIP survey according to internal protocol. The survey methodology changed compared with the previous year, and trainings and educational materials were provided to the mental health center (MHC) staff responsible for distributing and collecting the surveys. A vendor, IDS, was responsible for scanning the surveys and creating the data files used by DBH for calculating the results. Although steps were taken to ensure that survey data were complete and accurate, formal documentation of those validation processes was not in place. In addition, after the on-site visit, it was discovered that the survey data DBH delivered to the Department included non-Medicaid consumers. This error was discovered prior to the performance measure validation report generation process, and the updated survey results were included in Appendix E.
Key Recommendations
◆ DBH should more thoroughly document its process for distributing and collecting survey data, including detail on how the convenience sample was derived, the survey process, the timing of each activity, oversight of the vendor (IDS), and validation of data prior to submission to the Department. ◆ The Department should validate the survey data provided by DBH prior to rate calculation to ensure that only Medicaid consumers are included. ◆ The Department should investigate the possibility of DBH calculating the MHSIP rates for the BHOs because the BHOs already have the programming and could easily filter results for Medicaid consumers.

Table 17—Key Review Findings for Access Behavioral Care YSSF Survey Domains
Findings
DBH administered the YSSF survey according to internal protocol. The survey methodology changed compared with the previous year, and trainings and educational materials were provided to the MHC staff responsible for distributing and collecting the surveys. A vendor, IDS, was responsible for scanning the surveys and creating the data files used by DBH for calculating the results. Although steps were taken to ensure that survey data were complete and accurate, formal documentation of those validation processes was not in place. In addition, after the on-site visit, it was discovered that the survey data DBH delivered to the Department included non-Medicaid consumers. This error was discovered prior to the performance measure validation report generation process, and the updated survey results were included in Appendix E.
Key Recommendations
◆ DBH should more thoroughly document its process for distributing and collecting survey data, including detail on how the convenience sample was derived, the survey process, the timing of each activity, oversight of the vendor (IDS), and validation of data prior to submission to the Department. ◆ The Department should validate the survey data provided by DBH prior to rate calculation to ensure that only Medicaid consumers are included. ◆ The Department should investigate the possibility of DBH calculating the YSSF rates for the BHOs because the BHOs already have the programming and could easily filter results for Medicaid consumers.

Table 18 lists the validation result for each validated performance measure for **ABC**.

Table 18—Summary of Results		
Performance Measure		**Validation Result**
1.	Inpatient Utilization	**Fully Compliant**
2.	Hospital Average Length of Stay	**Fully Compliant**
3.	Follow-up After Hospitalization for Mental Illness (7- and 30-day follow-up)	**Fully Compliant**
4.	Emergency Department Utilization	**Fully Compliant**
5.	Hospital Recidivism	**Fully Compliant**
6.	Overall Penetration Rates	**Fully Compliant**
7.	Penetration Rates by Service Category	**Fully Compliant**
8.	Penetration Rates by Age Category	**Fully Compliant**
9.	Penetration Rates by Medicaid Eligibility Category	**Fully Compliant**

Indicators

- Inpatient Utilization
- Hospital Length of Stay
- Overall Penetration Rates*
- Penetration Rates by Service Category*
- Penetration Rates by Age Category*
- Penetration Rates by Medicaid Eligibility Category*
- Hospital Recidivism
- Emergency Department Utilization
- Follow-Up after Hospitalization for Mental Illness
- Consumer Perception of Access (MHSIP)**
- Consumer Perception of Quality/Appropriateness (MHSIP)**
- Consumer Perception of Outcomes (MHSIP)**
- Consumer Perception of Participation in Service/Treatment Planning (MHSIP)**
- Consumer General Satisfaction (MHSIP)**
- Consumer Link to Physical Health – Adults (MHSIP)**
- Consumer Perception of Access (YSSF)**
- Consumer Perception of Participation in Service/Treatment Planning (YSSF)**
- Consumer Perception of Cultural Sensitivity (YSSF)**
- Consumer Perception of the Appropriateness of Services (YSSF)**
- Consumer Perception of Outcomes (YSSF)**
- Consumer Link to Medical Visit – Children (YSSF)**

***Calculated by the Department**

****MHSIP/YSSF Survey Results**

The Department collaborated with the BHOs to create a scope document that serves as the specifications for measures being validated. The following verbiage from the scope document is reproduced in its entirety through page A-19; however, the table of contents and page numbers have been modified for use in this report.

Definitions

FY 2009-2010 BHO-HCPF Annual Performance Measures Scope Document

This document includes the details for calculations of the BHO-HCPF Annual Performance Measures for the five Colorado Behavioral Health Organizations (BHOs). Some of these measures are calculated by HCPF using eligibility data and encounter data submitted by the BHOs, other measures are calculated by the BHOs. With the exception of Penetration Rates, all measures are calculated using paid claims/encounters data. Penetration Rates are calculated using paid and denied claims/encounters data.

The Annual Performance Measures include:

- **Calculated by the BHO:**
  - Inpatient Utilization
  - Hospital Length of Stay
  - Hospital Recidivism
  - Emergency Department Utilization
  - Follow-up After Hospitalization for Mental Illness (7- and 30-day follow-up)

- **Calculated by HCPF:**
  - Overall Penetration Rates
  - Penetration Rates by Service Category

Definitions

Members: Individuals eligible for Medicaid assigned to a specific BHO. Membership is calculated by the number of member months during a 12-month period divided by 12, which gives equivalent members or the average health plan enrollment during the 12-month reporting period.

Covered Mental Health Disorder: The BHO Medicaid contract specifies that certain mental health diagnoses are covered on the current capitated system. These specific diagnose can be found in Appendix A or in the BHO Medicaid BHO contract Exhibit D. Only those services that cover mental health will be included in the calculations of performance measures; however, penetration rates will be calculated using both paid and denied claims/encounters, regardless of the mental health diagnoses.

Per 1000 members – A measure based on total eligible members per 1000.

Fiscal Year – Based on the State fiscal year July to June

Quarter – Based on fiscal year quarters (Jul-Sep, Oct-Dec, Jan-Mar, Apr-Jun)

Age Category – Based on HEDIS age categories: 0-12 (Child), 13-17 (Adolescent), 18-64 (Adult), and 65+ (Older Adult). Age category determination will be based upon the client's age on the date of service for all performance indicators except for inpatient hospitalization and penetration rates. For inpatient hospitalization, age category determination will be based upon the client's age on the date of discharge. For penetration rates, age category determination will be based upon the age of the client on the last day of the fiscal year.

24 Hour Treatment Facility – A residential facility that has 24-hr professional staffing and a program of treatment services and includes PRTF and TRCCFs. Does not include Nursing Facilities or ACFs (defined as an assisted living residence licensed by the State to provide alternative care services and protective oversight to Medicaid clients).

Hospital Discharge – A discharge from a hospital (non-residential) for an episode of treatment for a covered mental health diagnosis that does not result in a re-hospitalization within 24 hrs (transfer). There can be multiple discharges during the specified fiscal year period. The discharge must result in a paid claim for the hospital episode, except where the discharge is from a State Hospital for ages 21-64. Adult members on the list of discharges from the State hospital who are not eligible at the time of hospital admission should be dropped from the hospital discharge list. Adult members who lose eligibility during the hospital stay may remain on the hospital discharge list.

Hospital Admit – An admission to a hospital (non-residential) for an episode of treatment for a covered mental health diagnosis. There can be multiple admits during the specified fiscal year period. The admission must result in a paid claim for the hospital episode, except where the admission is from a State Hospital for ages 21-64.

HCPF— The Department of Health Care Policy and Financing for the State of Colorado.

HEDIS—Healthcare Effectiveness Data and Information Set

Indicators

1. Inpatient Utilization

Description: The total number of BHO member discharges from a hospital episode for treatment of a covered mental health disorder per 1000 members, by age group (see above for age categories) and total population. The discharge must occur in the period of measurement. Two indicators are provided: 1) Number of member discharges from a non-State hospital and 2) Number of member discharges from all hospitals (non-State and State hospitals). Age for this indicator is determined at hospital discharge. Please note: For members transferred from one hospital to another within 24 hours, only one discharge should be counted and it should be attributed to the hospital with the final discharge.

Denominator: Total number of members during the specified fiscal year (12-month period).

Numerator: All discharges from a hospital episode for treatment of a covered mental health disorder
Non-State Hospitals: All discharges from a non-State hospital episode for treatment of a covered mental health disorder during the specific fiscal year, July 1 through June 30.
All Hospitals: All discharges from a hospital episode for treatment of a covered mental health disorder during the specific fiscal year, July 1 through June 30.

Data Source(s): Denominator: Members by BHO provided by HCPF. Numerator: Discharge dates from non-State hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Discharge dates from the State hospital system, ages 21 through 64 years, will be provided by the State.

Calculation of Measure: BHO; Calculation: Numerator (non-state hospital)/Denominator x 1000; Numerator (all hospital)/Denominator x 1000

Benchmark: HEDIS for all hospital and Overall BHOs for all hospital and non-State hospital

2. Hospital Length of Stay

Description: The average length of stay (in days) for BHO members discharged from a hospital episode for treatment of a covered mental health disorder, by age group and total population. Two indicators are provided: 1) Average length of stay for members discharged from a non-State hospital episode for treatment of a covered mental health disorder during the specific fiscal year, July 1 through June 30 and 2) Average length of stay for members discharged from all hospital episodes for a covered mental health disorder during the specific fiscal year, July 1 through June 30. Age for this indicator is determined at hospital discharge.
Please note: For members transferred from one hospital to another within 24 hours, total length of stay for both hospitals should be attributed to the hospital with the final discharge. For final discharges from a State hospital, all days in the hospital episode will be included if the member was Medicaid eligible at the time of admission.

Denominators: Number of Members discharged from a hospital episode. The discharge day must occur within the specified fiscal year, July 1 through June 30.
Non-State Hospital: Total number of Members discharged from a non-State hospital during the specified fiscal year
All Hospitals: Total number of Members discharged from all hospitals during the specified fiscal year.

Numerators: Total days for all hospital episodes resulting in a discharge. Discharge day is not counted. The discharge day must occur within the specified fiscal year, July 1 through June 30. If the admit date and the discharge date are the same then the number of days for the episode is one.
Non-State Hospitals: Total days= Discharge date from the non-State hospital-Admit date
All Hospitals: Total days=Discharge date from all hospitals-Admit date

Data Source(s): Denominator: Number of Members discharged, from non-State hospitals and State hospitals, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Number of discharges from the State hospital system, ages 21 through 64 years, will be provided by the state hospital data file. Numerator: Hospital days (discharge date – admit date) from private hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Hospital days (discharge date – admit date) from the State hospital system, ages 21 through 64 years, will be provided by the State.

Calculation of Measure: BHO; Calculation: Numerator (non-State hospital)/Denominator (non-State hospital); Numerator (all hospital)/Denominator (all hospital)

Benchmark: BHO for all hospital and non-State hospital

3. Overall Penetration Rates

Description: Percent BHO Members with one contact (paid or denied) in a specified fiscal year (12-month period) by eligibility category, age, cultural/ethnic group (race).

- Age is determined by the member's age on the last day of the fiscal year**.**
- Medicaid eligibility category is the eligibility category on the member's most recent Medicaid eligibility span during the fiscal year.
- Cultural/ethnic group (race) is the race category on the member's most recent Medicaid eligibility span during the fiscal year.
- Mental health managed care enrollment spans with at least one day of enrollment during FY 2007-08 are analyzed.
- All enrollment spans identified as: enrollment begin date <= 6/30/2008 AND enrollment end date >= 7/1/2007.
- Member months are determined by counting number of clients with an enrollment span covering at least one day in the month, i.e., total member months per month as: enrollment begin date <= last day of the month AND enrollment end date >= first day of the month. Thus, if the client is enrolled for the full month the member month is equal to one and if enrolled for less than the full month the member month is a fraction between 0 and 1.
- BHO - Behavioral Health Organization
- FY - fiscal year
- FTE - full time equivalent
- MM - member months
- * NOTE: The Business Analysis Section tailors data to specific internal and external customer needs that are not met through existing reporting. Thus, calculations may differ from existing published figures due to several factors that may include, but are not limited to: the specificity of the request, retroactivity in eligibility determination, claims processing and dollar allocation differences between MMIS and COFRS.

Medicaid Eligibility Categories:

Eligibility Type Code	Description
001	OAP-A
002	OAP-B-SSI
003	AND/AB-SSI
004	AFDC/CWP Adults
005	AFDC/CWP CHILDREN
006	FOSTER CARE
007	BC WOMEN
008	BC CHILDREN
013	OAP STATE ONLY
020	BCCP-WOMEN BREAST&CERVICAL CAN
999	UNSPECIFIED

Medicaid Race Categories:

Race Code	Description
1	SPANISH AMERICAN
2	OTHER – WHITE
3	BLACK
4	AMERICAN INDIAN
5	ORIENTAL
6	OTHER
7	UNKNOWN
8	NATV HAWAIIAN OTH PACIFIC ISL

Denominator: Total BHO membership for the specified fiscal year (12-month period)

Numerator: Members with one contact in the specified fiscal year (12-month period) in each eligibility category, age group, and cultural/ethnic group

Data Source(s): BHO claims/encounter file (both paid and denied claims/encounters will be used).

Calculation of Measure: HCPF (by Overall, HEDIS age, eligibility category, cultural/ethnic [% total missing])

Benchmark: Overall BHO

4. Penetration Rates by Service Category

Description: Percent BHO Members with any paid or denied MH service grouped as inpatient, intensive outpatient/partial hospital, and ambulatory care in a specified fiscal year 12-month period. Initially, the ambulatory care rate will be calculated twice; the first rate will be calculated using HEDIS specifications only, and the second rate will be calculated using HEDIS specifications plus additional place of service and service codes specified by the BHOs that are used to encounter services not included in the original HEDIS specifications. See Attachment A for HEDIS specs and additional POS and service codes. Place of Service category 53 will be excluded for the intensive outpatient and partial hospitalization service category.

Denominator: Total BHO membership for the specified fiscal year (12-month period)

Numerator: Members with any MH service, grouped as inpatient, intensive outpatient/partial hospitalization, and ambulatory care in a 12-month period (see Attachment A).

Data Source(s): Denominator: HCPF; Numerator: Paid and denied claims/encounters

Calculation of Measure: HCPF; Calculation: Numerator (inpatient)/Denominator; Numerator (intensive outpatient/partial hospitalization)/Denominator; Numerator (ambulatory care)/Denominator

Benchmark: HEDIS and Overall BHO

Problems/Issues/Questions:
For ambulatory penetration rate see Description above and Attachment A for specifications for calculating the HEDIS and non-HEDIS rates.

5. Hospital Recidivism

Description: Proportion of BHO Member discharges from a hospital episode for treatment of a covered mental health disorder and readmitted for another hospital episode for treatment of a covered mental health diagnosis within 7, 30, 90 days by age group and overall (recidivism rates). Two indicators are provided: 1) **Non-State:** Recidivism rates for member discharges from a non-State hospital episode for treatment of a covered mental health disorder during the specific fiscal year, July 1 through June 30 and 2) **All hospital:** Recidivism rates for member discharges from all hospital episodes for a covered mental health disorder during the specific fiscal year, July 1 through June 30. Age for this indicator is determined at first hospital discharge.

Denominator: Total number of BHO member discharges during the reporting period. The population is based on discharges (e.g., one member can have multiple discharges).
Non-State Hospital: Total number of Member discharges from a non-State hospital during the specified fiscal year
All Hospitals: Total number of Member discharges from all hospitals during the specified fiscal year

Numerator: Number of BHO member discharges with an admission within 7, 30, and 90 days of the discharge, reported cumulatively.
Non-State Hospital: Total number of Member discharges from a non-State hospital, during the specified fiscal year, July 1 through June 30, and then admitted to any hospital (non-state or state) 7, 30, and 90 days after the discharge.
All Hospitals: Total number of Member discharges from all hospitals, during the specified fiscal year, July 1 through June 30, and then admitted to all hospitals 7, 30, and 90 days after the discharge.

Data Source(s): Denominator: Number of Member discharges, from private hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Number of discharges from the State hospital system, ages 21 through 64 years, will be provided by HCPF. Numerator: Admissions from non-State hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Admissions from the State hospital system, ages 21 through 64 years, will be provided by the State.

Calculation of Measure: BHO; Calculation (6 ratios): Numerator (7 days, non-state hospital)/Denominator (non-State hospital); Numerator (30 days, non-state hospital)/Denominator (non state hospital), Numerator (90 days, non state hospital)/Denominator (non state hospital); etc

Benchmark: Overall BHOs.

6. Emergency Department Utilization

Description: Number of BHO Member emergency room visits for a covered mental health disorder per 1,000 Members by age group and overall for the specified fiscal year 12-month period. For this measure include only paid encounters. Age for this indicator is determined on date of service.

Denominator: Total number of Members during the specified fiscal year (12-month period).

Numerator: ED visits that don't result in an inpatient admission within 24 hrs of the day of the ED visit. ED visit codes include: CPT 99281-99285 and 99291-99292; and revenue code 45x.

Data Source(s): Denominator: HCPF; Numerator: BHO encounter claim file.

Calculation of Measure: BHO; Calculation: Numerator/Denominator x 1,000

Benchmark: Overall BHO

7. Follow-up after hospitalization for mental illness

Description: The percentage of member discharges from an inpatient hospital episode for treatment of a covered mental health disorder to the community or a non-24-hour treatment facility and were seen on an outpatient basis (excludes case management) with a mental health provider by age group and overall within 7 or 30 days (follow-up rates). Two indicators are provided: 1) **Non-State:** Follow-up rates for member discharges from a non-State hospital episode for treatment of a covered mental health disorder during the specific fiscal year, July 1 through June 30 and 2) **All hospital:** Follow-up rates for member discharges from all hospital episodes for a covered mental health disorder during the specific fiscal year, July 1 through June 30. Age group is defined as 6 years and older as of the date of discharge.

Numerators: Total number of discharges with an outpatient service (see Attachment B) within 7 and 30 days (the 30 days includes the 7 day number also). For each denominator event (discharge), the follow-up visit must occur after the applicable discharge. An outpatient visit on the date of discharge should be included in the measure. See CPT, UB-92, HCPCS codes in Attachment B for follow-up visit codes allowed.
Non-state Hospital: All discharges from a non-state hospital during the specified fiscal year with an outpatient service within 7 and 30 days.
All Hospitals: All discharges from any inpatient facility for a specified fiscal year with an outpatient service within 7 and 30 days.

Denominators: The population based on discharges during the specified fiscal year July 1 through June 30 (can have multiple discharges for the same individual). Discharges for the whole fiscal year are calculated because the use of 90 day run out data provides the time to collect 30 day follow-up information.
Non-state Hospital: All discharges from a non-state hospital during the specified fiscal year.
All Hospitals: All discharges from any inpatient facility for the specified fiscal year.

Exclusions:

- Exclude those individuals who were readmitted within 30 days to an inpatient setting for all calculations
- Exclude discharges followed by admission to any non-acute treatment facility within 30 days of hospital discharge for any mental health disorder. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place.
    1. Refer to HEDIS codes in Appendix C to identify nonacute care. For residential treatment, compare using residential treatment per diem code. Due to the fact that residential treatment for Foster Care members is paid under fee-for-service, the BHOs cannot easily determine if a Foster Care member was discharged to residential treatment. Therefore, prior to official rate reporting, the HCPF Business Analysis Section will forward each BHO a list of foster care members who were discharged from an inpatient setting to a residential treatment facility, in order to assist the BHOs in removing these members from this measure.

Data Source(s): Denominator: Number of Member discharges, from non-State hospitals, all ages, and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Number of discharges from the State hospital system, ages 21 through 64 years, will be provided by the State. Numerator: Follow-up provided by each BHO based on paid claims in the BHO transaction system.

Calculation of Measure: BHO; Calculation: Includes 4 ratios: Numerator (7 days, non-state hospital)/Denominator (non-State hospital); Numerator (30 days, non-state hospital)/Denominator (non state hospital), Numerator (7 days, all hospital)/Denominator (all hospital), Numerator (30 days, all hospital)/Denominator (all hospital)

Benchmark: HEDIS and all BHOS

Attachment A
Covered Mental Health Diagnoses from Exhibit D of the Colorado Medicaid Community Mental Health Services Program

For calculating all performance measures, except penetration rates

- **295.00-298.99**
- **300.00-301.99**
- **307.00-309.99**
- **311.00-314.99**

Attachment B
Penetration Rates by Service Category

For calculating the penetration rates by service category performance measure

Description

The number and percentage of members receiving the following mental health services during July 1 and June 30 of the fiscal year.

- Any services
- Inpatient
- Intensive outpatient or partial hospitalization
- Outpatient or ED

Calculations

Count members who received inpatient, intensive outpatient, partial hospitalization, and outpatient and ED mental health services in each column. Count members only once in each column, regardless of number of visits. Count members in the *Any Services* column only if they had at least one inpatient, intensive outpatient, partial hospitalization, outpatient and ED visit during the measurement year.

For members who have had more than one encounter, count in each column the first visit in the measurement year and report the member in the respective age category as of the date of service or discharge.

Member months

Report all member months during the measurement year for members with the benefit. Refer to *Specific Instructions for Use of Services Tables.* Because some organizations may offer different benefits for inpatient and outpatient mental health services, denominators in the columns of the member months table may vary. The denominator in the *Any* column should include all members with any mental health benefit.

Inpatient

Include inpatient care at either a hospital or treatment facility with a covered mental health disorder as the principal diagnosis: 290, 293-302, 306-316.

Use one of the following criteria to identify inpatient services.

An Inpatient Facility code in conjunction with a covered mental health diagnosis. Include discharges associated with residential care and rehabilitation.

Codes to Identify Inpatient Service

Inpatient Facility codes : 100, 101, 110, 114, 124, 134, 144, 154, 204
Sub-acute codes : 0919
ATU codes : 190, H2013, H0018AT
RTC codes : H2013, 0191, 0192, 0193, H0018, H0019, S5135

MS—DRG
876, 880-887; exclude discharges with ICD-9-CM Principal Diagnosis code 317-319

Codes to Identify Intensive Outpatient and Partial Hospitalization Services

HCPCS	UB Revenue	
Visits identified by the following HCPCS, UB Revenue and CPT/POS codes may be with a mental health or non-mental health practitioner (the organization does not need to determine practitioner type).		
G0410, G0411, H0035, H2001, H2012, S0201, S9480	0905, 0907, 0912, 0913,	
CPT		**POS**
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	*WITH*	52
Visits identified by the following CPT/POS codes must be with a mental health practitioner.		
99221-99223, 99231-99233, 99238, 99239, 99251-99255,	*WITH*	52

Outpatient and ED

Codes to Identify Outpatient and ED Services: Additional BHO codes & POS for Indicator B: Outpatient & ED Services

CPT	HCPCS	UB Revenue
Visits identified by the following CPT, HCPCS, UB Revenue and CPT/POS codes may be with a mental health or non-mental health practitioner (the organization does not need to determine practitioner type).		
90804-90815, 96101-3, 96105, 96110, 96111, 96116, 96118-20, 96125	G0155, G0176, G0177, G0409, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, M0064, S9484, S9485, T1005, T1016, T1017, H0033, H0038, H0043, H0046, H2012, H2021, H2022, H2023, H2024, H2025, H2026, H2030, H2031, H2032, S0220, S0221, S9449, S9451, S9452, S9453, S9454, S9470	0513, 0900-0904, 0911, 0914-0919, 0762, 0769, 045x
CPT		**POS**
90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	*WITH*	05, 07, 11, 12, 15, 20, 22, 23, 49, 50, 53*, 71, 72, 19, 26, 32, 34, 41, 99
CPT		**UB Revenue**
Visits identified by the following CPT and UB Revenue codes must be with a mental health practitioner.		
98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99281-99285, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99510, 90772, 97535, 97537		045x, 0510, 0515-0517, 0519,-0523, 0526-0529, 0762, 0981-0983

* POS 53 identifies visits that occur in an outpatient, intensive outpatient or partial hospitalization setting. If the organization elects to use POS 53 for reporting, it must have a system to confirm the visit was in an outpatient setting.

- Note: The specifications presented here for the Penetration Rates by Service Category performance indicator are closely based upon HEDIS 2011 specifications.

Attachment C
HEDIS Follow-Up After Hospitalization for Mental Illness (FUH)

For calculating Follow-up after hospitalization for mental illness performance measure

Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of a covered mental health disorder and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.

1. The percentage of members who received follow-up within 30 days of discharge
2. The percentage of members who received follow-up within 7 days of discharge

Eligible Population

Ages	6 years and older as of the date of discharge.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No gaps in enrollment.
Event/diagnosis	Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a covered mental health diagnosis during July1 and June 30 of the fiscal year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge during July1 and June 30 of the fiscal year.
Mental health readmission or direct transfer	If the discharge is followed by readmission or direct transfer to an *acute facility* for any covered mental health disorder within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Although re-hospitalization might not be for a selected mental health disorder, it is probably for a related condition. Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after June 30 of the fiscal year. Exclude discharges followed by readmission or direct transfer to a *nonacute facility* for any covered mental health disorder within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. Refer to the following table for codes to identify nonacute care.

Codes to Identify Nonacute Care

Description	HCPCS	UB Revenue	UB Type of Bill	POS
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other nonacute care facilities that do not use the UB Revenue or Type of Bill codes for billing (e.g., ICF, SNF)				

Administrative Specification	
Denominator	The eligible population.
Numerators	
30-day follow-up	An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Refer to the following table for appropriate codes.
7-day follow-up	An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Refer to the following table for appropriate codes.

Codes to Identify Visits

CPT	HCPCS
Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner.	
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409, G0410, G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485

CPT		POS
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner.		
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	*WITH*	05, 07, 11, 12, 15, 20, 22, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255,	*WITH*	52, 53

UB Revenue
The organization does not need to determine practitioner type for follow-up visits identified by the following UB Revenue codes.
0513, 0900-0905, 0907, 0911-0917, 0919
Visits identified by the following Revenue codes must be with a mental health practitioner or in conjunction with any diagnosis code from Table FUH-A.
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983

- Note: The specification presented here for the Follow up Post Discharge performance indicator are closely based upon HEDIS 2011 specifications.

Consumer Perception of Services - MHSIP

Population: Medicaid adults and older adults responding to the MHSIP Consumer Survey.

Source: MHSIP Consumer Survey.

Measures (six): Percent of persons surveyed agreeing with each of the five domain scores measuring consumer perceptions of access, quality/appropriateness, outcome, participation, and general satisfaction. An additional performance measure reflects the percentage of adults surveyed who reported seeing a medical doctor or nurse face-to-face for health checks or illness.

The MHSIP Consumer Survey measures consumers' perceptions with these items:

Access

1. The location of services was convenient.
2. Staff was willing to see me as often as I felt it was necessary.
3. Staff returned my calls within 24 hours.
4. Services were available at times that were good for me.
5. I was able to get all the services I thought I needed.
6. I was able to see a psychiatrist when I wanted to.

Quality/Appropriateness

1. Staff believed I could grow, change and recover.
2. I felt free to complain.
3. Staff told me what side effects to watch for.
4. Staff respected my wishes about who is and is not to be given information about my treatment.
5. Staff was sensitive to my cultural/ethnic background.
6. Staff helped me obtain the information I needed so I could take charge of managing my illness.
7. I was given information about my rights.
8. Staff encouraged me to take responsibility for how I live my life.
9. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.)

Participation in Service/Treatment Planning

1. I, not staff, decided my treatment goals.
2. I felt comfortable asking questions about my treatment and medication.

Outcome (Positive Change)

1. I am dealing more effectively with my daily problems.
2. I am better able to control my life.
3. I am better able to deal with crisis.
4. I am getting along better with my family.
5. I do better in social situations.
6. I do better in school and/or work.
7. My symptoms are not bothering me as much
8. My housing situation has improved.

General Satisfaction

1. I liked the services that I received here.
2. If I had other choices, I would still get services from this agency.
3. I would recommend this agency to a friend or family member.

Numerator: The total number of respondents agreeing with the items.
Denominator: Total number of respondents with scores in each of the five domains.

Consumers Linked to Physical Health

Population: Medicaid adult and older adult clients.

Source: MHSIP Consumer Survey.

The MHSIP Consumer Survey measures consumers' perceptions with this item:

Consumers Linked to Physical Health

In the last year, did you see a medical doctor (or nurse) for a health check-up or because you were sick?

Measure: The proportion of persons completing the MHSIP Consumer Survey who report seeing a medical doctor or nurse (face-to-face) in the last year in a clinic, office, home visit, or emergency room setting.

Numerator: Number of persons surveyed who report seeing a medical doctor or nurse (face-to-face) in the last year.

Denominator: Number of respondents to the questions.

Consumer Perception of Services – YSSF

Population: Parents of Medicaid children responding to the YSSF Consumer Survey.

Source: YSSF Consumer Survey.

Measures (six): Percent of parents surveyed agreeing with each of the five domain scores measuring consumer perceptions of access, participation, cultural sensitivity, appropriateness, and outcomes. An additional performance measure reflects the percentage of parents surveyed who reported their child seeing a medical doctor or nurse face-to-face for health checks or illness.

The YSSF Consumer Survey measures consumers' perceptions with these items:

Access

1. The location of services was convenient.
2. Services were available at times that were good for me.

Participation in Service/Treatment Planning

1. I helped to choose my child's services.
2. I helped to choose my child's treatment goals.
3. I participated in my child's treatment.

Cultural Sensitivity

1. Staff treated me with respect.
2. Staff respected my family's religious/spiritual beliefs.
3. Staff spoke with me in a way that I understood.
4. Staff was sensitive to my cultural/ethnic background.

Appropriateness

1. Overall, I am satisfied with the services my child received.
2. The people helping my child stuck with us no matter what.
3. I felt my child had someone to talk to when he/she was troubled.
4. The services my child and/or family received were right for us.
5. My family got the help we wanted for my child.
6. My family got as much help as we needed for my child.

Outcome (Positive Change)

1. My child is better at handling daily life.
2. My child gets along better with family members.
3. My child gets along better with friends and other people.
4. My child is doing better in school and/or work.
5. My child is better able to cope when things go wrong.
6. I am satisfied with our family life right now.

Numerator: The total number of respondents agreeing with the items.
Denominator: Total number of respondents with scores in each of the five domains.

Consumers Linked to Physical Health

Population: Medicaid child clients.

Source: YSSF Consumer Survey.

The YSSF Consumer Survey measures consumers' perceptions with this item:

Consumers Linked to Physical Health

In the last year, did your child see a medical doctor (or nurse) for a health check-up or because he/she was sick?

Measure: The proportion of parents completing the YSSF Consumer Survey who report their child seeing a medical doctor or nurse (face-to-face) in the last year in a clinic, office, home visit, or emergency room setting.

Numerator: Number of parents surveyed who report their child seeing a medical doctor or nurse (face-to-face), other than in an emergency room, in the last year.

Denominator: Number of respondents to the questions.

Documentation Work Sheet

BHO Name:	Access Behavioral Care
On-Site Visit Date:	January 6, 2011
Reviewer:	Wendy Talbot and Patience Hoag

Data Integration and Control Element	Met	Not Met	N/A	Comments
Accuracy of data transfers to assigned performance measure data repository.				
◆ The Department and the BHO accurately and completely process transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the repository used to keep the data until the calculations of the performance measures have been completed and validated.	☒	☐	☐	
◆ Samples of data from the repository are complete and accurate.	☒	☐	☐	
Accuracy of file consolidations, extracts, and derivations.				
◆ The Department's and the BHO's processes to consolidate diversified files and to extract required information from the performance measure data repository are appropriate.	☒	☐	☐	
◆ Actual results of file consolidations or extracts are consistent with results expected from documented algorithms or specifications.	☒	☐	☐	
◆ Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	☒	☐	☐	
◆ Computer program reports or documentation reflect vendor coordination activities, and no data necessary to performance measure reporting are lost or inappropriately modified during transfer.	☒	☐	☐	

Data Integration and Control Element	Met	Not Met	N/A	Comments
If the Department and the BHO use a performance measure data repository, the structure and format facilitate any required programming necessary to calculate and report required performance measures.				
◆ The repository's design, program flow charts, and source codes enable analyses and reports.	☒	☐	☐	
◆ Proper linkage mechanisms have been employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	☒	☐	☐	
Assurance of effective management of report production and reporting software.				
◆ Documentation governing the production process, including Department and BHO production activity logs and staff review of report runs, is adequate.	☒	☐	☐	
◆ Prescribed data cutoff dates are followed.	☒	☐	☐	
◆ The Department and the BHO retain copies of files or databases used for performance measure reporting in the event that results need to be reproduced.	☒	☐	☐	
◆ The reporting software program is properly documented with respect to every aspect of the performance measure data repository, including building, maintaining, managing, testing, and report production.	☒	☐	☐	
◆ The Department's and the BHO's processes and documentation comply with standards associated with reporting program specifications, code review, and testing.	☒	☐	☐	

Appendix C. Denominator and Numerator Validation Findings for Access Behavioral Care

Reviewer Work Sheets

BHO Name:	Access Behavioral Care
On-Site Visit Date:	January 6, 2011
Reviewer:	Wendy Talbot and Patience Hoag

Denominator Elements for Access Behavioral Care				
Audit Element	***Met***	***Not Met***	***N/A***	**Comments**
◆ For each of the performance measures, all members of the relevant populations identified in the performance measure specifications are included in the population from which the denominator is produced.	☒	☐	☐	
◆ Adequate programming logic or source code exists to appropriately identify all relevant members of the specified denominator population for each of the performance measures.	☒	☐	☐	
◆ The Department and the BHO have correctly calculated member months and years, if applicable to the performance measure.	☒	☐	☐	
◆ The Department and the BHO have properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure.	☒	☐	☐	
◆ Parameters required by the specifications of each performance measure are followed (e.g., cutoff dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	☒	☐	☐	
◆ Exclusion criteria included in the performance measure specifications have been followed.	☒	☐	☐	
◆ Systems or methods used by the Department and the BHO to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	☐	☐	☒	Population estimates were not applicable to the measures under the scope of the audit.

Numerator Elements for Access Behavioral Care				
Audit Element	***Met***	***Not Met***	***N/A***	**Comments**
◆ The Department and the BHO have used appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	☒	☐	☐	
◆ Qualifying medical events (such as diagnoses, procedures, prescriptions, etc.) are properly identified and confirmed for inclusion in terms of time and services.	☒	☐	☐	
◆ The Department and the BHO have avoided or eliminated all duplication of counted members or numerator events.	☒	☐	☐	
◆ Any nonstandard codes used in determining the numerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible, as evidenced by a review of the programming logic or a demonstration of the program.	☐	☐	☒	Nonstandard coding was not used.
◆ Parameters required by the specifications of the performance measure are adhered to (e.g., the measured event occurred during the time period specified or defined in the performance measure).	☒	☐	☐	

Encounter Data

The measurement period for these performance measures is July 1, 2009, through June 30, 2010 (fiscal year [FY] 2009–2010).

Penetration Rates

The penetration rate is a calculation of the percentage of consumers served by the respective BHO out of all Medicaid-eligible individuals within the BHO service area.

Table D-1—Penetration Rate by HEDIS Age Group *for* Access Behavioral Care

	Enrollment	Members Served	Rate
Children 12 years of age and younger as of June 30, 2010	45,141	2,735	6.06%
Adolescents between 13 and 17 years of age as of June 30, 2010	9,040	1,679	18.57%
Adults between 18 and 64 years of age as of June 30, 2010	27,352	6,469	23.65%
Adults 65 years of age or older as of June 30, 2010	7,725	582	7.53%
Overall	89,258	11,465	12.84%

Table D-2—Penetration Rate by Service Category *for* Access Behavioral Care

	Enrollment	Members Served	Rate
Inpatient Care	89,258	312	0.35%
Intensive Outpatient or Partial Hospitalization	89,258	37	0.04%
Ambulatory Care	89,258	9,681	10.85%

Table D-3—Penetration Rate by Medicaid Eligibility Category *for* Access Behavioral Care			
	Enrollment	Members Served	Rate
AFDC/CWP Adults	12,943	2,222	17.17%
AFDC/CWP Children	23,387	1,690	7.23%
AND/AB-SSI	9,038	3,450	38.17%
BC Children	26,206	1,720	6.56%
BC Women	766	130	16.96%
BCCP-Women Breast & Cervical Cancer	60	20	33.32%
Foster Care	2,722	1,329	48.83%
OAP State Only	1	4	313.30%
OAP-A	7,324	553	7.55%
OAP-B-SSI	1,409	420	29.82%
Unspecified	4,989	893	17.90%

Hospital Recidivism

Table D-4—Hospital Recidivism *for* Access Behavioral Care							
Population	Time Frame	Non-State Hospitals			All Hospitals		
		Denominator (Discharges)	Numerator (Readmissions)	Rate	Denominator (Discharges)	Numerator (Readmissions)	Rate
Child 0–12 Years of Age	7 Days	92	3	3.26%	109	4	3.67%
	30 Days	92	6	6.52%	109	9	8.26%
	90 Days	92	19	20.65%	109	23	21.10%
Adolescent 13–17 Years of Age	7 Days	183	8	4.37%	218	12	5.50%
	30 Days	183	27	14.75%	218	34	15.60%
	90 Days	183	42	22.95%	218	56	25.69%
Adult 18–64 Years of Age	7 Days	302	13	4.30%	382	20	5.24%
	30 Days	302	49	16.23%	382	60	15.71%
	90 Days	302	90	29.80%	382	112	29.32%
Adult 65 Years of Age and Older	7 Days	5	1	20.00%	5	1	20.00%
	30 Days	5	1	20.00%	5	1	20.00%
	90 Days	5	1	20.00%	5	1	20.00%
All Ages	7 Days	582	25	4.30%	714	37	5.18%
	30 Days	582	83	14.26%	714	104	14.57%
	90 Days	582	152	26.12%	714	192	26.89%

Average Length of Stay

Table D-5—Hospital Average Length of Stay (ALOS) *for* Access Behavioral Care						
Population	Non-State Hospitals			All Hospitals		
	Denominator	Numerator	ALOS	Denominator	Numerator	ALOS
Child 0–12 Years of Age	92	1,012	11.00	109	1,296	11.89
Adolescent 13–17 Years of Age	183	1,788	9.77	218	2,055	9.43
Adult 18–64 Years of Age	302	2,362	7.82	382	7,871	20.60
Adult 65 Years of Age and Older	5	119	23.80	5	119	23.80
All Ages	582	5,281	9.07	714	11,341	15.88

Emergency Room Utilization

Table D-6—Emergency Room Utilization *for* Access Behavioral Care			
	Denominator	Numerator	Rate per 1,000 Members
Child 0–12 Years of Age	45,135	122	2.70
Adolescent 13–17 Years of Age	9,041	137	15.15
Adult 18–64 Years of Age	27,356	566	20.69
Adult 65 Years of Age and Older	7,726	10	1.29
All Ages	89,258	835	9.35

Inpatient Utilization

Table D-7—Inpatient Utilization *for* Access Behavioral Care						
Population	Non-State Hospitals			All Hospitals		
	Denominator	Numerator	Rate per 1,000 Members	Denominator	Numerator	Rate per 1,000 Members
Child 0–12 Years of Age	45,135	92	2.04	45,135	109	2.41
Adolescent 13–17 Years of Age	9,041	183	20.24	9,041	218	24.11
Adult 18–64 Years of Age	27,356	302	11.04	27,356	382	13.96
Adult 65 Years of Age and Older	7,726	5	0.65	7,726	5	0.65
All Ages	89,258	582	6.52	89,258	714	8.00

Follow-up After Hospitalization for Mental Illness

Table D-8—Follow-up After Hospitalization for Mental Illness *for* Access Behavioral Care			
Follow-up Period	Denominator (Discharges)	Numerator (Seen Within Date Criteria)	Follow-up Rate
7 Days (Non-State Hospital)	396	140	35.35%
30 Days (Non-State Hospital)	396	229	57.83%
7 Days (All Hospitals)	431	151	35.03%
30 Days (All Hospitals)	431	248	57.54%

Survey Results

Domain Scores

Based on Mental Health Statistics Improvement Program (MHSIP) and Youth Services Survey for Families (YSSF) survey data, the scores reflect the percentage of agreement by adults surveyed in each of five domains. In previous years, these surveys were mailed to consumers receiving services in a given time period. For FY 2009–2010, the surveys were made available to consumers coming into community mental health centers for appointments during the three-week period of September 20, 2010, to October 8, 2010. MHSIP and YSSF survey responses were collected using a five-point Likert scale, with 1 equal to strong agreement and 5 equal to strong disagreement. For the purposes of this report, only agreement results are displayed. Agreement is defined as a mean that is less than 2.5 on a scale of 1 to 5. Disagreement is defined as a mean that is greater than 2.5.

Mental Health Statistics Improvement Program (MHSIP)

Table E-1 displays the domain name, corresponding definition, and percentage of adults surveyed who agreed with the indicated domain definition.

Table E-1—MHSIP Domain Definitions and Scores *for* Access Behavioral Care

Domain	MHSIP Items in Each Domain	Percentage of Adults Who Agreed
Consumer Perception of Access	The location of the services was convenient. Staff was willing to see me as often as I felt it was necessary. Staff returned my calls within 24 hours. Services were available at times that were good for me. I was able to get all the services I thought I needed. I was able to see a psychiatrist when I wanted to.	**81.7%**
Consumer Perception of Quality/Appropriateness	Staff here believe I can grow, change, and recover. I felt free to complain. Staff told me what side effects to watch for. Staff respected my wishes about who is and is not to be given information about my treatment. Staff was sensitive to my cultural/ethnic background. Staff helped me obtain information so that I could take charge of managing my illness. I was given information about my rights. Staff encouraged me to take responsibility for how I live my life. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone lines, etc.).	**86.0%**

Table E-1—MHSIP Domain Definitions and Scores *for* Access Behavioral Care		
Domain	**MHSIP Items in Each Domain**	**Percentage of Adults Who Agreed**
Consumer Perception of Participation in Service/Treatment Planning	I, not staff, decided my treatment goals. I felt comfortable asking questions about my treatment and medication.	**79.1%**
Consumer Perception of Outcome	I deal more effectively with daily problems. I am better able to control my life. I am better able to deal with crises. I am getting along better with my family. I do better in social situations. I do better in school/work. My symptoms are not bothering me as much. My housing situation has improved.	**68.5%**
Consumer Perception of Satisfaction	I liked the services I received here. If I had other choices, I would still get services from this agency. I would recommend this agency to a friend or family member.	**91.3%**

Medical Doctor Contacts

Using MHSIP survey data, this performance measure reflects the percentage of adults surveyed who reported seeing a medical doctor or nurse face-to-face for a health checkup or illness.

Table E-2—Medical Doctor Contacts *for* Access Behavioral Care				
Doctor Visit in Clinic, Office, or Home Visit	**No Visit**	**Do Not Remember**	**Percentage With Doctor Visit outside of the Emergency Room**	**Total**
56	**14**	**19**	**62.9%**	**89**

Youth Services Survey for Families (YSSF)

Table E-3 displays the domain name, corresponding definition, and percentage of parents/guardians surveyed who agreed with the indicated domain definition.

Table E-3—YSSF Domain Definitions and Scores *for* Access Behavioral Care		
Domain	**YSSF Items in Each Domain**	**Percentage of Parents Who Agreed**
Consumer Perception of Access	The location of services was convenient. Services were available at times that were good for me.	**88.2%**
Consumer Perception of Participation	I helped to choose my child's services. I helped to choose my child's treatment goals. I participated in my child's treatment.	**93.9%**
Consumer Perception of Cultural Sensitivity	Staff treated me with respect. Staff respected my family's religious/spiritual beliefs. Staff spoke with me in a way that I understood. Staff was sensitive to my cultural/ethnic background.	**96.8%**
Consumer Perception of Appropriateness	Overall, I am satisfied with the services my child received. The people helping my child stuck with us no matter what. I felt my child had someone to talk to when he/she was troubled. The services my child and/or family received were right for us. My family got the help we wanted for my child. My family got as much help as we needed for my child.	**93.9%**
Consumer Perception of Outcome	My child is better at handling daily life. My child gets along better with family members. My child gets along better with friends and other people. My child is doing better in school and/or work. My child is better able to cope when things go wrong. I am satisfied with our family life right now.	**66.7%**

Medical Doctor Contacts

Using YSSF survey data, this performance measure reflects the percentage of parents/guardians surveyed who reported their child seeing a medical doctor or nurse face to face for a health checkup or illness.

Table E-4—Medical Doctor Contacts *for* Access Behavioral Care					
Doctor Visit in Clinic, Office, or Home Visit	**Doctor Visit in Emergency Room**	**No Visit**	**Do Not Remember**	**Percentage With Doctor Visit**	**Total**
29	**2**	**6**	**0**	**78.4%**	**37**