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The QIP successfully monitored clinical and service indicators and implemented interventions as needed throughout the year. The continual monitoring and oversight provided ensured that negative trends were addressed promptly, encouraging continual quality improvement. ............................................ 75

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## Abbreviations and Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>APA</td>
<td>American Psychiatric Association;</td>
</tr>
<tr>
<td>APT</td>
<td>Admissions per thousand</td>
</tr>
<tr>
<td>BH</td>
<td>Behavioral Health</td>
</tr>
<tr>
<td>CAP</td>
<td>Corrective Action Plan</td>
</tr>
<tr>
<td>CCM</td>
<td>Complex case management</td>
</tr>
<tr>
<td>CGX</td>
<td>Clinical Guidance Exchange</td>
</tr>
<tr>
<td>CHIP</td>
<td>Child Health Insurance Program</td>
</tr>
<tr>
<td>CIT</td>
<td>Clinical intake team</td>
</tr>
<tr>
<td>CLD</td>
<td>Clinical Learning and Development</td>
</tr>
<tr>
<td>CM</td>
<td>Case management</td>
</tr>
<tr>
<td>CPG</td>
<td>Clinical Practice Guideline</td>
</tr>
<tr>
<td>DM</td>
<td>Disease management</td>
</tr>
<tr>
<td>DSM</td>
<td>Diagnostic &amp; Statistical Manual</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Healthcare Effectiveness Data and Information Set.</td>
</tr>
<tr>
<td>HP</td>
<td>Health Plan</td>
</tr>
<tr>
<td>IP</td>
<td>Inpatient</td>
</tr>
<tr>
<td>IRR</td>
<td>Inter-rater reliability</td>
</tr>
<tr>
<td>LOB</td>
<td>Line of business</td>
</tr>
<tr>
<td>MY</td>
<td>Measurement year</td>
</tr>
<tr>
<td>NCQA</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary care physician</td>
</tr>
<tr>
<td>PRC</td>
<td>Peer review committee</td>
</tr>
<tr>
<td>QI</td>
<td>Quality improvement</td>
</tr>
<tr>
<td>QMS</td>
<td>Quality Management System</td>
</tr>
<tr>
<td>UM</td>
<td>Utilization Management</td>
</tr>
<tr>
<td>UTC</td>
<td>Unable to Contact</td>
</tr>
<tr>
<td>YOY</td>
<td>Year over year</td>
</tr>
<tr>
<td>YTD</td>
<td>Year to date</td>
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</table>
Introduction

A. Mission Statement

“Changing Health Behaviors, Improving Lives.”
Humana Behavioral Health is committed to changing health behaviors to improve lives. For more than 20 years, our commitment to well-being has resulted in positive outcomes for employers, health plans and insurers.
Our approach integrates the care of the mind and body – treating both the physical and mental together – to enhance health, and to increase personal and workplace productivity. This is exemplified by the name and brand change that was made in June 2015 from Humana Behavioral Health to Humana Behavioral Health.

B. Humana Behavioral Health Services

Humana Behavioral Health, a wholly-owned Humana subsidiary, proudly serves more than five million members by offering extensive behavioral health resources. These resources include behavioral healthcare, employee assistance program (EAP)/work-life services, behavioral pharmacy services, health coaches and web-based wellness tools. Humana Behavioral Health’s approach integrates care for the mind and body in order to enhance health and to improve our member’s well-being.

C. Quality Improvement Program

The Quality Improvement Program (QIP) is an essential part of Humana Behavioral Health’s health and productivity programs. The QIP provides continuous monitoring and measurement of clinical care quality, service quality, access and availability, prevention screening and consumer satisfaction among other things. The QIP establishes the structure, guidance and expertise needed for Humana Behavioral Health to meet quality benchmarks while striving for improvement year over year.
The QIP is developed with input from a variety of stakeholders, including Humana Behavioral Health’s Senior Leadership Team (SLT) and associates, as well as in-network practitioners. The effectiveness of the Humana Behavioral Health QIP is evaluated through the following activities:

- Monitoring and evaluating key performance indicators centered around quality of care and service
- Identifying opportunities for improvement
- Developing and monitoring interventions to re-measure effectiveness of the program and its interventions

The Humana Behavioral Health SLT has ultimate oversight of the QIP and collaborates with the Quality and Accreditation (Q&A) department to monitor progress. It is Q&A’s responsibility to oversee the development of all QIP documents, including the annual Quality Improvement (QI) Program Evaluation, the QI Program Description and the QI Work Plan.
The 2015 QI Program Evaluation serves as the summary of Q&A’s oversight of Humana Behavioral Health’s clinical and service activities for the year. The evaluation details the objectives,
methodology, and performance of the QIP’s activities. The evaluation is an important tool for stakeholders and health plans to use in their own reviews of the services provided to their members by Humana Behavioral Health.

In an effort to further align with Humana corporate as an enterprise, the QI Program Evaluation moving forward will present data from the fourth quarter of the prior year through the third quarter of the current year (i.e. this year’s document analyzes data from Q4 2015-Q3 2016).

Program Evaluation

Committee Assessment

1. Quality Improvement Committee

The Quality Improvement Committee (QIC) provided oversight of the Utilization Care Management Committee (UCM), Quality of Service Committee (QOS), and Peer Review Committee (PRC). The committee met a total of four times in 2016 at the regularly scheduled sessions during each quarter. The committee reviewed and monitored the following metrics at varying points throughout the year.

- Abandonment rate
- Time to answer
- Service level
- Claims
- Access and availability
- Credentialing
- Member and provider satisfaction survey results
- Complaints
- Welcome calls
- Contractual oversight reviews
- Appeals
- Member safety
- Quality improvement activities (QIA)
- HEDIS measures
- Over/under-utilization trends
- Self-management tools
- Behavioral health screenings
- Coordination of care
- Clinical practice guidelines
- Delegation activities
- Care management (CM) outcomes
- Clinical criteria renewal
• Policy and procedure reviews

The complete list of reports and schedules can be located on the 2016 QI Work Plan. Reports were also streamlined to guarantee consistency between reports, as well as to ensure applicable information was included in the documents. Minutes were taken during every meeting and were reviewed and approved by the committee. A quorum rule was implemented, consisting of 50 percent of the voting population plus one being present at all meetings, to ensure accurate and adequate representation from all departmental areas were included in the committee discussions.

In an effort to encourage improvements across the board, the QIC structure and attendees were evaluated for 2016. Increased participation from the Senior Leadership Team was expected at all scheduled quarterly meetings. The meeting will take place during the third month of each quarter in order to ensure that the meetings that QIC oversees take place prior to the QIC meeting. New participating providers joined the committee to ensure that quality feedback was being gained.

2. Utilization Care Management Committee (UCM)

The UCM continually monitored all utilization management (UM) and Care Management (CM) related metrics throughout 2016. The committee met quarterly in 2016, making a total of four meetings. Committee members reviewed, discussed, and responded to clinical indicators and issues managed by the Q&A and Behavioral Health Clinical Operations (BHCO) departments. The indicators included:

- Over/under-utilization trends
- Effectiveness of the UM and CM programs
- Service availability and hours of operation
- CM Goals met rate
- Program participation rate
- HEDIS measures
- Delegation activities relating to UM
- Inter-rater reliability rating
- Member safety
- Timeliness of adverse determinations and member notification

Once a quarter, the UCM presented relevant data to the QIC for review. A detailed description of the measures reviewed during the UCM meetings is provided in the 2016 Behavioral Health Clinical Services End of Year Evaluation document.

3. Quality of Service Committee

The QOS Committee provided focused oversight on all service related indicators and metrics. The reach of those indicators impacted members, providers, and various stakeholders. The QOS committee evaluated the overall service operation effectiveness through a review of performance indicators, barrier analyses, and proposed improvement activities. The committee aimed to identify, develop, and monitor opportunities for improvement through the
implementation of metric-specific corrective action plans (CAP) as needed. The QOS committee met four times during 2016 as specified by the work plan. In 2016, the committee monitored the following indicators:

- Customer Service and BHCO telephone queues - including telephone abandonment rate, answer times, and service levels
- Claims payment, re-pricing, and financial accuracy
- Access and availability to network providers and practitioners
- Credentialing and re-credentialing
- Member experience and provider satisfaction surveys
- Appeals
- Complaints
- Service-related QIAs
- Delegation activities

4. **Peer Review Committee**

The purpose of the Peer Review Committee (PRC) is to review the findings of investigations regarding quality concerns and sentinel events involving Humana Behavioral Health members receiving care from in-network providers. Humana Behavioral Health staff documented quality concerns and sentinel events in the Quality Management System database. Medical records were requested from the provider for all reported sentinel events to review for member safety. Medical records were also requested for quality concerns which indicated a level of severity that could potentially cause harm to a member. The medical director reviewed an analysis of the medical record and either recommended closure of the investigation for no issue or referred to the PRC. The PRC made requests for corrective action plans as a result of the investigation when warranted. The PRC met quarterly in 2016.

The PRC reviewed one new case during the reporting period of fourth quarter 2015 through third quarter 2016.

The committee voted to close the case as level B – quality concern identified with potential harm to member.

**Quality of Service**

1. **Network Availability**

   **Objective:**

   Humana Behavioral Health aims to provide an adequate network to its membership of over six million, inclusive of Medicare, commercial, and Exchange products. National Network Operations (NNO), with assistance from Q&A, aims to maintain a network availability standard of 90 percent. Humana Behavioral Health aims to maintain appropriate ratio standards for the number of members to practitioners and facilities within a specified mileage.

   **Methodology:**
Humana Behavioral Health assesses adherence to the network availability standards annually.

If the report identifies any deficiency in performance, a market level drill-down is completed to identify outliers, opportunities for improvement, and develop targeted CAPs. Only markets and counties with over 1,000 members will be analyzed for a market level drill-down. This threshold is utilized because Humana Behavioral Health can meet the needs of smaller membership population areas by referring those members to out of network providers and waiving the out-of-network costs. The results of changes in network size are reported to the QIC on an annual basis.

**Analysis and Barriers:**

*2016 Commercial Network Availability*

<table>
<thead>
<tr>
<th>Practitioners &amp; Facilities</th>
<th>Standards</th>
<th>2015 Results</th>
<th>2015 Avg. Distance</th>
<th>2016 Results</th>
<th>2016 Avg. Distance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MD</strong></td>
<td>U: within 10 mi</td>
<td>90.99%</td>
<td>7.1</td>
<td>93.86%</td>
<td>8.25</td>
</tr>
<tr>
<td></td>
<td>S: within 30 mi</td>
<td>79.91%</td>
<td>20.8</td>
<td>98.19%</td>
<td>5.25</td>
</tr>
<tr>
<td></td>
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<td>25</td>
<td>94.22%</td>
<td>24.38</td>
</tr>
<tr>
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<td>6.7</td>
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<td>7.47</td>
</tr>
<tr>
<td></td>
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<td></td>
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<td>94.25%</td>
<td>23.42</td>
</tr>
<tr>
<td><strong>Non-Doctoral Level Non-MD</strong></td>
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<td>98.49%</td>
<td>2.5</td>
<td>99.64%</td>
<td>1.43</td>
</tr>
<tr>
<td></td>
<td>S: within 30 mi</td>
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<td>9.9</td>
<td>99.81%</td>
<td>2.26</td>
</tr>
<tr>
<td></td>
<td>R: within 60 mi</td>
<td>97.90%</td>
<td>15.2</td>
<td>98.34%</td>
<td>12.23</td>
</tr>
<tr>
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<td>6.4</td>
<td>98.80%</td>
<td>4.85</td>
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<tr>
<td></td>
<td>S: within 50 mi</td>
<td>94.72%</td>
<td>18.1</td>
<td>99.42%</td>
<td>7.93</td>
</tr>
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<td>24.1</td>
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</tr>
<tr>
<td><strong>Residential</strong></td>
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<td>95.39%</td>
<td>7.1</td>
<td>97.21%</td>
<td>26.06</td>
</tr>
<tr>
<td></td>
<td>S: within 50 mi</td>
<td>94.58%</td>
<td>18.8</td>
<td>98.84%</td>
<td>9.27</td>
</tr>
<tr>
<td></td>
<td>R: within 100 mi</td>
<td>99.51%</td>
<td>24.8</td>
<td>99.67%</td>
<td>26.06</td>
</tr>
<tr>
<td><strong>Ambulatory</strong></td>
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<td>99.70%</td>
<td>6.1</td>
<td>97.77%</td>
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<td></td>
<td>S: within 50 mi</td>
<td>27.40%</td>
<td>17.7</td>
<td>99.80%</td>
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<td></td>
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<td>99.49%</td>
<td>23.9</td>
<td>99.64%</td>
<td>23.59</td>
</tr>
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<td>Practitioners &amp; Facilities</td>
<td>Standards</td>
<td>2015 Ratio</td>
<td>2016 Ratio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
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<td>---------------------</td>
<td>---------------------</td>
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</tr>
<tr>
<td>MD</td>
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<td>U: 13:2,500</td>
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<td>R: 27:2,500</td>
<td>R: 9:2,500</td>
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<td>U: 22:1000</td>
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</tr>
<tr>
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<td></td>
<td>S: 26:1000</td>
<td>S: 16:1000</td>
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<td>Residential Facility</td>
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<td></td>
<td></td>
<td>R: 59:45,000</td>
<td>R: 145:45,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In 2016, Humana Behavioral Health met all commercial ratio standards. Therefore, no CAP was initiated for commercial availability ratios and no opportunities for improvement were identified.
2016 Medicare/Medicaid Network Availability

<table>
<thead>
<tr>
<th>Practitioners &amp; Facilities</th>
<th>Standards</th>
<th>2015 Results</th>
<th>2015 Avg. Distance</th>
<th>2016 Results</th>
<th>2016 Avg Distance</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD</td>
<td>U: within 10 mi</td>
<td>88.07%</td>
<td>7.92</td>
<td>93.86%</td>
<td>8.25</td>
</tr>
<tr>
<td></td>
<td>S: within 30 mi</td>
<td>75.90%</td>
<td>25.52</td>
<td>98.19%</td>
<td>5.52</td>
</tr>
<tr>
<td></td>
<td>R: within 60 mi</td>
<td>91.68%</td>
<td>29.23</td>
<td>94.22%</td>
<td>24.38</td>
</tr>
<tr>
<td><strong>Doctoral Level Non-MD</strong></td>
<td>U: within 10 mi</td>
<td>89.77%</td>
<td>7.35</td>
<td>96.94%</td>
<td>7.47</td>
</tr>
<tr>
<td></td>
<td>S: within 30 mi</td>
<td>71.61%</td>
<td>27.83</td>
<td>98.23%</td>
<td>4.92</td>
</tr>
<tr>
<td></td>
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<td>90.78%</td>
<td>30.64</td>
<td>94.25%</td>
<td>23.42</td>
</tr>
<tr>
<td><strong>Non-Doctoral Level Non-MD</strong></td>
<td>U: within 10 mi</td>
<td>95.11%</td>
<td>3.89</td>
<td>99.64%</td>
<td>1.43</td>
</tr>
<tr>
<td></td>
<td>S: within 30 mi</td>
<td>81.64%</td>
<td>19.13</td>
<td>99.81%</td>
<td>2.26</td>
</tr>
<tr>
<td></td>
<td>R: within 60 mi</td>
<td>93.60%</td>
<td>22.25</td>
<td>98.34%</td>
<td>12.23</td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>U: within 20 mi</td>
<td>83.25%</td>
<td>15.23</td>
<td>98.80%</td>
<td>4.85</td>
</tr>
<tr>
<td></td>
<td>S: within 50 mi</td>
<td>78.53%</td>
<td>39.51</td>
<td>99.42%</td>
<td>7.93</td>
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<tr>
<td></td>
<td>R: within 100 mi</td>
<td>94.05%</td>
<td>40.19</td>
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</tr>
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<td><strong>Residential</strong></td>
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<td>79.03%</td>
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</tr>
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<td></td>
<td>S: within 50 mi</td>
<td>74.49%</td>
<td>44.39</td>
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</tr>
<tr>
<td></td>
<td>R: within 100 mi</td>
<td>92.73%</td>
<td>44.13</td>
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<td><strong>Ambulatory</strong></td>
<td>U: within 20 mi</td>
<td>94.94%</td>
<td>16.36</td>
<td>99.64%</td>
<td>23.59</td>
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<td></td>
<td>S: within 50 mi</td>
<td>12.86%</td>
<td>40.78</td>
<td>99.81%</td>
<td>6.81</td>
</tr>
<tr>
<td></td>
<td>R: within 100 mi</td>
<td>93.60%</td>
<td>41.19</td>
<td>99.77%</td>
<td>4.43</td>
</tr>
<tr>
<td>Practitioners &amp; Facilities</td>
<td>Standards</td>
<td>2015 Ratio</td>
<td>2016 Ratio</td>
<td></td>
<td></td>
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<tr>
<td>----------------------------------</td>
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<td>---------------</td>
<td>---------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MD</strong></td>
<td>1 per 2500</td>
<td>U: 7:2,500</td>
<td>U: 13:2,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>S: 17:2,500</td>
<td>S: 9:2,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>R: 29:2,500</td>
<td>R: 9:2,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doctoral Level Non-MD</strong></td>
<td>2 per 2500</td>
<td>U: 3:2,500</td>
<td>U: 23:2,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>S: 10:2,500</td>
<td>S: 16:2,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>R: 24:2,500</td>
<td>R: 10:2,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-Doctoral Level Non-MD</strong></td>
<td>2 per 2500</td>
<td>U: 10:2,500</td>
<td>U: 35:2,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>S: 22:2,500</td>
<td>S: 40:2,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>R: 37:2,500</td>
<td>R: 55:2,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Facility</strong></td>
<td>1 per 45,000</td>
<td>U: 13:45,000</td>
<td>U: 70:45,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>S: 34:45,000</td>
<td>S: 47:45,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>R: 37:45,000</td>
<td>R: 66:45,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Residential Facility</strong></td>
<td>1 per 45,000</td>
<td>U: 10:45,000</td>
<td>U: 50:45,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>S: 26:45,000</td>
<td>S: 32:45,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>R: 28:45,000</td>
<td>R: 47:45,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulatory Facility</strong></td>
<td>1 per 45,000</td>
<td>U: 13:45,000</td>
<td>U: 178:45,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>S: 35:45,000</td>
<td>S: 125:45,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>R: 41:45,000</td>
<td>R: 145:45,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In 2016, Humana Behavioral Health met all Medicare ratio standards. Therefore, no CAP was initiated for Medicare availability ratios and no opportunities for improvement were identified.
## 2016 Exchange Network Availability

<table>
<thead>
<tr>
<th>Practitioners &amp; Facilities</th>
<th>Standards</th>
<th>2015 Results</th>
<th>2015 Avg. Distance</th>
<th>2016 Results</th>
<th>2016 Avg. Distance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MD</strong></td>
<td>U: within 10 mi</td>
<td>63.12%</td>
<td>17.7</td>
<td>76.30%</td>
<td>12.2</td>
</tr>
<tr>
<td></td>
<td>S: within 30 mi</td>
<td>61.76%</td>
<td>29.4</td>
<td>84.20%</td>
<td>16.9</td>
</tr>
<tr>
<td></td>
<td>R: within 60 mi</td>
<td>91.21%</td>
<td>31.5</td>
<td>81.60%</td>
<td>38.0</td>
</tr>
<tr>
<td><strong>Doctoral Level Non-MD</strong></td>
<td>U: within 10 mi</td>
<td>67.69%</td>
<td>16.8</td>
<td>83.10%</td>
<td>10.1</td>
</tr>
<tr>
<td></td>
<td>S: within 30 mi</td>
<td>67.89%</td>
<td>27.4</td>
<td>85.40%</td>
<td>14.7</td>
</tr>
<tr>
<td></td>
<td>R: within 60 mi</td>
<td>92.61%</td>
<td>28.8</td>
<td>82.60%</td>
<td>36.7</td>
</tr>
<tr>
<td><strong>Non-Doctoral Level Non-MD</strong></td>
<td>U: within 10 mi</td>
<td>85.76%</td>
<td>8.8</td>
<td>93.80%</td>
<td>4.2</td>
</tr>
<tr>
<td></td>
<td>S: within 30 mi</td>
<td>78.62%</td>
<td>17.7</td>
<td>95.80%</td>
<td>6.8</td>
</tr>
<tr>
<td></td>
<td>R: within 60 mi</td>
<td>97.66%</td>
<td>20.1</td>
<td>91.70%</td>
<td>24.1</td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>U: within 20 mi</td>
<td>32.97%</td>
<td>101.7</td>
<td>47.10%</td>
<td>53.5</td>
</tr>
<tr>
<td></td>
<td>S: within 50 mi</td>
<td>52.48%</td>
<td>70.5</td>
<td>60.70%</td>
<td>61.7</td>
</tr>
<tr>
<td></td>
<td>R: within 100 mi</td>
<td>83.45%</td>
<td>70.2</td>
<td>78.00%</td>
<td>74.1</td>
</tr>
<tr>
<td><strong>Residential</strong></td>
<td>U: within 20 mi</td>
<td>22.45%</td>
<td>123.9</td>
<td>32.40%</td>
<td>104.6</td>
</tr>
<tr>
<td></td>
<td>S: within 50 mi</td>
<td>46.99%</td>
<td>82.4</td>
<td>44.40%</td>
<td>101.7</td>
</tr>
<tr>
<td></td>
<td>R: within 100 mi</td>
<td>72.95%</td>
<td>85</td>
<td>61.70%</td>
<td>107.6</td>
</tr>
<tr>
<td><strong>Ambulatory</strong></td>
<td>U: within 20 mi</td>
<td>54.68%</td>
<td>116.7</td>
<td>50.80%</td>
<td>85.0</td>
</tr>
<tr>
<td></td>
<td>S: within 50 mi</td>
<td>10.03%</td>
<td>70</td>
<td>64.90%</td>
<td>40.8</td>
</tr>
<tr>
<td></td>
<td>R: within 100 mi</td>
<td>86.68%</td>
<td>68.6</td>
<td>77.90%</td>
<td>77.2</td>
</tr>
</tbody>
</table>
Humana Behavioral Health began evaluating the Exchange network in 2016 and utilized very similar standards to the commercial availability. Based on the similar commercial standards, the Exchange network availability fell out of compliance with the 90 percent goal in all but three areas. One of the biggest barriers for the Exchange network is that it is considered to be very narrow versus the other lines of business which gives these members fewer options for treatment.

### 2016 Interventions:

NNO continued to compare the Humana Behavioral Health provider directory to competitors’ directories, state licensing board rosters, out-of-network claims, and the American Hospital Directory. In doing this, NNO was able to identify providers and facilities that have not been contracted and proactively reach out in an effort to broaden the network. The Data Collection and Verification (DCAV) team continued to ensure all current providers demographic data was up to date and identified additional locations for providers, closing the gap in some deficient

<table>
<thead>
<tr>
<th>Practitioners &amp; Facilities</th>
<th>Standards</th>
<th>2015 Ratio</th>
<th>2016 Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MD</strong></td>
<td>1 per 2500</td>
<td>U: 6:2500</td>
<td>U: 33:2500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S: 12:2500</td>
<td>S: 21:2500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>R: 39:2500</td>
<td>R: 16:2500</td>
</tr>
<tr>
<td><strong>Doctoral Level Non-MD</strong></td>
<td>2 per 2500</td>
<td>U: 6:2500</td>
<td>U: 49:2500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S: 13:2500</td>
<td>S: 34:2500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>R: 28:2500</td>
<td>R: 18:2500</td>
</tr>
<tr>
<td><strong>Non-Doctoral Level Non-MD</strong></td>
<td>2 per 1000</td>
<td>U: 7:1000</td>
<td>U: 51:1000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S: 18:1000</td>
<td>S: 35:1000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>R: 39:1000</td>
<td>R: 24:1000</td>
</tr>
<tr>
<td><strong>Inpatient Facility</strong></td>
<td>1 per 45,000</td>
<td>U: 2:45000</td>
<td>U: 64:45000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S: 10:45000</td>
<td>S: 45:45000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>R: 19:45000</td>
<td>R: 37:45000</td>
</tr>
<tr>
<td><strong>Residential Facility</strong></td>
<td>1 per 45,000</td>
<td>U: 1:45000</td>
<td>U: 29:45000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S: 5:45000</td>
<td>S: 21:45000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>R: 11:45000</td>
<td>R: 16:45000</td>
</tr>
<tr>
<td><strong>Ambulatory Facility</strong></td>
<td>1 per 45,000</td>
<td>U: 3:45000</td>
<td>U: 186:45000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S: 19:45000</td>
<td>S: 138:45000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>R: 31:45000</td>
<td>R: 88:45000</td>
</tr>
</tbody>
</table>
areas. Humana Behavioral Health’s contracting team within NNO is actively working on addressing all gaps to ensure an adequate network for the annual Centers for Medicaid and Medicare Services (CMS) filing, which should in turn improve the annual network availability report in 2017. The project will be ongoing, but should be concluded within six to 12 months.

Humana Behavioral Health focused on building and mirroring a network based on the medical market’s recruitment model. However, because the Exchange network is a narrow network, the standards and ratios will need to be re-evaluated for 2017 to ensure they are applicable and provide an accurate picture.

**Recommendations:**

Humana Behavioral Health will continually work to expand the provider network and annually monitor its commercial, Medicare and Exchange network availability. Humana Behavioral Health’s QIC will continue to monitor all deficient areas and implemented CAPs that are developed from the 2016 network availability report and make recommendations as necessary.

2. **Accessibility of Services**
   a) Emergent and Urgent Care

   **Objective:**
   Members or designees calling on behalf of a member seeking access to care during an emergent situation have access to services within one hour for life threatening situations and within six hours for non-life threatening situations. Urgent calls from a member or designee for access to services occur within 24 hours for Medicare/Medicaid members and within 48 hours for commercial members.

   **Methodology:**
   Data is collected from CGX, analyzed by the Quality Reporting Team and reported on a quarterly basis to the UCM and QIC Committees.

   **Analysis and Barriers:**
   - Emergent NLT 2016 Q1 had 99.8% with 3 cases out of compliance.
   - Emergent NLT 2016 Q2 had a 99.94% with 1 case out of compliance.
   - Q3 reached 100% compliance in all categories
   - Emergent LT and Urgent Accessibility were 100% complaint.

   **Interventions:**
   - Quality has worked with the HBH Reporting team to adjust the report for better efficiency and accuracy.
- The new report has been released into the production environment for use by the Quality and Accreditation team.

**Recommendations:**
- Continue quarterly monitoring and reporting to UCM and QIC as directed.

<table>
<thead>
<tr>
<th>Accessibility of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Level</td>
</tr>
<tr>
<td>Emergent LT</td>
</tr>
<tr>
<td>Emergent NLT</td>
</tr>
<tr>
<td>Urgent (COM)</td>
</tr>
<tr>
<td>Urgent (MCR &amp; MCD)</td>
</tr>
</tbody>
</table>

**a) Routine Care**

**Objective:**
The routine accessibility measure states that at least 85 percent of members or designees calling for routine services will have access to such care within 10 business days of a requested referral.

**Methodology:**
Data is collected from CGX, analyzed by the Quality Reporting Team and reported on a quarterly basis to the UCM and QIC Committee

**Analysis and Barriers:**
This metric met the 85 percent goal in quarter 2 at 90.11% percent compliance and Q3 at 89.40%

**Interventions:**
- Quality has worked with the HBH Reporting team to adjust the report for better efficiency and accuracy.
- The new report has been released into the production environment for use by the Quality and Accreditation team.

**Recommendations:**
- Continue quarterly monitoring and reporting to UCM and QIC.

<table>
<thead>
<tr>
<th>Routine Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal</td>
</tr>
<tr>
<td>85%</td>
</tr>
</tbody>
</table>
3. **Network Credentialing and Re-Credentialing**

**Objective:**

To ensure a network of qualified practitioners and providers is available to members by demonstrating compliance with all applicable regulatory credentialing/re-credentialing requirements and to ensure member safety. Network credentialing and re-credentialing are required to comply with all state and federal regulatory requirements, to comply with health plan standards, and to maintain accreditations and necessary certifications. The goals of newly credentialed providers are dependent upon the new contracts initiated by the NNO team with the objective to credential the providers within 7 days of receipt of the Credentialing department.

**Methodology:**

The Humana Corporate Credentialing department oversees credentialing for all Humana and ChoiceCare markets, including Humana Behavioral Health. Credentialing and re-credentialing data is presented annually to the Humana Behavioral Health QIC. The credentialing and re-credentialing process is centralized at the Humana enterprise level and is an industry-standard, systematic approach to the collection and verification of a provider applicant’s professional qualifications. The assessment and verification of these qualifications helps to confirm that each contracted network provider meets criteria relating to professional competence, which includes review of relevant training, academic background, licensure and certification, registration to practice in a health care field, verification of professional practice history and hospital affiliations (for physicians). Additionally, re-credentialing is conducted every three years or sooner after the original credentialing decision to ensure professional qualifications remain valid and current.

**Analysis and Barriers:**

<table>
<thead>
<tr>
<th>Credentialing Market</th>
<th>Initial Credentialing</th>
<th>Re-credentialing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioners</td>
<td>6,372</td>
<td>3,411</td>
</tr>
<tr>
<td>Organizations</td>
<td>252</td>
<td>128</td>
</tr>
</tbody>
</table>

Source: Humana Corporate Credentialing HBH market cred Jan 2016– Nov 2016, compared to Jan 2015-mid-Nov 2015

During 2016, Humana Corporate Credentialing completed credentialing of 6,372 new practitioners for the Humana Behavioral Health network. This is a significant increase compared to the 3,411 new practitioners credentialed in 2015. Additionally in 2016, 301 new facilities were credentialed; this is an increase compared to the 128 new facilities credentialed in 2015.
Re-credentialing efforts in 2016 were on target for the providers that were due for re-credentialing; 13,862 practitioners and 301 facilities were re-credentialed. For 2015, there were 8,934 practitioners and 349 facilities re-credentialed.

In 2016, the turnaround time for credentialing and re-credentialing was 3.80 days, compared to 3.52 days in 2015; although the turnaround time increased slightly, the team was still within the goal for turnaround time of 7 days. The goal changed from 14 days to 7 days mid-year and was due to a service level agreement with the NNO team. In addition, no Humana Behavioral Health providers were terminated for quality reasons in 2016. Furthermore, no complaints were received regarding the credentialing/re-credentialing process or alleging discrimination.

With primary use of the credentialing applications from, Council for Affordable Quality Healthcare (CAQH), the on-line platform for credentialing applications, any website issues will cause delay in getting practitioner applications. Compared to the significant web enhancement in 2015, the downtime decreased significantly, however there were a few instances with the website having issues. The Credentialing staff at Humana worked closely to monitor the status and availability of the website and did not have need to offer alternative processes as any issues were promptly corrected.

Compared to the process changed during the fall of 2015, the task flow process has aligned to Accelerated Provider Exchange System (APEX) very well. At the beginning of the year in 2016, there were still a few instances with catching up, but as the year progressed the flow and business rules have worked systematically as APEX was designed.

Interventions:

To continue the efficiency of the re-credentialing of providers, the Corporate Credentialing department continued to encourage providers to be credentialed through CAQH. Humana staff continued to work with CAQH to recommend enhancements to their process in order to keep the re-credentialing process timely and efficient in order to maintain the Humana Behavioral Health network. Although Humana Behavioral Health, required CAQH applications for network participation, recredentialing providers still had the option to use an alternative application.

Recommendations:

Beginning in 2017, the department has initiated a policy where providers will be required to use the CAQH credentialing systems. If practitioners do not have a CAQH application, VP approval will be required. This will streamline the credentialing process for all levels of credentialing. Providers who are not currently registered with CAQH are being faxed notification of the change and training options. Credentialing and re-credentialing activity will continue to be reported to the QOS Committee and QIC on a quarterly basis. Complaints related to this process will continue to be monitored and reported as needed. For 2017, Humana Behavioral Health will continue use of processing providers in the Accelerated Provider Exchange System (APEX).
4. **Telephone Queue Answer Time and Abandonment Rate**

a. **Average Speed of Answer (ASA) Time**
   
   **Objective:**
   
   Humana Behavioral Health monitors the customer service, provider relations and UM telephone queues against established goals and maintains an average call answer time of 30 seconds or less.

   **Methodology:**
   
   Time to answer is measured from the caller’s first ring to the connection with a live Humana Behavioral Health associate. The measure is inclusive of time needed to determine and deliver the call to the appropriate queue. Data is collected and monitored on a monthly basis and any metrics that fall below the target performance level are captured in a CAP.

   **Average Speed of Answer (ASA) In Seconds**

<table>
<thead>
<tr>
<th></th>
<th>Goal</th>
<th>Q1 2016</th>
<th>Q2 2016</th>
<th>Q3 2016</th>
<th>Q4 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Relations</td>
<td>30</td>
<td>17.3</td>
<td>23.6</td>
<td>38.9</td>
<td>27.1</td>
</tr>
<tr>
<td>Customer Service</td>
<td>30</td>
<td>12.3</td>
<td>21.2</td>
<td>38.9</td>
<td>27.1</td>
</tr>
</tbody>
</table>

   **Barriers:** Customer Service experienced an increase of calls and handle time during Q3 2016 with the incorporation of Humana One member and provider calls. These calls were previously handled by a dedicated team however when the calls merged, Mentor documents were updated which allowed our Medical Counterparts to route additional calls into the Contact Center.

   Interventions: Leadership noticed a decline in metrics and hired Limited Term Associates to assist with the increase in volume for Q3 and the forecasted increase for the beginning of the year. We received assistance from cross trained associates within Welcome Calls as well. With the additional support, the department was able to recover in Q4.

   **Customer Service and Provider Relations Queues**

   - Leaders identified how many staff in various roles and responsibilities were needed during peak volumes times. Other factors considered included the number of calls waiting as well as after call work (ACW) to drive leader’s online support and real time extra/overtime support needs.
   - Cross-functional staff training for the Welcome Call team was implemented. These specialists worked during morning and late afternoon hours to support the Customer Service during high call volumes peak times.
   - Information Specialist monitors the queues and adjust break and lunch schedules as needed to provide full coverage.
• An unscheduled absence “make up” option plan was implemented for up to eight hours specifically for specialists to gain additional production hours and reinforce attendance commitments.

**Recommendations:**

The telephone queue average time to answer will continue to be analyzed and monitored by the Staffing Optimization group (Staffing Ops). Appropriate CAPs will be put in place when monthly goals are not in compliance. These metrics will be discussed in the appropriate committees, such as the QOS Committee and QIC meetings per the work plan schedule.

b. **Abandonment Rate**

**Objective:**

Humana Behavioral Health’s customer service and provider relations queues will maintain an abandonment rate of five percent or less.

**Methodology:**

The abandonment rate is the percentage of calls disconnected prior to the calls being answered by a live person. The abandonment rate is calculated by dividing the number of calls abandoned after 30 seconds of hold time by the total number of calls received by a specific phone queue. The data is monitored on a monthly basis and any queue that falls below the target performance level is addressed in a CAP.

<table>
<thead>
<tr>
<th>Abandonment Rate</th>
<th>Goal</th>
<th>Q1 2016</th>
<th>Q2 2016</th>
<th>Q3 2016</th>
<th>Q4 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Relations</td>
<td>&lt;5%</td>
<td>1.10%</td>
<td>1.50%</td>
<td>2.10%</td>
<td>2.40%</td>
</tr>
<tr>
<td>Customer Service</td>
<td>&lt;5%</td>
<td>3.40%</td>
<td>3.90%</td>
<td>4.20%</td>
<td>3.20%</td>
</tr>
</tbody>
</table>

**Customer Service and Provider Relations Queues**

**Barriers:** Customer Service experienced an increase of calls and handle time during Q3 2016 with the incorporation of Humana One member and provider calls. These calls were previously handled by a dedicated team however when the calls merged, Mentor documents were updated which allowed our Medical Counterparts to route additional calls into the Contact Center.

**Interventions:** Leadership noticed a decline in metrics and hired Limited Term Associates to assist with the increase in volume for Q3 and the forecasted increase for the beginning of the year. We received assistance from cross trained associates within Welcome Calls as well. With the additional support, the department was able to recover in Q4.
**Recommendations:**

Ongoing analysis and monitoring will continue by the Staffing Ops department for the telephone abandonment rates. A CAP will be initiated if the metrics are out of compliance during a reporting period month or quarter. The BHCO team will report results and any CAPs quarterly to the QOS and QIC committees.

c. **Service Level**

**Objective:**

Humana Behavioral Health’s customer service and provider relations queues will maintain a service level of 80 percent or greater.

**Methodology:**

In order to assess the efficiency in which Customer Service handles call volume, the service level metric is utilized. The service level metric is a combination of total acceptable calls, abandoned calls, handled calls, calls abandoned above a threshold, and calls answered. The service level is calculated as follows: the number of acceptable calls handled multiplied by the sum of the actual handled calls and total abandoned calls divided by the sum of the actual handled calls and total abandoned minus the number of calls abandoned before the threshold of 30 seconds. This measure is monitored on a monthly basis and a CAP is implemented for any queue that performs below the goal.

<table>
<thead>
<tr>
<th>Service Level Rate</th>
<th>Goal</th>
<th>Q1 2016</th>
<th>Q2 2016</th>
<th>Q3 2016</th>
<th>Q4 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Relations</td>
<td>&gt;80%</td>
<td>86.9%</td>
<td>84.7%</td>
<td>76.5%</td>
<td>78.9%</td>
</tr>
<tr>
<td>Customer Service</td>
<td>&gt;80%</td>
<td>85.5%</td>
<td>80.9%</td>
<td>72.9%</td>
<td>83.2%</td>
</tr>
</tbody>
</table>

**Barriers:** Customer Service experienced an increase of calls and handle time during Q3 2016 with the incorporation of Humana One member and provider calls. These calls were previously handled by a dedicated team however when the calls merged, Mentor documents were updated which allowed our Medical Counterparts to route additional calls into the Contact Center.

**Interventions:** Leadership noticed a decline in metrics and hired Limited Term Associates to assist with the increase in volume for Q3 and the forecasted increase for the beginning of the year. We received assistance from cross trained associates within Welcome Calls as well. With the additional support, the department was able to recover in Q4.
Recommendations:

This service level measure will continue to be monitored and analyzed by the Staffing Ops department for compliance. A CAP will be implemented in the event of non-compliance. This metric will be reported by the Customer Service department to both the QOS and QIC committees.

5. Claims Statistics

a. Claims Processing Turnaround Time

Objective:

Humana Behavioral Health quarterly reports the turnaround time for claims re-pricing and claims payment within the scope of the Humana National contract requirements. The established benchmark for re-priced claims is seven days or fewer. The established benchmark for payment of a claim is 30 days or fewer.

Methodology:

The claims turnaround time performance is monitored monthly and reported on a quarterly basis. The formulas below are utilized to calculate compliance with these measures:

- Claims Paid Turnaround Time – The total number of days between claims receipt date and claims paid date for all claims paid during a set time period. This number is then divided by the total number of claims paid during that same time period.
- Claims Re-priced Turnaround Time – Average number of claims received per day, for a rolling 90-day period, divided by the current inventory on hand.

Analysis and Barriers:

<table>
<thead>
<tr>
<th>Claims Processing Turnaround Time</th>
<th>BENCHMARK</th>
<th>Q4 2015</th>
<th>Q1 2016</th>
<th>Q2 2016</th>
<th>Q3 2016</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>EAP Paid Claims TAT</td>
<td>≤30 days</td>
<td>11</td>
<td>15</td>
<td>17</td>
<td>10</td>
<td>13.25</td>
</tr>
<tr>
<td>Repriced Claims TAT</td>
<td>≤7 days</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>6</td>
<td>3.5</td>
</tr>
</tbody>
</table>

The average number of days to pay a claim in 2016 was 13.25 days. This was an increase from 11.92 days during 2015. Overall, the average number of days to re-price claims in 2016 was 3.5 days. This was a slight decrease with 3.83 days during 2015. We did identify that during Q2 2016, there was a staffing change that impacted the overall TAT for EAP Paid Claims.

Recommendations:
Continue to monitor the claims payment and re-pricing turnaround time and to maintain compliance with the goals. The results will continue to be reported to QOS and QIC on a quarterly basis.

b. Claims Payment Accuracy

Objective:

Humana Behavioral Health regularly monitors Humana EAP claims payment accuracy to ensure proper reimbursement. The performance for EAP claims payment accuracy is measured for compliance at 98 percent or greater.

Methodology:

This measure is defined as the rate of errors that cause the claim to be denied or paid erroneously. The total number of audited claims minus the number of payment accuracy errors, divided by the total number of audited claims is the calculation for this measure. Accuracy performance is monitored monthly and reported on a quarterly basis.

Analysis and Barriers:

<table>
<thead>
<tr>
<th>Claims Processing Turnaround Time</th>
<th>BENCHMARK</th>
<th>Q4 2015</th>
<th>Q1 2016</th>
<th>Q2 2016</th>
<th>Q3 2016</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>EAP Claims - Payment Accuracy</td>
<td>&lt; 98%</td>
<td>99%</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The EAP claims payment accuracy rate exceeded the goal at 100 percent during 2016. There was an increase from the 2015 rate of 99 percent. There were no barriers or challenges identified during the reporting period.

Recommendations:

Continue to monitor the EAP claims payment accuracy. The results will be reported to the QOS and QIC committees on a quarterly basis.

c. Claims Financial Accuracy

Objective:

Humana Behavioral Health examines and monitors claim financial accuracy to ensure proper reimbursement within the scope of the Humana National contract requirements. The performance goal for EAP claims financial accuracy is 99 percent or greater.

Methodology:
Financial accuracy errors are defined as over- or under-payments of paid claims. The measure is calculated by the total dollars audited minus the dollars over-/under-paid, divided by the total number of dollars audited.

**Analysis and Barriers:**

The EAP claims financial accuracy exceeded the goal at 100 percent during 2016, which was consistent with 2015’s result.

**Recommendations:**

Continue to monitor the EAP claims financial accuracy and maintain compliance. The results will be reported to the QOS and QIC committees on a quarterly basis.

6. **Complaints**

**Member Complaints**

a. **Member Complaints per 1000**

**Objective:**
Humana Behavioral Health is dedicated to serving members and resolving behavioral health concerns in a timely manner that balances the needs of members, practitioners and providers. The goal regarding member complaints is to receive 0.00-0.30 complaints per 1,000 members per quarter.

**Methodology:**
The ratio of complaints received is tracked and trended by complaint category. The ratio of complaints per 1,000 members is calculated by multiplying the total number of complaints received and 1,000 then dividing by the account membership.

<table>
<thead>
<tr>
<th>Member Complaints per 1000</th>
<th>Goal</th>
<th>Q1 2016</th>
<th>Q2 2016</th>
<th>Q3 2016</th>
<th>Q4 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Complaints per 1000</td>
<td>&lt;.30</td>
<td>0.0090</td>
<td>0.0047</td>
<td>0.0088</td>
<td>0.0018</td>
</tr>
</tbody>
</table>

**Analysis and Barriers:**
Humana Behavioral Health was delegated the process complaints for Humana beginning in the fourth quarter of 2015. Humana Behavioral Health met the goal of 0.00-0.30 complaints per 1,000 at 0.5 percent in the measurement period of the fourth quarter 2015 through the third quarter 2016.

**Recommendations:**
Humana Behavioral Health Quality and Accreditation (Q&A) will continue to monitor member complaints per 1,000 and report to the Quality of Service Committee (QOS) and Quality Improvement Committee (QIC) quarterly.
b. Member Complaints Turnaround Time

Objective:
Timely response to member complaints is essential in providing quality customer service. The goal is to respond within of 30 calendar days of receipt of the complaint.

Methodology:
Complaint turnaround time is indicated as the average number of days from the receipt of the complaint to resolution. All complaints received are logged for tracking and trending purposes and documented in the Humana Behavioral Health electronic database. Complaints are investigated and resolved through a process that considers the clinical urgency of the situation. Clinically urgent complaints are resolved in accordance with the medical immediacy of the issue. Humana Behavioral Health policy is that these complaints are to be resolved in one business day.

<table>
<thead>
<tr>
<th>Member Complaints Turn Around Time</th>
<th>Goal</th>
<th>Q1 2016</th>
<th>Q2 2016</th>
<th>Q3 2016</th>
<th>Q4 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Complaints Turn Around Time</td>
<td>&lt;30 Days</td>
<td>27.7</td>
<td>12.7</td>
<td>22.0</td>
<td>7.5</td>
</tr>
</tbody>
</table>

Analysis and Barriers:
The average turnaround time for completion of the complaint process was 17 days for in 2015. In 2016, the average turnaround time for completion of the complaint process was 18 days. Complaint processing for Humana members was completed through the Humana Quality Management System (QMS). The QMS system allows for a more centralized repository for tracking and trending complaints. This system also allowed for closer monitoring of turnaround times. The Quality team updated and conducted organization wide training for all member-facing associates on the use of the QMS system to promote consistency and accuracy in referrals.

Recommendations:
Complaint turnaround time will continue to be monitored on a weekly, monthly and quarterly basis by Humana Behavioral Health Q&A and reported to QOS and QIC quarterly.

c. Member Complaints by Category

Objective:
Humana Behavioral Health is dedicated to serving members and resolving behavioral health concerns in a timely manner by balancing the needs of members, practitioners and providers.

Methodology:
Each complaint is categorized by type for reporting purposes. Trends are identified and reported to the appropriate departments and quality committees, and process improvements are recommended as needed. Examples of complaint categories include:

- Quality of Care
- Access to Providers
- Access to Humana/Humana Behavioral Health
- Attitude/Service of Provider
- Attitude/Service of Provider Staff
- Billing/Financial
- Quality of Practitioner Office Site

Humana Behavioral Health requests a written response from the provider regarding the allegations and concerns presented by a member. The medical director completes a review of any complaints that are deemed a quality of care concern. Complaints may be referred to the Peer Review Committee for analysis. Annual member experience surveys are conducted to monitor the satisfaction with quality of service and attitude of providers.

Analysis and Barriers:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Care</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>Access to Provider</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Access to HBH Services</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Attitude/Service of Provider</td>
<td>27</td>
<td>0</td>
<td>27</td>
<td>12</td>
</tr>
<tr>
<td>Attitude/Service of Provider Staff</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Billing / Financial</td>
<td>6</td>
<td>0</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Quality of Practitioner Office</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>2</td>
<td>37</td>
<td>40</td>
</tr>
</tbody>
</table>

Humana Behavioral Health received a total of 42 member complaints in the fourth quarter 2015 through third quarter 2016 reporting period compared to 77 in the 2015 reporting period. The decrease was due to a change in the complaint process. In the early spring of 2016, all complaints had to be warm transferred to Humana Customer Service to be filtered for relevance before being sent through QMS. Quality of Care and Attitude complaints were sent to HBH to gather information for the cases. Billing complaints were investigated and resolved by Humana Inc. The data from the 2015 reporting period was updated to accurately represent the current QMS numbers and may differ from previous reports. QMS was still under development and included daily meetings until summer 2016. The updates to the data also reflect the change from legacy reporting out of Dimension to QMS data and complaint categories.

After any allegation against a provider was made, a response was requested from the provider. The responses were reviewed by a quality master’s level clinician and/or medical director. There was no quality of care concerns noted. In addition, there were no trends found with any specific provider. There were no complaints received regarding the case management program and there were no complaint appeals.
Interventions:
All complaints reviewed were brought to resolution. No interventions were implemented in the reporting period.

Recommendations:
Member complaints will continue to be monitored by Q&A and reported to QOS and QIC quarterly.

Provider Complaints
a. Provider Complaints per 1,000
Objective:
Humana Behavioral Health maintains a goal to receive fewer than 8.50 provider complaints per 1,000 providers.

Methodology:
Provider complaints are evaluated monthly and reported to the QIC. The ratio of complaints per 1,000 providers is calculated by multiplying the total number of complaints received and 1,000 then dividing by the provider membership within states with complaints. Humana Behavioral Health tracks and trends complaints per 1,000 providers.

<table>
<thead>
<tr>
<th>Provider Complaints per 1000</th>
<th>Goal</th>
<th>Q1 2016</th>
<th>Q2 2016</th>
<th>Q3 2016</th>
<th>Q4 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Complaints per 1000</td>
<td>&lt;8.5</td>
<td>0.4365</td>
<td>0.7253</td>
<td>0.2431</td>
<td>0.3152</td>
</tr>
</tbody>
</table>

Analysis and Barriers:
In 2015, Humana Behavioral Health received 16 provider complaints, resulting in an average of 0.4 complaints per 1,000 providers. This is similar data from 2014 in which there were 16 provider complaints (1.36 per 1,000). The difference in the complaints per 1000 providers’ calculation is due to the different state membership. Maintaining the low complaint numbers can be attributed to the efforts by the Provider Relations team to continue their focus of educating providers on the appropriate process to follow to ensure accurate and timely claims resolution.

Recommendations:
Humana Behavioral Health Q&A will continue to monitor provider complaints per 1,000. This performance indicator will continue to be reported to the QOS and QIC on a quarterly basis.

b. Provider Complaints Turnaround Time
Objective:
Timely response to provider complaints is essential in providing quality customer service. The goal is to resolve within of 30 calendar days of receipt of the complaint.

Methodology:
Provider complaints are documented in the Humana Behavioral Health electronic patient database and are logged for tracking and trending purposes. Humana Behavioral Health maintains a process to track and trend complaints to identify areas of dissatisfaction and compliance with federal and state regulations. Complaint turnaround times represent the average number of days between receipt of the complaint and resolution.

<table>
<thead>
<tr>
<th>Provider Complaints Turn Around Time</th>
<th>Goal</th>
<th>Q1 2016</th>
<th>Q2 2016</th>
<th>Q3 2016</th>
<th>Q4 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Complaints Turn Around Time</td>
<td>&lt;30 Days</td>
<td>17.0</td>
<td>7.3</td>
<td>17.0</td>
<td>13.5</td>
</tr>
</tbody>
</table>

**Analysis and Barriers:**
The average turnaround time for complaint processing in the 2016 reporting period was 13 days. In 2015, the turnaround time was 8 days. The slight increase to the turnaround time was attributed to training of a new member safety consultant in Q4 2015.

**Recommendations:**
Complaint turnaround time will continue to be monitored and reported to QOS and QIC quarterly.

c. **Provider Complaints by Category**

**Objective:**
Provider complaints are reviewed by a Master’s level or higher clinician and investigated to full resolution. All complaints are logged for tracking and trending purposes.

**Methodology:**
All Humana Behavioral Health provider complaints are analyzed and evaluated for trends in a number of categories including:
- Quality of Care
- Utilization Management/UR
- Access to HBH Services
- Billing/Financial
- Contracting/Credentialing

**Analysis and Barriers:**

<table>
<thead>
<tr>
<th>Provider Complaints</th>
<th>Humana Behavioral INN Prov</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints Per Category</td>
<td>Q4 2014 - Q3 2015</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>4</td>
</tr>
<tr>
<td>Utilization Management/UR</td>
<td>0</td>
</tr>
<tr>
<td>Access to HBH Services</td>
<td>6</td>
</tr>
<tr>
<td>Billing/Financial</td>
<td>4</td>
</tr>
<tr>
<td>Contracting/Credentialing</td>
<td>2</td>
</tr>
</tbody>
</table>
Humana Behavioral Health received 16 complaints from in-network providers. The majority of complaints reported in this category were issues related to the Utilization Management peer-to-peer review process, noted as either Utilization Management/UR or Access to HBH Services. The increase is attributed to updates to the data to reflect the change from legacy reporting out of Dimension to QMS data and complaint categories. Four complaints regarding billing and financial issues were received in 2016 and four in 2015. There were no trends noted.

Recommendations:
Humana Behavioral Health will continue to monitor and report provider complaints to the QOS and QIC quarterly.

7. Medicare Denial of Continued Stay (MDOC)

Objective:
Humana Behavioral Health allowed providers the opportunity to dispute adverse determinations regarding claims and contractual obligations. Humana Behavioral Health provided a thorough and fair review, taking into consideration all information obtained, gathered and/or submitted. All clinical care appeals and disputes are internally audited to evaluate and analyze appropriate handling and timely processing.

Methodology:
Upon denial, providers are given a letter of notification indicating the appeal rights that are available to them. In some instances, providers may be allowed the same dispute rights as the member based on CMS requirements for Medicare. In the event the denial is issued only to the provider, that provider has the right to one level of dispute resolution through Humana Behavioral Health. The provider dispute resolution categories are classified as claims, and contractual dispute resolution.

Analysis and Barriers:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Claims</th>
<th>Contractual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4 2014</td>
<td>76</td>
<td>141</td>
</tr>
<tr>
<td>Q1 2015</td>
<td>75</td>
<td>105</td>
</tr>
<tr>
<td>Q2 2015</td>
<td>73</td>
<td>118</td>
</tr>
<tr>
<td>Q3 2015</td>
<td>73</td>
<td>124</td>
</tr>
<tr>
<td>Reporting Year 2015 YTD</td>
<td>297</td>
<td>488</td>
</tr>
<tr>
<td>Q4 2015</td>
<td>73</td>
<td>153</td>
</tr>
<tr>
<td>Q1 2016</td>
<td>78</td>
<td>176</td>
</tr>
</tbody>
</table>
Disputes related to claims issues are comprised of providers appealing on their own behalf regarding an adverse determination or a disputed claim payment.

Contractual disputes allow Humana Behavioral Health participating providers the right to an internal dispute resolution process on a contractual notice of non-authorization.

Members are not responsible for payment on these claims and are held harmless as the provider’s contractual agreement is being disputed.

As of April 21, 2016 HBH discontinued the MDOC’s process at the request of Regulatory Compliance as these were determined to be organizational determinations. As a result the numbers significantly decreased during Q2 2016 and was not available during Q3 2016.

Interventions:

Currently the provider dispute process is being designed through collaboration with Humana Inc. to update workflows and processes. This should be completed by the end of the first quarter of 2017.

Recommendations:

A process will be implemented to address provider complaints due to the discontinuation of this process. This process should mirror the Humana Inc. process that is currently in place for provider complaints.

8. **Satisfaction**
   
a. **Member Experience Survey**
   
   **Objective:**
   To improve the level of satisfaction of Humana Behavioral Health Members
   
   **Methodology:**
   A survey is sent yearly, via the use of a vendor – *SPH Analytics*, mailed out to 1,650 members, with 450 completed surveys for a response rate of 31.1%. The survey consists of 37 questions. The survey period runs from January to May of each year. The vendor (*SPH Analytics*) sends weekly updates with results during the reporting period. At the end of the survey period, the vendor sends a completed report with all findings from members.
   
   **Analysis and Barriers:**
   For the Member Experience Survey, the results reflected that when asked the question: How likely are you to recommend Humana Behavioral Health to a friend or family member?
Of 254 eligible responses, 239 answered they are likely to recommend, while 15 members did not answer. This sample question includes responses from members that are male and female, and including high school graduates, members who have had some college experience, and members that are college graduates, also including White, Black/African American, Asian, Hispanic/Latino, and other ethnicities.

The overall percentage of all respondents indicates that 72% are likely to recommend HBH.

Another question included in the Member Experience Survey was: In the last 12 months, did you get counseling, treatment, or medicine for any of these reasons?

There were 246 eligible responses via mail. 15 members did not respond, while 231 responses were received, indicating 183 had received treatment, and 48 hadn’t received treatment.

The questions above are only a few questions, however there were several other questions provided to the members for responses.

In 2016 a new vendor was utilized who used a new standardized survey, the ECHO v. 3.0 which aligns with the CAHPS survey for behavioral health, in hopes to have a better understanding of satisfaction drivers for members. As a result the 2016 and 2015 surveys cannot be compared.

**Barriers and Interventions:**

One barrier noted in the Customer Satisfaction Survey was the member experience with customer service. Customers reported being passed from one person to another. When this issue was looked at more deeply it became clear that the number of call queues caused a lot of confusion which resulted in increased transfers and hold times. The intervention for this was a re-organization of the queues to eliminate the confusing process which is currently under way.

**Recommendations:**

HBH will continue to monitor the customer service queues to ensure that the process is as streamlined as possible. In 2017 HBH should focus on all member queues with the intention of making them as clear as possible.

**b. Practitioner Satisfaction Survey**

**Objective:**

To improve the levels of satisfaction amongst Humana Behavioral Health Practitioners

**Methodology:**

Yearly, a survey is sent out via mail to a sample size, depending on the amount of practitioners/providers Humana Behavioral Health utilizes. For 2016, 5,000 surveys were mailed to providers. Out of 5,000 surveys sent, only 766 completed surveys were received. The response rate was only 14% for the 2016 survey. The reporting period for this survey is January to May of each year. This survey was completed and compiled within Humana Behavioral Health, in the Quality and Accreditation department.

**Analysis and Barriers:**

For the Practitioner Satisfaction Survey, the target satisfaction rate is 90% in all categories. Based on the results of the 2016 survey, none of the categories met the target rate. Please see the categories and percentages listed below:
Barriers and Interventions:
The biggest barrier that was identified on the Provider Satisfaction Survey was the interaction with live staff during the claims process. Providers reported that it took a lot of time to follow the HBH call system in order to get updates on their claims that they had submitted. They also reported difficulties in general with the responsiveness of the customer service department. To address these barriers HBH was able to identify online tools that would allow providers to be able to check on the progress of their claims through the web-site rather than always needing to call and talk to a live person. Additionally, the customer services queues were reorganized to make fewer transitions from one queue to another reducing the hold times and allowing the department to be more responsive to providers.

Recommendations:
In 2017 HBH should continue to organize telephone queues in order to decrease the number of transfers and make the process much more clear. Additionally HBH should continue to build out additional on-line tools so that providers can quickly and easily get their common needs met without the need to talk to a live person. An additional step for this process should be for increased communication with providers so that they understand how to access these new tools.
9. **Service Quality Improvement Activities**

**Objective:**
To improve HBH Service Quality and HBH members experience through identification, development, and monitoring of opportunities for improvement through the implementation of Quality Improvement Activities.

a) **Improving Customer Service Levels**

**Methodology:**
In order to assess the efficiency in which Customer Service handles call volume the “service level” metric is utilized. The service level is industry method that measures the effectiveness and efficiency of an organization’s customer service phone queues. The service level metric includes total acceptable calls, abandoned calls, handled calls, calls abandoned above a threshold and calls answered in its calculation. Because service level is comprehensive numerous underlying factors affect the service level. Service level is measured in percentages and has a performance goal of 80 percent and the departmental stretch goal of 85 percent.

**Analysis and Barriers:**
- The outbound calls were not being measured and/or captured. Meaning the efficiency and FTE Hours required to manage outbound calls were not included in CS metrics nor were they being tracked.
- Complex and numerous phones queues caused confusion and process error resulting in higher abandonment and high talk time.
- Provider Relations refresher training resulting in a loss of 52 production hours.

**Interventions:**
- Implemented an unscheduled absence “make up” option for Specialists.
- Deployed cross-functionally trained Specialists/Welcome Calls to support CS during high volumes daily from 10-2:30 pm.

**Recommendations:**
- This QIA will be measured quarterly and presented to QIC

Improving Customer Service Levels QIA

<table>
<thead>
<tr>
<th></th>
<th>Q4 2015</th>
<th>Q1 2016</th>
<th>Q2 2016</th>
<th>Q3 2016</th>
<th>Q4 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS - Service Level</td>
<td>81%</td>
<td>82%</td>
<td>77%</td>
<td>77%</td>
<td>88%</td>
</tr>
</tbody>
</table>

b) **Improving Member Satisfaction with Complaint and Appeal Processing**
Methodology:
In order to ensure members are aware and capable of filing a complaint or an appeal, HBH includes the following question through the member satisfaction survey, "if you registered a complaint or initiated an appeal how would you rate the clarity of instructions on how to follow this process?" It is HBH’s goal to have all member experience measures scored at 90 percent or above, however for the above measure HBH scored 88 percent in 2016. A drill down analysis showed that Medicare members had a satisfaction score of 92 percent while Commercial members had a score of 85 percent.

Analysis and Barriers:
- Commercial Barriers include:
  - Commercial members are not given the same information as Medicare members who are given more tools, materials and guidance through the health care system.
  - The exchange membership is new to Humana and many associates did not have clarity on how to address specifically H1 insurance complaints and appeal processes. Additionally these members may think that any dissatisfaction they have with healthcare.gov is directly related to the insurance carrier when in fact they are separate.
  - Transition hand off between Humana and HBH causes member confusion. Humana and HBH associates are not fully confident in the applicable complaint and appeal process that applies to the specific entity.
- Medicare Barriers include:
  - Transition hand off between Humana and HBH causes member confusion. Humana and HBH associates are not fully confident in the applicable complaint and appeal process that applies to the specific entity.

Interventions:
- Reviewed the P&P and other training materials
- A new survey process was implemented in 2016, mirroring the survey from Humana Inc., The 2015 and 2016 member satisfaction surveys are not comparable between each other, the results from the 2015 were measured in percentage while the 2016 results were measured in percentiles.
- Members are able to use online tools through the Humana Behavioral Health web site in order to file complaints

Recommendations:
- Modify the current QIA because of the change in the satisfaction survey. The 2016 survey will be the new baseline data and the QIA will continue moving forward from 2016.

c) Improving Practitioner Satisfaction with Utilization Management
Methodology:
The Practitioner Satisfaction survey was administered by the Q&A department via two forms of written communication: 1) fax 2) mail. Practitioners qualified to participate in the survey if they submitted three or more behavioral health (BH) claims between January 1, 2015 – December 31, 2015. The 2016 Practitioner Satisfaction Survey population consisted of approximately 5,000 practitioners. Each provider was mailed a survey. The option to complete the practitioner satisfaction survey via the provider portal was not available for the 2016 survey year.

Analysis and Barriers:
- In 2016 the overall Satisfaction goal of 90 percent was not met for Humana Behavioral Health practitioners. Practitioner’s overall satisfaction with UM dropped below the performance goal of 90% in 2016; also as outlined above, the “ease and efficiency of submitting authorization requests” fell below at 82%.
- Practitioner’s comments indicated that the processing of claims is cumbersome and confusing and requires too many exchanges with HBH in order to resolve a named issue.
- Practitioner’s comments indicated that Humana Behavioral Health representatives were unable to determine certain member benefit information or in some cases provided incorrect information and that CSRs incorrectly route them to Humana and or vice versa.

Interventions:
- A review of the claims authorization P&P needs to be completed.
- The Learning Collaborative will focus on helping providers with issues such as claims authorizations.
- A training to address the changes on the claims authorization process will be offered to the providers through participation in the Learning Collaborative.

Recommendations:
- To continue to analyze and monitor the QIA quarterly

<table>
<thead>
<tr>
<th>Timeliness of Response to Auth Request</th>
<th>Goal</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>90%</td>
<td>94%</td>
<td>92%</td>
<td>84%</td>
</tr>
</tbody>
</table>

d) Improving Humana Behavioral Health’s Online Tools for Practitioners

Methodology:
Onlineauth (OLA) is a web-based application that originally allowed for initial requests for authorizations for Inpatient, Intensive Outpatient Program, and partial hospitalization admissions for mental health and substance use disorders (detox). A provider is also able to request psychological/neuropsychological testing and Initial and Continued Outpatient services (Therapy and Medication Management). Due to feedback from providers and internal staff, HBH has worked to incorporate changes to the process to increase the ease and functionality of OLA. The barriers listed below are based on calls with providers and facilities. Feedback from the survey did not contain specifics details; just there were problems with the ease of obtaining an auth through OLA.

**Analysis and Barriers:**
1. Providers have difficulty completing auth requests through OLA. An error message would indicate that the user would need to call in to request services.
2. The psychological testing list was missing the most recent version of tests that providers use.
3. Some assessment tools (tests) required responses from multiple sources, such as the parents/caregivers and teachers. OLA only allowed one version of the tool.
4. Providers lack knowledge to complete the auth on line

**Interventions:**
1. It has been identified that some OLA users are not completing screens per the directions on the screen and have become frustrated with OLA. In these cases, training helps the user better understand the screens. Online training, using available technology, is offered to providers that request training on OLA.
2. Testing lists were updated based on discussions with providers to include the most current version of standardized tests. -- two provider offices sent in a list of tests they use on a regular basis. Another psychologist was contacted to verify the appropriateness of the tests listed. Testing list will be reviewed quarterly and necessary updates will be made.
3. Tests requiring multiple responders (i.e., parents and teachers) now allow for the OLA user to select the appropriate 'responder'.
4. A training will be offered to providers that are part of the Learning Collaborative and measure the success of it during 2017

**Recommendations:**
- This QIA will be measured quarterly and presented to QIC

<table>
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</thead>
<tbody>
<tr>
<td>Practitioner Satisfaction Survey- Ease and efficiency of submitting authorization requests (electronically)</td>
<td>90%</td>
<td>89%</td>
<td>82%</td>
</tr>
</tbody>
</table>
Quality of Care

1. Clinical Practice Guidelines

   Objective:

   Humana Behavioral Health adopted Clinical Practice Guidelines (CPG) from the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP) to assist practitioners in making decisions regarding appropriate behavioral health care for specific clinical circumstances and to ensure consistency and improve patient care and safety. These evidence-based guidelines are known to be effective in improving health outcomes. Humana Behavioral Health chose practice guidelines for treatment of patients with Bipolar Disorder, Major Depressive Disorder, Substance Use and Schizophrenia as the current focus guidelines in the adult population. The clinical practice guideline for Schizophrenia was added in 2015. These guidelines were selected as the diagnoses are the most common among Humana Behavioral Health members. For adolescents and children, Humana Behavioral Health selected Attention-Deficit/Hyperactivity Disorder (ADHD), Depressive Disorders and Substance Use practice parameters. The performance goal was 85 percent.

   Methodology:

   Humana Behavioral Health reviews the records of a random selection of practitioners who saw 10 or more members three or more times in a 15-month period to allow for the claims time lag. Historical claims are used to gather a list of members seen by the practitioner and three charts are reviewed onsite. The opportunity to collaborate on the improvement of existing processes is provided. Corrective actions plans are requested from practitioners scoring below the goal of 85 percent. During record reviews, Humana Behavioral Health focuses on two elements for each guideline related to member safety.

   For the Bipolar Disorder CPG, Humana Behavioral Health measures performance with the prescription of mood-stabilizing medication and education of the patient or family regarding Bipolar Disorder. Both measures are based on specific recommendations in the guideline. The first is based on numerous recommendations in the CPG for first-line psychopharmacologic treatment. The second is based on recommendations about the importance of educating patients and appropriate family members.

   For the Major Depressive Disorder CPG, Humana Behavioral Health measures performance with the completion and revision of a risk assessment and education of the patient or family regarding diagnosis. Both measures are based on specific recommendations identified in the guideline. The first is based on a clear recommendation that an assessment of suicide risk is crucial. The second is based on a recommendation regarding the importance of educating patients and appropriate family members.
For the ADHD practice parameters, Humana Behavioral Health measures performance with the completion of an assessment for co-morbid disorders and referral to a support group such as Children and Adults with Attention Deficit-Hyperactivity Disorder (CHADD). Both measures were based on specific recommendations from the guideline. The first is based on the recommendation that co-morbidity should be assessed due to the high prevalence of co-morbid psychiatric conditions in ADHD patients. The second is based on a recommendation regarding the importance of self-help group support.

For the Substance Use practice guidelines, Humana Behavioral Health measures performance with the completion of an assessment for co-morbid disorders and referral to a support group such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). Both measures are based on specific recommendations in the guideline. The first is based on the recommendation that co-morbidity should be assessed due to the high prevalence of co-morbid psychiatric conditions in substance abuse patients. The second is based on a recommendation regarding the importance of self-help group support as active participation has been correlated with better treatment outcomes.

For the newly added Schizophrenia guideline, Humana Behavioral Health measures performance with the prescription of mood-stabilizing medication and education of the patient or family regarding Schizophrenia. Both measures are based on specific recommendations in the guideline. The first is based on numerous recommendations in the CPG for first-line psychopharmacologic treatment. The second is based on recommendations about the importance of educating patients and appropriate family members.
Analysis and Barriers:

<table>
<thead>
<tr>
<th>CPG Adherence</th>
<th>2015</th>
<th>2016</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>BPD: Appropriate medication</td>
<td>100%</td>
<td>100%</td>
<td>85%</td>
</tr>
<tr>
<td>BPD: Education</td>
<td>80%</td>
<td>72%</td>
<td>85%</td>
</tr>
<tr>
<td>MDD: Risk assessment</td>
<td>89%</td>
<td>88%</td>
<td>85%</td>
</tr>
<tr>
<td>MDD: Education</td>
<td>66%</td>
<td>68%</td>
<td>85%</td>
</tr>
<tr>
<td>Schizophrenia: Appropriate medication</td>
<td>100%</td>
<td>100%</td>
<td>85%</td>
</tr>
<tr>
<td>Schizophrenia: Education</td>
<td>75%</td>
<td>80%</td>
<td>85%</td>
</tr>
<tr>
<td>ADHD: Co-morbid assessment</td>
<td>98%</td>
<td>100%</td>
<td>85%</td>
</tr>
<tr>
<td>ADHD: Referral to support</td>
<td>85%</td>
<td>64%</td>
<td>85%</td>
</tr>
<tr>
<td>SA: Co-morbid assessment</td>
<td>100%</td>
<td>100%</td>
<td>85%</td>
</tr>
<tr>
<td>SA: Referral to support</td>
<td>80%</td>
<td>84%</td>
<td>85%</td>
</tr>
</tbody>
</table>

Summary analysis:

- Documentation of education regarding the diagnosis was below the goal for Bipolar, Major Depression and Schizophrenia in both 2015 and 2016.
- Documentation of education or referral to a support group met the goal for ADHD in 2015 and decreased to 64 percent in 2016.
- Documentation of a referral to a support group was below the goal for Substance Abuse in both measurement periods, but increased in 2016.
- Documentation of risk assessment was above the goal in 2015 and 2016 for Major Depression.
- Prescribing appropriate medication for Bipolar patients was 100 percent in 2015 and 2016.
- Assessment for co-morbid disorders in ADHD patients was above the goal in 2015 and 2016.

The analysis and barriers for the Bipolar Disorder, Major Depressive Disorder, Schizophrenia, ADHD, and Substance Use CPGs are provided as follows:

**Bipolar Disorder**

- **Appropriate Medication**: The aggregate score for appropriate medication use remained consistent at 100 percent in both measurement periods. There were no barriers to compliance with this element in the guideline. A list of Federal Drug Administration (FDA) approved medications for the treatment of Bipolar Disorder was used when reviewing this element.
- **Patient and Family Education**: The aggregate score for patient and family education decreased from 80 percent in 2015 to 72 percent in 2016. Affirmation of education being a major component of the therapeutic process was offered during the onsite visit feedback. Practitioners were encouraged to give themselves credit for the education they provide in the progress notes. Practitioners agreed that education was provided to
patients and/or families, but was not documented. Educational materials from pharmaceutical companies and mental health associations were available in many practitioner offices and waiting rooms. Practitioners confirmed the barrier was lack of time to document and forgetting to document that the education occurred. Many were unaware that documentation of education was necessary.

**Major Depressive Disorder**

- **Risk Assessment:** The aggregate score for risk assessment decreased from 89 percent in 2015 to 88 percent in 2016. The score remained above the goal of 85 percent. Barriers tend to remain the same year after year, however, a recent barrier continued into 2016 related to the transition from paper charting to electronic medical records (EMR). Most EMR systems were created for the medical community and later modified for behavioral health. Many practitioners obtained EMRs that did not offer the opportunity for the documentation of risk throughout the course of treatment. Many practitioners audited documented risk assessment in the initial evaluation, but failed to document risk again during the course of treatment, due in part to the lack of a reminder or a location within the EMR. Practitioners reported a comfort and familiarity with patients that kept them from documenting risk assessment on an ongoing basis. Many practitioners expressed frustration in feeling rushed between sessions and not having enough time. A few non-prescribers admitted to difficulty maintaining a 45 to 50 minute session parameter which kept them from having sufficient time to document thoroughly between clients. Some practitioners indicated that they believed if patients did not originally present with suicidal ideation, it was not necessary to document risk ongoing throughout treatment, especially if the patient was not diagnosed with a depressive disorder diagnosis.

- **Patient and Family Education:** The aggregate score for patient and family education was below the goal at 66 percent in 2015 and increased to 68 percent in 2016. Practitioners agreed they were providing education; however, they were not documenting it in the progress notes. Most practitioners had pharmaceutical company or mental health association pamphlets available in their waiting rooms and offices. Additional barriers reported were lack of time and remembering to document that the education occurred.

**Schizophrenia**

- **Appropriate Medication:** The aggregate score for appropriate medication use was above the goal at 100 percent in both measurement periods. No barriers were identified regarding compliance with this element in the guideline. A list of Federal Drug Administration (FDA) approved medications for the treatment of Schizophrenia was used when reviewing this element.

- **Patient and Family Education:** The aggregate score for patient and family education was below the goal at 75 percent in 2015 and increased to 80 percent in 2016. Practitioners
stated that education was provided, but not documented. Practitioners were encouraged to give themselves credit for the education they provide in the progress notes. Practitioners agreed that education was provided to patients and/or families, but was not documented. Educational materials from pharmaceutical companies and mental health associations were available in many practitioner offices and waiting rooms. Practitioners confirmed the barrier was lack of time to document and forgetting to document that the education occurred.

**Attention-Deficit/Hyperactivity Disorder**

- **Assessment for Co-morbid Disorders:** The aggregate score for assessing co-morbid disorders was above the goal at 98 percent in 2015 and increased to 100 percent in 2016.
- **Referral to a Support Group:** The aggregate score for referral to a support group decreased from 85 percent in 2015 to 64 percent in 2016, which was below the goal. Although practitioners stated they provided referrals to support groups, they admitted they failed to document this information. Time constraints and remembering to document were cited as the primary barriers. Practitioners were encouraged to give themselves credit by documenting the referrals in the progress notes. Practitioners are becoming more familiar with the support group CHADD. There are reported gaps in local support services provided to patients and families of patients through this organization. Although the practice parameter recommended referral to a support group such as CHADD, the organization does not appear to be as active on a local level. Several practitioners stated they would refer parents or guardians to the CHADD website for a list of active support groups in their area as well as educational information.

**Substance Use**

- **Assessment for Co-morbid Disorders:** The aggregate score for the assessment of co-morbid disorders was above the goal at 100 percent in both measurement periods. There were no barriers identified.
- **Referral to a Support Group:** The aggregate score for referral to a support group was 80 percent in 2015 and increased to 84 percent in 2016. Practitioners stated they routinely provided referrals to support groups, but did not document this information. Time constraints and remembering to document were cited as the primary barriers. Practitioners were encouraged to give themselves credit by documenting the referrals in progress notes.

**Interventions:**

The following interventions were implemented during the reporting period:
A narrated PowerPoint presentation on clinical practice guidelines was available on the Humana Behavioral Health website.

Sample progress notes and initial evaluation forms were distributed onsite via USB memory drives which align with the DSM and ICD-10 requirements. These forms include reminders for the important elements in the CPGs.

The CPGs were included on the USB memory drives for easy reference by practitioners.

Onsite visits allowed for face-to-face discussion, feedback and education regarding the importance of adherence to the established CPGs and noting deficiencies found at the time of the review.

Letters regarding individual performance were sent to the practitioner within 10 days with a detailed analysis of the score and individual results compared to the market aggregate.

Corrective action plans were requested from the practitioners scoring below the goal of 85 percent. Low scoring practitioners will be reviewed again within six months during the 2017 measurement period.

Educational handouts on Major Depression and Bipolar Disorder written in plain language were included on the USB drive and on the Humana Behavioral Health website. Paper copies of the guidelines and handouts were made available to practitioners on request.

Links to the guidelines were available on the Humana Behavioral Health website and on Humana.com.

- Education was offered via the website, provider manual, provider newsletters and provider forums/seminars.
- Collaboration with Humana Physician Organized Deliver System (PODS) was initiated to develop outreach to behavioral health practitioners by PODS representatives in late 2017 or 2018.
- Provider forums/seminars were conducted in large group practices. Forums were held in Kansas City in June, Milwaukee in July and Louisville in August.

**Recommendations:**

Recommendations for 2017 are as follows:

- Methodology was reviewed by the analytics staff to ensure appropriate sample size per market with a 95 percent confidence level and a five percent confidence interval. Methodology remains the same (audit practitioners seeing 10 or more members three or more times in a 15 month period) projecting review of 379 practitioners in 25 markets in 2017 with an audit floor of five practitioners per market.
- Re-audit practitioners on corrective action plans within six months instead of the current one year cycle.
2. **Self-Management Tools**

**Objective:**

Self-management tools are evidence based interactive tools that help members learn and identify risks factors, provide knowledge on overall well-being, recommend ways to improve health, and provide information on risk reduction or ways to maintain low risk. The goal of these tools is to support members with medical and behavioral health integrated resource to improve health in several areas.

**Methodology:**

Humana Behavioral Health uses an external vendor, Healthwise, that provides self-management screening tools available on Humana Behavioral Health’s website. Members are directed to access these resources through information on the back of their authorization letters. The information on the website is related to the following topics.

- Health weight (BMI) maintenance
- Smoking and tobacco cessation
- Encouraging physical activity
- Healthy eating
- Managing stress
- Avoiding at risk drinking
- Identifying psychiatric symptoms through self-assessment
- Recovery and resiliency
- Treatment monitoring

**Analysis and Barriers:**

A review of the data revealed that in the past year, 1,467 pages were viewed during 261 visits. The total number of visitors was 252 with average time spent per visit of 5 minutes and 20 seconds. An in depth analysis revealed that the average page views per month was 122 during
an average visits per month of 22 visits. Additionally, the top five topics viewed in no particular order included behavior rating scales for Attention Deficit/Hyperactivity Disorder (ADHD), interactive tools, ADHD, depression and other.

Barriers from expanding the use of self-management tools include the following:

- Based on the page views, it appears that the members may be unaware of this resource.
- During 2016, the authorization letters encountered system error prohibiting members from getting information on self-management tools.

**Interventions:**

- In 2017 there will be an enhancement of the system to rectify the issue with the authorization letters.

**Recommendations:**

Humana Behavioral Health’s Quality and Accreditation team will continue monitoring usage to examine and evaluate success of self-management tools.

**3. Behavioral Health Screening Programs**

**a. Screening Children Ages Three to Seventeen Diagnosed with Autism Spectrum Disorder (ASD) for ADHD**

**Objective:**

This screening tool is geared towards members with children ages three to 17 with a diagnosis of ASD to help gain awareness of other factors that may impact certain behaviors. The tool encourages parents to complete a checklist focused on various behaviors associated with ADHD to review with their child’s provider. The established benchmark for this screening tool’s participation rate is 90 percent.

**Methodology:**

The following is the process utilized for this screening tool:

- A list of members diagnosed with ASD within the previous six months’ time frame is provided by Humana’s behavioral health clinical analytics department.
- This list is not duplicated as it is restricted to members ages three to 17 with the diagnosis of ASD and a negative history of ADHD.
- A letter explaining the risk of ADHD and access to this screening tool is mailed to the parent or the guardian of the identified member based on the list.

**Analysis and Barriers:**
During Q3 2015, Quality and Accreditation department mailed 1,806 letters to members identified on the report. Only two opt-outs were requested and 34 returned letters for this screening program.

Likewise, for 2016 this screening program letters were mailed during Q2 and Q4. A total of 1,981 letters were mailed in Q2 2016, with a participation rate of 91 percent with no opt outs and 171 returned mailed.

1,274 letters were mailed in Q4 2016. The participation rate for Q4 2016 is pending at this time.

Barriers for this screening program included the following:

- Despite of the continued efforts to minimize duplicates and incorrect member information, this remained a challenge requiring manual cross-referencing of the reports.

Interventions:

- The Quality and Accreditation team worked closely with the clinical analytics teams to eliminate duplicates on the reports used for the screening programs in order to reduce the rate of returned mail.

Recommendations:

Humana Behavioral Health’s Quality and Accreditation team will collaborate with other departments to promote the use of this screening program as a viable preventative health tool. The responses from this tool should be shared with the Clinical Case Management department for targeted outreach to these members in order to better help them address the specific needs of these mental health disorders.

b. Screening for Tobacco Dependence among Members Who are Diagnosed with Bipolar Disorder

Objective:

This screening program encourages members ages 18 through 35 with diagnosis of bipolar disorder to be screening for tobacco use to help become aware on tobacco dependence patterns. Additionally, this screening tool is intended to reduce or eliminate tobacco use for better health. The goal is to meet 90 percent in participation rate.

Methodology:

- Twice a year, an unduplicated report is requested from the clinical analytics team on members who has been diagnosed with bipolar disorder and has received mental treatment within the previous six months.
• Based on the obtained list, a direct mail is sent to each member alerting them on this screening program along with a link to a self-assessment.

Analysis and Barriers:

For this screening program, in Q3 2015 a total of 1,120 letters were mailed to the identified members under the age of 35 with a diagnosis of bipolar disorder. In Q3 2015 there were 18 returned mail and one opt out. During Q4 2016, a mail out to 902 members was completed with pending participation rate at this time.

The barriers for this screening program included the following factors:

• Due to an error in the report for Q2 2016, a new report had to be generated to cover the required timeframes which affected the timeline of this screening program. A mail out was sent to members in Q4 2016.

Interventions:

• A request for accurate report with correct time frames was created in order to be aligned with the program description.

Recommendations:

Quality and Accreditation team will collaborate with teams within Humana Behavioral Health and Humana Inc., to increase promotion of this screening program. Expanding the scope of this tool will allow for a greater number of responses and more targeted outreaches can be completed in order to help educate members on the risks of tobacco.

4. Member Safety
   a. Quality Concerns
      Objective:
      Minimize risks that could compromise the quality of the care received by Humana Behavioral Health’s members through investigation of safety issues. Although imminent danger automatically triggers a review trends are also reviewed and trigger a reviewed when discovered.
      Methodology:
      Member safety is monitored through the reporting of quality concerns which are outcomes of treatment or actions that could possibly produce an unfavorable result. The Humana Behavioral Health Quality and Accreditation staff tracks quality concerns submitted through a shared database application by associates throughout the enterprise, the Quality Management System (QMS). Quality concerns are tracked and trended by practitioner and facility. This data is reported quarterly to the Utilization-Care Management Committee (UCM) and the Quality Improvement Committee (QIC).
An outlier is identified as an instance in which a facility or practitioner reached the threshold for a specific quality concern during a quarter. A facility or practitioner is classified as trending when the threshold for the same concern is reached in two consecutive quarters. When a trend is identified, a corrective action plan is requested from the provider via mail. A case is referred to the Peer Review Committee (PRC) when member safety is an imminent concern.

The thresholds for identifying outliers or trends were as follows:

- Adverse Outcome – greater than three per quarter;
- Atypical Practice – greater than three per quarter;
- Discharge Against Medical Advice (AMA) – greater than five percent of discharges per quarter;
- Discharge No Follow-up – greater than 20 percent of discharges per quarter;
- Significant Discrepancy – greater than 15 percent of discharges per quarter; and
- UR Ceased – greater than 15 percent of discharges per quarter.

**Analysis and Barriers:**

The below table represents the total number of Quality Concerns broken out by type. This data is used to view trends year over year in the number of overall Quality Concerns that are observed.
Humana Behavioral Health tracked 923 instances that were potential quality concerns in 2016. This amount represented an increase of cases compared to 2015.

The top three concerns in 2016, in descending order of the reporting frequency, were: UR Ceased, AMA and Discharge No Follow-up. The top three concerns were the same during 2015.

### Discharge No Follow-up

A complete discharge plan would be the name of the follow-up treating provider(s), the time and the date of the appointment. These appointments were reported to Humana Behavioral Health clinical advisors, who then reported any incomplete discharge plans as a quality concern.

Several barriers interfered with reaching the performance standard:

- Facilities often failed to notify Humana Behavioral Health of a member’s discharge plan; therefore, the event was reported as Discharge No Follow-up.
- Some members refused facility assistance to make aftercare plans and insisted on scheduling the appointments themselves.

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</thead>
<tbody>
<tr>
<td>Adverse Outcome</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Against Medical Advice (AMA)</td>
<td>77</td>
<td>102</td>
<td>95</td>
<td>72</td>
<td>346</td>
<td>153</td>
</tr>
<tr>
<td>Atypical Practice</td>
<td>11</td>
<td>12</td>
<td>14</td>
<td>11</td>
<td>48</td>
<td>52</td>
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<tr>
<td>Elopement</td>
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<td>0</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Discharge No Follow-up (DCnoFU)</td>
<td>33</td>
<td>20</td>
<td>46</td>
<td>36</td>
<td>135</td>
<td>106</td>
</tr>
<tr>
<td>Fall</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>10</td>
<td>21</td>
</tr>
<tr>
<td>Seclusion/Restraint</td>
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<td>0</td>
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<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>Seizure</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Significant Discrepancy</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Utilization Review Ceased (UR Ceased)</td>
<td>86</td>
<td>85</td>
<td>112</td>
<td>75</td>
<td>358</td>
<td>304</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>214</strong></td>
<td><strong>230</strong></td>
<td><strong>278</strong></td>
<td><strong>201</strong></td>
<td><strong>923</strong></td>
<td><strong>656</strong></td>
</tr>
</tbody>
</table>
Members may have had standing appointments with their outpatient practitioners and the specific time and date was not obtained by the facility discharge planner for documentation in the chart.

Many outpatient practitioners refused to schedule appointments with the facility stating that they have a high rate of no-shows in these cases. The practitioners insisted that the member or a family member call to schedule the appointments. Often, the appointment time and date was not relayed to the facility staff and not documented.

**UR Ceased**

UR Ceased was reported when a facility utilization reviewer fails to contact a Humana Behavioral Health clinical advisor for a scheduled review or to provide discharge information. The protocol in the Behavioral Health Clinical Operations (BHCO) department was to make three attempts to reach the facility utilization reviewer to learn the status of the member. If the attempts were unsuccessful, clinical operations associates reported the UR Ceased quality concern.

The barriers to reaching the performance standards included:

- A lack of understanding at the facility of the expectation to report discharge plans when a member left care.
- A member remained in a facility past authorized days and often the utilization review staff failed to close out the process with Humana Behavioral Health.

**AMA**

An AMA concern occurred when a member voluntarily left treatment despite the recommendation by the physician to continue. This issue applied only to inpatient (IP), residential treatment (RTC) and partial hospitalization (PHP) levels of care.

Barriers to improving the performance included:

- Members sometimes felt the facility was not meeting their needs and left treatment early.
- Members who received substance use treatment found recovery too difficult and left care.
- Members may have been admitted on an involuntary hold due to being an immediate threat to themselves or others. When the treatment became voluntary, the member chose to leave despite a recommendation by the physician to continue care.
- A member was in the facility at the request or demands of family, friends or employer and would often leave prematurely due to a lack of investment in treatment or a perception that it was not necessary.

**Interventions:**

*Discharge No Follow-up*
The Aftercare Follow-up (AFU) team utilized the vendor Eliza to make reminder calls to members. These calls reminded the member of their follow-up appointment. Additionally, calls are made to the member by an associate to verify there were no barriers that would keep the member getting to the appointment.

The AFU team assisted facilities in finding discharge appointments and community resources for members.

**UR Ceased**

- A clinical operations advisor educated facility staff about the expectation for communication of detailed and complete discharge plans.
- The AFU team assisted facilities in finding discharge appointments and community resources for members.

**AMA**

- The Humana Behavioral Health AFU team routinely contacted members who left AMA to assist the member in securing follow-up care.
- The clinical operations team provided intensive case management services to help qualifying members stay in appropriate treatment to maintain emotional stability.

**Recommendations:**
Humana Behavioral Health will continue to investigate, track, trend, and evaluate the above listed quality concerns in 2017.

**b. Sentinel Events**

**Objective:**
Sentinel events are instances where there is a potential for harm to a member or where harm has already occurred. Humana Behavioral Health monitors and reports sentinel events to identify issues in treatment with the objective to reduce these risks.

**Methodology:**
Clinical operations associates document sentinel events in the database. Documentation is requested from the treating practitioner and/or facility to evaluate the potential risk to member safety. An investigation of the records and data is conducted by a licensed clinician in the quality and accreditation department to identify possible deficits in safety protocol. The information is compiled in a summary and reviewed by a medical director. Corrective action plans are implemented with the practitioner or facility as necessary.

The case is closed with no further action required if the medical director determines that there was no issue warranting further review by the Peer Review Committee (PRC). The case is presented to the PRC when the medical director has concerns about the treatment the member received.

PRC participants review the case and vote to close the investigation, request additional information, or request the practitioner or facility submit a corrective action plan (CAP). An ad hoc PRC meeting may be convened if the medical director feels there is imminent danger to members.
**Analysis and Barriers:**

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</thead>
<tbody>
<tr>
<td>Abduction</td>
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<td>0</td>
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<tr>
<td>Attempted Suicide</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Homicide in Treatment</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impersonation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Patient Death in Treatment</td>
<td>3</td>
<td>16</td>
<td>8</td>
<td>5</td>
<td>32</td>
<td>33</td>
</tr>
<tr>
<td>Patient Abuse by Patient</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Provider Abuse</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Suicide Complete</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Ulcers</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6</td>
<td>22</td>
<td>13</td>
<td>6</td>
<td>47</td>
<td>59</td>
</tr>
</tbody>
</table>

Humana Behavioral Health experienced a decrease in sentinel events in 2016 compared to 2015. In 2016, patient deaths while in treatment decreased from 33 in 2015 to 32 in 2016. Additionally, there was a decrease in suicide attempts requiring medical treatment from 15 in 2015 to 5 in 2016.

A barrier to reviewing sentinel events was the extensive time lag between the request for records from the facilities or practitioners and the time the documentation was received. Numerous second and third request letters were sent in an effort to obtain the needed documentation. Additionally, facilities often did not submit all relevant materials needed during the initial submission. This resulted in increased efforts to obtain further documentation. As in the previous year, practitioners and facilities stated that they never received requests despite the request letters being sent by certified mail; they misplaced the request; or could not send members records as they thought they needed a release of information from the member.

**Interventions:**

Letters were sent the day the sentinel event is logged or the following day if received after hours. Providers were educated that Humana Behavioral Health has the authority to request records for investigations per the provider contract agreement. For out of network
providers, Humana Behavioral Health did not have the authority to require providers to comply with an investigation. However, an effort was made to request the information via phone calls to risk management offices in facilities to obtain the information to ensure quality of care was provided.

The introduction of the Medical Record Management system (MRM) in 2016 assisted in streamlining the record request process. If medical records were not sent in a timely fashion through MRM, the Member Safety consultant contacted the medical records department at the facility to verify receipt of records request and encourage compliance.

Medical records were reviewed by a licensed clinician in the Quality and Accreditation Department. If an issue was discovered in this review the case was then passed to a Medical Director for further review. If the Medical Director did in fact find an issue present in the case then the case would be further reviewed in the Peer Review Committee (PRC) and further action would be decided upon.

**Recommendations:**
Humana Behavioral Health will continue to investigate, track, trend and evaluate the above listed sentinel events in 2017.

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5. **Coordination of Care**

**Objective:**
The exchange of information between behavioral health practitioners and with primary care physicians (PCP) is measured annually as part of the treatment record documentation review process. Humana Behavioral Health requires network practitioners to obtain member consent in order to discuss treatment with the PCP and with other behavioral healthcare practitioners in an effort to strengthen treatment alliances and to collaborate on the member’s healthcare.

**Methodology:**
The coordination of care and exchange of information with primary care physicians was measured annually as part of the treatment record documentation review process. Through the review process 870 charts were reviewed. Humana Behavioral Health requires network practitioners to obtain additional member consent in order to discuss treatment with the primary care physician in an effort to strengthen treatment alliances and to collaborate on the member’s healthcare. Evidence of exchange of information was required as an inclusion in the member record maintained by the practitioner. Acceptable documentation of evidence was a faxed confirmation sheet, practitioner telephone notes, progress notes and/or copies of letters to the primary care physician. Members were also able to decline coordination of care. Practitioners were required to document a member’s refusal for the exchange of information. The goal was to achieve 85 percent compliance with the standards. CAPs were requested from those scoring below the goal.

**Analysis and Barriers:**

*Between Behavioral Healthcare Practitioners*
The score assessing if a practitioner presented a release of information form to the member to give authorization for exchange information was 66 percent in 2016, a decrease from 70 percent in 2015. The goal was not met. This decrease was not statistically significant. Of the members presented with the form, 100 percent authorized the exchange of information with a behavioral health practitioner during both measurement periods. Exchange of information with another treating behavioral health practitioner was 90 percent in 2015 and decreased to 88 percent in 2016, but remained above the goal. This decrease was not statistically significant. Evidence that the exchange of information took place within 60 days of the initial evaluation scored 99 percent in both measurement periods. Information exchanged with other behavioral health treating practitioners was sufficient at 99 percent in 2015 and increased to 100 percent in 2016. This increase was statistically significant.

*With Medical Health (PCP)*

The score assessing if a practitioner presented a release of information form to the member to give authorization for exchange information was 66 percent in 2016, a decrease from 70 percent in 2015. The goal was not met. This decrease was not statistically significant. Of the members presented with the form, 100 percent authorized the exchange of information with a behavioral health practitioner during both measurement periods. Exchange of information with another treating behavioral health practitioner was 90 percent in 2015 and decreased to 88 percent in 2016, but remained above the goal. This decrease was not statistically significant. Evidence that the exchange of information took place within 60 days of the initial evaluation scored 99 percent in both measurement periods. Information exchanged with other behavioral health treating practitioners was sufficient at 99 percent in 2015 and increased to 100 percent in 2016. This increase was statistically significant.

*With Medical Health (PCP)*
• The score assessing if a practitioner presented a release of information form to the member to give authorization for exchange information was 66 percent in 2016, a decrease from 70 percent in 2015.
  o The goal was not met.
  o This decrease was not statistically significant.
• Of the members presented with the form, 100 percent authorized the exchange of information with a behavioral health practitioner during both measurement periods.
• Proof of an actual exchange of information with the PCP increased from 59 percent in 2015 to 67 percent in 2016, but remained below the goal.
  o This increase was statistically significant.
• Evidence that the exchange of information took place within 60 days of the initial evaluation was 93 percent in 2015 and decreased to 92 percent during 2016, but remained above the goal.
  o This decrease was not statistically significant.
• Information exchanged with the PCP was sufficient at 93 percent in 2015 and increased to 98 percent in 2016.
  o The score remained above the goal and the increase was statistically significant.
• Practitioners who had a corrective action plan implemented in 2015 were reevaluated during 2016 and 68 percent increased their coordination of care score.
  o This is a decrease from 82 percent the previous year.
• Although barriers seem to remain static from year to year, a new barrier in the past year few years has become more prevalent.
  o Many practitioners were unaware that during their transition from paper charts to electronic medical records (EMR), the exchange of information process was dropped.
  o This was discussed with practitioners during the on-site visits. The organic nature of the paper chart made it easier for the practitioners to remember to follow through with the exchange of information which was somehow lost in the electronic process.
• Another common barrier was locating the evidence for the exchange of information in the EMRs.
  o There was a lack of consistency among staff when scanning the evidence into the chart.
  o Additionally, proof of exchange of information was routinely left out of the records audited via fax, email or mail, although specifically requested in the audit notification letter.
• Other barriers seen in previous years were evident again during this reporting period.
  o There continues to be a lack of awareness that exchange of information is part of the practitioner’s network contract, despite years of multiple educational
exposure through the provider newsletter, provider manual and Humana Behavioral Health website.

- Many practitioners reported they did not believe there was a need for the exchange of information, especially if they were not prescribing medications or if no co-morbid issues were present.
- Many reported time constraints and a lack of staff to handle the required exchange.
- Several practitioners reported feeling their clients or patients were high functioning and could discuss their medications and diagnosis with their PCPs.
- Confidentiality issues, particularly in small or rural communities, remained a concern.
  - Fewer practitioners expressed a belief that the exchange of information is a violation of the Health Insurance Portability and Accountability Act (HIPAA).
  - Many reported they would exchange information only if the request was initiated by the other behavioral health practitioner or PCP.
- They also expressed frustration that the PCP did not reciprocate in the exchange and coordination of care.
- Several practitioners expressed dissatisfaction with the decrease in reimbursement rates and refused to add any further requirements to what they already provide.

**Interventions:**
The following interventions were implemented during the reporting period:

- Flyer regarding the necessity of coordination of care with behavioral health practitioners developed and approved for inclusion in Humana Physician Organized Delivery System (PODS) packet for primary care physicians.
- Collaboration with PODS initiated to develop outreach to behavioral health practitioners by PODS representatives in late 2017 or 2018.
- Offer information regarding coordination of care/exchange of information on the website, in provider newsletters and the provider manual.
  - On-site visit allowed for face-to-face discussion, feedback and education regarding the importance of coordinating care and exchanging information with the PCP and noting deficiencies found at the time of the review.
  - Narrated PowerPoint presentation about coordination of care and exchange of information with medical providers was posted on the Humana Behavioral Health website.
  - Letters regarding individual performance sent to the practitioner within ten days with a detailed analysis of the score and individual results compared to the market aggregate outcome.
  - Corrective action plans were requested from the practitioners scoring below the minimum goal of 85 percent; will be reviewed again within six months in the 2017 measurement period.
- Tool-kit on USB drive included sample forms and the PowerPoint presentation narrated slides regarding exchange of information expectations.
- Sample coordination of care forms and release of information were available on the Humana Behavioral Health website.
- Education offered via website, provider manual, provider newsletters and provider forums.
- Provider forums continued in large group practices. Forums were held in Kansas City in June, Milwaukee in July and Louisville in August.

**Recommendations:**

Recommendations for 2017 are as follows:

- Methodology reviewed by analytics staff for appropriate sample size per market with a 95 percent confidence level and a five percent confidence interval. Methodology remains the same (practitioners seeing ten or more members three or more times in a 15 month period) projecting review of 379 practitioners in 25 markets in 2017 with an audit floor of five practitioners.
- Re-audit providers on corrective action plans within six months instead of the current one year.
- Increase frequency of individual practitioner audit to every two to three years instead of the current four to five years.
- Develop non-on-site options for audit through fax, email and/or mail.
- Develop other means of communication and education with providers as on-site feedback is no longer an option.

6. **Technology to Improve Care Coordination**

**Objective:**

Humana Behavioral Health utilizes technology to improve the member experience, offer convenience and ensure the appropriate use of health benefits. The technologies currently used are tele-health/tele-psych or e-visits, electronic refill reminders for medications, electronic prescribing, and electronic enrollment in wellness programs and coaching.

**Methodology:**

Humana Behavioral Health supports the utilization of tele-health or e-visits for members by authorizing and reimbursing for these services. Humana Behavioral Health is able to track the reimbursement of these visits through a GT code modifier. Humana Behavioral Health makes electronic-enrollment in wellness programs available to members through the Humana website.

**Analysis and Barriers:**

Data is collected and analyzed by the departments responsible for each technology within the organization.

**Interventions:**
Tele-psych services continued at Partners in Primary Care (PIPC) clinic in San Antonio, Texas for commercial members in 2016. Psychiatric services were provided in an in-network psychiatric practice, on a fee for service basis. Humana members may be identified for this service at any PIPC clinic in San Antonio. For the PIPC clinics in which tele-psych is not yet set up, members may attend this service at the original clinic.

Electronic refill reminders are available to Humana Behavioral Health members through the Humana Vitality website. Members can select electronic reminders through a secure portal. As a Humana subsidiary, Humana Behavioral Health practitioners have e-prescribing available to them through Surescripts. Surescripts is an electronic data system that connects doctors, nurses, pharmacists and others so they may communicate with each other in the treating of a patient, sharing information to reduce errors, improve quality and efficiency, and save money. The member’s prescription history is available within the practitioner’s electronic medical record and through Surescripts which facilitates access to the member’s prescriptions from other practitioners to check for possible medication interactions or duplicate prescriptions.

E-enrollment in wellness programs is available to Humana Behavioral Health members through the Humana website. Members enroll in the wellness program and register for coaching appointments through this website. Behavioral health related wellness coaching is scheduled with a Humana Behavioral Health wellness coach.

**Recommendations:**

Recommendations for technology to improve care coordination during 2017 include:

- Expand the tele-health project to more locations;
- Continue offering electronic prescriptions and refill reminders for members and practitioners; and
- Continue providing the opportunity for electronic enrollment in wellness and coaching programs.

### 7. Treatment Record Reviews

#### a. Outpatient Practitioners

**Objective:**

Humana Behavioral Health has developed guidelines for treatment record documentation, standards for availability of treatment records, requirements for the exchange of information and performance goals to define expectations for practitioners.

**Methodology:**

Humana Behavioral Health assesses compliance with treatment record documentation standards and exchange of information throughout the year and on an annual basis.
Consistent and complete treatment records are an essential component of quality patient care. Humana Behavioral Health reviews the records of a random selection of practitioners who saw 10 or more members, three or more times in a 15-month period. Historical claims data is used to gather a list of patients seen by the practitioner and three charts are reviewed onsite. The onsite visit allows for one-on-one discussion and education about the expectations of treatment record documentation and exchange of information. The minimum overall performance goal is a score of 85 percent. The opportunity to collaborate on the improvement of existing processes is offered.

Analysis and Barriers:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Record Review</td>
<td>96%</td>
<td>90%</td>
</tr>
<tr>
<td>Goal</td>
<td>85%</td>
<td>85%</td>
</tr>
</tbody>
</table>

- Treatment record documentation reviews were conducted with 271 individual practitioners in 25 market areas.
- CAPs were requested from 59 practitioners who scored below the goal.
- Results for treatment record documentation remained above the goal at 96 percent in both 2015 and 2016.
  - The decrease was statistically significant.
- Humana Behavioral Health supported practitioners with the standards for treatment record documentation through education and implementation of tools which facilitated compliance.
- The records reviewed showed evidence that the documentation was sufficient and, in most categories, above the goal.
  - Two audit items scored below the goal.
    - The documentation of prenatal events and developmental history for children and adolescents is required for clients aged 17 years and below. The score was 74 percent in 2015 and increased to 77 percent in 2016.
      - This decrease was not statistically significant.
    - Many practitioners were unaware that a child and adolescent developmental history was required when treating clients in that age range.
- Imminent risk or potential risk of harm to self or others decreased from above the goal at 88 percent in 2015 to below the goal at 83 percent in 2016.
  - This decrease was statistically significant.
  - This review item has consistently scored below the goal in previous audits until 2015.
    - Barriers remain with this audit item.
Most practitioners who failed to document risk on a regular basis in the chart admitted that they would not allow a client or patient to leave the office if they were in danger.

While most practitioners assess and document risk in the initial evaluation, many did not document risk frequently throughout the course of treatment. It is recommended that risk be documented at least every third session for adults and every session for children and adolescents. Practitioners expressed a comfort and familiarity with patients that kept them from feeling the need to document risk on an ongoing basis.

Lack of time to document was reported as another issue with a feeling of being rushed between patients. Many non-prescribers admitted to difficulty maintaining a 45 to 50 minute session parameter which resulted in insufficient time to document thoroughly between clients.

Most of the practitioners scoring below the goal indicated that they believed if the patient did not originally present with suicidal ideation, it was not necessary to document risk ongoing throughout treatment, particularly if the patient was not diagnosed with a depressive disorder.

A new barrier was discovered in 2014 and continued through the reviews of 2015 and 2016 related to the transition from paper charting to electronic medical records (EMR). Most EMR systems were created for medical practitioners and are modified for behavioral health. In the adoption of an EMR system, many practitioners failed to notice that the program did not include an area for the documentation of risk throughout the course of treatment.

**Interventions:**

The following interventions were implemented during the reporting period:

- A narrated PowerPoint presentation on treatment record documentation standards was available to practitioners on the Humana Behavioral Health website.
- Sample progress notes and initial evaluation forms were available in the provider portal. These forms include reminders for the important elements of the treatment record documentation standards.
Onsite visits allowed for face-to-face discussion, feedback and education regarding the importance of adherence to the established treatment record documentation standards and noting deficiencies found at the time of the review.

Letters regarding individual performance were sent to the practitioner within 10 days with a detailed analysis of the score and individual results compared to the market aggregate.

CAPs were requested from the practitioners scoring below the goal of 85 percent. Low scoring practitioners will be reviewed again during the 2017 measurement period.

Education was offered via the website, provider manual, provider newsletters and provider forums.

Collaboration with Humana Physician Organized Deliver System (PODS) was initiated to develop outreach to behavioral health practitioners by PODS representatives in late 2017 or 2018.

Provider forums/seminars were conducted in large group practices. Forums were held in Kansas City in June, Milwaukee in July and Louisville in August.

**Recommendations:**

Recommendations for 2017 are as follows:

- Methodology was reviewed by the analytics staff to ensure appropriate sample size per market with a 95 percent confidence level and a five percent confidence interval. Methodology remains the same (audit practitioners seeing 10 or more members three or more times in a 15 month period) projecting review of 379 practitioners in 25 markets in 2017 with an audit floor of five practitioners per market.
- Re-audit practitioners on corrective action plans within six months instead of the current one year cycle.
- Increase frequency of audit of a high volume practitioner from the current four to five years to every two to three years.
- Develop non-onsite options for audit through fax, email and/or mail.
- Develop other means of communication and education with providers as onsite feedback will no longer be an option.
- Continue to offer information regarding treatment record documentation standards on the website, in provider newsletters, and in the provider manual.
- Continue to send letters with individual and aggregate results of reviews to practitioners.

**b. Facilities**
Objective:

Humana Behavioral Health has established guidelines for the exchange of information between facilities and outpatient treating practitioners and standards for complete discharge planning with the goal of maintaining member safety. Continuity and coordination of care between behavioral health practitioners and facilities must be evidenced by 85 percent compliance with documentation of the exchange of information.

Methodology:

The exchange of information between behavioral health practitioners is measured for in-network facilities. Evidence of the exchange may occur in the form of faxed confirmation sheets, facility staff telephone notes, progress notes, patient discharge instructions and/or copies of letters to other behavioral health practitioners. Members are offered an opportunity to authorize the exchange of information through signing a release of information form indicating approval of the exchange. Complete discharge information is the name of the follow up treatment provider, the time and date of the appointment.

Analysis and Barriers:

<table>
<thead>
<tr>
<th>Exchange of Information Between Facilities</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation of attempt to obtain relevant information from previous outpatient practitioner</td>
<td>63%</td>
<td>60%</td>
</tr>
<tr>
<td>Documentation of communication with follow up outpatient practitioner</td>
<td>94%</td>
<td>72%</td>
</tr>
<tr>
<td>Release of information maintained in the medical record</td>
<td>100%</td>
<td>94%</td>
</tr>
<tr>
<td>Patient signed release of information form</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>Goal</td>
<td>85%</td>
<td>85%</td>
</tr>
</tbody>
</table>

Coordination of Care

Evidence of the exchange of information with practitioners treating patients prior to admission to the facility decreased from 63 percent in 2015 to 60 percent in 2016, but remained below the goal. This decrease was not statistically significant. Evidence of coordination of care with the follow-up provider decreased from 94 percent in 2015 to 72 percent in 2016. This decrease was statistically significant. Evidence that the patient was given the opportunity to sign a release of information form was above the goal at 100
percent in 2015 and decreased to 94 percent in 2016. The decrease was statistically significant. Evidence that the patient signed the release of information was 100 percent in both measurement periods. There were five corrective action plans requested from facilities in 2016.

Staff members at various facilities reported they were unaware of the requirement to exchange information with the current outpatient treating practitioner(s). Inconsistent placement of exchange of information evidence in the electronic medical record or paper chart hampered the audit process. Facility staff also reported that short lengths of stay hindered the attending physician, intake staff, social workers or the treatment team from obtaining information from the outpatient practitioner before the patient was discharged, particularly on weekends. At times it was found that the exchange of information was documented in a log within the medical records department and was unavailable to be viewed during the onsite record review.

**Discharge Planning**

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation of discharge plan</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Discharge plan includes date, time and name of follow up outpatient practitioner</td>
<td>100%</td>
<td>93%</td>
</tr>
<tr>
<td>Follow-up appointment was scheduled within 7 days of discharge</td>
<td>88%</td>
<td>81%</td>
</tr>
<tr>
<td>Goal</td>
<td>85%</td>
<td>85%</td>
</tr>
</tbody>
</table>

The result for evidence of discharge planning was above the goal at 100 in both measurement periods. Evidence of a complete discharge plan was 100 percent in 2015 and decreased to 93 percent in 2016. While still above the goal, the decrease was statistically significant. The discharge follow-up appointment within seven days decreased from 88 percent in 2015 to below the goal at 81 percent in 2016. The decrease was not statistically significant.

It was reported that if a member had a standing appointment, the information was not documented in the chart. Short lengths of stay hindered the facility discharge staff from scheduling a follow-up appointment. Discharge planners were available in some locations to obtain appointments after the patient had discharged and communicate this information to the member, but they failed to document this in the chart or the chart was already in the medical records area for breakdown and storage. Several facilities, particularly chemical dependency facilities, required the patient to make the follow-up appointment as a part of
the therapeutic process. Many times, this appointment was not documented in the chart.
In several markets, outpatient practitioners insisted on the patient or family member calling
to schedule the appointment, stating it helps decrease the number of no-show appointments. Additionally, members stated they would take care of scheduling their own follow-up appointments or refused follow-up care altogether. Parents or family members requested the opportunity to schedule the follow-up appointment so they could reconcile it with their own obligations. Frequently, the scheduled time and date were not provided to the discharge planner.

Interventions:
The interventions provided during the reporting period included:

- A narrated PowerPoint presentation about obtaining authorization with a focus on
  coordination of care and discharge planning was created and posted on the Humana
  Behavioral Health website.
- Letters reporting performance were sent to each facility reviewed and results were
  compared to the market aggregate.
- Identification of deficiencies was provided at the time of the review to the facility
  staff.
- Several sample forms were provided to facility discharge planners and staff to offer
  assistance in remembering, tracking and documenting the exchange of information.
  The form was created to track that a release of information was obtained for the
  previous outpatient practitioner and the follow-up practitioner. Justification for the
  lack of exchange of information or complete discharge planning was also noted on
  the form.
- Education was also provided through the Humana Behavioral Health website,
  provider manual and provider forums.

Recommendations:
Recommendations for 2017 include the following:

- Re-audit facilities on corrective action plans within six months instead of the current
  one year.
- Increase the frequency of audit requests for a facility from the current four to five
  years to every two to three years.
- Promote availability of discharge assistance from Humana Behavioral Health.
- Develop process for incentivizing providers to coordinate care with current treating
  practitioners and follow up practitioners.
- Encourage facilities to utilize PHP and IOP as an integral component of treatment.
- Develop non-on-site options for audit through fax, email and/or mail.
Develop other means of communication and education with facilities as on-site feedback is no longer an option.
- Discuss ideas to improve follow-up care with facility staff.
- Continue to offer information regarding discharge planning on the website and in the provider manual.

8. **HEDIS Measures**

a. **Follow-up after Hospitalization for Mental Illness (FUH)**

**Objective:**

The goal of this Health Effectiveness Data and Information Set (HEDIS) measure is to increase the rate of follow-up visits for members to receive continued mental health treatment after hospitalization via an outpatient visit, intensive outpatient treatment, or partial hospitalization with a mental health provider. There are two phases within this measure:

- 7-day: the percentage of members who received follow-up service(s) within seven days of discharge.
- 30-day: the percent of members who received follow-up service(s) within 30 days of discharge.

Goals for this standard are based on HEDIS 90th percentile results for reporting year 2016:

<table>
<thead>
<tr>
<th>Product</th>
<th>7-day</th>
<th>30-day</th>
</tr>
</thead>
<tbody>
<tr>
<td>COM HMO</td>
<td>73.87%</td>
<td>87.08%</td>
</tr>
<tr>
<td>COM PPO</td>
<td>62.74%</td>
<td>79.66%</td>
</tr>
<tr>
<td>MCR HMO</td>
<td>57.95%</td>
<td>76.19%</td>
</tr>
<tr>
<td>MCR PPO</td>
<td>48.33%</td>
<td>75.83%</td>
</tr>
</tbody>
</table>

**Methodology:**

The process involved with the FUH measure is as follows:

- Data is collected per the HEDIS specifications and annual rates are calculated by the health plan.
- Upon review from a National Committee of Quality Assurance (NCQA)-approved HEDIS auditor, the health plan constructs an analysis by market and aggregately of the measure results.
- The health plan provides the results to Humana Behavioral Health for further review and analysis.
Analysis and Barriers:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7-day</td>
<td>COM HMO</td>
<td>73.87%</td>
<td>39.98%</td>
<td>Below 25th</td>
<td>75.60%</td>
<td>37.36%</td>
<td>Above 10th</td>
<td>2.62%</td>
</tr>
<tr>
<td></td>
<td>COM PPO</td>
<td>62.74%</td>
<td>41.00%</td>
<td>Above 10th</td>
<td>63.60%</td>
<td>40.28%</td>
<td>Above 10th</td>
<td>0.72%</td>
</tr>
<tr>
<td></td>
<td>MCR HMO</td>
<td>57.95%</td>
<td>27.42%</td>
<td>Below 50th</td>
<td>62.20%</td>
<td>26.63%</td>
<td>Above 25th</td>
<td>0.79%</td>
</tr>
<tr>
<td></td>
<td>MCR PPO</td>
<td>48.33%</td>
<td>29.08%</td>
<td>Above 25th</td>
<td>44.60%</td>
<td>28.04%</td>
<td>Above 10th</td>
<td>1.04%</td>
</tr>
<tr>
<td>30-day</td>
<td>COM HMO</td>
<td>87.08%</td>
<td>61.20%</td>
<td>Below 25th</td>
<td>86.10%</td>
<td>56.89%</td>
<td>Above 10th</td>
<td>4.31%</td>
</tr>
<tr>
<td></td>
<td>COM PPO</td>
<td>79.66%</td>
<td>61.00%</td>
<td>Below 25th</td>
<td>80.30%</td>
<td>59.34%</td>
<td>Above 10th</td>
<td>1.66%</td>
</tr>
<tr>
<td></td>
<td>MCR HMO</td>
<td>76.19%</td>
<td>47.27%</td>
<td>Below 50th</td>
<td>77.80%</td>
<td>46.33%</td>
<td>Above 25th</td>
<td>0.94%</td>
</tr>
<tr>
<td></td>
<td>MCR PPO</td>
<td>75.83%</td>
<td>50.95%</td>
<td>Above 25th</td>
<td>70.40%</td>
<td>51.44%</td>
<td>Above 25th</td>
<td>-0.49%</td>
</tr>
</tbody>
</table>

Source: Data received from the Quality Analytics, HEDIS Three-Year Trending Report; NCQA Quality Compass

The above data reflects changes for the 7-day Phase between the 2015 and 2016 reporting years. There was an increase for all products. The Commercial HMO increased by 2.62%; Commercial PPO increased by 0.72%; the Medicare HMO increased by 0.79%; and the Medicare PPO plan increased by 1.04%.

The 30-day Phase reflects both increases and decreases from the 2015 to the 2016 results. The Commercial HMO experienced a significant increase from 56.89% to 61.20%. The Commercial PPO increased by 1.66% and the Medicare HMO increased by 0.94%. The Medicare PPO rate slightly decreased by 0.49%. The FUH rates fell short of the 90th percentile goal.

Barriers:

- The AFU team indicated members miss FUH appointments due to a lack of transportation to get to the appointment and did not have money for the copay.
- Facilities do not bill for members’ discharge appointments. Providers can bill the Rev 513 code for discharge planning, but do not take advantage of this billing code very often.
- Chronic members lacked engagement in case management and crisis plans.

Interventions:

- A referral is submitted to the Language Assistance Line (LAL) team to determine if there are any available local community resources that could assist members with lack of co-payments and transportation. AFU also conducts a search via the web to locate additional help in their community.
• Bridge outreach and training is actively being initiated with facilities in order for them to start using the Rev 513 code, which facilities can bill in order to be reimbursed for the work that they put into the discharge plan for the member. This will meet the FUH measures and help eliminate the copay and transportation issues for the FUH visit.

• Eligible members are triaged to case management for further follow-up to keep the members their healthiest and develop crisis plans.

Recommendations:

• Continue the bridge appointment initiatives to increase the performance of this measure to meet the goal reaching the 90th percentile.

• Continue education for facilities to encourage bridge appointments and billing the 513 code.

• Restructure UM and CM outreach to better connect with the member prior to discharge

b. Antidepressant Medication Management (AMM)

Objective:

The goal of this measure is to improve medication adherence for members ages 18 years and older who receive an initial diagnosis of depression and are treated with an antidepressant medication. There are two phases within this measure:

• Acute Phase: the percentage of members who remain on an antidepressant medication for at least 12 weeks, or 84 days.

• Continuation Phase: the percentage of members who continue with antidepressant medication for at least six months, or 180 days.

Goals for this standard are based on HEDIS 90th percentile results for reporting year 2016:

<table>
<thead>
<tr>
<th>Product</th>
<th>Acute Phase</th>
<th>Continuation &amp; Maintenance Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>COM HMO</td>
<td>78.44%</td>
<td>61.27%</td>
</tr>
<tr>
<td>COM PPO</td>
<td>73.18%</td>
<td>58.90%</td>
</tr>
<tr>
<td>MCR HMO</td>
<td>82.77%</td>
<td>72.25%</td>
</tr>
<tr>
<td>MCR PPO</td>
<td>80.54%</td>
<td>67.76%</td>
</tr>
</tbody>
</table>

Methodology:
The process involved with the AMM measure is as follows:

- Data is collected by the HEDIS measure specifications with annual rates calculated by the health plan.
- Upon review from an NCQA-approved HEDIS auditor, the health plan develops market-specific and aggregate overview of the results by line of business and product.
- The health plan releases the results to Humana Behavioral Health for further review and analysis.

**Analysis and Barriers:**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Phase</td>
<td>COM HMO</td>
<td>78.44%</td>
<td>63.87%</td>
<td>Below 50th</td>
<td>76.90%</td>
<td>61.74%</td>
<td>Above 25th</td>
<td>2.13%</td>
</tr>
<tr>
<td></td>
<td>COM PPO</td>
<td>73.18%</td>
<td>64.13%</td>
<td>Above 25th</td>
<td>73.80%</td>
<td>62.05%</td>
<td>Above 10th</td>
<td>2.08%</td>
</tr>
<tr>
<td></td>
<td>MCR HMO</td>
<td>82.77%</td>
<td>68.32%</td>
<td>Below 50th</td>
<td>79.40%</td>
<td>67.66%</td>
<td>Above 25th</td>
<td>0.66%</td>
</tr>
<tr>
<td></td>
<td>MCR PPO</td>
<td>80.54%</td>
<td>70.76%</td>
<td>Below 50th</td>
<td>78.70%</td>
<td>69.84%</td>
<td>Above 25th</td>
<td>0.92%</td>
</tr>
<tr>
<td>Continuation Phase</td>
<td>COM HMO</td>
<td>61.27%</td>
<td>47.85%</td>
<td>Above 25th</td>
<td>62.00%</td>
<td>45.71%</td>
<td>Above 25th</td>
<td>2.14%</td>
</tr>
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<td></td>
<td>COM PPO</td>
<td>58.90%</td>
<td>47.68%</td>
<td>Above 25th</td>
<td>59.90%</td>
<td>45.53%</td>
<td>Above 10th</td>
<td>2.15%</td>
</tr>
<tr>
<td></td>
<td>MCR HMO</td>
<td>72.25%</td>
<td>52.27%</td>
<td>Below 50th</td>
<td>69.60%</td>
<td>51.55%</td>
<td>Above 25th</td>
<td>0.72%</td>
</tr>
<tr>
<td></td>
<td>MCR PPO</td>
<td>67.76%</td>
<td>57.15%</td>
<td>Below 50th</td>
<td>67.40%</td>
<td>56.62%</td>
<td>Above 25th</td>
<td>0.53%</td>
</tr>
</tbody>
</table>

*Source:* Data received from the Quality Analytics report; HEDIS Quality Compass

A review of the Acute Phase data for the AMM measure reflects a constant increase across all plans for the between the 2015 and 2016 reporting years. There was an increase in the Commercial HMO of 2.13%; the Commercial PPO increased by 2.08%; the Medicare HMO increased by 0.66%; and the Medicare PPO plan increased by 0.92%.

The Continuation Phase data for the AMM measure reflects an increase across all plans for the between the 2015 and 2016 reporting years. The Commercial HMO plan increased by 2.14%; the Commercial PPO increased by 2.15%; the Medicare HMO increased by 0.72%; and the Medicare PPO plan increased by 0.53%. The majority of the AMM rates are trending toward the 50<sup>th</sup> percentile; however, none have met the 90<sup>th</sup> percentile goal.

**Barriers:**

- Member lacks education about the benefits of medication compliance
- Member forgets to take the medication or stops taking without MD input
- Lack of coordinated collaboration between HBH and providers in order to impact HEDIS measures.
Interventions:

- To increase the awareness of medication adherence, members and their prescribers received individualized data which reported their adherence patterns as well as educational materials.
- Humana Behavioral Health collaborated with the Transitions team, a unit of Humana corporate case managers who provided 30 days of intensive CM services for members referred to the program. Topics covered with the member included medication adherence, its importance and the potential negative impact of non-compliance.
- Humana Behavioral Health is developing a Collaborative with selected providers in order to create a space for continuous feedback and share best practices and suggestions amongst providers.

Recommendations:

Continue to monitor the interventions noted above to determine effectiveness and usefulness for improving this measure’s outcomes.

c. Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (ADD)

Objective:

This measure focuses on members from age six to 12 years that are newly prescribed ADHD medication with at least three follow-up care visits within a 10-month period. This measure has two phases:

- Initiation Phase: the percentage of members who complete one visit with a practitioner with prescribing authority within 30 calendar days of beginning a new ADHD prescription.
- Continuation and Maintenance (C&M) Phase: the percentage of members from the Initiation Phase that remain on their ADHD medication for at least 210 days and who had at least two follow-up visits with a practitioner within nine months (270 days) after the initiation phase ends.

Goals for this standard are based on HEDIS 90th percentile results for reporting year 2016:
Methodology:

- The process involved with the ADD measure is as follows:
  - Data is collected according to the HEDIS specifications for this measure with annual rates calculated by the health plan.
  - Upon review from an NCQA-approved HEDIS auditor, the health plan develops an analysis of the measure’s results by market and in aggregate.
  - The health plan submits the results to Humana Behavioral Health for further review and analysis.

Analysis and Barriers:

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiation Phase</td>
<td>COM HMO</td>
<td>78.44%</td>
<td>28.60%</td>
<td>Above 10th</td>
<td>54.20%</td>
<td>26.98%</td>
<td>Above 10th</td>
<td>1.62%</td>
</tr>
<tr>
<td></td>
<td>COM PPO</td>
<td>73.18%</td>
<td>28.49%</td>
<td>Below 10th</td>
<td>45.10%</td>
<td>25.22%</td>
<td>Below 10th</td>
<td>3.27%</td>
</tr>
<tr>
<td>Continuation &amp; Maintenance Phase</td>
<td>COM HMO</td>
<td>61.27%</td>
<td>30.25%</td>
<td>Above 5th</td>
<td>68.90%</td>
<td>30.55%</td>
<td>Below 10th</td>
<td>-0.30%</td>
</tr>
<tr>
<td></td>
<td>COM PPO</td>
<td>58.90%</td>
<td>33.21%</td>
<td>Below 5th</td>
<td>52.00%</td>
<td>31.56%</td>
<td>Below 10th</td>
<td>1.65%</td>
</tr>
</tbody>
</table>

Source: Data received from the Quality Analytics report; HEDIS Quality Compass

No data is collected for Medicare plans as it does not include the ADD population due to age criteria of the measure and the plan. Both the Commercial HMO and PPO plans showed increases for the Initiation Phases from 2015 to 2016. The Commercial HMO plan showed an increase of 1.62% while the Commercial PPO plan had a significant increase of 3.27%. The C&M Phases had a very slight decrease for the Commercial HMO plan of less than half percent; the Commercial PPO plan had an increase of 1.65%.

Barriers:

- Parent lacks education about the benefits of medication compliance
- Parent stops administering medication to member when symptoms improve
- Lack of coordinated collaboration between HBH and providers in order to impact HEDIS measures.

Interventions:
• Educational resources and online links to additional materials related to ADHD were made available on Humana Behavioral Health’s website.
• The website also offered self-management tools which provided tips, resources, and guidance for parents or guardians seeking help related to parenting children with ADHD.
• Humana Behavioral Health is developing a Collaborative with selected providers in order to create a space for continuous feedback and share best practices and suggestions amongst providers.

Recommendations:

Continue offering the resources mentioned above to parents or guardians of children diagnosed with ADHD. In addition, Humana Behavioral Health will continue to monitor and enhance as needed, utilization of its website for awareness and education on ADHD.

d. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) Objective:

This measure assesses the percentage of members, ages 13 years and older, that completed alcohol or other drug dependence (AOD) treatment in two phases after a new AOD diagnosis.

• Initiation Phase: the percentage of members who initiate AOD treatment within 14 days of the diagnosis.
• Engagement Phase: the percentage of members, from the initiation phase, who have completed two or more additional services within 30 days of the initiation phase visit.

Goals for this standard are based on HEDIS 90<sup>th</sup> percentile results for reporting year 2016:

<table>
<thead>
<tr>
<th>2016 NCQA Quality Compass 90th Percentile (IET)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Product</strong></td>
</tr>
<tr>
<td>COM HMO</td>
</tr>
<tr>
<td>COM PPO</td>
</tr>
<tr>
<td>MCR HMO</td>
</tr>
<tr>
<td>MCR PPO</td>
</tr>
</tbody>
</table>

Methodology:

The IET measure is determined by this process:
- Data is collected per the HEDIS specifications with annual rates calculated for this measure by the health plan.
- Upon review from an NCQA-approved HEDIS auditor, the health plan prepares an analysis by market and product line of the measure’s results.
- The health plan provides the results to Humana Behavioral Health for further review and analysis.

### Analysis and Barriers:

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Initiation Phase</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COM HMO</td>
<td>39.06%</td>
<td>32.33%</td>
<td>Below 50th</td>
<td>41.50%</td>
<td>31.88%</td>
<td>Above 50th</td>
<td>0.45%</td>
<td></td>
</tr>
<tr>
<td>COM PPO</td>
<td>40.43%</td>
<td>34.10%</td>
<td>Below 50th</td>
<td>42.50%</td>
<td>33.53%</td>
<td>Above 10th</td>
<td>0.57%</td>
<td></td>
</tr>
<tr>
<td>MCR HMO</td>
<td>47.04%</td>
<td>16.83%</td>
<td>Above 10th</td>
<td>48.20%</td>
<td>20.52%</td>
<td>Above 25th</td>
<td>-3.69%</td>
<td></td>
</tr>
<tr>
<td>MCR PPO</td>
<td>44.16%</td>
<td>33.34%</td>
<td>Below 50th</td>
<td>46.70%</td>
<td>33.02%</td>
<td>Above 25th</td>
<td>0.32%</td>
<td></td>
</tr>
<tr>
<td><strong>Engagement Phase</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COM HMO</td>
<td>15.72%</td>
<td>9.00%</td>
<td>Above 25th</td>
<td>17.30%</td>
<td>9.38%</td>
<td>Above 25th</td>
<td>-0.38%</td>
<td></td>
</tr>
<tr>
<td>COM PPO</td>
<td>19.13%</td>
<td>10.60%</td>
<td>Above 25th</td>
<td>19.70%</td>
<td>9.78%</td>
<td>Above 25th</td>
<td>0.82%</td>
<td></td>
</tr>
<tr>
<td>MCR HMO</td>
<td>7.00%</td>
<td>1.00%</td>
<td>Below 25th</td>
<td>6.20%</td>
<td>1.30%</td>
<td>Above 25th</td>
<td>-0.30%</td>
<td></td>
</tr>
<tr>
<td>MCR PPO</td>
<td>5.63%</td>
<td>2.07%</td>
<td>Above 25th</td>
<td>6.20%</td>
<td>2.18%</td>
<td>Above 25th</td>
<td>-0.11%</td>
<td></td>
</tr>
</tbody>
</table>

*Source: Data received from the Quality Analytics report; HEDIS Quality Compass*

A review of the baseline Initiation Phase data for the Commercial products revealed that 32.33% of Commercial HMO and 34.1% of Commercial PPO members initiated AOD treatment within 14 days of their initial diagnosis. The Commercial HMO rate increased by 1.42% from 2015 to the 2016 reporting year. A review of the baseline Initiation Phase data for the Medicare products revealed that 16.8% of Medicare HMO and 33.34% of Medicare PPO members initiated AOD treatment within 14 days of their initial diagnosis. While all rates fell short of the 90th percentile goal the baseline rates are closer to meeting the 50th percentile for both Commercial and Medicare.

A review of the baseline Engagement Phase data for the Commercial products revealed that 9.00% of the Commercial HMO and 10.6% of Commercial PPO members initiated treatment and had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. A review of the baseline Engagement Phase data for the Medicare products revealed that 1.0% of Medicare HMO and 2.07% of Medicare PPO initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. While all rates fell short of the 90th percentile goal, the baseline rates are trending around the 25th percentile for Commercial and Medicare.

**Barriers:**
• Primary care physicians (PCPs) often were not trained or aware of how to assess members for potential substance abuse issues.
• Members initially attended follow-up visits; however, they failed to complete a sufficient number of aftercare sessions to meet the measure’s criteria.
• Lack of coordinated collaboration between HBH and providers in order to impact HEDIS measures.

Interventions:

• Humana Behavioral Health offered materials for PCPs on assessment and treatment of substance use disorders.
• Humana launched a multi-year pilot that involved an integrated substance dependence program that used medical and psychosocial interventions, long-term coaching and online tools to aid members in their recovery.
• Humana Behavioral Health is developing a Collaborative with selected providers in order to create a space for continuous feedback and share best practices and suggestions amongst providers.

Recommendations:

Continue to monitor the aforementioned multi-year pilot to improve the outcomes for this measure. Educate PCPs on the assessment and treatment of substance use disorders.

9. Clinical Quality Improvement Activities

Objective:
To improve HBH Clinical Quality and HBH members clinical experience through identification, development, and monitoring of opportunities for improvement through the implementation of Quality Improvement Activities.

a) Improving Ambulatory Follow-up after Inpatient Discharge Rates

Methodology:
- This initiative measures the rate of follow-up visits for members to receive continued mental health treatment after hospitalization via an outpatient visit, intensive outpatient treatment, or partial hospitalization with a mental health provider. There are two phases within this measure:
  • 7-day: the percentage of members who received follow-up service(s) within seven days of discharge.
  • 30-day: the percent of members who received follow-up service(s) within 30 days of discharge.
- Data is collected per the HEDIS specifications and annual rates are calculated by the health plan.
Upon review from a National Committee of Quality Assurance (NCQA)-approved HEDIS auditor, the health plan constructs an analysis by market and aggregately of the measure results.

The health plan provides the results to Humana Behavioral Health for further review and analysis.

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>7-day</td>
<td>COM HMO</td>
<td>73.87%</td>
<td>39.98%</td>
<td>Below 25&lt;sup&gt;th&lt;/sup&gt;</td>
<td>75.60%</td>
<td>37.36%</td>
<td>Above 10&lt;sup&gt;th&lt;/sup&gt;</td>
<td>2.62%</td>
</tr>
<tr>
<td></td>
<td>COM PPO</td>
<td>62.74%</td>
<td>41.00%</td>
<td>Above 10&lt;sup&gt;th&lt;/sup&gt;</td>
<td>63.60%</td>
<td>40.28%</td>
<td>Above 10&lt;sup&gt;th&lt;/sup&gt;</td>
<td>0.72%</td>
</tr>
<tr>
<td></td>
<td>MCR HMO</td>
<td>57.95%</td>
<td>27.42%</td>
<td>Below 50&lt;sup&gt;th&lt;/sup&gt;</td>
<td>62.20%</td>
<td>26.63%</td>
<td>Above 25&lt;sup&gt;th&lt;/sup&gt;</td>
<td>0.79%</td>
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<tr>
<td></td>
<td>MCR PPO</td>
<td>48.33%</td>
<td>29.08%</td>
<td>Above 25&lt;sup&gt;th&lt;/sup&gt;</td>
<td>44.60%</td>
<td>28.04%</td>
<td>Above 10&lt;sup&gt;th&lt;/sup&gt;</td>
<td>1.04%</td>
</tr>
<tr>
<td>30-day</td>
<td>COM HMO</td>
<td>87.08%</td>
<td>61.20%</td>
<td>Below 25&lt;sup&gt;th&lt;/sup&gt;</td>
<td>86.10%</td>
<td>56.89%</td>
<td>Above 10&lt;sup&gt;th&lt;/sup&gt;</td>
<td>4.31%</td>
</tr>
<tr>
<td></td>
<td>COM PPO</td>
<td>79.66%</td>
<td>61.00%</td>
<td>Below 25&lt;sup&gt;th&lt;/sup&gt;</td>
<td>80.30%</td>
<td>59.34%</td>
<td>Above 10&lt;sup&gt;th&lt;/sup&gt;</td>
<td>1.66%</td>
</tr>
<tr>
<td></td>
<td>MCR HMO</td>
<td>76.19%</td>
<td>47.27%</td>
<td>Below 50&lt;sup&gt;th&lt;/sup&gt;</td>
<td>77.80%</td>
<td>46.33%</td>
<td>Above 25&lt;sup&gt;th&lt;/sup&gt;</td>
<td>0.94%</td>
</tr>
<tr>
<td></td>
<td>MCR PPO</td>
<td>75.83%</td>
<td>50.95%</td>
<td>Above 25&lt;sup&gt;th&lt;/sup&gt;</td>
<td>70.40%</td>
<td>51.44%</td>
<td>Above 25&lt;sup&gt;th&lt;/sup&gt;</td>
<td>-0.49%</td>
</tr>
</tbody>
</table>

**Analysis and Barriers:**
- The AFU team indicated members miss FUH appointments due to a lack of transportation to get to the appointment and did not have money for the copay.
- Facilities do not bill for members’ discharge appointments.
- Chronic members lacked engagement in case management and crisis plans.

**Interventions:**
- A referral is submitted to the LAL team to determine if there are any available local community resources that could assist members with lack of co-payments and transportation. AFU also conducts a search via the web to locate additional help in their community.
- Bridge outreach and training is actively being initiated with facilities in order for them to start using the 513 code. This will meet the FUH measures and help eliminate the copay and transportation issues for the FUH visit.
- Eligible members are triaged to case management for further follow-up to keep the members their healthiest and develop crisis plans.

**Recommendations:**
- Continue the bridge appointment initiatives to increase the performance of this measure to meet the goal reaching the 90<sup>th</sup> percentile.
- Continue education for facilities to encourage bridge appointments and billing the 513 code

a) Improving the Rate of Medication Compliance among Members with an Initial Diagnosis of Major Depressive Disorder

**Methodology:**
- Data is collected by the HEDIS measure specifications with annual rates calculated by the health plan.
- Upon review from an NCQA-approved HEDIS auditor, the health plan develops market-specific and aggregate overview of the results by line of business and product.
- The health plan releases the results to Humana Behavioral Health for further review and analysis.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Acute Phase</td>
<td>COM HMO</td>
<td>78.44%</td>
<td>72.99%</td>
<td>Below 75th</td>
<td>76.90%</td>
<td>61.74%</td>
<td>Above 25th</td>
<td>11.25%</td>
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<tr>
<td></td>
<td>COM PPO</td>
<td>73.18%</td>
<td>64.13%</td>
<td>Above 25th</td>
<td>73.80%</td>
<td>62.05%</td>
<td>Above 10th</td>
<td>2.08%</td>
</tr>
<tr>
<td></td>
<td>MCR HMO</td>
<td>82.77%</td>
<td>68.32%</td>
<td>Below 50th</td>
<td>79.40%</td>
<td>67.66%</td>
<td>Above 25th</td>
<td>0.66%</td>
</tr>
<tr>
<td></td>
<td>MCR PPO</td>
<td>80.54%</td>
<td>70.76%</td>
<td>Below 50th</td>
<td>78.70%</td>
<td>69.84%</td>
<td>Above 25th</td>
<td>0.92%</td>
</tr>
<tr>
<td>Continuation Phase</td>
<td>COM HMO</td>
<td>61.27%</td>
<td>49.70%</td>
<td>Above 50th</td>
<td>62.00%</td>
<td>45.71%</td>
<td>Above 25th</td>
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<td></td>
<td>COM PPO</td>
<td>58.90%</td>
<td>47.68%</td>
<td>Above 25th</td>
<td>59.90%</td>
<td>45.53%</td>
<td>Above 10th</td>
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</tr>
<tr>
<td></td>
<td>MCR HMO</td>
<td>72.25%</td>
<td>52.27%</td>
<td>Below 50th</td>
<td>69.60%</td>
<td>51.55%</td>
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<tr>
<td></td>
<td>MCR PPO</td>
<td>67.76%</td>
<td>57.15%</td>
<td>Below 50th</td>
<td>67.40%</td>
<td>56.62%</td>
<td>Above 25th</td>
<td>0.53%</td>
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</table>

**Analysis and Barriers:**
- Member lacks education about the benefits of medication compliance
- Member forgets to take the medication or stops taking without MD input
- Lack of coordinated collaboration between HBH and providers in order to impact HEDIS measures.

**Interventions:**
- To increase the awareness of medication adherence, members and their prescribers received individualized data which reported their adherence patterns as well as educational materials.
- Humana Behavioral Health collaborated with the Transitions team, a unit of Humana corporate case managers who provided 30 days of intensive CM services for members referred to the program. Topics covered with the member included medication adherence, its importance and the potential negative impact of non-compliance.
- Humana Behavioral Health is developing a Collaborative with selected providers in order to create a space for continuous feedback and share best practices and suggestions amongst providers.
Recommendations:
- Continue to monitor the interventions noted above to determine effectiveness and usefulness for improving this measure’s outcomes.

Overall Effectiveness and Summation

Accomplishments and Overall Effectiveness in 2016
Humana Behavioral Health experienced many positive changes throughout the company in 2016. Humana Behavioral Health worked to align behavioral health more closely with the Humana enterprise in enhancing holistic care for members. Under the guidance of the SLT and QIC, Humana Behavioral Health’s departments tracked, reported, and analyzed their performance against the previously set benchmarks outlined in the 2016 QI Work Plan.

One of the overarching goals for 2016 was strengthening partnerships among internal departments as well as enhancing integration with enterprise entities. These collaborations occurred in the form of cross functional training, joint task forces and partnership on projects designed to build the membership’s satisfaction with their Humana experience.

The QIP successfully monitored clinical and service indicators and implemented interventions as needed throughout the year. The continual monitoring and oversight provided ensured that negative trends were addressed promptly, encouraging continual quality improvement.

Opportunities for Improvement in 2017
As a whole, Humana Behavioral Health strives to improve programming and performance year over year. Based on the overall evaluation of the QIP in 2016, opportunities for improvement and growth have been identified to further the development of the QIP in 2017. Areas recognized as opportunities for improvement are listed below:

- Continued development and accuracy of reporting metrics and benchmarks for committees
- Increased integration with Humana Inc. for a seamless flow of information from one organization to the other
- Increase HEDIS scores and further develop pilots to assist in reaching the 75th percentile on all measures
- Modify the behavioral health screening programs to better serve members by providing more useful information
- Identify new projects to develop into QIAs
- Assist and promote the growth and expansion of the new unified clinical department and CCM program
- Increase the rate of exchange of information between medical and behavioral providers
- Partner with network providers to reduce quality indicators, lengths of stay, and improve outcomes
- Increase various audits in order to ensure the correct application of policies and procedures
- Continue audits of out of network providers to safeguard the services members receive
Approval

The 2015 End of Year Evaluation has been reviewed and approved.

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Lawrence Weinstein, MD          Date 4/28/2017
Chief Medical Officer
Member, SLT
Chairperson, QIC

______________________________
Sabrina Townsend, PhD            Date 4/28/2017
Director, Q&A
Chairperson, QIC