ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES

Performance Framework Data Dictionary

Coordination/Collaboration

July 2012

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COORDINATION OF CARE

DESCRIPTION

This performance measure determines the percent of AHCCCS members for whom behavioral health service providers communicate behavioral health clinical and contact information with the member's Primary Care Physician (PCP) and/or Health Plan.

ABBREVIATIONS

ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
AHCCCS – Arizona Health Care Cost Containment System
BHR – Behavioral Health Recipient
C/A – Child/Adolescent
CIS – ADHS Client Information System
COC – Coordination of Care
DD – Developmentally Disabled
DUG – ADHS/DBHS Demographic Data Set Users Guide
GSA – Geographical Service Area
MPS – Minimum Performance Standard
PCP – Primary Care Provider
SMI – Seriously Mentally Ill

MINIMUM PERFORMANCE STANDARD

Minimum:	85%
Goal:	95%

The MPS must be met for each review period by each GSA for both the C/A and Adult populations.

METHODOLOGY

Population
Performance is reported by GSA and for Title XIX/XXI C/A (up to age 21) and Adults (21 and over) with any Axis III diagnosis as described in the DUG and/or all SMIs.

DD-enrolled BHRs that meet identifying criteria are flagged for separate reporting.

ADHS/DBHS stratifies performance for the C/A population by Title XIX and Title XXI and by the following age bands for potential ad hoc reporting:

- 0 - 5.999
- 6 - 11.999
- 12 - 17.999
- 18 - 20.999

Reporting Frequency
Data and analysis are submitted each review period.

Data Source
Denominator data is collected by ADHS/DBHS from CIS, and identifies AHCCCS enrolled members as either eligible TXIX or TXXI. Numerator data is collected from chart reviews.

BHRs eligible to be included in this measure have an open EOC on the first day of the review period, had a continuously open EOC at least 90 days during the previous 6 months, and received a service during the previous 6 months other than transportation, lab, radiology, pharmacy, inpatient service, methadone treatment, or crisis.

Sampling
Random samples are drawn at the GSA level for Title XIX/XXI C/A and TXIX Adults. The sampling method utilizes a random selection of BHRs using at least a 90% confidence level with a 10% margin of error, divided by four (4).

Calculation
The overall rate for the measure is calculated by dividing the number of AHCCCS enrolled members with documentation of communication with the member's PCP and/or health plan by the total number of AHCCCS enrolled members in the denominator.

Numerator: Number of charts containing documentation of communication with the AHCCCS PCP/Health Plan.
Denominator: The total number of charts reviewed.

Timeline
The following submission schedule applies for the July 1, 2012 through September 30, 2013 contract:

Review Period	DBHS file to RBHA	RBHA file and analysis to DBHS
P1	November 15, 2012	January 30, 2013
P2	February 15, 2013	April 30, 2013
P3	May 15, 2013	July 30, 2013
P4	August 15, 2013	October 30, 2013
P5	November 15, 2013	January 30, 2014

If the day the file must be reported to ADHS/DBHS falls upon a weekend or holiday, it will be due the following working day.

RBHAs also provide a written analysis of current Coordination of Care data, analysis and trending via the electronic Quarterly Performance Improvement Report template (attached). This report is due to ADHS/DBHS 30 days after the end of each review period, and summarizes the most recent activity for this measure.

Process Steps

1. One Month and 15 Days after the Review Period

Via the Sherman server with e-mail notification to the RBHA, ADHS/DBHS provides the RBHA with an Excel workbook that contains identifying data for each randomly selected BHR. The file layout is included at the end of this chapter.

2. Three Months and 30 Days After the Review Period

Via the Sherman Server, with email notification to ADHS/DBHS, the RBHA returns the Excel workbook to ADHS/DBHS with an additional field where the RBHA documents communication with the PCP. The RBHA populates this field with a YES (Y) if documentation indicates the individual's diagnosis and current prescribed medications (including strength and dosage) were provided to the individual's assigned PCP. The RBHA uses a NO (N) if there is no documentation of communication with the PCP or if the documentation is incomplete. See file layout.

Scoring Criteria

For the purpose of determining if the record meets the requirements for coordination of care, the evidence must be dated to correspond with eligible dates for the review period.

RBHA Review Period		Eligible Dates for COC documents
P1	July 1 – September 30, 2012	October 1, 2011 – September 30, 2012
P2	October 1 – December 31, 2012	January 1, 2012 – December 31, 2012
P3	January 1 – March 31, 2013	April 1, 2012 – March 31, 2013
P4	April 1 – June 30, 2013	July 1, 2012 – June 30, 2013
P5	July 1 – September 30, 2013	October 1, 2012 – September 30, 2013

At least one of the following must be evidenced in the record:

1. ADHS/DBHS PM Form 4.3.1, Communication Document, or similar document completed in its entirety. PM Form 4.3.1 can be accessed in Section 4.3, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers, of the ADHS/DBHS Provider Manual at www.azdhs.gov/bhs/provider/sec4_3.pdf.

2. Progress Note containing a header entitled "Coordination of Care", dated and typed or legibly written, that clearly identifies the occurrence of required communication, the minimum required elements of the communication (current diagnosis and prescribed medications, including strength and dosage) and the date the communication was forwarded to the Health Plan/PCP.

The RBHA assembles copies of the required documentation for each record where present for possible subsequent request by ADHS/DBHS.

QUALITY CONTROL

RBHAs perform regular data validation studies of their contractors to verify that the services received by BHRs are documented in the medical record appropriately, and are reported to the RBHA in an accurate and timely manner. ADHS/DBHS receives summary reports of the data validation studies.

CONFIDENTIALITY PLAN

Preparation of the information for this performance measure includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. Publicly-reported data generated for this performance measure are aggregated at the GSA/RBHA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

LENGTH OF STAY AND READMISSIONS

DESCRIPTION

For BHRs discharged from a facility during the report month, RBHAs provide totals for authorized Length of Stay (LOS) and readmissions by level of care, behavioral health category, and funding source.

ABBREVIATIONS

ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
BHC – Behavioral Health Category
BHR – Behavioral Health Recipient
BQMO – Bureau of Quality Management Operations
C/A - Child/Adolescent
GMH - General Mental Health
HCTC - Home Care Training To Home Care Client
HIPAA - Health Insurance Portability and Accountability Act
LOS - Length of Stay
MM/UM – Medical Management/Utilization Management
RBHA – Regional Behavioral Health Authority
RTC – Residential Treatment Center
SA - Substance Abuse
SMI - Seriously Mentally Ill

MINIMUM PERFORMANCE STANDARD

Not applicable.

METHODOLOGY

Population
All Title XIX/XXI C/A and Adult BHRs and Non-TXIX/XXI C/A and SMI Adult BHRs who were discharged from a Level I, Level I Sub-acute, Level I RTC, Level II, Level III, or HCTC facility during the review period are to be included in this report. Consult the Covered Services Guide to determine the provider types associated with each level of care.

C/A age groups are stratified as follows:

- 0-5.999
- 6-11.999

- 12-17.999
- 18-20.999
- 0-17.999 Non-TXIX C/A

Title XIX and Title XXI C/As are combined.

Adult
- Age 21 and older
- Non TXIX/XXI SMI age 18 and older

All BHRs are stratified by BHC, age group, and facility type.

Data Source
RBHA inpatient/residential tracking logs.

Reporting Frequency
Data are reported monthly. Analysis is submitted quarterly.

Sampling
Not applicable.

Calculation

Length of Stay:
Data are reported separately for each level of care, for each behavioral health category, and for each funding source. Levels of care to be reported are: Level I, Level I Sub-acute, Level I RTC, Level II, Level III, and HCTC. Behavioral health categories to be reported for BHRs with TXIX/XXI funding source are: SMI, GMH, SA, and C/A. Behavioral health categories to be reported for BHRs with Non-Title XIX/XXI funding source are: C/A and SMI.

Report the authorized LOS for each stay in a facility for every discharge during this report month, regardless of when the recipient was admitted to the facility. Follow these guidelines.

1. Do not include the day of discharge in the count of LOS days.
2. Do not include same-day discharges (an admission and discharge occurring within the same 24-hour period) in the count of LOS days or number of discharges/clients discharged.
3. Do not include Court Ordered Evaluation (COE) days in the count of LOS days.
4. Do not include other payer days in LOS.
5. If a BHR is readmitted to the same level of care on the same day or day after discharge, exclude that discharge and consider it to be one stay.
6. Count all records showing a discharge to obtain the total Number of Discharges from each level of care.
7. Count the number of unique recipients to obtain the total Number of Clients Discharged from each level of care.
8. Add the LOS for all BHRs discharged from each level of care to obtain the Total LOS for each level.

For example, if a BHR is admitted to a Level I facility on June 21 and discharged on July 3, this 12 day-LOS would be included in the July report.

Readmissions:
Readmissions are reported separately for each level of care, for each behavioral health category, and for each fund source. Levels of care to be reported are: Level I, Level I Sub-acute, Level I RTC, Level II, Level III, and HCTC. Behavioral health categories to be reported for BHRs with TXIX/XXI funding source are: SMI, GMH, SA, and C/A. Behavioral health categories to be reported for BHRs with Non-Title XIX/XXI funding source are: C/A and SMI.

For BHRs discharged during the report month, count those having a subsequent readmission to the same facility level within 30 days. Note that the readmission may occur in the month following the report month. Follow these guidelines.

1. If a BHR is readmitted to the same level of care on the same day or day after discharge, exclude that discharge and consider it to be one stay.
2. Count all records showing a discharge to obtain the total Number of Discharges from each level of care.
3. Count the number of unique recipients to obtain the total Number of Clients Discharged from each level of care.
4. Total the readmissions for all BHRs discharged from each level of care to obtain the Number of Readmissions for each level.

For example, if a BHR was discharged from a Level I Sub-acute facility on July 25, then readmitted to the same facility level on August 5, the readmission would be included in the July report.

The Readmission Rate would be calculated as follows.
Numerator: Number of BHRs readmitted to a same level facility within 30 days.
Denominator: Number of BHR discharges from the same level facility.

Timeline
Data are reported to ADHS/DBHS 45 days after the reporting month via a comma delimited text file (file layout attached) submitted at the ADHS/DBHS Sherman Server.

Quarterly analysis is submitted to ADHS/DBHS 45 days after the final reporting month for the quarter using the MM/UM Indicator Report template located here (attached).

If the day the file must be reported to ADHS/DBHS falls upon a weekend or holiday, it will be due the following working day.

QUALITY CONTROL

Monthly files submitted by the RBHAs and processed at ADHS/DBHS electronically are checked programmatically for data errors. Errors are identified as erroneous or missing data in any of the

required fields. Files containing errors are returned to the RBHA for correction. Errors are recorded and tracked by ADHS/DBHS. RBHAs are subject to corrective action, up to and including sanctions if the error rate exceeds 5% in any field for three consecutive months.

RBHAs are responsible for verifying the accuracy of the data submitted for this measure and may be required to submit verification to ADHS/DBHS upon request. ADHS/DBHS may identify a random sample of behavioral health recipients and require that the RBHA submit documentation for validation purposes or perform such validation through on-site visits.

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