DIRECT CARE CLINIC DASHBOARD INDICATORS SPECIFICATIONS MANUAL

Last Revised 11/20/10

1. **ACT Fidelity**
2. **ISP Current**
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7. **Case Manager Case Loads**
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11. **Complaints per 1000 Enrollees**
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13. **PCP Coordination**
14. **Follow-Up after Discharge within 7 Days**
15. **Level I Admissions per 1000 Enrollees**
16. **Re-admissions within 30 Days**
17. **Title XIX Ratio**
18. **Encountering**

***Also Includes a Section for Interpreting and Utilizing the Dashboard Gauges and Features**

1. ACT FIDELITY

Assertive Community Treatment Teams meet fidelity to the ACT model as outlined in the court approved Maricopa County Case Management and Clinical Team Plan.

DEFINITIONS

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1. Small Caseload: Client/CM/CL ratio of 12:1
2. Team Approach: Provider group functions as a team; team members know and work with all clients.
3. Program Meeting: Program meets frequently to plan and review services for each client.
4. Appropriate Transitions to and from Supportive Teams: The program has a clearly identified mission to serve a particular population; it uses measurable and operationally defined criteria to screen out inappropriate referrals. Admission criteria should be pointedly targeted toward the individuals who typically do not benefit from usual services. In addition to these very general criteria, an ACT team should have some further admission guidelines tailored to their treatment setting.
5. Full responsibility for treatment services: ACT team directly provides psychiatric services, medication management, housing support, substance abuse treatment, employment/rehabilitative services, ILS services, transportation services, peer support services and case management services.
6. Responsibility for crisis services: Program has 24-hour responsibility for covering all psychiatric crises.
7. Responsibility for hospital admissions: All members of the ACT Team are expected to be involved in the admission process and discharge planning process. ACT Team members are expected to put services in place to meet the needs of the Recipient in the community, if necessary, to divert the hospitalization.
8. Responsibility for hospital discharge planning: The clinical team actively participates and coordinates with the inpatient treatment team to identify discharge plans through a staffing. The recipient is seen within 72 hours of being admitted and weekly while inpatient. A member of the clinical team shall maintain daily contact with the person via telephonic and/or face-to-face contact during the first five (5) working days following discharge.
9. Responsibility for Incarcerations: ACT team is closely involved with the jail system when a service recipient is arrested and in planning for Jail releases. The Case Manager or another member of the clinical team shall visit the incarcerated consumer within 72 hours of notification of incarceration and at least one face-to-face contact one time per month or as frequently as determined necessary during consumer's period of incarceration. The clinical team shall ensure that a member of the clinical team attends the staffing(s) to assist in the coordination of care and services.
10. Responsibility for jail discharge planning: Program is involved in planning for jail discharges. Upon release from General Population, the consumer shall see the Behavioral Health Medical Practitioner (BHMP) within 72 hours. Consumers released from LBJ IP Psych Unit shall be seen by a BHMP on the day of release (or the next business day, if the release occurs on a Saturday or Sunday). The clinical team shall provide services to the consumer in accordance with the plan for release and in order to ensure, promote and/or maintain the consumer's: Safety; Security; symptom reduction; Physical health; and Recovery and rehabilitation.
11. Community-based services: Program works to monitor status, develop skills in the community, rather than in office.

12. Frequency of contact: High number of face-to-face service contacts as needed.
13. Individualized substance abuse engagement/treatment: One or more members of the team provide direct treatment/engagement and substance abuse treatment/engagement for clients with substance use disorders.
14. Substance Abuse engagement/treatment groups: The ACT Team refers to Substance Abuse Specialist and/or Co-Located Substance Abuse Specialist to identifying if an individual needs Co-Occurring Residential Treatment vs. outpatient services in the community. The Co-Located staff also provide outreach and engagement and services are expected to be out in the community as well as in the office.
15. Meaningful Community Employment: One or more members of the team will work in conjunction with the service recipient to determine level of readiness for community employment
16. Meaningful Community Activity: One or more members of the team will work in conjunction with the service recipient to determine level of readiness for community integration
17. Housing: Housing needs should be determined and how much housing supports are needed to maintain a person in the community

METHODOLOGY

Population
Direct care clinical teams serving individuals on an Assertive Community Treatment (ACT) team (i.e., ACT Teams).

Inclusion Criterion
All ACT Teams (currently includes 14 teams)

Review Period
Quarterly

Sample Selection:
All (100%) ACT teams are selected for review each quarter. The sample frame consists of all recipients assigned to an ACT Team. The designated clinical reviewer randomly selects 10 records from a de-identified client list provided by each ACT Team leader. The sample is stratified and consistent across all 14 ACT Teams. The request for the sample is initiated by the clinical reviewer at the time the reviewer presents to the direct care clinic to conduct the fidelity review. The sample is neither representative nor proportional, but rather reflects the agreed upon methodology that was determined by Magellan and ADHS.

Data Source
Interviews with ACT team members and reviews of sampled behavioral health recipient medical records utilizing the ACT fidelity review tool. The consumer to staff ratio report is utilized to identify all relevant ACT team members.

Data Collection:
Data is collected by the assigned QI clinical reviewer from interviews with ACT team members and from the behavioral health recipients' medical record using the ACT Team Fidelity Tool. The information is collected at the time of the quarterly on-site clinic visit. Data is gathered from the following materials:

- Behavioral Health Recipient Medical Record (progress notes for the past 30 days, ISP and Assessment)
- Encounter Data
- Ratio Reports
- Operating Protocol
- Team Meeting Observation
- Interview with the clinical coordinator, substance abuse specialist, rehab specialist, and housing specialist

Scoring Guidelines:

- Each item on the scale is rated on a 3-point scale ranging from 1 ("Not implemented") to 3 ("Fully implemented").

- The scale ratings are based on current behavior and activities not planned or intended behavior.

- Overall scoring for ACT Fidelity will be completed as follows:

# of items on ACT Fidelity tools receiving a rating of "3"
Total # of items rated on ACT Fidelity tools

Scoring for each item on the tool is as follows:

1. Small Caseload – from the staff-consumer ratio report and clinical coordinator interview, calculate the number of clients presently served to the number of FTE staff. Rate the team as follows:
   - 1 for 16:1 or more
   - 2 for 13:1 – 15:1
   - 3 for 12:1 or less
2. Team Approach – from the clinical coordinator interview and record review, calculate the percent of recipients that had face-to-face contact with 3 or more team members within 30 day review period. Rate the team as follows:
   - 1 for 0-59%
   - 2 for 60-89%
   - 3 for 90-100%
3. Program Meeting – from the clinical coordinator interview, record review, direct observation of morning meeting, and morning meeting log, determine how frequently the team meets in the morning meeting to review all recipients. Rate the team as follows:
   - 1 for less than 3 times per week
   - 2 for 3 or more times a week, but does not review all recipients
   - 3 for 4 or more times a week and discusses all recipients
4. Appropriate Transitions to and from Supportive Teams – from the clinical coordinator interview, assess how well the team understands the admission and discharge criteria and if there are any significant barriers to appropriate transition. Rate the team as follows:
   - 1 for team has no clear understanding of the admission or discharge criteria or barriers to transition
   - 2 for team has some understanding of the admission and discharge criteria with minimal barriers to transition

   - 3 for team has clear understanding by the clinical team members of the admission and discharge criteria and no significant barriers to appropriate transition
5. Full Responsibility for Treatment Services – from the clinical coordinator interview and record review, determine how many of the ACT services the team provides to recipients (see definition). Rate the team as follows:
   - 1 for 5 or less of the services
   - 2 for 6-9 of the services
   - 3 for 9-10 of the services
6. Responsibility for Crisis Services – from the clinical coordinator interview, record review, and on call review, assess how well the team provides 24-hr crisis intervention. Rate the team as follows:
   - 1 for team has no responsibility for crisis services after hours
   - 2 for consultant role via phone for crisis services after hours
   - 3 for program provides 24-hr coverage and responds on site after hours
7. Responsibility for Hospital Admissions – from the clinical coordinator interview, chart review, and inpatient policy review, assess how well the clinical team follows the inpatient policy and involvement in the admission process. Rate the team as follows:
   - 1 for clinical team was not aware of the inpatient admission and did not follow the protocol
   - 2 for clinical team was aware of inpatient admission, but did not follow the protocol
   - 3 for clinical team followed the policy and was actively involved in the admission process
8. Responsibility for hospital discharge planning – from the clinical coordinator interview, chart review, and inpatient discharge policy review, assess how well the clinical team actively participated in the discharge planning of the recipient and met all requirements in the policy. Rate the team as follows:
   - 1 for clinical team was not involved in discharge planning and did not follow the discharge policy
   - 2 for clinical team had little involvement in discharge planning and did not follow the policy
   - 3 for clinical team followed the policy and was actively involved in the discharge planning process
9. Responsibility for Incarcerations – from the clinical coordinator interview, chart review, and continuity of care for incarcerated consumers policy review, assess how well the team followed the policy and was actively involved in the incarceration process. Rate the team as follows:
   - 1 for clinical team was not aware of incarceration and did not follow the policy
   - 2 for clinical team had little involvement when the recipient was incarcerated and did not follow the policy as expected
   - 3 for clinical team followed the policy and was actively involved in the incarceration process
10. Responsibility for jail discharge planning – from the clinical coordinator interview, chart review, and continuity of care for incarcerated consumers policy review, assess how well the team followed the policy and was actively involved in discharge planning. Rate the team as follows:
   - 1 for clinical team was not aware of incarceration and did not participate in discharge planning

  - 2 for clinical team saw the recipient, but had minimal involvement in discharge planning
  - 3 for clinical team followed the policy and was actively involved in discharge planning

11. Community-based services – from the clinical coordinator review, chart review, and encounters, calculate the percent of face-to-face contacts that occur in the community. Rate the team as follows:
    - 1 for less than 40% of contacts occur in the community
    - 2 for 40-74% of contacts occur in the community
    - 3 for 75-100% of contacts occur in the community
12. Frequency of Contact – from the record review and encounters, calculate the number of clinical team/recipient face-to-face contacts per month. Rate the team as follows:
    - 1 for 0-1 face to face contacts per month
    - 2 for 2-3 face to face contacts per month
    - 3 for 4 or more face to face contacts per month
13. Individualized Substance Abuse Engagement/Treatment – from the clinical coordinator interview, substance abuse specialist interview, and record review, determine how well the clinical team adequately assesses the recipient's substance abuse history, readiness for change, and provides services needed based on level of readiness. Rate the team as follows:
    - 1 for clinical team does not assess the recipient's substance abuse history, readiness for change or services needed
    - 2 for clinical team assesses the recipient's substance abuse history and readiness for change, but does not provide services needed based on level of readiness.
    - 3 for clinical team adequately assesses the recipient's substance abuse history, readiness for change, and provides services needed based on level of readiness.
14. Substance Abuse Engagement/Treatment Groups – from the clinical coordinator interview, substance abuse specialist interview, and record review, determine how well substance abuse is actively assessed and if there is continual engagement and regular groups available. Rate the team as follows:
    - 1 for substance abuse is not address – no engagement – no groups
    - 2 for some substance abuse services are offered, but no regular engagement into groups
    - 3 for substance abuse actively assessed and continual engagement – regular groups available
15. Meaningful Community Employment – from the rehab/employment specialist interview, assess how well meaningful community employment is actively addressed and continual engagement occurs. Rate the team as follows:
    - 1 for meaningful community employment is not addressed – no engagement
    - 2 for meaningful community employment services are offered, but no regular engagement
    - 3 for meaningful community employment actively assessed and continual engagement
16. Meaningful Community Activity – from the rehab/employment specialist interview, assess how well meaningful community activity is actively assessed and continual engagement occurs. Rate the team as follows:
    - 1 for meaningful community activity is not addressed – no engagement
    - 2 for meaningful community activity services are offered, but no regular engagement

    - 3 for meaningful community activity actively assessed and continual engagement

17. Housing – from the housing specialist interview, assess how well housing issues are addressed/service offered/recipient in stable housing/continued supports and engagement. Rate the team as follows:
    - 1 for housing issues not addressed/no engagement
    - 2 for housing issues/services offered with no regular engagement
    - 3 for housing issues addressed/service offered/recipient in stable housing/continued supports and engagement

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QUALITY CONTROL

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA compliant. All data is aggregated at the DCC and/or RBHA level, and is not presented at an individual client level.

Inter-Rater Reliability & Validation
On a quarterly basis, the Outcomes Director and ACT Team Manager will conduct on-site observations of one ACT Team Fidelity review per designated clinical reviewer to ensure the appropriate application of the review tool, interviews and collaborating evidence to assess fidelity with the ACT model. In addition, every six months, all clinical reviewers participate in an inter-rater reliability case that includes a sample medical record, team responses to interview questions and other required information necessary to fully apply the ACT Team Fidelity Tool. Scores are compared for consistency and training/technical assistance is provided as indicated. Clinical reviewers who consistently fail to meet accepted ranges of variability are subjected to additional training and oversight.

2. ISP CURRENT

The ISP is considered current if it has been completed and/or updated within the past 12 months and includes the person's signature and one other clinical team member's signature.

DEFINITIONS

1. ISP: Individual Service Plan
2. Accepted ISP: An accepted ISP is an ISP that is completed via the Claim Trak Client Information System and designated as completed by the assigned case manager, clinical coordinator or clinical director. In order for the ISP to be deemed accepted, the ISP must be current and signed by the behavioral health recipient as well as at least one other clinical team member.
3. Current: A current ISP is one that has been completed and/or updated within the past 12 months and has been accepted in the Claim Trak Client Information System.

METHODOLOGY

Population
All Title XIX/XXI eligible behavioral health recipients determined to be SMI with an open episode of care with Magellan and assigned to a Direct Care Clinic.

Inclusion Criterion
All Title XIX/XXI eligible behavioral health recipients determined to be SMI with an open episode of care with Magellan, assigned to a Direct Care Clinic and have a current and accepted ISP in the Claim Trak Client Information System.

Review Period
Monthly

Sample Selection:
All SMI Title XIX/XXI eligible behavioral health recipients with an open episode of care in the RBHA and assigned to a Direct Care Clinic (100% of the population). The sample is accessed and reviewed on the 5th day of the month following the completion of the reporting month. (e.g., October data is accessed on November 5th) by the Chief Quality Officer or designee. Each of the direct care clinics is represented in the sample proportionate to their assigned SMI recipients.

Data Source
DCC ClaimTrak. Claim Trak is Magellan's Client Information System and serves as an electronic medical record and reporting application. A report has been programmed within Claim Trak that depicts a point-in-time status of all accepted ISPs (both counts and as a percent of the total SMI recipient assignment at each of the direct care clinics).

Data Collection:
Data is queried from the DCC ClaimTrak system on the 5th day of the month following the completion of the reporting month (e.g., October data is accessed on November 5th) by the Chief

Quality Officer or designee. By utilizing the ISP Production Report within Claim Trak, each clinic's percent of accepted ISPs is derived and recorded on the DCC dashboard data collection spreadsheet.

Scoring Guidelines:

- Each ISP is assessed to determine if the ISP is current
- Overall scoring for ISP Current will be completed as follows:

$$\frac{\text{\# of ISPs determined to be current}}{\text{Total \# of open episode Title XIX/XXI eligible clients assigned to a DCC}}$$

QUALITY CONTROL

CONFIDENTIALITY PLAN

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Inter-Rater Reliability & Validation

On a monthly basis, Magellan QI reconciles a representative sample by Adult PNO. By utilizing the monthly ISP Quality sample each month, Magellan is able to determine if ISPs indicated as "accepted" or current in the Claim Trak application meet expectations for a current ISP (complete within the past 12 months, signed by the behavioral health recipient and signed by at least one clinical team member). When discrepancies are identified, the information is shared by the designated clinical reviewer with the clinic leadership team as part of the ISP quality audit debriefing that occurs at each clinic each month.

3. ISP QUALITY

DEFINITIONS

1. ISP: Individual Service Plan
2. Accepted ISP: An accepted ISP is an ISP that is completed via the Claim Trak Client Information System and designated as completed by the assigned case manager, clinical coordinator or clinical director. In order for the ISP to be deemed accepted, the ISP must be current and signed by the behavioral health recipient as well as at least one other clinical team member.
3. Current: A current ISP is one that has been completed and/or updated within the past 12 months and has been accepted in the Claim Trak Client Information System.

METHODOLOGY

Population
All Title XIX/XXI eligible behavioral health recipients determined to be SMI with an open episode of care with Magellan and assigned to a Direct Care Clinic.

Inclusion Criterion
All Title XIX/XXI eligible behavioral health recipients determined to be SMI with an open episode of care with Magellan, assigned to a Direct Care Clinic and have a current and accepted ISP in the Claim Trak Client Information System.

Review Period
Monthly

Sample Selection:
Magellan IT generates a report of ISPs completed within the past 45 days in ClaimTrak on the 5th day of the month following the completion of the reporting month (e.g., October data is accessed on November 5th). Utilizing the ISP completion report, Magellan QI Reporting generates a random sample with representation from all direct care clinics (14 records per direct care clinic per month). The final sample is compared it to the previous 3 reporting periods to ensure no duplication of names. In the event that replacement records are needed, Magellan QI Reporting will randomly query available records associated with the identified direct care clinic from the IT ISP completion report.

Data Source
DCC ClaimTrak. Claim Trak is Magellan's Client Information System and serves as an electronic medical record and reporting application. A report has been programmed within Claim Trak that generates a list of accepted ISPs across all direct care clinics specific to an identified date range (e.g., September 15, 2011 through October 31, 2011). The ISP completion report serves as the sampling frame for each direct care clinic (14 records are randomly selected).

Data Collection:
Data will be collected by the designated clinical reviewer from the sampled recipient medical record by reviewing the ISP, assessment documentation and progress notes using the ISP Quality/Outcomes Tool. Results are entered into a standardized data collection tool that generates clinic by clinic results over the past 6 months. The Chief Quality Officer or designee then records the final results on the DCC dashboard data collection spreadsheet.

Scoring Guidelines:

- Selected materials are reviewed to determine if the recipient ISP complies with the following criteria:
  d. The treatment plan has specific objectives to address the identified needs of the individual
  e. The treatment plan is based on the current assessment
  f. The treatment plan lists the specific services and frequency of services to be provided to achieve the objective
  g. The types and intensity of services are based on the needs of the individual

Sample calculations are queried from the ISP current indicator and include:
# of ISPs determined to be accepted over the past 45 days

- Scoring will be completed as follows for each of the 4 criteria:

$$\frac{\text{\# of ISPs meeting each criterion}}{\text{Total \# of ISPs reviewed}}$$

The results of each of the criteria are then averaged for each direct care clinic to determine a final value. (e.g., criterion d. 80%; criterion e. 100%, criterion f. 80%, criterion g. 100% = 360/4 – overall average score is 90%)

- Scores are aggregated over the previous six months and reported monthly

QUALITY CONTROL

CONFIDENTIALITY PLAN

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Inter-Rater Reliability & Validation:
All clinical reviewers participate in an inter-rater reliability case that includes a sample progress notes, assessment and ISP. Scores are compared for consistency and training/technical assistance is provided as indicated. Clinical reviewers who consistently fail to meet accepted ranges of variability are subjected to additional training and oversight.

4. RECIPIENT SATISFACTION

The purpose of the recipient satisfaction survey is to assess the level of satisfaction with experiences and quality of services at the direct care clinics.

DEFINITIONS

Rate of positive responses for the following survey questions during the reporting month:

In the past week, I was able to get the services I thought I needed;
I felt respected by staff;
I was seen in a timely manner; and
I believe I can grow, change and recover at this clinic.

METHODOLOGY

Population
All open episode of care recipients assigned to a direct care clinic have access to a satisfaction survey tool when presenting at the clinic.

Inclusion Criterion
Any behavioral health recipient that completes and submits a satisfaction survey tool during the review period.

Review Period
Monthly

Sample Selection:
Direct care clinics must demonstrate evidence that, at a minimum, tools were completed for 2% of the total assigned number of recipients at the clinic during the review period. The measure is not calculated at any clinic that does not meet the 2% threshold.

Data Source
Each PNO Clinic is required to submit all completed satisfaction survey tools to Magellan QI by the 5th day following the reporting month.

Data Collection:
Survey tools are made available at each direct care clinic. Recipients interested in completing the survey may complete one before or after their clinic appointment. Each clinic has provided secure and anonymous receptacles in the waiting area of the clinic.

Scoring Guidelines:
The average rate of positive responses for the following survey questions are calculated during the reporting month for each direct care clinic that meets the minimum 2% response rate:

Consumer Questionnaire

Please review the answer options below and indicate **your** answer by circling it.

1. In the past week I was able to get the services I thought I needed.

    - Strongly Disagree
    - Disagree
    - Neutral
    - Agree
    - Strongly Agree

2. I felt respected by Staff

    - Strongly Disagree
    - Disagree
    - Neutral
    - Agree
    - Strongly Agree

3. I was seen in a timely manner.

    - Strongly Disagree
    - Disagree
    - Neutral
    - Agree
    - Strongly Agree

4. I believe I can grow, change, and recover at this clinic.

    - Strongly Disagree
    - Disagree
    - Neutral
    - Agree
    - Strongly Agree

A positive response is considered to be any response that includes a selection of "agree" or "strongly agree".

QUALITY CONTROL

CONFIDENTIALITY PLAN

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Inter-Rater Reliability & Validation

Magellan QI collects all original satisfaction survey tools that are completed and utilized to calculate performance for each direct care clinic. Duplicate surveys, illegible surveys and surveys submitted without evidence of the assigned direct care clinic are not included in the calculation.

5. STAFFING – PHYSICIAN

Percent of behavioral health medical practitioner positions filled, including MDs, NPs, and PAs

DEFINITIONS

Behavioral health medical practitioner means an individual licensed and authorized by law to use and prescribe medication and devices defined in A.R.S. § 32-1901, and who is one of the following with at least one year of full-time behavioral health work experience:
a. A physician,
b. A physician assistant, or
c. A nurse practitioner.

METHODOLOGY

Population
All behavioral health medical practitioner targeted positions.

Inclusion Criterion
All behavioral health medical practitioners who are actively employed by or contracted with a PNO.

Review Period
Monthly

Sample Selection:
100% of employed behavioral health medical practitioners

Data Source
Month end PNO Staffing Reports and MDNS009M_A_DCC_Case_Load_Report_Detail from the Claim Trak SQL Server Reporting Services.

Data Collection:
Data is collected from the Month end PNO Staffing Reports and MDNS009M_A_DCC_Case_Load_Report_Detail from the Claim Trak SQL Server Reporting Services and reviewed on the 5th day for activity that occurred over the previous month.

Scoring Guidelines:
Scoring will be completed as follows:

$$\frac{\text{\# of actively employed behavioral health medical practitioner}}{\text{Total \# behavioral health medical practitioner targeted positions}}$$

QUALITY CONTROL

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA compliant. All data is aggregated at the DCC and/or RBHA level, and is not presented at an individual client level.

Inter-Rater Reliability & Validation
Behavioral health medical practitioner staffing data is concurrently validated by comparing clinic self-reported data to BHMP affiliations available via the Claim Trak Client Information System. When discrepancies are identified, the information is sent to the designed clinic and PNO for correction before the final calculations are produced.

6. STAFFING – CASE MANAGER

Percent of case manager positions filled.

METHODOLOGY

Population
All case manager targeted positions.

Inclusion Criterion
All case managers who are actively employed by a PNO.

Review Period
Monthly

Sample Selection:
100% of employed case managers.

Data Source
Month end PNO Staffing Reports and MDNS009M_A_DCC_Case_Load_Report_Detail from the Claim Trak SQL Server Reporting Services.

Data Collection:
Data is collected from the Month end PNO Staffing Reports and MDNS009M_A_DCC_Case_Load_Report_Detail from the Claim Trak SQL Server Reporting Services and reviewed on the 5th day for activity that occurred over the previous month.

Scoring Guidelines:
Scoring will be completed as follows:

$$\frac{\text{\# of actively employed case managers}}{\text{Total \# case manager targeted positions}}$$

QUALITY CONTROL

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA compliant. All data is aggregated at the DCC and/or RBHA level, and is not presented at an individual client level.

Inter-Rater Reliability & Validation
Case manager staffing data is concurrently validated by comparing clinic self-reported data to case manager affiliations available via the Claim Trak Client Information System. When discrepancies are identified, the information is sent to the designed clinic and PNO for correction before the final calculations are produced.

7. CASE MANAGER CASE LOADS

Percent of supportive case management caseloads less than or equal to established ratios for supportive teams.

DEFINITIONS

Supportive Case Management Treatment

Supportive Treatment is delivered and coordinated by multi-disciplinary staff based in mental health centers in various locations throughout Maricopa County. Supportive services are generally available Monday through Friday, 8:00 a.m. to 5:00 p.m. It is a recovery-focused and outcome oriented model of community psychiatric treatment. Interventions are designed to foster learning and growing in a supportive community atmosphere, focusing on consumer strengths as the springboard for all service planning and delivery. After-hours crisis services are available by contacting RBHA Crisis Phone Clinicians, who coordinate, as needed, with on-call Supportive Treatment clinicians, as well as with other providers within the contracted Crisis Network. Average caseload size is 30.

METHODOLOGY

Population

All supportive case managers who are actively employed by an Adult PNO and have an assigned supportive caseload.

Inclusion Criterion

All case managers who are actively employed by an Adult PNO and have an assigned supportive caseload that meets the following Case Management and Clinical Team Services Plan requirements:
-Supportive: 1:30

Review Period

Monthly

Sample Selection:

All supportive case managers who are actively employed by an Adult PNO and have an assigned caseload.

Data Source

The Staff-Consumer Ratio report is compiled each month via self-reported data by each direct care clinic site administrator or designee. A reporting template is provided to each clinic which identifies all supportive clinical teams, all case managers, clinical liaison, clinical coordinator and clinical director staff member's name, FTE status, reporting relationships and assigned caseloads. The reporting template must be submitted to Magellan QI by the 5th day of each month. Data is reconciled by QI Reporting by comparing the clinic self-reported data to case manager caseload affiliations available via the Claim Trak Client Information System.

Data Collection:
Data is collected from Staff-Consumer Ratio Report and complied by QI Reporting into a table that depicts each direct care clinic, the number of supportive case loads assigned to each clinic and the percentage of case loads that are less than or equal to the required ratio.

Scoring Guidelines:
Scoring will be completed as follows:

$$\frac{\text{\# of case managers with a supportive caseload less than or equal to 30}}{\text{Total \# case managers with a supportive caseload}}$$

QUALITY CONTROL

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA compliant. All data is aggregated at the DCC and/or RBHA level, and is not presented at an individual client level.

Inter-Rater Reliability & Validation
Caseload data is concurrently validated by comparing clinic self-reported data to case manager caseload affiliations available via the Claim Trak Client Information System. When discrepancies are identified, the information is sent to the designed clinic and PNO for correction before the final calculations are produced.

8. COT ADHERENCE

Percent of Title XIX/XXI eligible COT recipients seen face-to-face by a case manager within the past 30 days.

DEFINITIONS

Contact Guidelines: The recipient is seen as frequently as indicated in the ISP, but never less than one face-to-face contact per month by the Case Manager.

METHODOLOGY

Population
All Title XIX/XXI eligible recipients who are receiving court ordered treatment and are assigned to a direct care clinic.

Inclusion Criterion
All Title XIX/XXI eligible recipients who received a face-to-face contact by a case manager within the past 30 days.

Review Period
Monthly

Sample Selection:
100% of Title XIX/XXI eligible recipients who are receiving court ordered treatment.

Data Source
COT Adherence Report from DCC Claim Trak

Data Collection:
Data is queried from DCC Claim Trak and identifies COT recipients' last case manager face-to-face contact.

Scoring Guidelines:
Scoring will be completed as follows:

$$\frac{\text{\# of COT Title XIX/XXI eligible recipients who had case manager face-to-face contact in past 30 days}}{\text{Total \# Title XIX/XXI eligible COT recipients}}$$

QUALITY CONTROL

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA compliant. All data is aggregated at the DCC and/or RBHA level, and is not presented at an individual client level.

Inter-Rater Reliability & Validation

Every six months, a random sample of COT adherence cases that indicated a face-to-face contact with the case manager occurred in the past 30 days will be validated by Magellan QI by reviewing the electronic medical record via Claim Trak. Results and discrepancies will be shared with the Adult PNOs for follow-up as appropriate.

9. COMPETITIVE EMPLOYMENT

Percent of Title XIX/XXI eligible open episode of care behavioral health recipients determined to be SMI who are employed

DEFINITIONS

1. Employed: Demographic employment status field indicates recipient is employed full time without support; employed part time without support; employed full time with support; employed part time with support; competitively employed full time; or competitively employed part time

METHODOLOGY

Population
All Title XIX/XXI eligible behavioral health recipients determined to be SMI with an open episode of care with a PNO and assigned to a Direct Care Clinic.

Inclusion Criterion
All Title XIX/XXI eligible behavioral health recipients determined to be SMI with an open episode of care with a PNO, assigned to a Direct Care Clinic and have been indicated via the data demographic data set to meet the definition of employed.

Review Period
Monthly

Sample Selection:
All Title XIX/XXI eligible SMI behavioral health recipients with an open episode of care in the RBHA and assigned to a direct care clinic who have a complete data demographic record entered in the Magellan data demographic data warehouse.

Data Source
Data Demographic Data Set – via electronic transmissions, direct care clinics submit data demographic forms to Magellan which are downloaded to the data demographic data warehouse. The data demographic forms include a field that indicates the affiliated recipient's employment status.

Data Collection:
Data is queried from enrollment demographics table on the data warehouse that identifies the recipients' employment status. The data is collected by Magellan IT on the 5th day of the month following the reporting month. The data is complied into a table that depicts the name of each direct care clinic and the percent of recorded data demographic forms that meet the definition of employed against the total Title XIX/XXI eligible SMI behavioral health recipient count at each clinic.

Scoring Guidelines:
Scoring will be completed as follows:

$$\frac{\text{\# of employed Title XIX/XXI eligible SMI recipients}}{\text{Total \# Title XIX/XXI eligible SMI recipients}}$$

QUALITY CONTROL

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA compliant. All data is aggregated at the DCC and/or RBHA level, and is not presented at an individual client level.

Inter-Rater Reliability & Validation

Every six months, Magellan conducts data validation reviews for a random sample of behavioral health recipient records representative at the PNO level. The data validation reviews are conducted by Magellan QI clinical reviewers and assess the current data demographic information for selected fields (inclusive of the employment field) and compare with available medical record documentation for the same recipient. PNO level reports are generated and shared with PNOs and clinics. Any PNO that demonstrates more than a 5% discrepancy are required to implement actions to improve future performance.

10. MEANINGFUL ACTIVITIES

Percent of Title XIX/XXI eligible behavioral health recipients who are involved in meaningful activities

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DEFINITIONS

Meaningful Activities: Demographic employment status field indicates recipient is a student, a volunteer, a homemaker, in unpaid rehabilitation activities, in work adjustment training, or in transitional employment placement.

METHODOLOGY

Population
All Title XIX/XXI eligible SMI recipients with an open episode of care with a PNO and assigned to a Direct Care Clinic.

Inclusion Criterion
All Title XIX/XXI eligible SMI recipients with an open episode of care with a PNO, assigned to a Direct Care Clinic and have been indicated via the data demographic data set to be engaged in a meaningful activity.

Review Period
Monthly

Sample Selection:
All Title XIX/XXI eligible SMI recipients with an open episode of care in the RBHA and assigned to a direct care clinic who have a complete data demographic record entered in the Magellan data demographic data warehouse.

Data Source
Data Demographic Data Set – via electronic transmissions, direct care clinics submit data demographic forms to Magellan which are downloaded to the data demographic data warehouse. The data demographic forms include a field that indicates the affiliated recipient's meaningful activity status.

Data Collection:
Data is queried from enrollment demographics table on the data warehouse that identifies the recipients' meaningful activity status. The data is collected by Magellan IT on the 5th day of the month following the reporting month. The data is complied into a table that depicts the name of each direct care clinic and the percent of recorded data demographic forms that meet the definition of meaningful activity against the total Title XIX/XXI eligible SMI behavioral health recipient count at each clinic.

Scoring Guidelines:
Scoring will be completed as follows:

# of Title XIX/XXI eligible SMI recipients involved in meaningful activities

Total # Title XIX/XXI eligible SMI recipients

QUALITY CONTROL

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA compliant. All data is aggregated at the DCC and/or RBHA level, and is not presented at an individual client level.

Inter-Rater Reliability & Validation
Every six months, Magellan conducts data validation reviews for a random sample of behavioral health recipient records representative at the PNO level. The data validation reviews are conducted by Magellan QI clinical reviewers and assess the current data demographic information for selected fields (inclusive of meaningful activities) and compares with available medical record documentation for the same recipient. PNO level reports are generated and shared with PNOs and clinics. Any PNO that demonstrates more than a 5% discrepancy are required to implement actions to improve future performance.

11. COMPLAINTS PER 1000 ENROLLEES

Number of complaints received per 1000 enrollees

DEFINITIONS

Complaint: A member's expression of dissatisfaction with any aspect of their care other than an action.

Action: The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension or termination of a previously authorized service;
- The denial, in whole or in part, of payment of service;
- The failure to provide services in a timely manner;
- The failure to act within established timeframes for resolving an appeal or complaint and providing notice to affected parties; and
- The denial of the Title XIX/XXI eligible person's request to obtain services outside the network.

METHODOLOGY

Population
All behavioral health recipients with an open episode of care with a PNO and assigned to a direct care clinic.

Inclusion Criterion
All behavioral health recipients with an open episode of care with a PNO, assigned to a direct care clinic and are affiliated with a reported complaint to Magellan over the review period.

Review Period
Quarterly

Sample Selection:
100% of behavioral health recipients with an open episode of care with a PNO and assigned to a direct care clinic.

Data Source
QI Complaint Tracking Database.

Data Collection:
Data is queried from the QI Complaint Tracking Database and stratified into counts of complaints by direct care clinic.

Scoring Guidelines:
Scoring will be completed as follows:

(# of complaints / Total # open episode recipients) * 1000

QUALITY CONTROL

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA compliant. All data is aggregated at the DCC and/or RBHA level, and is not presented at an individual client level.

Inter-Rater Reliability & Validation
Complaint data is tracked, trended and reported each quarter. Fluctuations in data are reviewed and investigated to ensure consistency and accuracy of reporting. The Complaint Resolution Manager ensures that all reported complaints are entered into the QI Complaint Tracking Database. To ensure complaint categorization validity the QI Complaint Manager audits the top complaint categories for each population. This validity audit is conducted at the end of each quarter. The QI Complaint Manager reads all of the selected complaint files and makes the determination of whether the correct complaint category was applied by the QI Resolution Specialist. The results of the audit reviews are then presented to the QI Customer Service Committee. In addition, this information is shared among the content experts for each population for further review and to initiate an improvement plan.

12. ADVERSE INCIDENTS PER 1000 ENROLLEES

Number of adverse incidents reported from each direct care clinic per 1000 enrollees

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DEFINITIONS

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1. Adverse Incidents: Adverse Incidents include the following reported incidents:

- Deaths;
- Abuse or neglect reported to Adult Protective Services;
- Adverse Reaction to Medication;
- Medication Error(s);
- Member Rights Violation: Abuse;
- Member Rights Violation: Coercion;
- Member Rights Violation: Discrimination;
- Member Rights Violation: Exploitation;
- Member Rights Violation: Manipulation;
- Member Rights Violation: Neglect;
- Physical Abuse/Allegation;
- Physical Injury;
- Physical injury as result of restraint;
- Self-Inflicted Injury;
- Sexual Abuse/Allegation; and
- Suicide Attempt

METHODOLOGY

Population
All behavioral health recipients with an open episode of care with a PNO and assigned to a direct care clinic.

Inclusion Criterion
All behavioral health recipients with an open episode of care with a PNO, assigned to a direct care clinic and are affiliated with a reported adverse incident to Magellan over the review period.

Review Period
Quarterly

Sample Selection:
100% of behavioral health recipients with an open episode of care with a PNO and assigned to a direct care clinic.

Data Source
QI Risk Management Tracking Database

Data Collection:
Data is initially reported by direct care clinic to Magellan Risk Management utilizing the Incident, Accident and Death Reporting Form. Data is then entered, queried from the QI Risk

Management Tracking Database and stratified into counts of adverse incidents by direct care clinic

Scoring Guidelines:
Scoring will be completed as follows:

(# of adverse incidents / Total # open episode recipients) * 1000

QUALITY CONTROL

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA compliant. All data is aggregated at the DCC and/or RBHA level, and is not presented at an individual client level.

Inter-Rater Reliability& Validation
QI Risk Management ensures that all identified adverse incidents are reported by the assigned direct care clinic and that the reports are timely, accurate and complete. Data is tracked, trended and reported each quarter. Fluctuations in data are reviewed and investigated to ensure consistency and accuracy of reporting. Each quarter, a reconciliation of all reported incident, accident and death forms is compared to information entered into the Risk Management Tracking Database to ensure all reported adverse incidents are present.

13. PCP COORDINATION

For all Title XIX/XXI eligible behavioral health recipients assigned to a direct care clinic, there is evidence that the person's diagnosis and current prescribed medications has been provided to the person's assigned PCP at least annually.

DEFINITIONS

Coordination of Care Standard 2/COC 2 (Communication): Behavioral health service providers communicate with and attempt to coordinate care with the behavioral health recipient's acute Health Plan/PCP.

METHODOLOGY

Population
All Title XIX/XXI eligible behavioral health recipients with an open episode of care with a PNO and assigned to a Direct Care Clinic.

Inclusion Criterion
All Title XIX/XXI behavioral health recipients with an open episode of care with a PNO and assigned to a direct care clinic.

Review Period
Monthly

Sample Selection:
The same sample utilized for the ISP Quality measure is utilized for the PCP Coordination review. Magellan IT generates a report of ISPs completed within the past 45 days in ClaimTrak on the 5th day of the month following the completion of the reporting month (e.g., October data is accessed on November 5th). Utilizing the ISP completion report, Magellan QI Reporting generates a random sample with representation from all direct care clinics (14 records per direct care clinic per month). The final sample is compared it to the previous 3 reporting periods to ensure no duplication of names. In the event that replacement records are needed, Magellan QI Reporting will randomly query available records associated with the identified direct care clinic from the IT ISP completion report.

Data Source
Behavioral health recipient medical record as assessed by the QI Clinical Reviewer Team.

Data Collection:
Data will be collected from the behavioral health recipient medical record using the ISP Quality Validation and Coordination of Care Review Tool.

Scoring Guidelines:
Scoring will be completed as follows:

$$\frac{\text{\# of records determined to show appropriate PCP coordination over the most recent 6 months}}{\text{\# of records reviewed over the most recent 6 months}}$$

QUALITY CONTROL

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA compliant. All data is aggregated at the DCC and/or RBHA level, and is not presented at an individual client level.

Inter-Rater Reliability & Validation
All clinical reviewers participate in an inter-rater reliability case each quarter. Scores are compared for consistency and training/technical assistance is provided as indicated. Clinical reviewers who consistently fail to meet accepted ranges of variability are subjected to additional training and oversight.

14. FOLLOW-UP AFTER DISCHARGE WITHIN 7 DAYS

Percent of Title XIX/XXI eligible behavioral health recipients receiving a follow-up service within 7 days of discharge from a Level I facility.

DEFINITIONS

Level I Facility: A program licensed per 9 A.A.C. 20 and includes a psychiatric acute hospital (including a psychiatric unit in a general hospital), a residential treatment center for persons under the age of 21, or a sub-acute facility.

METHODOLOGY

Population
All Title XIX/XXI eligible behavioral health recipients with an open episode of care with a PNO and assigned to a Direct Care Clinic.

Inclusion Criterion
All Title XIX/XXI eligible behavioral health recipients with an open episode of care with a PNO, assigned to a Direct Care Clinic and discharged from a Level I facility and who received a follow-up service within 7 days of discharge during the reporting period.

Review Period
Quarterly

Sample Selection:
100% of Title XIX/XXI eligible behavioral health recipients discharged from a Level I facility over the review period.

Data Source
Integrated Provider Data System

Data Collection:
Data is queried from the Integrated Provider Data System and identifies the recipients discharge date from level I facility and the date of the follow-up service.

Scoring Guidelines:
Scoring will be completed as follows:

$$\frac{\text{\# Title XIX/XXI eligible recipients receiving a follow-up service within 7 days of discharge}}{\text{\# of Title XIX/XXI eligible recipients discharge from level I facility}}$$

Behavioral health recipients can be assigned to a direct care clinic before or during the Level I admission.

QUALITY CONTROL

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA compliant. All data is aggregated at the DCC and/or RBHA level, and is not presented at an individual client level.

Inter-Rater Reliability & Validation
The Integrated Provider Data System includes information that is validated through the use of automated edit checks, qualitative reviews, control chart analyses, comparisons with similar or identical data sources and reviewed by functional leads serving as subject matter experts.

15. LEVEL I ADMISSIONS PER 1000 ENROLLEES

Number of Title XIX/XXI eligible behavioral health recipients admissions to a Level I facility per 1000 enrollees

DEFINITIONS

Level I Facility: A program licensed per 9 A.A.C. 20 and includes a psychiatric acute hospital (including a psychiatric unit in a general hospital), a residential treatment center for persons under the age of 21, or a sub-acute facility.

METHODOLOGY

Population
All Title XIX/XXI eligible behavioral health recipients with an open episode of care with a PNO and assigned to a Direct Care Clinic.

Inclusion Criterion
All Title XIX/XXI eligible behavioral health recipients with an open episode of care with a PNO, assigned to a Direct Care Clinic and discharged from a Level I facility during the reporting period.

Review Period
Quarterly

Sample Selection:
100% of Title XIX/XXI eligible behavioral health recipients discharged from a Level I facility over the review period.

Data Source
Integrated Provider Data System

Data Collection:
Data is queried from the Integrated Provider Data System and stratified as count of Level I discharges within the report period

Scoring Guidelines:
Scoring will be completed as follows:

(# level I discharges / Total # open episode Title XIX/XXI eligible recipients) * 1000

Behavioral health recipients can be assigned to a direct care clinic before or during the Level I admission.

QUALITY CONTROL

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA compliant. All data is aggregated at the DCC and/or RBHA level, and is not presented at an individual client level.

Inter-Rater Reliability & Validation
The Integrated Provider Data System includes information that is validated through the use of automated edit checks, qualitative reviews, control chart analyses, comparisons with similar or identical data sources and reviewed by functional leads serving as subject matter experts.

16. READMISSIONS WITHIN 30 DAYS

Percent of Title XIX/XXI eligible behavioral health recipients readmitted to a Level I facility within 30 days of discharge

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DEFINITIONS

Level I Facility: A program licensed per 9 A.A.C. 20 and includes a psychiatric acute hospital (including a psychiatric unit in a general hospital), a residential treatment center for persons under the age of 21, or a sub-acute facility.

METHODOLOGY

Population
All Title XIX/XXI eligible behavioral health recipients with an open episode of care with a PNO and assigned to a Direct Care Clinic.

Inclusion Criterion
All Title XIX/XXI eligible behavioral health recipients with an open episode of care with a PNO, assigned to a Direct Care Clinic, discharged from a Level I facility and re-admitted to the same level of care within 30 days during the reporting period.

Review Period
Quarterly

Sample Selection:
100% of Title XIX/XXI eligible behavioral health recipients discharged from a Level I facility and re-admitted to the same level of care within 30 days over the review period.

Data Source
Integrated Provider Data System

Data Collection:
Data will be queried from the Integrated Provider Data System and identifies the recipient discharge date and succeeding admission dates.

Scoring Guidelines:
Scoring will be completed as follows:

$$\frac{\text{\# Readmissions within 30 days of discharge}}{\text{Total \# discharges}}$$

QUALITY CONTROL

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA compliant. All data is aggregated at the DCC and/or RBHA level, and is not presented at an individual client level.

Inter-Rater Reliability & Validation
The Integrated Provider Data System includes information that is validated through the use of automated edit checks, qualitative reviews, control chart analyses, comparisons with similar or identical data sources and reviewed by functional leads serving as subject matter experts.

17. TITLE XIX RATIO

Ratio of SMI open episode of care behavioral health recipients who are Title XIX eligible compared to the total open episode of care SMI population assigned to each direct care clinic.

DEFINITIONS

Title XIX: Refers to Title 19 of the Social Security Act, a program jointly funded by the states and the federal government that reimburses hospitals, physicians and other qualified providers for providing care to persons who meet the program's eligibility criteria

METHODOLOGY

Population
All behavioral health recipients determined to be SMI with an open episode of care with a PNO and assigned to a Direct Care Clinic.

Inclusion Criterion
All Title XIX eligible behavioral health recipients determined to be SMI with an open episode of care with a PNO and assigned to a Direct Care Clinic.

Review Period
Monthly

Sample Selection:
100% of behavioral health recipients determined to be SMI with an open episode of care with a PNO and assigned to a Direct Care Clinic.

Data Source
Maricopa RBHA Monthly Episode of Care Summary

Data Collection:
Data will be collected from the Maricopa RBHA Monthly Episode of Care Summary and identifies all behavioral health recipients determined to be SMI and their Title XIX eligibility status.

Scoring Guidelines:
Scoring will be completed as follows:

$$\frac{\text{\# of SMI recipients who are Title XIX eligible}}{\text{Total \# of SMI recipients}}$$

QUALITY CONTROL

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA compliant. All data is aggregated at the DCC and/or RBHA level, and is not presented at an individual client level.

Inter-Rater Reliability & Validation
At least annually, Magellan QI conducts validation audits utilizing the Treatment Record Review Tool to verify if a sample of SMI recipients reported as Title XIX eligible are in fact Title XIX eligible. Data discrepancies are reported to the PNO and Magellan's Eligibility Department for research and reconciliation.

18. ENCOUNTERING

Percentage of all encounters based on funding provided.

DEFINITIONS

Encounter: A record of a covered service rendered by a provider to a person with an open episode of care with a capitated PNO on the date of service.

METHODOLOGY

Population
All adult PNO submitted encounters recorded and adjudicated during the reporting period.

Inclusion Criterion
All adult PNO submitted encounters recorded and adjudicated during the reporting period.

Review Period
Monthly

Sample Selection:
100% of adult PNO covered service encounters recorded and adjudicated during the reporting period.

Data Source
ClaimTrak and CAPS data system.

Data Collection:
Data is collected from the ClaimTrak and CAPS data systems and stratified into the financial amount of encounters submitted by each direct care clinic.

Scoring Guidelines:
Scoring will be completed as follows:

$$\frac{\text{Financial amount of encounters submitted and adjudicated during the reporting period}}{\text{Allocated direct service funding}}$$

QUALITY CONTROL

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA compliant. All data is aggregated at the DCC and/or RBHA level, and is not presented at an individual client level.

Inter-Rater Reliability & Validation
All encounter and financial related reports are independently verified and validated.

INTERPRETING AND UTILIZING THE DASHBOARD GAUGES AND FEATURES

- The trend arrow in the upper left corner of the dashboard compares the current month's number of metrics met/exceeded with the previous two months' average.
- The large dark blue gauge located in the upper left corner of the dashboard represents the overall performance of the agency or site selected. The percentage is weighted to show the number of metrics achieved (as evidenced by success in either the white or green zones). The number of successful metrics is divided into 90% of the total available (17 or 18 per clinic depending on whether Assertive Community Treatment is applicable).
- The list of agencies located at the middle left side of the dashboard allows the user to select the RBHA, PNO, or DCC to be viewed.
- The drop down menu located at the bottom left side of the dashboard allows the user to select a metric and a brief description of the metric will appear in the box below the menu.
- The report periods (months) scrolling across the top of the dashboard allow the user to select a monthly report period to be viewed.
- The green "Guide" button located at the upper right of the dashboard allows the user to access the "Guide to Using *My Provider Outcomes Dashboard*".
- The red "Records" button located at the upper right of the dashboard allows the user to access the "Dashboard Records and Top Performers".
- The specifications drop-down located at the upper right of the dashboard allows the user to select what type of specifications to be viewed in the top center of the metric gauges of the dashboard. The specification options include the following:
  - Don't show – no specifications are shown in the gauges
  - Show – the target for each metric is shown in the gauges
  - Sample Size – the sample size for each metric is shown in the gauges
  - Weight – the weight or sample size selection method for each metric is shown in the gauges
  - Frequency – the frequency of data collection for each metric is shown in the gauges
  - Data Source – the data source for each metric is shown in the gauges
- The 18 metric gauges located throughout the dashboard are arranged into 4 groups: I) Clinical, II) Recovery, III) Coordination and IV) Accountability and Administrative.
  - The target for each metric is located at the top of the gauge where the white and yellow colors meet (due north).
  - A gauge needle appearing in the red or yellow areas indicate the metric did not meet the goal or target.
  - A gauge needle appearing in the white or green areas indicates the metric met or exceeded the goal or target.
  - A checkbox appearing at the bottom right of the gauge indicates the metric met or exceeded the goal or target.
  - Gauge color ranges for each metric are described below:
    - ACT Fidelity
      - Target – 74.9%
      - Green Zone – 86.95% and above

  - White Zone – 74.9% to 86.95%
  - Yellow Zone – 62.85% to 74.9%
  - Red Zone – below 62.85%
- ISP Current
  - Target – 89.9%
  - Green Zone – 94.45% and above
  - White Zone – 89.9% to 94.45%
  - Yellow Zone – 85.335% to 89.9%
  - Red Zone – below 85.335%
- ISP Quality 12
  - Target – 60%
  - Green Zone – 67.5% and above
  - White Zone – 60% to 67.5%
  - Yellow Zone – 52.5% to 60%
  - Red Zone – below 52.5%
- Customer Satisfaction
  - Target – 85%
  - Green Zone – 92% and above
  - White Zone – 85% to 92%
  - Yellow Zone – 78% to 85%
  - Red Zone – below 78%
- Employment
  - Target – 25%
  - Green Zone – 32.5% and above
  - White Zone – 25% to 32.5%
  - Yellow Zone – 17.5% to 25%
  - Red Zone – below 17.5%
- Community
  - Target – 25%
  - Green Zone – 32.5% and above
  - White Zone – 25% to 32.5%
  - Yellow Zone – 17.5% to 25%
  - Red Zone – below 17.5%
- Complaints/1000
  - Target – 2
  - Green Zone – 1 or fewer
  - White Zone – 2 to 1
  - Yellow Zone – 3 to 2
  - Red Zone – more than 3
- Adverse/1000
  - Target - 0.1
  - Green Zone – 0.05 or fewer
  - White Zone – 0.1 to 0.05
  - Yellow Zone – 0.15 to 0.1
  - Red Zone – more than 0.15
- Primary Care (COC2)

  - Target – 95%
  - Green Zone – 97% and above
  - White Zone – 95% to 97%
  - Yellow Zone – 93% to 95%
  - Red Zone – below 93%
- Physician Follow-Up
  - Target – 95%
  - Green Zone – 97% and above
  - White Zone – 95% to 97%
  - Yellow Zone – 93% to 95%
  - Red Zone – below 93%
- Admissions/1000
  - Target – 37.5
  - Green Zone – 12.5 or fewer
  - White Zone – 25 to 12.5
  - Yellow Zone – 37.5 to 25
  - Red Zone – more than 37.5
- No 30d Readmit
  - Target – 90%
  - Green Zone – 94.5% and above
  - White Zone – 90% to 94.5%
  - Yellow Zone – 85.5% to 90%
  - Red Zone – below 85.5%
- Title XIX
  - Target – 63%
  - Green Zone – 66.5% and above
  - White Zone – 63% to 66.5%
  - Yellow Zone – 59.5% to 63%
  - Red Zone – below 59.5%
- COT Adherence
  - Target – 95%
  - Green Zone – 97% and above
  - White Zone – 95% to 97%
  - Yellow Zone – 93% to 95%
  - Red Zone – below 93%
- Case Load Ratios
  - Target – 60%
  - Green Zone – 79.5% and above
  - White Zone – 60% to 79.5%
  - Yellow Zone – 40.5% to 60%
  - Red Zone – below 40.5%
- Staffing Physicians
  - Target – 95%
  - Green Zone – 97% and above
  - White Zone – 95% to 97%
  - Yellow Zone – 93% to 95%

        - Red Zone – below 93%
    - Staffing Case Mgrs
        - Target – 95%
        - Green Zone – 97% and above
        - White Zone – 95% to 97%
        - Yellow Zone – 93% to 95%
        - Red Zone – below 93%
    - Encounters
        - Target – 85%
        - Green Zone – 92% and above
        - White Zone – 85% to 92%
        - Yellow Zone – 78% to 85%
        - Red Zone – below 78%

- **Dashboard Glitch** – Some users have noted and reported a bug in the Business Objects Xcelsius software used to create this cutting-edge interactive dashboard. By clicking the mouse directly on an individual gauge, the information resets. This is because the tool is drawing from the latest user queries, which are initiated by selecting a month from the scrolling ticker at the top and an agency/site from the list at left. If this occurs, simply re-select the month and agency.