

QUALITY MANAGEMENT PROGRAM

INTRODUCTION

ValueOptions® of California, Inc. (VOC) is a wholly owned subsidiary of ValueOptions®, Inc. and a health care service plan licensed under the Knox-Keene Health Care Service Plan Act to provide mental health/substance abuse (MHSA) and employee assistance program (EAP) services to commercial clients. ValueOptions® of California also provides administrative services to ValueOptions® administrative services only accounts. To assure services are appropriately monitored and continuously improved, ValueOptions® of California has developed and implemented a comprehensive Quality Management (QM) Program. As a Knox-Keene Plan, ValueOptions® of California is regulated by the California Department of Managed Health Care (DMHC). Where there is conflict between ValueOptions®, Inc. requirements and Knox-Keene regulations, the QM Program reflects the Knox-Keene regulations for ValueOptions® of California business, if more stringent.

The QM Program includes strategies and major activities performed to ensure consistency and excellence in the delivery of services to all of our customers, providers, members, and employees. ValueOptions® of California applies this quality vision to the internal and external administration and operation of the MHSA and EAP services. All ValueOptions® of California employees and providers are responsible for adhering to the ValueOptions® of California QM Program. The complete QM Program includes a comprehensive program description, work plan, an annual QM Program evaluation and QM policies and procedures.

ValueOptions® of California utilizes a Continuous Quality Improvement philosophy through which we monitor and evaluate appropriateness of care and service, identify opportunities for improving quality and access, establish initiatives to accomplish agreed upon improvements, and monitor resolution of problem areas. Our philosophy is an ongoing process that spans every aspect of our program operations and unites our organization, members, providers and other stakeholders in a continuous upward spiral of quality improvement through planning, action, and evaluation. ValueOptions® of California is committed to sharing the QM Program ideals and accomplishments with all stakeholders.

QM Program Reporting Structure and Accountability

The ValueOptions® of California Board of Directors has ultimate accountability for the oversight and effectiveness of the QM Program. The Board has delegated authority for QM Program implementation and planning to the multi-disciplinary Quality Management Committee (QMC). ValueOptions® of California's Executive Director is administratively responsible for the direction and overall functioning of the QM Program and ensures allocation of adequate resources and staffing. The Medical Director is responsible for implementation of the QM Program.

The Board of Directors reviews and approves the QM Program Description, QM Program Evaluation, and QM Work plan at least annually, and at the time of any revision. The Board receives a quarterly summary of all QM activities included in the Work plan from the QM Committee.

Role of Participating Providers

Participating providers of ValueOptions[®] of California are informed about the Quality Management Program through the Provider Handbook, provider newsletter, web site information, direct mailings, seminars, and training programs. Opportunities for provider participation and input into the QM Program also include representation on the QM Committee, VOC Credentialing Committee, VOC Provider Appeals Committee, and Public Policy Committee. Through these committees, participating providers:

- Provide input into the ValueOptions[®] of California Clinical Criteria;
- Provide peer review and feedback on proposed practice guidelines, clinical quality monitors and indicators, new technology and any critical issues regarding policies and procedures of ValueOptions[®] of California;
- Review Quality Improvement (QI) activities and make recommendations for improvement plans to improve quality of clinical care and service;
- Review, evaluate and make recommendations for the credentialing and recredentialing of network providers; and
- Review, evaluate and make recommendations regarding sanctions that result from provider performance issues.

Role of Members/Consumers

ValueOptions[®] of California values its members/consumers and believes that members/consumers are resources and active participants in their treatment and recovery. Consequently, ValueOptions[®] of California invites and includes member/consumer input in the Quality Management Program, which is reflected in member participation on ValueOptions[®] of California's Public Policy Committee. This participation allows them to speak to health plan member issues. ValueOptions[®] of California also utilizes member suggestions that may be received through ValueOptions[®] of California's grievance or inquiry processes.

Scope of the ValueOptions[®] of California Quality Management Program

The ValueOptions[®] of California Quality Management Program monitors and evaluates quality across the entire range of services provided by ValueOptions[®] of California. QM Program activities encompass ValueOptions[®] of California's mental health and substance abuse (MHSA)

program and the Employee Assistance Program (EAP). The QM Program is intended to ensure that the structure and processes in place lead to desired outcomes for members, clients, providers, and internal clients. The scope of the QM Program includes:

- Clinical Services/Utilization Management Programs;
- Quality Improvement Activities/Projects;
- Outcome Measurement;
- Network Management/Provider Relations Activities;
- Satisfaction Surveys;
- Clinical Treatment Record Evaluation;
- Service Availability and Access to Care;
- Practitioner and Provider Quality Performance;
- Complaints and Grievances;
- Members Rights and Responsibilities;
- Patient Safety Activities;
- Clinical and Administrative Denials and Appeals;
- Quality Indicator Development and Monitoring Activities;
- Cultural Competency;
- Continuity and Coordination of Care;
- Credentialing/Recredentialing; and
- Site Visits

Several of the above activities and processes are described in greater detail in other sections of the Provider Handbook.

Quality Indicators

A major component of the quality management process is the identification and monitoring of meaningful quality indicators. These key performance indicators are selected by functional areas along with associated goals or benchmarks and are approved by the Quality Management Committee. Measures are reported to the ValueOptions® of California Board of Directors at least quarterly.

All functional areas are responsible for prioritizing their resources to meet or exceed performance goals or benchmarks established for each indicator. When trends are identified and performance objectives are not met, a corrective action plan is submitted to improve performance. Key performance indicators that are relevant to ValueOptions® of California's members and health care services include: access to services, complaints and grievances, satisfaction with services, and nationally recognized quality indicators such as HEDIS whenever possible.

Service Availability and Access to Care

ValueOptions® of California uses a variety of mechanisms to measure member's access to network providers. Providers are assessed based on the following standards:

- An individual with life-threatening emergency needs is seen immediately;
- An individual with non-life-threatening emergency needs is seen within 6 hours;
- An individual with urgent needs is seen within 48 hours;
- Routine office visits are available within 10 business days for MHSA and 7 calendar days for EAP; and
- An established process for after hours services

The following methods may be used to monitor provider availability and member access to care:

- Provider to member access ratios;
- A review of a provider whose practice is closed to new patients;
- Follow-up calls to members who have requested referrals through the clinical/EAP/HPS referral line. These calls monitor the results and timeliness of referral appointments given to members;
- Annual Geo-Access and network density analysis;
- Analysis and trending of information on appointment availability obtained during site visits;
- Analysis of complaints and grievances related to availability and access to care;
- Member satisfaction surveys specific to their experience in accessing care and provider routine appointment availability;
- Open shopper staff surveys for appointment availability, which is an approach to measuring timeliness of appointment access in which a surveyor contacts provider's offices to inquire about appointment availability and identifies from the outset of the call that he or she is calling on behalf of ValueOptions® of California.

In addition to these monitoring activities, providers are required by contract to report to network management when they are at capacity. This assists customer service in selecting appropriate, available providers for member referral.

Continuity and Coordination of Care

ValueOptions® of California monitors continuity and coordination of care throughout its continuum of behavioral health services. Processes are established to ensure members do not experience disruption of care as a result of changes that might occur in a transition to new providers due to a switch in health plans or to the disenrollment of an existing ValueOptions® of California provider. ValueOptions® of California also has mechanisms in place to monitor

continuity of care and coordination with general medical care and to evaluate the use of psychopharmacological medications. ValueOptions® of California monitors continuity and coordination of care indicators for the following areas including but not limited to:

- Transition of care due to terminated provider relationships
- Transition of care for new members
- Review of clinical indicators related to follow-up care standards
- Referrals/communication between PCP and ValueOptions® of California providers and among ValueOptions® of California providers
- Patients with co-existing medical and behavioral disorders
- Medication management and usage of psycho pharmaceuticals

As a ValueOptions® of California provider, you will be expected to provide coordination of care as appropriate, sharing information with a member's provider, within the context of providing quality care and within the guidelines of protecting a member's privacy. The company has mechanisms in place to monitor continuity of care and coordination with general medical care and to evaluate the use of psychopharmacological medications.

Improving Patient Safety

ValueOptions® of California is committed to supporting high-quality and cost-effective care provided in a safe and supportive environment. We recognize our responsibility to maintain a high-quality safe and secure health delivery system and to ensure that ValueOptions® of California is in compliance with local, state, and federal regulatory requirements. We recognize the need to develop systems and structures that can identify cases of poor quality of care service. These cases increase the risk of injury to our members and represent performance improvement opportunities. ValueOptions® of California is committed to collecting meaningful data regarding these cases, investigating them thoroughly, and identifying potentially high-risk behavior on the part of ValueOptions® of California or its provider network that might threaten the safety of our members. Data collection activities that support our commitment to patient safety are described in more detail in other sections of the Provider Handbook and include:

- Monitored events (including adverse incidents)
- Quality of Care Issues/Patterns
- Site Visits
- Treatment Record Audits
- Quality of Care Indicators
- Complaints and Grievances

Potential quality of care and/or service indicators monitored by ValueOptions® of California include, but are not limited to:

- ◆ Provider Inappropriate/Unprofessional Behavior
 - Sexual relationship with member
 - Seductive behavior, inappropriate physical contact
 - Aggressive behavior
 - Threats of aggressive behavior
 - Displays signs of substance abuse
 - Displays signs of mental health problems
 - Displays signs of organicity
 - Inappropriate pharmacy/drug prescribing

- ◆ Clinical Practice-Related Issues
 - Treatment Setting not Safe
 - Adequacy of assessment
 - Timeliness of assessment
 - Accuracy of diagnosis
 - Delay in treatment
 - Appropriateness of treatment
 - Effectiveness of treatment
 - Adequacy of referral
 - Failure to appropriately refer
 - Timeliness of referral
 - Failure to coordinate care
 - Abandoned member
 - Premature discharge
 - Inadequate discharge planning
 - Prescribed wrong, too much, too many, too little medication
 - Medication Error
 - Failure to follow Practice Guidelines
 - Failure to involve family in treatment
 - Over or under utilization of services

- ◆ Access to Care-Related Issues
 - Failure to provide appropriate appointment access
 - Lack of timely response to telephone calls
 - Prolonged in-office wait time
 - Session too short
 - Falling asleep

◆ Attitude and Service-Related Issues

- Failure to maintain confidentiality
- Poor communication skills
- Lack of caring/concern
- Poor or lack of documentation
- Fraud and Abuse
- Failure to release medical records
- Failure to allow site visit

◆ Other Monitored Events

- Self Inflicted harm requiring urgent or emergent medical treatment;
- Attempted suicide by a patient currently under treatment that results in inpatient admission;
- Unanticipated death (occurring in any setting) not related to the natural course of the patient's medical illness or underlying condition (e.g. suicide, homicide, death by medical cause);
- Violent/Assaultive behavior with physical harm to self or others (e.g. attempted murder, actual assault);
- Serious Adverse reaction (e.g. requiring medical treatment) to treatment (e.g. neuroleptic malignant syndrome, tardive dyskinesia, other serious reaction);
- Sexual behavior with other patients or staff, whether consensual or not, while in a treatment program;
- Elopements from a hospital or RTC where the patient is considered a danger to self or others;
- Injuries either in a facility or a provider office that require urgent or emergent medical treatment;
- Fire setting/property damage while in a treatment setting;
- Medication errors or major adverse drug reaction resulting in the need for urgent or emergent medical intervention;
- Withdrawal seizures while hospitalized for detoxification;
- Three or more hospitalizations within (1) calendar year;
- Readmission within thirty (30) days
- Accidental injuries while in a treatment setting;
- Breach of confidentiality;
- Inappropriate or unsafe use of seclusion or restraints;
- Allegations of abuse/neglect by a provider/facility while in treatment;
- Any request for a change of provider/facility while in active treatment;
- Human Rights Violations (e.g. neglect, exploitation);
- Other occurrences representing actual or potential serious harm to a member not listed above (e.g. staff misconduct, unexpected closure of a facility)

Quality of Care and Provider Service Issues/Patterns of Poor Quality/Service

ValueOptions[®] of California has a defined procedure for the identification, investigation, resolution and monitoring of quality of care issues, quality of provider service issues, and patterns of poor quality and service. A quality of care issue is any action or failure to take action that has the potential to decrease the likelihood of a positive health outcome and/or is inconsistent with current professional knowledge and/or puts the safety of the member at risk. A provider quality of service issue involves administrative or operational concerns or processes where a provider is not in compliance with ValueOptions[®] of California standards or contractual requirements. Patterns of poor quality of care or service can occur at the system level or provider/practitioner level. ValueOptions[®] of California's Quality of Care Committee oversees the quality of care and service review process. The Committee reviews cases and oversees the development and implementation of any corrective action plans required.

Complaints and Grievances

ValueOptions[®] of California's grievance policies and procedures have been developed to address customer complaints, quality of care and service issues, and appeals. The grievance process provides a system for resolving customer issues promptly and appropriately. ValueOptions[®] of California also offers an expedited grievance process when there is an imminent and serious threat to the health of the member. The ValueOptions[®] of California Medical Director oversees and reviews findings from the grievance process; grievance policy changes are submitted to the QM Committee for review and approval as applicable. The grievance process, a printable grievance form, and instructions for submitting grievances on-line are described in more detail in the ValueOptions[®] of California member section at http://www.valueoptions.com/members/ValueOptions_of_California/VOC_Information.htm.

Satisfaction Surveys

ValueOptions[®] of California is a customer-driven organization and therefore focuses on satisfaction as a key quality indicator. Satisfaction surveys are conducted with three key groups of customers:

- Member satisfaction surveys are performed at least annually and measure members' opinions of clinical care, network providers, and ValueOptions[®] of California administrative services.
- Provider satisfaction surveys are performed at least annually. These surveys measure provider's opinions regarding clinical and administrative practices as well as assess training needs.

- Client satisfaction surveys are conducted annually to assess performance in key areas. The results are used to improve service delivery to our clients.

Confidentiality

ValueOptions® of California employees maintain as confidential all information collected relating to past and present members, including identity, as well as personal information.

All PHI is kept strictly confidential and is maintained in accordance with all applicable regulatory (e.g. HIPAA, HITECH) and accreditation requirements including an established processes to protect the privacy and confidentiality of medical information in compliance with the Confidentiality of Medical Information Act, California Civil Code 56 et seq.

ValueOptions® of California ensures that all such information obtained during the utilization management process is used solely for the purposes of utilization management, quality management, disease management, discharge planning, case management, and claims payment. All ValueOptions® of California employees are required to sign a statement of confidentiality at the time of employment and annually thereafter.

All ValueOptions® of California employees, providers and delegated entities are expected to safeguard the confidentiality of Utilization Management and Treatment Records information related to both enrolled and disenrolled members. ValueOptions® of California maintains information systems to collect, maintain, and analyze information necessary for utilization management that incorporates adequate safeguards to ensure the confidentiality and security of Utilization Management and Treatment Records as well as a plan for secure storage, maintenance, tracking and destruction of member-identifiable clinical information.

All requests for authorizations for disclosure of information are reviewed and responded to in accordance with ValueOptions® of California policy, as well as applicable laws and regulations. Members or their personal representatives are entitled to receive copies of any information pertaining to themselves, on request, subject to limits placed by state and federal guidelines, and an evaluation of any potential risk of harm to the member entailed by such disclosure of information.

Confidential information may include but not be limited to:

- Protected Health Information (PHI);
- Authorization of mental health treatment;
- Claims processing information;
- Utilization review;
- Peer review;
- Response to congressional inquiries (made at the request of the member);

- Appeals; and
- Quality assurance

Individuals engaged in quality improvement activities maintain the confidentiality of the information used in such activities. All written reports, records or any work product or communication related to quality improvement activities are considered privileged and confidential information. Except when specific reference is necessary to meet the goals of the QM program, reference to individual providers or members are redacted to safeguard the person's identity.

All consumers and providers who participate on any ValueOptions® of California committees must also demonstrate their understanding of ValueOptions® of California's confidentiality policies and procedures by signing a confidentiality statement prior to committee participation. Subscriber group agreements, member Evidence of Coverage handbooks and participating provider contracts contain provision related to ValueOptions® of California's confidentiality requirements.

Cultural Competency

ValueOptions® of California defines cultural competency under the *Participating Provider Responsibilities* section of this Handbook.

Quality Improvement Activities/Projects

One of the primary goals of ValueOptions® of California's QM Program is to continuously improve patient care and services. Through data collection, measurement and analysis, aspects of care and service that demonstrate opportunities for improvement are identified and prioritized for quality improvement activities. Data collected for quality improvement projects and activities are frequently related to key industry measures of quality that tend to focus on high-volume diagnoses or services and high-risk diagnoses, services, or special populations. Data collected are valid, reliable and comparable over time. ValueOptions® of California takes the following steps to ensure a systematic approach to the development and implementation of quality improvement activities:

- Monitoring of clinical quality indicators;
- Review and analysis of the data from indicators;
- Identification of opportunities for improvement;
- Prioritization, based on risk assessment, ability to impact performance, and resource availability, of opportunities to improve processes or outcomes of behavioral healthcare delivery;
- Identification of the affected population within the total membership;
- Identification of the measures to be used to assess performance;

- Establishment of performance goals or desired level of improvement over current performance;
- Collection of valid data for each measure and calculation of the baseline level of performance;
- Thoughtful identification of interventions that are powerful enough to impact performance; and
- Analysis of results to determine where performance is acceptable and, if not, the identification of current barriers to improving performance.

ValueOptions[®] of California Annual Quality Management Work Plan

Annually, ValueOptions[®] of California develops a QM Work plan addressing the quality and safety of clinical care and the quality of service. The QM Work plan includes quality indicators from all departmental and functional areas, with goals and objectives scheduled for monitoring during the upcoming year.

Annual Evaluation of the ValueOptions[®] of California Quality Management Plan

The Quality Management Program is reviewed and evaluated annually. The evaluation consists of a comprehensive summary of the accomplishment of committee activity, quality improvement activities and indicators. The evaluation assesses the effectiveness in improving quality of care and service delivered by ValueOptions[®] of California. Barriers to achieving goals are identified and recommendations made to address the barriers in the following year's QM Work plan.