

VIII. Quality Management



A. Overview of the ValueOptions NorthSTAR Quality Management Program

ValueOptions is committed to providing a collegial, collaborative approach with the Provider community in order to create and sustain optimal practice patterns. One way that we do this is by applying the continuous quality improvement process to various provider performance monitors. The goal is to encourage providers to increase the efficiency and effectiveness of services through change in practice patterns.

1. Role of Participating Providers

ValueOptions' participating Providers are informed about the Quality Management (QM) Program through the Provider Manual, website, Provider meetings, seminars and training programs. Provider participation includes representation on the Company Quality Council (CQC), Quality Management Committee, Clinical Advisory Committees and other various sub-committees. Through these committees, the following is offered to participating Providers:

- Peer review and feedback on proposed practice guidelines, clinical quality monitors and indicators, new technology and ValueOptions policies and procedures.
- Review of Quality Management activities and the opportunity to make recommendations for plans to improve quality of clinical care and service.
- Review, evaluate and make recommendations for credentialing and recredentialing files, including provider performance issues.

2. Basic Tenets of the Quality Management Program

We believe optimal quality behavioral healthcare results from a close partnership between the company, our front line staff, the Provider, and the client. These are the basic tenets of the QM Program:

- Observing, reporting and anticipating service problems are essential to the quality process.
- Quality problems can be resolved, and service continually improved through systematic monitoring, evaluation, feedback, and training.
- Quality problems that result in inefficiencies or substandard service usually stem from faulty processes and systems, rather than individual performance. We believe individuals internally and externally share our desire to provide the highest quality service and care to the consumer.
- Accessible, valid, reliable and current data is vital to organizational decision-making.
- Continuous Quality Improvement is an important part of each employee's day-to-day work.
- High Quality Customer Service is the first and final consideration in every activity.

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- Education, training and retraining are critical to high quality customer service. These facilitate improvements in job performance quality and cause customer satisfaction to remain high.

Consistent with its NorthSTAR contractual obligations with the State, *ValueOptions* operates a Quality Management Program that complies with Social Security Act, §1932 and applicable federal regulations promulgated pursuant to the Balanced Budget Act of 1997 (BBA). *ValueOptions* also complies with the Quality Improvement System for Managed Care (QISMC) as set forth in 42 CFR, Part 422, Subpart D, with the following exceptions:

- ValueOptions, in collaboration with the State and with the external quality monitor, for State approval, develops and implements two Performance Improvement Projects
- Compliance with Quality Improvement System for Managed Care (QISMC) Standard 3.6.1 is not required
- ValueOptions complies with contractual requirements regarding record retention

ValueOptions Quality Management program applies to covered services received by all Enrollees regardless of their eligibility type.

3. Quality Improvement Model

ValueOptions utilizes a Continuous Quality Improvement (CQI) philosophy. This includes:

- Monitoring and evaluating appropriateness of care
- Identifying opportunities for improving quality and access
- Establishing initiatives to accomplish agreed upon improvements
- Monitoring resolution of problem areas

ValueOptions' practical commitment to these ideals is visible in the consistent benchmarking of our performance standards and the sharing of this data with all stakeholders.

ValueOptions CQI process is structured to:

- Delineate thresholds/benchmarks
- Identify responsible parties
- Implement corrective action plans and procedures for monitoring the effectiveness of the action plans
- Act upon the measured effectiveness of the quality improvement activities

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ValueOptions uses a four-step process improvement model to implement the process of Continuous Quality Improvement.

P - PLAN

D - DO

C - CHECK

A - ACT

The cycle of CQI begins with careful examination of data collected from monitoring mechanisms or quality indicators.

The annual work plan and work plan evaluation cycle ensures that continuous quality improvement is engaged at any indication of a trend toward lower than standard quality processes. Each step leads towards continuous improvement and quality monitoring in an annualized quality management cycle.

B. Improving Patient Safety

ValueOptions is committed to supporting high-quality care provided in a safe and supportive environment. The Texas Service Center recognizes the responsibility to manage a high-quality and safe healthcare delivery system to ensure that we are in compliance with local, state, and federal regulatory requirements. We recognize the need to utilize systems and structures that can identify situations that could decrease quality or increase the risk of injury to our members. We are committed to:

- Collecting meaningful comparative data
- Evaluating data to assist in the identification of potentially high-risk behaviors
- Trending/monitoring information to ensure that effective corrective actions are taken

Data collection activities that support our commitment to patient safety include:

1. Adverse Incidents

ValueOptions has developed a system for the identification, reporting and analysis of occurrences that represent actual or potential serious harm to the well being of the member or to others by the member while the member is in treatment. The types of incidents analyzed include:

- Self inflicted harm requiring medical treatment

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- Unexpected death occurring in any setting not related to the natural course of the patient's medical illness or underlying condition
- Violent and/or assaultive behavior with physical harm to self or others
- Sexual behavior with other patients or staff, whether consensual or not, while in a treatment program
- Elopements from hospital or residential treatment center where patient is considered a danger to self or others
- Injuries either in a facility or a provider office that require medical treatment
- Fire setting/property damage while in the treatment setting
- Serious adverse reaction to treatment requiring medical treatment
- Medication error resulting in the need for medical intervention

Providers are required to report Adverse Incidents to the Service Center within 24 hours of occurrence and/or of the provider's discovery of the incident. A *ValueOptions* Medical Director will guide all internal investigations, which may include requesting treatment records, written responses and if indicated, corrective actions. The Quality of Care committee is responsible to review and identify quality of care opportunities from Adverse Incident tracking and reporting.

2. Quality of Care Issues/Patterns of Poor Quality

ValueOptions has a defined procedure for:

- Identifying
- Investigating
- Resolution
- Monitoring

Increasing the awareness of Quality of Care issues decreases the likelihood of negative health outcomes. This represents a focused awareness of actions that are consistent with current professional knowledge or practice. Patterns of poor quality of care occur at the system level or provider/practitioner level. Patterns of poor quality at the system level may be indicated by multiple incidents of quality issues across multiple providers in the system. Patterns of poor quality at the practitioner level may be indicated by multiple similar incidents or several reported incidents associated with the practitioner. Examples of Quality of Care issues include:

- Treatment and/or discharge planning issues

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- Medication management issues
- Access to appropriate treatment
- Inappropriate or unprofessional behavior

C. Contract Compliance

Several mechanisms exist to monitor contract compliance. ValueOptions may conduct annual treatment record audits to monitor providers' technical compliance with completing treatment records. Feedback on compliance opportunities is communicated to the provider and if needed, a corrective action plan is implemented. Another mechanism is through clinical review, a Care Manager may identify issues related to administrative compliance or quality of care. These are noted and forwarded to the Quality Management Department for follow-up. All activity related to these issues is tracked and reported.

Provider Audits are used to assess contract compliance. These are conducted routinely to assess fidelity to the treatment model as well as determine overall compliance with Resiliency and Disease Management program requirements.

The method for communicating results that require improvement by an individual provider or facility is determined by the severity of the deficiencies to be improved and the monitoring protocol through which the need is identified. The communication can be in the form of a follow-up letter with detailed findings and recommendations for improvement. If necessary, the letter can include an approximate time for a follow-up review and/or a request for a corrective action plan. Other methods for communicating a need to improve are:

- Direct contact (written, in person, or telephonic)
- Follow-up letter with detailed findings
- Request for written response

Providers who join the *ValueOptions* network are trained that compliance with contractual requirements is a responsibility of each provider. The following list highlights some important compliance issues:

- Medical record documentation
- Timely report submission
- Policies and procedures
- Training attendance
- Consumer and eligible Enrollees rights

These are some of the issues that are evaluated, monitored, tracked, and reported by the Quality

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Improvement Director. If a compliance problem develops, the provider is requested to submit a corrective action plan to our Quality Management Department for approval and compliance monitoring.

1. Treatment Record Review

ValueOptions and its network providers must comply with the treatment records standards contained in the current National Committee for Quality Assurance (NCQA) Standards for Managed Behavioral Healthcare Organizations.

ValueOptions conducts treatment record audits of or ambulatory care sites that meet the selection criteria for treatment record review. Providers may also be randomly selected for site visits or treatment record reviews. Areas reviewed include:

- Proper identification of information contained within the record
- Demographic information including consent forms, emergency contacts and legal information
- Signatures by clinicians and review with patient
- Identification of appropriate medical conditions and communication with primary care physicians
- Presenting problems, psychiatric and medical history as well as DSM IV diagnoses
- Children and adolescents developmental histories
- Mental status evaluation
- Treatment Plan
- Legibility – the record is legible to someone other than the writer
- Medication allergies – Medication allergies, adverse reactions and relevant medical conditions are clearly documented and dated. If the patient has no known allergies, history of adverse reactions or relevant medical conditions, this is prominently noted.
- Special status situations –Such as imminent risk of harm, suicidal ideation or elopement potential. These are prominently noted, documented and revised in compliance with written protocols.
- Medications prescribed – Each record should indicate what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.
- Treatment plan goals and objectives
- Progress notes consistent with the treatment plan
- Description of strengths and limitations

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- Continuity of care with other providers
- Follow-up appointments and discharge plan

2. Provider Audits

ValueOptions' Clinical, Quality Management, and Provider Relations staff will routinely perform provider audits based on specific review criteria. The purpose of these audits is to determine compliance with contractual standards, state requirements, and clinical guidelines. Compliance with key indicators of quality and performance is evaluated and may include provider qualifications, treatment planning and documentation, program content and oversight of treatment progress, and fidelity of programs and services. Prior to the audit, the provider is given adequate notice regarding the date and time of the audit.

Refer to the Department of State Health Services website on Resiliency and Disease Management for additional information regarding Fidelity Toolkit and Audit Tools at <http://www.dshs.state.tx.us/mhprograms/RDM.shtm>.

Providers will be given initial feedback on audit results with a follow-up letter addressing specific audit results and any requested plan of correction.

D. Quality Indicators

A major component of the quality management process is the identification of key domains and quality indicators, which have the greatest impact on overall quality of care. Quality of care indicators (e.g., family involvement in a child's treatment, medication follow-up, etc.) are closely linked to successful outcomes. *ValueOptions* tracks these indicators and examines their relationship to factors such as re-admission and self-report of improved functioning. The key indicators tracked by *ValueOptions* include:

High Risk -Aspects of care that pose a risk to the patient if the care is not provided correctly. This includes providing care that is not indicated and failing to provide care that is indicated.

High Volume - Aspects of care that occur frequently or affect large numbers of patients. These can be problem-prone aspects of care, which in the past have tended to cause problems for patients.

Indicators are well-defined and measurable. These include:

- **Structure** indicators that pertain to the organization's structural capacity to provide care (e.g., numbers and qualifications of staff, physical plant characteristics, etc.)
- **Process** indicators that pertain to activities related to patient care (e.g., policies and procedures, protocols, etc.)

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- **Outcome** indicators that focus on the result of performing activities/functions for a patient

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The Texas Service Center monitors quality indicators monthly, and aggregates the data by quarter and by annual summary. Indicators are reviewed to identify any trends and performance improvement opportunities.

1. Examples of Quality Management Indicators:

- Appointment follow-up within 7 and 30 days after inpatient discharge for mental illness
- Readmission's within 30 days of inpatient discharge
- Clinical and Customer Service phone statistics: abandonment rate and average speed of answer
- Complaint rate and timeliness of complaint resolution
- UM timeliness of determinations and clinical appeals
- Claims turnaround and accuracy
- Member's perception of availability of first appointment within 7 days
- Member's perception of overall satisfaction with *ValueOptions*
- Network availability as measured by geographical access standards

E. Utilization Management Data

Utilization data in the form of reports or raw data is provided to the State on a quarterly basis. These reports are generated from our Data Warehouse. Reports cover utilization of multiple levels of care as well as readmission rates. Reports also generate identifying demographic characteristics of the NorthSTAR population (i.e., gender, age, sex, diagnosis). Information from these reports is used internally at *ValueOptions* to identify trends in utilization, problem areas for clinical intervention and quality improvement studies.

F. Focused Quality Studies

ValueOptions participates in the State's focused studies for quality improvement of care. Participation includes the design and implementation of the NorthSTAR focused studies as outlined by QISMC and in conjunction with the State agencies. These focus studies are related to the two member groups, which require coordination with the physical health plan – Care Coordination for Children in NorthSTAR and Clinical Outcomes of Chemical Dependency Treatment.

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“Care Coordination for Children in NorthSTAR” was initially completed by the External Quality Review Organization (EQRO) for NorthSTAR. One important aspect of care for children is the receipt of well child visits. The study reported that control groups from other locations within the state were 1.56 times more likely than NorthSTAR children to have a well child visit. While the study did not fully explore variables impacting this, it suggested that “implementing strategies for encouraging families to seek routine preventive care for their children might benefit those in the NorthSTAR program”.

G. Complaints and Administrative Appeals

1. Complaints

The Texas Service Center’s developed policies and procedures to address Enrollee and Provider complaints, and compliments. The Complaints Program provides a tracking system for resolving customer issues promptly and appropriately. Complaints and compliments are tracked by the Quality Management department monthly and reported to the Quality Management Committee. Categories of complaint types that are monitored include:

- Assess to Service
- Clinical
- Care Disruption
- Claims and Billing
- Service

2. Provider Administrative Appeals

Providers, facilities, and Members or their designated representatives have the right to initiate an appeal of any adverse administrative determination up to 60 calendar days from receipt of notification of the determination. Appeal requests may be made in writing, telephonically or by fax. All administrative appeals are acknowledged within 5 days (business days) with a final resolution provided within 30 days. The Provider or Facility rendering service is given the opportunity to submit written comments, documents, records and other information related to the appeal. *ValueOptions* takes all such submitted information into account when considering the appeal.

3. Administrative Appeal

An administrative appeal is a request by a member, member-designated representative, or provider to reconsider an administrative denial decision. Examples of administrative denials include failure to submit claims within 90 days of service, lack of pre-authorization, and services denied due to benefits exhausted.

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H. Clinical Treatment Record Evaluation

ValueOptions adheres to the clinical treatment record evaluation and guidelines as defined by NCQA. Periodic random auditing of treatment records at ambulatory care sites ensures that the records adhere to national standards of practice and reflect appropriate behavioral healthcare management. In addition to standard random audits, other conditions under which a treatment record audit could be triggered include:

- Quality of care issues
- Follow-up to an adverse incident
- Appeals
- Review of a case requiring intensive care management
- Instances of possible over or under utilization
- Potential High Volume provider (determined prior to initial credentialing)
- Questionable emergency admissions
- Instances of poly-pharmaceuticals
- Suspected or alleged fraud
- Texas Recommended Authorization Guidelines (TRAG) fidelity

I. Network Management Activities

The Quality Management Program contains the following provisions to determine whether providers who are licensed by their State and who are part of *ValueOptions* network are qualified to perform their services. *ValueOptions* National Credentialing Committee (NCC) has developed policies and procedures for the credentialing process, which include initial credentialing of providers, as well as its subsequent recredentialing of providers. The Network policy and procedure manual outlines the methods used to assure accuracy, currency and verification of documentation.

The NCC, comprised of participating providers from each major geographic region who represent the various disciplines within the *ValueOptions* network, have the final authority regarding network participation. The Chief Medical Officer participates in the credentialing program by reviewing and making recommendations on all malpractice issues and designating a member of the medical staff as the chair of the National Credentialing Committee. Providers have the right to correct erroneous information and may appeal a NCC decision through the Provider Appeals Committee.

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1. Service Availability and Access to Care

ValueOptions conducts audits to measure access of members to network providers. Providers are audited based on the following standards:

- An individual with emergency needs is seen immediately
- An individual with urgent needs is seen within 24 hours
- Routine office visits are available within 7 calendar days

The following methods are also used to measure availability and access to care:

- Quarterly Geo-Access analysis
- Evaluation of complaints and grievances related to availability and access to care
- Member satisfaction surveys

J. Members Rights and Responsibilities

It is the policy of *ValueOptions* to ensure that members are treated in a manner that respects their rights and dignity. Through a variety of approaches (i.e., member handbook, member training programs, etc.), members are informed of their rights and responsibilities. Each *ValueOptions* employee is expected to adhere to the members' rights and responsibilities policy and HIPAA standards. These materials are provided during orientation upon hire and annually.

K. Confidentiality and HIPAA Compliance

All patient information is kept strictly confidential. Individuals engaged in customer service, clinical care management or quality improvement activities maintain the confidentiality of all patient information they encounter. All written or electronic reports, records or any work product or communication related to quality improvement activities are considered privileged and confidential information. Exceptions are when specific reference is necessary to meet the goals of the QM program. References to individual providers or patients are de-identified and are referred to by number or initial only.

All *ValueOptions* staff receives extensive training on confidentiality and HIPAA standards upon hire. Annual re-training efforts reinforce the importance of confidentiality and adhering to HIPAA standards. All consumers and providers who participate on *ValueOptions* committees must also demonstrate their understanding of *ValueOptions* confidentiality policies and procedures by signing confidentiality statements prior to committee participation. Participating provider contracts are explicit in regard to treatment record confidentiality requirements.

L. Cultural Competency

ValueOptions is committed to exploring and incorporating concepts that ensure a system designed to provide care and services that are culturally competent and sensitive. Culturally

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sensitive care services are provided to all ethnic groups regardless of ethnocentric differences. *ValueOptions* incorporates the following cultural principles into its quality management program:

- Importance of culture
- Assessment of cross-cultural relations
- Expansion of cultural knowledge
- Adaptation of services to meet the specific needs of our members

M. Quality Management Committees

1. Texas Service Center Quality Management Committee (QMC)

The QMC is comprised of representatives from key operational units within the Service Center, Dallas Area NorthSTAR Authority (DANSA) and State NorthSTAR Program staff and a participating provider representative. The QMC is responsible for ensuring the quality, continuous improvement of clinical care, utilization management, and other services delivered to members within the Texas Service Center's responsibilities. The QMC is co-chaired by the Medical Director and the Quality Management Director. The duties of the QMC include:

- Assisting in the establishment of standards, criteria and policies and procedures
- Providing direction to the clinical staff for all CQI policies and procedures, state and accrediting body standards utilization management initiatives
- Reviewing and analyzing all indicators
- Identifying individual and aggregate quality and utilization problems and setting priorities for investigation and resolution.
- Developing corrective action and monitoring resolution

2. Texas Service Center QMC Sub-Committees:

To assist in the implementation of the goals of the Quality Management Program, the Texas Service Center has established sub-committees. Texas Service center QMC sub-committees serve as a focal point in meeting unique clinical community, provider relations and consumer needs. The collective input from these committees is fed through the quality reporting structure and is designed to:

- Facilitate provider input in the development of clinical guidelines and standards
- Facilitate consumer/member input in the development and implementation of services
- Monitor and evaluate guidelines, criteria, policies and procedures
- Assess, guide, and coordinate service center training activities

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- Facilitate the development and monitoring of quality indicators in the Service Center MBUs
- Coordinate local level initiatives associated with risk management
- Provide provider input in credentialing decisions
- Other quality improvement initiatives as necessary

3. Utilization Management Sub-Committee

Texas Utilization Management Subcommittee (UMC) is comprised of the Medical Director, the Clinical Director, the Clinical Managers, Quality Management Director and other staff based on the service center's needs. The purpose of the Utilization Management subcommittee is to address patient guidelines, clinical criteria, indicators, and protocols. The UMC is chaired by the Medical Director and/or Clinical Director and meets monthly or more frequently as needed. The key responsibilities of the UM committee includes:

- Provide oversight for the ACCESS LINE and triage functions
- Review and recommend new clinical technology for assessment
- Develop and monitor indicators to detect under and over utilization
- Evaluate provider utilization patterns
- Review and recommend studies to evaluate clinical care
- Review cases as requested by other subcommittees
- Develop and evaluate an ongoing program of clinical staff development

4. Quality of Care Sub-Committee (QOC)

The Quality of Care Subcommittee meets monthly to review all issues surrounding the quality of care provided by our network practitioners and facilities. Issues regarding potential problems with the quality of care are submitted to the subcommittee through the following methods:

- Complaint process
- Adverse Incident Reporting
- Medical Record Reviews
- Clinical Reviews
- Public information
- Other sources

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The subcommittee is comprised of the Medical Director, the Clinical Director, the Quality Director, Associate Medical Directors, Clinical Managers, Network Manager, and other representatives from varying departments on a consultative basis. The duties of this committee are to review potential quality of care concerns, make recommendations for the outcome of the investigation and corrective actions to implement, and reporting to the NCC regarding decisions related to continued network participation.

5. Public Sector Local Credentialing Sub-Committee

The Public Sector Local Credentialing Subcommittee is chaired by the service center Medical Director. This committee provides input into the NCC regarding local practitioners credentialing and recredentialing decisions.

6. Member Services Sub-Committee

The Member Services Committee is chaired by the Chief Operating Officer or designee and has authority over the implementation and monitoring of the member services performed at the Texas Service Center. Membership consists of Customer Service Supervisors, Quality Director, Appeals and Complaint Coordinator, Network Manager, Claims Manager, Clinical Care Manager, and others as indicated. The committee is responsible for establishing and maintaining mechanisms for the identification and review of opportunities for improvement involving service provision to Members and Providers.

7. Member and Provider Advisory Groups

The Provider and Member Advisory Groups are comprised of providers and/or members with an expressed interest in the quality of services offered. Each advisory group meets periodically to review and make recommendations in a variety of areas. Meeting agenda items may include the following:

- Input into the development of member handbooks, newsletters and other marketing materials
- Review of the consumer complaints and compliment process
- Review of member materials for content and readability
- Review of policies and procedures which impact client care (e.g., members' rights policy and procedure)
- Review and recommend responses to issues raised in consumer, provider and client satisfaction surveys
- Suggest topics for consumer and professional education and training on timely concerns pertinent to the consumer community (e.g., prevention and wellness)

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N. Texas Service Center Quality Management Resources

The Quality Management program has a well-developed infrastructure to support its activities. This includes a highly skilled staff as well as computer hardware and software that allows for storage and analysis of quality-related data, and resources of the Corporate Quality Management Department. Each Texas Service Center employee plays an active role in improving quality.

The service center *Medical Director* plays a significant consultative role in the quality management function. In addition to the Medical Director involvement, the Quality Management Department staff is dedicated 100% to quality management activities. These roles include a Director of Quality Management and a Complaint/Appeal Coordinator. The roles of these staff members are as follows:

1. Quality Management Director

The Quality Management (QM) Director is responsible for implementing the quality management program in the Texas Service Center. Under the direction of the Medical Director and Service Center Vice President, the QM Director collaborates with Customer Service, Clinical Operations, Account Services, Provider Relations and Claims to address quality improvement initiatives and areas for improvement. The QM Director collaborates with other members of the Senior Management Team to ensure effective coordination and integration of the Quality Management Program. The QM Director also provides consultation as needed to work groups to ensure the quality improvement efforts throughout the region are consistent with regulatory compliance and accreditation standards. In addition, the QM Director supervises the work of the QM staff, and coordinates with the operations teams in each department. Additional responsibilities of the QM Director include but not limited to the following:

- Preparation, review, implementation and tracking of the Annual QM Work Plan
- Complete Annual QM Work Plan Evaluation
- Coordination of Quality Management functions, activities and documentation
- Facilitation of Accreditation and Regulatory compliance activities
- Documentation of Quality Management Committee actions and accomplishments
- Oversight of QM data tracking, analysis processes and mechanisms
- Oversight of monthly and quarterly reports of service center quality management activities
- Research, design, implementation and oversight of NorthSTAR QM activities
- Measurement tool development, implementation and oversight
- Data gathering, input, interpretation and reporting
- Database design, maintenance and improvement

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- Coordination of audit schedules, processes and reporting
- Statistical analysis of data
- Report writing and report generation.
- Devising ways to develop, measure, track, trend, and report Continuous Quality Improvements throughout the Service Center

2. Complaint and Appeal Coordinator

The Complaint and Appeal Coordinator manages the complaint and administrative appeal investigation and resolution process. Additionally, this position supports quality management committee functions and provides complaint and appeal reports to external entities and for internal committee reporting.

3. Reporting and Data Analysis Support

The Texas Service Center Quality Management department relies on resources external to the department for data analysis and technical support. The business services and reporting department as part of the Information Service function for the Texas service center provides reporting resources that are needed to extract reports from the databases. The Texas Service Center works collaboratively with the state and DANSA to obtain satisfaction survey information from Members and Providers.

4. Quality Management and Utilization Management

The integration of QM and UM is assured through representation on key committees including the QMC, and UMC. These structures support the integration of clinical and quality management activities, assuring that immediate access to exceptional care is provided to all members in a consistent way, utilizing evidence based protocols. Clinical indicators have been established to measure the effectiveness of practice guidelines, over and under utilization, and the timeliness of utilization decision making.

Regular audits of clinical Care Managers, Physician Advisors, and Network Providers' documentation are performed to assure the quality of treatment decisions being made. Each service center is responsible for mechanisms to measure the inter-rater reliability of clinical decisions made by Care Managers and Physician Advisors. Aggregate reports to the QMC are conducted monthly and/or quarterly. When deficiencies are identified, corrective action plans are requested and monitored at the service center level, and collectively by the QMC.

5. Quality Management and Network Management

The quality of the network represents the strength of *ValueOptions* service delivery to members. Provider quality begins at the credentialing and recredentialing process, but continues through review of the provider performance information.

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Site visits are conducted at initial credentialing and regular intervals as indicated by ongoing monitoring to determine compliance with standards.

ValueOptions' participating providers can maintain feedback and communication through many avenues by joining various ValueOptions committees. For more detail regarding these committees and the participation opportunities, please refer to the overview portion in A. 1, entitled, "Role of Participating Providers" in this section of the manual.

6. Quality Management and Members Rights/ Customer Service

ValueOptions' values are reflected in our belief that people should be viewed as resources and active participants in their treatment and recovery. As part of this belief, *ValueOptions* utilizes member/consumer feedback as a vehicle for constructive input and participation in the quality management program. Members are selected to represent the cultural and ethnic backgrounds of our various service center populations and geographical regions.

ValueOptions is committed to excellence in customer service, and requires that all service centers conduct service observations to assure that all staff interfacing with providers and members complies with service excellence standards. The audits are done monthly at the Texas service center, and reported to the QMC annually or more frequent as needed.

Additionally, Quality Management integrates member's rights through the complaint tracking system, clinical appeals process, and by assuring that all staff are trained to protect confidentiality as detailed in this section (K. Confidentiality and HIPAA Compliance). The Texas Service Center maintains the operational structure of all complaints and appeals within the QM department to ensure attention to detail, and smooth operation.

7. Quality Management and Managed Information Systems (MIS)

Accurate and timely data are vital to a successful quality program. *ValueOptions* Quality Management Program is data driven, and interfaces with MIS to assure data integrity. For more details on this process, refer to the resources descriptions portion in N.3 entitled, "Reporting and Data Analysis Support" of this section of the manual.