

QUALITY MANAGEMENT PROGRAM

INTRODUCTION

ValueOptions® of California, Inc. (“VOC” or “the Plan”) is a wholly owned subsidiary of ValueOptions®, Inc. (“VOI”) 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 and public sector accounts. To assure services are appropriately monitored and continuously improved VOC has developed and implemented a comprehensive Quality Management Program (“QMP”). As a Knox-Keene Plan, VOC is regulated by the California Department of Managed Health Care (DMHC). Where there is conflict between VOI requirements and Knox-Keene regulations, the QM Program reflects the Knox-Keene regulations for VOC business, if more stringent.

The QMP 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. VOC applies this quality vision to the internal and external administration and operation of the MHSA and EAP program. All VOC employees and providers are responsible for adhering to the Quality Management Program. The QM Program includes a comprehensive program description, policies and procedures, and annual work plan.

VOC utilizes a Continuous Quality Improvement (CQI) 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. VOC is committed to sharing the QMP ideals and accomplishments with all stakeholders.

QM Program Reporting Structure and Accountability

The VOC 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 (QM) Committee. The Plan’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 review and approve the QM Program and QM Workplan at least annually, and at the time of any revision. The Board receives a quarterly summary of performance activity, and an annual QM Program evaluation of all QM activities from the QM Committee.

Role of Participating Providers

VOC participating providers are informed about the Quality Management Program through the Provider Manual, newsletter, and web site. Provider participation also includes representation on the QM Committee, Credentialing Committee, and Public Policy Committee. Through these committees participating providers make suggestions related to the following activities:

- Credentialing and recredentialing, including provider performance issues.

- Peer review and feedback on proposed practice guidelines, clinical review criteria, clinical quality monitors and indicators, and any critical issues regarding policies and procedures.
- QI activities and corrective action plan recommendations for improvement to quality of clinical care and service.

Role of Members/Consumers

VOC values are reflected in its belief that people should be viewed as resources and active participants in their treatment and recovery. Consequently, VOC utilizes member/consumer input as a vehicle for constructive input to the quality management program. Members participate on the Plan's Public Policy Committee enabling them to provide input into health plan member issues, which may impact the Plan's policy and procedure. The Plan also utilizes member suggestions that may be received through the Plan's grievance or inquiry process.

Scope of the VOC Quality Management Program

The ValueOptions® of California Quality Management Program monitors and evaluates quality across the entire range of services provided by the Plan. QMP activities encompass the Plan's mental health and substance abuse (MHSA) program and Health & Performance Solutions (HPS) i.e. EAP program. The QMP is intended to ensure the structure and processes that lead to desired outcomes for members, clients, providers, and internal clients is in place. The scope of the QM Program includes:

- Clinical Services/Utilization Management Programs
- Quality Improvement Activities
- Network Management/Provider Relations
- Credentialing/Recredentialing
- Site Visits
- Satisfaction Surveys
- Clinical Treatment Record Evaluation
- Service Availability and Access to Care
- Practitioner Quality Performance
- Complaints and Grievances
- Members Rights and Responsibilities
- Patient Safety Activities
- Clinical and Administrative Denials and Appeals
- Quality Indicators development and monitoring
- Continuity and Coordination of Care

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, which have the greatest impact and relevance, on overall quality of care and service to its members. These key quality 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 VOC 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 negative trends are identified, a corrective action plan is submitted to improve performance. Key quality indicators may include but are not limited to the following:

Service Availability and Access to Care

VOC monitors key indicators of access to care and services to ensure that health care services are available and accessible within a reasonable period of time to Plan members. The Plan monitors access indicators including but not limited to the following aspects of care or service:

- Emergent care
- Urgent care appointments
- Routine MHSA appointments
- Routine EAP appointments
- After hours services
- VOC Departments telephone access (abandonment and speed of answer rates)
- Geographic provider access (practitioners and facilities)
- Provider to member access ratios
- Providers closed to new patient

Providers and internal staff are evaluated against these standards through several mechanisms including but not limited to:

- Practitioner site visits
- Evaluation of Plan enrollment, provider network, and utilization data
- Evaluation of grievances
- Member satisfaction surveys
- Internal automated call reporting systems

Continuity and Coordination of Care

The Plan 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. Continuity and coordination of care indicators include but are limited to the following:

- 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 Plan providers and among Plan providers
- Patients with coexisting medical and behavioral disorders
- Medication management and usage of psycho pharmaceuticals

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

VOC 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 issue that decreases the likelihood of desired health outcomes and is

inconsistent with professionally recognized standards of practice. A provider quality of service issue involves administrative or operational concerns or processes where a provider is not in compliance with Plan standards or contractual requirements. Patterns of poor quality of care or service can occur at the system level or provider/practitioner level. The Plan'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

Plan 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. The Plan also offers an expedited grievance process when there is an imminent and serious threat to the health of the member. The Plan 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 member section of the valueoptions.com web site.

Satisfaction Surveys

VOC is a customer-driven organization and therefore focuses on satisfaction as a key quality indicator. Satisfaction surveys are conducted with three key customer groups:

- **Members:** A member satisfaction survey is performed at least annually and measures member opinions of clinical care, network providers, and Plan administrative services.
- **Providers:** A provider satisfaction surveys is performed at least annually. The surveys measure provider's opinions regarding clinical and administrative practices as well as assess training needs.

Clients: A client satisfaction survey is conducted annually to assess performance in key areas. The results are used to improve service delivery to our clients.

Improving Patient Safety

VOC is committed to supporting high-quality and cost-effective care provided in a safe and supportive environment. The Plan recognizes its responsibility to manage a high-quality safe healthcare delivery system and to ensure compliance with local, state, and federal laws and regulations. VOC recognizes the need to utilize systems and structures to identify situations that could decrease quality, increase the risk of injury to its members and identify performance improvement opportunities. The Plan is committed to collecting meaningful comparative data, tracking situations to assist in the identification of potentially high-risk behavior that may threaten the safety of its members; trending and monitoring information to ensure that effective corrective actions are taken. 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

Confidentiality

ValueOptions® of California (VOC) employees routinely maintain as confidential all information collected relating to:

- Past and present members, including identity, as well as personal information
- Organizational planning and development
- Financial status of the organization

The Plan maintains Personal Health Information (PHI) on a confidential basis in accordance with all applicable regulatory (e.g. HIPAA) and accreditation requirements including an established processes to protect the privacy and confidentiality of medical information in compliance with the requirements of State and Federal laws and regulations, including the Confidentiality of Medical Information Act, California Civil Code 56 et seq.

The Plan 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. Confidential information is made available during the course of the relationship between the patient and CCM as well as between the CCM and provider. All Plan employees are required to sign a statement of confidentiality at the time of employment and every annual evaluation thereafter.

All Plan staff are informed of confidentiality requirements and sign a confidentiality statement upon hire and on every annual evaluation. Periodic re-training reinforces the importance of confidentiality. All ValueOptions of California committee members must also demonstrate their understanding of the Plan's confidentiality policies and procedures by signing confidentiality statement prior to committee participation. Subscriber group agreements, member Evidence of Coverage handbooks and participating provider contracts contain provision related to the Plan's confidentiality requirements.

All Plan employees, providers and delegated entities are expected to safeguard the confidentiality of UM 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 UM 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.

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. Service Center management staff may also consult with the National Legal Department as needed.

Confidential information may include but not be limited to:

- Personal Health Information (PHI);
- Certification 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

Cultural Competency

ValueOptions® of California is committed to ensuring that all members, providers and employees are treated with dignity and respect concerning their values, culture, class, race, age, sexual orientation, ethnic background and religion. ValueOptions® of California recognizes and values the cultural diversity of the membership and the impact it has on the value of care and service provided to each member. ValueOptions® of California supports interventions that promote an effective health care encounter between a member and provider where language or cultural values regarding health care may vary. Such interventions may include providing culturally appropriate linguistic services to members, providing cultural diversity information for ValueOptions® of California staff interacting with membership. The Plan also participates in ValueOptions®' National Cultural Competency Steering Committee (NCCSC) development and operational oversight of the company-wide cultural competency plan.

ValueOptions® of California incorporates the following principles into its quality management program:

- The importance of culture and diversity
- The assessment of cross-cultural relations
- Expansion of cultural knowledge, and
- The adaptation of services to meet the specific cultural and linguistic needs of our members

Quality Improvement Activities/Projects

The primary goal of the Plan's QMP is to continuously improve patient care and services. Through data collection, measurement and analysis, aspects of care and service that evidence problems can be targeted for corrective action. Data collected for quality improvement projects and activities are related to key indicators of quality that focus on high-volume diagnoses or services and high-risk diagnoses, services, or special populations. Data are statistically valid, reliable and comparable over time.

VOC Quality Management Program Workplan and Evaluation

The Quality Management Program is reviewed and evaluated annually. The evaluation consists of a comprehensive analysis of the accomplishment of objectives, subcommittee activity, and the results of quality improvement activities and trending of indicator data. The evaluation assesses the overall effectiveness in improving quality of care and service delivered by as well as progress towards improving patient safety and influencing network -wide clinical practices. Barriers to achieving goals are identified and recommendations made to address those barriers.

As a result of this analysis of the previous year's findings, activities that need to be carried over into the next year are identified, and new activities proposed. The annual evaluation may also lead to identification of educational/training needs, the establishment and/or revision of policies

and procedures, or the alteration of operations to minimize risks in the delivery of care and service

It is the responsibility of the Service Center Director of Quality Management to prepare the evaluation and present findings and recommendations to the Service Center QM Committee, VOC Board of Directors, and applicable ValueOptions® committees.

Once the annual QM Program Evaluation is complete, the findings and recommendations resulting from the evaluation are incorporated into the next year's QM Program Description and Workplan.