Capital Health PLAN℠

An Independent Licensee of the Blue Cross and Blue Shield Association

Behavioral Health

Quality Improvement 2022 Program Description
Commercial/Individual and Medicare

Approval by Quality Improvement Management Team: 7/30/2015
Approval by Board of Directors: 3/29/2016, 11/29/2016, 11/28/2017, 11/27/2018, 11/13/2019,3/18/2020; 3/2021, 01/2022

CAPITAL HEALTH PLAN
2022 Behavioral Health Quality Improvement Program Description

INTRODUCTION
Capital Health Plan (CHP) strives to provide the people in Leon and surrounding counties (a seven county area of northern Florida) with high quality, affordable behavioral health care that: 1) focuses on delivery of evidence-based care provided by competent licensed behavioral health (BH) practitioners in an effective, timely and cost-effective manner 2) emphasizes low administrative costs and ethical business practices 3) is proactive and innovative in its quest to continually improve the health of the community. CHP incorporates this Quality Improvement (QI) Program as an integral part of its operation.

The Health Plan, a not for profit corporation, was incorporated in 1978. The first members were enrolled in 1982. The Plan operates in the service area of Leon and the surrounding counties of Jefferson, Wakulla, Gadsden, Calhoun, Liberty and Franklin. Capital Health Plan provides comprehensive health benefit coverage through an integrated health care delivery system to Commercial groups including Federal and Florida State Government employees, other large groups, small employers, and non-group enrollees. Medicare Advantage Part C and D services are provided through retiree and individual Medicare Advantage Part D (MAPD) plans for Medicare beneficiaries.

NETWORK
CHP's behavioral health network includes the following behavioral health and substance abuse treatment professionals:

- Psychiatrists
- Licensed psychologists
- Licensed marriage and family therapists
- Licensed professional counselors
- Nurse Practitioners
- State Certified Drug and Alcohol Counselors
- Licensed Clinical Social Workers
- Speech Therapists
- Physical Therapists
- Occupational Therapists

Care is delivered in a variety of settings including:

- Outpatient offices
- Hospitals (including general hospitals and private psychiatric hospitals)
- Partial hospital programs
- Residential treatment facilities
- Outpatient substance abuse programs
- Other community-based behavioral health programs
- Intensive outpatient therapy programs
- Outpatient rehabilitative facilities
- Other community based rehabilitation programs

QUALITY IMPROVEMENT PROGRAM SCOPE

QI activities address acute and chronic psychiatric and substance-abuse disorders as addressed in the

most recent Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) of the American Psychiatric Association. The QI program addresses the major treatments, interventions, and diagnostic modalities currently utilized by behavioral health practitioners:

- Psychiatric evaluation
- Pharmacotherapy
- Psychotherapy
- Group therapy
- Cognitive behavioral therapy
- Psychological testing

Clinical programs, including objectives for serving members with special healthcare needs to include severe and persistent mental illness, are further described in program documents specific to each. Annual screening for depression is incorporated into each selected program. The programs include:

- Center for Health Aging
- Complex case management
- Diabetic disease management program

QUALITY IMPROVEMENT PROGRAM OBJECTIVES

The purpose of the CHP Behavioral Health (BH) QI Program is to systematically monitor and evaluate the provision of behavioral healthcare services and the impact of these services on improved member outcomes. CHP uses data analysis to develop measurable interventions designed to improve member care and services. QI interventions are implemented with the target outcomes of increased member safety, improved functional outcomes, and increased satisfaction with services. The BH Program Description outlines the structure, processes, responsibilities, objectives, goals and initiatives involved in the QI program.

The QI program structure:

- Promotes education and information sharing throughout the organization to create and maintain a culture of service and performance excellence
- Develops and monitors key indicators of clinical and service quality, which reflect the needs of members, practitioners, providers and payers, accreditation agencies and regulatory bodies
- Identifies performance thresholds, goals and benchmarks for identified process and performance measures
- Develops targeted improvement plans for any area not meeting performance expectations

QUALITY IMPROVEMENT GOALS

CLINICAL BEHAVIORAL HEALTHCARE

- Promote recovery from mental illness through excellent member care and management
- Promote member recovery and resiliency to support improved healthcare outcomes
- Produce actionable, valid and reliable data to drive decision-making resulting in improved care
- Achieve scores on HEDIS clinical BH measures that demonstrate national leadership with scores that meet or exceed the 90th national percentile.
- Promote evidence-based clinical practice within the behavioral health network.
- Improve the mental health status of members through preventive/wellness activities, disease management, and case management.
- Coordinate clinical care to ensure seamless delivery of healthcare services across the medical and behavioral health networks.
- Create incentives which align goals of the health plan, behavioral health practitioners, and health plan staff.

MEMBER/PRACTITIONER SATISFACTION

- Improve member and provider satisfaction with CHP's network BH services.
- Achieve and maintain scores for CAHPS member satisfaction with behavioral health measures that meet or exceed the 90th national percentile.
- Improve BH services by addressing issues identified through CHP's Member Satisfaction with

Behavioral Health survey.
- Maintain optimal practitioner satisfaction by addressing issues identified through CHP's annual BH practitioner satisfaction survey, and the PCP satisfaction with BH survey.

ACCESS AND AVAILABILITY TO CARE AND SERVICES
- Maintain affordability of CHP's products.
- Maintain adequate access to behavioral health care for urgent care, non-life threatening emergencies, and routine care.
- Continually improve member access to behavioral health services, with particular emphasis on vulnerable and special need populations.
- Strive to meet member expectations by achieving access and availability targets.

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES
- Evaluate cultural needs of members including race, ethnicity and language; implement interventions to improve the availability of services when improvement opportunities are identified.
- Promote care given with understanding of, and respect for, the member's health related beliefs and cultural values.
- Ensure that BH practitioners respect health related beliefs, interpersonal communication styles and attitudes of the members, families and communities they serve.
- Maintain compliance with Affordable Care Act; Section 1557 (implemented in 2016).

PATIENT SAFETY
- Monitor and implement interventions to improve performance on HEDIS patient safety BH measures.
- Monitor and address adverse events, medication errors, adverse drug events and quality of care issues related to BH services through incident reporting, analysis and interventions.
- Conduct reporting of BH patient safety data according to applicable state and federal regulations.
- Implement interventions to ensure safety at CHP facilities through the CHP Safety Committee.

QUALITY IMPROVEMENT/ ACCREDITATION
- Maintain NCQA Accreditation.
- Maintain compliance with state and federal regulations related to BH and quality improvement.
- Implement QI initiatives according to priorities outlined in the 2021 QI Work plan:
    - Priority 1 improvement opportunities: implement areas that will have the most impact on all 3 ratings (Accreditation, NCQA Health Plan ratings, and STARS) as well as new interventions, or enhance current QI initiatives that are furthest away from the 90th national percentile.
    - Priority 2 improvement opportunities: implement areas that will impact at least 2 of the ratings scores (Accreditation, NCQA Health Plan ratings, and STARS) and continue to monitor and/or enhance current QI initiatives that the Health Plan is performing closer to the 90th national percentile.
    - Priority 3 improvement opportunities: implement areas that will impact at least 1 of the ratings scores (Accreditation, NCQA Health Plan ratings, and STARS) and continue to monitor and/or enhance current QI initiatives that the Health Plan is performing at or about the 90th national percentile.
- Integrate quality improvement (QI) processes throughout Capital Health Plan and its behavioral health delivery system, striving to integrate QI at every level of the organization.
- Integrate procedures for monitoring and ensuring compliance with accreditation standards related to BH to departments that provide the specified services. Maintain overall oversight monitoring procedures to ensure that CHP achieves the highest accreditation scores possible that will contribute to optimal national ratings.
- Integrate procedures for monitoring and ensuring compliance with CMS and other regulatory requirements related to BH and health plan quality programs.
- Allocate and distribute resources necessary to support BH QI initiatives.
- Integrate enrollee feedback into the design of the BH QI program through analysis of member satisfaction and complaint data.
- Set performance targets based on the national 90th percentile for measures when available
- Expand and standardize quality measurement and reporting capabilities through the behavioral health network.
- Develop the capability to conduct a virtual on-site NCQA survey.

- Develop the capability to submit HEDIS data electronically (new ECDS measures).
- Develop procedures to provide timely and accurate HEDIS member level data available for QI interventions.

ACCOUNTABILITY OF THE GOVERNING BODY

The Capital Health Plan Board of Directors maintains the ultimate accountability for the QI program. The Healthcare Delivery Committee, a committee of the Board, provides direct oversight to the QI program through quarterly review of QI program activities. This Board committee reports directly to the Board of Directors.

ACCOUNTABILITY OF QUALITY COMMITTEES

Capital Health Plan's QI committee structure supports the implementation of the Behavioral Health QI program. The Board of Directors and Health Delivery Committee have delegated the direct responsibility and authority for QI Program oversight to the Plan's Quality Improvement Management Team (QIMT). The Quality Improvement Management Team consists of key CHP senior managers, Medical Directors, Associate Medical Directors, department directors, and managers. QIMT relies on the following committees to oversee specific aspects of the BH QI program:

- The Quality Improvement Committee (QIC) coordinates, and provides oversight to clinical improvement activities. A CHP network psychiatrist participates on the QIC, and provides knowledge and expertise related to behavioral health care and services.
- The Medication Management Committee coordinates pharmacy QI activities and safe medication practices, and provides oversight for the formulary and delegated procedures. A CHP network psychiatrist participates on the committee, and contributes knowledge and expertise specific to BH medications.
- The Pharmacy Continuous Quality Improvement Committee reviews pharmacy data and information about medication quality-related events that occur within CHP health centers.
- Credentials Committee: reviews practitioner/provider information during initial credentialing/recredentialing; makes approval decisions, or recommendations for adverse decisions related to network participation.
- Compliance Committee: provides oversight for CHP's Compliance and HIPAA programs.

QUALITY COMMITTEES: MEETING/DECISION-MAKING PROCEDURES

Quality committees meet according to their planned schedule unless the chairperson cancels or reschedules a meeting, or the committee does not have a quorum for a specific meeting. A quorum for a meeting is met when the minimum of 50% of the committee members are present. Quality committees document the outcome of their meetings through meeting minutes. Committee members are offered the opportunity to review and suggest revisions to meeting minutes. The chairperson of each committee signs final meeting minutes to attest to committee acceptance of the minutes. All committee documentation is marked "confidential records for quality and/or peer review". Each eligible committee member is entitled to one vote per decision. Decisions are made by majority vote.

Credentials Committee - decision-making procedures:

- Each member reviews a checklist for practitioners and/or providers that have not been approved by a Medical Director, reviewing compliance with each credentialing or re-credentialing requirement.
- The committee reviews and evaluates information and discusses issues of concern;
- The committee makes approval decisions related to initial credentialing and/or re-credentialing;
- Adverse decision recommendations are brought before the CHP Senior Management Team for a final decision.

ACCOUNTABILITY OF KEY CHP MANAGERS

- The Chief Executive Officer (CEO) has the ultimate responsibility for the overall coordination and direction of the BH QI program. The CEO's ensures that the Plan's service and clinical improvement initiatives receive appropriate integration and linkage to CHP's strategic planning and budgeting processes, including allocation of financial and human resources for QI initiatives.
- The CHP Board of Directors and CEO appoints a primary care physician from the Physician Group of Capital Health Plan as the physician responsible for the medical aspects of the QI program. This physician works to

integrate and implement QI activities collaboratively with network BH practitioners and providers.

- The appointed primary care physician from the Physician Group of Capital Health Plan chairs the Quality Improvement Committee, and participates on the Medication Management Committee. A Medical Director participates on the Credentials Committee, who work together to integrate and implement QI activities collaboratively with network practitioners.
- CHP engages local network behavioral health (BH) practitioners to participate in the BH QI program. These experts provide oversight in specific aspects of the QI program.
    - A psychiatrist is involved with the quality aspects of the QI program, and participates on the QI Committee. He is involved with the development and maintenance of BH clinical practice guidelines and procedures, BH quality improvement initiatives, and monitoring of BH clinical practices.
    - A psychiatrist is involved with the utilization management and pharmacy aspects of the QI program. He is involved with the development and maintenance of BH UM criteria, UM decision-making procedures, and formulary management related to BH medications.
- The Senior Vice-President of Clinical Operations and Quality Improvement is an active member of QIMT, and is responsible for assuring that quality outcomes support the strategic initiatives of the Plan. The Senior Vice-President is responsible for reporting BH QI activities to the Board of Directors and providing feedback to the QIMT and QIC committees.
- The Senior Vice-President of Marketing and Administrative Services participates as an ad-hoc member of QIMT. The Senior Vice-President is responsible for communicating BH quality improvement activities to CHP's members through newsletters, member handbooks and other informational program materials. This Senior Vice-President provides oversight over benefit development/maintenance procedures, and develops member educational programs
- The Director of Clinical Quality and Performance Improvement leads and coordinates the BH quality improvement program, and is responsible for the day-to-day operation of the program. The Director develops data collection tools, then collects, analyzes and presents quality data to internal and external audiences to identify and monitor improvement activities. The Director provides expertise in QI tools and methods to teach and facilitate a culture of quality improvement at CHP. The Director is accountable for the administration of the HEDIS, and CAHPS national performance measurement programs. The Director is accountable to ensure that CHP maintains compliance with NCQA, and regulatory standards related to BH quality improvement programs.
- The Compliance Officer is accountable for CHP's Compliance program. The Compliance Officer also functions as CHP's HIPAA Privacy Officer and Risk Manager (meeting State of Florida Risk Management requirements related to clinical operations). The Vice-President of Information Systems is the designated HIPAA Security Officer. The two HIPAA officials work in partnership to provide leadership and coordination for CHP's HIPAA privacy and security program.

CONFIDENTIALITY OF MEMBER INFORMATION

Capital Health Plan is governed by a comprehensive confidentiality policy. All employees are provided a copy of this policy upon hire and are required to review and adhere to its mandates as a condition of employment. CHP complies with the requirements of HIPAA and all staff is trained in HIPAA regulations and the need to protect members' confidential protected health information (PHI). CHP requires all employees, committee members and board members to sign a statement that they understand their responsibility to preserve confidentiality. Behavioral health QI activities and related committee documents and data are privileged and confidential information. QIC minutes may be reviewed by outside entities as required by accreditation or regulatory requirements. However, minutes and related documents are distributed only to staff members directly involved in specific QI or UM activities or processes. All printed documents except originals are destroyed after the committee meeting and related documents and data are maintained in a secured area. All members and staff are required to review and sign a confidentiality agreement annually.

QUALITY IMPROVEMENT PERFORMANCE INDICATORS/ ACTIVITIES

A number of performance indicators and activities exist to support the goals of the QI Program. They are evaluated and prioritized annually based on:

- Recommendations from the previous year's QI Program Evaluation
- Capital Health Plan's Strategic Plan
- HEDIS data analyzed at the health plan level, staff vs. affiliates, and individual physicians.

- CAHPS member satisfaction data; CHP member satisfaction with behavioral health survey results
- BH practitioner satisfaction, and PCP satisfaction with BH survey data
- Member complaint and grievance data related to behavioral health services
- Analysis of clinical data, health risks, claims, demographic, race/ethnicity and language data
- Performance data from quality indicators and results of accreditation/regulatory surveys
- Clinical and service improvement activities
- Care coordination data and indicators
- Risk management and patient safety data
- Population health and case management program indicators
- Wellness and health promotion indicators
- Confidentiality/HIPAA indicators
- BH practitioner quality review and utilization management data

CARE FOR MEMBERS WITH COMPLEX HEALTH NEEDS

The CHP Case Management Program works with members with complex health needs to arrange and coordinate care and services. Members identified for the program include those with multiple chronic medical and/or BH conditions, physical or developmental disabilities, and members with severe mental illnesses. Case managers assess their needs, and provide interventions up to and including complex case management.

CHP's Nancy Van Vessem M.D. Center for Healthy Aging provides a comprehensive teamwork approach to the medical care of members with chronic and complex medical and/or BH conditions. The Center's physicians and staff work with members to support the physical, social and emotional aspects of chronic illness to achieve optimal clinical outcomes.

CONTINUITY/COORDINATION OF CARE

CHP monitors and analyzes data on an ongoing basis to ensure that members receive seamless, continuous and appropriate care. Specific indicators are routinely monitored that evaluate communication between medical and behavioral health services. The use of BH pharmacological medications is also routinely evaluated. Opportunities for improvement in the continuity and coordination of care are identified and addressed on an ongoing basis.

ADVERSE INCIDENTS AND QUALITY OF CARE ISSUES

The review and trending of adverse incidents (including adverse drug events and medication errors) and quality of care issues provides information on potential problems requiring further investigation. Investigation of individual events and trends in adverse incidents/quality of care issues are used to detect potential unsafe/ineffective treatments. Results from this activity may lead to interventions such as quality improvement activities, changes in policies, or clinical practice guidelines. Quality of care issues that are related to individual physicians are incorporated into recredentialing decisions.

USE OF EXTERNAL CONSULTANTS

CHP utilizes external board certified physician consultants to review and evaluate potential quality of care issues.

DELEGATION

Capital Health Plan delegates the following functions:

- Primary source verification for Credentialing of behavioral health practitioners is delegated to Med Advantage, Inc., an NCQA certified CVO (credentials verification organization).
- Web-based pharmacy claims and benefit information for all members with a pharmacy benefit are delegated to Prime Therapeutics, a pharmacy benefit management organization. Formulary development and maintenance, pharmacy utilization management criteria and determinations are also delegated to Prime Therapeutics.
- CHP provides member experience and/or clinical performance data as part of delegation agreements, if requested by the delegate. CHP provides a report with trended data results that are specific to the performance of the delegate.

REGULATORY AND ACCREDITING BODIES

Capital Health Plan maintains compliance with all regulatory and accrediting bodies overseeing managed care organizations. These regulatory/accrediting bodies include the following:

- National Committee for Quality Assurance (NCQA) – accreditation organization
- Florida Department of Health/ Agency for Healthcare Administration (AHCA)
- Office of Insurance Regulation

Compliance with these agencies includes, but is not limited to the following:

- Participating and coordinating quality/clinical site visits and inquiries by government regulatory agencies.
- Partnering with CHP's Compliance Program to implement and monitor compliance with new and existing HIPAA regulations.
- Preparing and submitting required regulatory reports and filings in a timely manner.
- Achieving minimum performance levels or above as required.

ANNUAL QI PLAN EVALUATION

The effectiveness of CHP's BH quality improvement program is evaluated by an annual evaluation of initiatives and measurement results for clinical, service, access, availability, continuity and utilization measures. The health plan's achievements and improvement opportunities are identified through the annual QI evaluation process.

CHP Quality Committees

Committee	Objectives	Membership

Committee	Objectives	Membership
Quality Improvement Management Team (QIMT) Meets minimum of 4 times per year, more often as needed.	• Review and approve the QI and Utilization Management program documents on an annual basis (program descriptions, work plans and program evaluations). • Assess and ensure progress toward annual QI, and Utilization Management goals. • Integrate the QI Program with strategic initiatives and budgeting processes. • Incorporate quality at all levels of the organization • Monitor and promote continual improvement in member and practitioner satisfaction surveys. • Monitor and promote continual improvement in practitioner access and availability of services. • Monitor and ensure compliance with accreditation and regulatory bodies. - • Prioritize, select and provide oversight to service quality initiatives, including risk management, patient safety and language/diversity activities. • Provide guidance and feedback to committees reporting to QIMT. • Report Quality related concerns to the Health Delivery Committee of the Board of Directors • Address and respond to Quality of Care issues	• SR. Vice-President of Clinical Operations and Quality Improvement • Medical Directors • Associate Medical Directors • Director, CQPI • Director of Nursing • Director of Nursing NVV Center • Director of Care Coordination • Claims Operations Director • Accreditation Manager • Network Services Manager • Decision Support Systems Manager • Ad-Hoc Corporate Compliance Officer/ Compliance Director • CEO
Quality Improvement Committee (QIC) Meets minimum of 4 times per year.	• Reviews and recommends revisions to BH QI program documents (program descriptions, work plans, program evaluations and quarterly reports) on an annual basis. • Prioritize, select and monitor BH quality initiatives, including clinical, service and patient safety. • Provide clinical expertise, feedback and analysis for BH clinical performance indicators and quality activities. • Review and approve BH clinical practice guidelines and preventive health guidelines at least every other year (according to established schedules).	• PGCHP Staff Physicians Medical Director • Practicing Network Physicians • Psychiatrist • Senior VP, Clinical Operations, QI • Director, CQPI • Director, Care Coordination • Compliance Officer • CHP Staff • Director Pharmacy Services
Compliance Committee Meets minimum of 4 times per year, more often as needed.	• Review and approve policies, procedures and practices related to compliance and HIPAA regulations. • Provide oversight for CHP's compliance and HIPAA programs.	• Compliance Officer • Chief Executive Officer • Senior Vice Presidents • Controller • Directors
CHP Safety Committee	• Review and approve policies, procedures and practices related to the safety within CHP facilities. • Provide oversight for the implementation of safety procedures. • Review incident reports regarding safety issues and recommend/approve solutions.	• IT Security Administrator • Director of Facilities • Sr. VP of Operations • Director of Nursing • Telecommunications Administrator • Directors, Supervisors and Managers

Medication Management Committee Meets minimum of 6 times per year, more often as needed.	• Monitor compliance with accreditation and regulatory requirements related to BH services. • Review and approve pharmacy policies and procedures on an annual basis. • Review and approve utilization and clinical criteria pertaining to BH medication use. • Review and approve updates and changes to the commercial formulary. • Monitor and promote continual improvement in safe medication practices. • Develop interventions to improve performance measures related to BH medication use. • Collaborate with the pharmacy benefit management company (PBM) to resolve benefit and quality issues. • Review and analyze routine reports from the PBM; review and provide oversight over delegated functions.	• Medical Director • Associate Medical Director • Director Pharmacy Services • Practicing Network Physicians • Network Psychiatrist • CHP Staff
Pharmacy Continuous Quality Improvement Committee Meets 4 times per year.	• Review pharmacy data and information about BH medication errors and quality-related events that occur within CHP medical centers. • Recommend improvement interventions as appropriate.	• Chair-Appointed PGCHP Physician • Medical Director • Practicing Physicians • Director Pharmacy Services • Sr. VP of Operations • Director of Nursing • CSR Representative • Director of Urgent Care • Eye Care Representative
Credentials Committee Meets minimum of 4 times during each calendar year, more often as needed.	• Review and approve BH practitioners and providers into the CHP network based on specific credentialing/recredentialing criteria. • Review and make recommendations for adverse decisions to the Senior Management Team. • Review and approve credentialing criteria, and policies and procedures on at least an annual basis. • Review and approve delegate credentialing policies and procedures on an annual basis. • Review and analyze delegate quarterly and annual credentialing reports; provide oversight over delegated functions in credentialing.	• Medical Director • Practicing Network Physicians • Manager, Network Services