

VALUE BEHAVIORAL HEALTH OF PENNSYLVANIA

GREENE COUNTY HEALTHCHOICES PROGRAM

**QUALITY MANAGEMENT/UTILIZATION MANAGEMENT WORK PLAN
AND PROGRAM DESCRIPTION 2009**

CONFIDENTIAL

**VALUE BEHAVIORAL HEALTH OF PENNSYLVANIA
GREENE COUNTY HEALTHCHOICES
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**VALUE BEHAVIORAL HEALTH OF PENNSYLVANIA
 GREENE COUNTY HEALTHCHOICES PROGRAM
 QUALITY MANAGEMENT/UTILIZATION MANAGEMENT WORK PLAN 2009**

I. BACKGROUND

The Commonwealth of Pennsylvania determined to roll out mandated managed care for physical and behavioral health in the mid 1990’s. Because the counties had ultimate authority with regard to behavioral health service authorization, the right of first refusal was given to each individual county. Southwest Pennsylvania contracts were implemented in January 1999. Value Behavioral Health of Pennsylvania (VBH-PA) was awarded contracts for nine (9) of the ten (10) counties in this region designated ready for HealthChoices, and was awarded and added five (5) new counties in July 2007. One county (Greene) declined the direct contract with the state for managed care and therefore VBH-PA holds that contract directly with the state of Pennsylvania. All other eight contracts are with the individual counties.

VBH-PA currently manages the state Medicaid behavioral health contract for fourteen counties in Western Pennsylvania. These include Armstrong, Beaver, Butler, Cambria, Crawford, Erie, Fayette, Greene, Indiana, Lawrence, Mercer, Venango, Washington, and Westmoreland counties accounting for 285,585 covered lives. The total population is divided equally between children and adults.

Demographics

County Type Profile

URBAN COUNTY	RURAL COUNTY	MIXED COUNTY
Beaver Erie	Armstrong Butler Cambria Crawford Fayette Greene Indiana Mercer Venango	Lawrence Washington Westmoreland

II. PURPOSE

The purpose of the Value Behavioral Health of Pennsylvania Quality Management/Utilization Management Work Plan is to provide a systematic method for continuously improving the quality, efficiency and effectiveness of the entire range of behavioral health services provided to all members of the County HealthChoices Program.

III. MISSION AND PHILOSOPHY

Value Behavioral Health of Pennsylvania's mission is to achieve clear leadership and excellence in the provision of behavioral healthcare and human services. We will continually expand and strive to improve the quality of services to our customers, members, and their communities.

We are a compassionate company, created to meet a healthcare and human service need and dedicated to the principles that sensitivity toward human needs and profitability are not mutually exclusive. High touch is supported and enhanced by high tech, and high performance is a prized recognized and rewarded standard.

Value Behavioral Health of Pennsylvania is an organization whose management is clearly focused on its responsibility to maintain a fiscally sound company, but will never permit that focus to diminish its responsibility to the delivery of exceptional care to those in need.

Our Customers

We will live up to the commitments we make to our customers. We will listen, understand and respond to our customers, both internal and external. Those constituents who receive and depend upon our services will receive:

- Immediate access to high quality clinical and human services; and
- Innovative programs and ideas to shape and track human services trends and outcomes, and to anticipate and address changing customer and community needs, which we will deliver in a proactive manner.

It is our objective to grow the business through retention and expansion of our customer base in new value-added markets and to prosper in an ethical manner.

Our Clients

Our primary goal is to understand, anticipate and meet the needs of our clients in the management of their healthcare services. In this regard, we strive to meet or exceed the expectations of our clients for building and maintaining efficient and effective systems of healthcare.

Our Members

Through our high quality system of healthcare, we strive to ensure that every eligible client receives safe, effective and responsive treatments to address their healthcare needs. We promote and support treatment models that recognize the integrity of the individual receiving services and that encourage self-reliance and an improved quality of life. We are dedicated to the recovery model as outlined in the Pennsylvania Call for Change, and consider our members to be the leaders for change.

Our People

We will attract and retain high performing talent. We will maintain a clear and unified focus on our mission and objectives. We are committed to providing a workplace environment that values creativity, innovation, and the discipline to achieve results, and encourages ownership, solutions to issues, and the aggressive pursuit of opportunities.

Our Providers

In our role as information broker, we will offer our providers the data and information they need to advise and make appropriate behavioral healthcare decisions with their patients. We will partner with providers within an environment that allows maximum time to concentrate on patient needs by providing timely access to information and data requested by customers and patients regarding care and outcomes.

IV. SCOPE AND ROLE OF THE QUALITY MANAGEMENT PROGRAM

Scope

The scope of the VBH-PA Quality Management/Utilization Management Work Plan includes the proactive collection, analysis, and reporting of data pertaining to the quality of behavioral health care and services, along with the development and implementation of systematic improvement efforts, across all components of the various delivery systems for all County HealthChoices Program beneficiaries, providers and organizations.

Quality Management Program Reporting

The VBH-PA County Quality Management Committees will provide regular reports of their activities, studies, findings, recommendations and the results of corrective actions to the counties, the VBH-PA CEO, and the Pennsylvania Department of Public Welfare. *Appendix A presents a detailed list of the Quality Management Reporting Requirements that will be met by VBH-PA.*

Corrective Action Planning

The VBH-PA Quality Management Committees (QMC) will take appropriate corrective actions whenever substandard care and services, or opportunities to improve care and services, are identified. The performance review process begins with data collection, which in turn drives the quality management activities that define thresholds. When the data indicate that structures, processes or outcomes have fallen outside an acceptable threshold, the appropriate responsible resources are identified and a corrective action plan is developed and submitted to the QMC. Corrective action plans may include: modification of the structures and processes of the service delivery system; modification of internal structures and processes; education of staff, providers and/or consumers; the chartering of a task-oriented quality improvement teams; and/or other measures, as appropriate.

The QMC oversees implementation of the corrective action plans. Additional data are collected and trended, and improvements are monitored until the desired threshold is achieved. The persons responsible and the types of corrective action all vary depending upon what is required. Corrective actions and follow-up are continuous. By continually monitoring performance standards, the QMC can determine if and when improvement is achieved.

V. ORGANIZATIONAL STRUCTURE AND RESPONSIBILITIES

The Pennsylvania Department of Public Welfare has ultimate responsibility for assuring a flexible, comprehensive and integrated Quality Management Program. The Pennsylvania Department of Public Welfare assumes responsibility for assuring that the Quality Management Program is implemented and maintained. The Pennsylvania Department of Public Welfare delegates responsibility for the Quality Management Program, and the necessary authority to take appropriate actions, to the County Administrator whom, in turn, delegates this responsibility and authority to the VBH-PA Quality Management Committees. VBH-PA reports the status and results of each project to DPW as requested.

Responsibilities at the Corporate Level

ValueOptions Quality Management program infrastructure is designed to allow top-down direction and bottom-up participation, thereby ensuring optimal patient outcomes. The Quality Management reporting structure encompasses active participation with and communication among staff members at *ValueOptions* corporate office, service centers, individual departments and representatives of participating providers and members. The structure is designed to identify existing problems, potential problems and opportunities for improvement as well as ensuring that all policies and procedures meet regulatory requirements and accreditation standards.

Committees and sub-committees are structured to facilitate the effectiveness of *ValueOptions'* quality management program. The following committees represent the Quality Management reporting structure at *ValueOptions*:

- Executive Quality Council (EQC)
- Company Quality Council (CQC)

The Vice President of National Quality Management is responsible for providing administrative support, coordination, implementation and oversight of the corporate quality management program. The Vice President of National Quality Management works collaboratively with each division to obtain consultation on any program activities that involve or affect the clinical care and patient safety.

Executive Quality Council (EQC)

The EQC is the governing body of the Quality Management and Utilization Management Program and maintains ultimate authority for overseeing its management direction. The EQC is co-chaired by the President of *ValueOptions* and the Chief Operating Officer of *ValueOptions* and meets quarterly. The EQC reviews and approves, at least annually, the Quality Management Program, articulates *ValueOptions'* corporate values, establishes priorities and allocates the appropriate resources necessary to accomplish the goals of the Quality Management and Utilization Management Program. Committee members are selected to ensure the appropriate representation of executive management.

EQC Responsibilities include:

- Ultimate accountability for the Quality Management Program.
- Communicating a quality vision and long-term business direction for all Divisions.
- Providing leadership to improve organizational performance.
- Determining whether services are within *ValueOptions*' capabilities in terms of resources for all Divisions.
- Establishing *ValueOptions* corporate policy.
- Assuring policy and procedure development and maintenance.
- Delegates authority to the CQC for overall review and implementation of various activities including, but not limited to:
 - Developing, implementing, and revising policies and procedures
 - Evaluating Corporate and service center quality management, utilization management, and Workplace Services program descriptions, evaluations, and work plans, at least annually
 - Identifying trends to improve efficiencies and quality of services
 - Evaluating the performance of all levels of operation and requesting and monitoring of corrective actions to ensure *ValueOptions* meets and exceeds established corporate goals and objectives.

VBH-PA Quality Management Committee Composition

The VBH-PA Quality Management Committees will be comprised of at least the following persons:

- VBH-PA Clinical Representative
- VBH-PA Quality Management Director
- County Representatives (at least one from each county)
- Consumer/Family Representatives
- Provider Representatives (MH & D&A)

Role of Participating Network Providers

VBH-PA participating providers are informed about quality improvement program efforts through the provider manual, provider forums, the *ValueOptions* and VBH-PA websites, and trainings. Providers participate on various committees including the Quality Management Committee, Clinical Advisory Committee, and the Provider Advisory Committee. Through these Committees, participating providers:

- Advise VBH-PA on all issues associated with the provider network.
- 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 VBH-PA.

- Review QI activities and make recommendations for improvements and corrective action plans to improve quality of clinical care and service.

Role of Consumers/Family Members

VBH-PA 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, consumer and family member committee membership is an opportunity for constructive input and participation in the quality management program. Consumer and Family Advocates are members of the Quality Management Committee, the Clinical Advisory Committee, the Consumer Advisory Committee and associated workgroups and represent the consumer and family member perspective regarding VBH-PA's system of care.

Role of the Quality Improvement Analysts

The Quality Improvement Analysts prepare monitoring reports including analysis of data, significant trends and any drill down information as appropriate. Monitoring reports are presented at QMC meetings. The Quality Improvement Analysts also serve as project leads for various studies, including writing QIAs, developing data collection tools, collecting and analyzing data, writing reports and presenting updates to stakeholders.

Role of the County

The County MH and D&A leaders provide oversight and address individual county practices that may have impacted data and trends. They also provide guidance and input into study designs, pilot projects, performance improvement plans and other special initiatives. County representatives serve as active members on each QMC and also provide oversight of VBH-PA through other avenues as designated by them.

Role of VBH-PA Clinical Department

Each QMC has a VBH-PA Clinical Department representative. The Clinical Department representative is able to provide insight into utilization management issues and provides clinical input into study designs, pilot projects, performance improvement plans and other special initiatives. Clinical representatives are supervisory level or above.

Role of VBH-PA Quality Management Director

The VBH-PA Quality Management Director reports to the VBH-PA CEO and has the overall responsibility for:

- Ensuring the operations of the seven (7) VBH-PA County Quality Management Programs, as defined by the VBH-PA/Counties Quality Management Committees and as outlined in the annual VBH-PA/County Quality Management Work Plans.
- Serving as the chair of each of the seven QMC's.
- Providing QM input into inter-departmental operations on a daily basis.

- Responsibility for the overall QM programs.

The VBH-PA Quality Management Department is comprised of staff with degrees in clinical as well as business-related fields. There is expertise in statistics as well as research and study design. The Quality Management Department works closely with the IS Department in order to obtain valid data that supports all associated Quality Management activities.

Role of VBH-PA Medical Director

The VBH-PA Medical Director will have the following responsibilities:

- Overseeing and ensuring the development of clinical practice standards, policies, procedures and performance.
- Overseeing and ensuring the review and resolution of quality of care problems.
- Overseeing and ensuring the grievance process related to service denials and clinical practice.
- Providing consistent input into the development, implementation and review of the internal Quality Management and Utilization Management Programs.
- Overseeing and ensuring the quality of behavioral health services, including rehabilitation and residential services for children and adolescents.
- Overseeing and ensuring the prior authorization and utilization review processes.

Responsibilities of the QMC

The QMC shall focus on the proactive collection, analysis, and reporting of data pertaining to the quality of behavioral health care and services, along with the development and implementation of systematic improvement efforts, across all components of the various delivery systems for all Greene County Program beneficiaries, providers and organizations. The QMC shall coordinate its activities with the following operations:

- Utilization Management: The VBH-PA Medical Director in conjunction with the VBH-PA Clinical Director monitors utilization management activities, and the Quality Management Department reports the results of the monitoring activities to the QMC including analysis of service under-utilization and over-utilization and analysis of consumer complaints and grievances.
- Provider Relations: The QMC will make available to appropriate authorities and stakeholders all available quality management information pertaining to providers, including the results of provider satisfaction surveys, provider profiling and provider chart audit results.
- Member Services: The QMC will review all aggregate reports related to consumer complaints and grievances, and will review the results of consumer satisfaction surveys and the findings of the Consumer/Family Satisfaction Teams (C/FST). Based on these reviews, the QMC's will identify quality of care issues, and assure the development of corrective action plans and the implementation of appropriate quality initiatives.

- Risk Management: The QMC is responsible for overseeing all aggregate information involving adverse incidents.
- Quality of Care. The Quality of Care Committee is responsible for reviewing and advising corrective actions for all quality of care concerns.
- Study Advisory: The QMC will lend interpretation and input to clinical and service-focused studies as lead by their area of expertise. In addition the QM department will seek input from the *ValueOptions* QIAAG.

Responsibilities of the QMC Chairperson(s)

The Chairpersons of the QMC are responsible for presiding over the meetings of the QMC's, and for assuring that the QMC complies with the requirements specified in the VBH-PA County Quality Management Work Plan.

Term of Membership

The term of membership on the QMC will be one year, with no limitation on the number of terms. QMC membership will be evaluated by the County no less than one time each year. Members who are absent from two or more consecutive scheduled meetings, without prior notification, may be subject to dismissal from the QMC. Vacancies will be filled as needed by the counties. All members agree to abide by the Bylaws and the terms of the confidentiality agreement.

Voting Privileges

All members of the QMC will be entitled to one vote each, with QMC decisions based on a simple majority.

Definition of Quorum

For the purpose of conducting business, a quorum will consist of one half of the voting members. Members who are not able to attend QMC meetings in person may participate by conference telephone calls, which will be pre-arranged by the VBH-PA Quality Management Director, or designee. In the event that a quorum is not reached, Robert's Rules of Order will apply.

Frequency and Scheduling of Meetings

The QMC will meet on a quarterly basis, and ad-hoc telephone meetings may be scheduled for critical incident closure.

Quality Management Committee Meeting Minutes

The VBH-PA Quality Management Department will record minutes at each QMC meeting. The minutes shall include: the names of members in attendance, and the names of members absent; the date and time of the meeting; agenda items; discussion; and, action items, including the responsible persons and the target completion dates.

The minutes of QMC meetings will be kept by the VBH-PA Quality Management Department in a secure location. The minutes will be sanitized to protect consumer and provider confidentiality, and will be made available for review by the Pennsylvania Department of Public Welfare, as required by law or contract.

Subcommittees

The QMC may designate subcommittees as necessary to assure the efficient operation of the VBH-PA Quality Management Program.

Urgent Issues

Issues that arise prior to the monthly meetings and need immediate attention will be reviewed by the VBH-PA Quality Management Director, and/or the VBH-PA Medical Director and reported at the next meeting of the QMC.

Role of DPW

DPW utilizes a vendor to conduct an annual review of various BH-MCO functions. Any required PEPS Action Plans will be reviewed at the QMC's. VBH-PA, through cross-departmental CQI strategies, will report on the status of performance improvement projects through the OMHSAS monitoring process, and quarterly reports will be submitted as required.

Allocated Resources for the Quality Management Program

- Personnel: The VBH-PA Quality Management Department utilizes the expertise of five Quality Improvement analysts, a Prevention Specialist and a Risk Management Specialist.
- Technical: VBH utilizes the VBH-PA Reporting Department (IS Director and Business Analysts) to provide administrative data reports.
- Statistical: VBH utilizes members of the department with statistical expertise such as staff with research background and completion of statistics classes. SPSS is oftentimes used for statistical analysis.

Data Sources

VBH-PA uses the CareConnect system for care management and claims data through the VO data warehouse (DW). The data sources available and used for QI measurement include claims, encounter data, authorization data, clinical treatment records, member demographics, clinical

quality issue reporting, satisfaction surveys, complaints and grievances, GeoAccess reports, and provider profile data.

Integration of Quality Management with Organizational Departments

A. Quality Management and the Governing Boards

The county is responsible to report QM information up to the governing HealthChoices Board.

B. Quality Management and Care Management/Member Services

The integration of Quality Improvement and Care Management is assured through representation on key committees including the QMC, CAC and QOCC as well as a joint meeting structure to address clinical quality activities. These structures support the integration of clinical quality management activities and indicators. Clinical indicators have been established to measure the effectiveness of practice guidelines, over and under utilization, and the timeliness of appointment referrals per state regulation. Regular audits are done on care managers and network providers' documentation to assure the quality of treatment decisions being made. Utilization management inter-rater reliability is assessed periodically. The results of these quality activities are shared with the QMC for evaluation and recommendations.

C. Quality Management and Network Management

The integration of Quality Management and Network Management occurs through cross-representation on key committees such as internal VBH-PA management meetings and workgroups. Provider quality reviews and performance data are evaluated by the QOCC, which includes the Provider Relations Director and the Clinical and Quality Directors. Additionally, provider profiles are reviewed at the Profiling Advisory Committee, which includes network representatives.

D. Quality Management and Member Rights

VBH-PA's 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, VBH-PA utilizes member/consumer input and participation in the quality management program. Data are collected per Act 68 laws governing members' rights regarding filing complaints and grievances. VBH-PA monitors for compliance.

E. Quality Management and Information Technology

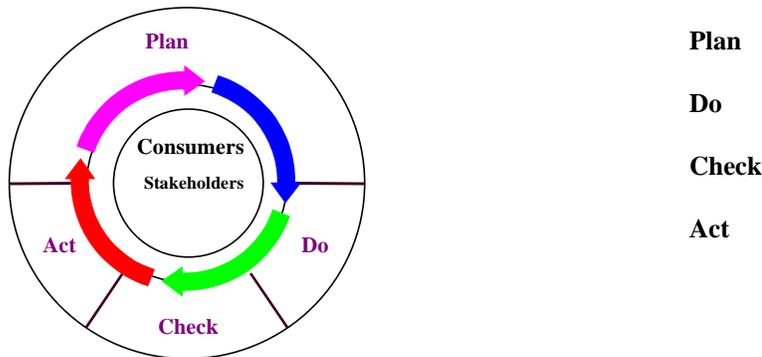
Accurate and timely data are vital to a successful quality program. VBH-PA's Quality Management Program is data driven, and interfaces with the VBH-PA Reporting Department to assure data integrity and accurate reporting. Semi-monthly cross-departmental meetings are held called the Data Integrity Committee. Additionally, semi-monthly QM/IS meetings are held to assure communication and accuracy of data requests.

Quality Improvement Model

VBH-PA commitment to these ideals is visible in the consistently high benchmarking of our performance standards and in the industry's recognition of *ValueOptions'* and VBH-PA program excellence. It is also evident in our commitment to national quality improvement initiatives. Our

quality program complies with National Committee on Quality Assurance (NCQA), and the American Accreditation HealthCare Commission/URAC.

Our quality initiatives are long-term commitments to improvement designed to eliminate barriers that inhibit performance. We operate under the culture of the quality improvement cycle:



By implementing a continuous quality improvement model, we use data to identify opportunities for improvement and monitor interventions. This process yields increased satisfaction and better outcomes for all stakeholders.

VBH-PA continuous quality improvement process is structured to:

- delineate thresholds/benchmarks
- identify responsible parties
- implement corrective action plans and monitoring procedures
- act upon the results of corrective action plans

Staff and Provider Training

VBH-PA staff provides ongoing quality management training to providers, consumers, and staff. Training is available regionally and on-site for provider or member groups upon request. Further training needs are identified through needs assessments and/or provider surveys. Annual training for VBH-PA employees generally includes, but is not limited to training regarding:

- Confidentiality
- Conflict of interest
- State and regulatory requirements
- Organizational Structure
- Policies
- Best Practices
- Contractual Requirements
- Patient Safety

VBH-PA employees may also receive training through *ValueOptions* on a variety of quality-related topics.

Provider forums are held at least four times annually on a variety of topics. An overview of the annual forums is given in the QM Annual Summary.

VI. GOALS AND OBJECTIVES

The Value Behavioral Health of Pennsylvania (VBH-PA)/Greene County Quality Management/Utilization Management Work Plan for 2008 govern the Quality Management functions of the Southwestern Pennsylvania HealthChoices Service Center for the Greene County HealthChoices Program for a period of one calendar year (i.e., January 1, 2008 through December 31, 2008). Each year, VBH-PA will develop a Quality Management Work Plan, which is based on goals and objectives to be accomplished by the Southwestern Pennsylvania HealthChoices Service Center. This Work Plan will reflect the ongoing quality improvement initiatives implemented in the previous year, and be developed as a direct result of our annual summary of QI activities:

Goal 1: Develop and implement a 2009 Quality Management/Utilization Management Work Plan that reflects the quality improvement initiatives identified through an analysis of 2008 Quality Management activities.

Objective 1.1: The 2008 Annual Summary will be submitted to the Greene County QMC by the February 25, 2009.

Objective 1.2: Draft of the 2009 Quality Management Plan will be submitted to the Greene County QMC by February 25, 2009 and voted for final approval at the next 2009 QMC Meeting.

Goal 2: Continue monitoring procedures for risk management (member safety)

Objective 2.1: Monitor high volume services and treatment monthly based on overall utilization. Report quarterly.

Objective 2.2 Monitor daily census for high volume by adult/child and by level of care.

Objective 2.3: Monitor high-risk members and treatment on an annual basis based upon the complex care management program.

Objective 2.4: Continue the procedures for monitoring behavioral health rehabilitation services for children and adolescents on a monthly basis. Report quarterly.

Objective 2.5: Develop a quality improvement strategy through collaboration with the providers, prescribers, and counties at the BHRS Summits targeting disengagement and therapeutic discharge.

Objective 2.6: Implement Functional Behavioral Assessment (FBA) for children with behavioral health needs compounded by developmental disorders, such as autistic and other pervasive developmental disorders.

- Objective 2.7: Upon DPW approval, implement the extended evaluation process. (ExACT)
- Objective 2.8: Continue to monitor quality of care issues through the QOCC on a monthly basis or on an ad hoc basis if warranted.
- Objective 2.9: Continue the procedures for monitoring critical incidents on a daily and monthly basis.

Goal 3: Continue monitoring procedures for coordination with primary health care.

- Objective 3.1: VBH-PA participates in the Southwest Regional Behavioral/Physical Health Joint Coordination Meetings. These meetings occur quarterly.
- Objective 3.2: Monitor the C/FST question monthly regarding satisfaction with physical health care.
- Objective 3.3: Continue to collaborate with OMHSAS, OMAP and the PH-MCO's on the statewide initiatives of smoking cessation and domestic violence.
- Objective 3.4: Utilize the provider chart audit question to analyze rate of notification to the PCP.
- Objective 3.5: Care managers will coordinate special needs cases with the PH-MCO Special Needs Units.
- Objective 3.6: Collaborate with Gateway Health Plan and UPMC for You (PH-MCO's) in joint projects (pharmacy and maternal depression).

Goal 4: Continue monitoring procedures for the evaluation of the effectiveness of services.

- Objective 4.1: Continue the procedures for monitoring the authorization and grievance processes on a monthly basis. Report quarterly.
- Objective 4.2: Continue the procedures for monitoring treatment outcomes based on individual study design.
- Objective 4.3: Continue to monitor readmission rates monthly and YTD. Report quarterly.
- Objective 4.4: Monitor and report on the follow-up after inpatient psychiatric admission HEDIS study (IPRO and PBC), quarterly. Continue to monitor and expand current performance improvement plans.

- Objective 4.5: Monitor and report on access to drug and alcohol services for members under 21 years of age (penetration) quarterly. Submit reports to OMHSAS per PBC requirements.
- Objective 4.6: Develop the Best Practice Standards for Level 3B (Medically Monitored Short-term Residential) providers for co-occurring disorders.
- Objective 4.7: Continue to monitor penetration rates annually by MH and D&A, age, gender and race.
- Objective 4.8: Continue to monitor involuntary rates by county, monthly. Report quarterly.
- Objective 4.9: Continue to monitor member satisfaction with access to services via C/FST data and the Annual Member Satisfaction Survey.
- Objective 4.10: Continue to monitor treatment outcomes using selected items from the SF-36 and the Symptom Distress Scale to measure improvement in health status. These items are included in the annual member satisfaction survey.
- Objective 4.11: Complete a new baseline pharmacy data report using a full year's worth of pharmacy claims data (2008) for all 14 VBH-PA counties. Request and examine medical records for members identified in the Pharmacy Data Baseline Follow-up Report as "questionable" cases.
- Objective 4.12: Analyze the outcomes data for the RTF/Substance Abuse Collaborative (RSAC) to determine efficacy of the pilots.
- Goal 5: Continue monitoring procedures for the evaluation of the quality and effectiveness of internal processes.
- Objective 5.1: Continue the procedures for monitoring telephone access standards and responsiveness. Report quarterly.
- Objective 5.2: Continue the procedures for monitoring the responsiveness and accuracy of member and provider services through satisfaction surveys to be reported annually (annual member and provider surveys).
- Objective 5.3: Continue monitoring overall utilization patterns and trends to be reported on a quarterly basis. Target Blended Case Management and Community Treatment Teams for trends in utilization.
- Objective 5.4: Target blended case management level of care for UM strategies, process improvements, and defining best practice protocols.

- Objective 5.5: Expand participation in the 3A Detox facility management project and initiate 3B Short Term Residential Rehab facility management. Report annually.
- Objective 5.6: Expand Facility Management for Acute Inpatient level of care for selected hospitals. Report annually.
- Objective 5.7: Develop new data collection tools for internal Care Connect audits for mental health and drug and alcohol inpatient, drug and alcohol rehab, BHRS, and RTF. Determine indicators based on targeted areas of importance by May 2009. Begin auditing process by July 2009.
- Objective 5.8: Continue monitoring complaints, including by level of care and category. Report quarterly.
- Objective 5.9: Continue the procedures for monitoring the peer review and grievance activities. Report quarterly.
- Objective 5.10: Review Consumer/Family Satisfaction Team data regarding satisfaction with VBH-PA services. Report quarterly.
- Objective 5.11: The clinical department will participate in the annual ValueOptions inter-rater reliability study and findings will be reported annually.
- Objective 5.12: Monitor and report the timeliness of referral decisions quarterly.

Goal 6: Evaluate the quality and performance of the provider network.

- Objective 6.1: Prepare provider profiles for BHRS, RTF, Outpatient Mental Health, Family Based Mental Health Services, and Inpatient Mental Health levels of care for 2008/2009, subsequent to claims lag. The Provider Profiling Advisory Committee will develop action plans based on outlier analysis.
- Objective 6.2: Continue monitoring the coordination with other service agencies and schools through provider chart audits reported on as chart audits are completed for each level of care.
- Objective 6.3: Continue to monitor the provider network, reported on a quarterly and annual basis. These reports include OOPA, capacity, PE&O, Exception Report (Geo Access), and changes in the provider network.
- Objective 6.4: Continue the procedures for monitoring the quality of service/treatment planning by ongoing provider treatment record review. Disseminate provider report cards, and monitor corrective action plans, as required. Target Family Based, Methadone, and BHRS providers for 2009. Report aggregate network data annually.

- Objective 6.5: Audit Mental Health and Drug and Alcohol Providers for documentation of a formal assessment for both substance abuse and mental health issues for a co-occurring disorder.
 - Objective 6.6: Increase the number of COD competent providers in the VBH-PA Provider Network.
 - Objective 6.7: Begin methadone chart auditing process.
 - Objective 6.8: Utilize the newly formed RTF Summits to develop revised RTF Best Practice standards. Revise the RTF data collection instrument to reflect new standards.
 - Objective 6.9: Target Telepsychiatry Program outcomes in Greene County.
- Goal 7: Continue monitoring procedures for the reporting of suspected/substantiated fraud and abuse.
- Objective 7.1: Continue the procedures for monitoring the reporting of claims fraud and abuse on a quarterly basis.
- Goal 8: Continue procedures for monitoring clinical records content, retention and storage through recredentialing process.
- Goal 9: Continue procedures for assessing member satisfaction with services.
- Objective 9.1: Continue utilizing information obtained from the Consumer/Family Satisfaction Teams, reported on a monthly basis.
 - Objective 9.2: Analyze the data obtained from the 2008 member satisfaction survey by May 2009.
 - Objective 9.3: Continue the annual member satisfaction survey process for 2009.
- Goal 10: Monitor preventative behavioral health programs.
- Objective 10.1: Pursue the idea (based on feedback from QMCs) to conduct provider forums or trainings subsequent to the findings of 2008 suicide assessment study, for the purpose of identifying and removing barriers for consumers to engage in treatment to prevent suicide attempts
 - Objective 10.2: Implement improvement strategies and perform third re-measure of the Second Generation Atypical (SGA) Antipsychotic Study.

Add a new indicator, referral to wellness support, to the audit of the 12 large volume providers in the original 9 counties, for the monitoring of metabolic syndrome with consumers prescribed SGA medications.

Objective 10.3: Develop a pilot program with Gateway Health Plan to improve adherence to medication management for SPMI consumers prescribed psychotropic medications.

Goal 11: Continue/develop the following studies and program improvement initiatives for calendar year 2009:

- Follow-up within 7 days and 30 days after inpatient (PBC/IPRO)
- D&A access (penetration) (PBC)
- Collaborate to develop quality improvement initiative for identified ROSI Administrative Indicator
- Re-measure of recovery outcomes in partial hospitalization program
- Partner with one MH and D&A provider in each county to measure a baseline for the Recovery Knowledge Inventory
- Monitor outcomes for Telepsychiatry
- Second Generation Atypical (SGA) Antipsychotic Study – re-measurement and baseline measures for referrals
- Understanding the Barriers to Utilizing Mental Health Treatment as Intervention to Suicidality – intervention stage
- COD baseline audit
- Develop improvement strategies subsequent to receipt of the IPRO RTF re-measurement
- PEPS corrective action plans
- Improving the Quality of Prescribing Patterns
- Analyze the outcomes data for the RTF/Substance Abuse Collaborative (RSAC) to determine efficacy of the pilots

Goal 12: Utilize Clinical Advisory Committee (CAC) workgroups to improve service delivery.

Goal 13: Target individual quality improvement initiatives for Greene County.

Objective 13.1: Monitor outcomes for Telepsychiatry

Objective 13.2: Establish outcome measures based on the Boston University Model for site-based Psychiatric Rehabilitation program

Objective 13.3: Collaborate to develop Quality Improvement Initiative for identified ROSI Administrative Indicator.

Objective 13.4: Monitor outcomes for service enhancements

Objective 13.5: Follow up intervention and re-measure of the Recovery Knowledge Survey with Greene County Providers

Objective 13.6: Implement a pilot study with Southwestern Regional Medical Center, Greene County Drug and Alcohol Assessment, and The CARE Center to identify and engage in treatment those persons hospitalized for a mental health issue that have a co-occurring disorder.

Goal 14: Evaluate and update the VBH-PA Quality Management Work Plan.

Objective 14.1: Complete the annual summary for 2008 Quality Management/Utilization Management Work Plan by March 2009.

Objective 14.2: Complete the annual 2009 Quality Management/Utilization Management Work Plan by March 2009.

VII. QUALITY MANAGEMENT ACTIVITIES

Total quality management and continuous quality improvement occur within the context of various planned activities. All Quality Management activities are governed by the analysis of the population we serve. A comprehensive analysis has been conducted by VBH-PA over the contract year. High-risk categories include children, SPMI adults, MISA clients, and medically complex cases. These activities will include, but are not limited to, the following:

A. Risk Management (Member Safety)

The VBH-PA Quality Management Committee will monitor high volume services and treatment, high-risk members and treatment, behavioral health rehabilitation services for children and adolescents, critical incident cases, and quality of care cases using the following procedures:

1. High Volume Services and Treatment

The VBH-PA Quality Management Department monitors monthly the top three levels of care for each county by cost and by number of distinct members. The aggregate reports are presented to the QMC quarterly.

The VBH-PA Clinical Department manages high volume services through a proactive medical management process utilizing daily census reports, measured against an annual CRCS target.

2. High Risk Members and Treatment

Annually a report will be given that will include those members who will be managed through the Complex Care Management program at VBH-PA in the following classes of

morbidity: MISA, SPMI, MH/MR, and medically complex. Outcome measures will be reported annually.

3. Behavioral Health Rehabilitation Services (BHRS) for Children and Adolescents

The QMC will monitor behavioral health rehabilitation services for children and adolescents. The VBH-PA Quality Management Department will prepare monthly reports showing service utilization distinct member count, total units per month, average units per member, and Autism Spectrum Disorders (ASD) distinct member analysis. Quarterly rates per thousand will be reviewed for BHRS distinct members, community services and waived services. Annually rates by levels of service, by diagnostic category and age/gender group for behavioral health rehabilitation services for children and adolescents will be reviewed. Current activities and improvement strategies associated with BHRS will be updated and reported to the QMC. Associated projects include the following:

- **BHRS Regional Summits:** two regional groups made up of BHRS providers, county and state officials, and VBH-PA staff. Their purpose is to work on improving the quality of BHRS services. This will be done through profiling, data sharing, adopting best practices, and joint work on mutually agreed upon projects. They meet quarterly.
- **BHRS Advisory Board:** a small group of BHRS providers and VBH-PA staff who will meet on a more frequent basis to identify and develop best practices as well as other important improvements needed in BHRS service delivery. The concept behind this group is to have a small, time-limited source of high quality information from BHRS providers in order to draft working documents for the larger BHRS Regional Summits to refine into proposals.
- **BHRS Autism Advisory Board:** a small group of BHRS providers who specialize in ASD and VBH-PA staff who will begin to meet in 2009 to identify and develop best practices in ASD as well as other important improvements needed in BHRS service delivery. This group may be time-limited or may evolve in to an ongoing advisory board. This group will coordinate all proposals to support the initiatives of the Pennsylvania Bureau of Autism Services (BAS).
- **VBH-PA will implement the BAS plan for credentialing providers to perform Functional Behavioral Assessment (FBA) for children with behavioral health needs compounded by developmental disorders, such as autistic and other pervasive developmental disorders. In addition, VBH-PA will authorize services and follow all reporting guidelines as set forth by the BAS.**
- **Extended Evaluation and Comprehensive Treatment (ExACT) Protocol** is a service option for any child who may benefit from a more comprehensive assessment of presenting problems and enhanced intervention planning. Upon DPW approval, the

ExACT protocol will be implemented. Training for prescribers and providers is planned prior to implementation.

- Continue to monitor the performance of providers enrolled in the Performance Based Contracting Program utilizing the CCASBE-LD data collection tool.

4. *Quality of Care*

Quality of Care issues will be reviewed by the VBH-PA Quality of Care Committee (QOCC). This committee is chaired by the Medical Director and is comprised of interdepartmental representatives as well as representatives from the counties. Issues are referred for review by VBH-PA and county HealthChoices staff, and include fraud and abuse, referrals of providers having more than three complaints in a three month period and providers that score below 65% in a chart audit. Per policy, QOCC reports founded quality of care concerns to the *ValueOptions* Provider Network Department as part of the recertification process. Additionally, the *ValueOptions* National Credentialing Committee (NCC) can make recommendations for suspension of referrals and disenrollment from the network, as warranted. QOCC makes recommendations to improve quality of care and monitors corrective action plans. Cases are reviewed and prepared for QOCC by the Quality Management Department, who also presents a quarterly overview of QOCC activities to the QMC.

5. *Critical Incidents*

The Greene County standards and procedures regarding critical incidents are described in the VBH-PA Policy and Procedure Manual. The procedures for monitoring critical incidents are described below.

Critical incidents are critical events or outcomes involving persons seeking or receiving HealthChoices services. Critical incidents include: consumer violent death; consumer death that appears to have resulted from suicide; consumer escape from a locked protective treatment setting; consumer death as a result of confirmed report of abuse, neglect or exploitation; consumer allegations of sexual abuse, neglect, or exploitation from a provider; consumer elopement from an unlocked treatment setting (e.g., RTF or foster home); consumer to consumer sexual assault or occurrence of sexual intercourse while in a locked protective treatment setting; consumer to consumer altercation requiring medical attention; all medication errors and unfavorable medication side effects; and/or other situations as defined by the County.

All critical incidents are logged in the ValueOptions information systems, attorney reviewed, and followed up as per ValueOptions Policy and Procedures. The VBH-PA Quality Management Director and Medical Director will be notified of any critical or serious incidents once they are identified as such. The counties are given critical incident tracking logs that provide specific case and provider information in an agreed upon time frame. Upon completion of the investigation of the most serious incidents, findings will be reported to the QMC for recommendations or closure.

Data from incident reports will be aggregated by the VBH-PA Quality Management Department. The aggregated data will include the number of critical incidents by month, and trends in incident type will be included in the report. Data on specific critical incidents are considered confidential and are maintained internally as an integral aspect of risk management. Quarterly, the VBH-PA Quality Management Department will review all reported incidents from the previous six months by member and by provider for trends in reporting or in the number of incidents.

Members for whom four or more incidents have been reported will be reviewed individually from a case management perspective to determine if further analysis is indicated clinically. This may include medical record reviews, Care Connect review including claims data, individual incident data and clinical/social issues that may be impacting treatment. A risk analysis will be completed by the Quality Management Department and when findings have merit, will be reviewed at Quality of Care Committee.

Providers will be reviewed against their own established reporting baseline regarding number of incidents. Since providers vary significantly in the number of members served and in their commitment to report all incidents, potential trends will be reviewed by provider volume, the type of incidents being reported and whether distinct members are involved in multiple incidents. These data will be reviewed and an analysis completed to determine if the provider should be reviewed by Quality of Care Committee.

The QMC will monitor these services in order to identify opportunities for improvement in treatment outcomes. The QMC will take appropriate corrective actions whenever opportunities to improve care and services are identified. When the data indicate that structures, processes or outcomes have fallen outside an acceptable threshold, the appropriate responsible resources are identified and a corrective action plan is developed and submitted to the QMC. The QMC will oversee implementation of the corrective action plans, and will continually monitor performance standards in order to determine if and when improvement is achieved.

B. Coordination with Primary Health Care

The Greene County HealthChoices Program has designed a system of service management that emphasizes communication and coordination between all participants in the consumer's health and behavioral health care delivery systems. In addition, the Greene County HealthChoices Program has actively worked with the PH-MCO's to develop agreements on the provision and coordination of services to its consumers. These agreements include issues such as: referral and communication protocols, medication management, transition plans, overall treatment program management, service provision for special needs populations, and consumer education issues. These agreements serve as guidelines for all parties involved as they collaborate in the provision of treatment services to the consumers.

In order to monitor coordination with primary health care services, VBH-PA in collaboration with the counties will complete the following activities. However, note that the coordination and research activities described below are subject to special confidentiality restrictions for drug and alcohol abusers, as defined by Pennsylvania Code Subsection 255.5, and the coordination and research activities will not apply in these cases.

1. Coordination and Interaction with PH-MCO Quality Management Activities

Quarterly coordination meetings occur and involve all stakeholders. Any issues identified through these coordination meetings requiring intervention will be reported to the QMC on an ad hoc basis. Coordination and interaction will be achieved through the following activities:

- VBH-PA will coordinate processes to collaborate with PH-MCO's when issues of mutual concern regarding members are identified.
- The VBH-PA Medical Director, or designee, will participate in all PH-MCO's pharmacy and therapeutics committees as an active member and act as a liaison regarding behavioral health pharmacy.
- VBH-PA participates in the P&T Best Practice Committee chaired by CCBHO and including representatives from all the physical health plans in order to conduct drug utilization review and develop other partnering strategies.
- Southwest Regional Behavioral/Physical Health Joint Coordination members will continue to work to provide regional consumer and provider education.
- All subcommittees will report back to the Joint Coordination Committee with any recommendations or improvement strategies.

2. Joint Studies with the PH-MCO's

The pharmacy data will be used for a joint project involving VBH-PA, Gateway Health Plan (a physical health managed care organization), and Coordinated Care Network (an organization that provides medication case management for Gateway Health Plan consumers) that will begin in early 2009 and will focus on improving member compliance with psychotropic medications, specifically antidepressants and antipsychotics. We will explore the feasibility of undertaking a Maternal Depression project as discussed with UPMC and RAND Corporation.

3. Coordination of care with the PCP

During provider chart audits VBH-PA collects data on evidence that a release of information has been obtained for collaboration with the PCP.

4. Other Activities

- a. Continue to collaborate with DPW and the PH/MCO regarding the risk categories of smoking cessation and domestic violence.

- b. VBH-PA will review the CFST question regarding satisfaction with the physical health care at the QMC quarterly meeting, and report any substandard results to the QMC's.
- c. The care managers at VBH-PA coordinate care with the PH-MCO Special Needs Units on a case by case basis. Continue collaboration meetings with individual physical health plans.

C. Evaluation of the Effectiveness of Services

The Quality Management Committee will evaluate the effectiveness of services provided to consumers and families using the methodologies described below. The Quality Management Committee (QMC) will take appropriate corrective actions whenever substandard care and services, or opportunities to improve care and services, are identified. When the data indicate that structures, processes or outcomes have fallen outside an acceptable threshold, the appropriate responsible resources are identified and a corrective action plan is developed and submitted to the QMC. The QMC will oversee implementation of the corrective action plans, and will continually monitor performance standards in order to determine if and when improvement is achieved.

The following domains and methodologies will be included:

1. Access to Services

The Greene County standards for access to services are described in the VBH-PA Member and Provider Services Policies and Procedures Manual, in the Access to Services Policy and Procedure. The Quality Management Committee will monitor access to services using the following methodologies:

- a. VBH-PA utilizes annual satisfaction data as well as C/FST data to report satisfaction on the following:
 - Percentage of consumers and families reporting that the time of service was convenient.
 - Percentage of consumers and families reporting they were able to get their initial appointment within 7 days.
 - Percentage of consumers and families who do not feel that the distance to their provider is a problem.
 - Percentage of consumers and families reporting that their provider is conveniently located.
 - Percentage of consumers and families reporting that their first appointment was timely.
- b. Penetration rates, which are defined as rates of eligible members accessing behavioral health services, will be reported to the QMC annually.

2. *Authorization/Utilization Management and Grievance Process*

The Greene County standards for service authorization/utilization management and the grievance process are described in the VBH-PA Clinical Policy and Procedure Manual, in the Clinical Certification Guidelines Policy and Procedure, and in the Non-Certification Guidelines Policy and Procedure. The Quality Management Committee will monitor service authorizations and the grievance process through the following methodologies in a monthly quarterly report:

- a. Quarterly Reporting:
 - Number of peer reviews, number of non-certifications, by county, service type (MH/DA), and level of care.
 - Number of consumer grievances, by county, and level of care.
 - Rate of resolution of non-certifications and grievances, within prescribed timeframes, by county, and level of care.
 - DPW Fair Hearings by volume.

3. *Treatment Outcomes and Clinical Quality Improvement Activities*

The Greene County HealthChoices Program will monitor treatment outcomes through the methodologies described below. However, note that the research activities described are subject to special confidentiality restrictions for drug and alcohol abusers, as defined by Pennsylvania Code Subsection 255.5, and the activities will not occur wherever these restrictions apply.

VBH-PA will evaluate the following domains in order to measure treatment outcomes:

- *Reduction of Symptoms.* In accordance with the methodology developed by the Mental Health Statistics Improvement Program (MHSIP), use of selected items from the SF-36 and the Symptom Distress Scale are recommended as the basis for measuring reduction in symptoms and improvement in health status for the adult and child/adolescent population. These items are contained in the annual member satisfaction survey.
- *Follow-up after Inpatient Psychiatric Admission.* VBH-PA will remeasure the four (4) follow up indicators for the IPRO specification and the under 21 year old population for PBC, on a quarterly basis and track submitted performance improvement plans for a targeted annual improvement rate of 3%.
- *Readmission Rates.* VBH-PA will provide reports on a quarterly basis to the QMC showing readmission rates within an acute level of care during the following intervals: 0-7 days; 8-30 days; and within 90 days. Readmission data will be reported on a monthly basis, and will be stratified by inpatient psychiatric, D&A Detox, and D&A Rehab, and consumer demographics (i.e., age group and gender). VBH-PA will target high volume providers and counties for improvement plans.

- ◆ Convene a 3B Medically Monitored Short-term Residential Workgroup to develop a best practice standard for this level of care.
- Outcomes *Studies*:
 - ◆ D&A Access (Penetration) (PBC). Re-measurement will occur quarterly and annually based on the percentage of the expected annual prevalence rate for users under age 21 (through the 20th year) receiving any substance abuse (SA) services.
 - ◆ Improving Recovery Environments in Partial Hospitalization. In 2009, we will target the quality improvement initiatives based on 7 item responses to the ROSI and RAS surveys collected in 4 PHP's in 2008. Those providers of PHP's from the initial study that also employ Peer Specialists will be invited to roll out Individualized Crisis Prevention Plans or WREP plans for each member in PHP. A re-measure of the recovery environment defined by the 7 indicators will be conducted by VBH-PA.
 - ◆ Outcomes for Telepsychiatry. VBH-PA will monitor and measure outcomes for the Telepsychiatry program in Greene County in an effort to reduce access to care barriers for rural consumers. Medication management of children who have been identified by their psychiatrist as stable and requiring routine follow up med checks will be able to access this service from their school. Parents will come to the school instead of traveling to the clinic. Every fourth visit will require them to return to the clinic for a face to face evaluation. Clinical staff from the school based mental health program offered by Centerville Clinics Incorporated will be available at school sites as needed while the psychiatrist remains at the clinic.
 - ◆ Recovery Readiness for Behavioral Health Staff. A recovery based initiative for each county will be implemented in 2009 with the goal of establishing a baseline of recovery knowledge and attitudes among behavioral health staff at provider agencies. Staff of one mental health and one drug and alcohol provider in each county will be surveyed using The Recovery Readiness Inventory published by Yale University, Department of Psychiatry. Results will be shared with providers for the purpose of identifying areas for staff training.
 - ◆ Improving the Quality of Prescribing Patterns. Determine follow-up initiatives related to the new baseline pharmacy data report using a full year's worth of pharmacy claims data (2008) for all 14 VBH-PA counties.
 - ◆ RTF/Substance Abuse Collaborative (RSAC). Two pilots were developed and implemented in 2008. Members in RTF's are screened using the CRAFFT screening instrument for AOD use/abuse and if screened positive, D&A treatment is initiated on site at the RTF by an outpatient providers. Outcomes measures were developed for the pilot and will be analyzed in 2009.
 - ◆ Co-Occurring Disorder (COD) Pilot. The COD pilot project was designed to provide D&A assessment and intervention while the member is on the

inpatient MH unit to assist in engaging the member in treatment and to assure linkage to outpatient D&A treatment following discharge. Greene County is interested in this pilot project for 2009.

- ◆ RTF Re-measurement Study. Three study indicators that reflect key areas of RTF health care quality were re-measured in 2008 by IPRO. They were family involvement, coordination of outpatient follow-up, and medication rationale documentation for all RTF members discharged in 2007. The individual charts were collected by VBH-PA and forwarded to IPRO for data collection. Improvement strategies will be developed subsequent to receipt of the IPRO RTF re-measurement results in 2009.
- ◆ COD Baseline Audit. In 2009, a co-occurring disorder indicator chart audit will be conducted on high volume MH/D&A providers to determine that documentation of a formal assessment process for both substance use and mental health issues occurs. A pre-existing chart audit checklist from OMHSAS will be utilized which addresses the various criteria for the baseline data collection.

4. Voluntary/Involuntary Rates

The Greene County Health Choices program will monitor the rates of voluntary and involuntary admissions to the mental health inpatient level of care on a monthly basis. These rates will continue to be monitored for trends. Report quarterly.

5. Pharmacy Utilization Rates

VBH-PA will produce a new baseline pharmacy report using calendar year 2008 pharmacy claims data, representing a full year's worth of data for all of VBH-PA's 14 counties. The new baseline report will be used to target quality improvement interventions regarding the prescribing and/or utilization of psychotropic medications. In addition, medical records will be requested and examined for members identified in the Pharmacy Data Baseline Follow-up Report as questionable cases requiring a closer look at their treatment history (a child under 2 years old that was diagnosed with ADHD; members with over 150 prescriptions filled in a year; and an adolescent that had over 100 prescriptions filled in a year).

The pharmacy data will be used for a joint project involving VBH-PA, Gateway Health Plan (a physical health managed care organization), and Coordinated Care Network (an organization that provides medication case management for Gateway consumers) that will begin in early 2009 and will focus on improving member compliance with psychotropic medications.

The QMC will take appropriate corrective actions whenever substandard care and services, or opportunities to improve care and services, are identified. When the data indicate that structures, processes or outcomes have fallen outside an acceptable threshold, the appropriate responsible resources are identified and a corrective action plan is developed and submitted to the QMC. The QMC will oversee implementation of the corrective action plans, and will

continually monitor performance standards in order to determine if and when improvement is achieved.

D. Evaluation of the Quality and Effectiveness of Internal Processes

No person may participate in the review and evaluation of any case or clinical activities in which he or she has been professionally involved or where judgment may be compromised. Utilization Management decision making is based solely on the clinical appropriateness of the care and services needed. VBH-PA does not incentivize individuals engaged in utilization review for issuing denials of coverage or service, or for rendering decisions that result in underutilization. Psychiatrists, psychologists and other mental health professionals who carry out care management or peer review activity must be free from conflict of interest when reviewing the work of providers. Among other things, this means that clinical staff, including peer reviewers, must not review the work of any health care facility or entity where they have active staff privileges and treat patients or from which they derive any income.

All internal policies and procedures will be reviewed annually and revisions made as warranted.

1. Telephone Access Standards and Responsiveness

The Greene County standards for telephone access are described in the VBH-PA Member and Provider Services Policy and Procedure Manual. The procedures for monitoring telephone access are described below.

- Total number of calls.
- Total number of calls answered.
- Total number of calls abandoned.
- Average speed of answer.
- Average abandonment delay.
- Average speed of answer.
- Abandonment rate.
- Average length of call.

2. Responsiveness and Accuracy of Member and Provider Services

The VBH-PA Quality Management Director will oversee separate consumer and provider satisfaction surveys annually in order to assess the responsiveness and accuracy of member services. Consumer and provider comments, both negative and positive, will be incorporated into the analysis. Findings of the surveys will be reported to the QMC annually.

3. Overall Utilization Patterns and Trends

The Pennsylvania Department of Public Welfare will receive quarterly and annual reports, produced by VBH-PA, that contain statistics to allow the assessment of quality

parameters, accessibility, productivity, and cost effectiveness. The reports will include the following statistics:

- Consumer volume by county;
- Consumer volume per age, gender, race, diagnosis;
- Volume by level of care; and
- Annual Percent Change

In 2009, Blended Case Management (BCM) and Community Treatment Team (CTT) utilization will be targeted for quarterly monitoring and trending.

As a result of utilization trends based on paid claims, chart audits were initiated in 2008 to address the increase in Blended Case Management utilization. Deficiencies were identified resulting in the elimination of the auto-pay process for some providers/counties. A prior authorization process will be put in place in 2009 to allow the clinical department to more closely monitor effectiveness of services.

A VBH-PA Work group, which will include BCM network providers, will develop best practice protocols for this level of care with the intention of disseminating to the network and auditing for compliance.

CTT will be monitored as a separate level of care in order to determine if it is impacting the increased outpatient utilization.

4. Facility Management

In 2009, VBH-PA will continue the Facility Management program for two Acute Inpatient hospitals. Each hospital will receive reporting information used to establish specific benchmarks. VBH-PA will monitor each facility weekly with length of stay and readmission rate comparisons against themselves and to the entire VBH-PA network. VBH-PA will meet with the providers monthly. The Facility Management team will attempt to expand the program to two additional facilities in 2009.

The Facility Management team hopes to expand the program for the Drug and Alcohol Facilities during 2009. Presently, we have targeted two medically monitored short-term residential (3B) facilities and five Inpatient 3A Acute Detox facilities.

5. Detox Outlier Management

Expand the 3A Detox facility management program to include two additional facilities. Implement an additional pilot for 3B non-hospital medically monitored drug and alcohol rehab for facilities currently enrolled in the 3A Detox project.

6. Appropriateness of Service Authorizations

The Greene County standards for appropriateness of authorizations are described in the VBH-PA Clinical Policy and Procedure Manual, in the Clinical Certification Guidelines

Policy and Procedure. The Quality Management Committee will monitor the appropriateness of authorizations through quarterly concurrent and retrospective Care Connect audits of a representative sample of mental health and drug and alcohol inpatient, drug and alcohol rehab, BHRS, and RTF are examined for appropriateness of care and compliance with program specifications. The audits will be conducted under the supervision of the VBH-PA Clinical Director, the Manager of Adult Services and Manager of Child, Adult and Family Service and/or designees. New chart audit indicators will be developed in May 2009, and the audit process will begin in July 2009. Quarterly reporting will begin in fourth quarter 2009.

These reports will be provided to the Quality Management Committee each quarter by the VBH-PA Clinical Director.

7. Complaint Tracking Process

The Greene County standards for processing complaints and grievances are described in the VBH-PA Member and Provider Services Policy and Procedure Manual, in the Complaint and Grievance Policy and Procedure, and in the Clinical Policy and Procedures Manual, in the Non-Certification Policy and Procedure and in the Level I and Level II Complaint and Grievance Policy and Procedure. The procedures for monitoring the processing of complaints are described below.

All complaints will be entered, routed, monitored, and reported from VBH-PA's internal system. They are assigned a tracking number that is used to identify the complaint in the database. The complaints are concurrently entered into an inquiry-tracking module. The complaint process is monitored daily by the Complaint Quality Analysts. Internal staff training is conducted by the Complaint Quality Analysts.

In addition, VBH-PA prepares quarterly reports for the QMC showing:

- The number of complaints received, by type.
- The number of complaints resolved.
- The number of complaints processed within the required timelines.
- The number of complaints by level of care.
- Complaint letters processed within the required timelines.

8. Peer Review and Grievance Tracking Process

All peer review and grievance activity will be entered, monitored and reported from VBH-PA internal system. These processes are coordinated daily by the Peer Advisor Coordinator and the Grievance Coordinator to assure accordance with timeliness guidelines. VBH-PA will prepare a quarterly report identifying peer review and grievance activities as listed below:

- The number of certifications and non-certifications by county.

- The total number of reviews by mental health or substance abuse.
- The number of reviews by level of care for each county.
- The number of reviews processed within the required time frames.
- The number of grievances received, resolved and processed within the required timelines.
- The number of DPW Fair Hearing requests.

9. Inter-rater Reliability

One element of the VBH-PA Quality Management program is to be able to demonstrate to members and stakeholders that utilization management decisions are made in a fair, impartial, and consistent manner so that the best interest of the members is served. VBH-PA has adopted policies and procedures as well as Medical Necessity Criteria that is based on scientific evidence and stakeholder input. VBH-PA will be appraising the consistency with which all staff that make clinical decisions apply these guidelines and criteria through Inter-Rater Reliability studies.

10. C/FST Data

The QMC will monitor the monthly CFST reports to identify any areas for improvement based on any low rates of satisfaction with VBH-PA services. Report quarterly.

11. Timeliness of Referrals

VBH-PA will report on timeliness of referrals monthly. Report quarterly.

E. Evaluation of the Quality and Performance of the Provider Network

1. Provider Profiling

VBH-PA will use a comprehensive provider profiling system to focus on the assessment of health care delivery and patterns and trends in care, rather than on individual occurrences of care. The provider profiling system serves as a quality management tool designed to support administrative and clinical processes. When the data indicate that structures, processes or outcomes have fallen outside an acceptable threshold, the appropriate responsible resources are identified and a corrective action plan is developed. The VBH-PA Provider Profiling Advisory Committee develops and oversees implementation of the corrective action plans, and monitors performance standards in order to determine if and when improvement is achieved.

The VBH-PA Provider Profiling Advisory Committee is comprised of representatives from Senior Management, Networks, Clinical, and Quality Management Departments. The VBH-PA Provider Profiling Advisory Committee meets to review outlier data based on indicators that are one or more standard deviations from the mean. If warranted, action plans are developed and progress toward resolution is monitored.

All reports will be submitted to the VBH-PA CEO, the county administrators, and the Pennsylvania Department of Public Welfare, as a means of monitoring progress. Additionally, report cards are disseminated to the appropriate network providers. Provider profiling information will be reported on the following levels of care for 2008/2009, subsequent to claims lag:

- RTF
- BHRS
- Mental Health Outpatient
- Family Based Mental Health Services
- Inpatient Mental Health

2. Coordination with Other Service Agencies and Schools

Appropriate and timely coordination of services among Behavioral Health Institutions, practitioners, ancillary providers, consultants, outpatient behavioral health practitioners or EAP/Employer if indicated, and schools enhances the likelihood of successful treatment outcomes for consumers. Communication among these entities allows for appropriate and timely interventions on the part of the responsible agency, resolution of problems during the early phases of treatment, and adequate discharge planning. It is the combination of these factors, added to the treatment services provided by the clinician and the active participation of the consumer that allow for successful resolution of the issues related to the consumer's care needs.

VBH-PA monitors the coordination of services through the provider treatment record review process.

3. *Network Management*

The Greene County HealthChoices Program standards for assuring that the provider network offers the full array of services to consumers are presented in the VBH-PA Clinical Policy and Procedure Manual, in the Geographic Guidelines Policy and Procedure. The procedures for monitoring provider network capacity are described below.

The VBH-PA Director of Member/Provider Network or his/her designee will present a written quarterly report to the Quality Management Committee, indicating:

- The network provider capacity report.
- Changes in the provider network including new provider and provider implementations.
- New program implementations.
- Prevention Education and Outreach (PE&O) Activities Report.
- Authorized out-of-network and out-of-area providers.
- Exception report (GeoAccess)

PE&O Staff will present a verbal report semi-annually on activities.

4. *Quality of Service Management Planning by Providers*

The Greene County standards and procedures for service management planning are described in the VBH-PA Clinical Policy and Procedure Manual, in the Clinical Documentation Policy and Procedure. The procedures for monitoring service management planning are described below.

In 2009 the Quality Management Department will randomly select a representative sample of clinical records from the high volume providers for BHRS, FBMHS, and Methadone. The following activities will be targeted:

- Utilize the newly formed RTF Summits to develop revised RTF Best Practice standards. Utilize internal Quality workgroup with Clinical input to revise the RTF data collection instrument to reflect updated standards. The tool will require validation and testing by the Clinical Department. Upon validation, a database will be designed by the IS Department to collect the data before implementation and audits can proceed.
- Target BHRS, FBMHS, and Methadone providers for 2009.
- FBMHS audits will begin in 2009.
- Subsequent to targeted level of care audits, QM will produce the statistical analysis and report.

- The Clinical Department and county partners will perform the methadone maintenance chart audit. Quality Management will produce the statistical analysis and report.
- COD Baseline Audit. In 2009, a co-occurring disorder indicator chart audit will be conducted on high volume MH/D&A providers to determine that documentation of a formal assessment process for both substance use and mental health issues occurs. A pre-existing chart audit checklist from OMHSAS will be utilized which addresses the various criteria for the baseline data collection.

VBH-PA completes the audits using the VBH-PA Clinical Record Audit Form, and prepares detailed written reports for the providers, requesting action plans when standards are not met. Providers overall scores are ranked as follows:

- 85% to 100% - VBH-PA standards met
- 76% to 84% - weaknesses identified
- 65% to 75% - follow up review will be conducted in six months
- 64% or less - audit results will be reviewed by the VBH-PA Quality of Care Committee (QOCC) for development of an action plan

VBH-PA will prepare summary reports for the Quality Management Committee as each level of care is completed and present the summary reports at the Quality Management Committee meetings.

Also included in the provider chart audit process is measuring provider compliance with treatment guidelines for ADHD, Major Depression, Bipolar Disorder and Schizophrenia. Scores for treatment guidelines are included in the report card sent to providers and monitored in aggregate for needed performance improvement plans.

5. *CCASBE-LD Performance Based Contracting Monitoring Process*

VBH-PA in attempt to ensure a comprehensive assessment for all HealthChoices children and adolescents will continue the CCASBE-LD monitoring process in 2009.

6. *Provider Satisfaction Survey Data*

Provider Satisfaction survey data is reviewed annually in order to compare year to year data to identify areas that have improved and any areas that may require a new action plans.

7. *C/FST Data*

The C/FST survey data is reviewed quarterly by the Quality Management Committee. The C/FST or County send a report card to the provider requesting a response for the items that fell below the 85% standard. Provider responses will be reported to the QMC

on a quarterly basis. Provider responses are monitored for comprehensiveness and appropriateness. Data are included in the provider profiles.

8. *Appointment Access Tracking*

A report is provided that measures the time between a member's phone call to the provider and the first offered appointment. These data will be collected through a chart review process.

9. *Telepsychiatry – Greene County*

VBH-PA will monitor and measure outcomes for the Telepsychiatry program in Greene County in an effort to reduce access to care barriers for rural consumers. Medication management of children who have been identified by their psychiatrist as stable and requiring routine follow up med checks will be able to access this service from their school. Parents will come to the school instead of traveling to the clinic. Every fourth visit will require them to return to the clinic for a face to face evaluation. Clinical staff from the school based mental health program offered by Centerville Clinics Incorporated will be available at school sites as needed while the psychiatrist remains at the clinic.

10. *Increase the number of COD competent providers in the VBH-PA Provider Network*

VBH-PA is in discussion with WPIC to coordinate the required training modules needed to become COD competent. We are considering offering video training across the 14 counties.

11. *Southwest Regional Medical Center - Hospital Networking*

The VBH-PA, and Greene County Human Services began monthly meeting in 2008 with Southwest Regional Medical Center for the purpose of exploring ways in which the hospital can become a more active partner in local behavioral health services. These meetings will continue in 2009. As a result:

- Behavioral Health Director will join QMC in 2009
- The Structured Outpatient Supervisor will join the Greene County Co-occurring Council
- The Structured Outpatient Program will be sending their primary therapist to the Drop In Center quarterly to engage the consumers in group discussions
- A COD pilot study is being explored

F. Reporting of Suspected/Substantiated Fraud and Abuse

The Greene County policy and procedures for reporting of fraud and abuse are contained in the Information Systems Policies and Procedures and in the Claims Fraud Policy and Procedures. The policy and procedures incorporate the following items:

- Definitions for fraud and abuse.
- Accountable staff/function.
- Reporting requirements for staff and providers.
- Time frames.
- Integration with QM.

Internal staff training is conducted annually by the Fraud & Abuse Coordinator and interface with the Bureau of Program Integrity (BPI) is utilized as warranted.

VBH-PA will prepare a written report quarterly, and will present the report to the QMC. The report will include the following items:

- All allegations of fraud and/or abuse, by type of event, sanitized to protect confidentiality.
- All substantiated instances of fraud and abuse.
- Analysis of any trends/patterns.

The QMC will take appropriate corrective actions whenever substandard care and services, or opportunities to improve care and services, are identified. When the data indicate that structures, processes or outcomes have fallen outside an acceptable threshold, the appropriate responsible resources are identified and a corrective action plan is developed and submitted to the QMC. The QMC will oversee implementation of the corrective action plans, and will continually monitor performance standards in order to determine if and when improvement is achieved.

G. Clinical Records Content, Retention and Storage

The Greene County policies and procedures for clinical records content, retention and storage are contained in the VBH-PA Clinical Policy and Procedure Manual, in the Confidentiality Policy and Procedure. Additionally, VBH-PA will adhere to the detailed policies and procedures required for HIPAA Compliance unless the PA Preemptive Analysis indicates otherwise. VBH-PA will take the following physical and procedural steps to ensure the confidentiality of consumer records:

Physical Security. The following procedures will be required:

- VBH-PA stores all clinical history information in secured files 24 hours per day, seven days per week, with limited access.
- VBH-PA staff will not discuss member's personal healthcare information with unauthorized personnel.
- All claims are stored in files with limited access 24 hours per day, seven days per week. The claims processing system also incorporates additional security access codes to protect the confidentiality of claimants.
- VBH-PA staff with access to on-line data has production passwords with access limited only to that data needed to complete their duties.

Information Systems Security. In addition to the physical security of the building and areas in which medical records and documents are kept, VBH-PA emphasizes the ability to protect the confidentiality and integrity of the data maintained within the systems. VBH-PA will ensure the integrity and confidentiality of all data in accordance with Commonwealth and federal laws and regulations including HIPAA. VBH-PA has built protective measures into our MIS system, including physical controls, data segregation, and password protection. These protective measures are detailed below.

In VBH-PA's computer systems, three levels of access are assigned at the terminal level:

- Security access via the local area network (facilities in Novell Network operating system).
- If access is via dial/up, we use system assigned, encrypted passwords verified in each use by our MCI internal network. In addition, dial/up connections are terminated if there is no activity from the user during a 30-minute period.
- Security access direct to the mainframe system (UNIX and OS/400 level security).

Each individual has a log-on and confidential password for each level of access. All passwords are protected (i.e., do not appear on the screen). The system security can limit access based upon the terminal or workstation location. For example, the system administrator's log-on and password can only be executed from specific terminals defined by the system administrator. The system security also has the ability to limit access to individual users based upon their region or location. Access can be limited at an individual level as well as a group level. Multiple users for example, may belong to a group profile that then may be used to limit access for a specific region or location.

VBH-PA automatically terminates system access to anyone with a log-on that has not been utilized for 45 days. The system currently prompts users to change passwords every eight weeks. If there are any unauthorized attempts to access the system, these are recorded and followed up on immediately. The system administrator is alerted by the system of the location of an unsuccessful log-on. This could be an attempt to log-on using a valid log-on ID or an invalid ID. The system administrator will make this determination and take appropriate action. The system also has a "time-out" feature that will automatically sign-off a terminal or workstation if unattended for defined period of time.

System security as well as application security can limit individual user access to specific screens, functions, and fields within a screen. System and application security (which incorporates individual staff's ability to access specific screens) combined also provides protection against access of confidential data through unauthorized use of system report writers and other system utilities that can access the system database.

Staff Training. All staff are required to take HIPAA Confidentiality Training upon initiation of employment. All VBH-PA are required annual confidentiality statements. Staff training on confidentiality matters and HIPAA requirements occurs annually as well as on an as-needed basis.

External Provider Review. Provider confidentiality protocols, as well as documentation standards are monitored through an environmental site visit, recertification, and chart auditing process. Providers are given a report of findings and a corrective action plan is requested if standards are not met. These data will be reported to the QMC in an aggregate format and blinded for provider confidentiality.

The QMC will take appropriate corrective actions whenever substandard care and services, or opportunities to improve care and services, are identified. When the data indicate that structures, processes or outcomes have fallen outside an acceptable threshold, the appropriate responsible resources are identified and a corrective action plan is developed and submitted to the QMC. The QMC will oversee implementation of the corrective action plans, and will continually monitor performance standards in order to determine if and when improvement is achieved.

H. Assessment of Member Satisfaction

In order to determine whether behavioral health services are meeting the needs and expectations of consumers, family members including parents of children and adolescents, and persons in recovery, VBH-PA has established systems and procedures to routinely assess member and family satisfaction. These systems and procedures include the use of consumer/family satisfaction team (CFST) data as well as an annual telephonic survey of member/family satisfaction. Findings and resulting recommendations from the survey and C/FST activities are to be incorporated into the ongoing quality management and improvement program.

Members' Rights and Responsibilities

It is the philosophy of VBH-PA that our members are treated in a manner that respects their rights and cultural diversity. VBH-PA informs members of their rights and responsibilities through a member handbook, as well as through other means. Policy information regarding member rights and responsibilities is also provided to new employees during orientation

1. Consumer/Family Satisfaction Team (C/FST) Program

The purpose of the Consumer/Family Satisfaction Team program is to determine whether consumers and family members are satisfied with services, and to help ensure that problems related to service access, delivery and outcome are identified and resolved in a timely manner. This is primarily accomplished by gathering information through face-to-face discussions with consumers, parents of children and adolescents, families, and persons in recovery, with follow-up reports provided to VBH-PA, the counties, and feedback to providers.

The C/FST will have the following areas of observation and discussion with consumers, parents of children and adolescents, family members and persons in recovery:

- Involvement in treatment decisions.
- Choice of providers.
- Family involvement in treatment.
- Knowledge of benefits, treatment options.
- Awareness of the complaint and grievance process (and satisfaction with outcome if processes were used).
- Perception of accessibility and acceptability of services (i.e., geographic, language/culture).
- Perception of effectiveness/outcomes of treatment.
- Satisfaction with timeliness and convenience of the service delivery system.
- Knowledge of and satisfaction with member services.
- Satisfaction with dignity, respect, and hopefulness offered during treatment.
- Overall satisfaction with services.
- Satisfaction with comfort level of facility where services are provided.
- Freedom from sense of coercion or fear of retribution.
- Satisfaction with physical health care services

The C/FST program will meet the following minimum requirements:

- C/FST members must include consumers of mental health services, family members including parents of children and adolescents, and persons in recovery.
- C/FST members must ensure an environment in which consumers, parents of children and adolescents, family members and persons in recovery feel free to express any concerns.
- Interaction between C/FST members and consumer/family members for the purpose of assessing consumer/family satisfaction must be primarily face to face.
- C/FST members must be paid at least as much as other persons in the general workforce doing similar work in the same community.
- The C/FST program must be independent of any service provider or any other agency that might create a conflict of interest.
- The C/FST program must have a Director.
- The C/FST program must report problems identified to the Greene County HealthChoices Program.
- The C/FST will have the delegated authority to collect and disseminate the needed information.

In order to participate as a member of the C/FST, individuals must have a basic knowledge of mental illness and addictive diseases, including emotional, behavioral and substance abuse disorders of children and adolescents. C/FST members must also have an understanding of the cultural diversity of the community being served in order to ensure culturally sensitive interactions. VBH-PA will provide a minimum of two hours of orientation and training on Program operations, policies and procedures to C/FST members annually.

All Greene County HealthChoices Program service providers will be required to cooperate with the C/FST and its activities, and will be expected to give access to, and to provide interview space for, DPW approved consumer satisfaction activities.

2. *Annual Survey of Member Satisfaction*

The purpose of the Member Satisfaction Survey is to determine the extent to which the Greene County HealthChoices Program membership is satisfied with overall Program operations and services, and to identify areas, which need improvement. The intent of the survey will be to determine whether the membership is knowledgeable about, and satisfied with, the behavioral health program, including core functions such as member services, as well as to assess whether service availability, service access, and services provision and effectiveness are meeting the membership's needs and expectations.

The survey will be conducted at least annually. The survey is telephonic and the calls are made to a representative sample of the Greene County HealthChoices Program total membership, with a sampling of members in the priority population groups as well as a sampling of members who filed complaints and grievances. The satisfaction survey information received from consumers and their families will be aggregated by FactFinders, the *ValueOptions* survey vendor, who will conduct the data analyses. To effectively report findings related to administrative and clinical system performance, FactFinders uses statistical methods that are used by operations research and health/social science research.

I. Preventative Behavioral Health Services

The VBH-PA Prevention Specialist will work to coordinate and develop the preventative health programs. The Prevention Specialist will monitor and evaluate the programs through data collection and analysis, as well as act as a consultant to our provider partners. Program information will be distributed to the member population and the provider network.

The PE&O Manager participates in the monthly PE&O/Consumer Affairs/Recovery & Resiliency Conference Call for the Public Sector Division of ValueOptions, for the purpose of ongoing dialogue and sharing of resources to move the Recovery Model forward across all services.

1. In 2008, an exploratory study examined the relationship between adverse incidents reporting suicidality and effective use of mental health services. The results indicated many consumers who reported suicide attempts have had mental health services within 7 days prior, and more than half of SMI consumers in focus groups indicated that they would not tell their therapist if they were feeling suicidal. All high volume providers were sent: the study results, pain and intent scale, best practice guidelines, and a crisis prevention planning template. Re-measurement was conducted and quality improvements reported to QMC's. In 2009, an internal multi-department meeting will explore the idea of conducting forums or focus groups to review the study's findings, subsequent improvement initiative, and additional assessment resources to further

remove barriers to both consumers and therapists in maximizing the therapeutic interventions to suicidality.

2. A Second Generation Atypical antipsychotic medication study was begun in 2006 and re-measured in 2007 and 2008. Literature supports that weight gain associated with atypical anti-psychotic medications, can cause metabolic syndrome, placing a person at risk of obesity, high cholesterol, high blood pressure and elevated fasting glucose, all of which increase the likelihood of diabetes and cardiovascular disease. A follow-up chart audit was performed to track the rate at which outpatient providers monitored consumers taking these medications for risk factors. The percent of providers monitoring various risk factors improved. Providers received their results along with the study aggregate analysis and recommendations for continued improvement. A third re-measurement will be conducted in 2009 to see if measurable improvement continues in the 12 large volume outpatient providers serving the original nine counties. In addition, a new indicator will be added to the audit to determine if referrals to supportive treatment or wellness programs, aimed at preventing or managing the symptoms of metabolic syndrome, are being made by prescribers.
3. A pilot program will be developed with Gateway Health Plan to support SPMI consumers and help them move into recovery. Gateway Health can be utilized as a vendor for resource coordination and case management targeting persons prescribed anti-psychotic medications, with the goal of helping individuals improve their medication management skills and maximize the benefits of this level of care.

Quarterly updates will be reported to the QMC when available. The QMC will take appropriate corrective actions whenever substandard care and services, or opportunities to improve care and services, are identified. When the data indicate that structures, processes or outcomes have fallen outside an acceptable threshold, the appropriate responsible resources are identified and a corrective action plan is developed and submitted to the QMC. The QMC will oversee implementation of the corrective action plans, and will continually monitor performance standards in order to determine if and when improvement is achieved.

J. Clinical Advisory Committee (CAC) and Workgroups

Utilization issues are discussed at the CAC Workgroups. Workgroups are comprised of county stakeholders, consumers/family members, providers and VBH-PA staff. The CAC serves as the primary forum for discussion and problem solving related to any pertinent aspect of the service center clinical operations including the development and revision of medical necessity criteria, recommendations for best practice guidelines and the development of clinical studies.

K. Quality Improvement Initiatives for the Greene County

Outcomes for Telepsychiatry. VBH-PA will monitor and measure outcomes for the Telepsychiatry program in Greene County in an effort to reduce access to care barriers for rural consumers. Medication management of children who have been identified by their

psychiatrist as stable and requiring routine follow up med checks will be able to access this service from their school. Parents will come to the school instead of traveling to the clinic. Every fourth visit will require them to return to the clinic for a face to face evaluation. Clinical staff from the school based mental health program offered by Centerville Clinics Incorporated will be available at school sites as needed while the psychiatrist remains at the clinic.

Psychiatric Rehabilitation. Psychiatric Rehabilitation site based program will be implemented in Greene County January 2009. The program will operate according to the Boston University Model and evidenced based practices. Outcomes data will be collected based upon the published Readiness Assessment Tool and subsequent Role Recovery Goals. A report will be produced annually.

ROSI Administrative Indicators. VBH-PA will collaborate with Greene County and the ROSI Review Panel in establishing the Administrative Data Profile based upon six indicators identified by OMHSAS from the Recovery Oriented Systems Indicators. One indicator will be identified for a quality improvement initiative.

Service Enhancements. In 2008 the continuum of care was expanded to include Community Treatment Teams using Telepsychiatry, Mobile Outpatient Services, Peer Support Services, an Enhanced Personal Care Home, Donor Crisis Stabilization Unit, and a new County Hospital/Community Liaison whose primary function is to support and track mental health diversion consumers. VBH-PA will monitor for a decrease in Inpatient hospital utilization and an improvement in the follow-up after discharge rate (IPRO).

Recovery Readiness. A training intervention will be developed jointly with Greene County Human Services and CRCSI in response to the baseline measure of the Recovery Knowledge Survey data from providers in 2008. A re-measure will be conducted.

Co-Occurring Disorder (COD) Pilot. The COD pilot project was designed to provide D&A assessment and intervention while the member is on the inpatient MH unit to assist in engaging the member in treatment and to assure linkage to outpatient D&A treatment following discharge. Greene County is interested in this pilot project for 2009. A pilot study will be explored with Southwest Regional Medical Center, Greene County Human Service D&A Assessment Unit, and The CARE Center.

VIII. CONFIDENTIALITY

All documentation that is created as a result of the VBH-PA Quality Management Program is confidential, and will be maintained in compliance with applicable legal requirements and Greene County HealthChoices Program policies and procedures pertaining to confidentiality. Such documentation includes, but is not limited to, QMC minutes, quality management data and reports, records of clinical care and services, and administrative records and reports. All participants in QMC meetings, including both QMC members and guests, will sign a statement attesting to the foregoing.

VBH-PA recognizes the need for the careful handling of all clinical and claims information, particularly as it relates to behavioral health treatment. Consequently, we will follow and clearly communicate strict confidentiality guidelines designed by the Commonwealth as well as federal guidelines where applicable. VBH-PA will take the lead in implementing confidentiality procedures for the HealthChoices Program. These confidentiality policies will comply with Federal and Pennsylvania drug and alcohol confidentiality requirements.

VBH-PA recognizes that Pennsylvania State regulations governing the confidentiality of Drug and Alcohol Abuse Patients Records and HIV Related Information are unique to Pennsylvania. Specifically, drug and alcohol patient records are protected by federal law and Pennsylvania State Law P.S. 1690.108 (Act 63) and Pennsylvania State Regulation 28 Pa. Code Subsection 709.28 and 4 Pa. Code Subsection 255.5. In particular, VBH-PA is committed to compliance with the Pa. Code Subsection 255.5 in requests for information from providers of drug and alcohol treatment services. All records kept by VBH-PA will be kept in strict compliance with the Confidentiality HIV Related Information Act 148 of 1990.

Conflict of Interest

No person may participate in the review and evaluation of any case or clinical activities in which he or she has been professionally involved or where judgment may be compromised. Utilization Management decision making is based solely on the clinical appropriateness of the care and services needed. *ValueOptions* does not incentivize individuals engaged in utilization review for issuing denials of coverage or service, or for rendering decisions that result in underutilization. Psychiatrists, psychologists and other mental health professionals who carry out care management or peer review activity must be free from conflict of interest when reviewing the work of providers. Among other things, this means that clinical staff, including peer reviewers, must not review the work of any health care facility or entity where they have active staff privileges and treat patients or from which they derive any income

IX. EVALUATION AND UPDATE PROCESS

The VBH-PA Quality Management/Utilization Management Work Plan is continuously evaluated, in order to determine the overall effectiveness of the Quality Management Program. The evaluation will result in an annual written report which includes: a description of completed and ongoing Quality Management/Utilization Management activities; trending of measures to

assess performance in the quality of clinical care and the quality of service; an analysis of whether there have been demonstrated improvements in the quality of clinical care and the quality of service; and, an evaluation of the overall effectiveness of the Quality Management Program. The results of the VBH-PA Quality Management/Utilization Management Program Annual Evaluation are reported to the counties, VBH-PA's CEO and the Pennsylvania Department of Public Welfare, as a means of monitoring progress.

X. PEPS REQUIRED QUARTERLY REPORTING (QM HIGHLIGHTS)

QM will supply required quarterly summary report of key areas reviewed at QMC per specifications of the quarterly summary QM highlights sample report (Attachment S).

Reports for Value Behavioral Health of Pennsylvania Quality Management/Utilization Management Work Plan - 2009

Activity	Data Source	Report #	Aspect of Care/Service	Scope	Frequency	Performance Goal	Sample Size	Responsibility
Risk Management	DW	1	High Volume Services and Treatment. <i>Objective 2.1</i>	<ul style="list-style-type: none"> ➤ Top 3 levels of care by county, cost and number of distinct members. ➤ Daily census reports by adult/child by level of care (<i>Objective 2.2</i>) 	Monthly; report monthly (new counties) and quarterly (seasoned counties) Daily	Monitor for trends Meet annual CRCS targets	100% of cases	VBH-PA QM Department and Clinical Department
	DW	2	High Risk Members and Treatment. <i>Objective 2.3</i>	Service utilization by criteria category of individual high-risk members by category: <ul style="list-style-type: none"> ➤ MISA SPMI, MH/MR and Medically Complex. ➤ Utilization will be measured before, during and after. ➤ Fayette high utilizer reports 	Annual Quarterly	Manage clients to utilize the least restrictive level of care appropriate	100% of members enrolled in CCM for 1 yr.	VBH-PA QM Department and Clinical Department

Activity	Data Source	Report #	Aspect of Care/Service	Scope	Frequency	Performance Goal	Sample Size	Responsibility
	DW	3	BHR Services <i>Objective 2.4</i>	Service utilization by: <ul style="list-style-type: none"> ➤ Distinct Members by County ➤ Paid units and average units per member ➤ ASD Distinct Members ➤ Strength Based Utilization ➤ DM/1,000 BHRS vs. Child Community Services and waived services Associated Projects: <ul style="list-style-type: none"> ➤ BHRS Regional Summits – develop QI strategy targeting disengagement and therapeutic discharge (<i>Objective 2.6</i>) ➤ BHRS Advisory Board ➤ BHRS Autism Advisory Board ➤ Implement BAS plan for credentialing providers to perform Functional Behavioral Assessments (<i>Objective 2.7</i>) ➤ Implement ExACT process (upon DPW approval) (<i>Objective 2.8</i>) ➤ Implement Independent Prescriber Model (Butler and Lawrence counties) (<i>Objective 2.5</i>) ➤ Continue monitoring performance measures for Independent Prescriber Model (NWBHP) (<i>Objective 2.5</i>) ➤ Monitor CCASBE-LD Performance Based Contracted providers ➤ In NWBHP counties, CCASBE-LD monitoring to be an indicator in IP report cards 	Monthly; report monthly (new counties) and quarterly (seasoned counties) Quarterly Ongoing	Improve the quality of BHR services	100% of cases Selected populations	VBH-PA QM Department VBH-PA QM Department and Clinical Department
	Internal	4	Quality of Care <i>Objective 2.9</i>	The number of cases reviewed by the QOCC, based on the types of issues reviewed, and by provider and type of action taken.	Quarterly	Providers will comply with committee recommendations.	100% of cases	VBH-PA QM Department

Activity	Data Source	Report #	Aspect of Care/Service	Scope	Frequency	Performance Goal	Sample Size	Responsibility
	Internal	5	Critical Incidents <i>Objective 2.10</i>	<ul style="list-style-type: none"> ➤ Frequency and type of critical incidents by population category (e.g., age, gender, diagnosis, etc.). ➤ Frequency and type of critical incidents by service type. ➤ Frequency of mental health and drug and alcohol Early Discharges. ➤ Members for whom 4 or more incidents have been reported in past 6 months will be reviewed individually ➤ Provider trends (provider volume, type of incidents reported, DMs involved in multiple incidents) 	Quarterly	Monitor for trends Close all founded adverse incidents.	100% of critical incidents	VBH-PA QM Department
Coordination with Primary Health Care		6	Coordination and Interaction with PH-MCO's <i>Objectives 3.1 – 3.6</i>	<ul style="list-style-type: none"> ➤ Participate in Physical/Behavioral Health Joint Committee ➤ Review the C/FST question monthly regarding satisfaction with physical health care. ➤ Collaborate with DPW regarding statewide initiatives (Smoking Cessation, Domestic Violence) ➤ Provider Chart Audits to review PCP notification ➤ Coordinate individual cases between VBH-PA service managers and the PH-MCO Special Needs units. ➤ Collaborate with PH-MCO's on joint projects (Gateway – pharmacy; UPMC for You – maternal depression) 	Ongoing	To improve interactions between HMOs.		VBH-PA QM Department, Clinical Department, and Networks Department
Evaluation of Effectiveness of Services	DW	7	Authorization and Grievance Process <i>Objective 4.1</i>	<ul style="list-style-type: none"> ➤ Number of Peer Reviews, by county, service type (MH and DA), and level of care. ➤ Number of consumer grievances, by county, and level of care. ➤ Rate of resolution and compliance with turn around times for peer review, and grievances. ➤ Number of DPW Fair Hearings by county. 	Monthly; report monthly (new counties) and quarterly (seasoned counties)	Monitor for trends. Timeframes will be met 100% of the time per state law (Act 68) requirements	100% of cases	VBH-PA QM Department

Activity	Data Source	Report #	Aspect of Care/Service	Scope	Frequency	Performance Goal	Sample Size	Responsibility
	DW	8	Treatment Outcomes: Readmission Rates <i>Objective 4.3</i>	<ul style="list-style-type: none"> ➤ Readmission rates within an acute level of care during the following intervals: 0-7 days; 8-30 days; and within 90 days. ➤ Readmission data will be stratified by inpatient psychiatric, D&A Rehab and D&A Detox, and consumer demographics (i.e., age group, gender). ➤ Readmission rates will be normalized by members per 1000 by county. 	Monthly; report monthly (new counties) and quarterly (seasoned counties)	Performance goal is to improve to 13.5%. DPW Benchmark is 10%	100%	VBH-PA QM Department
	DW	9	Treatment Outcomes: QI Activity for Butler County Readmissions <i>Objective 4.3</i>	<ul style="list-style-type: none"> ➤ Review Butler County Readmission Study completed in 2008. ➤ Develop action plans as appropriate. 	2009	Per action plan	Butler County readmissions	VBH-PA QM Department; SW6 QMC
	DW	10	Treatment Outcomes: Follow-up after inpatient psychiatric stay (HEDIS) 7 day/30 day <i>Objective 4.4</i>	Methodology: HEDIS specifications for a follow-up rate of within 7 days of discharge and 30 days of discharge. <ul style="list-style-type: none"> ➤ P4P ➤ IPRO ➤ PBC 	Quarterly	DPW Gold Standard-90% HEDIS mean 32% Individual county performance goals per QIA	100% of members with a MH IP stay	VBH-PA QM Department
	DW	11	Service Quality Improvement Activity for D&A Access (Penetration) <i>Objective 4.5</i>	PIP developed to improve access (penetration) for youth under 21 years of age for D&A services	Quarterly-subsequent to receipt of OMHSAS specs	DPW Gold Standard 65% Individual by county per QIA	Youth <21	VBH-PA QM Department
	DW	12	Treatment Outcomes: 3B Readmissions <i>Objective 4.6</i>	Convene 3B Medically Monitored Short-term Residential Workgroup to develop best practice standards.	2009	Improve use of continuum of care	3B readmissions	VBH-PA Clinical Department and QM Department
	DW	13	Access to Services: Penetration Rates <i>Objective 4.7</i>	Penetration Rates based on enrollment figures and members currently receiving mental health and substance abuse services by county, age, gender, and race groups.	Annually	>= 10% MH >= 1.3% D&A	100% of cases	VBH-PA QM Department

Activity	Data Source	Report #	Aspect of Care/Service	Scope	Frequency	Performance Goal	Sample Size	Responsibility
	DW	14	Involuntary and Voluntary rates <i>Objective 4.8</i>	Mental health adult inpatient admissions rates for involuntary and voluntary commitment.	Monthly; report monthly (new counties) & quarterly (seasoned counties)	Monitor for trends; VBH-PA average for 2004: 80% voluntary, 20% involuntary	100%	VBH-PA QM Department
	C/FST data and annual member satisfaction survey	15	Member satisfaction with access to services <i>Objective 4.9</i>	<ul style="list-style-type: none"> ➤ Member satisfaction with timeliness of first appointment and availability of first appointment within 7 days ➤ Member satisfaction with convenience of provider location ➤ Member satisfaction with convenience of appointment times ➤ Member satisfaction with distance to provider 	C/FST data monitored monthly and quarterly Annual member satisfaction survey	85%	Random sample	VBH-PA QM Department and Clinical Department
	Annual Member Satisfaction Survey	16	Treatment Outcomes: Reduction of Symptoms <i>Objective 4.10</i>	Use of selected items from the SF-36 and the Symptom Distress Scale are recommended as the basis for measuring reduction in symptoms and improvement in health status. These items will be contained in the annual consumer satisfaction survey.	Annual	Satisfaction rate greater than or equal to 85%	Population based Sample	VBH-PA QM Clinical Department
	DW	17	Treatment Outcomes: Readmission Rates for SMI population in Westmoreland County <i>Objective 4.11</i>	<ul style="list-style-type: none"> ➤ Continue to monitor & report on readmission rate for SMI population quarterly (PBC) ➤ Continue to monitor & expand current PIP's. 	Quarterly & YTD Ongoing	Per PIP	100%	VBH-PA QM Department
	DW	18	Develop Children's Initiatives for the SW6 Counties <i>Objective 4.12</i>	<ul style="list-style-type: none"> ➤ Produce county specific utilization reports targeting child and adolescent utilization ➤ Distribute for review & discussion at SW6 Oversight Committee meetings ➤ Develop county specific initiatives based these reports 	2009	Develop reports	TBD	Tom Caringola and Laverne Cichon

Activity	Data Source	Report #	Aspect of Care/Service	Scope	Frequency	Performance Goal	Sample Size	Responsibility
	DW	22	Overall Utilization Patterns and Trends. <i>Objective 5.3</i>	<ul style="list-style-type: none"> ➤ Consumer utilization by county - specific trends ➤ Utilization by level of care ➤ Consumer utilization per age, gender, and diagnosis. ➤ Average length of treatment episode for inpatient and non-hospital detox and rehab. ➤ Target Blended Case Management and Community Treatment Teams for trends in utilization 	Quarterly Annual consumer utilization Quarterly	Outlier analysis ALOS 6 days	100% of cases	VBH-PA QM Department and Clinical Department
	Hybrid	23	Blended Case Management <i>Objective 5.4</i>	<ul style="list-style-type: none"> ➤ Develop UM strategies and process improvements ➤ Work group (VBH & BCM network providers) will develop best practice protocols ➤ Institute prior authorization process in 2009 to monitor effectiveness of services (clinical) 	Ongoing	Monitor the quality of Blended Case Management services	N/A	VBH-PA QM Department and Clinical Department
	DW	24	3A & 3B Outlier Management <i>Objective 5.5</i>	<ul style="list-style-type: none"> ➤ Expand 3A Detox facility management project ➤ Initiate 3B Short Term Residential Rehab facility management project 	2009	Per project requirements	N/A	Project Manager
	DW	25	Facility Management <i>Objective 5.6</i>	Expand Facility Management for Acute Inpatient level of care for selected hospitals.	Ongoing Report annually	Maintain projected average length of stay	All admissions to selected providers	VBH-PA Medical Director Clinical Department
	Internal Chart Audits	26	Appropriateness of Service Authorizations <i>Objective 5.7</i>	<ul style="list-style-type: none"> ➤ Develop data collection tools for internal CareConnect audits for MH & D&A inpatient, D&A rehab, BHRS, & RTF ➤ Determine indicators by May 2009 ➤ Begin auditing July 2009 	2009	85%	Random sample	VBH-PA Clinical Department and QM Department

Activity	Data Source	Report #	Aspect of Care/Service	Scope	Frequency	Performance Goal	Sample Size	Responsibility
	Access Database	27	Complaint Tracking <i>Objective 5.8</i>	<ul style="list-style-type: none"> ➤ The number of complaints received by issue type. ➤ The number of complaints resolved. ➤ The number of complaints processed within the required timelines. ➤ The number of complaints by level of care and category. 	Monthly; report monthly (new counties) & quarterly (seasoned counties)	Complaints will be processed within the required turn around time - <u>100%</u> of the time (per Act 68).	All Complaints	VBH-PA Clinical Department and QM Department
	DW/ Access Database	28	Peer Review and Grievance Tracking Process <i>Objective 5.9</i>	<ul style="list-style-type: none"> ➤ The number of peer reviews, the number of certifications and non-certifications by county and level of care ➤ The number of peer reviews by mental health or substance abuse issue type ➤ The number of grievance level I, II and DPW Fair Hearings by county. ➤ The number of peer reviews and grievances processed within the required time frames. 	Monthly; report monthly (new counties) & quarterly (seasoned counties)	Peer Reviews and grievances will be processed within the required turn around time – 100% of the time. (per Act 68)	All Peer Reviews and Grievances	VBH-PA Clinical Department
	Access Database	29	Inter-rater Reliability <i>Objective 5.11</i>	Inter-rater reliability study results will be reported for all staff making clinical decisions to monitor utilization management decisions.	Annual	80% of clinicians must achieve greater than 75%	All staff making clinical decisions	VBH-PA Clinical Department
	DW	30	Timeliness of referrals <i>Objective 5.12</i>	Monitor turnaround times for all callers requesting referrals	Monthly; report monthly (new counties) & quarterly (seasoned counties)	100%	N/A	VBH-PA QM Department
Evaluation of the Quality and Performance of the Provider Network	DW	31	Comprehensive Provider Profiling System <i>Objective 6.1</i>	Provider Profiling will be reported for: <ul style="list-style-type: none"> ➤ RTF ➤ BHRS ➤ Outpatient Mental Health ➤ Inpatient Mental Health ➤ Family Based Mental Health Services 	Annual	Provider Profiling Advisory Committee will develop actions plans based on outlier analysis.	High volume providers in each level of care	VBH-PA Clinical Department and QM Department

Activity	Data Source	Report #	Aspect of Care/Service	Scope	Frequency	Performance Goal	Sample Size	Responsibility
	Provider Chart Audits	32	Documentation of attempt to coordinate with other service agencies and schools <i>Objective 6.2</i>	Monitor question number 30 on provider chart audit tool.	Upon completion of each LOC	85% Compliance	Random Sample	VBH-PA QM, Member Provider Service and Clinical Departments
	Network	33	Network Management <i>Objective 6.3</i>	<ul style="list-style-type: none"> ➤ The provider capacity report. ➤ Changes in the provider network including new providers and programs. ➤ PE&O activities report. ➤ The availability and capacity of out-of-network and out-of-area providers. ➤ GeoAccess (Exception) Reports 	Quarterly	Monitor compliance per RFP	100%	VBH-PA Network Department
	Provider Chart Audits	34	Quality of Service: Audit compliance with Best Practice Standards <i>Objectives 6.4, 6.5 & 6.7</i>	1. Target the following levels of care: <ul style="list-style-type: none"> ➤ Methadone Maintenance ➤ BHRS ➤ Family-Based Mental Health Services ➤ COD baseline audit (<i>Objective 6.5</i>) 2. Associated activities: <ul style="list-style-type: none"> ➤ Develop further methadone strategies (SW6 only) 	2009	Overall score of 85%	Random sample	VBH-PA QM, Clinical Departments
	Provider chart audit tool	35	Compliance with practice guidelines <i>Objective 6.4</i>	<ul style="list-style-type: none"> ➤ ADHD ➤ MDD ➤ Bipolar ➤ Schizophrenia 	Upon completion of LOC per Chart audit	85%	Random sample	VBH-PA QM Department
	Provider Chart Audits	36	Co-occurring disorders <i>Objectives 6.5 & 6.6</i>	<ul style="list-style-type: none"> ➤ Audit MH and D&A providers for documentation of formal assessment for both substance abuse and mental health issues using OHMSAS checklist ➤ Increase the number of COD-competent providers in VBH-PA provider network by providing training by WPIC 	2009	Overall score of 85% TBD	Random sample TBD	VBH-PA QM, Clinical Departments
	Hybrid	37	Best Practice Standards – RTF <i>Objective 6.8</i>	<ul style="list-style-type: none"> ➤ Use RTF Summits to develop revised RTF Best Practice Standards ➤ Revise RTF data collection instrument to reflect new standards 	2009	N/A	N/A	VBH-PA QM, Clinical Departments

Activity	Data Source	Report #	Aspect of Care/Service	Scope	Frequency	Performance Goal	Sample Size	Responsibility
	Hybrid	38	Access to care barriers <i>Objective 6.9</i>	<p>GREENE COUNTY Continue to monitor Greene County's telepsychiatry program. Collect and report on outcome measures:</p> <ul style="list-style-type: none"> ➤ Compliance with scheduled appointments pre and post implementation of Telepsychiatry, ➤ Quality assurance monitoring through survey data collected from consumer, psychiatrist and school. <p>CAMBRIA COUNTY</p> <ul style="list-style-type: none"> ➤ Implement telepsychiatry program ➤ Develop outcome measures 	As scheduled by Centerville Clinics school based mental health program 2009	Improve communication with technical support TBD	100% Telepsych appointments TBD	VBH-PA QM Department VBH-PA QM Department, Cambria County
	Access Database	39	Comprehensiveness of evaluations (CCASBE-LD)	<p>Measurement of 4 domains:</p> <ul style="list-style-type: none"> ➤ Identifying Information ➤ Reason for Referral/Relevant Referral Information ➤ Results of Assessments ➤ Discussion/Dx./Recommendations ➤ Monitor through provider report card 	Annual	85%	Random	Network Department
Reporting of Fraud and Abuse	Access Database	40	Fraud and Abuse <i>Objective 7.1</i>	<ul style="list-style-type: none"> ➤ All allegations of fraud and/or abuse, by type of event, sanitized to protect confidentiality. ➤ All substantiated instances of fraud and abuse. ➤ Analysis of any trends and patterns 	Quarterly	Monitor for Trends	100% of all referred cases	Fraud and Abuse Coordinator

Activity	Data Source	Report #	Aspect of Care/Service	Scope	Frequency	Performance Goal	Sample Size	Responsibility
Assessment of member and provider satisfaction	C/FST Satisfaction Survey	41	Consumer/Family Satisfaction Teams <i>Objective 9.1</i>	Includes monthly analysis and reporting of data; quarterly reporting to DPW. Continue to work with counties and C/FSTs to bring provider feedback information into reporting.	Monthly	Overall satisfaction rate of 85%	Voluntary surveys	VBH-PA QM Department
	Annual Satisfaction Survey	42	Member Satisfaction <i>Objective 9.2</i>	<ul style="list-style-type: none"> ➤ Overall satisfaction with VBH-PA ➤ Provider ratings ➤ Access to care ➤ Outcomes of treatment ➤ Toll free number services (VBH-PA) ➤ Problem resolution ➤ Special Populations and grievances ➤ Accuracy of information received when calling VBH-PA ➤ Received all information needed on first call to VBH-PA 	Annually	Overall satisfaction rate of 85%.	Random sample and population based (those who filed a C or G, and special pops)	VBH-PA QM Department
	Annual Provider Satisfaction Survey	43	Provider Satisfaction	Areas scoring above 85% included: <ul style="list-style-type: none"> ▪ Overall satisfaction with VBH-PA ▪ Ease of the initial certification procedure ▪ Care Managers generally make coverage decisions that are appropriate ▪ Processing of credentialing application is completed in a timely manner ▪ VBH-PA pays claims accurately ▪ When calling about claims, it is easy to reach someone who can help you ▪ Peer advisor gave information about applicable criteria and reasons for decisions 	Annually	Overall satisfaction rate of 85%	Random sample	VBH-PA QM Department
Monitoring of Preventative Behavioral Health Programs	Hybrid	44	Understanding the Barriers to Utilizing Mental Health Treatment as Intervention in Suicidality (intervention stage) <i>Objective 10.1</i>	Convene internal multi-departmental meeting to explore idea of conducting forums or focus groups to review the study's findings, subsequent improvement initiative, and additional assessment resources to identify and remove barriers for consumers to engage in treatment to prevent suicide attempts.	2009	TBD	TBD	VBH-PA QM/ Prevention Specialist

Activity	Data Source	Report #	Aspect of Care/Service	Scope	Frequency	Performance Goal	Sample Size	Responsibility
	Chart Audit	45	Second Generation Atypical (SGA) Antipsychotic Study <i>Objective 10.2</i>	Seasoned counties: <ul style="list-style-type: none"> ➤ Implement improvement strategies ➤ Perform 3rd re-measurement ➤ Add new indicator, referrals to wellness supports, and collect baseline data New counties – baseline study	2009	Improvement over re-measurement (seasoned counties) Baseline (new counties)	Per original study design	VBH-PA QM Department, Prevention Specialist
	Hybrid	46	Pilot program with Lawrence County Drop-In Center <i>Objective 10.3</i>	<ul style="list-style-type: none"> ➤ Open dialogue with Lawrence County and its Drop in Center to collaborate on a program targeting support for SPMI consumers prescribed SGA medications. ➤ Incorporate education on metabolic syndrome and supportive strategies for preventing or managing the side effects caused by SGA medications. 	2009	TBD	TBD	VBH-PA QM Department, Prevention Specialist
	Hybrid	47	Pilot program with Gateway Health Plan <i>Objective 10.4</i>	<ul style="list-style-type: none"> ➤ A pilot program will be developed with Gateway Health Plan to improve adherence to medication management for SPMI consumers and to help them move into recovery. 	2009	TBD	TBD	VBH-PA QM Department, Prevention Specialist
Studies	Hybrid	48	RTF/Substance Abuse Collaborative (RSAC) pilot project outcomes	<ul style="list-style-type: none"> ➤ Analyze outcomes data for RSAC project to determine efficacy of the pilots. 	2009	Per study design	Per study design: 100% of members referred for D&A assessment	VBH-PA QM Department
	ROSI	49	Improving Recovery Environments in Partial Hospitalization	New counties: baseline study Seasoned counties: <ul style="list-style-type: none"> ➤ Target QIA's based on results of 2008 study. ➤ Peer specialists in partial programs to roll out Individual Crisis Prevention Plans/WREP plans. ➤ Re-measure to be completed 	2009	Per study design	Per original study design	VBH-PA QM Department
	RRI	50	Recovery Readiness for Behavioral Health Staff	<ul style="list-style-type: none"> ➤ Partner with one MH and one D&A provider in each county to measure a baseline for the Recovery Readiness Inventory (RRI) 	2009	TBD	TBD	VBH-PA QM Department, Prevention Specialist

Activity	Data Source	Report #	Aspect of Care/Service	Scope	Frequency	Performance Goal	Sample Size	Responsibility
	Pharmacy claims data	51	Improving the Quality of Prescribing Patterns	<ul style="list-style-type: none"> ➤ Complete a new baseline pharmacy data report using a full year's worth of pharmacy claims data (2008) for all 14 VBH-PA counties ➤ Request and examine medical records for members identified in the Pharmacy Data Baseline Follow-up Report as "questionable" cases ➤ Develop QIA's based on findings in new baseline report 	2009	Per study design	100% of pharmacy claims for psychotropic medications filled in 2008	VBH-PA QM Department
	Hybrid	52	Co-Occurring Disorders (COD) Pilot Project	<ul style="list-style-type: none"> ➤ SW6 – Begin dialogue with Southwood Hospital and D&A Services of the Care Center to implement COD project ➤ GREENE COUNTY – Begin dialogue with Greene County to gauge interest in implementing COD project 	2009	Per study design	Per study design	VBH-PA QM Department
	Hybrid	53	RTF Re-measurement Study	<ul style="list-style-type: none"> ➤ Improvement strategies will be developed upon receipt of IPRO RTF re-measurement study results (based on charts submitted to IPRO in 2008). 	2009	TBD	TBD	VBH-PA QM Department
	PEPS	54	PEPS Corrective Action Plans	<ul style="list-style-type: none"> ➤ Monitor PEPS corrective action plans 	2009	TBD	TBD	VBH-PA QM Department

Activity	Data Source	Report #	Aspect of Care/Service	Scope	Frequency	Performance Goal	Sample Size	Responsibility
COUNTY-SPECIFIC QUALITY IMPROVEMENT ACTIVITIES								
BEAVER COUNTY								
Individual QI Initiatives	Hybrid		Co-occurring disorders / CCISC Model <i>Objectives 13.1 – 13.5</i>	<ul style="list-style-type: none"> ➤ Advance the Comprehensive, Continuous, Integrated System of Care (CCISC) Model ➤ Review provider survey data (from HPW Associates) to determine providers' progress w/COD capability ➤ Increase number of consumer/family members on the CCISC Steering Committee ➤ Educate community organizations about CCISC ➤ CCISC Steering Committee to provide updates at each quarterly Beaver County QMC; QMC members to monitor progress & provide input 	2009 Quarterly	N/A	N/A	VBH-PA QM Department, Account Executive, CCISC Steering Committee, Beaver County QMC
CAMBRIA COUNTY								
Individual QI Initiatives	Hybrid		Access to care barriers <i>Objective 13.1</i>	<ul style="list-style-type: none"> ➤ Implement telepsychiatry program ➤ Develop outcome measures 	2009	TBD	TBD	VBH-PA QM Department, Cambria County
	Hybrid		Co-occurring disorders <i>Objective 13.2</i>	<ul style="list-style-type: none"> ➤ Implement COD pilot project with Conemaugh Hospital and New Visions ➤ Monitor outcome measures 	2009	Per study design	Per study design	VBH-PA QM Department, Cambria County
	Hybrid		Improving continuum of care <i>Objective 13.3</i>	<ul style="list-style-type: none"> ➤ If county receives approval from state to implement Assertive Community Treatment (ACT), VBH will work collaboratively with the county to collect and monitor outcomes. 	2009	TBD	TBD	VBH-PA QM Department, Cambria County
	Hybrid		Cambria County UM Continuum of Care Study <i>Objective 13.4</i>	<ul style="list-style-type: none"> ➤ Continue the UM Continuum of Care Study developed in 2008 to improve Cambria County's continuum of care. ➤ Target following levels of care: BHRS (incl. summer camp); RTF; & peer support services. 	2009	Decrease utilization of BHRS & RTF Increase availability &/or utilization of other LOC's and services	100% of cases	VBH-PA QM Department, Cambria County

Activity	Data Source	Report #	Aspect of Care/Service	Scope	Frequency	Performance Goal	Sample Size	Responsibility
ERIE COUNTY								
Individual QI Initiatives			BHRS <i>Objective 13.1</i>	➤ Implement Erie County local BHRS Summit group and work collaboratively with VBH-PA regional summits.	2009	N/A	N/A	VBH-PA QM Department, Erie County
	Erie County performance measures		BH-MCO performance measures <i>Objective 13.2</i>	➤ Develop QI strategies based on annual results of Erie County Performance Measures	2009	TBD	N/A	VBH-PA QM Department, Erie County
	ROQI		Residential Outcomes Quality Initiative <i>Objective 13.3</i>	➤ Develop QI strategies based on the results of the Residential Outcomes Quality Initiative (ROQI) project.	2009	TBD	TBD	VBH-PA QM Department, Erie County
	DW, Erie County data		TSS authorizations <i>Objective 13.4</i>	➤ Work collaboratively with Erie County to conduct a drill-down study to look at TSS authorizations vs. actual services delivered.	2009	TBD	TBD	VBH-PA QM Department, Erie County
FAYETTE COUNTY								
Individual QI Initiatives	Pharmacy claims data		SPMI Mobile Meds Pilot Project <i>Objective 13.1</i>	<ul style="list-style-type: none"> ➤ Implement a pilot project regarding the use of long-acting antipsychotics delivered by mobile outreach teams to treat SPMI population in Fayette County who are non-compliant on their oral medications. ➤ Use pharmacy claims data in pilot project. 	2009	TBD	TBD	VBH-PA QM Department, Medical Director, Fayette County
	DW		Utilization <i>Objective 13.2</i>	➤ Monitor utilization related to children in substitute care by analyzing utilization data and implementing QI strategies.	2009	TBD	100% of cases	VBH-PA QM Department, Fayette County

Activity	Data Source	Report #	Aspect of Care/Service	Scope	Frequency	Performance Goal	Sample Size	Responsibility
GREENE COUNTY								
Individual QI Initiatives	Hybrid		Access to care barriers <i>Objective 13.1</i>	Continue to monitor Greene County's telepsychiatry program. Collect and report on outcome measures: <ul style="list-style-type: none"> ➤ Compliance with scheduled appointments pre and post implementation of Telepsychiatry, ➤ Quality assurance monitoring through survey data collected from consumer, psychiatrist and school. 	As scheduled by Centerville Clinics school based mental health program	Improve communication with technical support	100% Telepsych appointments	VBH-PA QM Department, Greene County
	Readiness Assessment Tool		Psychiatric rehabilitation <i>Objective 13.2</i>	Establish outcome measures based on the Boston University Model for site-based Psychiatric Rehabilitation program	2009	Per model	Per model	VBH-PA QM Department, Greene County
	ROSI		Recovery <i>Objective 13.3</i>	Collaborate w/Greene County & ROSI Review Panel to develop QI initiative for identified ROSI Administrative Indicator	2009	TBD	TBD	VBH-PA QM Department, Greene County
	DW		Service enhancements <i>Objective 13.4</i>	Monitor outcomes for service enhancements: <ul style="list-style-type: none"> ➤ Decrease in MH inpatient utilization ➤ Improvement in FUH rate (IPRO) 	2009	Lower MH IP utilization Increased FUH rate	100% of cases	VBH-PA QM Department, Greene County
	Recovery Knowledge Survey		Recovery readiness <i>Objective 13.5</i>	Follow up intervention and re-measure of the Recovery Knowledge Survey with Greene County providers	2009	Per study design	Per study design	VBH-PA QM Department, Greene County
	Hybrid		Co-occurring disorders <i>Objective 13.6</i>	Begin dialogue with Greene County to gauge interest in implementing Co-Occurring Disorder (COD) pilot project	2009	Per study design	Per study design	VBH-PA QM Department, Greene County

Activity	Data Source	Report #	Aspect of Care/Service	Scope	Frequency	Performance Goal	Sample Size	Responsibility
NWBHP COUNTIES								
Risk Management	IP database; DW		BHRS <i>Objectives 2.5 & 2.7</i>	Associated Projects: <ul style="list-style-type: none"> ➤ Continue monitoring performance measures for Independent Prescriber Model (NWBHP) (<i>Objective 2.5</i>) ➤ In NWBHP counties, CCASBE-LD monitoring to be an indicator in IP report cards (<i>Objective 2.7</i>) 	Monthly & quarterly	Improve the quality of the IP model	100% of cases	VBH-PA QM Department and Clinical Department
	Hybrid		BHRS <i>Objective 2.6</i>	<ul style="list-style-type: none"> ➤ Monitor TSS school utilization subsequent to implementation of the School Wide BHRS Pilot Project in Crawford County. ➤ Develop consumer and school personnel satisfaction survey questions. 	Per pilot project	Reduce TSS utilization in schools	100% of cases	VBH-PA QM Department, NWBHP Counties
Individual QI Initiatives	Hybrid		PREP program <i>Objective 13.1</i>	Subsequent to approval of the PREP quality indicators, monitor data for outcomes and development of any quality improvement strategies.	2009	TBD by PREP CQI committee	TBD	VBH-PA QM Department, NWBHP Counties
	Hybrid		BHRS <i>Objective 13.2</i>	Monitor the indicators targeted in the BHRS work plan: <ul style="list-style-type: none"> ➤ Produce the IP report card for 2008 by the end of the 1st quarter 2009 ➤ Monitor CFST survey process for IP's to assure there is adequate data to add to provider report cards for 2009 ➤ Monitor the CCASBE auditing process to assure that there is adequate data to add to provider report cards for 2009 	2009	Per BHRS work plan	Per BHRS work plan	VBH-PA QM Department, NWBHP Counties
	DW		Utilization <i>Objective 13.3</i>	Collaborate with individual counties to develop quality improvement strategies for: <ul style="list-style-type: none"> ➤ Readmission rates ➤ Utilization patterns 	2009	TBD	100% of cases	VBH-PA QM Department, NWBHP Counties

Activity	Data Source	Report #	Aspect of Care/Service	Scope	Frequency	Performance Goal	Sample Size	Responsibility
SOUTHWEST SIX COUNTIES								
Evaluation of Effectiveness of Services	DW		Treatment Outcomes: Readmission Rates for SMI population in Westmoreland County <i>Objective 4.11</i>	<ul style="list-style-type: none"> ➤ Continue to monitor & report on readmission rate for SMI population quarterly (PBC) ➤ Continue to monitor & expand current PIP's. 	Quarterly & YTD Ongoing	Per PIP	100%	VBH-PA QM Department
			Develop Children's Initiatives for the SW6 Counties <i>Objective 4.12</i>	<ul style="list-style-type: none"> ➤ Produce county specific utilization reports targeting child and adolescent utilization ➤ Distribute for review & discussion at SW6 Oversight Committee meetings ➤ Develop county specific initiatives based these reports 	2009	Develop reports	TBD	Tom Caringola and Laverne Cichon
Evaluation of the Quality and Performance of the Provider Network	Provider Chart Audits		Quality of Service: Audit compliance with Best Practice Standards <i>Objective 6.7</i>	Associated activities: <ul style="list-style-type: none"> ➤ Develop further methadone strategies based on methadone chart audits (SW6) 	2009	Overall score of 85%	Random sample	VBH-PA QM, Clinical Departments
Individual QI Initiatives			BHRS <i>Objectives 13.1 & 13.2</i>	<ul style="list-style-type: none"> ➤ Develop and review alternatives for the delivery of Behavioral Health Services in the schools ➤ Enlist parents and schools as partners in better management and quality improvement of Behavioral Health Services through development and distribution of a toolkit/training for school personnel 	2009	TBD	TBD	VBH-PA QM Department; SW6 counties
	IP database		BHRS <i>Objective 13.3</i>	Implement an agreed upon independent prescriber model for Butler and Lawrence Counties	2009	TBD	TBD	VBH-PA QM Department; SW6 counties
			Co-occurring disorders <i>Objective 13.4</i>	Begin dialogue with Southwood Hospital and D&A Services of the Care Center to implement COD pilot project	2009	Per study design	Per study design	VBH-PA QM Department; SW6 counties
	DW		Quality Improvement Activity for Butler County Readmissions <i>Objective 13.5</i>	<ul style="list-style-type: none"> ➤ Review Butler County Readmission Study completed in 2008. ➤ Develop action plans as appropriate. 	2009	DPW gold standard (10%)	Butler County readmissions	VBH-PA QM Department; SW6 counties

Activity	Data Source	Report #	Aspect of Care/Service	Scope	Frequency	Performance Goal	Sample Size	Responsibility
	GAIN instrument		Drug & alcohol services	Work in collaboration with SBHM to implement a D&A model in Westmoreland County utilizing the GAIN to measure outcomes	2009	TBD	TBD	VBH-PA QM Department; SW6 counties