2024 Quality Improvement Program Description

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I. Access Behavioral Health Background, Historical Information, and Overview

Access Behavioral Health (ABH) is a Managed Behavioral Health Organization, accredited by the National Committee for Quality Assurance (NCQA) and is Florida licensed as an insurance entity (TPA). ABH has served Medicaid members in the Florida panhandle since 2001 and brings over 20 years of experience in processing member enrollment, re-enrollment, disenrollment, assigning the primary behavioral health care manager, provider and member customer service, call center support, benefit plan management, care coordination, case management, utilization management, claims payment, encounter reporting, provider credentialing, quality management, provider network management, and managing risk based contracts (capitated, sub-capitated, and other alternative payment methodologies).

The Quality Improvement Program at Access Behavioral Health (ABH) provides a formal mechanism whereby ABH can systematically and objectively monitor, evaluate, improve, and impact the quality, efficiency, safety, and effectiveness of care to our members. Through this process, ABH is able to identify and focus on opportunities for improving the quality of clinical service delivery by our network of providers. The Quality Improvement plan helps ensure accountability of staff and network providers for the quality of care and services provided to ABH members.

Access Behavioral Health maintains a network of contracted behavioral healthcare providers. The Quality Improvement Department governs the quality assessment and improvement activities of our network providers and spans the system to any function that impacts the quality of service delivered to our members. The ABH QI Department accomplishes this governance via internal and external monitoring of care management, utilization management, the development and maintenance of a provider network, member safety, and monitoring of clinical services to ensure that all members receive the highest quality care and service.

This document serves as an overview of the ABH QI Program's governance, scope, goals, objectives, structure and responsibilities. The ABH Quality Improvement Program Description outlines the methodology used for the continuous assessment and management of a quality management system inclusive of quality assurance, quality improvement, and risk management.

The QI Program Description is an overview of how priorities for improvement are identified and chosen, the role of the Quality Management Committee as well as its structure, and the tools and methodologies employed on a regular basis for provider evaluation. Also included is a description of how these drive the continuous Quality Improvement activities of ABH under the MMA Health Plans. The Quality Improvement Program Description includes all outcomes and performance measures for Quality, Utilization Management, Member Satisfaction, Clinical Practice Guidelines, and other operation and tasks of ABH. Quality Improvement Activities are

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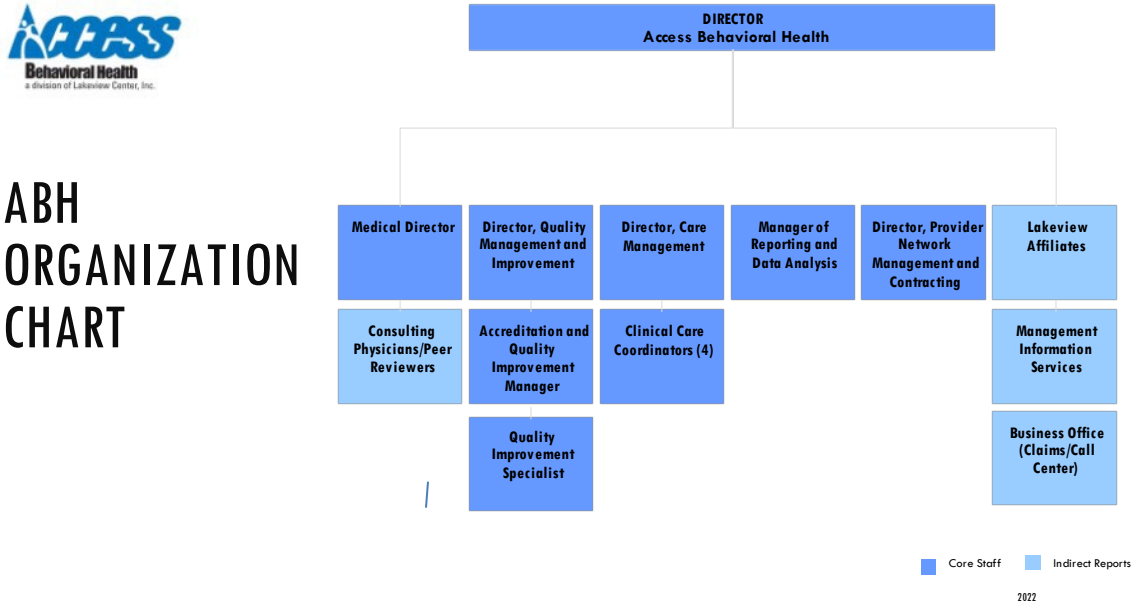
ongoing, opportunities for improvement identified, and interventions applied. The Quality Improvement Work Plan is evaluated annually.

The ABH QI_UM Annual Work Plan is a separate document.

II. Program Structure

The overall ABH Organization is structured as follows:



III. ABH Quality Improvement Program

The ABH Quality Improvement Program consists of four departments:

1. Quality Management and Improvement;
2. Utilization Management;
3. Network Management; and
4. Reporting

These four areas are integral to Quality and together, with separate areas of responsibility, make up the totality of the ABH Quality Improvement (QI) Program. The QI Program provides a

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means whereby all functions of ABH, both clinical and non-clinical, can be tracked, trended, and reviewed by the oversight body, the Quality Management Committee (QMC). Opportunities for improvement are identified, and interventions to address those opportunities applied.

The QI program monitors, evaluates, and continually improves the care and services to all ABH members delivered in both outpatient and inpatient behavioral health settings. ABH integrates quality improvement into all functional areas. Participation in the QI program is required of all contracted network Providers and Practitioners. Providers and Practitioners participate in the QI process through satisfaction surveys, committee and sub-committee meetings, as well as through the implementation of Corrective Action Plans whenever barriers and opportunities for improvement are identified.

The QI Program oversees both clinical quality outcomes and service utilization measures to include:

- Timely access to services;
- Care Coordination between Behavioral Health and Behavioral Health Providers and Behavioral Health and Medical Providers;
- Provider and Practitioner credentialing and re-credentialing;
- HEDIS and other performance outcomes;
- Behavioral Health screening programs;
- Clinical Practice Guidelines;
- Medical records documentation audits;
- Utilization management;
- Member/provider satisfaction;
- Member inquiries/complaints;
- Member self-management tools; and
- Fraud/waste/abuse prevention;

The major responsibilities of the four components of the ABH QI Program are:

A. Quality Management and Improvement (QMI)

- Provider and Practitioner monitoring/Medical Records Audits
- Member Safety
- Member Satisfaction
- Member and Provider Complaints Resolution
- HEDIS and Performance Measures
- Clinical Practice Guidelines (CPG's)
- Monthly, Quarterly, and Annual Quality Reports, and annual Committee Approval
- Credentialing and Re-Credentialing
- Quality of Care and Incident Reporting
- Fraud, Waste, and Abuse
- Self-Management Tools
- Screening Programs
- Access to Services and

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- Facilitation of Quality Management Committee Meetings

B. Utilization Management (UM)

- UM Authorizations and utilization review;
- Case management for inpatient and SIPP services;
- Care Coordination;
- Provider Satisfaction with the UM process;
- Call Center Communication; and
- Daily, Monthly, Quarterly, and Annual UM Reports.

C. Network Management

- Manage network provider negotiations and contracting;
- Provider network analysis that meets health plan requirements;
- Provider network performance management in conjunction with ABH Quality Management Department and health plans; and
- Ensure Culturally, Ethnically, Racially, and Linguistically Competent Network.

D. Data Analysis and Reporting

- HEDIS and Performance Measure Analysis;
- Gap reports for underperforming providers;
- Population Assessments, and
- Intervention Analysis and Re-Measurement.

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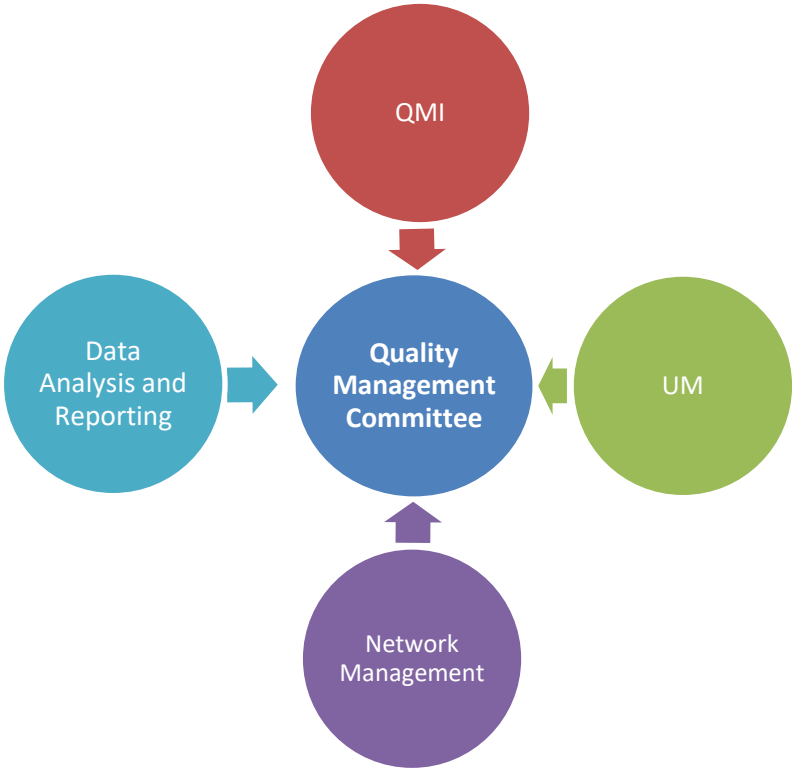
IV. Reporting Relationships of QI Department Staff and the QI Committee

ABH is the governing body for all activities as defined by contractual obligations. The Quality Management Committee (QMC) consists of the ABH Director, the ABH Medical Director, the Quality Management and Improvement Director, the Director of Care Management, the Director of Network Management, the Accreditation and Quality Improvement Manager, and the Senior Reporting and Data Analyst.



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V. Resources and Analytical Support

ABH has the following resources available for implementation of the QI Program:

- Director (PMP): 1.0 FTE
- Medical Director (MD): 1.0 FTE
- QMI Director (LMHC): 1.0 FTE
- Care Management Director (LMHC): 1.0 FTE
- Accreditation and QI Manager (LMHC): 1.0 FTE
- Quality Specialist: 1.0 FTE
- Network Management and Contracting Director (MS): 1.0 FTE
- Senior Reporting and Data Analyst (MS) 1.0 FTE
- Information Systems Staff: 2.5 FTE
- Care Management/Care Coordinator (RN/LMHC): 4.0 FTE
- Call Center Staff: 1.0 FTE
- Claims Adjudication Staff: 4.0 FTE
- Finance: 1.5 FTE

VI. Delegated QI Activities:

Primary source verification and monthly sanction check activities are delegated to the Council for Affordable Quality Healthcare (CAQH). CAQH is a certified credentials verification organization (CVO) by the National Committee for Quality Assurance (NCQA). Credentialing decisions are retained by Access Behavioral Health.

VII. Collaborative Activities

ABH engages in collaborative activities with providers, practitioners, the Health Plans, and the community. Examples of some of our collaborative activities include**:**

- Participation in the Community Behavioral Health/Child Welfare Integration Meetings
- Participation in Trauma Informed Care Committees
- Regional Mental Health Summit
- Mental Health Task Force of NW FL
- Baker Act Coordinator Meeting
- Child of Concern Meetings
- Quarterly quality meetings with Behavioral Health Homes (BHHs)
- Quarterly quality meetings with in network hospitals
- Participation in Coordination of Care activities for SIPP
- Coordination of Care visits with Health Plans to Primary Care Physicians
- Joint Operation Meetings with Health Plans
- Ad hoc clinical staffing with Health Plans
- Lakeview Center Crisis Intervention Team

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VIII. Patient Safety

Patient Safety is addressed via the following established mechanisms:

- Environment of Care Monitoring by Quality Staff
- Incident Reports
- Death Reviews
- Quality of Care Referrals
- Member Complaints
- Provider Office Site Quality Reviews and/or Complaints
- Medical Record Reviews and
- Member complaints and/or grievances as reported by health plans

Reports are generated from this information by the Senior Reporting and Data Analyst and/or the QI Program Director, and any trends identified and tracked. Opportunities for improvement or barriers to patient safety are presented to the QI-UM Committee for investigation and resolution. Interventions are included on the QI Evaluation and re-measured as appropriate.

IX. Involvement of a Designated Behavioral Healthcare Practitioner

The ABH Medical Director is the designated Behavioral Healthcare Practitioner of the QI Program. The Medical Director is a board-certified psychiatrist and reports to the Director of Access Behavioral Health. The Medical Director's role is to provide supervision and oversight to the Quality Improvement program, the QMC, and all QMC sub-committees. The Medical Director oversees the utilization review functions for the Care Management Department and oversees the ABH Utilization Management Plan. The Medical Director provides support and consultation to ABH QI staff on medical records reviews issues.

X. QI Committee Oversight

The Quality Management Committee (QMC) is the governing body of the ABH QI Program and is responsible for oversight of the QI Program, along with its sub-committees. The QMC is responsible for ensuring the quality improvement processes outlined in this plan are implemented, measured, re-measured, reviewed on a regular basis, and updated as needed. The QMC also serves as an advisory group and communication forum for all ABH Quality Improvement components.

The QMC is the decision-making body ultimately responsible for implementation, coordination, and integration of all QI activities for ABH. The QMC reviews and approves all ABH Policies and Procedures, Program Descriptions, Work Plans, and the Annual Evaluation. The QMC is also the designated anti-fraud unit for Access Behavioral Health's Anti-Fraud Plan.

The QMC meets quarterly and ad hoc meetings are called when necessary. The Director of Quality Management and Improvement is responsible for conducting the meeting.

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The authority to implement the ABH Quality Improvement Program plan is held by the QMC. The QMC is assigned oversight responsibilities to all ABH quality improvement efforts. Quarterly reports, pertinent reports, data analysis, and recommendations or actions are presented to the QMC for consideration. This process allows ABH to routinely monitor the activities and effectiveness of the QI program. This monitoring by the QMC includes, but is not limited to:

- Reviewing data and reports to identify trends that may require corrective action
- Ensuring practitioner participation in the QI process
- Analyzing and evaluating the results of QI activities
- Monitoring the implementation and effectiveness of corrective action
- Identifying needed actions
- Determining the need for follow up and/or ad hoc committees
- Reporting conclusions and actions as appropriate to meet the goals of ABH QI

The QMC is comprised of ABH Directors and Managers who work together to achieve program goals and objectives. The QMC's focus is on key quality outcome areas designed to improve overall system effectiveness of service delivery to ABH members. Although each component and subcommittee operates to achieve specific objectives and processes that are operationalized through the ABH QI Program, all components operate as a whole to create the ABH Quality Program.

XI. Roles of the ABH QMC Members

The Director of Access Behavioral Health is responsible for the overall operations of Access Behavioral Health. The Director of Access Behavioral Health ensures that the ABH network has the capacity and capability of meeting the behavioral healthcare needs of members.

The ABH Medical Director is the **designated Behavioral Healthcare Practitioner** who provides supervision and oversight to the Quality Improvement program, the Quality Management Committee, and all subcommittees. The Medical Director reports to the Director of Access Behavioral Health. The Medical Director oversees the utilization review functions for the Care Management Department and the ABH Utilization Management Plan. The Medical Director provides support and consultation to ABH and provider staff.

The Director of Quality Management and Improvement is the senior level quality staff person responsible for and with the authority to manage the Quality policies and procedures (including Credentialing and Rights and Responsibilities). This role reports to the Director of Access Behavioral Health. The Director of Quality Management and Improvement coordinates the Quality Management Committee, compliance and quality monitoring activities, and other activities related to quality management of the ABH network. This position is also responsible for leading the QMC meetings.

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Accreditation and Quality Improvement Manager reports to the Director of Quality Management and Improvement. The Accreditation and Quality Improvement Manager is responsible for designing, building and strategizing quality programs that meet NCQA, CMS, and Health Plan requirements and that improve performance and population health outcomes for ABH members. This position is also responsible for oversight of quality interventions for HEDIS and other performance measures.

The Director of Network Management and Contracting reports to the Director of Access Behavioral Health. The Director of Network Management and Contracting is responsible for provider negotiations, contracting and network management, ensuring that the provider network meets the needs of the Medicaid members for access to services, and meets contractual requirements for provider and practitioner to member ratios. The Director of Network Management and Contracting is responsible for updating contract terms that meet CMS, Florida Medicaid, and NCQA requirements.

The Director of Care Management is responsible for the functions and operations of the Care Management Department. This position reports to the Director of Access Behavioral Health. The Director of Care Management oversees the utilization review, utilization management, care coordination, and authorization processes for ABH. The Director of Care Management works closely with the Medical Director in coordination of care and outreach to primary care physicians, to medical providers, and to other behavioral health care providers.

The Senior Reporting and Data Analyst reports to the Director of Access Behavioral health, and is responsible for all phases of development, preparation, and distribution of reports. This includes all contractual reports for the monitoring of performance-based Health Plans requirements, all internal scheduled and ad hoc reports that support ABH operations, and any quantitative data analyzation and visualization. The Senior Reporting and Data Analyst also assists in the accreditation preparation and corrective action monitoring of ABH.

Minutes are recorded at each meeting using a standardized format which includes topic, discussion, recommendations, follow up, and applicable graphs or associated reports. Follow up items become topics for the next meeting. The minutes are reviewed and approved at the beginning of the subsequent meeting with any changes or corrections noted.

All members of the QMC annually sign a confidentiality attestation.

XII. Sub-Committees of the QMC, Their Function, and Accountability

A. **Quality**: The Quality subcommittee has two purposes: To communicate mandated quality requirements to ensure that all members understand what is necessary in order to comply with mandated activities. Secondly, the Quality subcommittee provides input, as applicable, for the activities that are not mandated by contracts or AHCA. An example of this would be to provide input in what quality improvement activities would be mutually beneficial to study and implement intentional interventions to improve the outcome for members. The Quality subcommittee is

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responsible for oversight of provider and practitioner adherence to HEDIS measures and other performance measures. The subcommittee identifies improvement opportunities and develops interventions to address deficits, including monitoring of individual occurrences of poor quality service and clinical care leading to potential quality of care issues. The Quality Subcommittee is responsible for monitoring applied interventions, including re-measurement when applicable.

The Quality subcommittee is responsible for:

- Oversight of the Clinical Practice Guideline studies;
- Self-management tools;
- Behavioral Health Screening Tools management.
- Quality Improvement Activities
- System Improvement & Effectiveness
- IS Functions (Data Collection and Data Reporting)

The Quality Subcommittee's members are the ABH Medical Director, ABH QMI Director, the ABH Care Management Director, the Accreditation and Quality Improvement Manager, the ABH Quality Specialist, the ABH Senior Reporting and Data Analyst, the ABH Director of Network Management and Contracting, and network providers. Provider partner(s) are responsible for aiding in the completion of ABH goals and objectives through participation in the ABH QI program. Provider and practitioner representatives participate in advancing network adequacy issues, especially for members with special needs. The Quality subcommittee is accountable to the QMC and meets at least twice per year.

B. **Credentialing**: The Credentialing Subcommittee is responsible for reviewing clean files for individual and/or organizational applicants. The Credentialing Subcommittee adheres to the ABH Credentialing Policies and Procedures for approving or denying admission to the network. The Credentialing Subcommittee has the authority to pend an application or to provisionally approve an applicant based on network needs. The Credentialing Subcommittee has the authority to terminate a provider for quality, safety, or other reasons.

The Credentialing Subcommittee is responsible for:

- Oversight of the ABH Provider Network
- Ensuring adequate network capacity
- Approving, denying, pending, or terminating providers from the network

Committee members include the ABH Medical Director, Director of ABH, Director of Network Management and Contracting, Director of Care Management, Director of QMI, the Accreditation and Quality Improvement Manager, the Quality Improvement Specialist and a range of provider representative(s).

Provider representatives must recuse themselves from voting if they have a conflict of interest in the outcome of a Credentialing Subcommittee decision.

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The Credentialing Subcommittee meets on an ad hoc basis and is accountable to the QMC.

C. **Quality Improvement-Utilization Management (QI-UM):** The QI-UM Subcommittee is responsible for oversight of all clinical issues that arise as a result of QI Program functions. This includes:

- Compliance with HEDIS and Contract Performance measures
- Oversight of Provider Monitoring
- Network adequacy and performance against standards

The QI-UM Subcommittee members include: All members of the Quality Management Committee, Utilization Management Care Coordinators, and provider partners. The QI-UM Subcommittee also oversees all functions related to Utilization Review and Care Coordination. This includes:

- Utilization Review and Management,
- Care Coordination between Behavioral Healthcare Providers,
- Care Coordination between Behavioral Healthcare and Medical Providers,
- Continuity of Care of ABH members.

The QI-UM Subcommittee meets quarterly and is accountable to the QMC.

D. **Rights, Responsibilities and Safety (RRS):** The Rights, Responsibilities, and Safety Subcommittee is responsible for:

- HIPAA compliance
- Member complaints
- Critical Incidents
- Quality of Care concerns
- Environment of Care issues
- Confidentiality of members

Subcommittee members include: The ABH Medical Director, the Director of ABH, the QMI Director, the Director of Network Management and Contracting, the Accreditation and Quality Improvement Manager, the Quality Specialist, at least one provider representative, and the Director of Care Management. The RRS Subcommittee meets at least annually and is accountable to the QMC.

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XIII. Annual QI Work Plan & Evaluation

The annual Quality Improvement Work Plan and the Annual Evaluation are collaborative documents written by the Directors of QMI and Care Management and are approved by the QMC. The purpose of the QI Work Plan is to reflect ongoing activities throughout the year and address the following:

- Annual activities and objectives,
- The timeframe to complete each activity,
- The responsible parties,
- Monitor the previously identified issues and
- Evaluate the effectiveness of the QI program.

The annual work plan serves as a corrective action plan for previously identified opportunities for improvement and applied interventions, if any. The Work Plan is a dynamic document and updates are presented to the QMC annually for review, discussion, and revision if necessary.

The annual Evaluation is a review of all activities for the prior year with a status report on each measure or activity. This annual Evaluation is presented to the Quality Management Committee for approval annually. The annual evaluation is shared with providers after approval by the QMC.

The annual Work Plan includes all of the following objectives and activities:

- Improving quality of clinical care
- Improving safety of clinical care
- Quality of service
- Members' experience
- The time frame for each activity's completion
- The staff responsible for each activity
- Monitoring of previously identified issues
- Evaluation of the QI Program (separate document)

The annual evaluation is a description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service, trending of measures to assess performance in the quality and safety of clinical care and quality of service, and analysis and evaluation of the overall effectiveness of the QI program, including progress toward influencing networkwide safe clinical practices.

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The annual evaluation includes the following:

- Completed and ongoing QI activities
- Trending of QI measure results
- An analysis of the effectiveness of the QI program, to include adequacy of QI program resources, QI Committee Structure, practitioner participation and leadership involvement in the QI Program, and if there is a need to restructure or change the QI program for the subsequent year.

Policies and procedures supporting the Quality Improvement Program are reviewed and approved annually by the QMC and updated as needed. Based on the annual program evaluation, the QI Work Plan from the year prior is revised, and a new QI Work Plan for the coming year is developed.

XIV. Serving a Diverse Membership

ABH has a diverse membership in terms or race, language, and ethnicity. To ensure a Provider Network that can adequately serve ABH members and meet their needs and preferences, ABH holds specific standards, practices, skills, service approaches, techniques and strategies that match the service population and increase the quality and appropriateness of services.

Ways in which ABH serves a diverse membership are as follows:

- Promotes diversity in recruiting and hiring of employees by:
  - Including candidates from underrepresented groups and women
  - Creating an inclusive job description (i.e. gender neutral language)
  - Blind review resumes and
  - Include a diverse interview panel
- Annual cultural competency training is required for all ABH employees
- Reducing health care disparities in clinical areas; e.g. recruiting for child psychiatrists for Regions 1 and 2
- Improving cultural competency in materials and communications; e.g., asking Providers for languages spoken and including this information in our online Provider Directory
- Improving the network adequacy to meet the needs of underserved groups; e.g., ensuring adequate Infant Mental Health Providers are available to the courts
- Improving member satisfaction through Single Case Agreements when necessary to meet a member need or preference.

Cultural competence is about adapting mental health care to meet the needs of members from diverse cultures. One key aim of ABH is to improve their access to care. Cultural competence seeks to improve the quality of care. Its broader societal purpose is to reduce or eliminate mental health disparities affecting disenfranchised groups.

In terms of cultural competence, ABH seeks to ensure adequate service to culturally and linguistically diverse membership through the following strategies:

- A language bank service and the language line to ensure that language is not a barrier.
- Spanish speaking therapists are available proportionately to the membership need.

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- Making all available languages spoken by ABH Providers available on the online directory
- ABH Help Line with a Spanish speaking option
- Provider profiling to ensure adequate cultural and linguistically diverse providers to match the membership.

XV. Goals and Objectives of the ABH Quality Improvement Program

The ABH Quality Improvement Program is responsible for the timely availability and access of quality behavioral health care services to our members.

Goal: Improve the quality of care of ABH members as evidenced by investigation into any reported quality of care concerns, member complaints, and grievances. To ensure the ABH network is adequate to meet the needs of the membership.

Objectives:

- Monitor and evaluate the quality of care provided to ABH members by participating network providers
- Maintain an adequate provider network through the credentialing and re-credentialing process
- Maintain an organized and effective framework for Quality Improvement functions
- Ensure coordination of care between behavioral health care providers and medical providers
- Assess compliance with medical records documentation standards
- Monitor member safety
- Monitor member satisfaction
- Monitor HEDIS and other provider performance measures
- Ensure that behavioral health services are culturally and linguistically diverse as required to meet the needs of our membership.

Goal: To meet or exceed access to care standards and goals as outlined by HEDIS and contracts with Health Plans.

Objectives:

- Ensure that available, appropriate, accessible, and timely services fully meets or exceeds standards
- Monitor Utilization Management outcomes based on HEDIS and other national benchmarks
- Ensure coordination of care between behavioral and medical healthcare providers
- Ensure coordination of care between behavioral and behavioral healthcare providers
- Ensure effective care coordination exists to meet the needs of members with complex needs
- Educate providers about ABH policy regarding utilization review, medical necessity, medically recommended, clinical care criteria, quality of care, peer review and practice guidelines

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- Provide a structure for the sharing of information and the collaboration of knowledgeable parties in the improvement efforts of the organization via the ABH Quality Management Committee and subcommittees
- Conduct secret shopper calls quarterly to ensure appointment wait times are in accordance with HEDIS and health plan standards.
- Provide appointment wait time score cards to providers with results and any corrective action plans that may be applicable.

Goal: Maximize satisfaction of ABH members and providers through continuous quality improvement.

Objectives:
- Ensure timely access to services through ABH helpline, ABH website, geographic access monitoring and quarterly secret shopper surveys
- Resolve member inquiries and complaints within 24 hours
- Ensure provider compliance with HIPAA and other local, state, and federal regulations
- Conduct annual provider Satisfaction Survey
- Conduct annual member experience survey with goal score of 4.5 across all areas
- Identify opportunities for improvement in member and provider satisfaction and apply interventions.

Goal: Maximize the safety and quality of behavioral healthcare delivery to ABH members through continuous quality improvement.

Objectives:
- Conduct annual member Satisfaction Surveys with goal score of 4.5 across all areas.
- Address member safety issues at Quality Management Committee meetings and Rights, Responsibilities, and Safety Sub-Committee meetings when appropriate
- Identify Opportunities for Improvement and apply Interventions
- Review service utilization data to identify over- and under-utilization patterns
- Ensure timely access to emergency appointments
- Offer members Self-Management Tools in print and on ABH website
- Assist network providers with establishment of safe clinical practices
- Complete an annual work plan and evaluation of the QI_UM Program
- Review 100% of critical incidents, member complaints, and grievances to ensure the safety and quality of care is maintained for all members

XVI. Quality Improvement Processes

ABH uses a variety of monitoring systems, both qualitative and quantitative, for identifying barriers or gaps in service, identifying opportunities for improvement, and for applying interventions to maintain continuous quality improvement. The monitoring of specific outcomes is designed, measured and assessed by the ABH Quality Department. Trends are identified and tracked, and performance improvement opportunities identified.

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The outcome and performance measures used by ABH are objective, measurable, and based on state and national benchmarks.

Methodologies used for tracking outcomes and performance include:

- Review and selection of benchmarks for each HEDIS measure
- Tracking and trending of data
- Identification of opportunities for improvement based on available data
- Implementation of interventions or corrective actions for identified opportunities for
- Improvement
- Re-measurement to determine the effectiveness of the interventions based on available data
- Improvement and/or reaching a goal or benchmark

DATA SOURCES

ABH organizes and analyzes the following broad data sources, when available, for identification of improvement opportunities:

- HEDIS Measures
- Member Satisfaction Surveys
- Provider satisfaction surveys
- Medical records review data
- Geographic Access and Availability of Providers, including specialty
- Continuity and coordination of care processes and data
- Level of Care Criteria
- Credentialing and Re-Credentialing data
- Pharmacy data
- Lab data
- Quality of care concerns
- Member complaints
- Provider complaints
- Utilization management data
- Feedback from external regulatory and accrediting agencies
- Office site visits reports
- Provider background screenings

XVII. Outcome Measures

Access Behavioral Health has developed a data system that adequately supports the collection, tracking, and analysis of data necessary to perform utilization management activities, reviews of clinical/administrative performance related to levels of care, clinical outcomes, and adherence to Medicaid clinical/administrative standards.

Additional outcomes that ABH monitors regularly include contractually mandated HEDIS, UM, and internally defined improvement.

END OF DOCUMENT

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