



2026 Quality Improvement Program Description

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

Access Behavioral Health (ABH) is accredited in Behavioral Health (BHA) 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 25 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 can 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.

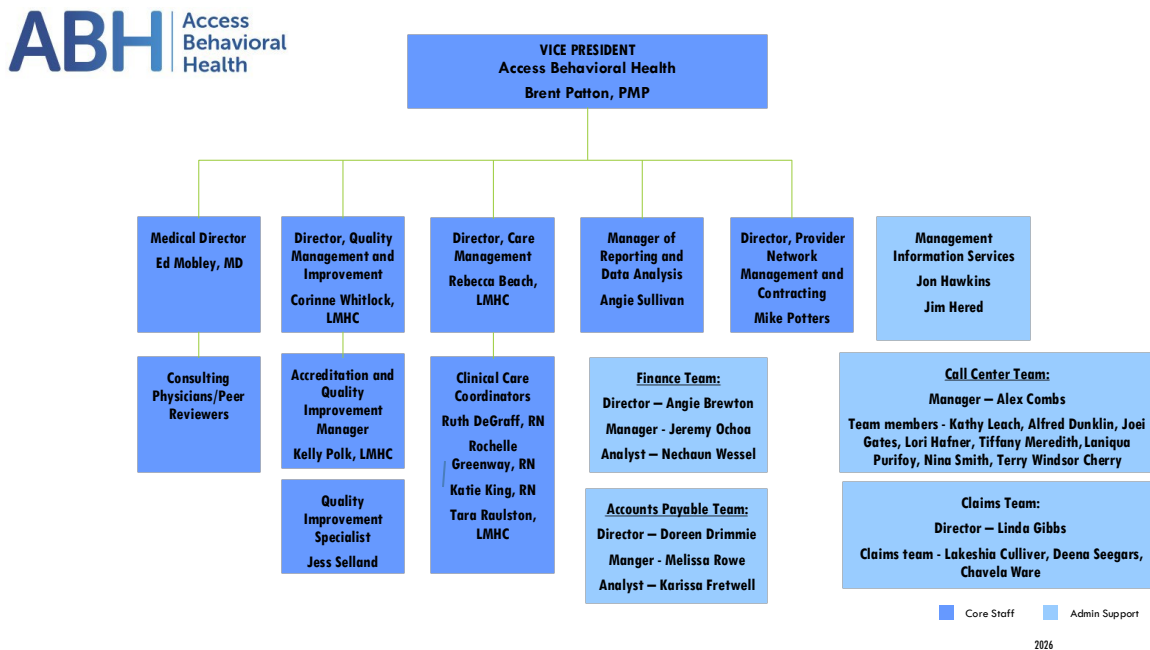
This document serves as an overview of the ABH QI Program's governance, scope, goals, objectives, structure and responsibilities. The ABH Quality Improvement Program Description outlines the methodology used for the continuous assessment and management of a quality management system inclusive of quality 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, Network and other operation and tasks of ABH. Quality Improvement Activities are ongoing, opportunities for improvement identified, and

interventions applied. The Quality Improvement Utilization Management Work Plan is a separate document and evaluated quarterly and annually.

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 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 and is outlined in the Provider Handbook

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

- Clinical Measurement Activities;
- Timely access to services;
- Coordination of Behavioral Healthcare
- Provider and Practitioner credentialing and re-credentialing;
- Provider complaints
- HEDIS and other performance outcomes;
- Behavioral Health screening programs (Population Health Management);
- Medical records audits;
- Utilization management;
- Member inquiries
- Member self-management tools; and
- Fraud/waste/abuse prevention;

The major responsibilities of the four functional areas of the ABH QI Program are:

A. Quality Management and Improvement (QMI)

- Clinical Measurement Activities;
- Provider and Practitioner monitoring/Medical Records Audits;
- Coordination of Care Opportunities;
- Member Safety;
- Member Satisfaction;
- Call Center Communication;
- Provider Complaints Resolution;
- HEDIS and Performance Measures
- Monthly, Quarterly, and Annual Quality Reports, and annual Committee Approval;
- Credentialing and Re-Credentialing;
- Quality of Care and Critical/Adverse Incident Reporting;
- Fraud, Waste, and Abuse;
- Self-Management Tools;
- Screening Programs;

- QI Program Structure;
- Work Plan and ABH Annual Evaluation;
- Training employees to improve quality of healthcare or services or decreasing disparities; and
- Facilitation of Quality Management Committee Meetings, and all subcommittee meetings.

B. Utilization Management (UM)

- Clinical criteria for UM decision making;
- UM Authorizations and utilization review;
- Case management for inpatient and SIPP services;
- Denials and notifications;
- Appeals;
- Information Integrity; and
- Daily, Monthly, Quarterly, and Annual UM Reports

C. Network Management

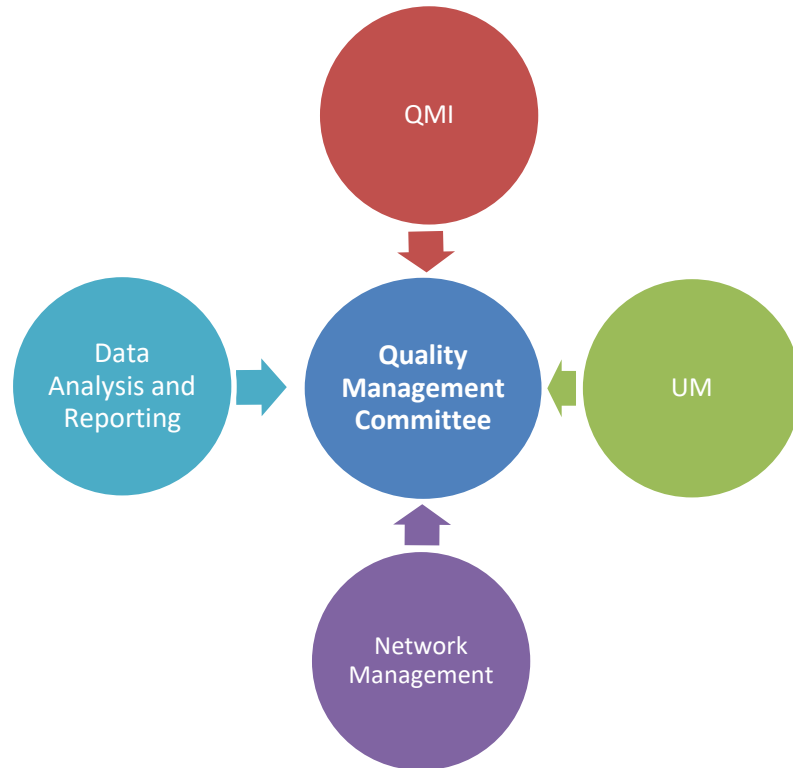
- Access to Services;
- Practitioner and Provider directories (online and print);
- Manage network provider negotiations and contracting;
- Provider network analysis that meets health plan requirements;
- Provider network performance management in conjunction with ABH Quality Management Department and health plans;
- Provide analysis and consultation that assists ABH Behavioral Health Homes in network performance improvement; and
- The network of providers meets the needs of the ABH membership;
- Provider terminations and continued access to care

D. Data Analysis and Reporting

- HEDIS and Performance Measure Analysis;
- Gap reports for underperforming providers;
- Hospital scorecards;
- Population Assessments,
- Intervention Analysis and Re-Measurement;
- Utilization monitoring and reporting;
- Clinical measurement monitoring and reporting;
- Performance Improvement Plan trend analysis

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 Vice President of ABH, the ABH Medical Director, the Quality Management and Improvement Director, the Director of Care Management, the Director of Provider Network Management and Contracting, the Accreditation and Quality Improvement Manager, and the Senior Reporting and Data Analyst.



V. Resources and Analytical Support

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

- Vice President (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: 2.0 FTE
- Claims Adjudication Staff: 4.0 FTE
- Finance: 1.5 FTE

VI. Delegated QI Activities: Primary source verification for credentialing and recredentialing applicants and monthly sanction check activities for in network practitioners 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 collaborative activities include:

- Participation in the Community Behavioral Health/Child Welfare Integration Meetings
- County Integration and Alliance quarterly meetings
- Participation in the Human Trafficking Task Force
- Regional Mental Health Summit monthly
- Mental Health Task Force of NW FL
- Baker Act Coordinator Meeting
- Family Team Staff Meetings
- Quarterly quality meetings with Behavioral Health Homes (BHHs)
- Quarterly quality meetings with ABH 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
- Monthly meetings with clients (Health Plans) and Health Plan Joint Operating Committees
- Lakeview Center Crisis Intervention Team

VIII. Patient Safety

Patient Safety is addressed via the following established mechanisms:

- Environment of Care Monitoring by Quality Staff
- Critical/Adverse Incident Reports
- Death Reviews
- Quality of Care Referrals
- Provider Office Site Quality Reviews and
- Medical Record Reviews

Reports are generated from this information by the Senior Reporting and Data Analyst and/or the QI Program Director, and any trends are identified and tracked. Opportunities for improvement or barriers to patient safety are presented to the Quality Management Committee or a designated subcommittee for investigation and resolution. Interventions are included in 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 Vice President 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. Quality Management 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.

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 and determining which to pursue
- 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 PD and annual Work Plan and
- Annual review and approval of all policies and procedures

The QMC is comprised of the ABH Vice President, 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 Vice President of Access Behavioral Health is responsible for the overall operations of Access Behavioral Health. The Vice President of Access Behavioral Health ensures that the ABH network has the capacity and capability of meeting the behavioral healthcare needs of members while also meeting all performance aspects of ABH's health plan contracts.

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 Vice President 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 Vice President of Access Behavioral Health. The Director of Quality Management and Improvement serves as the committee chair of the Quality Improvement and Utilization Management Subcommittee, the Quality Management Committee and the Quality Subcommittee. This individual is responsible for compliance and quality monitoring activities, and other activities related to quality management of the ABH network. This position is responsible for updating the quality sections of the work plan and the annual evaluation.

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 Accreditation and QI Manager is also responsible

for coordinating and conducting a variety of annual quality audits and the management and oversight of any applicable corrective action plans.

The Director of Network Management and Contracting reports to the Vice President 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 Vice President 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 Vice President 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. Action or 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. The QMC has the authority to review/approve minutes from all subcommittees.

All members of the QMC annually sign a confidentiality attestation.

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

- A. Credentialing:** The Credentialing Subcommittee is responsible for reviewing all files for individual and/or organizational credentialing 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 terminate a provider for quality, safety, or other reasons.

The Credentialing Subcommittee is responsible for:

- Reviewing all applicant files for consideration of credentialing;
- Approving, denying, or terminating providers from the network

Committee members include the ABH Vice President, 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.

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

- B. Contracting and Network Subcommittee (NET):** The NET Subcommittee will review all contracts with providers prior to execution. The committee will determine the appropriate service array and associated billing codes for the contract. Approved contracts will be forwarded to the Credentialing Committee to initiate the credentialing process. This committee meets within 10 days of the completed contract (prior to execution).

The following network activities/measures are reviewed and analyzed on a quarterly basis by the QMC or a designated subcommittee. They are reflected in the ABH evaluation and Work Plan:

- Availability of Practitioners and Providers (network ratios and geographic access)
- Accessibility of Services (timely access to services including after-hours)
- Assessment of Network Adequacy (Out of Network requests)
- Continued Access to Care (Provider terminations, continued access and care transitions)
- Continuity of Care of ABH members.
- Practitioner and Provider Directories (Updates, accuracy, and usability testing)

Committee members include the ABH Vice President, ABH Medical Director, Director of Network Management and Contracting, Director of Care Management, Director of QMI, the Accreditation and Quality Improvement Manager, and the Quality Improvement Specialist.

- C. Quality Improvement-Utilization Management (QI-UM):** The QI-UM Subcommittee is responsible for reviewing data and performing a quantitative analysis of results at least annually. When goals are not achieved, this subcommittee performs a qualitative analysis to determine barriers and appropriate interventions. The QI-UM

Subcommittee is responsible for oversight of all clinical issues that arise as a result of QI Program functions. This includes:

- Performance measures
- Coordination of Behavioral Healthcare
- Member Safety
- Confidentiality and HIPAA compliance
- Annual website review for accuracy and functionality
- Behavioral Health Screening Programs
- Oversight of Provider Monitoring
- Network adequacy and performance against standards
- Self-Management Tools
- Behavioral Health Screening Tools

The QI-UM Subcommittee members include: All members of the Quality Management Committee, Network Subcommittee, 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

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

XIII. Annual QI Work Plan & Evaluation

ABH Work Plan:

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. It is reviewed quarterly and annually by the QIU_UM Subcommittee.

The annual Work Plan includes 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)

ABH Evaluation:

The annual evaluation is a written and visual document 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.

The ABH Evaluation updates all activities quarterly for the current measurement year, with measurement comparisons for the prior year. The evaluation is reviewed quarterly after each data update, by the QI/UM Subcommittee for quantitative and qualitative analysis, measurement trends, barriers, and potential intervention. The evaluation is shared with Health Plans every quarter. The final annual evaluation is also available on the ABH website following QMC approval of the document.

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.
- The QIUM Subcommittee's quantitative analysis and qualitative analysis when goals are not achieved.
- Completed and ongoing UM activities
- Claims assessment, turn-around times, volume
- Network adequacy
- Member and provider demographics
- Contractual service metrics

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 serves members from 14 counties in the Florida Panhandle, described as Region A. 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. This includes:

- 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 training regarding the quality of or experience with healthcare services or reducing disparities cultural competency training is required for all ABH employees
- Reducing health care disparities in clinical areas; e.g. recruiting for child psychiatrists for Region A.
- 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.
- Listing all available languages spoken by ABH Providers in the practitioner and provider 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

ABH Quality Improvement goals and objectives can be found in the annual work plan.

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.

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 and quantitative and qualitative analysis
- Implementation of interventions or corrective actions for identified opportunities for improvement
- Re-measurement to determine the effectiveness of the interventions based on available data
- Performance 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, both provided by the health plans and internally generated
- 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, when provided by the health plans
- Lab data, when provided by the health plans
- Critical Incidents/Quality of care concerns
- Provider complaints
- Utilization management data
- Feedback from external regulatory and accrediting agencies
- Office site visit reports
- Provider background screenings
- Claims/encounter data

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.

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