

# Humana Behavioral Health Quality Improvement

## 2017 Program Description

Approved by QIC: March 28, 2017



**Humana**  
Behavioral Health™

Commercial  
Exchange  
Medicare

## Revision History

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## Introduction

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*“Changing Behaviors, Improving Lives.”*

Humana Behavioral Health (HBH) utilizes a mind-body-spirit wellness approach to lead consumers in changing behaviors that improve lives. Humana Behavioral Health is committed to offering holistic care to enhance health, increase personal as well as workplace productivity and encourage improved vitality. For over 20 years, the organization’s commitment to well-being has resulted in positive outcomes for consumers, employers, health plans and insurers.

The Quality Improvement Program (QIP) provides objective and systematic monitoring and evaluation on the quality, safety, and effectiveness of care and service that HBH provides. This multidimensional approach enables HBH to focus on opportunities for improving clinical care, service quality, consumer safety, and consumer experience. The QIP promotes the accountability of all associates and affiliated behavioral health personnel for the quality of care and services provided to the consumers we serve.

Humana Behavioral Health contracts with employers, health plans and other entities to perform utilization review and to maintain a behavioral health care provider network. The managed care services provided by HBH include utilization management, discharge planning, care management, development and maintenance of a provider network, benefit administration and claims processing. Humana Behavioral Health ensures that all customer groups (e.g. consumers, providers, employer groups) receive the highest quality of care and service.

Humana Behavioral Health is a national health and productivity solutions company with corporate operations in Irving, Texas. In this respect, HBH provides total managed behavioral health care, integrated medical-behavioral health services, and care management in co-source, carve-out models to just over four million consumers.

## Authority

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The Senior Leadership Team (SLT) of HBH has authority, accountability and organizational governance for the HBH QIP, as granted by Humana’s Board of Directors and Corporate QIP. The SLT exercises its oversight of the program by reviewing and evaluating all behavioral health care services.

## Scope

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The QIP is annually evaluated and revised to remain responsive to the changing conditions of the behavioral health environment. The scope of the QIP is to monitor, evaluate and continually improve the care and services for all lines of business managed by HBH including Commercial, Exchange, Medicare, and Medicaid accounts. The program encompasses services rendered in a variety of settings including admissions to inpatient facilities (IP); day and partial hospitalization programs (PHP); residential/rehabilitative care (RTC); structured intensive outpatient programs (IOP); as well as routine and specialized outpatient services (OP) such as medication management, therapy for mental health and substance abuse treatment, or psychological testing.

The methodology of the QIP includes identification of metric performance goals and benchmarks, data sources, data collection, establishment of baseline measurements, trending, measuring, analyzing, and development and implementation of interventions. In order to fulfill the goals and objectives of the QIP, HBH has integrated quality improvement into all functional areas. Additionally, participation in the QIP is required of all contracted network providers who deliver behavioral healthcare to consumers. All staff, practitioners and consumers are asked to participate in the quality management process through satisfaction surveys, committee meetings, performance improvement teams (PIT) and corrective action plans (CAP) which are implemented as part of the business plan whenever opportunities are identified.

## Goals and Objectives

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## A. Strategic Goals and Objectives

The QIP's primary objective is to continuously improve the quality of care provided to consumers, which enhances their overall health. To support the company's mission and to improve the quality of care and service provided to its consumers and providers, HBH has adopted the following goals and objectives:

- Improve consumer experience and practitioner satisfaction by identifying and addressing potential opportunities for growth
- Promote overall collaboration with the Humana Health Plan regarding quality improvement initiatives and coordination of care efforts, with practitioners through treatment record reviews and behavioral health screenings, and addressing consumer safety issues with providers
- Encourage associate participation in cultural diversity and inclusion opportunities and training in order to improve HBH's outreach to its diverse membership communities
- Monitor utilization management (UM) and care management (CM) services to ensure consumers are receiving the right care at the right time
- Assess HBH's membership population, including children and adolescents, individuals with disabilities and persons with serious and persistent mental illness, in order to provide appropriate services for their unique needs
- Monitor continuity and coordination of care across the behavioral health care delivery system and take necessary actions to ensure and improve continuous, collaborative treatment
- Collaborate with relevant medical delivery systems and primary care physicians to monitor and improve coordination between behavioral health and medical care
- Provide consumers with interactive self-management tools that help determine risk factors, secure guidance on health issues, identify ways to improve health, and support reducing risk
- Act as a liaison for other HBH departments regarding quality improvement, accreditation surveys, and other quality-related areas

## B. Cultural Diversity and Inclusion

In creating a diverse and inclusive managed behavioral health team, HBH promotes internal and external programs that provide essential foundations to the development and advancement of the organization's outreach to its diverse membership and communities.

Humana Behavioral Health believes that providing cultural awareness, sensitivity and inclusivity training on an annual basis is the first step in building a strong foundation. Additional tools and information available to HBH associates in order to foster culturally competent communication with consumers include these topics:

- *Gender Identity and Transition*
- *Engaging Generational Differences*
- *Effective Multicultural Relationships and Introduction to Workforce Generations*
- *Implicit Bias Project*

Additional training is provided to associates on the use of the language line translation service for consumers with limited English proficiency. A variety of Network Resource Groups (NRG) exist as voluntary organizations open to all associates. NRG's help associates to understand the diverse needs of the consumer. The groups also provide personal and experience-based forums for exchanging ideas, building community, and driving measurable business outcomes.

Other initiatives include the creation of local inclusion and diversity councils tasked to implement the corporate-wide inclusion and diversity strategy across the United States. Each

council consists of two committees specifically focused on community partnership and cultural awareness. Inclusion and diversity days occur throughout the year with the goal to foster a rich environment for celebrating today's diversity, while cultivating a more inclusive tomorrow. Educational workshops, guest speakers and informational booths are all a part of inclusion and diversity days.

Lastly, HBH provides practitioners with information regarding cultural agility, cross-cultural competencies and cultural intelligence through provider newsletters to support practitioners in offering culturally competent interactions with consumers.

### **C. Integration of Quality Improvement with Corporate Goals**

The Humana corporate-wide goal is for consumers to be 20 percent healthier by the year 2020. Humana Behavioral Health aims to meet this goal by incorporating an integrated care delivery model that is inclusive of care delivery, consumer experience, and clinical and consumer insights. The HBH QIP is working toward an integrated care delivery model by improving the overall behavioral health status of its consumers in order to enhance their physical health and overall well-being. The QIP's progress is being monitored through the use of the Healthcare Effectiveness Data and Information Set (HEDIS), internal quality studies, and health outcomes data. Humana Behavioral Health is also committed to improving the communities where its consumers live through participation in public health initiatives on both national and local levels, and aspiring to meet public health goals (e.g. Health Outcome Surveys, state benchmarks).

The QIP focuses on improving care provided to HBH consumers as well as services provided to providers and consumers. Applying this focus to all monitored QIP key performance indicators will assist HBH in attaining the corporate goal by 2020. Progress toward the goal will be monitored consistently throughout the year.

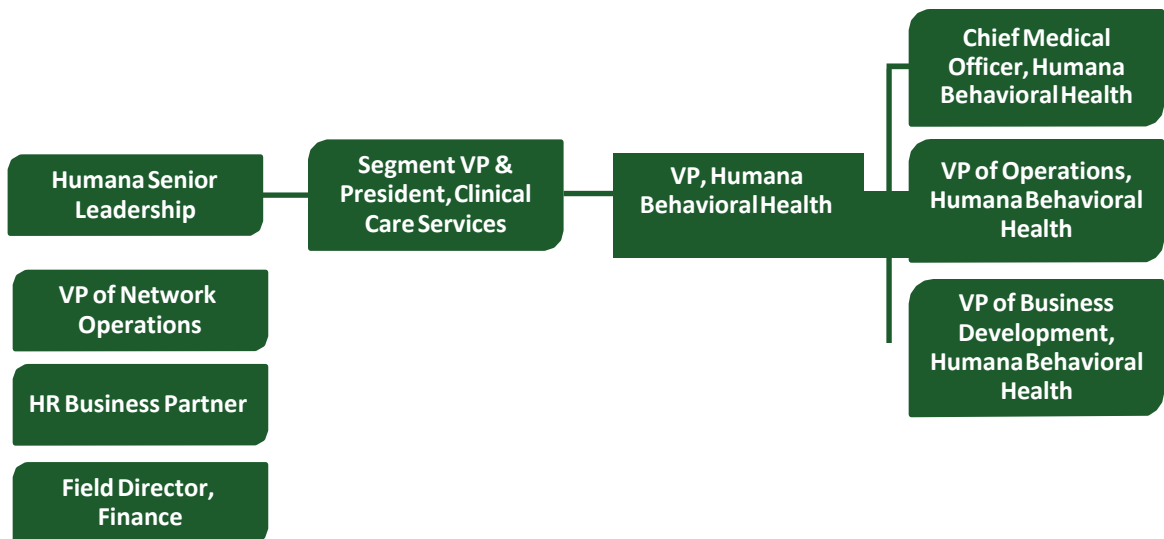
## Program Structure and Oversight

The following resources provide continuous oversight over the QIP:

### A. Senior Leadership Team

The SLT has assigned responsibility for the direction and implementation of the quality program to the Quality Improvement Committee (QIC), which is responsible for ensuring the quality improvement processes outlined in this plan are implemented and monitored. The SLT also serves as an advisory group and communication forum for the Quality Improvement (QI) sub-committees.

The members of the SLT include:



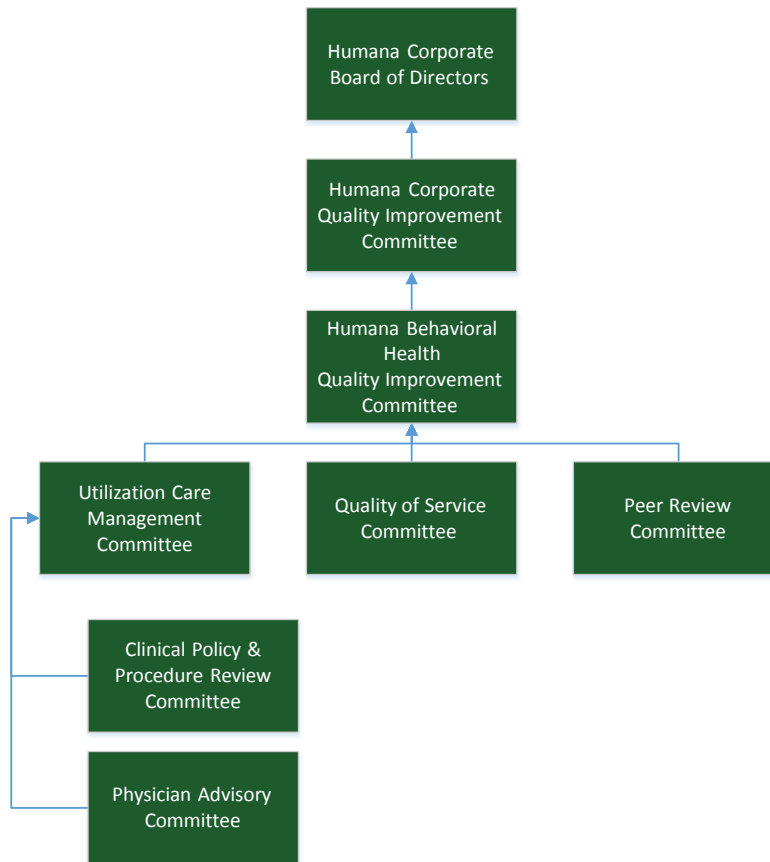
Annually, the SLT reviews and approves the QI Program Description, QI Program Evaluation, and QI Work Plan. Humana Behavioral Health's SLT entrusts the QIC to implement the QIP. As a voting member of the SLT, the Chief Medical Officer (CMO), or designee, is designated to oversee quality activities as the chair of QIC.

### B. Committees

#### 1. Quality Improvement Committee

The QIC is an action body, as granted by the SLT, which is responsible for the assimilation, implementation and management of all HBH quality improvement activities and key performance indicators. The QIC convenes at least quarterly; however the committee may meet more frequently or convene on an ad hoc basis as deemed necessary. The QIC consists of the SLT, department directors, and the Quality and Accreditation (Q&A) team. The Q&A team then reports its findings to the health plan as dictated by the Humana Corporate QIC Work Plan.

The QIC has oversight of the Humana Behavioral Health QI sub-committees including, but not limited to: Utilization-Care Management Committee (UCM), Quality of Service Committee (QOS), and Peer Review Committee (PRC). The QIC provides direction to all committees and ensures coordination between committees. The accountability and coordination of the QIP is as follows:



All sub-committees report to the QIC on a quarterly basis per the objectives and processes outlined in the annual QI Work Plan. The QI Work Plan identifies specific indicators, objectives, benchmarks/goals, and timeframes for the QIP for that year. Humana Behavioral Health utilizes numerous monitoring systems, both qualitative and quantitative, for providing continuous quality improvement.

Annually, QIC membership is analyzed to determine if all departments are accurately represented. Voting members may appoint a designee as necessary upon approval by the chairperson. The QIC also has voting non-staff members that include in-network providers of various levels.

The QIC's roles and responsibilities include:

- Providing guidance to other departments regarding key performance indicators
- Analyzing data from reports and identifying trends or opportunities for improvement
- Monitoring organizational progress in meeting QIP goals and benchmarks, as outlined in this program description and the annual QI Work Plan
- Identifying appropriate committee responses and ensuring follow-up as needed
- Annually reviewing the QIP's objectives and effectiveness through the review and approval of the QI Program Description, QI Program Evaluation and QI Work Plan
- Providing oversight and approval authority over quality improvement activities and projects
- Recommending policy decisions
- Reviewing and approving clinical practice guidelines



- Providing oversight, tracking and review of the QIP service and clinical data including studies, sentinel events, consumer experience and practitioner satisfaction surveys, treatment record review, grievance and appeals and over/under utilization
- Reviewing and acting on requirements/recommendations of external quality review entities, including related regulatory and accreditations requirements
- Serving as a forum for representatives from all departments to exchange department-specific information, share ideas for effective improvement activities and establish working relationships for improved performance

QIC meeting minutes are recorded and logged using a standardized format including topic, discussion, recommendation and follow-up. Follow-up items automatically become an agenda item for the sub-committees and are reported in the next QIC meeting. The chairperson and committee review the minutes for accuracy and completeness. The chairperson and Q&A director sign and date the minutes after approval by the committee in the following QIC meeting.

Please reference the QIC Charter for more information regarding the committee.

## **2. Utilization-Care Management Committee**

The UCM monitors all clinical activities throughout HBH. The *Behavioral Health Clinical Services Program Description* documents the methodology used to assess the degree of clinical adherence to standards, practices, and activities designed to continuously improve clinical services. The *Behavioral Health Clinical Services Program Description* is available upon request.

The primary responsibility of the UCM is to monitor utilization of clinical services, including utilization review and care management. The UCM is co-chaired by the director of Behavioral Health Clinical Operations and the medical directors. The UCM and the QIC share relevant data between committees and work collaboratively to address issues. The UCM reports to the QIC via the QI Work Plan and makes recommendations regarding quality of care initiatives and clinical process improvements. The UCM receives reports from other clinical-related sub-committees (see chart above) as noted below:

- UM Trend Committee – This committee reviews and monitors the potential over/under utilization of financial trends. This committee intervenes and develops action steps to address identified negative trends.
- Physician Advisory Committee – This committee focuses on improving the internal physician review process. Providers who are members of this group have an opportunity for input regarding clinical quality issues, including practice guidelines and best practices. The committee also reviews medical necessity criteria and new technology as deemed necessary.
- Clinical Policy and Procedure Review Committee – This committee updates, reviews, and approves departmental policies and procedures based on current processed, accreditation standards, and state and federal regulations.

The UCM meets at least quarterly. A quorum, as outlined by the *UCM Charter*, is required for all meetings.

## **3. Quality of Service Committee**

The QOS is a multidisciplinary committee responsible for developing and monitoring quality of service indicators, initiatives, interventions, and evaluation of overall

operational service effectiveness. Quality indicators include, but are not limited to: telephone queues, access to services, availability of the provider network, consumer experience, practitioner satisfaction, claims processing, and complaints.

The QOS reports to the QIC via the QI Work Plan and makes recommendations regarding quality of service initiatives and service process improvements. Functions of the QOS include:

- Overseeing consumer experience and practitioner satisfaction survey activities, including recommending interventions
- Monitoring metrics and trends of consumer complaints
- Monitoring metrics and trends of consumer and provider telephone queues for time to answer, abandonment rate, and service level
- Monitoring routine access to care and provider availability, identifying trends and recommending opportunities for improvement
- Reviewing, approving, and monitoring service quality improvement activities or projects
- Reviewing and approving service-related operational policies and procedures
- Reviewing CAPs as needed

The QOS meets at least quarterly and is chaired by the Contact Center Operations Director or their designee. A quorum, as outlined by the *QOS Charter*, is required for all meetings.

#### **4. Peer Review Committee**

The PRC is a group of internal clinical professionals and outside in-network providers who review member safety concerns. The PRC receives its authority from the QIC. All matters of the meeting are confidential; however minutes are kept regarding the cases discussed. The PRC meets at least quarterly and a quorum, as outlined by the *PRC Charter*, is required for all meetings.

The purpose of this committee is to review potential quality concerns, escalated complaints and sentinel events. Corrective Action Plan's are implemented as appropriate. The PRC may recommend disciplinary actions including, but not limited to, network termination.

## **Staff Responsibilities**

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Humana Behavioral Health establishes and outlines responsibilities of staff through careful evaluation of the overall program. The QI initiative is a shared responsibility, requiring commitment from staff across all departments. Specific Humana Behavioral Health staff members are charged with the responsibility of overseeing daily QI activities in order to meet the goals of the program.

### **A. Chief Medical Officer**

As assigned by the SLT, the CMO provides leadership, direction, and oversight of the QIP and its activities. As a chairperson for QIC, the CMO will also serve as a liaison to the SLT. The CMO will provide consultation on all quality improvement initiatives to assure the organizational goals are met. This position must be held by a board-certified psychiatrist in good standing, with responsibilities to:

- Provide clinical guidance and oversight for physician reviewers
- Maintain oversight of all staff performing clinical quality-related functions
- Obtain and provide behavioral health/medical health practitioner guidance and information to and from the SLT, QIC and regional medical director groups
- Review, evaluate and participate in the development of indicators and related

- performance goals
- Provide recommendations regarding continuing education needs in accordance with the findings of relevant QI activities

## **B. Medical Director**

The Medical Director reports directly to the CMO. This position must be held by a board-certified psychiatrist in good standing. As designated by the CMO, the Medical Director will serve as chairperson for the QIC and is involved with the development, adoption, revision, and distribution of QI initiatives. Throughout the course of their work, the Medical Director will provide advice and consultation to assist with the management of all quality improvement initiatives to assure that organizational goals are met. For additional responsibilities see the Medical Director Job description.

## **C. Director, Quality and Accreditation**

The Director of Q&A must be a master's level clinician with QI experience or be a Certified Professional in Healthcare Quality (CPHQ) with a minimum of three years behavioral health QI experience. For additional responsibilities see the Director of Q&A job description.

## **D. Clinical Manager, Quality and Accreditation**

The Q&A Clinical Manager reports directly to the Q&A Director and interfaces with the CMO and Medical Director routinely regarding quality of care issues. The Clinical Manager must be a licensed clinician who oversees clinical initiatives, care coordination, clinical quality initiatives, preventive health screenings, and reports to Humana Health Plan. For additional responsibilities see the Q&A Clinical Manager job description.

## **E. Service Manager, Quality and Accreditation**

The Q&A Service Manager also reports directly to the Q&A Director and interfaces with various Directors regarding service issues. The Service Manager must have extensive experience in service and grievances and appeals for behavioral healthcare. For additional responsibilities see the Q&A Service Manager job description.

## **F. Quality Consultant**

There are Quality Consultant positions for the service and clinical Q&A teams. The Service Consultant must have extensive experience in quality and accreditation preferably in behavioral healthcare and may hold a bachelor's or master's degree or be a CPHQ. The Clinical Consultant must be a licensed master's level clinician with extensive clinical experience preferably in quality and accreditation. All Consultants report to the corresponding Service and Clinical Managers and also interface with the Q&A Director routinely regarding quality of care and service issues. For additional responsibilities see the Quality Consultant job description.

## **G. Quality Analyst**

The Quality Analyst staff, clinical and service, supports the mission and directives of the Q&A department. For additional responsibilities see the Quality Analyst job description.

## **H. Quality Specialist**

The Quality Specialist staff, clinical and service, supports the mission and directives of the Q&A department. For additional responsibilities see the Quality Specialist job description.

The Humana Behavioral Health Q&A department maintains written policies and procedures that govern all aspects of the QI process. These policies and procedures are written by Q&A staff and are reviewed and approved, at least annually, by the QIC. All policies and procedures are made available to HBH associates. All patient records, reports, committee minutes, studies, and other proprietary documentation are considered confidential and treated as such. This information is submitted to affiliated HBH committees and sub-committees as appropriate. This distribution is restricted to staff

who need to know the information.

## **Interdepartmental Coordination of Quality**

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In congruence with the QIP's objective of acting as a liaison to other departments regarding quality-related items, the Q&A department partners with all of HBH to ensure process improvement and quality of service and care. All departments are monitored for staff compliance with policies and procedures as well as progress made in meeting established benchmarks. The following is a brief description of the department monitoring functions that help to ensure coordination of QI activities in all areas of the organization:

### **A. Contact Center Operations**

- Monitor telephone queue performance including time to answer, abandonment rate, and service level metrics
- Receive and route customer complaints

### **B. Behavioral Health Clinical Operations**

- Review encounter data, noting trends and taking actions as necessary
- Monitor compliance with UM and CM requirements
- Ensure physician reviewer and clinical staff adherence to level of care guidelines and medical necessity criteria
- Evaluate productivity reports and take action as necessary
- Review of UM and CM files for compliance with outlined requirements and policies and procedures

### **C. National Network Operations**

- Educate providers about updates and changes to HBH services via the provider manual, newsletter, provider forums, and website
- Monitor the timeliness of the credentialing process for adherence to regulations and health plan contracts
- Maintain an adequate provider network to ensure compliance with access and availability standards

### **D. Information Technology**

- Provide system resources dedicated to the QIP and its objectives
- Maintain data integrity of the provider and consumer electronic database

### **E. Data Operations**

- Monitor the timeliness and accuracy of claims processing
- Maintain current consumer benefit and eligibility information
- Ensure the accuracy of the

### **F. Audits**

- Monitor Humana Behavioral Health's adherence policies and procedures as accreditation requirements
- Maintain appropriate licensure of Medical Director(s) at Humana Behavioral Health
- Ensure Health Insurance Portability and Accountability Act (HIPAA) compliance
- Track suspected areas of fraud and abuse
- Oversee the risk management process

### **G. Marketing**

- Monitor internal/external communication

## **Quality Improvement Processes**

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Measurement activities provide an opportunity to evaluate the quality of care and services being delivered to consumers. Humana Behavioral Health uses data collection, measurement, and analysis to track clinical and service metrics. The QIP ensures the measurement activities are meaningful, impactful, and will lead to improvements overall. Ongoing system analysis is performed to indicate progress on implemented improvement action plans. The QIC analyzes the data and identifies and prioritizes opportunities for improvement. Interventions are implemented as appropriate to improve performance and the effectiveness of the interventions is evaluated.

The following aspects of service and care are focus areas for measuring effectiveness of the QIP:

## **A. Aspects of Service**

### **1. Health Services Contracting**

Humana Behavioral Health contracts with practitioners and providers across the United States. All contracts require cooperation with all QI activities, provision of access to treatment records to the extent permitted by law, adherence to HIPAA regulations, and permission for Humana Behavioral Health to use practitioner and provider performance data. Practitioners and providers also sign a statement affirming that Humana Behavioral Health permits them to freely communicate with consumers about their treatment regardless of benefit coverage limitations.

### **2. Availability of Practitioners and Providers**

Quality and Accreditation works closely with the National Network Operations (NNO) department to ensure that Humana Behavioral Health maintains an adequate network of behavioral health practitioners and providers. The Q&A department monitors how effectively this network meets the needs and preferences of its consumers. A membership assessment is prepared annually to identify the characteristics of the population Humana Behavioral Health serves to ensure that the network adequately meets those needs of the population.

The QIC has established quantifiable and measurable standards for the number and type of behavioral health practitioners and providers, as well as standards for geographic distribution of this network. The QIC analyzes performance against the standards at least annually. Based on the data collected, opportunities for improvement are identified and interventions are implemented as appropriate.

### **3. Accessibility of Services**

Humana Behavioral Health has established mechanisms to ensure consumer access to behavioral health care and services. The Q&A department collects and aggregates data to measure performance against the standards at least quarterly. The QIC reviews the data to ensure compliance for the following behavioral health accessibility standards:

- Provide emergent care for life-threatening emergencies immediately, not to exceed one hour
- Provide emergent care for non-life-threatening emergencies within six hours
- Provide urgent care within 48 hours for commercial consumers
- Provide urgent care for Medicare/Medicaid consumers within 24 hours
- Provide routine office visit appointments for at least 85 percent of members within 10 business days

### **4. Telephone Access**

The Q&A department collects and aggregates data to measure adherence to its telephone access standards and to ensure compliance with the performance standards that follow:

- Maintain an average call answer time of no more than 30 seconds. Time to answer is

measured from the first ring to the connection with a live HBH associate.

- Maintain an abandonment rate of five percent or less which is the number of calls disconnected prior to the calls being answered by a live associate.
- Maintain a service level of 85 percent or greater. Service level is measured by comprehensively measuring how call volumes are handled.

#### **5. *Member Experience***

Annual consumer experience surveys are conducted via mixed media through mail and telephonically with consumers to assess their level of satisfaction with services, accessibility, availability, and acceptability. The survey also analyzes the likelihood of a member to recommend Humana Behavioral Health services to a friend or relative through the use of a net promoter score (NPS) question. Another method used to identify consumer experience is through the tracking and trending of consumer complaints. The QIC uses data from the surveys and complaints to identify opportunities for improvement and implements interventions as appropriate.

#### **6. *Practitioner Satisfaction***

Humana Behavioral Health conducts annual practitioner satisfaction surveys via the mail to measure the level of satisfaction with customer service; claims processing; credentialing/re-credentialing; provider relations; and knowledge, efficiency and timeliness of UM. The survey also analyzes the likelihood of a practitioner to recommend Humana Behavioral Health services to a peer or colleague through the use of a NPS question. The QIC also uses any written comments, whether compliments or complaints, practitioners submit on the survey as important feedback for process improvement decisions.

#### **7. *Client Satisfaction***

Annually, HBH's QIC analyzes client satisfaction with program services by reviewing client complaints, compliments and concerns from the previous year. If complaints or concerns are expressed, HBH implements interventions or action plans to address the issue(s) and bring resolution for the client.

Humana Behavioral Health's clients currently include Humana, Inc. and the International Brotherhood of Electrical Workers (IBEW). Humana Behavioral Health's parent organization, Humana, Inc., may submit information regarding their satisfaction to H B H during quarterly Corporate QIC meetings. Standalone clients, such as IBEW, may submit information regarding their satisfaction to their respective account executive during the respective client-driven quarterly meetings which are attended by the HBH account executive. All satisfaction information is then provided to the Humana Behavioral QIC for review and action, as necessary, at least annually.

#### **8. *Collaboration with Medical Delivery Systems***

Humana Behavioral Health works closely with the medical delivery system and the Humana Health Plan to ensure that the medical and behavioral health needs of consumers are addressed in a manner that supports their overall health in all treatment settings. This collaboration is facilitated through HBH staff and health care practitioner's consistent involvement in the health plans QI committees. Participation by HBH in these committees includes discussion of QI initiatives, measurement results, and updates on behavioral health activities. The health plan committee members provide input and feedback to Humana Behavioral Health on the information presented. Specific collaborative areas include the behavioral health screening programs, self-management tools, strategies to improve performance on HEDIS measures, care management services, and methods to improve continuity and coordination of care and exchange

of information between behavioral health and medical practitioners.

### **9. Service Quality Improvement Activities/Projects**

Humana Behavioral Health continuously aims to identify areas needing improvement. In this process, the QIP implements quality improvement activities (QIA) or projects designed to improve the quality of service received by consumers and providers. There are currently four active service QIAs that focus on:

- *Improving the Access and Referral (A&R) Medicare Member Queue Abandonment Rate* – Callers will receive prompt service as evidenced by a queue abandonment rate of five percent or less.
- *Improving Customer Service Levels* – A comprehensive measurement of the effectiveness and efficiency of the customer service telephone queues.
- *Improving Member Satisfaction with Complaint and Appeal Processing* – Activity focused on improving member satisfaction with timely resolution of complaints and appeals via the measured satisfaction rate on the annual member experience survey.
- *Improving Humana Behavioral Health's Online Tools for Practitioners* – Improvement goal is centered on improving satisfaction with the OnlineAuth.com tool that is provided to practitioners. Satisfaction is measured annually via the practitioner satisfaction survey.

### **10. Member Rights and Responsibilities**

Humana Behavioral Health is committed to treating consumers in a manner that respects their rights and responsibilities. Member rights and responsibilities are posted on HBH's website, listed in the provider manual, and information is included on authorization and denial letters. Practitioners and providers are also required, per their contract, to grant these same rights and responsibilities to HBH consumers. Consumers have the ability to submit suggestions for changes to the current rights and responsibilities list.

### **11. Health Literacy**

Humana Behavioral Health has written policies and procedures in place requiring that all distributed consumer materials are written in plain language at an eighth grade reading level or below, per the national average reading level. In providing documents to consumers that are written in plain language, Humana Behavioral Health aims to positively affect health care outcomes and costs by helping consumers truly understand the health care information they receive. All associates involved in creating or dispersing consumer materials must perform a Fleishman-Kincaid readability test to ensure that the document meets the above mentioned reading level requirements and has received the required health plan approval prior to disbursement of the document.

## **B. Aspects of Care**

### **1. Sentinel Events and Quality Concerns**

Humana Behavioral Health associates identify and report negative consumer treatment events that may potentially compromise safety. The monitoring of sentinel events and quality concerns are part of HBH's member safety program. The most severe events are considered sentinel events (SE) and are immediately documented in the member and practitioner/provider electronic database and reported to Q&A. Sentinel Events such as a member death, completed suicide, and homicide while in treatment are immediately reported to the medical director. Medical records are requested and reviewed by member safety staff and forwarded to the medical director for review. Cases are closed as appropriate or presented to the PRC for

discussion and action planning. An ad hoc PRC meeting may be conducted to review the risk issues of these cases if member safety is imminently compromised.

The following are considered SEs:

- Suicide attempts requiring medical intervention while in treatment at any level of care
- Death by suicide while in treatment at any level of care
- Homicide while in treatment at any level of care
- Patient death other than completed suicide while in active treatment, a treatment setting, or at home
- Allegation of patient abuse, molestation, assault, or sexual assault by a **practitioner, provider or staff** while in a treatment setting
- Allegation of patient abuse, molestation, assault, or sexual assault by a **patient** while in a treatment setting
- Patient abduction of any age while in IP, RTC, or PHP levels of care
- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed healthcare provider at any level of care
- Reported stage three or four pressure ulcers acquired after admission to an IP health care facility

Licensed Associates document quality concerns (QC) in the member electronic database and report these to the Q&A member safety staff to be tracked and trended for potential quality issues.

The following are the categories of QCs:

- Against medical advice (AMA) discharge from IP, RTC or PHP care
- Treatment-related incident where patient suffers unexpected adverse outcome causing temporary or permanent impairment
- Elopement while in treatment
- Discharge from any intensive level of care without adequate discharge plans
- Seclusion in a locked room or the use of mechanical restraints more than three times within a 24-hour period
- Inappropriate, atypical, or questionable medical practice or treatment regimen
- Seizure during withdrawal
- Significant contrary information between clinical information given, documentation in the treatment record or billed charges
- Utilization review ceased with an unknown case outcome
- Patient fall during treatment while in an IP treatment hospital setting

In any of these circumstances, the provider may be asked to give clarifying information and documentation regarding the event and if necessary, a CAP may be implemented. QC data is tracked and trended by Q&A member safety staff. The Q&A will collaborate with the medical director to determine appropriateness of practitioner and provider interventions. Other entities such as the QIC and the PRC may be involved in determining appropriateness of provider or practitioner actions prior to closure of an investigation.

## **2. Clinical Practice Guidelines**

The QIC has adopted clinical practice guidelines (CPG) for Major Depressive Disorder, Bipolar Disorder, Substance Use, and Schizophrenia as recommended by the American Psychiatric Association (APA). Additionally, a CPG has been adopted regarding the practice parameters for Attention Deficit/Hyperactivity Disorder, Depressive Disorder and Substance Use in children



and adolescents as recommended by the American Academy of Child and Adolescent Psychiatry (AACAP). These guidelines are reviewed at least every two years by the QIC and updated as appropriate. Q&A staff educates practitioners regarding the importance of following these practice guidelines in the treatment of their patients through provider newsletters, regional provider seminars, provider manual, and onsite reviews. Information is sent to practitioners with instructions for accessing these guidelines via the HBH, APA, and AACAP websites. Practitioners also may access a summary of the guidelines and an algorithm which serves as a quick guide to the treatment of these disorders through the HBH website or they may request a printed copy. Practitioners are informed that documentation of the adherence to these guidelines will be measured annually during random treatment record reviews. Data on adherence to the CPGs is collected and analyzed at least annually.

### **3. *Coordination and Continuity of Care***

The QIP supports the coordination of care and exchange of information among behavioral health practitioners and providers as well as with primary care physicians. The Q&A department strives to ensure that this process is streamlined, effective, and measures activities implemented to improve coordination.

Humana Behavioral Health uses the following methods to improve the coordination of care between all treating practitioners:

- Educate practitioners regarding the importance of the exchange of information with other behavioral health practitioners and primary care physicians
- Educate consumers on the importance of providing behavioral health practitioners with the names and addresses of other treating providers
- Conduct periodic record reviews to assess practitioner and facility compliance with the documentation of the exchange of information
- Request CAPs from practitioners and facilities that do not meet the goal for coordination of care
- Mail a coordination of care and release of information form to all practitioners with any initial authorization of care with a letter informing them of the expectations for the exchange of information
- Collaborate with the health plan through the integrated care management program to manage care for consumers with co-existing medical conditions
- Collaborate with the Q&A staff of contracted health plans to encourage exchange of information with medical providers

### **4. *HEDIS***

Humana Behavioral Health has implemented programs designed to improve the quality of clinical care related to behavioral health HEDIS measures. Components of the behavioral health programs include, but are not limited to:

- Follow-up After Hospitalization for Mental Illness – The percentage of consumers six years of age and older who were hospitalized for mental health treatment who were seen on an ambulatory basis or day/night treatment by a mental health provider within 7 and 30 days of discharge.
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – The percentage of adolescents and adults diagnosed with alcohol and other drug dependence disorders that initiate treatment within 14 days of diagnosis and have two additional follow-up sessions within 30 days of the first treatment episode.
- Antidepressant Medication Management –
  - Effective Acute Phase Treatment: The percentage of consumers 18 years old or older that were diagnosed with a new incident of depression, were treated with

antidepressant medication and remained on the drug during the entire 84 day (three months) acute treatment phase

- Effective Continuation Phase Treatment: The percentage of consumers 18 years old or older that were diagnosed with a new episode of depression, treated with antidepressant medication and continued the medication for at least 180 days (six months).
- Follow-up Care for Children Prescribed Attention-Deficit, Hyperactivity Disorder (ADHD) Medication –
  - Initiation Phase: The percentage of consumers six to 12 years old who have been prescribed an ADHD medication and completed one follow-up visit with a prescribing practitioner during the first 30 days of beginning a medication regimen.
  - Continuation and Maintenance Phase: The percentage of consumers six to 12 year olds with an ADHD prescription who remained on the medication for at least 210 days and had two follow up visits with a medical or mental health practitioner within nine months of the end of the Initiation Phase.
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications – Measures the percentage of consumers 18- 64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
- Diabetes Monitoring for People with Diabetes and Schizophrenia – The percentage of consumers 18-64 years of age with schizophrenia and diabetes, who had both an LDL-C test and an HbA1c test during the measurement year.
- Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia – The percentage of consumers 18-64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.
- Adherence to Antipsychotic Medications for Individuals With Schizophrenia – The percentage of consumers 19-64 years of age during the measurement year with schizophrenia who were prescribed and remained on antipsychotic medication for at least 80 percent of their treatment period.
- Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics – The percentage of children and adolescents one to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents – The percentage of children and adolescents one to 17 years of age who were on two or more concurrent antipsychotic medications.
- Metabolic Monitoring for Children and Adolescents on Antipsychotics – The percentage of children and adolescents one to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

Data for these indicators is collected at least annually. The results of the data are analyzed by the QIC and interventions are developed for areas that are identified as opportunities for improvement. Additional quality improvement initiatives may be implemented as identified.

## **5. Clinical Quality Improvement Activities/Projects**

Humana Behavioral Health continuously aims to identify areas needing improvement. In this process, the QIP implements QIAs or projects designed to improve the quality of care provided to consumers. There are currently three active clinical QIAs that focus on:

- Improving the Rate of Diabetes Testing for Persons with a Diagnosis of Schizophrenia or

Bipolar Disorder Who Are Taking Antipsychotic Medications

- Improving the Rate of Medication Compliance Among Members With an Initial Diagnosis of Major Depressive Disorder
- Improving the Rate of Follow-up After Hospitalization for Mental Illness

## **6. Treatment Record Review**

The QIC develops policies and procedures for treatment record documentation standards and reviews. The standards describe required treatment record content, organization, ease of retrieving treatment records, confidential patient information and standards and performance goals for participating practitioners. The policies and procedures establish treatment record standards in order to facilitate communication, coordination and continuity of care and to promote efficient, confidential and effective treatment. Providers are notified of treatment record standards via the HBH website, the provider newsletter, provider forums, welcome letters to newly credentialed practitioners and the provider manual. The Q&A department measures adherence to these standards through provider record reviews on an annual basis. Data is analyzed and reviewed by the QIC. When opportunities for growth are identified, interventions are implemented.

## **7. Consumer Safety**

Humana Behavioral Health is committed to a comprehensive patient safety program that provides consumers with a network of practitioners and providers that consistently demonstrate safe and supportive practices. The Q&A department receives SEs and QCs and investigates and processes according to HBH policy and procedures in an effort to provide the safest provider network and treatment for consumers. Q&A collaborates with other departments to assist in identifying trends and addressing consumer safety promptly and effectively. In addition, the QIP collects data from multiple sources to identify opportunities for improvement.

Data sources include, but are not limited to:

- Member experience survey
- Continuity and coordination activities
- Complaints
- Clinical quality activities office site visits and treatment record reviews

## **8. Behavioral Health Screening Programs and Preventive Health Initiatives**

Humana Behavioral Health currently has two behavioral health screening programs that provide an opportunity for earlier intervention in mental health and substance use issues. The first screening focuses on identifying tobacco dependence among consumers who have been diagnosed with Bipolar Disorder. The second screening focuses on identifying children, ages three to 17, who have been diagnosed with Autism Spectrum Disorder (ASD) in order to ADHD. Once consumers are identified for either screening, letters are sent informing the consumer/caregiver about the availability of the online assessment. Data regarding the number of identified consumers who accessed the online screenings is tracked and trended on a quarterly basis and presented to QIC.

The Q&A department continues to offer additional preventive health information on ADHD, post-partum depression (PPD) and depression in senior adults. Practitioners and providers can request, via telephone or the provider portal, to be mailed educational

Information on these topics to provide to consumers. Data regarding these requests is tracked and trended on a quarterly basis and presented to QIC.

## **9. Consumer Self-Management**

Humana Behavioral Health seeks to empower consumers in maintaining or improving their current health status by providing appropriate self-management tools designed to assist consumers with managing their health. These tools are offered to all consumers through the HBH website and provide guidance on health-related issues. Educational information is also given regarding recommendations on methods to improve health and reduce risks.

#### **10. *Serving Consumers with Complex Health Needs***

At least annually, the characteristics of HBH's consumer population are assessed through the annual membership assessment. The current goals of the CM program are evaluated against the needs of consumers with complex health conditions identified in the annual assessment. Program resources and processes are updated in order to better serve consumers who meet the criteria for the CM program. The goal of the program is to holistically coordinate services for consumers across the behavioral and physical health continuum. When serving consumers with complex health needs, the CM program utilizes a collaborative process to assess, plan, implement, coordinate, monitor, and evaluate options and services to meet an individual's health needs. Humana Behavioral Health associates serve as the consumer's liaison and build partnerships with the consumer's community on the consumer's behalf.

#### **C. Delegation Oversight**

Humana Behavioral Health has delegated certain functions of quality, UM, and credentialing to other entities. When functions are delegated to another organization, Humana Behavioral Health conducts a pre-assessment evaluation of the organization's capacity to perform the proposed delegated activities prior to entering into a delegation agreement. Pre-assessment delegation evaluations may include review of the following items, but are not limited to:

- The formal, written contract of delegated activities
- The delegated entity's program description, program evaluation, and work plan
- Policies and procedures
- Reports, files, or committee minutes related to the delegated activities for the past 12- 24 months

Once deemed appropriate, the contract is signed by both parties. Humana Behavioral Health performs continuous oversight and annual evaluation of the above mentioned items for the delegated functions. If deficiencies are discovered, a CAP is created and agreed upon by both parties. HBH staff monitors the correction of the identified deficiencies. Humana Behavioral Health retains the right to reclaim the delegated function if satisfactory correction of deficiencies does not occur. Annual audit results are presented to the QIC and other sub-committees for approval or disapproval of continued delegation.

#### **D. Data Collection, Analysis, and Reporting**

Humana Behavioral Health, alongside Humana Health Plan, has developed the Clinical Guidance Exchange (CGX) and Customer Care Portal2 (CCP2) electronic information management systems which are specifically designed for managed behavioral health data. The systems permit the collection, management, and integration across the medical and mental health care continuum of consumer demographic information, clinical data, admission and treatment approvals, practitioner and provider networks, and claims processing. The systems can provide customized reports on a periodic basis (i.e. monthly, quarterly, annually) or ad-hoc to monitor and evaluate penetration rates, utilization patterns, demographic trends, care management trends, and other care delivery-related information. Additionally, HBH utilizes both internal and external personnel for statistical analysis of data.

## E. Quality Improvement Corrective Actions

The principles of continuous QI in behavioral healthcare dictate that remedial or corrective actions are necessary in response to complaints, critical incidents or identified out of compliance issues.

### 1. Implementation and Evaluation

Appropriate remedial or corrective actions may be taken by HBH under, but not limited to, the following circumstances:

- Inappropriate or substandard services provided by a provider or practitioner
- Failure to meet quality indicators or other quality monitoring activity performance standards
- Failure to meet requirements of the contract agreement or provider manual

The following procedures are used to implement and evaluate remedial/corrective actions regarding providers or practitioners:

- Humana Behavioral Health network providers may have their network status suspended and/or terminated for failure to comply with HBH administrative, clinical and/or quality requirements as stated in the provider manual and/or contract/agreement
- NNO will notify all involved parties, including providers and staff, about the issue(s) and the requirements for remedial or corrective action(s)
- The decision may be appealed by the provider to change the network status by formally requesting in writing a review within the specified time frames outlined in the provider manual, provider contract and appropriate policies and procedures

### 2. Effectiveness

The effectiveness of remedial or corrective action requires continual monitoring and evaluation of the implemented plan to identify measurable changes and improvements.

- Measureable improvement of the desired change
- Improvement is maintained over a specified time period
- Improvement in the quality of treatment and/or service is continually reflected in daily operations
- Improvements continually meet the requirements of the standards outlined in the action plan
- Supporting documentation of the required outcomes and improvements is provided

## Annual Review

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### A. Quality Improvement Program Evaluation

An annual evaluation of the QIP is conducted to assess the overall effectiveness of HBH's QI processes. This evaluation reviews all aspects of the QI Work Plan, focusing on whether the program has demonstrated improvement in the quality of care and service provided to consumers. This document is developed by the Q&A department and reviewed and approved each year by the QIC and SLT. The results of the annual evaluation are used to develop and prioritize the next year's annual QI Work Plan. The written annual evaluation document contains the following:

- A description of completed and ongoing QI activities
- A review of trends to assess quality and safety of clinical care, as well as quality of service
- An analysis to determine if the quality of clinical care and service to consumers have exhibited improvements

- Related interventions as identified
- A review of how resources are utilized to improve the quality of care and service to consumers
- Recommendations for enhancements or revisions to the upcoming year's QI Work Plan

Humana Behavioral Health's website and newsletter notifications inform all stakeholders, including consumers and providers of the details of the QIP and annual evaluation. Paper copies of the QI Program Description, QI Work Plan, and QI Program Evaluation are available to stakeholders for review and hard copies may be requested.

## **B. Quality Improvement Work Plan**

The annual QI Work Plan focuses on the QIP goals, objectives, and planned projects for the upcoming year. The content of the QI Work Plan will change annually with the needs of the organization, its consumers, and providers. Continuous evaluation and reporting by the QIC and other committees, entities and/or individuals will identify the need to add new information or modify the existing data during the program year. The QIC reviews and approves the QI Work Plan and its content annually.

## **C. Policies and Procedures**

Policies and procedures for the QIP are maintained by the Q&A department. Revisions are made to existing policies and procedures based on necessity throughout the year. If changes are made, the policy and procedure is presented to the QIC for review and approval. However, all policies and procedures must be reviewed and presented to the QIC for approval at least annually. A table of contents containing all policies and procedures is maintained by all HBH departments that includes that department's policy numbers, titles, last date of revision, last annual review date, and references.

## **Confidentiality**

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Humana Behavioral Health adheres to existing corporate confidentiality policies. The organization strictly adheres to HIPAA regulations to ensure that consumer rights related to confidentiality are fully protected and involve the following:

- Implementation of corporate and departmental confidentiality policies in accordance with state, federal and accreditation regulations and standards
- Protection of the identity of involved individuals, except when identification is necessary in the performance of QI activities
- Maintenance of confidential documents in secure locations

All HBH associates, consultants, including temporary staff and interns, are required to sign a confidentiality statement within the annual Ethics and Compliance training modules prior to participating in any work activities. Outside committee members also sign a confidentiality statement annually as part of their contract renewal.

## Approval

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The 2017 QI Program Description has been reviewed and approved.



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Lawrence Weinstein, MD  
*Chief Medical Officer*  
Member, SLT  
Chairperson, QIC

**3/28/2017**

Date



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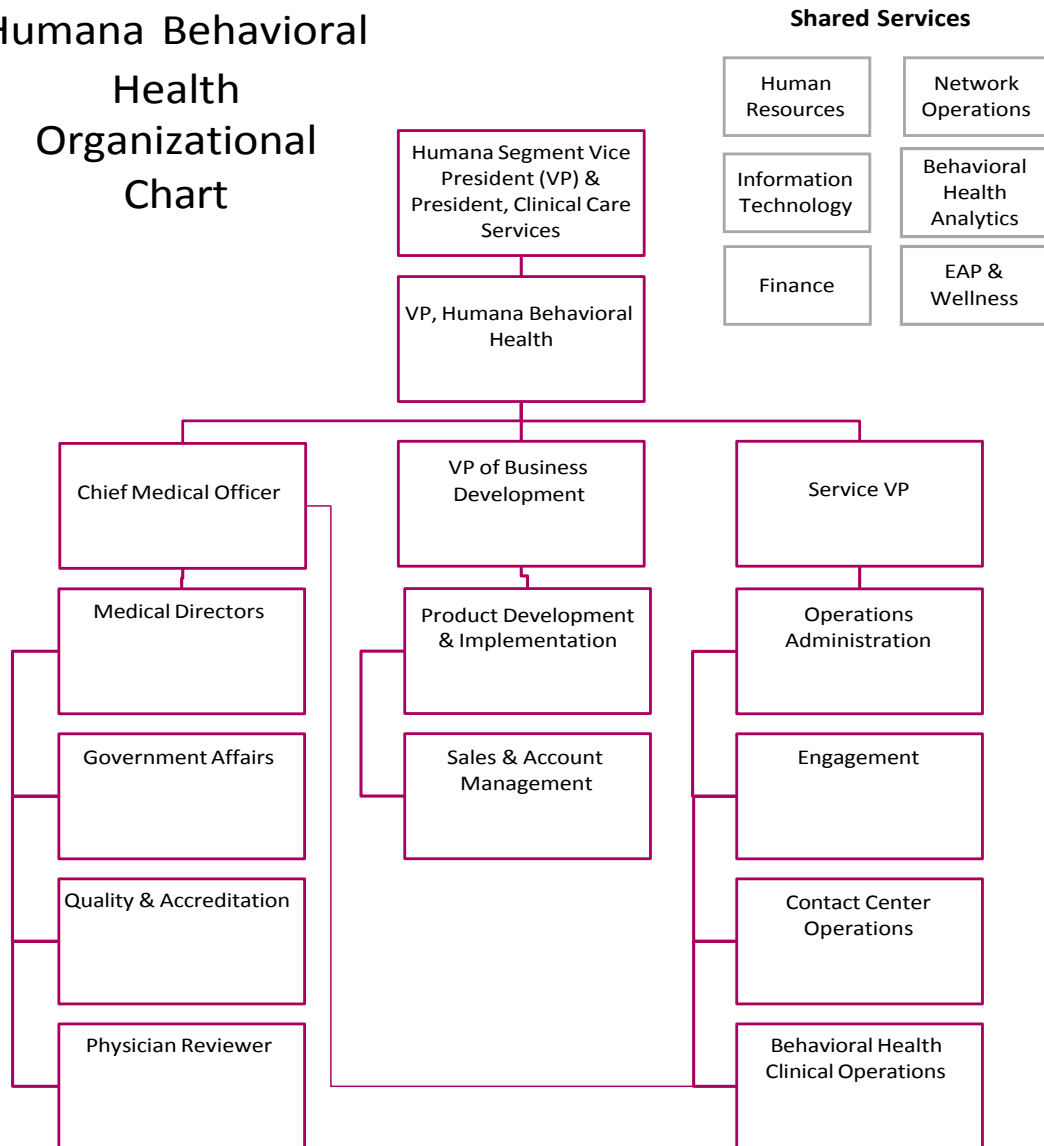
Sabrina Townsend, Ph.D.  
*Director, Q&A*  
Chairperson, QIC

**3/28/2017**

Date

## Appendix A – Organizational Charts

### Humana Behavioral Health Organizational Chart





# Quality and Accreditation Organizational Chart

