Community Mental Health Affiliation of Mid-Michigan

QUALITY IMPROVEMENT PLAN

2010

CMHAMM Governing Body Approval: 03/18/10
xxCMH Board Reviewed: xx/xx/xx

Quality Assessment & Performance Improvement Program (QAPIP)
2010

PURPOSE: The purpose of this plan is to implement and maintain a quality improvement program that achieves, through ongoing measurement and intervention, improvement in aspects of clinical care and non-clinical services that can be expected to affect consumer health status, quality of life, and satisfaction.

I. DESCRIPTION OF THE QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

A. Structure (MA 6.7.1, 6.7.1.1) (GF 6.8.1.1) (42 CFR Subpart D 438.240)

The structure of the QAPIP allows each Medicaid Service Provider Agency to establish and maintain its own unique structure for monitoring, evaluating, and improving quality. The CMHAMM Quality Improvement Workgroup (QIW) is responsible for ensuring the effectiveness of each Medicaid Service Provider's QAPIP with additional oversight by the PIHP Leadership Committee, Affiliation Steering Committee and final review/authority resides with the PIHP governing body.

Affiliation-wide process improvements will be assigned by the QIW under the auspices of the PIHP to an active Affiliation Committee/Workgroup or task-specific Process Improvement Team.

B. Components and Activities (MA 6.7.1.1) (GF 6.8.1.1)(42 CFR Subpart D 438.240)

The components and activities of the QAPIP are focused around seven key areas: 1) Service Authorization, 2) Enrollee Rights, 3) Provider Network Management, Credentialing and Privileging, 4) Quality Management, 5) Financial Management, 6) Information Systems Management, and 7) General Management.

It is intended that within the scope of the areas identified above, all demographic groups, care settings, and types of services within the affiliation will be represented.

C. Role of Recipients (MA 6.7.1.)

Recipients of services will participate in the QAPIP through involvement on workgroups, process improvement teams, advisory groups and QI Committees at the local and Affiliation level. Said recipients will provide input into policy and program development, performance indicator monitoring, affiliation activities/direction, self-determination efforts, QISMC projects, satisfaction findings, consumer advocacy, local access and service delivery, consumer/family education, etc.

D. Mechanisms for Adopting and Communicating Improvements (MA 6.7.1.1)

Each Medicaid Service Provider Agency will identify opportunities for process and outcome improvements for their agency. These opportunities will be reported to the Affiliation Quality Improvement Committee on a minimum of a quarterly basis. A standing agenda item has been added and will be reviewed during each meeting. Each member will have the opportunity to report on identified opportunities for improvement and the process that will be implemented. During future meetings the results from the quality process and outcome improvement projects will also be discussed. This information will be captured in the workgroup minutes.

The minutes that include the outcome and process improvement projects by affiliate members will be posted on the Affiliation website and presented periodically but not less than annually to the Affiliation Steering Committee and the governing body.

E. Goals (GF 6.8.1.1)

1. Implement a reporting process for affiliate CMHSPs to use to report status of local activities towards completion of CMHAMM QI Plan goals, by 3/31/10.
2. Annually review and revise CMHAMM QI policies and procedures.
3. Adopt standardized category names for collecting data across the affiliation on grievances and inquiries, by 6/30/10.
4. Develop or modify a procedure that requires the analysis of critical incidents for the purpose of identifying opportunities for quality improvement in supports and services (reference ARR, Section 9), by 5/31/10.
5. Develop guidelines to ensure that quality of supports and services are regularly and consistently assessed throughout CMHAMM's entire provider network (reference ARR, Section 9), by 5/31/11.
6. Develop a list of acceptable methods for measuring consumer outcomes and protocols for submitting outcomes data to the PIHP for review and, when necessary, recommendations (reference ARR, Section 9), by 5/31/11.

II. ACCOUNTABILITY AND RESPONSIBILITIES OF THE QAPIP (MA 6.7.1.1) (GF 6.8.1, 6.8.2) (42 CFR Subpart D 438.242)

The PIHP governing body is accountable and responsible for reviewing and approving the PIHP QAPIP and the QAPI annual plan. The governing body will establish and demonstrate an ongoing commitment to quality improvement; applying principles of quality improvement to its activities; reviewing written performance improvement reports, the action taken, and the results of those actions; reviewing and approving the QI Plan and goals a minimum of annually; and acknowledging and celebrating successes.

III. DESIGNATED SENIOR OFFICIAL (MA 6.7.1.1) (GF 6.8.1.1, GF.IV) (42 CFR Subpart C 438.100)

The PIHP's Director of Quality is the designated senior official and has the responsibility for ensuring the implementation of the PIHP QAPIP across the affiliation. Additionally, the Director of Quality and the QIW is committed to the goals of the quality improvement plan and for creating an environment that is conducive to the success of quality improvement efforts, ensuring affiliation involvement, removing barriers to positive outcomes, and monitoring results of the quality improvement program across the PIHP and reports to the PIHP governing body as indicated above in section II.

The PIHP and Medicaid Service Provider Agency Medical Directors will demonstrate an ongoing commitment to quality improvement; participating on committees and work teams as needed, reviewing quality improvement reports, sentinel events, and critical incidents; and assisting in establishing clinical outcomes for the Affiliation. The PIHP and Medicaid Service Provider Agency Medical Directors will provide clinical oversight related to quality and utilization of services through consultative committee involvement.

The PIHP has delegated to the Medicaid Service Provider Agency Quality Improvement Directors the responsibly for assessing compliance of the PIHP Quality Improvement Plan annually (via review of current DCH contract requirements) and recommending revisions to the plan. The Medicaid Service Provider Agency QI Directors are also responsible for evaluating the effectiveness of their quality improvement program (via quarterly reporting to the PIHP) which will include assurances that local committees are meeting as needed; have established roles/functions; and are maintaining documentation of local QI activities and tracking issues over time.

IV. STAKEHOLDER PARTICIPATION (MA 6.7.1.1) (GF.6.9.3.3)

In addition to the participation of recipients of services in quality improvement activities, the PIHP and its Medicaid Service Providers will strive to involve other stakeholders such as providers, family members, community members, and other service agencies whenever possible and appropriate. Opportunities for stakeholder participation include PIHP governing body and Medicaid Service Provider Board of Directors membership; Consumer Advisory activities at the local, affiliation and state levels; completion of satisfaction surveys; participation on quality improvement work teams or monitoring committees; and focus group participation. Stakeholder input will be utilized in the planning, program development, and evaluation of services, policy development, and improvement in service delivery processes.

V. PERFORMANCE MEASUREMENT (MA 7.0.2) (GF.6.5.1.1) (42 CFR Subpart D 438.204)

The PIHP in conjunction with the QIW is responsible for ensuring that each Medicaid Service Provider Agency is measuring its performance through the use

of standardized performance indicators as established by the state. Standardized definitions will be utilized across the affiliation to ensure accuracy of the data. Indicators may also be established in areas identified for possible improvement. On an annual basis, or as new standards are issued, the PIHP and QIW, in coordination with the CMHAMM Information Systems (IS) Workgroup, will review the MDCH established performance indicators to assure that systems are in place for monitoring and reporting as needed throughout the affiliation. Negative statistical outliers will be analyzed when they occur.

VI. USE OF PERFORMANCE MEASUREMENT DATA (MA 7.0.2) (GF.6.5) (GF.6.5.1.1) (GF.6.8.1.1)

Each Medicaid Service Provider will be responsible at the local level for the accurate data collection of the Michigan Department of Community Health (MDCH) performance indicators and for studying and improving any compliance indicators in which performance does not meet or exceed state threshold. Said improvement efforts will be reported to the PIHP.

The PIHP is responsible for oversight of affiliate data collection, documentation, and data reporting processes to ensure compliance with PIHP, State and Federal processes and requirements. The PIHP in conjunction with the QIW will be responsible for monitoring the overall performance of the Affiliation.

The PIHP is responsible for quarterly analyses of data from the behavior treatment review committee where intrusive and restrictive techniques have been approved for use with beneficiaries and where physical management has been used in an emergency situation. Only techniques that have been approved during the person-centered planning by the beneficiary or his/her guardian, and are supported by current peer-reviewed psychological and psychiatric literature may be used with beneficiaries. Data shall include numbers of interventions and length of time the interventions were used per person.

VII. QISMC – QUALITY IMPROVEMENT SYSTEM FOR MANAGED CARE (MA 6.7.11) (GF.6.5.1.1) (GF 6.8.1.1) (42 CFR Subpart D 438.242)

The PIHP will be responsible for implementation of the QISMC standards for Affiliation-wide performance improvement projects. Said projects will focus on achieving demonstrable and sustained improvement in services likely to have beneficial effects on health outcomes and consumer satisfaction. Topics identified for potential projects will be prioritized and selected based on stakeholder and Medicaid Service Provider Agency input and will closely adhere to QISMC standards. Topics for potential QISMC projects may also be assigned by the MDCH.

Selection and prioritization of projects will be based on the following three factors:

Focus Area: Clinical (prevention or care of acute or chronic conditions; high volume or high risk services; continuity and coordination

	of care), or Non-Clinical (availability, accessibility, and cultural competency or services; interpersonal aspects of care; appeals, grievances, and other complaints.)
Impact:	Affects a significant portion of consumers served and has a potentially significant affect on quality of care, services, or satisfaction.
Compliance:	Adherence to law, regulatory, or accreditation requirements.

<u>The 2010 Affiliation QISMC projects include:</u>

1. **Access to Services for Children who are Medicaid Beneficiaries.** This project is required by MDCH as the FY2010 project, as continued from FY2009. The focus is the improvement of penetration rates for children with serious emotional disturbance, children with a developmental disability, and children who have both a serious emotional disturbance and a developmental disability. Measurement shall be established following guidance by MDCH.
2. **Coordination of Care with Primary Care Providers** This project was required by MDCH as the 2006 project, and was continued per MDCH suggestion for 2007 to correct any problems that had been identified by the EQR validation process. The coordination of care project was revised to focus on encouraging communication by identifying and using the communication methods preferred by CMH clinicians and primary care physicians. The project included 100% of the Medicaid enrollees who are receiving Assertive Community Treatment (ACT) services or meet ACT criteria**.**
   Having successfully completed this project, and recognizing the importance of continued focus on coordination of care, the QIWG established its 2008 project as Coordination of Care and Community Provider Education. The goal was to establish a face to face relationship between the QHPs and their providers and CMHSP medical mental health providers by developing an educational/training program both primary care and mental health medical providers to attend, offering opportunities for increased collaboration. During the 2008 year, 3 educational/training events were held, bringing together medical staff representatives from both mental health and primary care, and held simultaneously from 3 different sites within the CMHAMM region. Given the mounting success of these events, the QIWG has continued this project during 2009, having held 4 events, and will continue during 2010.

VIII. SENTINEL EVENTS (MA 6.7.1.1) (GF.6.5.1.1)

In an effort to assure and maximize safe clinical practices and stress the importance of member safety, established processes are in place throughout the Affiliation that effectively:

- Identify and report the occurrence of critical health and safety incidents;
- Evaluate the factors involved, which caused critical health and safety incidents to occur;
- Identify and implement actions to eliminate or lessen the risk of critical health and safety incidents from future occurrence.

Specifically, this includes detailed administrative policy and procedures established by and located at each Board relative to identification, reporting requirements, review, root cause analysis commencing within 2 business days of the event, and follow up of incidents considered sentinel events. Individuals involved in the review of sentinel events shall have the appropriate credentials to review the scope of care. Sentinel event reporting procedures, including review, investigation, and follow up, will be in accordance with the CMHAMM Sentinel Event Procedure and applicable guidelines issued by MDCH in the Medicaid Specialty Services and Supports Contract.

IX. QUANTITATIVE AND QUALITATIVE ASSESSMENTS OF MEMBER SATISFACTION WITH SERVICES (MA 6.7.1.1) (GF 6.8.1.1) (GF.6.9.3.3)

The opinions of the consumers, their families and other stakeholders are essential to identify ways to improve processes and outcomes. Satisfaction surveys and focus groups are an effective means to obtain input on both qualitative and quantitative experiences with services.

A. The PIHP assesses satisfaction of its consumers, families and stakeholders regularly through standardized surveys. The surveys will address quality, availability, and accessibility of care. The results of the surveys are collected, analyzed and reported by the PIHP Evaluation Specialist who identifies strengths and areas for improvement and makes recommendations for action as appropriate. The data is aggregated and reported in a number of ways:
   - as a PIHP
   - by each Medicaid Service Provider member
   - by specific reporting units within each affiliation member as requested
   - by provider

B. The data is used to identify best practices, demonstrate improvements, or identify problem areas. The results of each survey are presented to the PIHP governing body; PIHP Leadership Group Affiliation Consumer Advisory Council; Medicaid Service Provider Agencies; local Quality Improvement Steering Committees and Boards of Directors. Findings will also be shared as appropriate with stakeholders on a local level through such means as advisory councils, staff/provider meetings and printed materials.

C. The annual standardized surveys include:
   - Open cases
   - Closed cases
   - Residential satisfactions surveys:
     - All residents of specialized residential
     - Parents or guardians of all persons who reside in specialized residential homes
     - Case managers/support coordinators of all persons who reside in specialized residential homes

- Professionals or organizations that refer persons to CMH for services
- Clinical Contractors of Affiliation members

D. Each respondent to a survey has the opportunity to provide specific written comments in addition to expressing a level of satisfaction/dissatisfaction to the various questions. Sources of dissatisfaction are investigated and remedial action is taken on individual cases as appropriate. When an individual chooses to identify him or herself, a designated staff will respond. All written comments are aggregated and reported in the written survey report. In addition, the outcome of each contact with a respondent is recorded and reported to the PIHP Director of Quality Improvement.

E. Focus groups are conducted, as needed to obtain input on specific issues such as redesign of programs, and development or revisions in policies. Examples of improvements or changes that have occurred as a direct result of the surveys will be detailed in the annual Affiliation Quality Improvement Report. Satisfaction surveys and aggregate reports are available for review at each of the Medicaid Service Provider locations.

X. PRACTICE GUIDELINES (MA 6.7.1.1) (GF 6.9)(42CFR Subpart D 438.236)

The PIHP has established Practice Guidelines based on the Medicaid Provider Manual that meet the needs of persons served and ensure that each individual receives the most efficacious services. The care guidelines have been developed with input from the Affiliation Utilization Management Workgroup, Medicaid Service Provider, and the PIHP leadership group and the PIHP clinical directors in accordance with the MDCH Medicaid Provider Manual, and are mutually agreed-upon by MDCH and the PIHP. Decisions for utilization management, consumer education, and eligibility for services are consistent with the guidelines. Practice Guidelines are reviewed and updated annually or as needed; and are disseminated to appropriate providers. Guidelines are also available upon request to persons served and other stakeholders.

The PIHP will assure that standardized guidelines are implemented uniformly by each Medicaid Service Provider Agency. The application of the Practice Guidelines is monitored through standardized measurement tools as developed by the PIHP. Outcome measures will be valid and reliable. When nationally accepted care guidelines are available, clinicians review those guidelines for possible adoption of all or part, by the Medicaid Service Provider Agency.

XI. QUALIFICATIONS FOR SCOPE OF PRACTICE (MA 6.7.1.1) (GF 6.4.2) (42 CFR Subpart D 438.214)

A. Credentialing, Provider Qualification and Selection

The PIHP is responsible for ensuring that each provider, employed and contractual, meets all applicable licensing, scope of practice, contractual, and Medicaid Provider Manual requirements. The PIHP has written

policies and procedures, in compliance with MDCH's Credentialing and Re-credentialing Processes (January 2007, Attachment P.6.4.3.1), establishing processes for ensuring the credentialing and re-credentialing of its providers, initially upon employment/contract initiation, and minimally every two (2) years thereafter. The policies and procedures outline the credentialing/re-credentialing process, provider appeals process, and PIHP reporting requirements.

Credentialing Processes for Licensed Providers of Care

1. **Application:** Initially, a written application is completed, signed and dated by the provider, including authorization to conduct criminal background checks.
2. **Certification and/or Licensure:** Primary source verification of professional licensure or certification.
3. **Educational Background:** Primary source verification of graduation from an accredited school.
4. **Professional & Healthcare Integrity:** Review of history of professional liability claims, disciplinary status with regulatory boards or agencies, and Medicare/Medicaid sanctions will be conducted by the Contract Manager or Human Resources Department.
5. **Prior & Relevant Work History:** Review of prior relevant work experience will be conducted by the Supervisor, Contract Manager, and/or Human Resources Department.

Re-credentialing shall include primary source verification of certification and/or licensure and review of professional and healthcare integrity as defined above.

Processes for Non-Licensed Providers of Care

The PIHP is responsible for ensuring that non-licensed providers of care and support are qualified to perform their jobs.

The PIHP will ensure, minimally, the following:

1. Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following:
   a. Educational background
   b. Relevant work experience
2. A program shall train new personnel with regard to their responsibilities, program policy, and operating procedures.
3. A program shall identify staff training needs and provide in-service training, continuing education, and staff development activities.

The CMHAMM Provider Network Management Workgroup (PNMW), in collaboration with the QIW, is responsible for managing credentialing procedures within the Affiliation. The PIHP is responsible for oversight of affiliate credentialing processes to ensure compliance with PIHP and State requirements.

B. Adequacy of Network

The PIHP is responsible to ensure CMHSP compliance with the adequate network standards of the BBA. The PIHP is also responsible for monitoring network adequacy across the affiliation.

C. Training Policy and Activities

The PIHP will ensure that each Medicaid Service Provider will maintain an orientation process for all new staff to minimally ensure training on job responsibilities, agency policy, and standard operating procedures in accordance with accreditation and applicable rules and regulations. Particular attention is devoted to confidentiality and recipient rights. The orientation and introductory employment period performance evaluation processes will identify initial (within 90 days of hire) and annual training requirements. Job specific training needs will be developed on an on-going basis during supervision and performance evaluations.

1. **Cultural Competence:** The PIHP will ensure each Medicaid Service Provider Agency has cultural competency training annually for all staff. Potential topics: Native American Culture, Aging, Empathy Training with NAMI, etc. Evidence of successful completion of the training will be maintained within the personnel or contractor file.
2. **Provisions for In-Services Training, Continuing Education, and Staff Development:** The PIHP will ensure adequate opportunities for staff training across the affiliation. Training can be requested by staff or suggested by supervisory staff. Approval of training/conference requests may be based upon relevance to the staff person’s job and availability of funding.

XII. VERIFICATION OF SERVICE DELIVERY (MA 6.7.1.1) (GF.6.4.2)

The PIHP has a standardized methodology, approved by MDCH, for verifying that Medicaid services claimed by providers were delivered. The PIHP has delegated to the Medicaid Service Provider Agency the responsibility for implementing the primary Medicaid claims verification process at the local level.

Verification elements include the following:

- Determination as to whether services provided are eligible for payment as listed in the Medicaid Provider Manual.
- Determination that the individual receiving the service was Medicaid eligible at the time of service.

- Determination as to whether services provided were authorized in the person centered plan.
- Determination as to whether there is documentation that services claimed were actually provided in the amount, scope and duration authorized.
- Determination that the provider held the necessary credentials to provide the service.

A secondary Medicaid claims verification audit is completed annually by the PIHP. The purpose of the audit is to confirm that the primary Medicaid claims audit findings are accurate and consistent with Medicaid standards.

If the secondary review findings do not agree with the primary review that will be considered an error. A written report will be provided to each Medicaid Service Provider member identifying the findings of the secondary review. The Medicaid Service Provider will report actions taken to correct identified deficiencies to the PIHP Director of Operations.

The PIHP will present an aggregate report of findings and recommendations from the Medicaid Claims primary and secondary reviews to the PIHP Leadership Committee, the Affiliation QI Workgroup, Affiliation Steering Committee, and the PIHP Governing Body annually.

XIII. UTILIZATION MANAGEMENT (MA 6.7.1.1) (GF.6.4.2) (GF.6.9) (42 CFR Subpart D 438.208, 438.210, 438.100)

The PIHP has established criteria for determining medical necessity, information sources and processes that are used to review and approve provision of services.

The PIHP has mechanisms to identify and correct under- and over-utilization of services as well as procedures for conducting prospective, concurrent, and retrospective reviews. Qualified health professionals will supervise review decisions. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to provide treatment in consultation with the primary care physician as appropriate.

The reasons for treatment decisions are clearly documented and available to the person served. Information regarding all available appeals processes and assistance through customer services is communicated to the consumer. Notification requirements will be adhered to in accordance with the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Community Health.

The PIHP is responsible for oversight of affiliate authorizations and second opinions and appeals processes to ensure compliance with PIHP, State and Federal requirements.

XIV. CUSTOMER SERVICES & ENROLLEE RIGHTS AND RESPONSIBILITIES (MA 6.3.2) (GF 6.8.1.1;6.3) (42 CFR Subpart C 438.100-438.102) (DCH Customer Service Standards)

The PIHP is committed to culturally competent service delivery acknowledging enrollee rights and responsibilities, ensuring all of the rights as established in Federal and State law. To ensure and monitor consumer rights, each Medicaid Service Provider will maintain an Office of Recipient Rights that is in substantial compliance with the requirements of Chapter 7 of the Michigan Mental Health Code.

The PIHP shall ensure that Customer Services within the Affiliation meet DCH standards. Customer Services will include the following functions:

- Welcoming and orienting individuals to services, benefits, and the provider network;
- Providing information about how to access mental health, primary health, and other community services;
- Providing information about how to access various rights processes;
- Helping individuals with problems and inquiries regarding benefits;
- Assisting people with and oversee local complaint and grievance processes; and
- Tracking and reporting patterns of problem areas for the organization.

The PIHP shall ensure that a customer services handbook is provided to the Medicaid beneficiary when they first come in to services and periodically thereafter. The handbook will include State standardized information on benefits, services, and rights, as well as include unique Affiliation and local contact information and operations. Accommodations shall be available for helping individuals understand the information, and shall be available in alternate languages to meet the prevalent languages spoken in the PIHP’s service area.

XV. CLINICAL RECORDS/PEER REVIEW (MA 6.8.1) (GF 6.9.2)

Qualitative and quantitative clinical record reviews will be completed by each Medicaid Service Provider Agency on a quarterly basis. An affiliation record review methodology has been developed and to ensure validity of the data, staff completing the reviews are trained in that methodology. The review is completed using a standardized record review tool developed by the PIHP. Completed reviews will be forwarded to the PIHP for scoring and aggregation. Results will be reviewed and acted upon through the QIW and the quality improvement process of each Medicaid Service Provider Agency.

The PIHP is responsible for oversight of Affiliate review methodology to ensure compliance with Affiliation processes and requirements. The PIHP in conjunction with the QIW will be responsible for monitoring the overall performance of the Affiliation.