

THE CENTER FOR HEALTH CARE SERVICES
Quality Improvement Support Services Directorate
FY 2008 Quality Management Plan

Quality Management Plan

Purpose and Mission

The Center is committed to excellence through continuous quality monitoring and improvement in a comprehensive performance measurement program. This effort requires ongoing communication with consumers, employees, stakeholders, Board of Trustees, Behavioral Health Planning and Network Advisory Committee (BH PNAC)), clinical providers and all levels of management. Furthermore, the Center supports an effective Quality Management Program consistent with its mission, vision, and values (see below). The Quality Management Plan (QM Plan) is implemented as approved by the Center's Leadership Team (LT). Decisions concerning center-wide operations are made by the LT. Reporting of QM goals and directives occurs as needed at biweekly LT meetings; at monthly Executive Management Team (EMT) meetings, and quarterly at Full Management Team (FMT) meetings. (See *addendum* for roster of staff positions represented at these meetings.) The QM Plan establishes quality data collection and clinical oversight to assist Center administration and providers in making judgments related to policy issues, delivery of care, funding and growth; supporting information for insurance and benefits claims; aiding in defending consumers and providers in legal affairs; promoting cultural competence and educating providers. The implementation and oversight of the Quality Management Plan is delegated to the Center's Quality Improvement Services (QIS) Directorate. The Behavioral Health Planning Network Advisory Committee(s) (BH PNACs) meet bimonthly and, from the Chief Operating Officer, receive status reports on overall achievement of Center goals and objectives as well as specific reports that are requested concerning network oversight audit findings.

The Center's comprehensive continuous quality improvement (CQI) plan uses data, trend, and cost analysis to profile performance at the individual, unit, program and network levels. The CQI Plan guides root cause analysis, corrective actions for identified problems, and monitoring of corrective actions. The CQI Plan reflects a continuous process, which improves and informs the delivery system of outcome results, and demonstrates a commitment to quality services for all individuals served within the Center's provider network.

Mission, Vision, and Values

MISSION

The Center for Health Care Services improves the lives of people with mental health, developmental disability, and substance abuse challenges.

VISION

Transformed lives, transformed communities

VALUES

Founded on the hopes of those we serve and driven by integrity, we believe in creating environments that inspire and promote

- Respect for one another and Empowerment for all
- Quality and Accountability
- Creativity and Innovation

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Corporate Compliance

Purpose: In 2005, the federal government passed the Deficit Reduction Act, which established “healthcare fraud” as a crime. The law was extended to include fraud committed against: private insurers and providers, managed care companies, and the federal health plans i.e. Medicare, Medicaid, and Champus. Efforts to detect and prevent healthcare fraud have been implemented in full force by the federal government. Extensive governmental resources are being used to investigate, prosecute, sanction, fine, or jail those who are involved with, or are convicted of healthcare fraud offenses. The Center for Health Care Services’ Board of Trustees is vested in protecting its reputation, its consumers and employees, its financial stability and long-term viability. The Center’s Compliance Plan (CHCS Board of Directors Policy No. 6.12; Eff. Date 4/9/07) ensures early detection of issues, reduces vulnerability to lawsuits, protects the Center against allegations of fraud or abuse, moves the Center toward efficient and consistent operations, establishes organizational memory, and demonstrates commitment to ethical behavior and excellence in service delivery. The Compliance Plan comprises the Center’s plan to reduce waste, fraud and abuse of resources.

The Center’s Compliance Plan addresses the seven (7) key elements of an effective plan: administrative responsibilities, the Compliance Committee, education and training, monitoring activities, reporting alleged misconduct and investigation procedures, corrective action plans, annual compliance review and revisions to the Compliance Plan.

The Compliance Plan is not intended to set forth all practices of the Center that are designed to achieve compliance. In addition to the Compliance Plan, the Center has a Quality Management Plan and other policies and procedures to assure ethical and responsible practices. In combination, the Center’s compliance efforts are described in each plan, and coordinated to direct the Center’s overall compliance effort.

QUALITY INDICATORS

I. Mental Health and Substance Abuse Programs

For FY 2008 the Center’s mental health and substance abuse programs will continue to utilize the outcomes measures from the Texas Department of State Health Services (DSHS). The variables to be monitored and assessed are derived from the DSHS Community Mental Health and Substance Abuse Services Resiliency and Disease Management (R&DM) Fidelity Toolkit. In addition, in FY08, the Center is integrating into its comprehensive QM Plan use of the national health care improvement indicators from the Institute of Medicine. The Center’s Substance Abuse Program is accredited by CARF and maintains compliance with applicable statutes and regulations adopted by the Texas Department of State Health Services and the federal agencies, regulating Substance Abuse services, including the Substance Abuse & Mental Health Services Administration (SAMHSA) and the Drug Enforcement Agency (DEA).

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A. Resiliency and Disease Management (R&DM) from Texas Department of State Health Services (DSHS)

R&DM Fidelity tools are designed to measure the extent and faithfulness of the implementation of the evidence-based practices set forth in the R&DM model that direct service delivery for the State's mentally ill consumers. Fidelity concepts and Tools measure the Center's actual program implementation, as indicated by reported and documented activities and behaviors in the following areas:

1. Adult Mental Health (AMH)

- AMH TIMA Manual
- AMH TIMA Patient and Family Education Program (TIMA PEEP)
- AMH Cognitive Behavioral Therapy (CBT) for the Treatment of Depression
- AMH Psychosocial Rehabilitation (Rehabilitative Case Management)
- AMH Assertive Community Treatment (ACT)

2. Children's Mental Health (CMH)

- CMH Child and Adolescent Patient and Family Education Program (CA TIMA PEEP)
- CMH Cognitive-Behavioral Therapy for Children and Adolescents with Anxiety and Depression Fidelity Manual
- CMH Skills Training for Children and Adolescents with Externalizing Disorders and their Parents and Primary Caregivers
- CMH Wraparound Planning for Children and Adolescents with Serious Emotional Disturbances and their Families

Semi-annual Rapid Reviews will be completed by each service unit with the assistance of Quality Improvement Services-Quality Management (QIS-QM) and results will be reported to the Executive Management Team (EMT).

In addition, QIS will assist units in conducting quarterly clinical staff peer reviews to insure compliance with RDM, Performance Contract, and billing requirements. QIS-QM will provide additional clinical training, auditing, and quality improvement coaching as needed. Reports will be made to the Executive Management Team (EMT) by QIS-QM.

B. Substance Abuse Program Indicators

1. In addition to maintaining accreditation with CARF, performance at the Center's Substance Abuse Program is measured by DSHS indicators utilizing some or all of the following eight (8) components:

- i) Efficacy: The degree to which the care for the consumer results in the desired outcomes.

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- ii) Appropriateness: The degree to which the care provided is relevant to the consumers' clinical needs.
- iii) Effectiveness: The degree to which the care is provided, in the correct manner, utilizing best practices and produces the desired outcome for the consumer.
- iv) Continuity: The degree to which care is coordinated among practitioners, among organizations and over time.
- v) Safety: The degree to which the risk of an intervention and in the care environment is reduced to consumers and others.
- vi) Efficiency: The relationship between outcomes and the resources used to deliver consumer care.
- vii) Respect: The degree to which consumers and their families (when appropriate) are involved in care decisions with sensitivity and respect for the consumers' abilities needs, expectations, preferences and cultural differences.
- viii) Satisfaction: The services are provided in response to consumers' strengths, needs and abilities and preferences.

C. Institute of Medicine National Health Care Improvement Indicators

The Institute of Medicine's (IOM) published reports, *To Err Is Human* (IOM, 2000), and *Crossing the Quality Chasm; a New Health System for the 21st Century* (IOM, 2001), created a new framework for defining and evaluating healthcare quality and outlined a series of six aims that serve as core values for all health care services. Mental Health Corporations of America (MHCA) is a nationwide alliance of select leadership organizations that provide behavioral health services. MHCA has undertaken a national transformation quality initiative utilizing the IOM's six core indicators: *safe; effective; efficient; patient-centered; timely, and equitable*. As a member organization of Mental Health Corporations of America (MHCA), the Center is participating in this national initiative with a quality improvement project focused on the aim of "timely" services, i.e. evaluating and improving timeliness of care from the perspective of the consumer.

II. Early Childhood Intervention (ECI)

The Center's ECI program adheres to State and Federal guidelines and outcomes performance requirements for ECI programs. The current indicators for all ECI contractors are:

- i. Timely Services (28 days from signed IFSP)
- ii. Services in Natural Environments
- iii. Percent enrolled birth to 1 year
- iv. Percent enrolled birth to 3 years
- v. 45-day time lines
- vi. Transition Plans and Time Lines

The performance of each local ECI program is reported based on these six indicators.

III. Long Term Care Services

The Center's Long Term Care Services programs utilize an array of quality and performance indicators, including:

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- i. Consumer satisfaction measures
- ii. Adverse incidents reporting
- iii. Licensure components, including cleanliness, recreation, and safety
- iv. Census Information
- v. DADS Data Verification Review Results

Consumer and Staff Satisfaction Surveys

The Center will begin participating in MHCA's national benchmarking survey in FY08. In addition, the Center will administer an internal consumer satisfaction survey instrument, and will continue to conduct exit surveys with departing staff.

The MHCA national benchmarking survey assesses consumers' engagement and overall experience of care and quality as well as the effectiveness of treatment and other services/supports. The survey also examines the satisfaction of referral sources with services provided. A companion staff satisfaction survey further contributes to evaluating system performance. Analyses of this survey data provides participating organizations with insight as to how well they are meeting customers' expectations along with information pertinent to the organization's quality improvement efforts. The information can be analyzed from many different perspectives to support a range of quality assurance/improvement initiatives.

OVERSIGHT

The Management Team Meeting structure (EMT, LT, and FMT) and QIS form the structure through which the entire organization participates in continuous quality improvement. The Center's continuous quality improvement goals are integrated into ongoing business activity and routine activities. **QIS** works directly with units, presenting reports and operational concerns to **EMT, FMT and/or LT** for final action

Medical Peer Review and Nursing Peer Review operate as specified by Section 85.204, Health and Safety Code for physicians, and Occupation Code, Chapter 303 for nurses. Critical or unusual incidents involving consumers may be reviewed by the Professional Review Committee for incidents such as physical restraint and seclusion, breaches of confidentiality, quality of client care related to diagnosis and treatment, elopements, exposure to hazardous substances/infectious diseases, medication errors, serious injuries to consumers or staff, serious property damage involving client or staff, incidents of sexual contact between consumers and staff, and major safety violations. Deaths are reviewed by the Death Review Committee. All proceedings and records of the above shall be privileged.

Center physicians are organized into a structure that identifies a lead physician for each clinic. These leaders meet as a Medical Executive Committee (MEC) and from the membership designate a Medical Director/Chief of Staff. The MEC sets the direction for the implementation of TIMA and overall functioning of medical services. The MEC conducts monthly peer reviews to support continuous quality improvement.

MONITORING

Monitoring involves the collection of data for the purpose of evaluation. In this plan the data are the performance measures designated by the quality indicators. Actual performance measures are compared to quality indicator benchmark or threshold levels.

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Monitoring methods include:

- Unit and Department Reports
- Network Oversight
- Employee Job Performance Evaluations
- Clinical Service Reviews and Audits
- On-Site Programmatic Reviews
- On-Site Administrative Reviews
- Business Objects RDM Reports on Performance Indicators

QUALITY MANAGEMENT PROCESS

1. Internal Quality Management Plans (IQMP's) are the foundation for the Center's Quality Improvement efforts. Each IQMP is tailored to the services, processes, requirements, needs and goals of a specific unit, program, division or department.

For FY 08, the Center is developing a new phase of its QI efforts by initiating Quality Circles at each of its internal units to address common key indicators identified by the Management Teams. QIS will provide guidance and oversight for these Quality Circles, assisting them in identifying problems germane to their area of operation, and developing IQMPs and action plans for resolving problems.

2. Internal Quality Management Plans (IQMP's) are submitted to QIS and Contract Monitoring for review, and then submitted to the Leadership Team for approval. New Contracts have 90 days from contract start to submit their IQMP's and everyone else must submit an IQMP annually (whether revised or not) by September 30th. The Leadership Team reviews annual plans for approval in November of each year.

3. Unit (or Program, Division or Department) Quality Management Reports are standard format performance reports of quality indicators with an attached Plan of Correction if any of the indicators do not meet the required threshold or benchmark.. Reports are submitted to QIS monthly, or as directed via an email attachment. QIS prepares summary reports that are presented for review by the EMT, LT, and/or FMT.

4. The EMT meets monthly to review assigned indicators based on their areas of concern. Monitoring and evaluation processes allow collection of data and monitoring of important aspects of care or service. The monitoring process consists of the aggregate data of these assigned quality indicators and consideration of implications of the information and taking action to correct, identify causes and/or investigate solutions regarding findings or areas of concern.

5. The Leadership Team considers the implications of the reports and directs action as deemed necessary. Findings are also reported to the Board of Trustees and the Center's Network Advisory Committee and Public Advisory Committees as warranted.

6. The focus of the Center's comprehensive continuous quality improvement plan is to achieve outcome excellence through analysis of processes and variables that affect desired quality goals. Clinical Service Directors and Department Heads define quality goals based on analysis of their customers/stakeholders' expectations. Then, using the JCAHO ten steps CQI Process, prioritize important aspects of quality service of care and initiate improvement efforts. Through ongoing measurement, either by the clinical monitoring and

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evaluation process or other collection method, Service Directors will monitor their progress toward meeting Service quality goals.

7. The JCAHO Ten Step CQI process is applicable to both Administrative Services and Clinical Support processes. The QIS Director and staff will assist Department Directors with developing methods of determining and prioritizing critical administrative and clinical service aspects affecting their components in order to implement CQI processes in their programs. In addition, the QIS staff will facilitate training and coaching for CQI/Quality Circle teams as they engage in the improvement process.

The JCAHO Ten Step Process

1.	Assign responsibility for monitoring and evaluation activities.
2.	Delineate scope of service or care provided in the department.
3.	Identify the most important aspects of care or service.
4.	Identify indicators for monitoring the most important aspects of care/service.
5.	Establish thresholds (control limits) for the indicators.
6.	Collect and organize data.
7.	Evaluate results of data.
8.	Take action to improve care.
9.	Assess effectiveness of the actions taken.
10.	Communicate the results.

INTERNAL QUALITY MANAGEMENT PLANS

This plan requires the Local Authority and its provider network to develop Internal Quality Management Plans (IQMP's) specific to their functions. IQMP's are the foundation of the Quality Management Plan. Each department or service whether a provider of services or an authority or administrative support department develops its own IQMP that is coordinated and approved through the Executive Management Team (EMT). The Center establishes benchmarks for excellence, internal and external accountability and ongoing quality improvement efforts by implementation of IQMP's at all administrative and provider sites, through the appropriate Center committees and administrative departments. This plan also requires contracts with local area network providers (private) and internal providers to stipulate quantifiable performance measures for contract evaluation through completion of quarterly Provider Profiles.

All Center employees whether they are network providers or employees of network management or central administration, are responsible for implementing the **Center's Quality Management Plan**. All staff levels must commit to providing quality services.

1. Development and Implementation of Internal Quality Management Plans (IQMP's) – The Quality Evaluation Process

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- a. A Provider initiated Fidelity Review to use as a guide for plan development: All local area network services (Local Authority, Central Administration and Clinical, plus contracting private providers) are required to develop, implement and actively monitor an Internal Quality Management Plan (IQMP) specific to their function. IQMP's are designed to provide a means of evaluating service delivery or in the words of the JCAHO "Doing the right thing and doing it the right way."
- b. The development, implementation and monitoring of Internal Quality Management Plans and their corresponding quality indicators are the responsibility of the Contract Provider, Service Director, or designee. Plans will be revised annually, or as needed, to reflect the needs of the customers as well as the service. All revised plans are to be completed and submitted through the Quality Improvement Services Directorate-Quality Management for review and approval by the Executive Management Team before implementation. Proposed IQMP's are to be submitted to the Quality Management Department by September 30 of each year or within 30 days of the provider contract date.

2. IQMP's will include the following:

- a. A plan to administer and evaluate consumer/customer satisfaction and include the survey instrument(s).
- b. A plan to evaluate clinical documentation and quality of care provided including protocols to be used (clinical programs only).
- c. Key Quality of Care and/or Service indicators (based on consumer/customer expectations, key aspects of clinical care, DSHS/TCOOMI or Medicaid Standards, etc.) It is understood that each department or service has customers. Clinical programs have consumers who receive clinical treatment and administrative services or departments have customers who need and use their services. While the clinical services consumers have been recognized as the Center's traditional customers, the latter must also be recognized as customers. Without the support of the administrative departments the clinical services units can not perform their functions.
- d. A plan to complete Internal Service Reviews using applicable licensing, regulatory, contract and/or other standards.

3. Quality Management Indicators (QMI's) for Monitoring and Evaluation

- a. All IQMP's will include a documented and monitored QMI section addressing the following plan requirements:

REQUIREMENT	EXPLANATION
Quality Indicators	Measurable objectives identifying acceptable performance
Monitoring Rationale	Reason the indicator was chosen
Monitoring Methodology	The process of evaluating the units' performance levels

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Monitoring Frequency	How often performance will be measured
Person(s) Responsible	The person(s) responsible for implementing the evaluation
Optimal/Minimal Range	Acceptable performance level range

- b. To ensure compliance with DSHS, Medicaid, TCOOMMI, and other standards, the IQMP must effectively measure performance using the appropriate Quality Indicators.
- c. Performance Profiling reviews critical performance variables monthly and/or quarterly on individual, Unit, and Center levels. Results provide an overview of Center performance.
- d. Although the Center QMIs must be monitored (as they pertain to a given department, program, unit or service) IQMPs may incorporate additional indicators for monitoring and evaluation relevant to that unit or department's services.
- e. To ensure continued compliance with DSHS, Medicaid, TCOOMI and other required standards, the IQMP must effectively measure performance using the appropriate Quality Indicators after a reduction of force and provide feedback to the LT.

All providers of consumer services will submit an Internal Quality Management Plan (IQMP) to the LT through QIS. The Plan will include outcome measures based on department and other contract requirements. Provider IQMPs will be reviewed by QIS and Contract Monitoring and approved through the EMT. The IQMP will include specific quality indicators which measure, at a minimum, contract targets, over and under utilization of services, consumer access, quality of service delivery and consumer satisfaction.

All Program services provided by or through the Center are required to develop and submit an Internal Quality Management Plan.

During the first quarter of each fiscal year, all service providers will review governing agencies' standards and regulations and develop methodologies to ensure that they (Center and local area network contract service providers) satisfy those standards and service contract requirements.

The following describes quality indicators for inter-organizational service.

a. Data Management:

- The Center's Data Management system will be available for use during normal working hours (8:30 AM to 5:30 PM, Monday – Friday).

b. Information Systems:

- The Help Desk will acknowledge receipts of service requests and provide an estimation of when the problem will be resolved.
- The Help Desk will resolve most services requests within three working days of submission.

c. Fiscal Services:

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- Monthly revenue and expense reports will be submitted to units within ten working days of end of month.
- Financial reports will be accurate. Unit financials will contain no more than one error per month.
- Fiscal services will correct errors and respond within ten working days of receipt of error tracking form.

d. Payroll:

- The names of employees no longer employed by the unit will be removed from the payroll schedule within five working days of request. Corrected payroll schedule will be received by the unit in time for the next unit payroll calculation.

e. Human Resources:

Request for Human Resource Action Forms (RHAFs) are processed within three working days of receipt.

f. Purchasing:

- Purchase orders will be filled within two weeks. If a vendor is unable to meet this requirement, purchasing will locate another vendor who is able to deliver the order within two weeks.

g. Staff Development:

- All changes in Center training requirements are communicated to unit supervisors prior to implementation. Any new requirements/guidelines (based on state/federal rules) are communicated to all staff affected. Unit specific training may occur based on significance of changes or on supervisor request. Training changes will be communicated to the affected units within five days of the change
- Training schedules are published quarterly via intranet posting and copies routed to units that do not have intranet access. Training schedules will be published at least monthly to insure that staff can schedule required training
- Training compliance reports are sent to supervisors quarterly advising them/staff of training requirements. Supervisors are instructed to give the reports to individual staff. Reports are also available on request for any staff or supervisor via e-mail or routing. Staff will be informed quarterly of their training needs status

h. Safety and Maintenance:

- Work Orders will be addressed within three working days, including notifying requesting party of the status of the work order. Safety and Maintenance work order requests are processed electronically in the MUNIS system.

i. Credentialing:

- Staff licensing status will be kept current and available to managers every month.
- Licensure status is monitored monthly, and reminders are sent to staff with expiring licenses 90, 60, and 30 days out from expiration. Managers are copied on reminders.

j. Clinical Records:

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- Proposed new forms will be reviewed and a response regarding their acceptance provided to the submitting party within one month.
- Approved forms will be presented by Directors or designee at program management meetings on at least a monthly basis.
- Clinical Records will review and provide a response regarding approval to remove closed consumer records from outpatient clinics within two weeks of the request.

k. Quality Improvement Services:

- Audit procedure changes will be communicated to affected units within five working days of approval.
- Under normal circumstances, units will receive three days notice of audit or review.

l. Contract Administration/Provider Relations:

- Staff will provide updates on changes to program management at least quarterly.
- Will track and follow the suspense of all reports required by funding agencies, and will report their status to the President/CEO for action as required.

In addition,

- All external provider invoices will be reconciled to supporting services prior to payment.
- New Generation Medications data will be entered into CARE within three days of receipt of forms from outpatient clinics

m. Resource Development – Development and Community Action Office:

- Resource Development will conduct and periodically update gaps/needs assessment across all direct service programs and identify and pursue sources to fund identified needs.
- Will ensure that resource efforts directed at funding opportunities are distributed equally among all programs, or as indicated by assessed needs.
- Will insure that information on the Center's website is checked for current status and updated at least monthly.
- Will update and present the Center's Communication Plan at management team meetings on at least an annual basis.

n. Legal Services:

- Legal Services will provide timely information, advice and work product regarding proposed contractual or other proposed actions by the Center, having a legal element.

o. Clinical Services

- Units will conduct Continuous Quality Improvement (CQI) peer reviews to assess the quality of services provided on a monthly basis
- Units will participate in quarterly DSHS Data Verification audits.
- Units providing services under R&DM will conduct a semi-annual Rapid Review for these services

p. Utilization Management

- Will authorize services within 3 days of receipt of TRAG-R
- External contract service provider statements of medical necessity will be completed within 10 days of the TRAG-A.

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q. Consumers Rights

- The Consumers Rights Officer will investigate reports of alleged abuse, neglect and exploitation upon receipt of same within 21 business days. (If additional witnesses are identified via investigation process, an extension of an allowable time frame, with a date of completion, will be identified.)

QIS (Network Oversight) AUDITS AND REVIEWS (Clinical and Administrative)

PURPOSE: To ensure that consumers receive services that are appropriate and documented in compliance with all applicable regulatory requirements.

PROCEDURES:

- All programs will be audited/reviewed by QIS and/or Contract Monitoring within 45 days of their opening and as scheduling permits. Audit/review protocols will be developed from standards set forth by regulatory agencies, using the strictest standards as the audit benchmarks.
- Notification of audit/review will be made prior to the appearance of the audit/review team. All providers will receive a minimum of 24 hours' written or e-mail notice of the audit/review, the sample list of client case numbers (if applicable), the time period from which the sample was selected (if applicable), copies of the audit/review protocols, and the date and time the audit/review will begin.
- The audit/review team will meet with the provider at the beginning of the audit/review to explain the procedure and answer questions regarding the audit/review procedures and the parameters of the audit/review. Providers are encouraged to have knowledgeable staff present during the audit/review to resolve any questions during the documentation review.
- For audits/reviews that could result in revenue payback, two categories will be identified; one for billable services (based on funding source requirements) and one for quality of the documentation and provider practices (based on quality standards of the mental health professions, best practice guidelines, etc.). All services determined to be inappropriate for billing will be refunded to the pay source and recouped from the provider.
- The quality component reflects the Center's efforts to monitor and improve the quality of services. This may result in required remedial training in the areas identified.
- Written reports are organized to separate "billable" services from quality components.

Note: In addition to the standard QIS audit/review protocols used to verify service provision, consumers that have any Substance Abuse Disorder will be further reviewed using the QM protocol for Services to Persons with Co-Occurring Psychiatric and Substance Use Disorders (COPSD). Included in all reports will be indications of compliance with Chapter 411 N.

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AUDITS/REVIEWS

For clinical and administrative audits/reviews:

- For clinical audits/reviews, the review sample will be developed by randomly selecting one (1) chart per each clinical provider at the identified unit for a pre-determined time period.

Although the sample is drawn from a specific time period, the complete chart will be subject to audit/review to ensure that all supporting documents (i.e., Diagnosis, TRAG/Uniform Assessment, Treatment Plan, and service reviews) are in place, are current and meet funding source, TAC, and RDM requirements for each service in the audit sample. Additionally, other issues discovered in the process of auditing the identified services may expand the scope of the audit.

- All programs are expected to attain a score of 95% or higher on billable services. This score measures compliance with funding sources and is determined by the audit of progress notes and supporting documents for the selected service. Non-billable services are also expected to reach a target of 95% compliance.
- On the final day of the audit/review, the audit/review team and the provider will meet for a preliminary review of results. This preliminary report will consist of an overview of the current findings and detailing the process that will be taken once the final results are established.
- Within fifteen (15) working days of the completion of the audit, the written report of audit findings will be forwarded to the Director of QIS who will distribute the report to the provider. An Audit/Review Exit meeting may be held between the Center and the provider. QIS will review the audit findings and any questions can be addressed at this time.
- All programs that score under 95% will be required to complete a Plan of Correction. This plan will specifically outline how the provider will correct deficiencies and is due to QIS within fifteen (15) working days from the date of the Audit Exit meeting and/or written notification of audit/review findings by the QISS Director. QIS reserves the right to request a shorter response time if results warrant a more timely response.
- Individual providers' scores/deficiencies are reported. If an individual provider's service verification is not accepted, the program's Plan of Correction must specify retraining of the provider. Additionally, that provider's services will be suspended from billing until such time as the Unit Manager has attested that the provider has been retrained and has demonstrated the ability to adequately document services.
- Administrative audits/reviews will identify items that are not in compliance with acceptable standards. 100% compliance is expected.
- Technical Assistance from QIS and/or Contract Monitoring can be requested to assist with the formulation of the Plan of Correction.
- A quality score of less than 95% on clinical audits/reviews and less than 100% on administrative audits/reviews will require response from the provider. The QIS and/or Contract Monitoring staff

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will work with the program to identify and correct sources of quality problems. Remedial training or technical assistance may be required, depending on the nature of the concern.

FOLLOW-UP AUDITS/REVIEWS

For clinical and administrative audits/reviews:

QIS will review the Plan of Correction and notify the Provider by letter regarding acceptance within fifteen (15) working days of receipt.

- A Follow-up Audit will be conducted beginning at least 30 days from the date that the QIS accepted the Plan of Correction. If the Provider fails to submit a Plan of Correction the Follow-up Audit may be conducted at any time after the deadline for the Plan of Correction has passed.
- For clinical audits/reviews, the sample will be developed by randomly selecting one (1) chart per each clinical provider at the identified unit for a pre-determined time period.
- Although the sample is drawn from a specific time period, the complete chart will be subject to audit/review to ensure that all supporting documents (i.e., Diagnosis, TRAG/Uniform Assessment, r Treatment Plan, and service reviews) are in place, are current and meet funding source, TAC, and RDM requirements for each service in the audit sample. Additionally, other issues discovered in the process of auditing the identified services may expand the scope of the audit.
- All programs are expected to attain a score of 95% or higher on billable services. This score measures compliance with funding sources and is determined by the audit of progress notes and supporting documents for the selected service. Non-billable services are also expected to reach a target of 95% compliance.
- On the final day of the audit/review, the audit/review team and the provider will meet for a preliminary review of results. This preliminary report will consist of an overview of the current findings, detailing the process that will be taken once the final results are established.
- Within fifteen (15) working days of the completion of the audit, the written report of audit findings will be forwarded to the Director of QIS who will distribute the report to the provider. An Audit/Review Exit meeting may be held between the Center and the provider. QIS will review the audit findings and any questions can be addressed at this time.
- All programs that score under 95% will be required to complete a Plan of Correction. This plan will specifically outline how the provider will correct deficiencies and is due to QIS within fifteen (15) working days from the date of the Audit Exit meeting and/or written or e-mail notification of audit/review findings by the QIS Director.
- Individual providers' scores/deficiencies are reported. If an individual provider's service verification is not accepted, the program's Plan of Correction must specify retraining of the provider. Additionally, that provider's services will be suspended from billing until such time as the Unit Manager has attested that the provider has been retrained and has demonstrated the ability to adequately document services.

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- Administrative audits/reviews will identify items that are not in compliance with acceptable standards. 100% compliance is expected.
- Technical Assistance from the QIS and/or Contract Monitoring can be requested to assist with the formulation of the Plan of Correction.
- A quality score of less than 95% on clinical audits/reviews and less than 100% on administrative audits/reviews will require a response from the provider. The QIS and/or Contract Monitoring staff will work with the program to identify and correct sources of quality problems. Remedial training or technical assistance may be required, depending on the nature of the concern.
- All programs that score under 95% on clinical audits/reviews will be placed on vendor hold. The effective date of vendor hold will be the date of the Follow-up Audit/Review Exit meeting.
- A provider will not be able to bill for services lacking appropriate Authority documentation.
- Individual providers' scores must also be reported. If an individual provider scores below 95% on billable services, the provider's billing is suspended, regardless of whether the unit as a whole passed the audit/review, until retraining is documented and accepted by the QIS.
- Technical Assistance from QIS and/or Contracts Monitoring can be requested.

FINAL AUDITS/REVIEWS

For Clinical Audits/Reviews:

The Provider's Plan of Correction outlines how the provider plans to correct deficiencies and is due to QIS within fifteen (15) working days from the date of the Follow-up Audit Exit meeting.

QIS will review the Plan of Correction and will notify the Provider by letter when the plan is accepted

- A Final Audit/review will be conducted beginning 30 days from the date that QIS accepted the Plan of Correction.
- For the clinical audits/reviews, the sample will be developed by randomly selecting one (1) chart per each clinical provider at the identified unit for a pre-determined time period.
- Although the sample is drawn from a specific time period, the complete chart will be subject to audit/review to ensure that all supporting documents (i.e., Diagnosis, TRAG/Uniform Assessment, r Treatment Plan, and service reviews) are in place, are current and meet funding source, TAC, and RDM requirements for each service in the audit sample. Additionally, other issues discovered in the process of auditing the identified services may expand the scope of the audit.
- All programs are expected to attain a score of 95% or higher on billable services. This score measures compliance with funding sources and is determined by the audit of progress notes and supporting documents for the selected service.

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- On the final day of the audit/review, the audit/review team and the provider will meet for a preliminary review of results. This preliminary report will consist of an overview of the current findings, detailing the process that will be taken once the final results are established.
- Within fifteen (15) working days of the completion of the audit, the written report of audit findings will be forwarded to the Director of QIS who will distribute the report to the provider. An Audit/Review Exit meeting may be held between the Center and the provider. QIS will review the audit findings and any questions can be addressed at this time.
- All programs that score under 95% will be required to complete a Plan of Correction. This plan will specifically outline how the provider will correct deficiencies and is due to QIS within fifteen (15) working days from the date of the Audit Exit meeting and/or written notification of audit/review findings by the QIS Director.
- Individual providers' scores/deficiencies are reported. If an individual provider's service verification is not accepted, the program's Plan of Correction must specify retraining of the provider. Additionally, that provider's services will be suspended from billing until such time as the Unit Manager has attested that the provider has been retrained and has demonstrated the ability to adequately document services.
- Administrative audits/reviews will identify items that are not in compliance with acceptable standards. 100% compliance is expected.
- Technical Assistance from QIS and/or Contracts Monitoring may be requested to assist with the formulation of the Plan of Correction.
- A quality score of less than 95% on clinical audits/reviews and less than 100% on administrative audits/reviews will require response from the provider. The QIS and/or Contracts Monitoring staff will work with the program to identify and correct sources of quality problems. Remedial training or technical assistance may be required, depending on the nature of the concern.
- If 95% compliance for billable services is achieved, vendor hold will be removed.
- If the provider is unable to obtain 95% compliance for billable services the audit results are sent to the Leadership Team for review and action as appropriate.

For Administrative Reviews:

- QIS and/or Contracts Monitoring staff will conduct audits/reviews and re-audits/reviews until deficiencies have been corrected. If corrections are not made after two re-audit/reviews the issue will be sent to the Leadership Team for appropriate action.

RANDOM/FOCUSED AUDITS/REVIEWS

Random, focused audits may occur at any time without notice. These audits will be triggered if other administrative audits, billing concerns, or documentation concerns identify a need for the collection of additional data of a particular nature or required by a funding source.

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- Audit protocols specific to the request will be developed by QIS and/or Contracts Monitoring. These audits/reviews may be accomplished by QIS and/or Contracts Monitoring or QIS and/or Contracts Monitoring may be available for consultation and data analysis.
- The Administrative Audits conducted by QIS and/or Contracts Monitoring identify deficiencies concerning informing consumers of their rights, i.e. confirmation that information concerning rights and crisis access is prominently displayed in areas frequented by consumers. In addition, random, focused audits concerning the documentation of the distribution of rights information to individual consumers are conducted.

Random/focused administrative audits may be conducted to insure that corrective action has been sustained.

PROVIDER PEER REVIEW

- QIS will distribute a random sample to each unit (obtained from Data Management) of reported services that are to be reviewed at least quarterly. At least one service per provider will be identified for review. The full roster of clinical personnel and array of services, i.e., Rehabilitative Training/Coordination, Medication Related Services, COPSD, and/or Crisis provided by internal and/or external provider units may be included in the sample set. Other units, such as Long Term Care Services and ECI may, under arrangement, self-select their sample.
- Provider units will conduct at a minimum, quarterly Unit peer reviews as identified in the Program/Unit Quality Management Plan. QIS may provide assistance with conducting these reviews, and results will be reported to QIS, Program/Unit administration, with any areas of special concern reported to the Executive and/or Leadership Teams. QIS may require plans of correction from Units identifying deficiencies in the course of the Peer Review.
- Program/Unit administration may request technical assistance from the QIS as the need arises.

R&DM RAPID REVIEWS

- All units providing RDM services will conduct a semi-annual Fidelity Review of these services using as a sample cases identified by QIS and Data Management
- QIS will assist with the Fidelity Reviews and will review and validate unit findings.

SURVEYS

- QIS will coordinate the survey process as determined by the Department of State Health Services and will report results to Center and Program management. Consumer and Employee Satisfaction surveys will be conducted on a regular basis. Results will be analyzed by QIS with trends and other relevant data being reported to management team meetings.
- QIS is available to provide technical assistance to all Center units on the development of unit-specific survey instruments, and plans for implementation as the need arises.

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CONTRACT OBLIGATIONS

QIS conducts and/or participates in all required audits/reviews as required and/or conducted by funding agencies. Findings from required audits (i.e. Data Verification, RDM Fidelity Reviews, TIMA) that are found to be out of compliance with contractual targets will be reported to Executive Management, and a Plan of Correction will be created to address identified deficiencies. QIS will actively include relevant staff in the process of developing and implementing Plans of Correction.

UTILIZATION REVIEW

Formal reviews of consumer utilization and appropriateness of services on a prospective, concurrent and retrospective basis is performed by Utilization Management, Quality Management and Contract Monitoring staff.

Measuring, Assessing and Improving Service Capacity and Access to Service

- A. Utilization Management (UM): The Utilization Management Committee meets at a minimum of once per quarter to monitor utilization of CHCS clinical resources to assist the promotion, maintenance and availability of high quality care in conjunction with effective and efficient utilization of resources. The objectives of the UM Committee include processes to:
- Assure the overall integrity of the utilization management process to include timely and appropriate assignment of DSHS Mental Health levels of care based on the DSHS UM Guidelines;
 - Approve and oversee the appeals system for adverse determination decisions;
 - Analyze utilization patterns and trends to include gaps in services, rates of no shows for appointments/services, billing issues, underdeveloped frequently requested services, existing services that are under and over-utilized, and barriers to access; and
 - Establish mechanisms to report, in a timely manner, quantitative and qualitative information on service utilization and service delivery to management and staff, the Board, providers and other interested persons.
- B. Request for Services: Additionally, CHCS monitors access to services by monitoring appeals of termination, reduction, and denial of services.

Special Note:

Audits, Reviews, Surveys, and Studies are formal activities that result in a written report and may have consequences for the unit or service being audited or reviewed.

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In contrast, Technical Assistance is an informal process when initiated by the provider or unit. It is an effort on the part of the provider or unit to monitor and improve the quality of services or procedures. This QIS service is not intended to put the provider at risk for negative consequences. The exception is when fraud or other illegality is found or suspected. In that case, technical assistance triggers a full audit.

Attachments:

Roster of Executive and Leadership Teams