THE CENTER FOR HEALTH CARE SERVICES
Quality Improvement Support Services
FY 2010 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

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 nine (9) key elements of an effective plan: administrative responsibilities, the Compliance Committee, policy guidelines, education and training, monitoring activities, reporting alleged misconduct and investigation procedures, corrective action plans, annual compliance review and report, 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 for CHCS PROGRAMS

I. Mental Health and Substance Abuse Services

For FY 2010 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. The Center has implemented additional outcomes measures for mental health services to align its quality improvement oversight with established clinical best practices.

The Center's Opioid Dependence Treatment and Detoxification Programs administered by Substance Abuse Services are accredited by CARF and maintain compliance with applicable statutes and regulations adopted by the Texas Department of State Health Services and federal agencies regulating substance abuse services including the Substance Abuse & Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) and the Drug Enforcement Agency (DEA).

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

QIS conducts quarterly clinical staff peer reviews to insure compliance with RDM, Performance Contract, and billing requirements and to evaluate, monitor, improve and resolve areas of concern. These comprehensive reviews include evaluation of adherence to fidelity with the RDM model and to other clinical best practices. QIS provides programs with clinical training and quality improvement consultation as needed to address areas identified for performance improvement.

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B. Substance Abuse Program Indicators

1. Performance at the Center's Substance Abuse Program is evaluated and monitored to improve and resolve areas of concern and to ensure that services meet benchmark standards for the following eight (8) components:

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

The Center's Opioid Dependence Treatment and Detoxification programs maintain accreditation with CARF.

II. Early Childhood Intervention (ECI)

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

Percent of infants and toddlers with IFSPs who:

- Received the early intervention services on their IFSPs in a timely manner (28 days from signed IFSP)
- Primarily receive early intervention services in the home or programs for typically developing children
- Demonstrate improved
  - Social-emotional skills (including social relationships)
  - Acquisition and use of knowledge and skills (including early language/communication, and
  - Use of appropriate behaviors to meet their needs.

Percent of families participating in Part C who report that early intervention services have helped the family:

- Know their rights
- Effectively communicate their children's needs; and
- Help their child develop and learn

Effective General Supervision Part C/Child Find:

- Percent of infants and toddlers birth to 1 with IFSPs compared to:
  - Other states with similar eligibility definitions; and
  - National data

- Percent of infants and toddlers birth to 3 with IFSPs compared to:
  - Other states with similar eligibility definitions; and
  - National data

- Percent of eligible infants and toddlers with IFSPs for whom an evaluation and assessment and an Initial IFSP meeting were conducted with Part C's 45-day timeline.

Effective General Supervision Part C/Effective Transition:
- Percent of all children exiting Part C who received timely transition planning to support the child's transition to preschool and other appropriate community services by their third birthday including:
  - IFSPs with transition steps and services;
  - Notification to local LEAs, if child potentially eligible for Part B;
  - Transition conference, if child potentially eligible for Part B.

III. Long Term Care Services

The Center's Long Term Care Services programs conducts all operations in accordance with all applicable state, federal and accreditation guidelines, and utilizes an array of quality and performance indicators, including:
- Consumer satisfaction measures
- Adverse incidents reporting
- Licensure components, including Environment and Life safety checks
- Census Information
- Audits and Reviews by DADS, AACOG, HHSC, DARS, State Fire Marshall, Social Security Administration

The Internal Auditing Team, composed of LTC Division Staff, reviews all records and trend results for continuous improvement and directs corrective action as needed

IV. Home Health

The Center administers a Home Health Care program which meets requirements for Medicare, DADS, and Community Health Accreditation Program (CHAP) accreditation. A comprehensive performance improvement process integrates the Home Health Agency's mission into the CHCS mission to facilitate and support Home Health's approach that selects, reviews and analyzes outcomes specific to the needs, scope of services and products of the Home Health agency.

CHCS Home Health Care operations are driven by a Performance Improvement Plan which is designed to:

- Delineate expectations and plan and manage processes to measure, assess and improve the Home Health Agency's governance, management, clinical and support activities
- Promote positive patient outcomes through the application of optimal patient care, treatment and services based on clinically sound principles and current knowledge
- Identify, on an ongoing basis and in a coordinated and collaborative manner, areas for improvement in the quality of care, treatment and services
- Evaluate, monitor, improve and resolve areas of concern

The performance improvement plan, established by the senior management of the organization and Home Health management in collaboration with staff members and the Center's Quality Improvement Services

department, with the support and approval of the Board of Trustees, is comprehensive in scope and provides a vehicle to monitor patient care, treatment and services with the goal of identifying and resolving any processes, functions, financials and/or services that may adversely impact patient care, treatment and services, while striving to continuously facilitate patient outcomes.

Performance improvement evaluation is based on these Medicare, DADS and CHAP “dimensions of performance” that routinely assess the adequacy, appropriateness, effectiveness and outcomes of care, services and supplies provided:

- Efficacy of the procedure, treatment or service relative to the patient’s condition
- Appropriateness of a specific test, procedure or service to meet the patient’s needs
- Availability of a needed test, procedure, treatment or service to the patient who needs it
- Timeliness with which a needed test, procedure, treatment or service is provided to the patient
- Effectiveness with which tests, procedures, treatment and services are provided
- Continuity of the services provided to the patient with respect to other services, practitioners, providers and over time
- Safety of the patient (and others) to whom the services are provided
- Efficiency with which services are provided
- Respect and caring with which services are provided

V. Head Start Mental Health Services

Performance at the Center’s Head Start Mental Health Services Program is evaluated and monitored by CHCS Head Start administration and by CHCS Quality Improvement Services to improve and resolve areas of concern and to ensure that services meet established program standards and goals.

Program evaluation considers the following dimensions:

Program strengths to include, but not limited to:

- Collaborations with local/community-based services
- Exemplary fiscal practices to ensure the safeguarding of Federal dollars
- Highly successful efforts to address and improve school readiness
- Expansion of the program and increased accessibility
- Extraordinary accommodations for children/families (e.g. children with disabilities)
- Innovative program design and management

Communication

- Effective two way communication between Mental Health staff and staff in other service areas
- Effective two way communication between Mental Health staff and parents

Planning

- Plans for formulating and achieving program goals and strategies to achieve goals

Record Keeping

- Effectiveness in maintaining accurate and timely Mental Health records

Ongoing Performance Monitoring

- A comprehensive process is implemented for monitoring

- Monitoring measures, tools or instruments, materials and procedures
- Staff responsibilities for ongoing monitoring of respective service areas
- Analysis and documentation of progress toward achieving program goals and complying with performance requirements
- Follow-up for findings or problems identified through data collection, and how findings are corrected and documented

Consumer and Staff Satisfaction Surveys (samples attached)
The Center administers consumer satisfaction survey instruments at all of its operational units, as well as surveys of existing staff and exit surveys to departing staff. The consumer surveys assess consumers' engagement and overall experience of care and quality as well as the effectiveness of treatment and other services/supports. QIS coordinates the survey process as determined by the Department of State Health Services and reports results to Center and Program management. Staff satisfaction surveys further contribute to evaluating system performance. Analyses of this survey data provides insight as to how well the Center is 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. 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.

ADMINISTRATIVE OVERSIGHT

I. Management Structure

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, and the Planning and Operations Committee of the Board of Directors** for final action. In addition, QIS staff participates in the Center's Utilization Management Committee, Compliance Committee, Data Integrity Team, and Safety and Risk Management Committee to ensure fidelity, integrity and compliance in all Center operations.

II. Oversight of Medical Services

1) On a monthly basis the medical director reviews general revenue disbursements for medication expense. Reports are reviewed with representatives of the medical staff at the monthly Medical Services Committee meeting and are included in program benchmarks reviewed at the Executive Management Team meetings.

2) Physician peer review of charts is conducted quarterly at the Medical Services Committee meeting.

3) On a regular basis under the auspices of the Director of QIS selected charts are audited for completion related to medication documentation including informed consent documents and routine laboratory orders pertinent to the particular medication(s).

4) Approximately quarterly, the medical director evaluates the prescribing practices of New Generation Medications (NGMs). Rates of NGM poly-pharmacy are checked against a benchmark that has the total number of patients prescribed two concurrent NGMs less than or equal to 8%.

5) Irregularities or problem trends that come to the attention of the medical director through these or other means will be discussed in follow up at the next regularly scheduled medical services committee meeting as needed.

6) The medical director will identify and review the chart of any patient concurrently on 3 or more NGM medications.

7) Individual situations, by case or aggregated by prescriber, will be handled in private sessions between the Medical Director and the individual prescriber.

8) Documentation related to these activities will be maintained through the QIS system of the center.

II. Risk Management

As part of its continuous quality improvement culture, the Center assesses and responds to risk factors on an ongoing basis. The Center's Risk Management program includes:

A. Incident Reporting: Adverse incidents involving consumers, family members of consumers, staff, visitors, and/or Center property are reported on the Center's standard reporting form and submitted to the Director of QIS for review and needed action. Incidents categorized as critical or sentinel are responded to with immediacy. All employees receive training on incident reporting in New Employee Orientation, and all Center staff receive refresher training. Contractors are also required to complete Incident Report training.

B. Peer Review: Peer review activities are conducted for case management and therapist staff at mental health operations, and for physician and nursing staff throughout the Center. 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 Subcommittee of the Professional Review Committee.

Center physicians are organized into a structure that identifies a lead physician for each clinic. These leaders meet as a Medical Services Committee (MSC) and from the membership designate a Chief Medical Officer. The MSC sets the direction for the implementation of clinical best practices and overall functioning of medical services. The MSC conducts monthly peer reviews to support continuous quality improvement.

C. Safety and Risk Management Committee: The Safety and Risk Management (SRM) Committee is a formal committee of the Center which meets monthly to evaluate reports and issues related to safety and risk management in the Center's operations and facilities. Membership of the Committee includes the following

permanent members: The Director of Quality Improvement Services, who serves as the Chair; the Director of Safety, Maintenance and Transportation, who serves as the Vice Chair; the Chief Administrative Officer, or designee ; Legal Counsel, Director of Human Resources, or designee; Chief Medical Officer *or* Director of Nursing; Directors, or designee, of each Program providing services at the Center.

The SRM databases maintained by QIS are used to provide aggregated data and trend level analysis reports to the Committee. The databases are used to identify unacceptable variation in performance, to monitor the effects of actions taken, to identify areas in need of staff training and to evaluate the effectiveness of the SRM Action Plans. Other data sources may be identified by the committee for review.

The SRM Committee is authorized to request corrective Action Plans for identified trends or specific incidents. The SRM reviews and discusses pending SRM Action Plans, including status reports on completion of SRM recommendations, and requests any further action necessary, if any. The Director of QIS reports regularly on SRM activities to the Leadership Team, Executive Management Team and the Planning and Operations Committee of the Board of Trustees.

MONITORING ACTIVITIES AND STRUCTURE

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.

Monitoring methods include:

- Unit and Department Reports
- Clinical Services Reviews and Audits
- On-Site Programmatic Reviews
- On-Site Administrative Reviews
- Committee Analysis and Reports (Compliance; SRMC, Data Integrity)
- Employee Job Performance Evaluations and Staff Surveys
- Consumer Satisfaction Surveys
- Incident Reporting
  Network Oversight

Action Plans, Plans of Improvement (POIs), and Provider Profiling are the foundation of the Center's Quality Improvement process. The Center establishes benchmarks for excellence, internal and external accountability and ongoing quality improvement efforts by implementation of Action Plans and POIs at all administrative and provider sites. Each department or service, whether a provider of services or an authority or administrative support department, develops Action Plans and POIs as a means of analyzing and improving business processes. Action Plans reflect the processes and and goals of a specific unit, program, division or department, and are developed under the Center's mission and performance benchmarks established by the Management Teams. Plans of Improvement are required to demonstrate correction to identified deficiencies. This plan also requires contracts with local area network providers to stipulate quantifiable performance measures for contract evaluation through review of Provider Profiles.

QIS provides guidance and oversight for Action Plans, POIs, and Provider Profiling and assists with identifying problems germane to areas of operation and developing strategies for resolving problems.

Action Plans and POIS are submitted to QIS and Contract Monitoring (in the case of externally contracted operations) as directed for review, and then submitted to the Core Leadership Team as needed to inform and/or guide the business of the Center. Units have 30 days from date of notice to submit their Action Plans and POIs to QIS for review and acceptance. Depending on the issue(s) identified, action plans may be included on the agenda of the Safety and Risk Management Committee, Compliance Committee, Data Integrity Team and/or presented to the Core Leadership Team and/or the Planning and Operations Committee of the Board of Directors. 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. QIS monitors and evaluates key aspects of services and business processes and reviews data to correct, identify causes and/or investigate solutions regarding findings or areas of concern. QIS prepares summary and outlier reports that are presented for review by the EMT, LT, and/or FMT. The EMT includes development and review of performance benchmarks at its monthly meetings. The Core Leadership Team considers the implications of the reports and directs action as deemed necessary. Findings are also reported to the Board of Trustees, the Center's BHPNAC, and other committees as warranted.

NETWORK PROVIDER QUALITY MANAGEMENT PLANS

In addition to all Center staff, employees of network providers 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**

   a. All contracting private providers are required to develop, implement and actively monitor an Internal Quality Management Plan (IQMP) specific to their function. 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 to the Director of Quality Improvement Services and Director of Contracts and Procurement for review and approval. Proposed IQMP's are to be submitted 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, and regulatory, accreditation and best practices standards).

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

All IQMP's will include a documented and monitored QMI section which will specify quality indicators to be measured, *at a minimum*, contract targets, over and under utilization of services, consumer access, quality of service delivery and consumer satisfaction.

a. :

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
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. For deficiencies or negative outliers a timeline for corrective action will be indicated.

c. To ensure compliance with all regulatory, accreditation and best practices standards the IQMP must effectively measure performance using the appropriate Quality Indicators.

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 satisfy those standards and service contract requirements.

QIS AUDITS AND REVIEWS (Clinical and Administrative)

QIS, in collaboration with the Center's Utilization Management and Contracts Departments, maintains a regular schedule of audits and reviews of both internal and external/contracted providers to ensure that consumers receive services that are appropriate and documented in adherence to all applicable regulatory and accreditation requirements.

AUDIT PROCESS OVERVIEW PROCEDURES:

NEW SERVICE DELIVERY

- All service delivery programs will be audited/reviewed by QIS and/or Contract Monitoring within 45 days of their opening and thereafter on a regularly scheduled basis. Audit/review protocols will be developed from standards set forth by regulatory and accrediting agencies, and clinical best practices, using the highest standards as the audit benchmarks.

NOTIFICATION OF AUDITS

- 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), and the date and time the audit/review will begin. QIS and Contract Monitoring reserve the right to audit/review without advance notice. The review team is available to explain the parameters of the audit/review and the process to be utilized in advance of the audit/review.

POST AUDIT REVIEW AND REQUIRED RESPONSES

- The audit/review team will meet with the provider after results of the audit/review are tabulated to review and discuss the results. Providers are encouraged to have all management staff, and provider staff where appropriate, present during the audit/review to resolve any concerns. Where audit results do not meet performance benchmarks, a Plan of Correction is required within 14 calendar days, and deficiencies found are to be corrected/in compliance within 30 calendar days from the report. A follow-up visit to site may be completed 30 to 45 days after date of formal report to verify attainment of compliance. A report of results of follow-up site visit is given to the provider indicating either attainment of compliance, or need for additional plan of correction.

INTRA-AGENCY RECOUPMENT PROCESS

- When QIS audits/reviews of internal and/or external contracted providers find that billed services are not supported and therefore inappropriate for billing (e.g. documentation, medical necessity, authorization), results will be reported to the CHCS Revenue Department. The manager of the provider unit is responsible for providing any appropriate supporting materials to counter the findings *within fourteen days* to the QIS department. If such evidence is not provided within fourteen days of the unit's receipt of the report, or if the supporting materials submitted are not valid, QIS will verify the findings to the Revenue Department for refunding to the payor source and recoupment from the providing unit. For areas where deficiencies in practice are recognized, remedial training may be required. Appeals of recoupment findings may be made (1) for external/contracted providers: to CHCS Contract Department; (2) for internal units: to QIS.

AUDIT PARAMETERS

- For clinical audits/reviews, the review sample will be developed by randomly selecting services by 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, assessment, treatment plan, physician orders, service milieu, etc.) are in place, are current and meet all funding source, regulatory and accreditation 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.

- Within thirty (30) working days of the completion of the audit, the written report of audit findings will be distributed to the provider. A Post-Audit/Review meeting may be held between the QIS staff and the provider. QIS will review the audit findings and any questions can be addressed at this time. The Provider may be asked to meet with other Center administrative management, depending on the scope and results of the audit.

- All programs that score under 95% may 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 fourteen (14) calendar days from the date of the Post-Audit meeting and/or written notification of audit/review findings by the QIS 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 may 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.

- Technical Assistance from QIS and/or Contract Monitoring can be requested to assist with the formulation of the Plan of Correction.

FOLLOW-UP AUDITS/REVIEWS

QIS will review the Plan of Correction and notify the Provider by letter regarding acceptance within thirty (30) calendar days of receipt.

- A Follow-up Audit may 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.

- Programs that do not meet required benchmarks may be placed on vendor hold.

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.

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

UTILIZATION REVIEW

Formal reviews of consumer utilization and appropriateness of services on a prospective, concurrent and retrospective basis are 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.

Attachments:
Roster of Executive and Leadership Teams
Consumer Satisfaction Survey Samples