

NORTH SOUND MENTAL HEALTH ADMINISTRATION

2008-2009 QUALITY MANAGEMENT PLAN

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Section 1

PROGRAM DESCRIPTION

Purpose

As the public mental health authority for five Counties in Washington State (Island, San Juan, Skagit, Snohomish, and Whatcom), it is the purpose of the North Sound Mental Health Administration (NSMHA) to ensure the provision of quality and integrated mental health services for the five counties (San Juan, Skagit, Snohomish, Island, and Whatcom) served by the NSMHA Prepaid Health Plan (PIHP). Services are provided to Medicaid and non-Medicaid recipients, in accordance with the State of Washington Mental Health Contracts, using monies available through Federal and State funding sources.

NSMHA Mission Statement

We join together to enhance our community's mental health and support recovery for people with mental illness served in the North Sound region, through high quality culturally competent services.

The NSMHA is committed to:

1. Ensuring that the mental health system of the five counties is "consumer-driven."
2. Ensuring that consumers receive services that meet their individual needs appropriately.
3. The development and management of an Integrated Delivery System.
4. Ensuring that services are accessible and locally available 24 hours a day, 7 days per week.
5. Ensuring that services are culturally sensitive, appropriate and built on recipient strengths.
6. Treating people with mental illness with respect and dignity.
7. Providing services that are community based and designed to assist the individual maintain an optimal level of functioning.

Principles for Quality Management in the North Sound System

Quality Management's overall goal is the best possible service delivery system within our financial resources. Our system will;

- Maintain quality management capabilities on a Regional basis through a single, integrated model at NSMHA
- Hold administrative costs to a minimum in order to maximize resources available for direct consumer services
- Demonstrate the NSMHA Mission, Values and Principles, which include consumer voice, choice and ownership, as well as recovery and resilience.
- Be responsive to consumers and advocates through a system that listens to their needs and offers appropriate services and support.
- Meet state and federal requirements, to include requirements mandated by the State of Washington Mental Health Division (MHD), Centers for Medicare/Medicaid Services (CMS), the Balanced Budget Act (BBA), the Health Insurance Portability and Accountability Act (HIPAA) and the State of Washington's External Quality Review Organization (EQRO)
- Implement a shared vision of quality services and a system that is effective, coherent, transparent and easy to navigate for all stakeholders
- Engage provider staff and their perspectives regarding service delivery
- Assure consistency and focus over time in our service delivery models
- Acknowledge successful delivery models
- Achieve the right balance between resources devoted to service delivery and quality management activities to assure minimal impact on delivery of services, and
- Create a culture of measurement, with data driven decisions

The region-wide Quality Management system will measure, report, and make recommendations on the efficiency of NSMHA and contracted provider organizations quality management activities. Development of these measures is part of the Quality Management Work Plan. Quality management activities for NSMHA and provider staff will be conducted so as to include the following principles;

- Create a collaborative approach and a "no blame" environment
- Work at understanding one another's perspectives
- Honor one another's intrinsic roles and responsibilities
- Acknowledge the dynamic tensions in the system and seek ways to manage these
- Develop mechanisms for accountability at all levels of the system
- Celebrate successes as well as focusing on areas for improvement
- Involve consumers and advocates in the process
- Involve provider staff and their perspectives regarding the quality management process
- Keep things simple and achievable, don't add complexity to what we must do to meet state and federal requirements
- Maintain a sustained focus over time that balances service delivery with quality management
- Prioritize tasks and when adding something, look at what can be taken away
- Track information reliably, with data that has integrity
- Make decisions based on data

Scope of Services

The NSMHA Quality Management Plan addresses mental health services for children and adults who are enrolled with contracted NSMHA providers. Outpatient mental health services include Brief Intervention Treatment, Crisis Services, Day Support, Family Treatment, Inpatient Evaluation and Treatment, Group Treatment Services, Individual Treatment Services, Intake Evaluation, Inpatient Certification for Voluntary Hospitalization, Intensive Outpatient Services, Medication Management, Medication Monitoring, Mental Health Services Provided in Residential Settings, Peer Support, Psychological Assessment, Rehabilitation Case Management, Special Population Evaluation, Stabilization Services, Therapeutic Psychoeducation, Supported Employment, Respite Care and Mental Health Clubhouse. Services are provided to eligible Medicaid-covered enrollees, and, as funds allow, to non-Medicaid enrollees.

Any person in the North Sound five-county area, regardless of funding source, is eligible for crisis services.

Accountability of NSMHA to the Mental Health Division

The NSMHA is the managed care entity accountable to the State of Washington Mental Health Division (MHD) for oversight of the mental health services delivered by its contracted providers to eligible Medicaid enrollees and, as funds allow, to non-Medicaid recipients as well. NSMHA has an obligation to insure that the care and services delivered by service providers meet the standards of the NSMHA provider contracts, NSMHA Clinical Eligibility and Care Standards Manual, the State of Washington Center for Medicaid Services (CMS) Waiver, relevant State of Washington Administrative Codes (WACs), and the Revised Codes of Washington (RCWs). When NSMHA quality review activities indicate the need for a corrective action from providers to address quality management activities, the corrective action plans are reported to the regional Quality Management Oversight Committee and to the NSMHA Board of Directors.

The specific MHD Quality Management Plan expectations of the NSMHA are:

The regional support network must implement a process for continuous quality improvement in the delivery of culturally competent mental health services. The regional support network must submit a quality management plan as part of the written biennial plan to the mental health division for approval. All changes to the quality management plan must be submitted to the mental health division for approval prior to implementation. The quality management plan must include:

- Roles, structures, functions and interrelationships of all the elements of the quality management process, including but not limited to the regional support governing board, clinical and management staff, advisory board, Ombuds service and quality review teams
- Procedures that ensure that the quality management activities are effectively and efficiently carried out with clear management and clinical accountability, including methods to:
 - Collect, analyze and display information regarding:
 - The capacity to manage resources and services, including financial and cost information and compliance with statutes, regulations and agreements
 - System performance indicators
 - Quality and intensity of services
 - Incorporation of feedback from consumers, allied service systems, community providers, Ombuds and quality review team
 - Clinical care and service utilization including consumer outcome measures; and
 - Recommendations and strategies for system and clinical care improvements, including information from exit interviews of consumers and practitioners

- Monitor management information system data integrity
- Monitor complaints, grievances and adverse incidents for adults and children
- Monitor contract with contractors and to notify the MHD of observations and information indicating that providers may not be in compliance with licensing or certification requirements
- Immediately investigate and report allegations of fraud and abuse of the contractor or subcontractor to the MHD
- Monitor delegated administrative activities
- Identify necessary improvements
- Interpret and communicate practice guidelines to practitioners
- Implement change
- Evaluate and report results
- Demonstrate use of all corrective actions to improve the system
- Consider system improvements based on recommendations from all on site monitoring, evaluation and accreditation/certification reviews
- Review, update and make NSMHA Quality Management Plan available to community stakeholders
- Targeted improvement activities, including
 - Performance measures that are objective, measurable and based on current knowledge/best practice including at least those defined by the mental health division in the agreement with the regional support networks
 - An analysis of consumer care covering a representative sample of at least ten percent of consumers or five hundred consumers, whichever is smaller
 - Efficient use of human resources, and
 - Efficient business practices

MHD/NSMHA Contractual Expectations Regarding Quality Management

The Prepaid Inpatient Health Plan (PIHP) contract between NSMHA and the State of Washington's Mental Health Division (MHD) for the period from October 2007 thru September 2009 contains the following quality management expectations for NSMHA (pp 21-22):

The Contractor (**NSMHA**) shall participate with MHD in the implementation, update and evaluation of the Quality Strategy located on the MHD internet website.

- (dshs.wa.gov/Mental Health Division/MHD Quality Strategy/DSHS/MHD)

The Contractor shall conduct an **annual review** of the CMHA's within the contracted network. All collected data including PIHP monitoring results, external quality review findings, agency audits, sub-contract monitoring activities, consumer Grievances and services verification shall be incorporated into this review. This review must be included in the PIHP's ongoing quality management program.

This review may be combined with a formal review of services performed pursuant to the State Mental Health Agreement between the Contractor and MHD.

The annual review must at least address the following:

- Timely access that meets the Access Standards of this Agreement.
- Consistent referrals for Healthy Child screens for EPSDT.
- Efforts to pursue and report third party revenue.
- Quality Improvement activities including Performance Improvement Projects.
- The Implementation of Practice Guidelines and the provider implementation of Practice Guidelines.
- The implementation of the GAIN-SS and the co-occurring assessment for quadrant placement of individuals.
- Efforts to create the expectation and support the delivery of mental health services that are driven by and incorporate the voice of the Enrollee and those they identify as family.
- The degree to which mental health services delivered are age, culturally and linguistically competent.
- Monitoring activities performed are in place to make sure that attempts are made to provide mental health services in the least restrictive environment.
- A review of services that are being provided that promote recovery and resiliency.
- Local efforts to provide services that are integrated and coordinated with other formal/informal service delivery systems.

The Contractor shall provide quality improvement feedback to CMHAs, the Advisory Board, and other interested parties. The Contractor will maintain documentation of the activities and provide the documentation to MHD upon request.

The Contractor shall invite Enrollees and Enrollees' families that are representative of the community being served, including all age groups, to participate in planning activities and in the implementation and evaluation of the public mental health system. The Contractor must be able to demonstrate how this requirement is implemented.

The Contractor shall attempt to complete a Consumer Outcome Assessment using the Telesage instrument on every individual at the time of the intake evaluation and attempt to complete a follow-up assessment 3 months after the initial intake and every 6 months there-after.

Performance Improvement Projects - The Contractor must identify where improvement is needed and continue or implement at least two Performance Improvement Projects (PIP), at all times during the Contract period. This must include at least one clinical and one non-clinical project. The PIPs can be a mix of PIPs identified by the MHD for statewide improvement and projects identified by the RSN for local improvements. The Contractor shall evaluate the PIPs for increased or sustained improvement over time.

The Contractor shall participate with MHD in review activities. Participation will include at a minimum:

- The submission of requested materials necessary for a MHD initiated review within 30 days of the request.
- The completion of site visit protocols provided by MHD.
- Assistance in scheduling interviews and agency visits required for the completion of the review.

The Contractor may establish measures designed to maintain quality of services, controls costs and is consistent with its responsibilities to enrollees.

NSMHA/Providers Contractual Expectations Regarding Quality Management

NSMHA contracts with the following service providers:

bridgeways, Catholic Community Services, Compass Health, Interfaith, Lake Whatcom Center, Sea Mar Behavioral Health, Sunrise Services, Volunteers of America and Whatcom Counseling and Psychiatric Clinic.

NSMHA contracts with all five (5) counties, Island, San Juan, Skagit, Snohomish and Whatcom for Administrative Services and Jail Services. Also, NSMHA contracts with Snohomish County for Integrated Crisis Response Service.

The NSMHA contract with each of these providers contains a core, constant set of expectations regarding quality management activities that include requiring providers comply with the NSMHA Quality Management Plan. NSMHA monitors each providers quality management activities during Administrative, Fiscal and Quality Assurance/Improvement Audits. Other NSMHA quality management review activities of providers include clinical care reviews, such as care advocacy, grievance and/or critical incident reviews, clinical record reviews, using the Mental Health Division's Outpatient Record review tool and Utilization Management reviews, as appropriate.

Specific quality management expectations of all NSMHA contracted providers, as defined in the contract with each individual provider are as follows:

- CONTRACTOR (**PROVIDER**) shall participate with the NSMHA in the implementation, updates and evaluation of the MHD Quality Strategy located on the MHD website that is hereby incorporated by reference.
- CONTRACTOR shall comply with the NSMHA Quality Management Plan, or any successor, incorporated herein as Attachment IX.
- CONTRACTOR shall ensure its Quality Management (QM) activities comply with all applicable law and standards including, but not limited to: WAC 388-865-0280, -0425 and the NSMHA QM Plan, NSMHA policies and procedures; or their successors. In addition:
 - CONTRACTOR shall maintain an ongoing, planned, systematic, organization-wide quality management process to design, measure, analyze and improve its performance, including identification of innovations or best practice.
 - CONTRACTOR shall ensure Quality Assurance and Quality Improvement data is analyzed, reported and acted upon by its members and affiliates. This shall be demonstrated by written records maintained by Contractor.
 - CONTRACTOR shall present to NSMHA every six (6) months (March 31st and September 30th), a Quality Management report integrating all quality management program activities and data, in order to facilitate NSMHA's determination of the effectiveness of the overall regional system of care. This report shall be in a mutually agreed format and document the results of the CONTRACTOR's Quality Management plan activities and:
 - a. Identify areas of efficiency and effectiveness of system operations and the quality of care for consumers.
 - b. Identify areas of deficiency with plans to achieve expected improvement.
 - c. Status of implementation of all NSMHA approved corrective action plans.

Advocacy

The NSMHA values the input and perspectives of individual consumers, advocates and stakeholders, as well as input from consumer and family member organizations such as the National Alliance on Mental Illness (NAMI). The NSMHA Office of Consumer Affairs supports and solicits input from these groups. The NSMHA Advisory Board provides a monthly forum for these groups to express their views to the NSMHA. The NSMHA believes that the voice of consumer, family and advocates is an essential component of the quality management process, providing vital input regarding important aspects of care from those most directly affected by such care. The NSMHA feels that the Quality Management plans of all contracted providers should emphasize and incorporate consumer, family members and advocates into their ongoing quality assurance and quality improvement processes.

Delegation/Delegated Functions

Delegation is defined as a formal process by which the NSMHA gives another entity the authority to perform certain functions on its behalf, such as credentialing, inpatient authorization, and quality management. Although the NSMHA can delegate the authority to perform a function, it cannot delegate the responsibility for assuring that the function is performed appropriately. The NSMHA shall assure that delegated functions are performed appropriately through the monitoring of all such functions. Any function delegated to a provider requires the submission of a formal plan by the NSMHA to MHD detailing how the delegated function will be monitored.

Current NSMHA delegated functions to Volunteers of America (VOA) include:

- The Access Line
- Community Psychiatric Inpatient Services Management, and
- Customer Service

Specific contractual requirements of these delegated functions are included in the following contracts, which are effective from January 1, 2008 thru June 30, 2009.

- Medicaid- Contract # NSMHA-VOA-Medicaid-2008-2009, and
- State Mental Health- Contract # NSMHA-VOA-SMH-2008-2009

Remedial Action, Recommendations and Sanctions

The NSMHA is responsible to the MHD for any remedial action required of NSMHA by the MHD. Contracted NSMHA providers are responsible to NSMHA for any remedial action required by NSMHA. Any remedial action required of providers by the NSMHA is reported to the regional Quality Management Oversight Committee and to the NSMHA Board of Directors.

The NSMHA may require any contracted provider to plan and execute corrective action. Corrective action plans developed by contracted providers must be submitted for approval to the NSMHA within 30 calendar days of notification. Corrective action plans must be provided in a format acceptable to the NSMHA. The NSMHA may extend or reduce the time allowed for corrective action depending upon the nature of the situation as determined by the NSMHA.

The full information detailing provider responsibilities and requirements regarding remedial actions may be found in each provider's contract with the NSMHA, in the "Oversight, Remedies and Termination" portion of the contract.

Structure of the NSMHA Quality Management Program

The NSMHA Quality Management (QM) Program is intended to be an open, inclusive process through which the NSMHA collects and analyses information received from multiple sources throughout the region. The function of the NSMHA QM Program is to implement the quality management strategies identified in the current NSMHA Quality Management Plan. Input from providers, consumers, advocates and NSMHA staff is integrated into the NSMHA quality management process on a regular, ongoing basis. Four core groups involved in monthly review of quality management activities are:

- The NSMHA Board of Directors
- The NSMHA Advisory Board
- The NSMHA Quality Management Oversight Committee (QMOC)
- The NSMHA Quality Management Committee (QMC)

Briefly, the roles of these groups are as follows;

- The NSMHA Board of Directors is the governing body of NSMHA. It is comprised of elected officials (or their delegates) from Island, San Juan, Skagit, Snohomish and Whatcom counties, Tribal representatives and the Chair and Vice Chair of the NSMHA Advisory Board. The Board meets monthly throughout the year. The NSMHA Board of Directors is responsible for the adoption and oversight of NSMHA's annual Quality Management Plan and for acting upon all quality management recommendations forwarded by NSMHA's (QMOC).
- The NSMHA Advisory Board is comprised of consumers, advocates and other interested parties from throughout the Region. It meets monthly to review issues of concern and relevance to mental health consumers and their families/support sources. The purpose of the NSMHA Advisory Board is to provide independent advice and input to the NSMHA Board of Directors as well as to local jurisdictions and service providers. Reports from the NSMHA Advisory Board are a regular agenda item at the monthly NSMHA Board of Directors meetings.
- The NSMHA Quality Management Oversight Committee (QMOC) is a standing committee of the NSMHA Board of Directors. QMOC is comprised of NSMHA and provider staff, consumers, a Tribal representative, advocates and elected officials or their representatives. A member of the NSMHA Board of Directors serves as the Chair of QMOC. The QMOC Chairperson reports monthly to the Board of Directors regarding regional quality management activities, results and/or recommendations. QMOC is responsible for the oversight of quality management systems throughout the region and for reviewing all quality management activities conducted throughout the region.
- The NSMHA Quality Management Committee (QMC) is comprised of NSMHA and provider clinical and quality management staff. This committee reviews quality management activities performed at both the regional and the provider level. The committee makes recommendations based upon results of quality management activities and forwards these recommendations to QMOC. QMC operates in a collaborative, open communication manner and strives for consensus. Through this process of consensus, QMC works to standardize, operationalize and implement regional quality management activities, including the policies and procedures to define such activities. After review and discussion at QMOC, the recommendations from the Quality Management Committee are either forwarded to the NSMHA Board of Directors or returned by QMOC to the Quality Management Committee for further review.

The Board of Directors, acting in its role as the governing body of NSMHA, reviews the quality management recommendations and decides to either accept the recommendations from the Advisory Board and/or QMOC, or to return the matter to either the Advisory Board or QMOC for further study. If the Board does decide to accept the quality management recommendation proposed, the current NSMHA QM Plan is changed accordingly, with such changes presented to the Board for their final approval. If the Board decides to return the quality management recommendation to either the Advisory Board or QMOC for further study, the Chair of the Advisory Board or QMOC returns the matter to their respective group for further analysis and review. When this review/analysis is complete, the matter is again presented to the Board of Directors, with recommendations included.

Note:

The NSMHA is certified as a Coordinated Quality Improvement Program (CQIP), in accordance with the State of Washington Department of Health. CQIP is a voluntary program which provides protection of information and documents received and reviewed in the course of quality review investigation activities. The protected information and documents may not be subpoenaed or used in court proceedings as discovery evidence.

Two internal NSMHA committees, the Integrated Quality Management Committee and the Critical Incident Review Committee, review regional quality management information on a monthly basis. These two committees operate under the aegis of the NSMHA Coordinated Quality Improvement Program.

Because the NSMHA Integrated Quality Management Committee and Critical Incident Review committees are protected by CQIP status, both are able to review provider information and reports related to consumer health and safety concerns without the risk of the provider's information being subject to disclosure or court ordered subpoenas. This straightforward, unencumbered opportunity to review information regarding consumers promotes the NSMHA "no blame culture" and allows NSMHA and provider staff to problem solve in the most expedient, consumer responsive manner. The focus of action is directed toward helping the consumer rather than trying to determine where any fault lies.

Through this ongoing review process, both the Integrated Quality Management Committee and the Critical Incident Review Committee are able to make timely, data-driven decisions and bring these decisions forward as recommendations to the regional Quality Management Committee. The QMC in turn brings the recommendations forward to the Quality Management Oversight Committee (QMOC) who approve them as is, amend and approve them or return them for further review. When QMOC brings the quality management recommendations to the Board of Directors, the Board, like QMOC, can approve them as is, approve with amendments or return to QMOC for further study.

Flow of information through the NSMHA Quality Management Program

The NSMHA QM Program is designed to constantly review, measure and assess the effectiveness of regional quality management activities throughout the region. This is accomplished through the work of and recommendations from committees comprised of NSMHA and provider staff, consumers and advocates. All NSMHA committees have written Charters, describing the purpose, membership, primary objectives and expected outcomes of the committee. The committees investigate various aspects of care related to the provision of quality services region wide and prepare reports, including recommendations, regarding their activities and results.

At NSMHA, there are two types of quality review committees; internal committees, comprised of NSMHA staff and external committees, comprised of NSMHA and provider staff. The attached NSMHA Quality Management Organizational Chart (Illustration 1) depicts how quality management activities are reviewed by the internal and external committees. The Organizational Chart is intended to represent how information flows through the QM Program, from the originating group or committee on to the next committee, et cetera. The chart also illustrates how internal NSMHA QM information is forwarded to both internal and external QM committees. Examples of internal NSMHA and external committees are listed below.

Internal NSMHA Committees	External Committees
Critical Incident Review Committee- monthly	Integrated Crisis Response System - monthly
Internal Quality Management Committee- monthly	Medical Directors meeting- quarterly
General Quality Specialist Committee- every two weeks	Quality Management Oversight Committee- monthly
Specific Quality Specialist meetings- every two weeks	Quality Management Committee- monthly
	Advisory Board- monthly
	Utilization Management Subcommittee- bi monthly

These committees, as well as other ad hoc groups, review regional quality management activities on an ongoing basis. Coordination of multiple quality management activities and committees is facilitated by the Quality Management Committee (QMC). The QMC analyzes quality management information from multiple indicators and determines what overall trends and patterns are evident throughout the region. Based upon information received from multiple sources, the QMC suggests areas for further study and review, as well as brings forward recommendations about quality activities currently in place that are producing positive results. The QMC reviews both strengths and weaknesses of regional quality management activities and brings consensus recommendations regarding quality management to the Quality Management Oversight Committee (QMOC) on a regular basis. QMOC then decides, by Committee vote, whether to bring the quality management recommendation to the Board of Directors or to return the issue to the QMC for further study.

Information regarding all quality management activities is recorded in meeting minutes, by all committees. Reports and other information generated by committees is published on the NSMHA website, for ease of access by all interested parties. The NSMHA QM Program is responsive to ongoing quality management regionally due to its comprehensiveness, interconnections and flexibility. All contributors to regional quality management activities are given a voice in the NSMHA QM Program.

SECTION 2

Standards for Record Reviews

NSMHA has developed review instruments that are based on specific sources, such as the Washington Administrative Codes (WAC's), MHD Access To Care Standards, the contract between NSMHA/MHD, the contract between NSMHA/providers, the NSMHA Clinical Eligibility and Care Standards, the Revised Codes of Washington (RCW's), etc. All review instruments contain specific references to the sources that have been cited in the tool development.

All review instruments are developed in collaboration with providers. Drafts are shown to providers and their input is solicited. Review instruments are pre-tested with providers prior to their implementation at provider agencies. Results are reviewed with provider staff to determine the reliability and validity of the review instrument.

NSMHA staff use current versions of the following types of review instruments:

- Initial Review Instrument
- Concurrent Review Instrument
- Retrospective Review Instrument
- Crisis System Services Review Instrument, and

The MHD Outpatient Record Review Tool is used by NSMHA Quality Specialists during the Clinical Record review portion of the NSMHA Administrative Audit, conducted annually with all contracted providers. (See QM Plan 2008-2009, Work Plan section, Quality Assurance, Goal #1, Objective #1, "NSMHA Administrative Audits").

The MHD Outpatient Record Review Tool is a document developed by MHD. It is WAC specific and reviews services provided on an outpatient basis according to the following review areas:

Clinical Records	Case Management
Intake Evaluation	Psychiatric Treatment
Mental Health Specialist	Consumer Employment
Crisis Planning	Community Support (Less Restrictive Agreements)

QM Plan 2008-2009 Work Plan

QUALITY ASSURANCE

Goal #1: To ensure services provided throughout the Region are effective and appropriate

Focus Area: NSMHA Administrative Audit

NSMHA Crisis System Record Review

NSMHA Jail Services Review

NSMHA Review of Evaluation and Treatment Facilities

Objective #1: Provider agencies meet defined contract standards and compliance expectations per Washington Administrative Codes (WAC's), Revised Codes of Washington (RCW's) and all applicable State and Federal contract requirements.

Requirement Source	<ul style="list-style-type: none"> • Prepaid Inpatient Health Program (PIHP) – pg 21, Section 8, Quality Management <ul style="list-style-type: none"> ○ Subsection 8.1 • State Mental Health Contract (SMHC) – pg 14, Section 6, Quality of Care <ul style="list-style-type: none"> ○ Subsection 6.1
Task	Conduct multiple NSMHA Audits of each contracted provider annually, determine if Audit standards are being met.
Measurement	<p>Specific review tools used during each Audit are:</p> <ul style="list-style-type: none"> • NSMHA Administrative Audit <ul style="list-style-type: none"> • MHD Outpatient Record Review tool, version dated 12/14/2001 • NSMHA Administrative Audit tool, version dated 3/3/2007 NSMHA Crisis System Record Review <ul style="list-style-type: none"> • NSMHA Crisis Response Contact Sheet Check List, version dated 3/2006 NSMHA Jail Services Review <ul style="list-style-type: none"> • NSMHA Jail Services Review Tool, version dated 1/2007 NSMHA Review of Evaluation and Treatment Facilities <ul style="list-style-type: none"> • MHD E&T Clinical Review Tool, version dated 8/7/2006
Reports Produced	<p>NSMHA Administrative Audit and Outpatient Record Review</p> <ul style="list-style-type: none"> • Comprehensive review of Administrative, fiscal and quality assurance/improvement activities per provider reviewed. Report details areas of strength as well as addressing any areas of deficiency. Recommendations regarding quality improvement activities are included. Also, a Corrective Action Plan is requested, if needed, identifying how the provider plans to address any areas of deficiency. <p>NSMHA Crisis System Record Review</p> <ul style="list-style-type: none"> • Report summarizes results of crisis records from the regional Integrated Crisis Response System. Records are reviewed from Snohomish County, Compass Health and Whatcom Counseling and Psychiatric Clinic. Report addresses whether all appropriate services have been conducted and documented during a crisis investigation. <p>NSMHA Jail Services Review</p> <ul style="list-style-type: none"> • Report summarizes results of Jail Services records reviewed in the five regional counties. Specifically, reports address services in; <ul style="list-style-type: none"> ○ Snohomish County- provided by Snohomish County Community Mental Health staff ○ Skagit County- provided by Skagit County Community Health staff ○ Whatcom County- provided by Whatcom Counseling and Psychiatric Clinic staff ○ Island and San Juan Counties- provided by respective County staff • Reports detail whether expected services are being provided per contract standards and identifies areas of strength as well as quality improvement.

	<p>NSMHA Review of Evaluation and Treatment Facilities</p> <ul style="list-style-type: none"> • Report details WAC and RCW compliance results evident in clinical records reviewed at each of the two (2) regional E&T's. Report addresses areas of strength as well as quality improvement. <p>NOTE: To minimize disruption to providers who are scheduled for multiple audits during the audit cycle, NSMHA staff will attempt to schedule as many of these audits as possible simultaneously for the provider.</p>
Communication Flow	<p>Results from all audits conducted will be reported to the provider being reviewed during the Exit Interview component of the audit.</p> <p>Available audit results will then be presented and discussed at the NSMHA Internal Quality Management Committee (IQMC), held monthly. Audit results, as well as any recommendations from IQMC will then be presented at the next scheduled meeting of the Regional Quality Management Committee (QMC).</p> <p>Following discussion at QMC, audit results, and any QMC recommendations will be presented to the Regional Quality Management Oversight Committee (QMOC),</p> <p>QMOC reports all audit results, including recommendations by IQMC, QMC and QMOC to the Regional Board of Directors at the Board's next scheduled monthly meeting.</p>
Staff Responsible	<p>Contracts Coordinator, Margaret Rojas Quality Specialists, Terry McDonough and Sandy Whitcutt</p>
Timeline	<p>All audits are conducted annually</p>
Outcomes	<p><u>Administrative Audit and Outpatient Record Review-</u> will demonstrate that services are being provided in accordance with expected contractual and WAC standards, as evidenced by;</p> <ul style="list-style-type: none"> • Provider staff will achieve an overall score of 90% or higher on the MHD tool, AND a score of 90% or higher in each cluster of the MHD tool. • Provider staff will submit a Corrective Action Plan to NSMHA to address any Findings noted in any area of the NSMHA Audit tool <p><u>Crisis System Record Review-</u> will demonstrate that 90% of records reviewed contain all necessary episode information, as indicated by scoring on the NSMHA Crisis Response Contact Sheet Check List</p> <p><u>Jail Services Review-</u> will demonstrate that services are in place and being provided in accordance with NSMHA Jail Services contract expectations in 90% of the records reviewed.</p> <p><u>Review of Evaluation and Treatment Facilities-</u> will demonstrate that services provided are in accordance with the WAC and RCW requirements in the MHD E&T Clinical Review Tool in 90% of the records reviewed.</p>

QM Plan 2008-2009 Work Plan

QUALITY ASSURANCE

Goal #1: To ensure services provided throughout the region are effective and appropriate

Focus Area: NSMHA delegated functions

Objective #2: Consistent application of NSMHA standards in performance of NSMHA functions delegated to Providers

Requirement Source	<ul style="list-style-type: none"> • PIHP = pg 24, section 9, Subcontracts <ul style="list-style-type: none"> ○ Subsection 9.1, Delegation, pg 24 • SMHC = pg 16, section 7, Subcontracts <ul style="list-style-type: none"> ○ Subsection 7.1, Delegation, pp 16-17
Task	<p>To monitor, review and provide oversight of NSMHA functions that have been delegated to providers. Currently, NSMHA has delegated three (3) functions to the Volunteers of America (VOA). These functions are;</p> <ul style="list-style-type: none"> • The Access Line, • Community Psychiatric Inpatient Services Management, and • Customer Service
Measurement	<p>Compliance with, adherence to specific conditions for the Access Line, Community Psychiatric Inpatient Services Management and Customer Service detailed in the NSMHA/VOA Medicaid contract pp 24-26, and the NSMHA/VOA State Mental Health contract pp 23-25</p> <p>Meetings will occur every six months between NSMHA and VOA staff to review and analyze results from the current quarter. Any pertinent issues of strength, concern and/or adjustment will be discussed at these meetings and decisions or recommendations reached regarding these issues will be included in quarterly reports.</p>
Reports Produced	<p>Reports will be produced every six months addressing each of the three delegated functions. These reports will;</p> <ul style="list-style-type: none"> • Provide the number and types of calls in received in each area of delegated function • Describe quarterly issues of strength, concern and/or adjustment • Summarize decisions/recommendations concluded during quarterly meetings between NSMHA and VOA staff
Communication Flow	<p>Reports will be presented every six months to the NSMHA Internal Quality Management Committee (IQMC). Following discussion and review by IQMC, the report and any recommendations from IQMC will be presented at the next scheduled meeting of the Regional Quality Management Committee (QMC).</p> <p>Following discussion at QMC, report results, and any QMC recommendations will be presented to the Regional Quality Management Oversight Committee (QMOC),</p> <p>QMOC reports all report results, including recommendations by IQMC, QMC and QMOC to the Regional Board of Directors at the Board's next scheduled monthly meeting.</p>

Staff Responsible	Quality Specialist, Charissa Fuller
Timeline	Reports will be produced every six months
Outcomes	<ul style="list-style-type: none"> • NSMHA functions delegated to VOA will be implemented in a manner consistent with the contract between NSMHA and VOA. • Delegated functions will be performed in a manner to enhance consumers connection to appropriate inpatient as well as outpatient mental health services. • Ongoing meetings between NSMHA and VOA staff will address how to design, measure, analyze and improve the performance of the delegated functions.

QM Plan 2008-2009 Work Plan

QUALITY ASSURANCE

Goal #2: To ensure that callers seeking information about mental health services in the region receive appropriate information and assistance

Focus Area: Customer Service Standards

Objective #1: NSMHA staff respond to customer service requests in a manner consistent with Customer Service standards defined in the NSMHA/MHD contract

Requirement Source	<ul style="list-style-type: none"> • PIHP = pg 10, section 5, Information Requirements <ul style="list-style-type: none"> ○ Subsection 5.2, Customer Service, pg 11 • SMHC = pg 9, section 4 Information Requirements <ul style="list-style-type: none"> ○ Subsection 4.2, Customer Services, pp 10-11
Task	NSMHA staff perform customer service activities in accordance with NSMHA customer service standards
Measurement	<p>Per NSMHA/MHD PIHP contract 2007-2009, The NSMHA shall:</p> <ul style="list-style-type: none"> • Provide customer service that is customer-friendly, flexible, proactive and responsive to consumers, families and stakeholders. • Provide a toll free number for customer service inquiries. A local telephone number may also be provided for enrollees within the local calling area. <p>At a minimum, Customer Service staff shall:</p> <ul style="list-style-type: none"> • Promptly answer telephone calls from consumers, family members and stakeholders from 8 AM until 5 PM Monday through Friday, holidays excluded • Respond to consumers, family members and stakeholders in a manner that resolves their inquiry. Staff must have the capacity to respond to those with limited English proficiency or hearing loss. • Customer service staff must be trained to distinguish between a benefit inquiry, third party insurance issue, appeal or grievances and how to route these to the appropriate party. At a minimum, logs shall be kept to track the date of the initial call, type of call and date of attempted resolution. This log shall be provided to the Mental Health Division (MHD) upon request. <p>Customer Service standards will be reviewed quarterly by NSMHA Customer Service staff at an internal meeting. At this meeting staff will assess whether customer service standards were met during the quarter. If staff feel these standards have not been met, appropriate quality improvement activities will be initiated.</p>
Reports Produced	<p>Customer service reports will be prepared every six months. These reports will;</p> <ul style="list-style-type: none"> • Summarize quarterly customer service data as reported in the Customer Service log, detailing types of calls received, resolution of calls and source of calls • Summarize the input from the quarterly NSMHA internal Customer Service meetings, including areas of strength as well as any areas where performance needs to improve in order to meet customer service standards

Communication Flow	<p>Reports will be presented every six months to the NSMHA Internal Quality Management Committee (IQMC). Following discussion and review by IQMC, the report and any recommendations from IQMC will be presented at the next scheduled meeting of the Regional Quality Management Committee (QMC).</p> <p>Following discussion at QMC, report results, and any QMC recommendations will be presented to the Regional Quality Management Oversight Committee (QMOC),</p> <p>QMOC reports all report results, including recommendations by IQMC, QMC and QMOC to the Regional Board of Directors at the Board's next scheduled monthly meeting.</p>
Staff Responsible	Quality Specialist, Diana Striplin
Timeline	Customer service logs will be maintained on a daily basis at NSMHA. Every six months, reports will be produced regarding results of the review of these service logs.
Outcomes	<ul style="list-style-type: none"> • Customers calling NSMHA will receive prompt, friendly and responsive assistance from NSMHA staff. • Callers will receive the necessary information they need to address their question/concern or be referred to the appropriate resource for that information. • Reviews will identify any possible areas for potential quality improvement activities.

QM Plan 2008-2009 Work Plan QUALITY ASSURANCE

Goal #2: To ensure that services delivered to consumers throughout the region meet or exceed expected standards

Focus Area: Complaint and Grievances, Appeals and Fair Hearings

Objective #2: Trends in complaint and grievance data are monitored and responded to

Requirement Source	<ul style="list-style-type: none"> • PIHP = pg 36, section 13, Grievance System, pp 36-41 • SMHC = pg 28, section 11, Grievance System, pp 28-29
Task	Gather, review and summarize regional complaint and grievance data from consumers. Perform trend analyses every six months to determine current levels of complaints and/or grievance as compared to previous reported levels.
Measurement	Mental Health Division's "Exhibit N" report for current reporting period and historic reporting periods for comparison
Reports Produced	NSMHA Complaint and Grievance Exhibit N report
Communication Flow	<p>Reports will be presented every six months to the NSMHA Internal Quality Management Committee (IQMC). Following discussion and review by IQMC, the report and any recommendations from IQMC will be presented at the next scheduled meeting of the Regional Quality Management Committee (QMC).</p> <p>Following discussion at QMC, report results, and any QMC recommendations will be presented to the Regional Quality Management Oversight Committee (QMOC),</p> <p>QMOC reports all report results, including recommendations by IQMC, QMC and QMOC to the Regional Board of Directors at the Board's next scheduled monthly meeting.</p>
Staff Responsible	Quality Specialist, Diana Striplin
Timeline	As established by the Mental Health Division, at least every six months
Outcomes	<ul style="list-style-type: none"> • Complaint and grievance data is tracked, trends are responded to. • Complaints are settled at the lowest level • Consumers receive services they are satisfied with and feel meets their needs • Review data to establish a regional baseline for comparative purposes • Identify potential areas for quality improvement activities

QM Plan 2008-2009 Work Plan QUALITY ASSURANCE

Goal #3: To ensure consumer, staff and community safety throughout the region

Focus Area: Risk Management

Objective #1: Critical incidents presenting safety concerns are identified, reported and addressed per MHD contractual standards

Requirement Source	<ul style="list-style-type: none"> • PIHP = pg 8, section 3, Incident Reporting • SMHC = pg 8, section 3, Incident Reporting
Task	<p>The NSMHA Critical Incident Review Committee (CIRC) shall review all critical reported incidents. The intent of these reviews is to determine whether or not appropriate steps were taken during the incident to limit harm to the involved consumer(s) and provider staff, and that steps were taken subsequent to the incident to reduce the probability that a similar type of incident will occur in the future.</p> <p>CIRC Lead staff shall report all incidents that are designated as “MHD reportable” to the Mental Health Division.</p>
Measurement	NSMHA Critical Incident Review Log
Reports Produced	NSMHA Critical Incident Semi-Annual Report
Communication Flow	<p>Reports will be presented every six months to the NSMHA Internal Quality Management Committee (IQMC). Following discussion and review by IQMC, the report and any recommendations from IQMC will be presented at the next scheduled meeting of the Regional Quality Management Committee (QMC).</p> <p>Following discussion at QMC, report results, and any QMC recommendations will be presented to the Regional Quality Management Oversight Committee (QMOC),</p> <p>QMOC reports all report results, including recommendations by IQMC, QMC and QMOC to the Regional Board of Directors at the Board’s next scheduled monthly meeting.</p>
Staff Responsible	Quality Specialist, Kurt Aemmer
Timeline	<ul style="list-style-type: none"> • July 31, 2008 Critical Incident Semi-Annual report reflects January thru June 2008 Critical Incident Report activities • January 31, 2009 Critical Incident Semi-Annual report reflects July thru December 2008 Critical Incident Report activities • July 31, 2009 Critical Incident Semi-Annual report reflects January thru June 2009 Critical Incident Report activities • January 31, 2010 Critical Incident Semi-Annual report reflects July thru December 2009 Critical Incident Report activities
Outcomes	<ul style="list-style-type: none"> • Appropriate risk management activities will be utilized by providers responding to critical incidents • NSMHA will respond to all noted trends involving regional safety • Establish and maintain a regional data base involving Critical Incidents for comparative purposes • Review all Critical Incident episodes for potential quality improvement activities

QM Plan 2008-2009 Workplan QUALITY IMPROVEMENT

Goal #1: To ensure services provided throughout the region are effective and appropriate

Focus Area: Seclusion and Restraint review at both regional Evaluation and Treatment Facilities, E&T's

Objective #1: Monitor the use of seclusion and physical restraints at both regional E&T's

Requirement Source	NSMHA selected this as a Quality Improvement activity based upon E&T review in 2006. It had been a NSMHA Performance Improvement Project (PIP) in 2006.
Task	Conduct a review of restraint and seclusion usage at both regional E&T's
Measurement	<ul style="list-style-type: none"> • Both E&T's will send in daily reports of their seclusion and restraint events. • NSMHA will compile seclusion and restraint event data on a monthly basis
Reports Produced	<ul style="list-style-type: none"> • A report will be produced that compares the monthly totals of reported seclusion and restraint events at the E&T's. The report will address; <ul style="list-style-type: none"> ○ The number of seclusion and restraint events at each E&T ○ The combined number of seclusion and restraint events at both E&T's ○ An annual overview of the monthly seclusion and restraint usage levels at each E&T ○ A determination regarding the overall pattern of seclusion and restraint events and whether the frequency of these event is increasing, decreasing or remaining static
Communication Flow	<p>Reports will be presented annually to the NSMHA Internal Quality Management Committee (IQMC). Following discussion and review by IQMC, the report and any recommendations from IQMC will be presented at the next scheduled meeting of the Regional Quality Management Committee (QMC).</p> <p>Following discussion at QMC, report results, and any QMC recommendations will be presented to the Regional Quality Management Oversight Committee (QMOC),</p> <p>QMOC reports all report results, including recommendations by IQMC, QMC and QMOC to the Regional Board of Directors at the Board's next scheduled monthly meeting.</p>
Staff Responsible	Quality Specialist, Charissa Fuller
Timeline	Reports will be produced annually
Outcomes	<ul style="list-style-type: none"> • Potential reduction of seclusion and restraint events at both E&T's • Establishment of a baseline regarding regional seclusion and restraint usage for comparative purposes. • Review of seclusion/restraint results for potential quality improvement activities

QM Plan 2008-2009 Work Plan

QUALITY IMPROVEMENT

Goal # 1: To ensure services provided throughout the region are timely, effective and appropriate

Focus Area: Expedited Assessment requests

Objective # 2: Expedited Assessment requests are offered and completed within timelines identified in NSMHA Clinical Policy 1505.00, Authorization for Ongoing Outpatient Services

Requirement Source	NSMHA Clinical Policy 1505.00, "Authorization for Ongoing Outpatient Services"
Task	Conduct monthly reviews comparing the number of Expedited Assessment requests from VOA staff to the actual number of Expedited Assessments scheduled by agency providers
Measurement	<ul style="list-style-type: none"> • VOA staff send monthly reports to NSMHA staff regarding the number of Expedited Assessment requests made to provider scheduling staff • NSMHA staff compare the number of VOA requests to actual number of Expedited Assessments scheduled to determine if the numbers match • If the numbers do NOT match, NSMHA staff investigate the issue to determine if: <ul style="list-style-type: none"> ○ VOA staff have made appropriate Expedited Assessment requests per NSMHA Policy 1505.00 ○ Provider scheduling staff have accommodated the VOA request by scheduling and conducting the Expedited Assessments per NSMHA Policy 1505.00
Reports Produced	Monthly reports will be produced, reviewing the previous months data regarding number of requested versus number of scheduled Expedited Assessments. If the number of VOA requested Expedited Assessments does not match the number of Expedited Assessments scheduled by providers, NSMHA staff will investigate the numeric discrepancy to determine the cause for the difference. These reports will be summarized on a quarterly basis.
Communication Flow	<p>Reports will be presented every six months to the NSMHA Internal Quality Management Committee (IQMC). Following discussion and review by IQMC, the report and any recommendations from IQMC will be presented at the next scheduled meeting of the Regional Quality Management Committee (QMC).</p> <p>Following discussion at QMC, report results, and any QMC recommendations will be presented to the Regional Quality Management Oversight Committee (QMOC),</p> <p>QMOC reports all report results, including recommendations by IQMC, QMC and QMOC to the Regional Board of Directors at the Board's next scheduled monthly meeting.</p>
Staff Responsible	Quality Specialists, Terry McDonough and Sandy Whitcutt
Timeline	Reports produced monthly, summarized every six months. Any emerging issues will be brought forward through appropriate channels, i.e., Internal Quality Management Committee, Utilization Management Sub-Committee, Regional Quality Management Committee or Regional Quality Management Oversight Committee
Outcomes	<p>Consumers requiring Expedited Assessments will receive them. Review/report results will demonstrate that:</p> <ul style="list-style-type: none"> • VOA staff are making appropriate requests for Expedited Assessments • Provider agency staff are appropriately scheduling Expedited Assessments <p>NSMHA will establish a baseline regarding Expedited Assessments requested and performed and evaluate for possible quality improvement activities.</p>

QM Plan 2008-2009 Work Plan UTILIZATION MANAGEMENT

Goal #1: To ensure services provided throughout the region are effective and appropriate

Focus Area: Utilization Reviews of outpatient services provided meet contract expectations

Objective #1: Outpatient services provided to consumers are in accordance with expectations defined in the NSMHA/MHD contract and all relevant WAC's

Requirement Source	<ul style="list-style-type: none"> • PIHP = pg 30, section 11, Care Management <ul style="list-style-type: none"> ○ Subsection 11.1 Utilization Management Program, pp 30-31 ○ Subsection 11.2, Resource Management, pp 31-33 • SMHC = pg 21, section 9, Care Management Program <ul style="list-style-type: none"> ○ Subsection 9.1, Utilization Management Program, pp 21-22 ○ Subsection 9.2, Resource Management, pp 22-23
Task	<p>Three separate tasks will be performed;</p> <ul style="list-style-type: none"> • Conduct monthly reviews of provider outpatient service records using NSMHA Utilization Review instruments (Initial, Concurrent and Retrospective Reviews). • NSMHA reviewers leave a written request with providers for each chart that does not meet guidelines, asking for clarification • Conduct monthly reviews of provider billing information for accuracy and completeness (Encounter Validation Reviews) <p>Note: Utilization Review requests to providers are proportional to the number of NSMHA clients they are serving. Larger providers are reviewed monthly, smaller providers are reviewed quarterly.</p>
Measurement	<p>Two separate measurement instruments will be used;</p> <ul style="list-style-type: none"> • Utilization Reviews will be performed using the NSMHA Initial, Concurrent and/or Retrospective Utilization Review tools • Encounter Validation reviews will be performed by comparing data submitted to NSMHA by providers against documented information present in the outpatient record.
Reports Produced	<p>Two separate reports will be produced;</p> <ul style="list-style-type: none"> • Utilization Review Report- This report details results from monthly Utilization Reviews performed throughout the Region. Reports detail results from charts reviewed in terms of; <ul style="list-style-type: none"> ○ the number of charts that met all diagnosis, eligibility and provision of service guidelines in the utilization review tools, and ○ the number of charts reviewed that did not meet diagnosis, eligibility and/or provision of service guidelines. Providers respond in writing within 30 days to the Requests for Change, and change either the diagnosis, eligibility or provision of service information in the chart to conform with guidelines. • Encounter Validation Report- This information is presented to MHD per contract defined timelines, once every six months. Information in the report is included in the NSMHA Quality Management Plan Integrated Report, which is produced every six months.

Communication Flow	<p>At the conclusion of each Utilization Review, NSMHA reviewers will meet with agency staff to debrief review results and leave them a copy of any Requests for Change.</p> <p>Reports will be presented every six months to the NSMHA Internal Quality Management Committee (IQMC). Following discussion and review by IQMC, the report and any recommendations from IQMC will be presented at the next scheduled meeting of the Regional Quality Management Committee (QMC).</p> <p>Following discussion at QMC, report results, and any QMC recommendations will be presented to the Regional Quality Management Oversight Committee (QMOC),</p> <p>QMOC reports all report results, including recommendations by IQMC, QMC and QMOC to the Regional Board of Directors at the Board's next scheduled monthly meeting.</p>
Staff Responsible	<p>Staff responsible for preparing Utilization Review reports-</p> <ul style="list-style-type: none"> • Sandy Whitcutt and Terry McDonough, NSMHA Quality Specialists <p>Staff responsible for preparing Encounter Validation Reports-</p> <ul style="list-style-type: none"> • Michael White, NSMHA IS/IT Administrator
Timeline	<p>Utilization Review reports are produced monthly and reported to provider upon completion. Summaries of UR reports are presented every six months to appropriate committees.</p> <p>Encounter Validation reports are produced every six months.</p>
Outcomes	<p><u>Utilization Review Outcomes-</u></p> <ul style="list-style-type: none"> • Utilization Review reports will demonstrate that outpatient services are being appropriately provided in at least 80% of all cases reviewed, both on a regional average, as well as by individual providers. • Instances of service provision appropriately delivered at a 90% level or above will be highlighted as areas of regional excellence. • Instances of service provision delivered at a level under 80% will generate a NSMHA request for a Corrective Action Plan (CAP) from the specific provider who has scored under 80%. This (CAP) will identify how the provider plans to improve their compliance with Utilization Review guidelines. NSMHA staff will track the implementation of the CAP to verify that the implemented corrective actions are implemented and effective. <p><u>Encounter Validation Outcomes</u></p> <ul style="list-style-type: none"> • Encounter Validation reports will be used to establish a baseline that determines the percent of times the NSMHA data received from providers matches the data found in the clinical record. Each six month period, this percentage will be expected to improve. Failure to improve the "data match" percentage over any preceding six month period may become an area of Quality Improvement to add to the NSMHA Quality management Plan 2008-2009.

QM Plan 2008-2009 Workplan UTILIZATION MANAGEMENT

Goal #1: To ensure services provided throughout the region are effective and appropriate

Focus Area: Eligibility standards

Objective #2: Consistent application of eligibility standards for outpatient services across the region by age levels and levels of care

Requirement Source	<ul style="list-style-type: none"> • PIHP = pg 30, section 11, Care Management <ul style="list-style-type: none"> ○ Subsection 11.1 Utilization Management Program, pp 30-31 ○ Subsection 11.2, Resource Management, pp 31-33 • SMHC = pg 23, section 9, Care Management Program <ul style="list-style-type: none"> ○ Subsection 9.1, Utilization Management Program, pp 21-22 ○ Subsection 9.2, Resource Management, pp 22-23 ○ Subsection 9.4, Medicaid Personal Care, pp23-24
Task	<p>Three separate tasks will be performed;</p> <ul style="list-style-type: none"> • Quality Specialist staff will review all service authorization/reauthorization requests regionally to verify the requests are in compliance with established eligibility criteria • Quality Specialist staff will review all provider submitted Denial Review requests, make a decision to either uphold the providers Denial Request or overturn the Denial Request and have the provider admit the applicant to outpatient services • Quality Specialist staff will review all requests for renewal or initiation of Medicaid Personal Care services received throughout the region
Measurement	<p><u>Authorization/Reauthorization Requests-</u></p> <ul style="list-style-type: none"> • Providers meet established eligibility criteria, as identified in the MHD Access To Care Standards and the NSMHA Clinical Eligibility and Care Standards. <p><u>Denial Review Requests-</u></p> <ul style="list-style-type: none"> • Providers meet established eligibility/denial criteria and the MHD Access To Care Standards through paperwork submitted to NSMHA. <p><u>Medicaid Personal Care Requests</u></p> <ul style="list-style-type: none"> • Medicaid Personal Care requests meet established eligibility/denial criteria. The criteria defined in the State Mental Health Contract, Section 9, Care Management Program, Subsection 9.4, Medicaid Personal Care will be used.
Reports Produced	<p>Two separate reports will be produced;</p> <ul style="list-style-type: none"> • Authorization/Reauthorization Report- • Denial Review Request Report- This report details the number of Denial Review Requests, by age group, submitted by providers to NSMHA and then either upheld or overturned by NSMHA staff. This report will present results for individual providers as well as regional results regarding Denial Review Requests.

Communication Flow	<p>Reports will be presented every six months to the NSMHA Internal Quality Management Committee (IQMC). Following discussion and review by IQMC, the report and any recommendations from IQMC will be presented at the next scheduled meeting of the Regional Quality Management Committee (QMC).</p> <p>Following discussion at QMC, report results, and any QMC recommendations will be presented to the Regional Quality Management Oversight Committee (QMOC),</p> <p>QMOC reports all report results, including recommendations by IQMC, QMC and QMOC to the Regional Board of Directors at the Board's next scheduled monthly meeting.</p>
Staff Responsible	<p><u>Authorization/Reauthorization Report-</u></p> <ul style="list-style-type: none"> • Prepared by NSMHA IS/IT Dept, reviewed and discussed with providers by NSMHA Quality Specialist staff, Sandy Whitcutt and Terry McDonough <p><u>Denial Review Request Report</u></p> <ul style="list-style-type: none"> • Quality Specialist staff, Sandy Whitcutt and Terry McDonough
Timeline	<p><u>Authorization/Reauthorization Report-</u></p> <ul style="list-style-type: none"> • Presented every six months <p><u>Denial Review Request Report</u></p> <ul style="list-style-type: none"> • Presented every six months <p><u>Medicaid Personal Care Report</u></p> <ul style="list-style-type: none"> • Presented every six months
Outcomes	<p><u>Authorization/reauthorization Requests-</u></p> <ul style="list-style-type: none"> • A report detailing number and type of requests received, identified by age, diagnosis and risk factors will be presented and analyzed every six months. This report will be used to establish a data base for the Region. <p><u>Denial Review Request Report</u></p> <ul style="list-style-type: none"> • Denial Review Request (DRR) reports will indicate that NSMHA reviewers agree with provider DRR's at an average of 80% or higher for any consecutive three month period reviewed. Averages of agreement at or above 90% will be presented as an area of regional excellence. Any provider scoring below 80% agreement with NSMHA reviewers for any consecutive three month period will be asked to present a Corrective Action Plan to NSMHA detailing how problematic issues leading to NSMHA overturns of providers DRR's will be corrected. The overall provider and regional outcome will indicate that eligibility decisions are being made in accordance with MHD Access To Care Standards, as per contractual requirements. <p><u>Medicaid Personal Care Report</u></p> <ul style="list-style-type: none"> • The report will indicate that all approved requests for Medicaid Personal Care services were responded to in a timely and appropriate manner by NSMHA staff. The report will also identify any trends in capacity or fund availability that may occur.

QM Plan 2008-2009 Work Plan UTILIZATION MANAGEMENT

Goal # 1: To ensure services provided throughout the region are appropriate and effective
Focus Area: Residential Placement

Objective # 3: Consumers requiring a residential placement in addition to outpatient services due to their mental illness have access to such placement and receive proper screening and placement, as resources allow.

Requirement Source	<ul style="list-style-type: none"> • PIHP = pg 48, section 14, "Benefits" <ul style="list-style-type: none"> ○ Subsection 14.3.12, Mental health services provided in residential settings, pg 50 • SMHC = Pg 40, section 12, "Services" <ul style="list-style-type: none"> ○ Subsection 12.8, Outpatient mental health services and residential programs, ○ Subsection 12.11.10, Mental health services provided in residential settings, pg 45 • NSMHA Clinical Policy and Procedure #1532.00, "Residential Placement"
Task	NSMHA Quality Specialists will review and approve all requests for Residential Placement for clients throughout the region.
Measurement	<p>Two types of measurement will be performed to review this task;</p> <ul style="list-style-type: none"> • Ongoing review of all requests for residential placement by the NSMHA Intensive Outpatient Services Screening Committee. Approval decisions made by this Screening Committee mean the consumer is approved for residential placement for the next six month period. The Screening Committee shall track the number of residential placement requests, the percentage of such requests approved and the reasons for requests that are not approved. • Concurrent reviews of clinical records for clients in residential placements, to determine that they qualify for such placement and that appropriate outpatient mental health services are in place to maintain the residential placement. <p>The Screening Committee and the concurrent review component will both utilize the LOCUS measurement tool to verify that need for residential placement is identified in the scoring on the LOCUS instrument.</p>
Reports Produced	<p>Two reports will be produced;</p> <ul style="list-style-type: none"> • One report will summarize the review of requests for residential placement done by the NSMHA Intensive Outpatient Services Screening Committee, including the number of requests reviewed, approved, not approved and the reasons for any non approvals. It will also detail the current status of available residential placement sites. • One report will summarize the results of concurrent reviews of clinical records for clients in residential placement. This report will detail the degree to which charts reviewed show appropriate placement criteria have been met for clients in residential placement. It will also report the number of charts reviewed that indicate the client may be ready for planning toward a more independent residential setting.

Communication Flow	<p>Reports will be presented every six months to the NSMHA Internal Quality Management Committee (IQMC). Following discussion and review by IQMC, the report and any recommendations from IQMC will be presented at the next scheduled meeting of the Regional Quality Management Committee (QMC).</p> <p>Following discussion at QMC, report results, and any QMC recommendations will be presented to the Regional Quality Management Oversight Committee (QMOC),</p> <p>QMOC reports all report results, including recommendations by IQMC, QMC and QMOC to the Regional Board of Directors at the Board's next scheduled monthly meeting.</p>
Staff Responsible	<p>NSMHA Intensive Outpatient Services Screening Committee report-</p> <ul style="list-style-type: none"> • NSMHA Quality Specialist Laura Davis <p>NSMHA Residential Concurrent Review report-</p> <ul style="list-style-type: none"> • NSMHA Quality Specialists Sandy Whitcutt and Terry McDonough
Timeline	Both reports will be produced every six months
Outcome	Screening Committee results and concurrent review results will indicate that clients receiving residential placement meet eligibility requirements for this placement and, if appropriate, are receiving the necessary assistance and skill development to pursue more independent community-based living.

QM Plan 2008-2009 Workplan UTILIZATION MANAGEMENT

Goal #1: To ensure services provided throughout the Region are effective and appropriate

Focus Area: Intensive Outpatient (IOP) Services

Objective #4: Services to consumers that facilitate community living, psychosocial rehabilitation and recovery are provided in accordance with expectations defined in the NSMHA/MHD contract and NSMHA Clinical policy 1527.00, "Intensive Outpatient Services".

Requirement Source	<ul style="list-style-type: none"> • PIHP = pg 41, section 14, "Benefits", <ul style="list-style-type: none"> ○ subsection 14.3.7, pg 43, High Intensity Treatment, and • SMHC = pg 29, section 12, "Services", <ul style="list-style-type: none"> ○ subsection 12.3.5, Outpatient Mental Health Services, pg 37 ○ subsection 12.3.5.1.5, High Intensity Treatment, pg 38
Task	NSMHA Quality Specialists will review and authorize all requests for service involving consumers being considered for Intensive Out Patient (IOP) services
Measurement	<p>Three measurements will be performed for Intensive Out Patient (IOP) services;</p> <p><u>Adults:</u></p> <ul style="list-style-type: none"> • Initial approval reviews to determine consumer's eligibility for Intensive Out Patient (IOP) services • Concurrent reviews of service to determine consumers remain eligible for services and are receiving appropriate services, based upon their level of need <p><u>Children:</u></p> <ul style="list-style-type: none"> • A review of IOP Services for Children, such as Wraparound Services and the Children's Hospital Alternative Program (CHAP)
Reports Produced	<p>Three separate reports will be produced;</p> <p><u>Adults:</u></p> <ul style="list-style-type: none"> • One report will summarize the results of all Initial Approvals reviewed during a six month period. This report will detail; <ul style="list-style-type: none"> ○ The number of approvals reviewed and approved or denied ○ The reasons for any denial of Initial Approval request ○ The current program usage level and resultant system capacity for Intensive Out Patient (IOP) service • One report will summarize the results of all Concurrent Utilization Reviews performed during a six month period. This report will detail; <ul style="list-style-type: none"> ○ The current effectiveness of services being provided ○ The adherence of service provision to appropriate contract standards and NSMHA policies ○ The determination that consumers receiving services continue to need and be eligible for Intensive Out Patient (IOP) services

	<p><u>Children:</u></p> <ul style="list-style-type: none"> • One report will summarize the usage of Children’s IOP Services. This report will detail; <ul style="list-style-type: none"> ○ The level of IOP usage ○ The effectiveness of IOP usage ○ Any quality improvement activities that Children’s IOP usage patterns may suggest
Communication Flow	<p>Reports will be presented every six months to the NSMHA Internal Quality Management Committee (IQMC). Following discussion and review by IQMC, the report and any recommendations from IQMC will be presented at the next scheduled meeting of the Regional Quality Management Committee (QMC).</p> <p>Following discussion at QMC, report results, and any QMC recommendations will be presented to the Regional Quality Management Oversight Committee (QMOC),</p> <p>QMOC reports all report results, including recommendations by IQMC, QMC and QMOC to the Regional Board of Directors at the Board’s next scheduled monthly meeting.</p>
Staff Responsible	<ul style="list-style-type: none"> • NSMHA Quality Specialist Laura Davis – IOP Approval report, Adults • NSMHA Quality Specialists Sandy Whitcutt and Terry McDonough – IOP Concurrent Review of services report • NSMHA Quality Specialists Julie de Losada and Angela Frazer-Holtz – IOP Approval report, Children
Timeline	<ul style="list-style-type: none"> • The report addressing Intensive Out Patient (IOP) services will be presented every six months
Outcome	<ul style="list-style-type: none"> • Issues regarding eligibility for services or appropriate provision of services to clients will be reviewed by NSMHA QS staff and presented to appropriate quality management committees on an ongoing basis. System implications will be presented. • Initial Approval reviews will indicate that in 90% of cases reviewed, appropriate referrals are made for Initial Authorizations. • Concurrent Utilization reviews will indicate that consumers receive appropriate Intensive Out Patient services as indicated by meeting contractual expectations and NSMHA Policy 1527.00 “Intensive Outpatient Services”, in 90% of the cases reviewed. • Review of IOP services for Children will demonstrate a 90% approval rate by NSMHA staff reviewing the requests.

QM Plan 2008-2009 Work Plan UTILIZATION MANAGEMENT

Goal #2: To ensure consumers receive care in the least restrictive environment

Focus Area: Care in the least restrictive environment

Objective #1: Consumers receive appropriate services that are medically necessary and provided in the least restrictive environment for the consumer

Requirement Source(s)	<ul style="list-style-type: none"> • PIHP contract- pg 30, Section 11, Care management <ul style="list-style-type: none"> ○ Subsection 11.1, Utilization Management Program, pp 30-31 ○ Subsection 11.2, Resource management, pp 31-33 • SMHC contract- pg 21, Section 9, Care Management Program <ul style="list-style-type: none"> ○ Subsection 9.1, Utilization Management Program, pp 21-22 ○ Subsection 9.2, Resource Management, pp 22-23
Task	Review services provided to consumers who experience either lengthy or repeat hospitalizations to determine if either the length of stay or number of admissions can be decreased.
Measurement	<p>Multiple measurements will be implemented, including;</p> <ul style="list-style-type: none"> • NSMHA Utilization Review tool, either Initial, Concurrent or Retrospective • Length of Stay inpatient ranges, relevant to diagnosis and gender • Review of consumer's clinical file, with attention to current Treatment and Crisis Plans, as well as recent progress notes and proposed interventive/supportive strategies
Reports Produced	<p>Two reports will be produced-</p> <ul style="list-style-type: none"> • A case by case, consumer specific report will be prepared for each case reviewed by the NSMHA Care Advocates during a six month period. One report will detail results from adult cases reviewed; the other report will detail results from child cases reviewed. • A second report that summarizes results from all adult and child cases reviewed during the previous six months and focuses more on trends or patterns will also be produced. One report will be produced regarding adults; another will be produced regarding children.
Communication Flow	<p>Reports will be presented every six months to the NSMHA Internal Quality Management Committee (IQMC). Following discussion and review by IQMC, the report and any recommendations from IQMC will be presented at the next scheduled meeting of the Regional Quality Management Committee (QMC).</p> <p>Following discussion at QMC, report results, and any QMC recommendations will be presented to the Regional Quality Management Oversight Committee (QMOC),</p> <p>QMOC reports all report results, including recommendations by IQMC, QMC and QMOC to the Regional Board of Directors at the Board's next scheduled monthly meeting.</p>
Staff Responsible	<p>NSMHA Adult Care Advocate- Laura Davis NSMHA Child Care Advocate- Angela Fraser-Holtz</p>

Timeline	Both reports described above will each be produced once every six months.
Outcome	Consumers who currently experience frequent hospitalizations or spend long times in a hospital once admitted will realize a reduction in both frequency and length of hospital admissions. Services found to be effective will be utilized to maximize the consumer's ability to maintain themselves in the community and to maximize their natural support system.

QM Plan 2008-2009 Work Plan UTILIZATION REVIEW

Goal # 2: To ensure consumers receive care appropriate to their identified level of need
Focus Area: LOCUS/CALOCUS

Objective # 2: Consumer treatment plans address needs identified in the LOCUS/CALOCUS

Requirement Source	NSMHA sponsored regional training and contract expectations with providers
Task	<ul style="list-style-type: none"> • Review LOCUS/CALOCUS scores in clinical records at intake and 180 day intervals, determine if the LOCUS/CALOCUS identified need is sufficiently addressed or explained in the current treatment plan • Review Training Plans submitted by providers that identify how they plan to train their staff on conducting LOCUS/CALOCUS, and how they plan to review the training in order to achieve and maintain inter-rater reliability among staff.
Measurement	<ul style="list-style-type: none"> • The LOCUS/CALOCUS tool scores reported by providers will be used as the measure by which consumer needs are identified • The Training Plans submitted by providers will be reviewed to determine if they adequately address the training needs for scoring and inter-rater reliability.
Reports Produced	<p>Three reports will be produced;</p> <ul style="list-style-type: none"> • One report will summarize results from charts opened less than six months, comparing the number of charts with appropriate connection between identified needs and treatment plan, using the LOCUS/CALOCUS instrument completed at intake • One report will summarize results from charts opened more than six months, comparing the number of charts with appropriate connection between identified needs and treatment plan, using the LOCUS/CALOCUS instrument which is most current (usually the one done at the 180 Day Review) • One report will summarize the review of the providers Training Plans by NSMHA staff
Communication Flow	<p>Reports will be presented every six months to the NSMHA Internal Quality Management Committee (IQMC). Following discussion and review by IQMC, the report and any recommendations from IQMC will be presented at the next scheduled meeting of the Regional Quality Management Committee (QMC).</p> <p>Following discussion at QMC, report results, and any QMC recommendations will be presented to the Regional Quality Management Oversight Committee (QMOC),</p> <p>QMOC reports all report results, including recommendations by IQMC, QMC and QMOC to the Regional Board of Directors at the Board's next scheduled monthly meeting.</p>
Staff Responsible	<p>Quality Specialists Terry McDonough and Sandy Whitcutt, review of provider charts Quality Specialist Charissa Fuller- review of provider LOCUS/CALOCUS training plans</p>
Timeline	Reports will be presented every six months

Outcomes	<ul style="list-style-type: none">• Consumers will receive appropriate types, intensity and duration of services for needs identified by the LOCUS instrument• Providers will submit and implement appropriate Training Plans designed to implement LOCUS/CALOCUS training and to establish inter-rater reliability testing at their agencies.
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QM Plan 2008-2009 Work Plan UTILIZATION MANAGEMENT

Goal #3: To ensure that all services are available to consumers who need them
Focus Area: Availability of Services, Out of Network Referrals

Objective #1: Services defined in the NSMHA/MHD contract are available for consumers who need them

Requirement Source	<ul style="list-style-type: none"> • PIHP = pg 41, section 14, Benefits <ul style="list-style-type: none"> ○ Subsection 14.3.23, page 48 • SMHC = No requirement for this in the state contract, not a benefit
Task	Review all requests for Out of Network services submitted by providers to verify that the service is not currently available within the regional provider network.
Measurement	NSMHA/MHD PIHP contract 2008-2009, pg 48 <ul style="list-style-type: none"> • If the contractor (provider agency) is unable to provide the services covered under this Agreement, the services must be purchased within 28 days for an enrollee with an identified need. The Contractor (NSMHA) must continue to pay for the medically necessary mental health services <u>outside the service area</u> until the Contractor is able to provide them within its service area.
Reports Produced	Summary reports addressing all Out of Network requests will address; <ul style="list-style-type: none"> • Decisions reached regarding these specific requests • Review of requests to determine any pattern regarding service(s) NOT available within the region • Determination if any additions need to be made to services available within the region
Communication Flow	Reports will be presented every six months to the NSMHA Internal Quality Management Committee (IQMC). Following discussion and review by IQMC, the report and any recommendations from IQMC will be presented at the next scheduled meeting of the Regional Quality Management Committee (QMC). Following discussion at QMC, report results, and any QMC recommendations will be presented to the Regional Quality Management Oversight Committee (QMOC), QMOC reports all report results, including recommendations by IQMC, QMC and QMOC to the Regional Board of Directors at the Board's next scheduled monthly meeting.
Staff Responsible	NSMHA Adult Care Advocate, Laura Davis NSMHA Child Care Advocate, Angela Frazer-Holtz
Timeline	Reports produced every six months
Outcome	Consumers will be able to access appropriate mental health services, in a timely manner, from a provider outside the North Sound region, if necessary

QM Plan 2008-2009 Work Plan UTILIZATION MANAGEMENT

Goal #3: To ensure that all services are available to consumers who need them
Focus Area: Availability of Services, Performance Measures

Objective #2: Performance Measures defined in the NSMHA PIHP and SMHC contracts, as well as those previously selected by the NSMHA Quality Management Oversight Committee are tracked.

Requirement Source	<ul style="list-style-type: none"> • PIHP = Section 8, pg 21, Quality Management <ul style="list-style-type: none"> ○ Subsection 8.7, Performance Measures, page 22 • SMHC = Section 6, pg 14, Quality of Care <ul style="list-style-type: none"> ○ Subsection 6.7, Performance Measures, pg 15
Task	To track performance measures through data collection and determine compliance with the required measurement and to review any noted trends for under or over utilization in the data.
Measurement	<p>The following Performance Measures will be tracked:</p> <ul style="list-style-type: none"> • Medicaid Older Adult Penetration rate • Inpatient Utilization rate • Co-occurring Disorders • State Hospital Bed Utilization • Medicaid Outpatient Utilization rate • Location of services for Youth • Employment status of Adults • Telesage Outcome Assessment done at Intake • Time from Assessment to first non-crisis appointment does not exceed 14 days • Outpatient services provided w/in 7 days following a hospital discharge
Reports Produced	Data will be reviewed and presented in control chart format. All performance measures will be assessed for any noted trends, variation from previous averages and comparison to the current Washington State averages in these areas.
Communication Flow	<p>Reports will be presented annually to the NSMHA Internal Quality Management Committee (IQMC). Following discussion and review by IQMC, the report and any recommendations from IQMC will be presented at the next scheduled meeting of the Regional Quality Management Committee (QMC).</p> <p>Following discussion at QMC, report results, and any QMC recommendations will be presented to the Regional Quality Management Oversight Committee (QMOC),</p> <p>QMOC reports all report results, including recommendations by IQMC, QMC and QMOC to the Regional Board of Directors at the Board's next scheduled monthly meeting.</p>
Staff Responsible	NSMHA Quality Specialists Terry McDonough and Kurt Aemmer

Timeline	Reports produced annually, at the end of the calendar year
Outcome	Data reports will indicate that Performance Measures reviewed meet Washington State averages, or, if the measures fail to meet State averages, that the overall number compared against itself, is rising.