Washington External Quality Review Organization

North Sound
Prepaid Inpatient Health Plan

External Quality Review
2006

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Introduction and Scope

The Balanced Budget Act of 1997 (BBA) requires that states conduct an annual evaluation of their Prepaid Inpatient Health Plans (PIHPs) to determine compliance with Quality Assessment Program contractual standards established by the Centers for Medicare and Medicaid Services (CMS). The State of Washington Mental Health Division (MHD) has chosen to complete this requirement by contracting with an External Quality Review Organization (EQRO); APS Healthcare (APS) is the EQRO for the Mental Health Division in this state.

According to the BBA, the quality of healthcare delivered to Medicaid clients enrolled in PIHPs must be tracked, analyzed, and reported annually. Oversight activities of the EQRO focus on evaluating quality outcomes, timeliness of care, and access to care and services provided to Medicaid beneficiaries. The *CMS Protocols for Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans* (published February 11, 2003) describes the steps required of an EQRO to ensure that BBA standards for managed care organizations, defined in 42 CFR, are being followed. APS Healthcare followed these protocols in conducting the review of this PIHP.

North Sound Mental Health Administration PIHP (NSMHA or North Sound) is responsible for managing mental health care and services for Medicaid consumers in Snohomish, Whatcom, Island, San Juan, and Skagit counties, as well as eight (8) local Tribal sovereign nations. The PIHP is located in Mt. Vernon, Washington and is governed by a board comprised of elected officials from each of the member counties, the President and Vice President of the Regional Advisory Board, and representatives from each of the 8 Tribal sovereign nations. The PIHP Administrator reports to the Board of Directors. The PIHP contracts with an LLC, Associated Provider Network (APN) to develop, fund, manage, and oversee care throughout the region; services to the Spanish-speaking population and crisis services are provided through additional specialty contracts. North Sound serves approximately 1300 adult and child consumers on a monthly basis. Total annual Medicaid enrollment in the PIHP is about 159,000. The PIHP delegates access, inpatient authorization, and utilization management (UM) to a non-profit organization and partially delegates information technology (IT) functions to a private firm.

This report covers the period between January 5, 2006, and January 4, 2007, and reflects continuous improvements achieved over the previous two review periods. It should be noted that the PIHP review period has been re-defined to individual annual schedules rather than a universal calendar period.

The 2006 review included:

1. an assessment of the PIHP's completion of corrective action (CA) plans related to the 2004 EQR;
2. operational and clinical practices that last year were found to be below minimal acceptable levels, as defined in the Centers for Medicare and Medicaid Services (CMS) standards (Subparts);

3. an update on the PIHP's information system capabilities related to timeliness, accuracy, and completeness of data submitted by the PIHP to the State (for Performance Measure calculation);
4. a review of progress on Performance Improvement Projects (PIPs), including application of CMS validation protocol to one PIP;
5. an evaluation of PIHP conduct of Encounter Validation (EV); and
6. an assessment of the PIHP's Quality Assurance and Improvement Plan (QAI) and clinical oversight activities.

APS seeks to foster a culture of continuous quality improvement; accordingly, in addition to presenting 2006 results, this report includes indicators or comments on change over the last two review years for topics that have been annually reviewed.

The review was conducted in two phases; a desk review of documents prepared and submitted by the PIHP for the review period, followed by a site visit and interviews with the PIHP and two subcontracted network providers selected by the WAEQRO. The desk review provided an opportunity to make an initial determination of the PIHP's progress with respect to meeting required Federal and State regulations and standards. The PIHP interview included administrators and other key staff responsible for quality, care, and administrative functions. Interviewees were asked to provide an update on changes in their organization, provider network, and overall system of care since the last review. In addition, PIHP staff responded to a series of questions designed to enhance understanding of the documentation and responses to specific elements of the topical areas being reviewed (see, Attachment #12, Site Visit Agenda).

Interviews with network providers were conducted with two separate groups: key management personnel, followed by more extensive interviews with direct service staff. This process allowed an opportunity to assess the degree to which the PIHP's operational standards and contract requirements are integrated throughout their provider network and regional system of care. In addition, APS was able to explore how the PIHP's ongoing quality improvements were directly and/or indirectly impacting the quality of care provided.

Review process descriptions and attachments specific to each topic area are included in those sections of the report. General communications to the PIHPs can be found in Attachments 1, 2, 3, and 4; and site visit information is found in Attachments 12, 13, and 16.

The following table describes in detail the APS 2006 planning and review activities.

Activity	Timeline	Documents/Content
Planning		
1. Define 2006 review activities and determine date parameters for review year	April-May, 2006	Internal planning and meetings with MHD
2. Develop or revise review tools and procedures for: • Quality Assurance and Improvement	June-August, 2006	

Activity	Timeline	Documents/Content
• PIHP Encounter Validation review • Subparts – to reflect 2 MHD/PIHP contracts • Review of 2004 Corrective Actions		
3. Finalize tools and procedures	August, 2006	Internal and MHD meetings
4. Develop review schedule and communication materials	June-July, 2006	Internal and MHD meetings
5. Draft report template and data display tools	July-Sept., 2006	
6. Finalize report template	October, 2006	Internal and MHD meetings
Pre-Onsite Activities		
1. Send general information letter to all PIHPs	August 1, 2006	Overview of review year and changes in content/process
2. Send documentation request and site visit dates to PIHP	December 4, 2006	Detailed description of review topics, documents needed, instructions for submission, due date, and date of site visit
3. Send Site visit agenda to PIHP	December 18, 2006	Formal agenda/names of network providers to be visited
4. Conduct pre-onsite call with PIHP	December 27, 2006	Review attendees, logistics; confirm addresses/contact information
5. Conduct desk review of submitted materials		
Onsite Activities	January 18 & 19, 2007	
1. Interview PIHP staff		
2. Interview network provider staff		
3. Identify and request additional documents		
4. Provide timeline for report production		
Post Onsite Activities		
1. Phone interview with Ombuds	January 25, 2007	
2. Complete initial scoring and results documentation; construct report		
3. Draft report to PIHP	February 15, 2007	
4. Debrief conference call	February 27, 2007	Review results; answer questions; consider scores questioned
5. Final report to PIHP and MHD	March 12,	

Activity	Timeline	Documents/Content
	2007	

The WAEQRO wishes to recognize and thank the PIHP for compiling the requested documentation and for their time and attention during the site visit and related activities. Following submission to the PIHP of a draft report (post-site visit), the PIHP was provided the opportunity to submit a response in writing. NSMHA did submit a written response. The WAEQRO and PIHP staff then held a telephonic debriefing to review the report and the PIHP response. This final report is based on these activities, and is submitted to the PIHP and to the State of Washington Mental Health Division.

Changes in the PIHP Environment

WAEQRO views changes in the PIHP environment as operational, programmatic, or system-wide events that have had a significant impact on the overall service delivery system or in quality improvement activities since last year's review.

For the NSMHA PIHP, the following event is significant:

- The PIHP was approved to hire 7 new FTEs since the 2005 review and has filled 5 of those positions. This infusion of resources will enhance NSMHA's ability to effectively manage and improve mental health services in their region.

2006 Review Process Barriers

The following issues significantly affected WAEQRO's ability to conduct a comprehensive and thorough review:

- In the 2005 CMS report, APS identified a system-wide deficiency in the understanding and conduct of Performance Improvement Projects. APS provided technical assistance to some PIHPs; however, training for all PIHPs occurred just before the beginning of the 2006 review year. Therefore, those PIHPs reviewed earlier in the year did not have time to modify their PIPs to conform with CMS protocols prior to their EQR. Many of these PIPs had not progressed since the 2005 review.

- The policies and procedures submitted for review contained blank place holders for dates they were effective, revised, and reviewed. In addition, some policies were dated and approved by the PIHP Board of Directors with a motion number, while others were dated and approved by the PIHP Executive Director with no motion number. Consequently, the WAEQRO was unable to determine if all the policies and procedures submitted for review had been officially adopted. They were, however, considered in scoring the subparts.

- The PIHP's sample network provider contracts did not contain dated signatures of contracting parties. The WAEQRO was unable to determine if the contract references were from officially executed contracts. The sample contracts, however, were considered in scoring the Subparts.

- One provider did not have sufficient notice with respect to making direct service staff available for the site visit; therefore, only management participated in the interview.

2006 Review Results

This report provides results and a summary of NSMHA PIHP's performance in the five EQR activities conducted by APS. For each activity, the report describes the objectives, methods of data collection and analysis, description of data, and conclusions and recommendations drawn from the data. Included is an assessment of strengths and necessary improvements related to the quality of mental health services provided to Medicaid enrollees.

A. STATUS OF 2004 CORRECTIVE ACTIONS

At the end of the 2004 EQR, MHD issued corrective actions to the PIHPs. The PIHPs were required to submit acceptable corrective action plans to MHD. During the 2006 EQR, APS reviewed the PIHP's corrective action(s) not meeting "Expected Performance" as of 2005. The following table represents the current status of NSMHA PIHP's remaining corrective action(s).

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
438.242	**Health Information Systems**			
	Verifying the accuracy and timeliness of data. Missing policy and procedure that defines expectations for accuracy and timeliness for new system.	Submit a corrective action plan to the MHD by 3/2/054	Corrective action plan was submitted to MHD on 3/5/05	At the time of the 2004 review, the PIHP had just implemented a new IT system and was defining the processes for using this new system. The PIHP developed policies and procedures defining expectations for data timeliness and accuracy. They currently employ processes to continually verify data accuracy and timeliness. This item should be considered closed.

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
438.606	**Source, Content and Timing of Certifications**			
	Certifications. Timing of certifications could not be verified with related batch submittals.	Submit a corrective action plan to the MHD by 3/2/05	Corrective action plan was submitted to MHD on 3/5/05	At the time of the 2004 review, the PIHP had just implemented a new IT system and was in the process of submitting data after a long period of inactivity. The PIHP has since transmitted their backlog of data. Since that initial review, they developed a data certification process and have successfully met this requirement. This item should be considered closed.

B. SUBPART REVIEW

In conducting the 2006 Subpart review, APS followed guidelines set forth in the Centers for Medicare and Medicaid Services (CMS) protocols. Methods of data collection and analysis were uniformly applied to each Subpart. Common elements involved the use of a standardized data collection monitoring tool developed by the Washington State Mental Health Division (MHD), extensive document review and analysis, standardized scoring methodology, and onsite reviews that included interviews with PIHP staff and members of their provider networks (see, Attachment #11, Subpart Documentation Request). Interview questions and their sequence reflected the content and order of the Subparts; following this sequence complied with CMS protocols with respect to conducting reviews in a logical fashion that assists in identifying each PIHP's overall performance and compliance with Federal and State regulations.

The Subparts addressed in the reviews included the following:

- Subpart C-Enrollee Rights and Protections
- Subpart D-Quality Assessment and Performance Improvement
    - Access Standards
    - Structure and Operation Standards
    - Measurement and Improvement Standards
- Subpart F-Grievance System
- Subpart H-Certifications and Program Integrity

Scoring of the Subparts

A comprehensive, MHD-designed, External Quality Review (EQR) compliance review tool and set of scoring guidelines were adapted from the CMS protocols for the 2004 review. With the exception of modifications made in 2005, the same review tool and scoring guidelines were utilized during the 2006 Subpart review (see, Attachment #5, Subpart Review Tool, and Attachment #6, Scoring Guides). The review tool and scoring guidelines were designed to identify degree of compliance with the Balanced Budget Act (BBA), and specific MHD contract requirements and priorities, as well as strengths and areas of needed improvement.

Throughout the scoring and analysis, the concept of "Expected" performance recurs. A score of Expected denotes either of the following:

- A score of 3 or better for Subparts C, D and F, or
- A score of 1 for Subpart H.

To advance along the path of continuous quality improvement (CQI), MHD requested that the 2006 Subpart review focus on those elements that scored below Expected in 2005.

Accordingly, items not reviewed in 2005 include the following.

- Elements in Subparts C, D, and F that scored 3 and above, and all components in Subpart H with a score of 1 during the 2005 review (Note: All Subpart H data certification elements are rescored every year);
- Questions 60 and 63-65 that relate to Performance Measurement Data are only scored when the WAEQRO conducts a direct Encounter Validation, which was not conducted this year;
- Questions 68-70 that pertain to the Information Systems Capability Assessment (ISCA), which was not conducted this year; and
- All items associated with the Performance Improvement Projects (PIPs), as PIPs were scored using the CMS PIP Protocol and will be discussed in a separate section of this report.

Subparts C, D, and F were scored using the two scoring guides developed by the MHD. Scoring Guide 1 was used for scoring MHD-required policies, procedures, and contract language based on BBA requirements and provisions. Scoring Guide 2 is used for scoring BBA provisions for which MHD does not specifically require policies and procedures; the guide does, however, require that specific mechanisms, processes, and/or analyses be in place. These scoring guides use a 6-point scale, zero to five (0-5), which denotes the following:

- Zero (0) = No Compliance (no documentation/processes);
- One (1) = Insufficient Compliance (documentation/processes exist);
- Two (2) = Partial Compliance (documentation processes available/distributed to personnel);
- Three (3) = Moderate Compliance (personnel trained, aware of documentation/processes);
- Four (4) = Substantial Compliance (provision articulated, implemented locally);

- Five (5) = Maximum Compliance (provision thoroughly/consistently implemented).

The minimum Expected performance on each element scored in Subparts C, D, and F is 3.

Subpart H was scored differently in that it was based on a 2-point scale of zero to one (0-1), as follows:

- Zero (0) = No Compliance (insufficient evidence)
- One (1) = Compliance (sufficient evidence exists)

The minimum Expected performance on each element scored in Subpart H is one.

The following sections portray a graphical and narrative review of Subpart results for the NSMHA PIHP. The results are presented by each Subpart and include a graphical depiction of the PIHP's 2006 scores, with a roll-up of 2004 and 2005 combined scores of 3 or higher in Subparts C, D, F, or a score of 1 in Subpart H. Also included is a narrative detailing the specific elements scored in the 2006 review. Finally, the results encompass a scoring frequency analysis, scoring trends since 2004, and an assessment of strengths, opportunities for improvement, and recommendations.

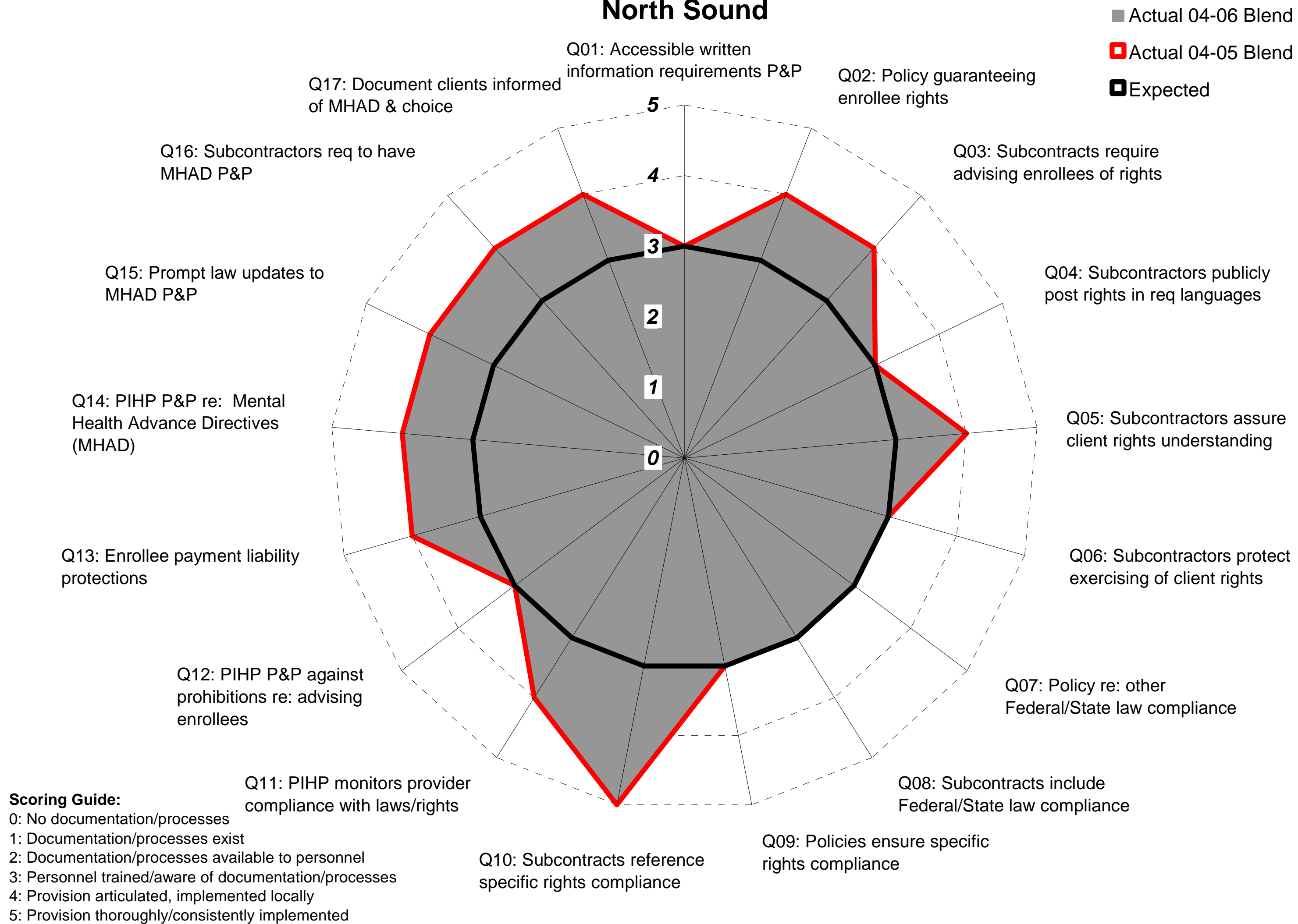
Subpart Radar Charts

The PIHP is expected to meet independent expectations for each element reviewed. It is not appropriate to average scores across items or Subparts. Given the large number of Subpart elements, it is easier to display these scores graphically with a Radar Chart. Radar charts resemble dartboards. Each spoke records results for a single element from the Subpart review. Unlike a dartboard, radar charts plot the highest scores near the outer perimeter and lowest scores at the center. The resulting polygon provides a means of assessing overall performance specific areas of strength, and opportunities for improvement.

The radar charts for Subparts C, F, and H depict all scores addressed for those Subparts. Subpart D is divided into 3 charts that group related topic areas. The PIHP's combined scores from 2004 and 2005 are plotted as a heavy red polygon. The gray polygon reflects combined scores from 2004 through 2006, including those that improved and those that remained the same.

For Subparts C, D, and F, the minimum desired score is 3.0. Thus, the heavy black ring plotted at 3.0 for each item is a proxy for "Expected" performance. It is important to note that not all elements of each Subpart require clinical staff involvement; some scores would be quite acceptable at a 3 (three) or 4 (four) level. In Subpart H, the 0-or-1 scoring system is applied. "Expected" performance is 1.0 for the items in this Subpart.

These charts offer PIHP management information to assist in decision-making and prioritizing for on-going quality improvements. From a process perspective, one can quickly see obvious deficiencies that invite attention. Trends regarding progress from policy/procedure development to full implementation at the provider level are immediately evident.



Scoring Guide:
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1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

2004-2006 Subpart Scoring Trend and Detail for
North Sound

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
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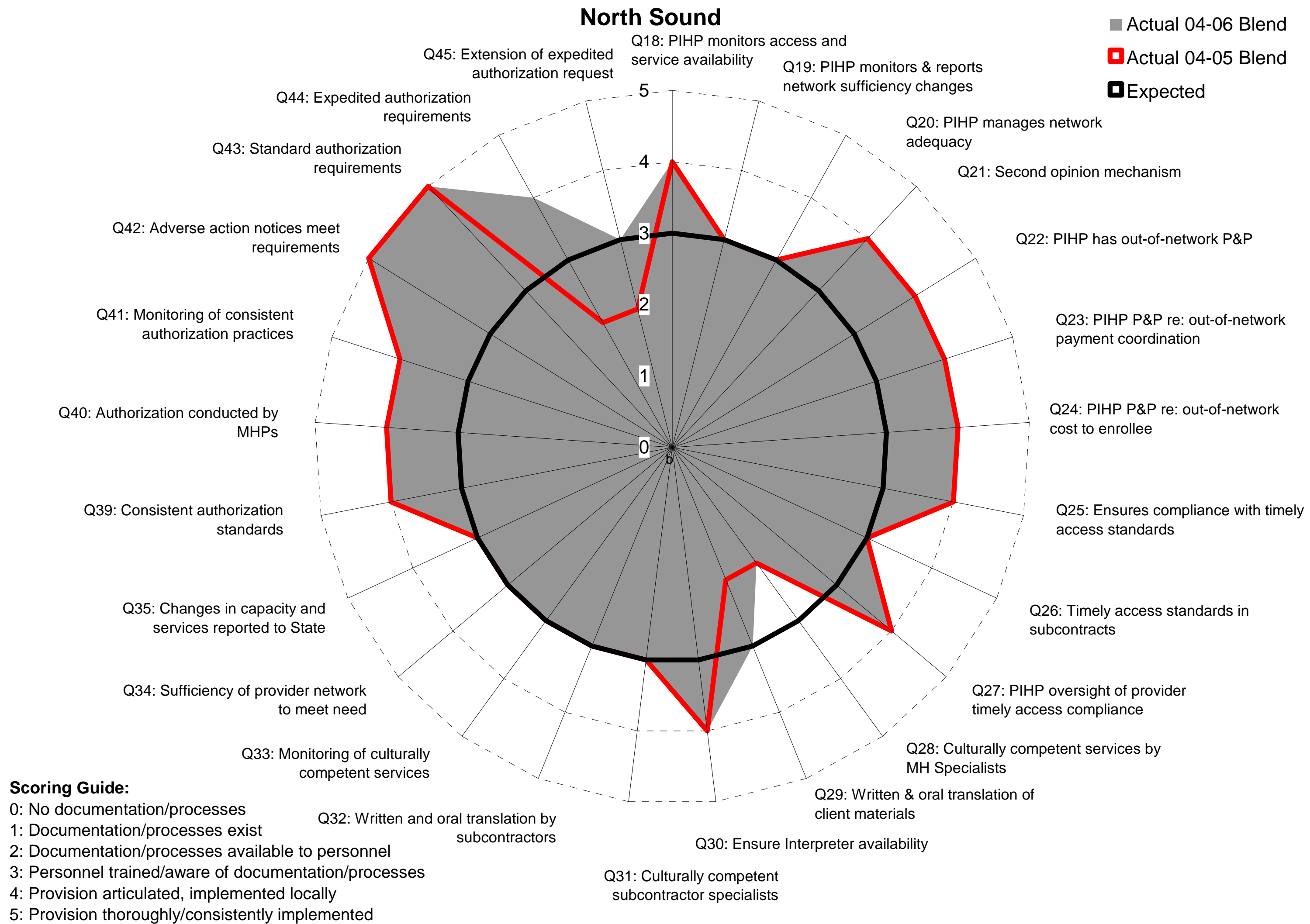
Subpart C: Enrollee Rights & Protections	04-05 Score	2006 Score	04-06 Blend
Q01: Accessible written information requirements P&P	3		3
Q02: Policy guaranteeing enrollee rights	4		4
Q03: Subcontracts require advising enrollees of rights	4		4
Q04: Subcontractors publicly post rights in req languages	3		3
Q05: Subcontractors assure client rights understanding	4		4
Q06: Subcontractors protect exercising of client rights	3		3
Q07: Policy re: other Federal/State law compliance	3		3
Q08: Subcontracts include Federal/State law compliance	3		3
Q09: Policies ensure specific rights compliance	3		3
Q10: Subcontracts reference specific rights compliance	5		5
Q11: PIHP monitors provider compliance with laws/rights	4		4
Q12: PIHP P&P against prohibitions re: advising enrollees	3		3
Q13: Enrollee payment liability protections	4		4
Q14: PIHP P&P re: Mental Health Advance Directives (MHAD)	4		4
Q15: Prompt law updates to MHAD P&P	4		4
Q16: Subcontractors req to have MHAD P&P	4		4
Q17: Document clients informed of MHAD & choice	4		4

NSMHA PIHP
2006 Subpart Review Results

Subpart C – Enrollee Rights and Protections

North Sound Mental Health Administration achieved Expected compliance for all Subpart C scores in 2005. Therefore, no Subpart C review elements were re-scored in 2006.

Subpart D (Part 1): Access Standards



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2004-2006 Subpart Scoring Trend and Detail for North Sound

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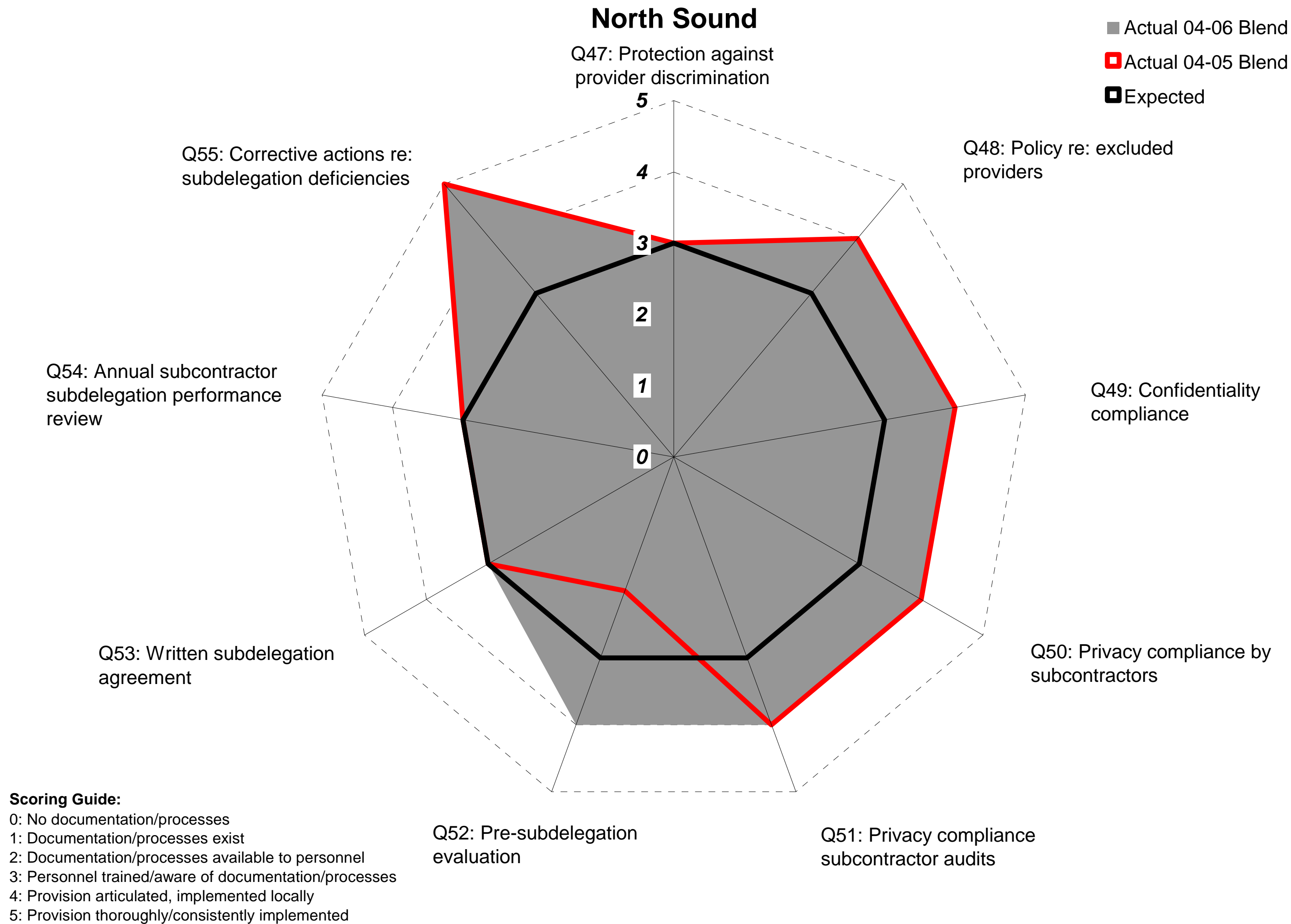
Subpart D (Part 1): Access Standards	04-05 Score	2006 Score	04-06 Blend
Q18: PIHP monitors access and service availability	4		4
Q19: PIHP monitors & reports network sufficiency changes	3		3
Q20: PIHP manages network adequacy	3		3
Q21: Second opinion mechanism	4		4
Q22: PIHP has out-of-network P&P	4		4
Q23: PIHP P&P re: out-of-network payment coordination	4		4
Q24: PIHP P&P re: out-of-network cost to enrollee	4		4
Q25: Ensures compliance with timely access standards	4		4
Q26: Timely access standards in subcontracts	3		3
Q27: PIHP oversight of provider timely access compliance	4		4
Q28: Culturally competent services by MH Specialists	2	2	2
Q29: Written & oral translation of client materials	2	3	3
Q30: Ensure Interpreter availability	4		4
Q31: Culturally competent subcontractor specialists	3		3
Q32: Written and oral translation by subcontractors	3		3
Q33: Monitoring of culturally competent services	3		3
Q34: Sufficiency of provider network to meet need	3		3
Q35: Changes in capacity and services reported to State	3		3
Q39: Consistent authorization standards	4		4
Q40: Authorization conducted by MHPs	4		4
Q41: Monitoring of consistent authorization practices	4		4
Q42: Adverse action notices meet requirements	5		5
Q43: Standard authorization requirements	5		5
Q44: Expedited authorization requirements	2	4	4
Q45: Extension of expedited authorization request	2	3	3



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2004-2006 Subpart Scoring Trend and Detail for North Sound

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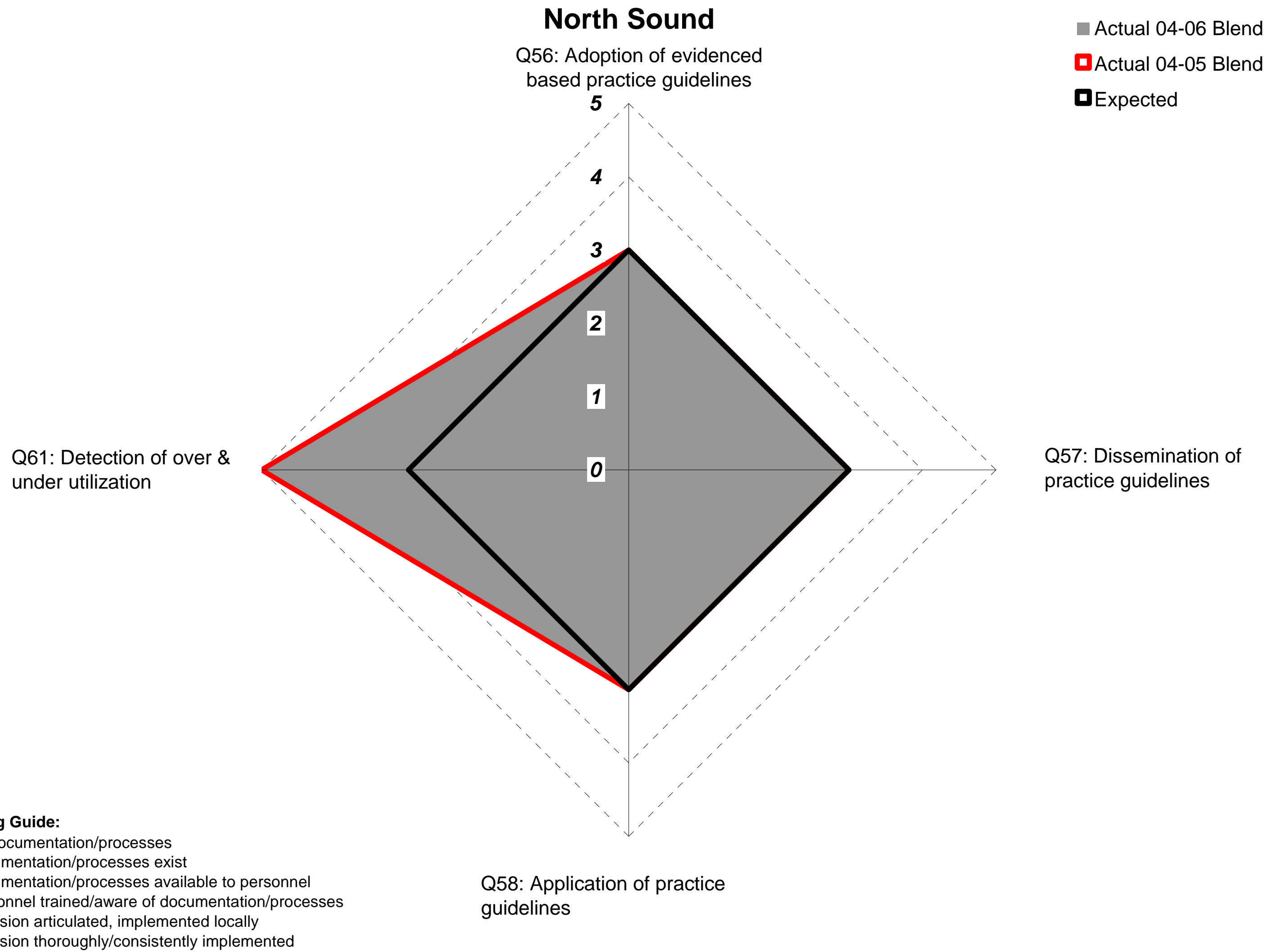
Subpart D (Part 2): Structure and Operation Standards	04-05 Score	2006 Score	04-06 Blend
Q47: Protection against provider discrimination	3		3
Q48: Policy re: excluded providers	4		4
Q49: Confidentiality compliance	4		4
Q50: Privacy compliance by subcontractors	4		4
Q51: Privacy compliance subcontractor audits	4		4
Q52: Pre-subdelegation evaluation	2	4	4
Q53: Written subdelegation agreement	3		3
Q54: Annual subcontractor subdelegation performance review	3		3
Q55: Corrective actions re: subdelegation deficiencies	5		5



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Subpart D (Part 3): Measurement and Improvement Standards	04-05 Score	2006 Score	04-06 Blend
Q56: Adoption of evidenced based practice guidelines	3		3
Q57: Dissemination of practice guidelines	3		3
Q58: Application of practice guidelines	3		3
Q61: Detection of over & under utilization	5		5

Subpart D – Quality Assessment and Performance Improvement

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
438.206 (c)(2)	**Furnishing of Services Continued**	
[Q28]	**PIHP ensures culturally competent service delivery utilizing Mental Health Specialists** Evidence: • PIHP submitted excerpt from sample '06-'07 NSMHA-APN Medicaid Contract that states, "Assure that services are timely, appropriate and sensitive to the age, culture, language, gender and physical condition of the consumer. Provide alternative service delivery models to make services more available to underserved persons as defined in WAC 388-865-0150." No standards, expectations, or specific requirements related to Mental Health Specialists are stipulated in contract. • No relevant policy and procedure was submitted for this provision. • 2006 PIHP Administrative Audit Results Summary on documented Mental Health Specialist services provided by Bridgeways, Compass Health, and SeaMar. • NSMHA 2006 Capacity Management Report showing a decrease in staffing levels and proportionate decrease in Mental Health Specialists between 11/2004 and 10/2006. • PIHP staff reported that although they monitor the provision of Mental Health Specialist services based on WAC, they do not have a policy that stipulates their standards and expectations for Mental Health Specialist Services. Recommend PIHP develop such a policy. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q29]	**Written and oral translation of client materials** Evidence: • Revised Interpreter and Translation Services Policy #1515.00 and Cultural and Linguistic Competency Policy #1521 jointly incorporate the requirements for written and oral translation of client materials. • Accommodation / Access To Services Policy #4508.00, indicates the PIHP and its providers make available telecommunication devices and services, and certified interpreters for deaf, sight, or hearing impaired clients, and limited English proficient clients; and other specialized disability	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	services to clients as necessary in order to access and utilize mental health services. The policy states, "any Limited English Speaking (LES)/Limited English Proficient (LEP) person has the right to interpreter and translation services at every aspect of service delivery, at no cost, without significant delay, and in the language in which they prefer to communicate." • DSHS Public Mental Health System Benefits Booklet translated in all DSHS required languages. • PIHP Privacy Notice translated in 5 of the required DSHS languages. • January 2006 PIHP Interpreter Availability Study includes a list of the PIHP's contracted providers and the organizations with whom they have agreements to provide certified interpreter services. • Copies of PIHP Spanish-translated communications related to a particular consumer's appeal. • PIHP Cultural Competence Training Module with post test. Reviewer unable to determine if this training occurs on an ongoing basis, or when the last training occurred. • Provider management reported client rights, grievance procedures, HIPAA privacy practices, and DSHS benefits booklet must be available to clients in required DSHS languages. In addition, management reported that they have no client materials in Braille or audio devices; when needed, however, their staff are required to read required client materials directly to clients when needed. One Provider also stated they had some client materials in large print. • Direct service staff were able to articulate languages that must be available in written translation and how to access interpreters including American Sign Language interpreters. Staff indicated that family members and friends are sometimes used as interpreters. • PIHP staff reported that the Ombuds and QRT inspect each network provider facility to ensure that rights are posted in client sight in all required DSHS languages. The last facilities review was conducted in 2005 and yielded mixed results. No client rights facilities review was conducted during the review period. • PIHP staff also reported that they have no formal monitoring mechanism to monitor provider use of certified interpreters. • The PIHP Interpreter and Translation Services Policy #1515.00 requires that major written client information be provided in the client's own language. "Major written client information" includes: o Washington State Medicaid Benefit Booklet (for	

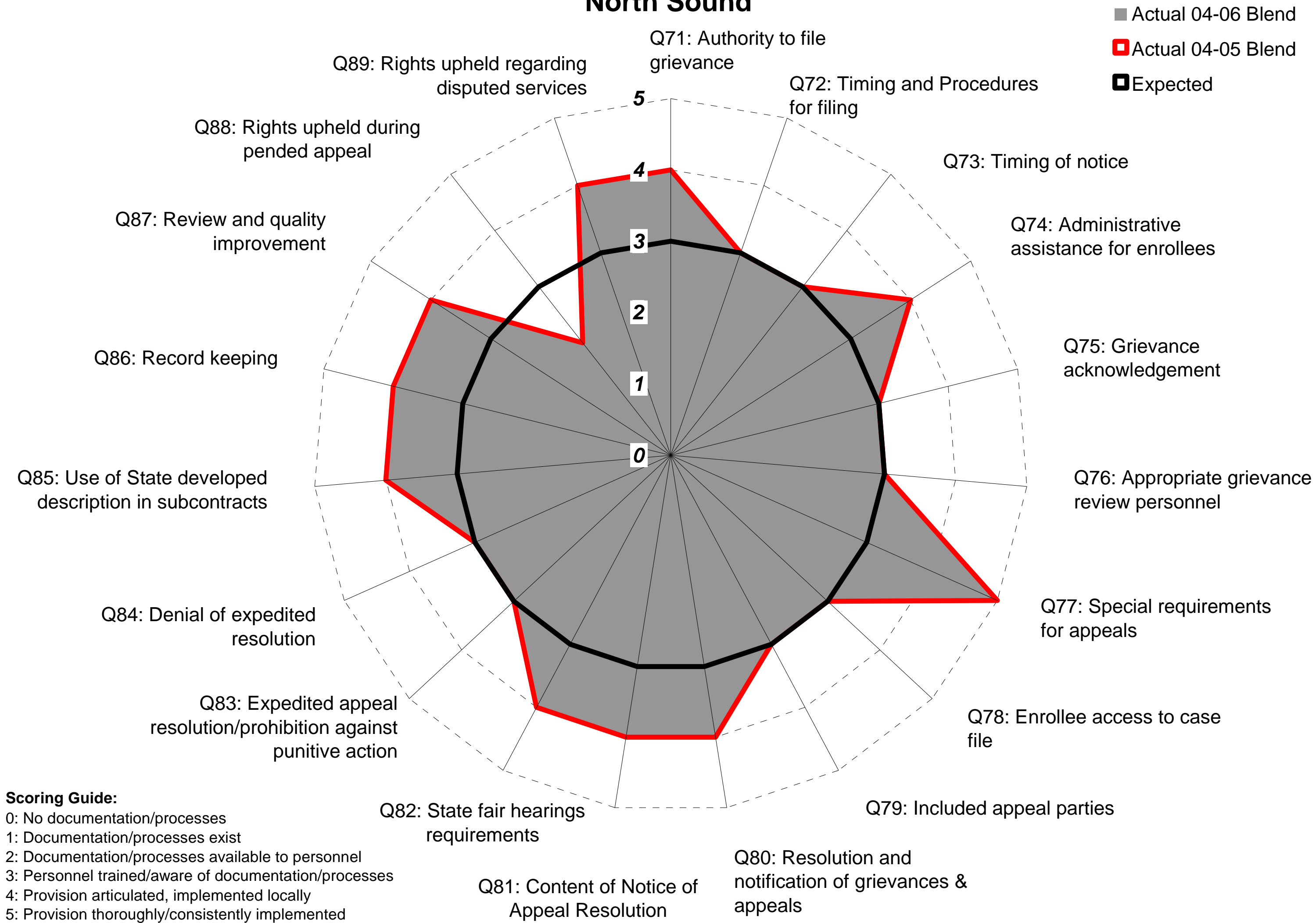
CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	Medicaid enrollees) o North Sound Mental Health Administration Prepaid Inpatient Mental Health Plan Brochure o Notice of Privacy Practices o Notice of Action (for Medicaid enrollees) The PIHP staff and provider management were not able to show evidence that all of these documents (with the exception of the Washington State Medicaid Benefit Booklet) are translated and available to clients in the required DSHS languages. • Recommend that the PIHP and provider network update their client materials to be in compliance with PIHP policy #1515.00. In addition, clarify specific standards related to client materials for all major sensory impairments. Also, recommend that the PIHP institute formal annual monitoring of written and oral translation of client materials, including facility checks and use of certified translators.	
	(Moderate Compliance)	3
438.210(d)	**Timeframe for decisions**	
[Q44]	**Procedures for expedited authorization decisions** Evidence: • Revised Assessments for Ongoing Services Policy #1504.00, revised Authorization for Ongoing Outpatient Services Policy #1505.00, and Continued Stay and Re-authorization Policy #1539.00 contain required procedures for expedited authorization decisions. • Authorization Process Workgroup Meeting minutes from 6/01/06 through 11/1/06 provide evidence of related discussions, and the development of an expedited authorization design to be incorporated into the PIHP authorization process. • Quality Management Committee (QMC) Meeting minutes from 7/20/06 and 10/19/06 indicate that the PIHP updated the QMC on progress of the Authorization Process Workgroup, and the implementation of the authorization process redesign. • Additional documentation submitted for review: o January-June 2006 Denial Report o July-December 2006 Denial Report o 2006 Authorization Process Report, including Expedited Authorizations and Authorization Extensions (September-December) o Authorization Process Flow Chart-November 2006 • PIHP staff reported that expedited authorization policies and procedures have been implemented, including extensions.	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	The providers have been informed of this process through the Authorization Process Workgroup and Quality Management Committee (QMC). Expedited authorizations are tracked electronically by a designated field in the data base. • Network provider management reported assigned staff participated in the Authorization Process Workgroup Meeting. Provider Management was able to articulate the expedited authorization process. • Direct Service staff were able to describe that expedited authorization means "quicker turnaround", but did not know the required number of days by which the authorization must occur. • Recommend additional training for direct service staff. (Substantial Compliance)	4

[Q45]	**Extension of expedited authorization request**
	Evidence:
	• Revised <u>Authorization for Ongoing Outpatient Services Policy #1505.00</u>, and <u>Continued Stay and Re-authorization Policy #1539.00</u> contain required procedures for extension of expedited authorization decisions.
	• <u>Authorization Process Workgroup Meeting</u> minutes from 6/01/06 through 11/1/06 provide evidence of related discussions, and the development of an expedited authorization design to be incorporated into the PIHP authorization process.
	• <u>Quality Management Committee (QMC) Meeting</u> minutes from 7/20/06 and 10/19/06 indicate that the PIHP updated the QMC on progress of the Authorization Process Workgroup, and the implementation of the authorization process redesign.
	• Additional documentation submitted for review:
	  o January-June 2006 Denial Report
	  o July-December 2006 Denial Report
	  o 2006 Authorization Process Report, including Expedited Authorizations and Authorization Extensions (September-December)
	  o Authorization Process Flow Chart-November 2006
	• PIHP staff reported that expedited authorization policies and procedures have been implemented, including extensions. The providers have been informed of this process through the Authorization Process Workgroup and Quality Management Committee (QMC). Expedited authorizations are tracked electronically by a designated field in the data base.
	• Network provider management reported that assigned staff participated in the Authorization Process Workgroup Meeting. Provider Management was able to articulate the expedited	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	authorization process, although at one provider, management believed that an expedited authorization extension could only be requested by the client. • Direct Service staff were able to describe that expedited authorization means "quicker turnaround", but did not know the required number of days by which the authorization must occur or if an extension was allowed. • Recommend additional training for provider management and direct service staff. (Moderate Compliance)	3
438.230(b)	**Sub-contractual Relationships and Delegation-Specific Conditions**	
[Q52]	**Evaluation of Subcontractor ability to perform delegated functions** Evidence: • Subcontractural Relationships and Delegation Policy #5002.00, Sample Delegation Plan Form Policy #1548.01, and Delegation of NSMHA Functions and Responsibilities Policy #1548.00 collectively contain the requirements and procedures for evaluation of subcontractor ability to perform delegated functions. • NSMHA Pre-Contract Evaluation for Delegation of Inpatient Certification and Utilization Management and Readiness Review-Volunteers of America (VOA), dated January 4, 2007(?). • NSMHA Pre-Contract Evaluation for Delegation of Access and Readiness Review-Volunteers of America, dated January 4, 2007(?). • NSMHA-VOA-Medicaid-06 contract which specifies delegated services, activities, and responsibilities for Access Line, Inpatient Certification, and Utilization Management. • Access Transition Meeting notes, dated 4/4/06, provide evidence of preparations and planning for the May 1, 2006 transition of the Access Line from Compass Health to VOA. • November 2006, VOA Access Report, shows evidence of tracking data on number and types of calls. • Raintree 2001 RFP-evaluation tool, scores, and reference check process related to partial delegation of management information services. • PIHP staff explained that dates on the Pre-Contract Evaluation for Delegation documents listed above automatically change to the date the document was last updated. PIHP staff were unable to provide the original evaluation documents as requested by the WAEQRO.	

CFR Reference	Subpart Review Results *Subpart D*	Score 0-5
	(Substantial Compliance)	4



Scoring Guide:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

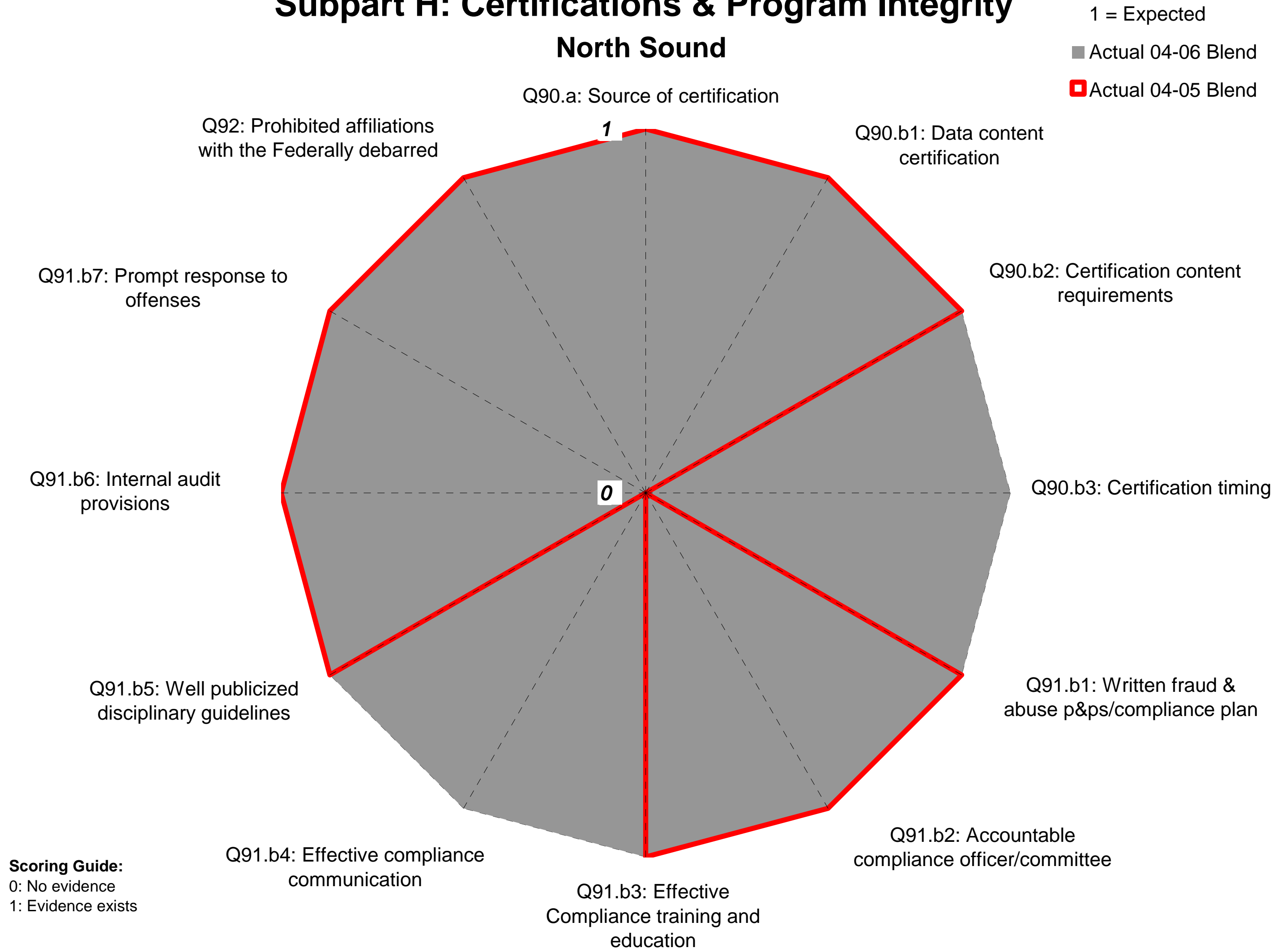
2004-2006 Subpart Scoring Trend and Detail for North Sound

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented

Subpart F: Grievance System	04-05 Score	2006 Score	04-06 Blend
Q71: Authority to file grievance	4		4
Q72: Timing and Procedures for filing	3		3
Q73: Timing of notice	3		3
Q74: Administrative assistance for enrollees	4		4
Q75: Grievance acknowledgement	3		3
Q76: Appropriate grievance review personnel	3		3
Q77: Special requirements for appeals	5		5
Q78: Enrollee access to case file	3		3
Q79: Included appeal parties	3		3
Q80: Resolution and notification of grievances & appeals	4		4
Q81: Content of Notice of Appeal Resolution	4		4
Q82: State fair hearings requirements	4		4
Q83: Expedited appeal resolution/prohibition against punitive action	3		3
Q84: Denial of expedited resolution	3		3
Q85: Use of State developed description in subcontracts	4		4
Q86: Record keeping	4		4
Q87: Review and quality improvement	4		4
Q88: Rights upheld during pended appeal	2	2	2
Q89: Rights upheld regarding disputed services	4		4

Subpart F – Grievance System

CFR Reference	Subpart Review Results *Subpart F*	Score 0-5
438.420	**Continuation of Benefits while the PIHP Appeal and the State Fair Hearing are Pending**	
[Q88]	**Continuation of benefits while the appeal and State fair hearing are pending** Evidence: • Appeal Policy #1003.00 contains procedures related to continuation of benefits while an appeal is pending, including the accurate filing timeframe which has been erroneous in past reviews. • Fair Hearing Policy #1004.00 **does not contain** procedures for the continuation of benefits while a State fair hearing is pending. • No evidence of training related to this review element was submitted. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Partial Compliance)	2



Scoring Guide:
0: No evidence
1: Evidence exists

2004-2006 Subpart Scoring Trend and Detail for North Sound

Scoring Guide for Subpart H:
0: No evidence
1: Evidence exists

Subpart H: Certifications & Program Integrity	04-05 Score	2006 Score	04-06 Blend
Q90.a: Source of certification	1	1	1
Q90.b1: Data content certification	1	1	1
Q90.b2: Certification content requirements	1	1	1
Q90.b3: Certification timing	0	1	1
Q91.b1: Written fraud & abuse p&ps/compliance plan	1		1
Q91.b2: Accountable compliance officer/committee	1		1
Q91.b3: Effective Compliance training and education	1		1
Q91.b4: Effective compliance communication	0	1	1
Q91.b5: Well publicized disciplinary guidelines	1		1
Q91.b6: Internal audit provisions	1		1
Q91.b7: Prompt response to offenses	1		1
Q92: Prohibited affiliations with the Federally debarred	1		1

Subpart H – Certifications and Program Integrity

(The following questions are scored with a 0 or 1)

CFR Reference	Subpart Review Results *Subpart H*	Score 0-1
438.606	**Source content and timing of certifications**	
[Q90.a]	**Certification of data to State by legal authority** (a) Evidence of certifications. (Compliance)	1
[Q90.b1]	**Accuracy, completeness and truthfulness of data** (b) Content Certification To the accuracy, completeness and truthfulness of the data	
	(Compliance)	1
[Q90.b2]	**Accuracy completeness and truthfulness of documents specified by State** (2) To the accuracy, completeness and truthfulness of the documents specified by the State (Compliance)	1
[Q90.b3]	**Certification submitted concurrently with data** (3) Timing of the certification (Compliance)	1
438.608	**Program Integrity Requirements**	
[Q91.b4]	**Effective lines of communication between Compliance Officer and employees** Evidence: • Revised Business Ethics and Regulatory Compliance Program Policy #2001.00, NSMHA Personnel Policies and Procedures Manual, and NSMHA Guidelines for Business and Ethical Conduct (Requires all employees to sign an acknowledgement confirming they have received the code, understand that it represents PIHP policies and agree to abide by it), collectively meet the requirements of this provision. • MHD Compliance Plan Audit with PIHP Administrator response and clarification to items scored unknown, or below met. • Copy of PIHP Website Fraud and Abuse Page showing regional, State and Federal hotlines, contacts, and resources. No local hotline or contact information for the PIHP Compliance Officer included. Recommend that this information be added to the PIHP fraud and abuse web page. • Provider Management reported that they were familiar with the PIHP policies related to program integrity and had participated in fraud and abuse training during the review period. However,	

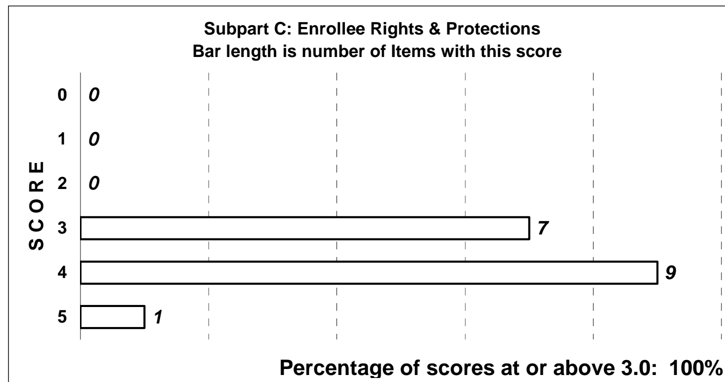
	provider management was unaware of available fraud and abuse hotlines.	
	(Compliance)	1

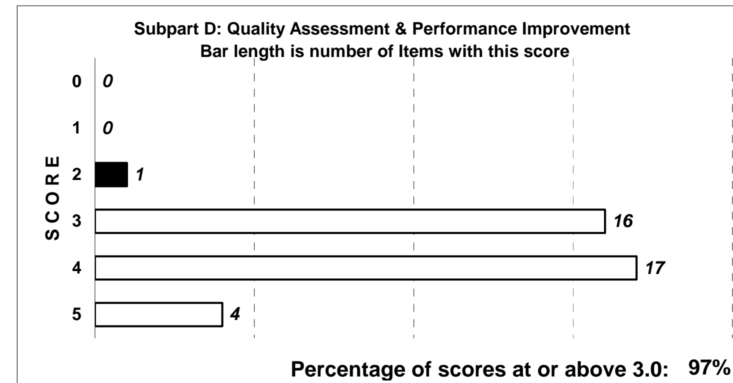
Scoring Frequency Overview

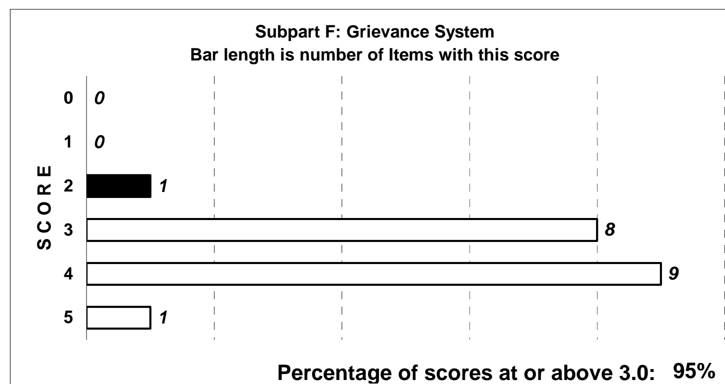
APS Healthcare EQRO (Washington State)
Scoring Frequency Overview for North Sound

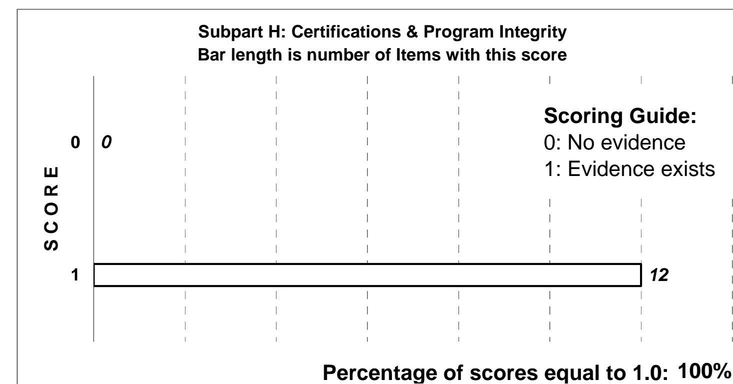
These charts depict combined 04-05 scores of 3.0 or higher (Subparts C, D, F) or 1.0 (Subpart H), with 2006 results for all remaining items.

Scoring Guide for Subparts C, D and F:
0: No documentation/processes
1: Documentation/processes exist
2: Documentation/processes available to personnel
3: Personnel trained/aware of documentation/processes
4: Provision articulated, implemented locally
5: Provision thoroughly/consistently implemented









Scoring Frequency Overview Chart Discussion

The charts above depict cumulative 2004, 2005, and 2006 scores for all Subpart items scored for each of those years. Thus, the bar chart for each Subpart displays the frequency of scores from the "blended" 2004-2006 reviews.

The percentage of scores at or above the Expected level for each Subpart is:

Subpart C: 100%
Subpart D: 97%
Subpart F: 95%
Subpart H: 100%

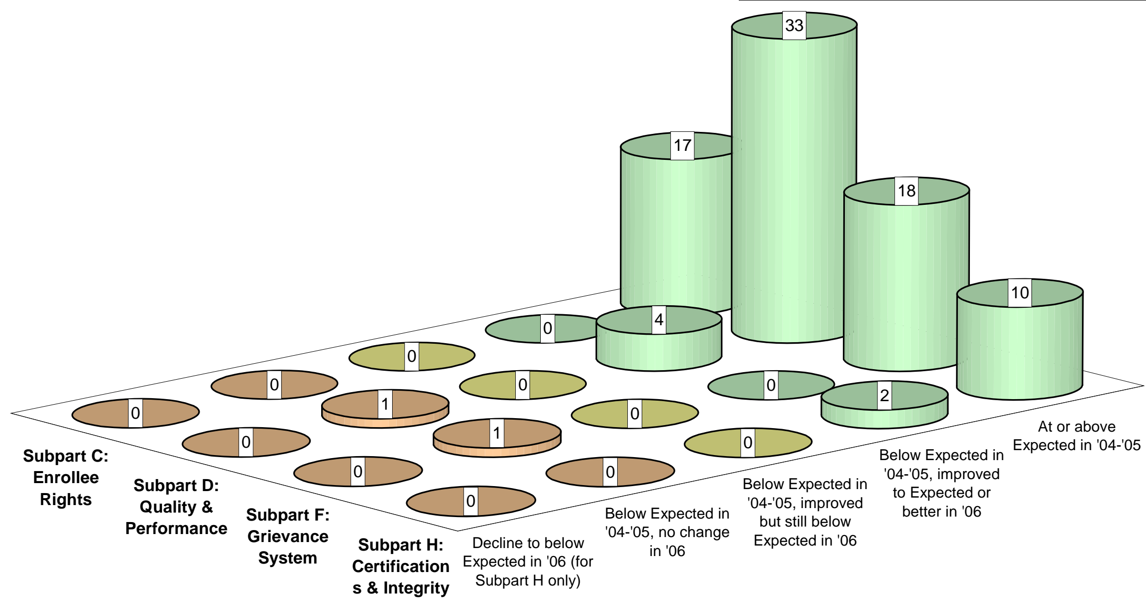
By prioritizing enrollee rights and protections, North Sound Mental Health Administration achieved Expected compliance for Subpart C in 2005. In addition, in 2006 the PIHP has met all requirements associated with Program Integrity.

The PIHP continues to make progress with respect to Subpart D, and has achieved Expected compliance for all review elements with one exception: PIHP ensures culturally competent service delivery utilizing Mental Health Specialists. North Sound Mental Health Administration has also achieved Expected compliance for all but one review element in Subpart F-Grievance Systems. Overall, North Sound Mental Health Administration has achieved a high level of Expected compliance within all four Subparts.

Score Trend Summary for:
North Sound

"Expected" means:

- A score of **3.0** or better for **Subparts C, D and F**
- A score of **1** for **Subpart H**



Score Trend Category	Subpart C: Enrollee Rights Item Count	Subpart C: Enrollee Rights Percent	Subpart D: Quality & Performance Item Count	Subpart D: Quality & Performance Percent	Subpart F: Grievance System Item Count	Subpart F: Grievance System Percent	Subpart H: Certifications & Integrity Item Count	Subpart H: Certifications & Integrity Percent
Decline to below Expected in '06 (for Subpart H only)	n/a	n/a	n/a	n/a	n/a	n/a	0	0.0%
Below Expected in '04-'05, no change in '06	0	0.0%	1	2.6%	1	5.3%	0	0.0%
Below Expected in '04-'05, improved but still below Expected in '06	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Below Expected in '04-'05, improved to Expected or better in '06	0	0.0%	4	10.5%	0	0.0%	2	16.7%
At or above Expected in '04-'05	17	100.0%	33	86.8%	18	94.7%	10	83.3%
Total	**17**	**100.0%**	**38**	**100.0%**	**19**	**100.0%**	**12**	**100.0%**

Score Trend Summary Discussion

The above chart and table show both the number of items as well as the relative percentage of items that fall into one of five categories applicable to the 2004/2005 and 2006 reviews:

1. *Decline to below Expected in 2006 (for 90.a-90.b3 in Subpart H only)*
2. *Below Expected in 2004/2005, no change in 2006*
3. *Below Expected in 2004/2005, improved but still below Expected in 2006*
4. *Below Expected in 2004/2005, improved to Expected or better in 2005*
5. *At or above Expected in 2004/2005*

Subpart C *Enrollee Rights* and Subpart F *Grievance System* are each internally coherent functional areas; therefore, a summary of score progress in these areas may be helpful to management. From a functional perspective, Subparts D and H cover disparate subject areas, thus reducing the value of any generalizations or summaries.

Prior to the 2006 review, North Sound Mental Health Administration performance relative to Subpart C (*Enrollee Rights*) showed 17 of 17 items (100%) already at or above the Expected level of performance. Therefore, the North Sound Mental Health Administration was not re-scored on any Subpart C review elements in 2006.

For Subpart F (*Grievance System*), North Sound Mental Health Administration entered the 2006 review with 18 of 19 items (94.7%) already at or above Expected. After the 2006 review, North Sound Mental Health Administration had no score changes in Subpart F; therefore, 18 items (94.7%) remain at the Expected level of performance.

Although North Sound Mental Health Administration did not show improvement in Subpart F, improvement in other required Subparts reflects focused efforts on continuous quality improvement during 2006.

Subpart Strengths

- The PIHP has a well-designed outpatient authorization process that incorporates expedited authorizations; an easy-to-follow flow chart effectively displays the process.
- The PIHP Guidelines for Business and Ethical Conduct effectively explains issues related to program integrity and fraud and abuse. Considered a best practice, employees are required to sign an acknowledgement confirming their receipt and understanding of the document, as well as agreement to abide by its standards.

Subpart Challenges

- PIHP documentation of training related to Subpart review elements was limited.
- PIHP was unable to provide dated originals of the Pre-Contract Evaluations for Delegation and Readiness Review of Volunteers of America that relate to delegation of Access, and Inpatient Certification and Utilization Management. Maintaining dated originals of official PIHP documents is imperative.

Subpart Recommendations

1. Develop policy and procedures that stipulate PIHP standards and expectations related to the use of Mental Health Specialists in the delivery of culturally competent services.

2. Update PIHP and provider client materials to comply with PIHP policy #1515.00. In addition, clarify specific standards related to client materials that pertain to all major sensory impairments.

3. Institute formal, annual monitoring of written and oral translation of client materials; include facility checks for required, posted client materials and review provider use of **certified** translators.

4. Incorporate into the PIHP's grievance system policies and procedures related to the requirement for continuation of benefits while a State fair hearing is pending.

5. Clarify procedure to officially adopt and approve new and revised policies and procedures. Include dated signatures of PIHP officials or designees, date(s) of review and revisions, effective date of the policy, and motion number (if applicable).

6. Continue to prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.

C. Performance Measurement

The PIHP's primary responsibility in the performance measurement arena involves assurance of timely, accurate, and complete submission of data as specified by the State. This data is used by the MHD to calculate the measures being evaluated by the WAEQRO. Other performance measures calculated by the PIHP for their Performance Improvement Projects (PIPs) may also be evaluated. This year's PIP review is limited a technical assistance review, and as a result, local measures have not been reviewed.

The 2006 encounter validation review significantly relates to the evaluation of performance measures calculated by the State. The measures are only as accurate as the data on which they are based. Overall performance by the PIHPs in their encounter validation efforts will be reflected in the State-wide report for CMS due in spring of 2007.

Below is a range of topics tracked by the WAEQRO, which if effectively addressed, would significantly enhance the accuracy and usefulness of PIHP data. Each includes a summary of this year's status and, as appropriate, a statement of previous conditions.

1. Mapping non-standard codes
   The crosswalk between local codes and the codes required by the State is maintained by Sound Data Systems (SDS). SDS provides services to the provider network and acts as coordinator for this function. Codes not mapped in the crosswalk are not accepted by the PIHP's Raintree system.

2. Unique member ID
   The PIHP searches for possible duplicate members and eliminates them by merging duplicates with the originals.

3. Tracking across product lines and tracking individuals through enrollment, disenrollment and re-enrollment
   PIHP staff can track individuals across product lines using client financial data in their IT system. By using the three (3) year history of eligibility data offered by the State, and by querying their own data imported into an SQL database, the PIHP is able to track individuals through the process of enrollment, disenrollment, and re-enrollment.

4. Calculating member months
   The PIHP calculates member months using data made available by the MHD. Staff is working to better understand this data and how it relates to other State-published statistics, as well as internal measures generated by their own data.

5. Member database
   The PIHP presently maintains an SQL database containing member data made available by the MHD. They are using this data as a first step in eligibility checks and for calculating various performance indicators used in management reports.

6. Provider Database
   The PIHP maintains a provider database and has begun using it to manage their provider network.

7. Data easily under-reported
   The PIHP has a policy that governs out-of-network services.

PM Summary

North Sound PIHP has fairly strong data screening processes but fared poorly in the comprehensive encounter validation exercise conducted by APS in the 2005 review. In this year's analysis and encounter validation review (described below), the PIHP's efforts were fairly comprehensive but fell short of the contract requirements. but were fairly comprehensive. With the previous EV results and current overall score of Partially Met, the general state of the PIHP's data is evaluated as "fair". The PIHP is taking steps to bring their data quality up to good (using the terms "fair" and "good" as general measures, with "poor" being the worst with low confidence in the data, "fair" showing mid-level confidence, and "good" showing excellent confidence).

PM Strengths

- The PIHP expends considerable effort to ensure that its data is timely, accurate, and complete.

PM Challenges

- The challenges listed in the Encounter Validation section (below) also apply here.

PM Recommendations

1. The recommendations in the Encounter Validation section (below) also apply here.

D. Performance Improvement Projects

As stated in the Barriers to the Review, PIHP progress on PIPs was minimal this past year; the benefits of increased focus at the State level, including ongoing training and technical assistance, will be evident as the review year progresses. Consequently, PIPs were not formally scored for the 2006 review year, although the CMS validation tool was used to evaluate and provide feedback on previously developed (or new) PIPs.

APS reviewed one of two submitted PIPs for NSMHA PIHP: Restraint and Seclusion at E&Ts, which was identified by the PIHP as clinical. Included in the document request were the PIP project description, minutes of meetings, data/reports related to sampling and/or pre- or post- measurement, and data collection tools. In addition, the PIHP completed its own self-validation as a technical assistance exercise designed to increase understanding of the steps in the process and evaluate their performance. Site visit interviews focused on increasing the WAEQRO's understanding of the basis and plan for the PIP, and strategies for improving the PIP or developing new ones based on what was learned in training provided by MHD in September, 2006. (See, Attachment #7, PIP Review Information, and Attachment #8, Instructions for Submission of PIP Materials).

Ratings of Met, Partially Met, Not Met and N/A were applied to each step in the PIP process; however, formal scoring has been deferred this review year for reasons described above. Critical elements in each step were highlighted on the tool to identify those questions or activities that are minimally necessary for a valid process and outcome. Comments and suggestions have been included in each Step and in the Summary where they could be helpful. A summary of findings, along with an overall, Met/Partially Met/Not Met indicator can be found at the end of the validation tool.

NSMHA developed this PIP based on risk analyses and investigation of consumer incidents, including a death, while in seclusion and/or restraints at their Evaluation and Treatment Centers (E&T); the documentation submitted reflected progress on this PIP during Study Year 2. Initially the PIHP identified two related study topics: reduction of injury and illness while in seclusion/restraint, and reduction of incidence of seclusion/restraint. The topic related to injury and illness was ultimately dropped (per discussion with the PIHP at the site visit) due to data analysis problems they recognized (described below); however, the summary and analyses submitted for EQRO review retained the description and data related to that question. The PIHP implemented three (3) important interventions – intensified monitoring of consumers while in seclusion/restraint, adoption of JACHO-recommended procedures for minimizing threatening behaviors, and inclusion of a thorough medical assessment at admission. Their analysis yields a strong correlation between a reduction in the use of S/R and implementation of the JCAHO procedures; the EQRO review validated those findings.

Performance Improvement Project Validation
Review year 2006

Activity 1: Assess the Study Methodology

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Step 1: Appropriate Study Topic *The study topic:*					
1.1 Reflects high-volume or high-risk conditions (or was selected by the State).	X				High-acuity, complex, and involuntarily detained consumers in seclusion and/or restraint in an evaluation and treatment center (E&T).
1.2. Is selected following collection and analysis of data (or was selected by the State).	X				Review of "incidents" during periods of restraint/seclusion, including one death; discovery during case reviews that medical assessments were lacking or incomplete at intake.
1.3. Addresses a broad spectrum of key aspects of enrollee care and services (or was selected by the State).				X	PIP topic selected in response to a specific incident that raised seclusion/restraint issues to several operations and oversight committees.
1.4 Includes all eligible populations that meet the study criteria.	X				100% of consumers admitted to two E&T centers were examined in this study.
1.5. Does not exclude members with special health care needs.				X	All mental health consumers are considered to have special healthcare needs.

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
1.6 Has the potential to affect member health, functional status, or satisfaction.	X				Decrease in both incidence of seclusion/restraint and incidents of illness, injury, or death at E&Ts will have a positive effect on consumer health and functional status.
Totals for Step 1:	**4**	**0**	**0**	**2**	
Number of shaded critical evaluation elements met for Step 1: 1/1					
Step 2: Clearly Defined, Answerable Study Questions ***The written study question or hypothesis:***					
2.1. States the problem as a question(s) in a format that maintains focus and sets the study's framework.		X			Two questions are presented, each related to separate, distinct interventions with different outcome measures. Study Question #1 resists statistical confirmation because the desired incidence of death is zero. Moreover, baseline counts of illness/injury have not been captured. As a result, only Study Question #2 is viable. Questions are formulated clearly around specific impact of the intervention(s) on the population/process being studied.
2.2 Is answerable/provable.		X			Study Question #1 resists statistical confirmation because the desired incidence of death is zero. Moreover, baseline counts of illness/injury have not been captured. As a result, only Study Question #2 is viable.

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Totals for Step 2:	**0**	**2**	**0**	**0**	
Number of shaded critical evaluation elements met for Step 2: 0/2					
Step 3: Clearly Defined Study Indicators ***Study indicators:***					
3.1. Are well defined, objective, and measurable.		X			More complete description of "clients restrained/secluded" and "incidents of injury/illness or death" would enhance clarity. Clarity is also compromised because indicators are variously described as targeting *events*, *admissions*, *clients*, and *incidents*.
3.2. Are based on practice guidelines, with sources identified.	X				Introduction includes references to most recent national efforts to reduce or eliminate use of seclusion/restraint as well as to related WA State regulatory changes. Specific citations are desirable with respect to initiatives in which these indicators have improved outcomes.
3.3 Allow for the study question/hypothesis to be answered or proven.		X			See comments in 3.1 above.
3.4 Measure changes (outcomes) in health or functional status, member satisfaction, or valid process alternatives.	X				Seclusion and restraint events, as well as incidents of illness, injury, or death associated with such interventions are clear indicators of process alternatives and consumer health.
3.5 Have available data that can be collected on each indicator.		X			Documentation of incidents of illness or injury during the baseline period (Jan 2004 – Apr

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
					2005) is not provided, suggesting comprehensive records were not available as they were for the post-intervention period (May 2005 – Nov 2006).
3.6 Include the basis on which each indicator was adopted, if internally developed.	X				Adopted based on emerging national standards and internally desirable changes in practice and outcomes.
Totals for Step 3:	**3**	**2**	**0**	**0**	
Number of shaded critical evaluation elements met for Step 3: 0/0					
Step 4: Accurately Identify Study Population ***The method for identifying the study population:***					
4.1. Is accurately and completely defined.	X				Population includes all admissions to E&T during the study period.
4.2. Includes requirements for the length of a member's enrollment in the MCP.				X	Study covers all admissions, including uninsured consumers, rather than just Medicaid-eligible enrollees.
4.3 Captures all members to whom the study question applies.	X				All consumer admission data is contained in information systems; critical incident database and daily seclusion/restraint reporting governed by policy and monitored by PIHP.
Totals for Step 4:	**2**	**0**	**0**	**1**	
Number of shaded critical evaluation elements met for Step 4: 2/2					
Step 5: Valid Sampling Methods ***Sampling methods:***					

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
5.1. Consider and specify the true (or estimated) frequency of occurrence (or the number of eligible members in the population).	X				100% of consumers admitted to two E&T centers were examined in this study. Study covers all admissions, including uninsured consumers, rather than just Medicaid-eligible enrollees.
5.2. Identify the sample size (or use the entire population).				X	Population includes all admissions to E&T during the study period.
5.3. Specify the confidence interval to be used (or use the entire population).				X	See 5.3
5.4 Specify the acceptable margin of error (or use the entire population).				X	See 5.3
5.5 Ensure a representative sample of the eligible population.				X	See 5.3
5.6 Are in accordance with generally accepted principles of research design and statistical analysis.				X	See 5.3
Totals for Step 5:	**1**	**0**	**0**	**5**	
Number of shaded critical evaluation elements met for Step 5: N/A					
Step 6: Accurate/Complete Data Collection ***The data collection methods provide for the following:***					
6.1. Identification of data elements to be collected.	X				Desired data elements not present in electronic information systems were abstracted from paper-based records.

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
6.2. Identification of specified sources of data.	X				Sources include critical incident database; daily seclusion and restraint tally reports; electronic information systems for number of admissions and length of stay.
6.3. A defined and systematic process for collecting baseline and remeasurement data.		X			Documentation of incidents of illness or injury during the baseline period (Jan 2004 – Apr 2005) is not provided, suggesting comprehensive records were not available as they were for the post-intervention period (May 2005 – Nov 2006). Additional detail regarding collection and assembly of all relevant data is desirable. Summary does not make clear who coordinates data assembly, validates it, and prepares it for analysis.
6.4. A timeline for collection of baseline and remeasurement data.	X				Baseline defined as period between January 2004 and April 2005. Remeasurement period is May 2005 through November 2006.
6.5. Qualified staff and personnel to abstract manual data.			X		Not addressed
6.6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.		X			Documentation of incidents of illness or injury during the baseline period (Jan 2004 – Apr 2005) is not provided, suggesting comprehensive records were not available as they were for the post-intervention period (May 2005 – Nov 2006).

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
					Daily seclusion/restraint report tallies event categories but not consumer-specific information, introducing opportunities for single, very acute, and complex cases to confound the time series.
6.7 A manual data collection tool that supports inter-rater reliability.		X			Poor inter-rater reliability in the daily seclusion/restraint tally report might influence study results. The report design pre-dates the study, suggesting that user training issues may be insignificant. Although the study's summary documents some instances of counting errors between nursing shifts, an examination of user reporting bias with this reporting tool would boost reliability confidence.
6.8 Clear and concise written instructions for completing the manual data collection tool.		X			User uncertainty surrounding incident counting rules occurred when adopting the pre-existing daily seclusion/restraint report as a data collection tool.
6.9 An overview of the study in written instructions.			X		Existing operational reports were employed as manual data collection instruments; study-related instructions do not appear to have been incorporated into these documents.
6.10 Automated data collection algorithms that show steps in the production of indicators.		X			Study Summary provides an "analyst's eye" narrative overview of how the analysis unfolded over time. Greater detail and consistency of how the data was manipulated is desirable; for example:

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
					• Give p-values for the correlation analysis (as was provided in the regression model) • Add descriptive clarity for independent variables such as "time period to allow for month to month trends to be accounted for" used in regression model • Specify methods of converting month totals to moving averages, particularly at extremes of the time period in question.
6.11 An estimated degree of automated data completeness.			X		Not addressed
Totals for Step 6:	**3**	**5**	**3**	**0**	
Number of shaded critical evaluation elements met for Step 6: 0/1					
Step 7: Appropriate Improvement Strategies Planned/implemented intervention(s) for improvement are:					
7.1 Related to causes/barriers identified through data analysis and QI processes.	X				Summary of PIP development identifies consideration of potential causes and barriers, and interventions were developed to address those hypotheses.
7.2 System changes that are likely to induce permanent change.	X				Changes in intake procedures and seclusion/restraint monitoring have a strong chance of impacting outcomes.
7.3 Revised if original interventions are not successful.				X	Continued monitoring of events will be required to assess success of interventions.

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
7.4 Standardized and monitored if interventions are successful.				X	Continued monitoring of events will be required to assess success of interventions.
Totals for Step 7:	**2**	**0**	**0**	**2**	
Number of shaded critical evaluation elements met for Step 7: 1/1					
Step 8: Sufficient Data Analysis and Interpretation ***The data analysis:***					
8.1. Is conducted according to the data analysis plan in the study design.			X		Data collection design and activities were carried out during or before the analysis plan was developed.
8.2. Allows for generalization of the results to the study population if a sample was selected.				X	100% of consumers admitted to two E&T centers were examined in this study.
8.3. Identified factors that threaten internal or external validity of findings.	X				Investigators reasonably conclude that external validity may have limited application because of consumer demographics that vary significantly from typical inpatient facility experience. Identified threats to internal validity are noteworthy and may constitute uncontrolled variables in the study design.
8.4. Includes an interpretation of findings.	X				Results are interpreted using at least three different and separate approaches: correlation of incident count to policy adoption; regression modeling of incident count based on independent variables; and control charting and analysis.

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
8.5 Is presented in a way that provides accurate, clear, and easily understood information.		X			See comments in 6.10 above and 9.2 below.
8.6 Identifies initial measurement and remeasurement of study indicators.	X				Study describes a baseline period and a remeasurement period; however, a second, post-intervention measurement period has not yet occurred.
8.7 Identifies statistical differences between initial measurement and remeasurement.		X			See comments in 9.2 below.
8.8 Identifies factors that affect ability to compare initial measurement with remeasurement.	X				Separate but related initiatives launched during the post-implementation period may constitute uncontrolled variables in the study design.
8.9 Includes the interpretation of the extent to which the study was successful.	X				See related comments in 9.2 below.
Totals for Step 8:	**5**	**2**	**1**	**1**	
Number of shaded critical evaluation elements met for Step 8: 0/1					
Step 9: Real Improvement Achieved ***There is evidence of "real" improvement based on the following:***					
9.1. Remeasurement methodology is the same as baseline methodology.				X	A second, post-intervention measurement has not yet occurred.
9.2. There is documented improvement in		X			Reduction in illness/injury is not known

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
processes or outcomes of care.					because baseline counts are not presented. Absence of death in measurement period is a positive finding, but is not amenable to statistical analysis. Correlation analysis suggests desirable declines in both monthly seclusion and restraint incidence, but p-values were not provided. Regression model has extraordinary variance explanation, but variable definitions lack clarity, and documentation of precise data preparation/manipulation is not provided.
9.3. The improvement appears to be the result of planned intervention(s).		X			See comments in 9.2 above.
9.4. There is statistical evidence that observed improvement is true improvement.		X			See comments in 9.2 above.
Totals for Step 9:	**0**	**3**	**0**	**1**	
Number of shaded critical evaluation elements met for Step 9: N/A					
Step 10: Sustained Improvement Achieved ***There is evidence of sustained improvement based on the following:***					
10.1 Repeated measurements over comparable time periods demonstrate sustained improvement, or the decline in improvement is not statistically significant.				X	Continued monitoring of events will be required to confirm that measured change is persisting.

Component/ Standard	Met	Partially Met	Not Met	N/A	Comments
Totals for Step 10:	**0**	**0**	**0**	**1**	
Number of shaded critical evaluation elements met for Step 10: N/A					

Activity 2: Evaluate Overall Validity and Reliability of Study Results

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP/STUDY FINDINGS
Met = High confidence/Confidence in reported PIHP PIP results or plan/activities reported** * Partially Met = Low confidence in reported PIHP PIP results or plan/activities reported** ***** Not Met = Reported PIHP PIP results or plan/activities not credible**
Summary of Aggregate Validation Findings * ☐ **Met**   * * ☒ **Partially Met**   *** ☐ **Not Met**

Summary of PIP validation findings:

This study examines restraint and seclusion incidence with an admirable commitment to improvement, as reflected in the range of analytic tools employed to detect evidence of change. The study design was not completely specified when data collection commenced, and symptoms of this are apparent retrospectively.

Reduction in illness/injury during seclusion or restraint is not known because baseline counts appear to have been unavailable. The absence of death during measurement period is a positive finding, but is not amenable to statistical analysis, as the Summary indicates. Hence, the predominant focus of this project is the effort to reduce incidents of seclusion and restraint.

The correlation analysis of adopting the new policy suggests desirable declines in both monthly seclusion and restraint incidence, but p-values were not provided. Using work files supplied by the investigators, p-values were reconstructed for these favorable correlations and found to be significant at the 95% level. The regression model explains an extraordinary amount of variance, but definitions of the introduced variables lack clarity; in addition, the preparatory data manipulation for this model is not well documented. A guideline might be to provide enough specificity to allow a third party to duplicate the analysis with the same starting data set. Nevertheless, given the favorable and significant results from the policy correlation study, the more elaborate, multivariate confirmation may be unnecessary.

PIP Strengths

- Commitment to employing tools and techniques from social and health service research and statistical quality control.
- Appreciation of study design aspects influencing reliability, validity, significance, and sources of bias.
- Topic of study has clear implications for quality of care, especially consumer safety and emphasis on patient-centric affairs.

PIP Challenges

- Design appears to have evolved during execution of the analysis, contributing to some procedural inconsistencies.
- Individual patients experiencing multiple seclusion/restraint events appear to confound the data.
- Due to lack of data, Study Question #1 does not lend itself to statistical analysis.

PIP Recommendations

1. Remove Study Question #1 from scope because of difficulty measuring the significance of unobserved events.
2. To reduce the confounding impact of individual, high-utilizing consumers, explore revising results metric to "number of unique consumers experiencing at least one seclusion (restraint) event."
3. Given activities to manage seclusion/restraint events that parallel this study, one might consider evaluating three different periods: Baseline (Jan 2004 – April 2005), Implementation Period (May 2005 – Nov 2005), and Post-Intervention Period (Dec 2005 – Nov 2006).

E. Encounter Validation

This year's encounter validation review was designed to examine the PIHP's own encounter validation efforts. A tool was developed by APS using the CMS encounter validation protocol, making minor adjustments to fit the PIHP's task. The standard used was the requirement specified in the 2005-2006 contract between the MHD and the PIHP. The evaluation was conducted through a desk review of documents submitted by the PIHP prior to the onsite visit. If necessary, follow-up questions were asked during the visit to help clarify items reviewed in the desk review.

Prior to each PIHP site visit, APS included an Encounter Validation (EV) review description and document request in the general communication to the PIHP, outlining all EQR document submission requirements. (See, Attachment #10, Encounter Validation Document Request). A desk review of submitted documentation was conducted using the Encounter Validation tool developed for this process. During the site visit, follow-up interviews were conducted with PIHP staff and, in some cases a data/record comparison was reviewed.

Encounter Validation Review Process

The protocol used to evaluate the PIHPs follows the same sequential logic as the formal CMS protocol, as applicable to the PIHP's particular environment. APS reviewed the following elements/activities related to the PIHP's conduct of an encounter validation:

Step 1 –Review of the PIHP's contract with the State and with their providers, data dictionaries, policies and procedures (and any memoranda of understanding) identify their requirements for collection and submission of encounter data.

Step 2 – Review the PIHP's efforts to evaluate the capability of their providers to produce timely, accurate, and complete encounter data. The WAEQRO evaluated PIHP environments using the ISCA tool in the first year's review activity and encouraged PIHPs to undertake a similar task to better understand the capabilities of their own provider agencies.

Step 3 – Evaluate efforts by the PIHP to analyze its provider agency electronic encounter data for accuracy, timeliness, and completeness. The contract between the PIHPs and the State requires the PIHP to verify accuracy and timeliness of reported data and requires that they screen data for completeness, logic, and consistency.

Step 4 – Review documentation of the PIHPs' encounter/matching exercise (data/medical record comparison). Evidence of such effort may include:

- Documentation of sampling methodology (to ensure a scientifically sound and representative sample);
- A description of how the encounter validation process is employed within their provider network; and
- Worksheets with actual validation results.

Step 5 – Submission of findings. The WAEQRO reviewed reports required by the State for the encounter validation as well as internal reports generated by these activities.

Step 6 – If follow-up activities were required (i.e., corrective actions), the WAEQRO reviewed any relevant documentation of those activities.

Scoring

Please refer to the chart below for details on scoring.

EV Element Scoring Methodology	
Met	1. All documentation necessary or a component thereof must be present; **and** 2. PIHP Staff are able to provide reviewers with responses that are consistent with each other and with the documentation. 3. For overall score, #4 and #5 must be ***Met,*** and #3 must be at least ***Partially Met***
Partially Met	1. Some of the documentation contains required components, and staff are able to provide responses that are consistent with each other and with the documentation provided; **or** 2. Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice; **or** 3. There is compliance with all documentation requirements, but staff are unable to consistently articulate processes during interviews. 4. For overall score, #3 can be any score. #4 and/or #5 can be ***Partially Met.***
Not Met	1. No documentation is present, and staff have little or no knowledge of processes or issues addressed by the requirements; **or** 2. None of the requirements were found to be in compliance. 3. For overall score, #4 and/or #5 are marked ***Not Met***.
N/A	1. The standard or element was found to be not applicable to the PIHP.

PIHP Encounter Validation Process Review

Item	*Rating*	*Comments*
1. Data requirements		
PIHP documents data requirements, including definition of data required to be sent, by whom, to whom, when, and in what format, including any completeness standards defined.	Partially Met	The PIHP defines its data requirement in a single reference document it maintains. When changes are made, this document is revised and sent to all PIHP network providers. With the exception of defining completeness standards, the documentation satisfies relevant requirements.
PIHP communicates data requirements to all entities responsible for data entry and submission.	Partially Met	Data standards are developed with Sound Data, the entity that manages the PIHP's provider IT systems. When changes are made, the reference document is updated and all parties receive copies. Missing from this document is inclusion of a completeness standard.

2. Network capability to produce accurate and complete encounter data		
PIHP assesses and documents the processes, capabilities, and potential vulnerabilities of the provider agencies' IT systems.	Not Met	The NS PIHP did not conduct an evaluation of its providers' capability to produce timely, accurate, and complete data.

3. Analysis of provider agencies' data for accuracy and completeness		
PIHP employs review processes that	Partially Met	The PIHP employs an array of pre and post submission processes to

PIHP Encounter Validation
Process Review

Item	Rating	Comments
include analyzing the entire data set submitted by the provider agencies for accuracy and completeness.		ensure that data is accurate and complete. A specific data analysis to validate the entire data set for completeness and accuracy is being accomplished. Through use of various reports, the PIHP looks for issues of data completeness and accuracy. These reports identify issues, but do not provide information needed to calculate actual completeness values needed for this analysis. The reports do not provide trend data that would help gauge progress toward eliminating reported issues. There is no mechanism to evaluate or provide a rationale for the selection of data elements for review. The various processes used for pre and post submission screening are documented and scheduled in a yearly master calendar.
Tools are defined by the PIHP to evaluate and document their data analysis findings.	Partially Met	The PIHP uses standardized queries on an established schedule to analyze their data. No evidence was submitted indicating that report results are reviewed and analyzed, or that they trigger follow-up activity.
Data is evaluated in a frozen state and archived for future possible use.	Not Met	Data was not frozen prior to conducting the analysis.

4. Review of medical records (encounter validation/matching exercise)		
PIHP has documented a process description that meets the contract requirement for an encounter validation.	Met	The data elements checked by the PIHP were: • Client Number • Client Name

PIHP Encounter Validation
Process Review

Item	Rating	Comments
At a minimum the PIHP checks the clinical records against the data for agreement in type of service, date of service, and service provider.		• Client DOB • Client Gender • Service Date • CPT/HCPCS • Minutes of Service The method used to select the records reviewed ensured that the provider was checked and that the service actually took place.
PIHP includes additional data elements in matching exercise.	Partially Met	Additional data elements were present in the PIHP review. If the PIHP had a method to identify data that is seldom (if ever) verified, such data could be added to reviews on a rotating basis to ensure its eventual scrutiny.
Effective tools are defined and used by the PIHP to capture the results of this exercise.	Met	The PIHP tool supported the capture of the results required,

5. Submission of findings		
PIHP reports to the State as required, detailing the encounter validation efforts and results.	Partially Met	The report to the state lists number of encounters per provider agency audited, the number of minutes matching (or not), number of procedure codes matching/not matching, and the number successfully cross-walked. Ideally, the report should contain the information requested by this tool. At a minimum, documentation should contain:

PIHP Encounter Validation
Process Review

Item	Rating	Comments
		• A process description; • Sampling methodology; • Standards used; • Tools employed; • Summary of provider network capabilities and/or possible areas for improvement(s); • Data analysis results; • Data matching exercise results; and • Summary findings, conclusions drawn, and corrective actions requested (if any).
PIHP regularly reports to the provider agencies the findings of the studies.	Not Met	No evidence was submitted indicating that results were shared with their provider agencies.
PIHP regularly reports internally for quality improvement activities.	Not Met	No evidence was submitted indicating that results were shared internally.

6. Follow-up activities		
PIHP has policy and procedure for documentation and oversight of follow-up activities or corrective actions required of provider agencies, based on the findings of a review activity. Evidence that PIHP	Not Met	No evidence was submitted to satisfy this item.

PIHP Encounter Validation Process Review

Item	Rating	Comments
maintains focus of oversight through to completion of requirements.		
If warranted, evidence of follow-up activity was presented.	N/A	

Summary of Encounter Validation Findings

Score Met _17_%

Met = High confidence/Confidence that PIHP encounter validation process is effective

Partially Met = Low confidence in that PIHP encounter validation process is effective

Not Met = No confidence in PIHP encounter validation process

Summary of Aggregate Validation Findings

☐ Met ☒ Partially Met ☐ Not Met

Summary of encounter validation findings:

The encounter validation efforts made by this PIHP met the requirements set forth in the contract between the MHD and the PIHP. The PIHP does a good analysis of its data for completeness and accuracy, but information is missing in the reports relative to the status and progress of these items.

The overall finding of Partially Met was reached upon consideration of the scores in #3, 4, and 5 in the tool indicated above. To the PIHP's credit, had the entire tool been used in computing the score, the PIHP would have fared equally well, with 17% of all items meeting a score of Met, 33% at Not Met, and the remaining 50% at Partially Met.

EV Strengths

- The PIHP reviews data integrity on a scheduled basis.
- The standardization of reports employed by the PIHP to check its data ensures consistency and comparability of results.
- The PIHP requires documentation with respect to errors they or their providers identify in data analysis.

EV Challenges

- With the PIHP's implementation of a new contracting model, provider network operation becomes more complex from an IT standpoint.
- Lack of analysis and trending of data reviews constrains the PIHP in its understanding of the true status of its data integrity.

EV Recommendations

1. Define a data completeness standard.

2. Analyze provider network capability to produce accurate and complete encounter data.

3. Incorporate trend data into accuracy and completeness reports to enable analysis and tracking in this area.

4. Develop a method to freeze data when calculating its completeness.

5. Develop and document a selection process and create a matrix to ensure that all data is eventually checked.

6. Document efforts with provider agencies to evaluate and address problematic data uncovered in report.

7. Document internal PIHP discussions relative to encounter validation efforts; these results should be discussed in the PIHP's quality management forum.

8. Define a policy and procedure to capture triggers and processes for corrective actions based on these results. Ideally, a broader corrective action policy could be referenced in a data completeness standard.

F. Quality Assurance & Improvement

As an optional activity for 2006, APS conducted an expanded review of the PIHP's Quality Assurance and Improvement (QAI) processes, focusing specifically on the scope and usefulness of the Quality Management Plan, and on the effectiveness of PIHP oversight of the quality of clinical care being provided. This review year is intended to establish a baseline, with the ultimate goal that all PIHPs will be scoring at the highest level with fully effective QAI plans and activities in place. Essential elements for effectiveness in both arenas are:

1. the extent to which the PIHP's quality management system is structured to ensure the regular, consistent, and useful collection and reporting of data related to management of the system, service delivery process and quality, and consumer satisfaction;

2. the extent to which the quality assurance and improvement process is fully integrated into the overall management and service delivery system of the PIHP;

3. the extent to which the PIHP follows its plan to monitor the clinical performance of its provider network, including activities related to appeals, grievances, and fair hearings; and

4. the extent to which the PIHP uses the information (data) to analyze agency and system strengths and challenges and takes effective action at the appropriate level.

APS reviewed the PIHP's Quality Management Plan, organizational charts, Annual Work Plan, minutes of relevant meetings, data and reports submitted to committees involved in QAI activities, the chart review tool (including scoring methods) used in clinical audits and completed review tools, letters, review reports to the providers, corrective action requests sent to providers, and provider responses. Onsite interviews with PIHP and provider staff focused on clarifying structure and procedures, reporting mechanisms, actual frequency of activities, and provider involvement in quality improvement activities at all levels.

The PIHP's Quality Management Plan was evaluated with a tool that assesses the degree to which the plan addresses all elements of a complete QAI process, reflects a structure that could ensure an effective QAI process, and defines a data-driven reporting process. The completed tool, with detailed comments, can be seen in Attachment #14, "QAI Plan Requirements." A summary of those results is included in the table below.

The results of the clinical oversight evaluation are presented below. Criteria for scoring can be found in Attachment #15, "QAI Score Criteria." The detailed comments are intended to provide technical assistance, anticipating that the next such review will show improvement in this important aspect of PIHP operations. The charts and tables following the review tool are provided as alternative options for viewing the results.

Scoring: Each element for each standard may achieve up to 4 points on a 0-4 scale. Fully Met = 4 and indicates that the PIHP consistently accomplishes or has in place all aspects of the element; Partially Met is indicated by scores of 1, 2, or 3, to reflect the degree to which the element approaches fully Met; and Not Met indicates that the element is not present or is very

inconsistent or incomplete. *Achieving the target score of 4 on all elements would indicate that the PIHP has a comprehensive and effective QA&I Plan and effectively monitors the quality of care provided throughout its network.*

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PIHP Quality Assurance and Improvement Review
2006 External Quality Review

Scoring: Each element for each standard may achieve up to 4 points on a 0-4 scale. Fully met = 4 and indicates that the PIHP consistently accomplishes or has in place all aspects of the element; Partially Met is indicated by scores of 1, 2, or 3, to reflect the degree to which the element approaches fully met; and Not Met indicates that the element is not present or is very inconsistent or incomplete. Achieving the target score of 4 on each element indicates that the PIHP has a comprehensive and effective QA&I Plan and effectively monitors the quality of care provided throughout its network.

PIHP:

Requirement	Met	PM	Not Met	Findings Comments
Standard **1. The PIHP plans for ongoing assessment and improvement of the quality of public mental health services in its service area. (2006-7 Contract Section 7.2)**				
A. PIHP has QA and I plan that is comprehensive and clearly defines structure, accountability, and process.		3		• The QAI Plan includes most components of a comprehensive plan, such as: mission, vision and guiding principles, goals, and scope of program. reporting processes and its • Language reflects a consumer-driven process and recovery model. • Plan describes the scope of activities of the QAI Program; however, detail is scattered and difficult to track. • Flow charts depict structure of the internal and external QAI process, which is somewhat complex and possibly redundant.

PIHP:

Requirement	Met	PM	Not Met	Findings Comments
				• Plan stipulates that final decisions are made by Board of Directors. • The Quality Management Oversight Committee (QMOC) is responsible for oversight of the QAI Plan and receives reports from internal and external committees. This committee is chaired by a Board member. • The duties of the Quality Manager are not included in either the plan or related policies, nor were other explanatory documents submitted which relate to that position. • Plan includes description of development and implementation of Performance Improvement Projects (PIPs). • Plan includes a table of performance indicators under heading, "Work Plan"; however, detail regarding measurement and benchmarks is not consistently included. • Work Plan table of indicators states that the QM Department generates an Annual QM Report; however, the Plan does not specifically state how this report is to be used or when it will be produced. • Missing from the Plan are an annual

PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				work plan and a process for an annual update and review of the QAI Plan (see below).
B. Plan includes annual review of PIHP Quality Assurance and Improvement program.		**1**		• The Integrated Report includes some elements of a plan review; however, the QAI Plan does not specifically address the annual review and approval process.
C. Plan includes annual work plan and process for review of associated activities and progress.			**0**	• PIHP did not provide an annual work plan that includes targeted, focused, quality improvement activities to be addressed for the specific year.
D. Plan includes routine and ad hoc provider review activities, including scope, frequency, follow-up, and use of results for system improvement.		**3**		• Plan includes references of annual clinical and administrative record reviews of all providers in the Work Plan section. • The "Work Plan" section of the Plan references annual clinical and administrative reviews of all providers and monthly and bi-annual reporting of clinical chart review findings to QMOC. The Plan also states that the QMOC decides what recommendations to forward to the Board of Directors (BOD). • Follow up on chart reviews is described as a function of the CQIP Committee, using the External Monitors Matrix (EMM) for reporting and tracking purposes. • The plan references use of corrective

PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				actions (CA) to address review deficiencies. Details of the CA process are not included. • The Plan does not describe the use of reports to ensure effective operational oversight of improvement activities.
E. Plan includes involvement of providers and consumers and their families on regular basis in all aspects of QA and I process.	**4**			• Plan describes use of provider and consumer satisfaction surveys. • Consumer/family involvement in North Sound Quality Management is expressed in the mission, principles, and advocacy sections of the plan. • Committee membership includes providers, consumers, family members, and advocates at every level of the QAI system.
F. PIHP demonstrates implementation of QA and I Plan as written, including annual work plan.		**3**		• Consumers and advocates are well represented at committee meetings. • IQMC minutes reflect several specific and focused quality assurance activities which could be included in an annual Work Plan. • Provider management reported that PIHP conducts site visits as defined in plan. • Committees such as QMC, QMOC, and IQMC meet regularly as reflected in the Plan and discuss consumer satisfaction,

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PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				PIPs, grievances and appeals, and quality improvement activities. • The 4th biennial Quality Management Plan Integrated Report submitted for the period June-Dec, 2005 includes: o A review of most indicators on the QM Plan and comparison of data from administrative audits; o Recommendations for quality improvement activities that were adopted, such as proposed PIPS and a medication management study. • The PIHP did not submit clear evidence of Board approval of the Plan. The QM Plan cover page indicates that the Plan was approved by the Board in 12/05. However; no board signature of approval, committee minutes, or Board minutes confirmed this approval. • Practice does not reflect the current plan in the following areas: o PIHP does not track performance indicators using the External Monitors Matrix (EMM) as described in the plan. o PIHP stated that the CQIP Committee described in the Plan does not exist.

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PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				○ Committee meeting notes do not reflect participation of fiscal staff.
Standard 1 Count (Target 6 Met):	**1**	**4**	**1**	**Target Points: 24 Actual: 14**
__**Standard**__ **2. PIHP evaluates and ensures improvement in the quality and effectiveness of the regional system of care.** **(2006-7 Contract, Section 7.2)**				
A. Clinical chart reviews are conducted for each network provider, according to QI Plan, on regular basis.	**4**			• Schedules indicate that all providers annually receive one audit each for Administrative and Clinical Record Reviews. • Evidence that site visits and chart reviews occur as scheduled includes: ○ Reports to providers of site visits; ○ Completed chart review summaries for each provider; ○ Updates on reviews at QMOC meetings; and, ○ Confirmation by provider management and direct service staff that reviews are conducted as described in the plan.
B. Review Tool is effective for measuring performance related to assessments, treatment plans, ongoing care, and required/indicated periodic review.		**3**		• The tool, together with the interpretive guide is structured for clear evaluation of timeliness, eligibility, treatment planning,

PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				and service provision. • Review tool is used for 4 types of reviews (initial authorizations, concurrent reviews, high-need utilizers, and retrospective). Reports provided for reviews indicate that scores are tallied and reported for individual providers and the overall system in each category. • Although IT staff verbally described methodology, evidence of intermediate methodology to arrive at scores was not provided.
C. Review process incorporates training and inter-rater reliability testing of all staff conducting reviews.		**3**		• Report submitted by PIHP depicting scores of all review items for all reviewers supports PIHP capacity to compare scores of individual reviewers; however, no documentation was provided related to use of the information. • Comprehensive scoring guide assists with consistency of scoring across reviewers. • No evidence of a training plan for the review tool was submitted; however, RSN staff confirmed that new reviewers are trained by current reviewers prior to conducting their first review. • Neither the QM Plan nor the QM Policy addresses reliability of scores across

PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				reviewers and over time.
D. PIHP maintains effective system for identifying and following up on any improvements/corrective actions required of providers.		**3**		• QM policies provide a thorough description of the system for following up on required charting changes as well as agency-wide recommendations and corrective actions. • "Request for Change" letter and samples submitted for review support the procedure for chart corrections. • The RSN submitted documentation of corrective action plan requests and follow-up that is consistent with staff description. • Providers described the general framework for recommendations and corrective actions; however, specific thresholds for action related to types/severity of quality of care issues are not documented in submitted materials. • The RSN did not submit evidence of a systematic monitoring mechanism for Corrective Action plans and implementation.
Standard 2 Count (Target 4 Met):	**1**	**3**	**0**	**Target Points: 16 Actual: 13**

PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
<u>Standard</u> **3. Results of reviews are analyzed by designated committee and action taken to improve performance where needed; network, advisory board and other interested parties are informed on regular basis of findings and performance improvement activities. (2006-7 Contract Section 7.4)**				
A. QI Committee (or other designated committee) regularly reviews results of provider quality oversight activities.		**3**		• QMOC minutes across the year document discussions of reports and data related to customer satisfaction survey results, updates for the Integrated Report, complaints and grievances, and clinical and administrative chart reviews. Recommendations from the QMOC to the Planning Committee and the Board are included in the minutes. • The monthly Internal Quality Management Committee (IQMC) minutes focus on quality of care issues, generated from review of complaints and grievances and comparison of data from administrative and clinical audits. Recommendations are made to QMC and progress is tracked on quality improvement efforts, such as medication management, assessment evaluations, and creation of review process templates. • Meeting minutes from QMC, QMOC,

PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				and IQMC submitted do not reflect discussion of corrective action oversight activities.
B. PIHP analyzes and trends individual provider performance.		**2**		• PIHP submitted for review a system-wide report of 2006 chart review scores, which documents each provider's performance on each review; however, the PIHP did not submit evidence related to use of the report for analyzing provider performance. • PIHP submitted individual provider summary reports, describing both positive and problematic performance areas that are sent to providers following the reviews. • The PIHP did not submit evidence of trending individual provider scores over time.
C. PIHP analyzes and trends system-wide performance.		**2**		• PIHP submitted for review a system-wide report of 2006 chart review scores, which documents each provider's performance on each review and aggregates performance of the system; however, the PIHP did not submit evidence related to the use of the report for analyzing and trending the information.
D. PIHP communicates regularly with network, Board, and others regarding results of system-wide analyses and		**3**		• Evidence that clinical quality is shared across the system:

PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
improvement activities.				o IQMC meeting minutes include discussion of clinical chart reviews and recommendations that are forwarded to the QMC for action. o Provider management and staff confirmed that agency and system chart review findings are discussed at the PIHP level and in internal meetings. o Provider management and direct service staff were able to describe recent PIHP quality improvement activities. o QMOC reviews critical incidents and barriers to service. o The PIHP maintains a website, posting dashboard utilization reports as well as Integrated Reports as they are produced. • Because the PIHP did not submit minutes of Board meetings, the WAEQRO is unable to ascertain the extent to which results of clinical oversight activities are discussed and/or acted upon at the Board level.
Standard 3 Count (Target 4 Met):	**0**	**4**	**0**	**Target Points: 16 Actual: 10**

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PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
Standard **4. PIHP incorporates results of grievances, fair hearings, appeals and actions into system improvement (2006-7 Contract Section 7.3)**				
A. PIHP has effective methods and systems for tracking timeliness and outcomes of actions, appeals, grievances, and fair hearings which are consistently applied.		**2**		• PIHP provided, for the review year, complete records of all appeals and grievances and follow-up related to findings contained in those records. • PIHP reviews activities related to grievance findings in the administrative audits. • No evidence was provided related to system-wide documenting and tracking compliance with requirements such as timeliness for these activities.
B. PIHP has methodology and regularly incorporates grievance and appeal activity and analyses into QA and I reviews and system improvement activities.	**4**			• QMC and IQMC minutes reflect discussion of Exhibit N reports. • Exhibit N report includes follow-up on issues from previous reports, as well as a description of system improvement activities such as an IQMC plan to study medication issue and RSN training of providers on the complaint process. • Ombuds reports presented at QMOC, QMC, IQMC meetings are incorporated into the Integrated Report as recommendations. Several quality improvement activities identified by the

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PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				Ombuds became formal quality improvement activities and PIPs.
C. PIHP ensures that network provider staff and PIHP Ombuds understand and appropriately facilitate consumer access to appeal, grievance, and fair hearing procedures.	**4**			• PIHP provides staff, providers, and Ombuds training on the grievance and appeal system. Evidence includes: o Training schedules, attendance sheets, and curriculum information; o PIHP administrative audit checklist includes documentation of required training from staff files. o Providers (managers and direct service staff) reported receiving training by the RSN on grievance and appeal system in 10/06. • Provider management accurately described the grievance, appeal and fair hearing process and documentation. • Line staff reported little involvement with grievances and appeals, as they occur infrequently. They referenced knowledge of availability of policies, access to supervisors, and referral to Ombuds for such matters. • Telephone interview with Ombuds reviewed knowledge of their job and involvement in QAI: o The two Ombuds accurately described the grievance and appeal process and their role in assisting

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PIHP:				
Requirement	**Met**	**PM**	**Not Met**	**Findings Comments**
				clients. o Both attend many meetings, such as ICMC, QMC, QMOC, CIRC, Training, and the Policy sub-committees. o Both Ombuds participate in and provide training for the system. o One person contributed sections to QM Plan. • Both provide input in many forums which resulted in action to address issues in the system.
Standard 4 Count (Target 3 Met):	**2**	**1**	**0**	**Target Points: 12 Actual: 10**
Grand Totals Count (Target 17 Met):	**4**	**12**	**1**	**Target Points: 68 Actual: 47**

Summary Quality Assurance and Improvement Findings

NSMHA achieved the highest score possible on 4 items. Another 12 items were partially met. Of these, all but 4 rated at the high end of partially met. Only 1 item was unmet: the expectation of having an annual plan to track quality improvement activities during the course of the year. NSMHA achieved a total score of 47/68 (69%), of items possible on the first year of review of the Quality Assurance and Improvement Plan. Two key changes recommended are to revise the Quality Management Plan to reflect current practices and use data collected to analyze and report trends at both the provider and system levels. Data analysis capacity combined with the abilities of individual staff and consumer representatives form a strong quality assurance and improvement

program with documented implementation.

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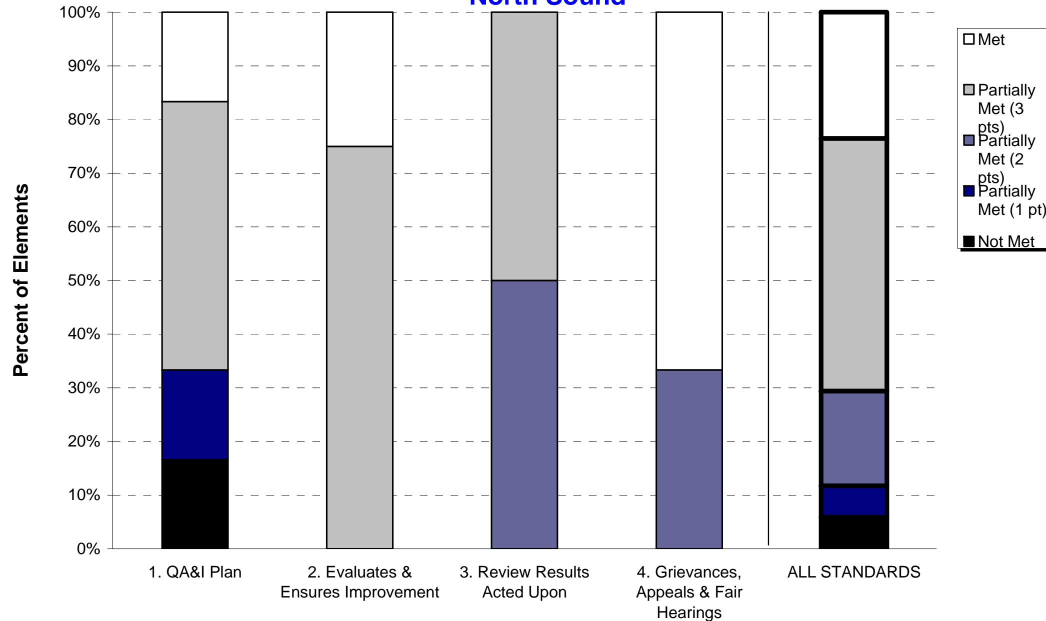

I. Frequency of Scores

Standard:	Total Number of Elements	Number of "Met" Elements	Number of "Partially Met" [3 points] Elements	Number of "Partially Met" [2 points] Elements	Number of "Partially Met" [1 point] Elements	Number of "Not Met" Elements
1. QA&I Plan	6	1	3	0	1	1
2. Evaluates & Ensures Improvement	4	1	3	0	0	0
3. Review Results Acted Upon	4	0	2	2	0	0
4. Grievances, Appeals & Fair Hearings	3	2	0	1	0	0
ALL STANDARDS	**17**	**4**	**8**	**3**	**1**	**1**

QAI Strengths

- The scoring tools created for clinical chart reviews, along with the interpretive guides and data collection system, provide a good base for an inter-rater reliability process.
- The PIHP has benefited from having on staff Ombuds who are confident in working throughout the system to meet the needs of consumers.
- The Biennial Quarterly Integrated Report provides considerable information to assess on-going and planned quality improvement activities over the course of six months.
- Information Services staff routinely attend the QMC.

QAI Challenges

- The Quality Assurance and Improvement Plan is not consistent with practice and/or current policy and procedure and does not include important detail.
- Use of the External Monitoring Matrix was dropped as too

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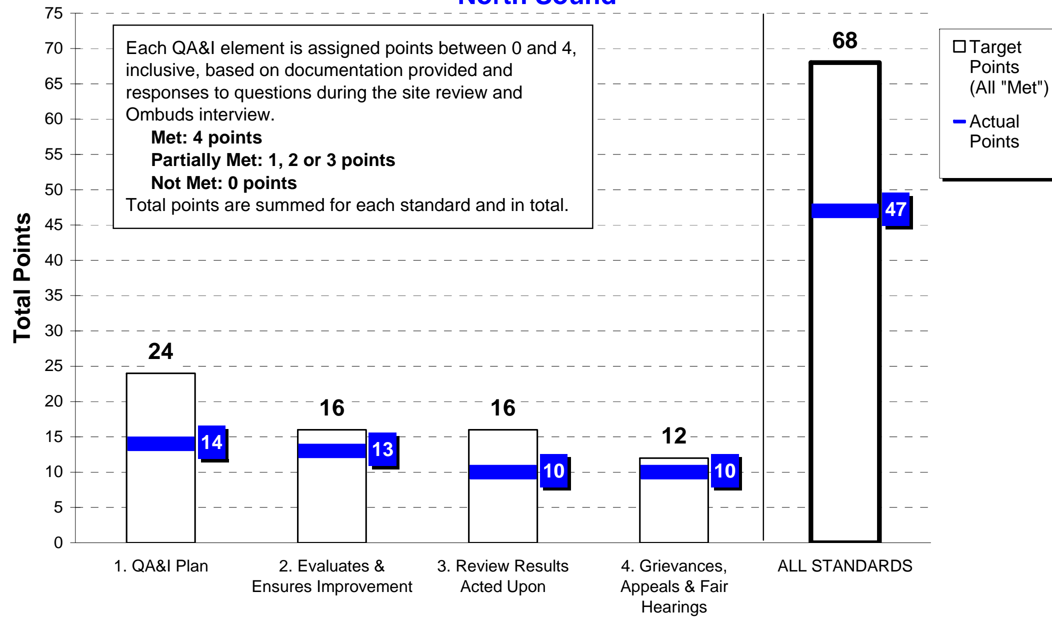

II. Cumulative Points

Standard:	Target Points (All "Met")	Actual Points
1. QA&I Plan	24	14
2. Evaluates & Ensures Improvement	16	13
3. Review Results Acted Upon	16	10
4. Grievances, Appeals & Fair Hearings	12	10
ALL STANDARDS	**68**	**47**

cumbersome as long ago as 2005; however, no replacement monitoring tool has been approved.

- The placement of the Quality Manager in the organizational chart may affect his/her authority to ensure implementation of the plan as written.
- Annual quality improvement activities, including ongoing follow-up, are discussed in the Integrated Report; however, the PIHP does not have an annual work plan that defines and focuses these activities.

QAI Recommendations

1. Revise QAI Plan to eliminate inaccuracies and increase clarity of structure and process.

2. Annually identify several quality improvement activities based on data from the previous year as the base for an annual quality improvement work plan.

3. Consider change in structure to ensure that the Quality Manager has the decision-making and oversight authority needed to effectively manage the QAI system.

4. Including Finance representation on the Quality Management Committee would ensure that all aspects of RSN operations are integrated and participating in the QAI process.

5. Increase detail of meeting minutes relative to discussions of data analysis and recommendations.

6. Create a matrix of indicators that clearly and specifically defines performance measures, measurement calculations, targets for performance, thresholds for further action, and reporting frequency and responsibility.

7. Continue to develop data analysis capabilities to support effective use of gathered and reported information. Develop reports that trend results of quality oversight activities over time, for individual agencies and for the system as a whole.

8. Add information to reports documenting the authors, the date the report was written, relevant information regarding how the data was collected and analyzed, and any reliability/validity issues.

Recommendations

Subpart Recommendations

1. Develop policy and procedures that stipulate PIHP standards and expectations related to the use of Mental Health Specialists in the delivery of culturally competent services.

2. Update PIHP and provider client materials to comply with PIHP policy #1515.00. In addition, clarify specific standards related to client materials that pertain to all major sensory impairments.

3. Institute formal, annual monitoring of written and oral translation of client materials; include facility checks for required, posted client materials and review provider use of **certified** translators.

4. Incorporate into the PIHP's grievance system policies and procedures with respect to the requirement for continuation of benefits while a State fair hearing is pending.

5. Clarify procedure to officially adopt and approve new and revised policies and procedures. Include dated signatures of PIHP officials or designees, date(s) of review and revisions, effective date of the policy, and motion number (if applicable).

6. Continue to prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.

PM Recommendations

1. The recommendations in the Encounter Validation section (below) also apply here.

PIP Recommendations

1. Remove Study Question #1 from scope because of difficulty measuring the significance of unobserved events.

2. To reduce the confounding impact of individual, high-utilizing consumers, explore revising results metric to "number of unique consumers experiencing at least one seclusion (restraint) event."

3. Given activities to manage seclusion/restraint events that parallel this study, one might consider evaluating three different periods: Baseline (Jan 2004 – April 2005), Implementation Period (May 2005 – Nov 2005), and Post-Intervention Period (Dec 2005 – Nov 2006).

EV Recommendations

1. Define a data completeness standard.

2. Analyze provider network capability to produce accurate and complete encounter data.

3. Incorporate trend data into accuracy and completeness reports to enable analysis and tracking in this area.

4. Develop a method to freeze data when calculating its completeness.

5. Develop and document a selection process and create a matrix to ensure that all data is eventually checked.

6. Document efforts with provider agencies to evaluate and address problematic data uncovered in report.

7. Document internal PIHP discussions relative to encounter validation efforts; these results should be discussed in the PIHP's quality management forum.

8. Define a policy and procedure to capture triggers and processes for corrective actions based on these results. Ideally, a broader corrective action policy could be referenced in a data completeness standard.

QAI Recommendations

1. Revise QAI Plan to eliminate inaccuracies and increase clarity of structure and process.

2. Annually identify several quality improvement activities based on data from the previous year as the base for an annual quality improvement work plan.

3. Consider change in structure to ensure that the Quality Manager has the decision-making and oversight authority needed to effectively manage the QAI system.

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8. Add information to reports documenting the authors, the date the report was written, relevant information regarding how the data was collected and analyzed, and any reliability/validity issues.

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Attachments

Attachment 1 – 2006 Review Information Letter

Attachment 2 –- Document Submission Information

Attachment 3 – 2006 PIHP Information Request Update

Attachment 4 – Roadmap to PIP

Attachment 5 – Subpart Review Tools

Attachment 6 – Subpart Scoring Guides

Attachment 7 – Performance Improvement Project Review Information

Attachment 8 – Instructions for Submission of PIP Materials

Attachment 9 – Quality Assurance and Improvement Review Instructions

Attachment 10 – 2006 Encounter Validation Document Request

Attachment 11 – Subpart Documentation Request

Attachment 12 – Site Visit Agenda

Attachment 13 – Site Visit Letter

Attachment 14 – QAI Plan Requirements Tool

Attachment 15 – QAI Review Scoring Criteria

Attachment 16 –- List of Site Visit Attendees