

**Peninsula Regional Support Network  
Quality Management Plan  
FY 2011-2012**

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**QUALITY MANAGEMENT POLICIES AND PROCEDURES**

**Policy Name:** Quality Management Plan

**Policy Number:** 10.01

**Reference:** State Mental Health Contract; Prepaid Inpatient Health Plan; PRSN provider state contract; PRSN provider PIHP contract; WAC 388-865-0280 and 42 CFR 438-240

**Effective Date:** 2000

**Revision Date(s):** 10/2011

**Approved by:** PRSN Executive Board

**OVERVIEW**

The Peninsula Regional Support Network (PRSN) Quality Management Plan is a working document created to ensure the on-going practice of evaluating, monitoring and improving the quality of mental health services delivered within the three counties served by the PRSN. The Quality Management Plan is approved by the PRSN Quality Improvement Committee (QUIC) and the Executive Board and facilitated by PRSN staff.

**ELEMENTS OF THE QUALITY MANAGEMENT SYSTEM**

Executive Board

The Executive Board is the main leadership and decision-making body of the PRSN. The Executive Board is comprised of three county commissioners from each constituent county: Kitsap, Jefferson and Clallam. The Executive Board meets quarterly and receives updates from the Quality Improvement Committee (QUIC) and recommendations from the PRSN Advisory Board, Quality Review Team (QRT) and staff, as appropriate. Based on recommendations, the Executive Board may require contract modifications.

PRSN Staff

The PRSN staff manages and facilitates the daily operations of the network. The PRSN staff consists of one full-time administrator who supervises a full-time Quality Assurance Manager/HIPAA Officer, Clinical Review Manager, Resource Development Manager/Compliance Officer Children's Services Coordinator, Fiscal Officer, and an administrative support position. These staff members provide technical support to providers and are on-site as needed or at least quarterly. They also provide support to the QRT, QUIC, Advisory and Executive Boards. Information Systems services are contracted through Kitsap Mental Health Services. The PRSN contracts with a not-for-profit administrative services organization, CommCare, for service authorization, and utilization management. If any position is vacant, other staff will assume the responsibilities of that position in facilitating the Quality Management Plan.

### Advisory Board

The purpose of the PRSN Advisory Board is to provide community and consumer input to the Executive Board and staff. The Advisory Board consists of five members from each of the three constituent counties. At least 51% of the board consists of mental health consumers or their family members. The Advisory Board meets monthly to review reports from the PRSN staff, QUIC and QRT. The Advisory Board then makes recommendations to the PRSN staff and Executive Board. At least two members of the QUIC serve on the Advisory Board.

### Ombuds

The PRSN Ombuds advocates for clients and assists providers to ensure dignified and quality services. The Ombuds operates independently from the PRSN and providers. The Ombuds reports to the QUIC, QRT and PRSN Administrator trends concerning client perceptions, family satisfaction and ancillary provider issues.

### **Quality Improvement Committee (QUIC)**

The QUIC provides oversight of the quality improvement process and activities for the PRSN. PRSN strives to achieve a QUIC membership comprised of at least 6 members who represent the perspective of those who have received or are receiving services in a publicly funded mental health system. These members may include representatives from the QRT, the Advisory Board, peer counselors or the Ombuds staff. Membership may also include an individual or family member of an individual who is not affiliated with one of these groups, who has received or is receiving publicly funded mental health services. Finally, there are representatives from each of the four providers, and a PRSN staff to facilitate. At least one member is an individual whose perspective and experiences support the interests of children and families. The QUIC meets at least quarterly, to review system-level trends and to make recommendations to the PRSN regarding quality assurance issues and opportunities for improvement within the network. The QUIC also provides direct oversight of the PRSN Compliance Plan and Utilization Management Committee.

### Quality Review Team (QRT)

The purpose of the QRT is to monitor and evaluate the delivery of mental health services within the PRSN. The QRT consists of five to ten members who are appointed by the PRSN Advisory Board and are representative of the demographics of the region. It includes consumers, family members and advocates. The QRT gathers information by conducting biennial, on-site reviews of each provider and reports their findings along with recommendations to the providers, the PRSN, the QUIC, Advisory Board, and to the State of Washington Department. At least one QRT member serves on the QUIC.

### Utilization Management Committee (UMC) and Clinical Directors Meeting (joined)

The Utilization Management Committee and Clinical Directors meeting have been combined, and are co-chaired by the PRSN Resource Development Manager and Adult Services Manager. It systematically monitors and evaluates service authorization, clinical appropriateness and utilization trends to ensure enrollees are receiving timely and appropriate services to meet their needs. The members are responsible for the PRSN Utilization Management Plan and Levels of Care documents. In addition, the members evaluate the network to ensure there is adequate services and appropriate use of resources throughout the system. This process is continuous and focuses on quality and

cost effectiveness. The Committee meets monthly and consists of the PRSN Resource Development Manager, PRSN Adult Services Manager, provider representatives, and the CommCare Clinical Care Manager. The PRSN Administrator and the CommCare Psychiatric Medical Director may provide consultation to the UMC. The meeting reports trends and region-wide issues to the PRSN Administrator; and to the QUIC, as applicable.

### Mental Health Service Providers

There are five community mental health providers located in Kitsap, Jefferson and Clallam Counties. They are; Peninsula Community Mental Health Center, West End Outreach Services, Jefferson Mental Health Services, Kitsap Mental Health Services and RMH Services. Providers have an organizational structure and quality assurance systems unique to their agency. The provider agencies have their own Quality Management (QM) Plan that incorporates the PRSN QM Plan.

### **PURPOSE**

The activities of this plan seek to assure the following qualities within the system:

- Cultural competency
- Age appropriate services
- Commitment to recovery, rehabilitation, and reintegration philosophies
- Clinical practices based on valid and reliable evidence
- Coordination and continuity of care
- Appropriate utilization of services
- Maintenance of capacity
- Accessibility
- Enrollee participation
- Stakeholder participation
- Continuous system improvement

### **MONITORING TOOLS AND ACTIVITIES**

The quality management functions of the PRSN monitor performance in four main areas: quality of services, satisfaction, administrative practices, and compliance. The PRSN analyzes information gathered through quality assurance tools and activities to develop improvement strategies to enhance quality in any one or more of the identified categories.

The following chart describes the quality assurance activities and tools used to monitor performance in each of four categories:

	<b>Quality of Services</b>	<b>Satisfaction</b>	<b>Administrative Practices</b>	<b>Compliance</b>
<b>Surveys</b>	Quality Review Team (QRT) Site Visits and Reports  WIMIRT Consumer Satisfaction Data			
<b>Reports</b>	Quality Indicators Tracking  Ombuds Monthly Activity and quarterly Exhibit N Reports  Resource Utilization Trends	Ombuds Monthly Activity and quarterly Exhibit N Reports	Provider Performance Summary Report  Revenue and Expenditure Report	ASO Monthly Authorization Report  Peninsula Regional Assessment Tool (PRAT) Report
<b>Reviews</b>	Standard Chart Reviews  Practice Guideline Reviews  Crisis Chart Reviews  High Utilizer Chart Reviews  Under-Utilization Chart Reviews  Residential Services Reviews  Evaluation and Treatment Center Reviews  Ad Hoc Reviews  Sentinel Events Reviews/Tracking  Annual Review	QRT Site Visits  Complaint, Grievance and Appeal Tracking  Annual Review	Provider and Subcontractor Administrative Review  Sub delegation Contractor Reviews  Annual Review	Chart Reviews (as listed in Quality of Services column)  Data Integrity Reviews  Provider and Subcontractor Administrative Reviews  PRSN Compliance Plan  Sub delegation Contractor Reviews  Annual Review

<b>Meetings</b>	QUIC Meeting	QUIC Meeting	QUIC Meeting	QUIC Meeting
	QRT Meeting	QRT Meeting	UMC & Clinical Directors Meeting	UMC & Clinical Directors Meeting
	UMC & Clinical Directors Meeting	UMC & Clinical Directors Meeting	DMHP Meeting	DMHP Meeting
	DMHP Meeting	DMHP Meeting		
	Clinical Staffing/Care Management Meetings			

## COLLECTING AND ANALYZING INFORMATION

Information regarding the quality and appropriateness of care consumers receive through the network services is gathered from the array of sources and activities, as listed above. Trends and issues identified through the collection and analysis of information are reported to the providers, the PRSN Administrator, the QUIC and/or the Advisory Board. Plans for collecting and analyzing information are as follows:

### **Chart Reviews and Other Targeted Reviews**

**Description:** The standard and crisis chart reviews are a key quality assurance activity performed by the PRSN staff to monitor and analyze the quality and intensity of services as well as the fit between services needed and those actually provided (See 9.05a Standard Chart Review Tool and 9.05b Crisis Chart Review Tool). Additional chart review tools may be developed when trends are identified through the results of quality assurance activities that warrant and ad hoc review.

Specifically, these chart review tools and processes:

- evaluate the continuity of services from the consumer's request for services through discharge,
- assess the degree to which services progress the consumer toward recovery and resiliency,
- incorporate items from the Department Licensing tool for inter-rater reliability,
- include items that evaluate provider compliance with the PRSN contract, policies and pertinent WAC regulations;
- include items that monitor crisis services, timeliness of response, incorporation of individual and family voice and provision of services in least restrictive environments;
- Include items that Monitor appropriateness of authorization practices for outpatient admission and continuing care,
- Include items that monitor over and underutilization of services,
- client needs such as age related, cultural and linguistic related, coordination of care for special populations, housing and linkages with other systems, and
- cultural and linguistic competence;
- monitor that consumer rights are clearly stated;
- monitor and explore targeted issues as identified by quality indicators tracking or other indicators,

- evaluate treatment plans for timeliness, participation of enrollee and natural supports, applicable consultation with specialists, and other WAC requirements, and
- monitor coordination of care with other systems, and with consumers' PCP

**Data Collection and Analysis Plan:** The PRSN staff conducts analyses of consumer care covering a representative sample of at least five hundred consumers, primarily through chart reviews, annually. In general, the numbers of reviews are divided proportionally among providers based on the number of individuals served. The representative sample may include the following types of targeted reviews:

- Reauthorization-focused
- Admission-focused
- Crisis Services
- High Utilization
- Underutilization Reviews
- Intake reviews of Individuals not authorized for care
- Supported Employment Services
- Residential Services
- Evaluation and Treatment Center Services
- Practice Guideline Adherence

Additional analyses of care may be conducted as indicated by results of monitoring activities. Data collected from chart reviews are compiled and analyzed by PRSN staff as reviews are completed. Reports are prepared and compared with previous reviews to identify trends and evidence of improvement. Review results are reported to the providers, and the PRSN Administrator. System-wide trends are reported to QUIC.

### **Practice Guideline Reviews:**

**Description:** The PRSN adopts practice guidelines based on valid and reliable research-based clinical evidence demonstrating their utility in driving positive clinical outcomes, reflecting promising practices, or reflecting a consensus of national mental health professionals. The PRSN practice guidelines are adopted from the American Psychiatric Association (APA), and include one for Schizophrenia and one for Bipolar Disorder. (See 11.15 Practice Guidelines). Each practice guideline has a corresponding monitoring tool. (See 11.15c Bipolar Practice Guideline Chart Review Tool and 11.15d Schizophrenia Bipolar Practice Guideline Chart Review Tool)

**Data Collection and Analysis Plan:** At least once per year a sample of charts of active clients with a diagnosis of schizophrenia, and bipolar disorder will be reviewed for adherence to the appropriate guideline. Results will be provided to providers.

### **Over and Under-Utilization Monitoring Project**

**Description:** PRSN expects each consumer to receive the right type and amount of service. PRSN has a variety of mechanisms in place to detect both overutilization and underutilization of services. These include: Reports and data describing utilization trends, Quality Indicator Tracking, Administrative Reviews, and Admission and Reauthorization focused Chart Reviews, and other quality assurance monitoring results. When potential over and under utilization trends are detected, PRSN responds by developing specific projects to investigate, define, and correct system problems. These projects may be developed in consultation with stakeholders through the Advisory Board, QUIC, UMC, or Network Provider Clinical Directors.

**Data Collection and Analysis Plan:** PRSN has multiple methods to detect over and under utilization such as:

- Examination of authorized level of service and service provision match and clinical appropriateness through chart reviews
- Reports that examine trends of inpatient utilization including length of stay at the evaluation and treatment center versus community hospitals
- Data describing authorization and service trends and patterns
- Quality indicators measuring inpatient utilization per capita for youth, follow-up services after inpatient services, timely access to services, and inpatient readmission rates
- Data describing utilization patterns for specific modalities of service
- Complaint and grievance patterns

**Current projects include:**

**Overutilization:** The PRSN generates a report identifying consumers who have had more than one hospitalization within 30 days. PRSN will evaluate data and services. Services will be evaluated using the crisis chart review tool which has a section with review items for high utilization only (See 11.09 and 11.09b). System trends and improvement plans are reported to QUIC as identified.

**Underutilization:** PRSN identifies a sample of intakes of clients for whom a determination that “access to care standards” were not met. These intakes are reviewed for thoroughness, quality, and whether adequate information was documented to justify the determination. This project is completed at least once per year. Regional trends are reported to the QUIC. The QUIC may delegate any regional trends to the appropriate regional committee for problem solving, with results reported back to QUIC.

**Over/Underutilization:** PRSN’s Children’s Care Manager provides monitoring and leadership regarding the authorization of continued care for youth inpatient stays as well as requests for admissions to Children’s Long Term Inpatient Programs (CLIP) to ensure that services for youth are provided in the least restrictive setting. This monitoring is provided at least weekly.

**Sentinel Events**

**Description:** The PRSN assures all sentinel events occurring within the network are reported to The Department and reviewed in a standardized way as per policy. (See PRSN Policy 2.01 Sentinel Events)

**Data Collection and Analysis Plan:** Sentinel events are monitored through provider reports. The PRSN records, reports, and reviews sentinel events occurring within the region (see PRSN Policy 2.01 Sentinel Events). The PRSN works with the provider(s) to collect and forward information to The Department regarding efforts to prevent or lessen the possibility of similar incidents in the future, as appropriate. Chart reviews and targeted reviews of provider critical incident files may be performed as necessary. The UMC/Clinical Directors may review specific incidents and recommend further, region-wide system improvements, when trends are identified. Compliance with this policy will also be monitored through the Administrative Review process.

**Data Integrity Reviews**

**Description:** The PRSN monitors the accuracy of data reported by comparing it to documentation in the clinical notes.

**Data Collection and Analysis Plan:** a random sample equal to or greater than 411 encounters sent to The Department for services during the contract year are compared with service documentation in the clinical file. The encounters are selected from 100 client charts. Verification for each randomly selected encounter record includes the following minimum data elements: recipient ethnicity, date of service, name of service provider, service location, procedure code (i.e., CPT and HCPCS) and modifier (if applicable), service unit/duration, and provider type, and whether the service code agrees with treatment described. Analysis and reporting includes findings of error rate for each data element and aggregate the results for the following categories:

- Match – Match reflects cases where there are exact matches of all the minimum data elements for each randomly selected sample between the Subcontractor’s encounters and those in the clinical records
- No Match – No match reflects cases where the Subcontractor’s encounters do not match the clinical records. There are three (3) error types for this category:
  1. Erroneous – Encounters that occurred and are presented by an electronic record, but contain incorrect data or missing any of the minimum data elements.
  2. Missing (i.e., Not in Encounter Record) – Clinical record contains evidence of a service but is not represented by an electronic record.
  3. Unsubstantiated (i.e., Not in Medical Record) – Encounters submitted by the Subcontractor but either cannot be verified in the clinical record or is duplicated.

PRSN will aggregate the findings by the error types. Reports are provided to each provider at least annually. Review results are also reported to the PRSN Administrator, and PRSN Compliance Officer. System-level trends are reported to the QUIC.

### **Peninsula Regional Assessment Tool (PRAT) Report**

**Description:** PRSN monitors the timely authorization process outlined in the provider contract and PRSN Level of Care requirements. The PRAT is a tool used by all of the providers in the region to describe an assessment and request for authorization of services. The PRAT Report analyzes the number of PRATs submitted to CommCare more than two weeks past the service request date. It also identifies the number of admission, continuing care, and inactivation authorization requests sent to CommCare from each provider, which allows the UMC to target trends by type of PRAT request. Finally, it monitors the time taken from request for authorization to authorization decision by CommCare.

**Data Collection and Analysis Plan:** The data for this report is gathered monthly and sent to PRSN by CommCare and analyzed by the Resource Development Manager. The report is reviewed at the monthly UMC meetings.

### **Resource Utilization Trends Reports**

**Description:** The Resource Utilization Trends report is generated by CommCare and describes statistics and patterns regarding authorization and utilization of services. The description includes inpatient, outpatient, and residential services; and call volume. Additionally, there is an inpatient length of stay (LOS) report used to more closely review

inpatient legal status, client age, total discharges by agency, LOS, and E&T and community hospitals being utilized.

**Data Collection and Analysis Plan:** Per the PRSN Utilization Management Plan, utilization management data is collected from the monthly authorization tracking reports. (See 7.06 Utilization Management Plan) The Resource Development Manager and the UMC analyzes the reports for trends and opportunities for improvement relating to service authorization and utilization.

### **Quality Indicators Tracking**

**Description:** The PRSN has established Quality Indicators as part of the PRSN Quality Management Work Plan that measure performance, effective service delivery and network efficiency. (See 10.04 Quality Indicators) Contract and CFR requirements; and data collected from chart reviews, administrative reviews, satisfaction surveys, Provider Performance Summary reports and other data maintained in the PRSN Information System drive the Quality Indicators. All Performance Indicators required by contracts with The Department are included as quality indicators. Additionally there are at least three ongoing regional performance indicators identified with input from the PRSN Advisory Board, as required by contract, and reflect one of the following areas:

- Access and Availability
- Care Coordination and Continuity
- Effectiveness of Care
- Quality of Care
- Hope, Recovery, and Resiliency
- Empowerment and Shared Decision Making
- Self Direction
- Cultural Competency
- Health and Safety Measures
- Consumer Health Status and Functioning
- Community Integration and Peer Support
- Quality of Life and Outcomes
- Promising and Evidence-Based Practices
- Provider effectiveness and satisfaction
- Integrated Programs and Systems Integration

A report describing these indicators and their progress is delivered to The Department annually by January 15<sup>th</sup> and includes the following information:

- Name of the indicator
- Study population and time period
- Numerator/Denominator
- Data source/sample size if applicable
- Exclusion Criteria, if any
- Justification for choosing each measure
- Improvement Target
- Annual calculation and progress
- Explanation or Corrective Action Plan if target is not reached

Regional Performance Indicators are identified on the Quality Indicators Document and reviewed quarterly at QUIC and annually by the PRSN Advisory Board Stakeholder input to development of all Quality Indicators is achieved through consultation with the Advisory Board and the QUIC.

**Data Collection and Analysis Plan:** The Quality Assurance Manager collects data, calculates measures, and develops an analysis for each quality indicator. Findings are reported to providers as appropriate. All indicators are reported to QUIC at least annually. The QUIC evaluates the impact and effectiveness of the indicators and modifies them as appropriate. Baseline and targets are established for each indicator. Data collected and analyzed for each indicator assists the PRSN to identify necessary improvements and implement change to enhance the overall quality of mental health services within the region. All results of contract indicators required by the state will be made available to the public.

### **Regional Surveys**

**Description:** Consumer satisfaction and outcome data for the PRSN is collected from several two sources, including:

1. **QRT Interviews:** The QRT gathers information about consumer satisfaction and quality of service (See 9.06 Quality Review Team).
2. **The Mental Health Statistics Improvement Program (MHSIP) Survey:** The MHSIP survey is conducted once per year by the Washington Institute for Mental Illness Training and Research (WIMIRT). Clients who have received mental health services are randomly selected to participate in the survey. Various outcomes, including National Outcome Measures (NOMS) and satisfaction ratings are measured.

### **Data Collection and Analysis Plan:**

1. The QRT conducts biennial, on-site interviews of each provider and ancillary providers. Findings and generated improvements are presented to the PRSN Advisory Board, and may be reviewed by the QUIC if recommended by the Advisory Board.
2. Once the annual results are published, PRSN staff develops a summary for review and discussion by the QUIC of the MHSIP survey results annually. Agency specific MHSIP results may also be provided as deemed necessary by the QUIC.

The QUIC uses information from these sources to determine the degree to which mental health services are driven by individual/family voice and participation and meeting the needs of consumers, and to shape improvement activities in the region.

### **Complaint, Grievance, and Appeal Tracking**

**Description:** The PRSN has a system in place for individuals to pursue complaints, grievances, and appeals; and access DSHS administrative Fair Hearings. (See Chapter 6 - Complaint, Grievances and Appeals Policies) The PRSN generates the Exhibit N report, as required by The Department, which tracks PRSN grievances, appeals and DSHS Fair Hearings for adult and children's services. PRSN also tracks agency complaints on a separate quarterly report.

**Data Collection and Analysis Plan:** All PRSN contracted provider agencies report complaints to the PRSN on a biannual basis. The Ombuds forward monthly reports on complaints and grievances in the network to the QUIC and PRSN Administrator. The Ombuds also report trends and issues they have identified to the QUIC at quarterly intervals. The PRSN collects grievance data directly submitted and resolved within the PRSN office. All service denial and appeal data is collected from CommCare. PRSN compiles The Department Exhibit N report from the above referenced sources. The QUIC will review Exhibit N each quarter to assess trends and inform quality assurance activities.

### **Utilization Management /Clinical Director's Meetings and Clinical Staffing Meetings**

**Description:** PRSN staff members provide technical assistance, collaboration, and leadership regarding effective clinical practices, adherence to statutes, and utilization and resource management through regional meetings with Clinical Director's, DMHPs, and through clinical staffing meetings as a means towards system improvement.

**Data Collection and Analysis Plan:** If concerning trends are identified they are presented to the appropriate group for development of a plan to address the issue. The QUIC maintains oversight through feedback loops including information about plans and outcomes of the issues addressed at regional clinical meetings.

#### **Provider Performance Summary Report:**

**Description:** The PRSN generates a quarterly Provider Performance Summary Report to describe numbers of services and hours for each state plan modality, utilization rates for inpatient services and crisis services, penetration rates and other performance statistics. These are calculated by agency and for the region as a whole.

**Data Collection and Analysis Plan:** The Provider Performance Summary is reviewed by the PRSN Administrator, the Executive Board, the QUIC, and by the UMC when issues of concern regarding utilization, such as over or under utilization, or capacity are revealed. Concerns and identified trends will be reported to the providers and the Advisory Board.

#### **Administrative and Sub-Delegation Reviews:**

**Description:** The PRSN has a standardized process for network provider and sub-delegation administrative reviews (See 9.03 Provider-Subcontractor Administrative Review Policy). The purpose of the reviews is to monitor provider and subcontractor administrative and compliance practices.

**Data Collection and Analysis plan:** Provider and Sub-delegation Administrative Reviews will be conducted annually by PRSN Staff. (See 9.03a PRSN Administrative Review Tool, 3.10a Subcontractor Delegation and Assessment Tool, ASO; and 3.10b Subcontractor Delegation and Assessment Tool, IS) These reports provide feedback and recommendations using measurement standards consistent with industry standards. Results of Administrative Reviews are summarized for the Advisory Board, and system-wide-trends are reported to QUIC. (See PRSN Policy 9.03 Provider-Subcontractor Administrative Review)

#### **Compliance Plan**

**Description:** The PRSN Compliance Plan establishes a culture within the network that promotes prevention, detection, and resolution of instances of conduct that do not conform to federal and state law; and federal and state funded health care program requirements. (See 5.17a Compliance Plan, FY 2011 and 5.17b Compliance Plan Checklist, FY 2009-20011) PRSN staff members, governing board members, QUIC members, QRT members, network contractors and subcontractors that encompass the operations of the PRSN are expected to act in accordance with the PRSN Compliance Plan.

**Data Collection and Analysis Plan:** The Compliance Plan includes mechanisms to immediately investigate and report allegations of Medicaid fraud and abuse to The Department. The PRSN compliance officer reviews compliance plans and evidence of applicable trainings through the administrative reviews occurring annually for each provider and subcontractor. The PRSN facilitates regional implementation(s) of new state and federal compliance requirements, such as monthly excluded parties reviews. Should investigations into potential compliance allegations warrant a corrective action plan, the corrective action plan is reviewed by QUIC. The review includes consideration as to

whether the compliance issue is a system-wide trend, warranting regional investigation. Recommendations are made as appropriate. The PRSN compliance Officer provides an annual overview of each fiscal year compliance issues to the QUIC.

### **Revenue and Expenditure Reports:**

**Description:** Financial and cost information for each provider is gathered and analyzed by the Administrator through biannual revenue and expenditure reports, annual provider audits and the annual cost report.

**Data Collection and Analysis Plan:** The financial and cost information is compared against statewide averages and historical trends. Each network provider is monitored annually by a PRSN team which examines justification for all line item expenditures, and ties expenditures reported in the agencies Revenue and Expenditure report back to agency primary records. Fiscal reports are shared with staff from the Division of Behavioral Health and Rehabilitation, and if unsubstantiated billings are identified network providers are required to return funds. Regional meetings occur quarterly with agency financial directors to provide technical assistance and clarification of the Revenue and Expenditure report.

### **Annual Review**

**Description:** PRSN ensures that reviews of the network providers within the region are conducted at least annually to include:

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

Collected data such as monitoring activities and results, external quality review findings, agency audits, consumer Grievances and services verification are incorporated into feedback and quality assurance activities.

**Data Collection and Analysis Plan:** Elements described above are collected through chart reviews, administrative reviews, and other review processes described in this plan.

## **PERFORMANCE IMPROVEMENT PROJECTS**

In addition to monitoring performance in quality of services, satisfaction, administrative practices, and compliance, PRSN also conducts two performance improvement projects (PIPs) at all times. (See PRSN Policy 10.02 Performance Improvement Projects) These projects are aimed at assessing and improving processes, and thereby outcomes, of care.

All PIPs conducted by PRSN will target improvement in relevant areas of both clinical care and non-clinical services, and will seek to improve services beyond minimal compliance with contract terms and statutes.

## **INCORPORATING FEEDBACK**

PRSN will incorporate feedback from monitoring and analysis activities described in this plan. This feedback is incorporated into the PRSN quality management and improvement processes from a variety of stakeholders including:

- **Consumers and family members**
  - Feedback is continually gathered from their participation on the QRT, QUIC and Advisory Board.
  - Input is gathered through the consumer and family focus groups which are facilitated biennially for each provider by the QRT.
  - Satisfaction data for the PRSN is collected from the Washington Institute for Mental Illness Training and Research (WIMIRT)
- **Network Providers**
  - Input is gathered through their participation on the QUIC and UMC.
  - Input may also be gathered through Clinical Director's meetings, DMHP meetings, the UMC, the QUIC, or other meetings.
- **Other Stakeholders**
  - Feedback is gathered and incorporated from the monitoring activities of the External Quality Review Organization (EQRO).
  - Feedback is incorporated from the monitoring activities of The Department.
  - Results of monitoring activities described in this plan are summarized and reviewed by the QUIC, and reported to the Advisory Board and Executive Board as appropriate. Results of each monitoring activity will be documented and communicated to each network provider, as applicable.
- Each Network Provider is expected to develop a plan to address areas needing improvement.
- The QUIC identifies opportunities for improvement and makes recommendations based on findings. Recommendations may include development of procedural changes or clinical practices. Changes may be facilitated by the Network Providers, the Advisory Board, the UMC, the Clinical Directors, or other processes developed within the PRSN.
- The Clinical Directors Meeting, facilitated by the PRSN Clinical Review Manager, use monitoring results and recommendations made by the QUIC to inform their choices when developing clinical standards, changing clinical practices, and/or implementing evidenced based practices.
- The Clinical Review Manager uses results from the monitoring process to inform the PRSN sponsored trainings for Network Providers.
- Utilization Management Committee, facilitated by the PRSN Resource Development Manager, uses the information from the quality assurance activities described in this plan, to identify barriers to improvement and maximize utilization management mechanisms.
- The Designated Mental Health Professional (DMHP) meeting, facilitated by the PRSN Clinical Review Manager, addresses issues directly related to the crisis and inpatient coordination aspects of the delivery system.

- The PRSN administrator may meet with executive directors from each provider agency as necessary to review and discuss administrative issues, agency compliance and cost efficiency. The QUIC may coordinate with any of these processes to develop system interventions, as necessary.
- Based on information from the PRSN administrator and QUIC, the Advisory Board evaluates whether implementation of system changes are effective and may make recommendations for system-wide improvements to enhance the quality of services within the network. The advisory board may report their recommendations the PRSN administrator and/or the Executive Board for further action.
- The Executive Board may require contract modifications. When the Executive Board requires contract modifications, the PRSN Administrator is responsible for implementation. The PRSN Administrator and staff evaluate if contract terms resulting from Executive Board action are effectively and consistently implemented throughout the network.

## **ACCOUNTABILITY**

The PRSN Executive Board, consisting of the three elected county commissioners from each constituent county, demonstrates ultimate local accountability. The PRSN must respond to direct citizen feedback about the quality and sufficiency of services available and local cost shifts (to jails or public health), and develop strategies to meet the unique cultural and geographic characteristics within the catchment area.

Providers and subcontractors are held accountable for compliance with statutes, regulations, contract requirements and agreements through the PRSN Compliance Plan, annual Provider and Subcontractor Administrative Reviews and Sub-delegation Reviews, and other quality assurance activities described in this plan. All feedback and plans resulting from it will be documented. Information generated from each of these functions is disseminated to the Administrator and summarized for the QUIC and the Advisory Board.

**Administrative Reviews:** If deficiencies or areas for improvement are noted in the results of an administrative review, corrective action plans are required within 30 days of receiving the written report from the PRSN. (See PRSN Policy 9.09 Corrective Action Plan)

**Chart Reviews:** Both summaries and Individual feedback for each chart review are provided providers following the completion of the reviews. Feedback includes recommendations regarding any issues of concern as well as notations highlighting exceptional examples of quality care or documentation. It is expected that providers will address any issues of concern. Feedback will include systemic patterns of strengths and areas requiring improvement. Generally, tabulated items scoring below 90% on a particular review summary require a system level action plan for improvement, and may result in a formal request for a corrective action plan. Regional trends are identified annually.

**Timely Authorization Process:** When the percentage of overdue PRATs reaches 15 or more in any given month for a provider, a corrective action plan is required. Each corrective action plan is presented and reviewed at the monthly UMC meeting.

**QRT:** When the QRT conducts in-depth appraisals of each provider's services, they make recommendations to the ancillary providers. Providers are expected to respond within 30

to 60 days in writing to the QRT recommendations, stating which recommendations they will implement including timeframes, and provide explanations for the recommendations they do not plan on implementing. Providers are also expected to provide a report within 12 months describing their current status regarding implementation of recommendations.

**Quality Indicators:** When any quality indicator measure falls below the established benchmark as described in this policy (see 10.04 Quality Indicators) for more than one quarter without at least a 10% improvement, a system level action plan for improvement may be required, and a formal request for a corrective action plan may be requested. All benchmarks for quality indicators that are also core performance measures required by The Department will be consistent with those provided in the contract between PRSN and The Department. When a quality indicator that is required by The Department does not meet the threshold described in this policy, a performance improvement project may be required by The Department.

- **Data Integrity:** Data discrepancies in the clinical record that are identified through the data integrity review process must be corrected as possible. A formal request for a corrective action plan will be requested on any analysis that reveals an error rate outside of acceptable standards. Acceptable standards are as follows:

Type	Acceptable Standards	
	Year 1	Year 2
Match	≥ 90%	≥ 95%
No Match	≤ 10%	≤ 5%
Unsubstantiated (Not in Medical Record)	≤ 4%	≤ 2%

When specific performance issues become apparent through any other monitoring and analysis process, PRSN staff may require system level problem solving, including a formal request for a corrective action plan. The PRSN has policies and procedures in place to request corrective action plans from providers and subcontractors. (See PRSN Policy 9.09 Corrective Action Plan) The PRSN staff is responsible to monitor that providers have effectively implemented corrective action plans. PRSN staff may also provide technical assistance, collaboration, and leadership regarding effective clinical practices and adherence to statutes through meetings with Clinical Director's, DMHPs, the UMC, and clinical staffing meetings as a means towards system improvement. Providers will provide a status of corrective action implementation at quarterly QUIC meetings.

## REVIEW OF QUALITY MANAGEMENT PLANS AND STRATEGIES

The quality management plan is reviewed at least annually. The necessity for quality management plan changes are identified through QUIC meetings and quality management activities described in this plan. Information, analysis, trends and recommendations are reported monthly to the Advisory Board.

The quality management plan may be revised by PRSN staff upon recommendation of the QUIC. Such recommendations are based on data and analysis from the full range of quality assurance activities, including results from the Performance Improvement Projects, results received from external quality reviews, and The Department reviews. Changes to the plan must also occur when required by contract obligations or changes in relevant statutes. Examples of revisions that may occur include, but are not limited to:

- **Revision of the Quality Indicators:** The Quality Indicators focus on the clinical and non-clinical objectives with the intent to measure and improve overall, sustainable quality within the system. The QUIC is responsible for incorporating the analysis of Quality Indicator results into the quality improvement activities conducted by the PRSN. Existing Quality Indicators may be modified, or additional quality indicators may be developed and incorporated.
- **Revision of the Quality Improvement Work Plan:** The Quality Improvement Work Plan is a document that provides a summary and general timeline for all quality assurance activities. This may be revised to reflect any other changes in the overall plan.
- **Revision of any other aspect of the overall Quality Management Process:** Any other process, such as the processes used for monitoring or incorporating feedback may be revised through this process.

All changes to the plan are submitted to The Department for approval prior to implementation. The approved Quality Management Plan is then disseminated to providers and other stakeholders within the network.

Network service providers are required to develop a Quality Management Plan unique to their agency. Expectations for these plans are informed by regional trends, unique trends or characteristics of each agency, contract requirements, and relevant statutes. The PRSN evaluates provider plans for objective and measurable performance indicators. The plans are approved by the PRSN and monitored through the annual Administrative Review process.



**PENINSULA RSN**  
**QUALITY MANAGEMENT PLAN**

**Policy Name:** Performance Improvement Projects

**Policy Number:** 10.02

**Reference:** Section six of the State Mental Health Contract; Section eight of the Prepaid Inpatient Health Plan; Section five of PRSN provider state contract; Section seven of PRSN provider PIHP contract; WAC 388-865-0280 and 42 CFR 438-240

**Effective Date:** 02/2008

**Revision Date(s):**

**Approved by:** PRSN Executive Board

**CROSS REFERENCES:**

- Plan: Quality Management Plan

**PURPOSE**

To ensure that the PRSN assess and improve processes, and thereby outcomes, of consumer care through methodologically sound practices of designing, implementing, and reporting improvement projects.

**DEFINITIONS**

**Improvement strategy:** an intervention designed to change behavior at an institutional, practitioner or beneficiary level.

**Quality Indicator:** A quantitative or qualitative characteristic (variable) reflecting a discrete event or status that is to be measured.

**PROCEDURE**

PRSN shall conduct two Performance Improvement Projects (PIPs). There shall be at least one project aimed at improving relevant areas of clinical care, and one aimed at improving non-clinical services in process at all times. The goal of each project is to achieve significant and sustainable improvement in care that is expected to have a

favorable effect on health outcomes and enrollee satisfaction. Projects shall consist of ongoing measurements and intervention to sustain improvements over time.

Each project shall be developed and executed by adhering to the following steps:

1. **Select the study topic:** Topics selected for study must reflect the Medicaid enrollment in terms of demographic characteristics, prevalence of disease and the potential consequences (risks) of the disease.
2. **Define the study question(s):** The question the study is designed to answer shall be clearly stated, in writing.
3. **Select the quality indicator(s) to be studied:** Each project shall have one or more quality indicators for use in tracking performance and improvement over time. All indicators must be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research.
4. **Use a representative and generalizable study population:** Once a topic has been selected, measurement and improvement efforts developed must be system-wide (i.e., each project must represent the entire Medicaid enrolled population to which the PIP study indicators apply). The study may review:
  - data for that entire population, or
  - a sample of that population.

Sampling must be representative of the identified population.

5. **If sampling is necessary, use sound sampling techniques:** Sampling techniques must provide valid and reliable (and therefore generalizable) information on the quality of care provided.
6. **Reliably collect data:** Procedures used to collect data for a given PIP must ensure that the data collected on the PIP indicators are valid and reliable. The strategy for developing a data collection plan should include:
  - clear identification of the data to be collected,
  - identification of the data sources and how and when the baseline and repeat indicator data will be collected,
  - specification of who will collect the data, and
  - identification of instruments used to collect the data.

The study design should specify a data analysis plan which defines statistical analysis techniques and which reflects the following considerations:

- whether qualitative or quantitative, or both will be collected,
- whether the data will be collected on the entire population or a sample,

- whether the measurements obtained from the data collection activity will be compared to the results of previous or similar studies, and
- whether the PIP will be compared to the performance of an MCO/PIHP, a number of MCOs/PIHPs, or different provider sites.

**7. Implement intervention and improvement strategies:**

- Interventions undertaken should be related to causes/barriers identified through data analysis and quality indicator processes
- Interventions must be system interventions such as
  - educational efforts,
  - changes in policies,
  - targeting of additional resources, or
  - other organization-wide initiatives to improve performance
- If quality indicator actions were successful, the new process should be standardized and monitored.
- If repeated measures indicate that quality indicator actions were unsuccessful, possible causes should be identified, and possible solutions, such as a different improvement strategy, should be considered and implemented.

**8. Analyze data and interpret study results:** Data analysis should be conducted by examining performance on the selected quality indicator using the statistical analysis techniques defined in the data analysis plan. The following should be considered to ensure that data analysis and interpretations are appropriate and valid:

- The analysis of the findings should be conducted according to the data analysis plan.
- The results and findings should present numerical PIP data in a way that provides accurate, clear, and easily understood information.
- The analysis should identify:
  - initial and repeat measurements of the prospectively identified indicators for the project,
  - statistical significance of any differences between the initial and repeat measurements,
  - factors that influence the comparability of initial and repeat measurements, and
  - factors that threaten the internal or external validity of the findings.
- The analysis of the study data should include an interpretation of the extent to which the PIP was successful and what follow-up activities are planned as a result.

**9. Plan for “real” improvement:** A plan should be documented to evaluate whether any change in performance is real. This plan should address the following:

- whether there is quantitative improvement in processes or outcomes of care according to the predetermined project indicators,
- whether the improvement has “face” validity in that it appears to have been the result of the planned quality indicator intervention as opposed to some unrelated occurrence, and
- whether there is any statistical evidence that any observed performance improvement is true improvement.

10. **Achieve sustained improvement:** To ensure that the improvement on a project is sustained, additional measurements of the quality indicator must be made after the first repeat measurement. Sustained improvement should be demonstrated through repeated measurements over comparable time periods.

11. **Timeframes:** Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

## **MONITORING**

- PIPs are monitored through the PRSN data system, typically on a quarterly basis.
- Selection of topics and progress on PIPs are monitored by QUIC.

PRSN Quality Improvement Work Plan	FY 12/Contract Year 11-12																		
R=Activity is for Region, K=Activity is for KMHS, P= Activity is for PCMHC, J=Activity is for JMHS, W=Activity is for WEOS	2nd FY/1st contract year			3rd FY/2nd contract year			4th FY/3rd contract year			1st FY/4th contract year			FY 13/ Contract year 11-12						
Activity	OCT-10	NOV-10	DEC-10	JAN-11	FEB-11	MAR-11	APR-11	MAY-11	JUN-11	JUL-11	AUG-11	SEPT-11	OCT-11	NOV-11	DEC-11	Frequency	Data Source	Reported to:	Lead Staff
<b>Chart Reviews</b>																			
Adult Intake/Reauthorization	P		K		J		W									Annually	Chart Reviews	Clinical Directors, PRSN Administrator, QUIC	Clinical Review Manager
Adult Crisis	P		K		J		W									Annually	Chart Reviews	Clinical Directors, PRSN Administrator, QUIC	Clinical Review Manager
Adult Employment	P		K		J		W									Annually	Chart Reviews	Clinical Directors, PRSN Administrator, QUIC	Clinical Review Manager
Adult Zero PRAT	P		K		J		W									Annually	Chart Reviews	Clinical Directors, PRSN Administrator, QUIC	Clinical Review Manager
Children Intake/Reauthorization		K	P		J		W									Annually	Chart Reviews	Clinical Directors, PRSN Administrator, QUIC	Clinical Review Manager/ Childrens Services Coordinator
Children Crisis		K	P		J		W									Annually	Chart Reviews	Clinical Directors, PRSN Administrator, QUIC	Clinical Review Manager/ Childrens Services Coordinator
Children Adult Employment		K	P		J		W									Annually	Chart Reviews	Clinical Directors, PRSN Administrator, QUIC	Clinical Review Manager/ Childrens Services Coordinator
Children Adult Zero PRAT		K	P		J		W									Annually	Chart Reviews	Clinical Directors, PRSN Administrator, QUIC	Clinical Review Manager/ Childrens Services Coordinator

Activity	2nd FY/1st contract year			3rd FY/2nd contract year			4th FY/3rd contract year			1st FY/4th contract year			FY 13/ Contract year 11-12			Frequency	Data Source	Reported to:	Lead Staff
AIU/Keller House Chart Reviews								K								Annually	Chart Reviews	Clinical Directors, PRSN Administrator, QUIC	Clinical Review Manager/ Childrens Services Coordinator
Second Street Residential Review										P						Annually	Chart Reviews	Clinical Directors, PRSN Administrator, QUIC	Clinical Manager
Underutilization Project Chart Reviews								R								Annually	PRSN IS and Chart Reviews	QUIC, Agency Directors	Quality Assurance Manager
<b>Quality Indicators Reviews and Calculations</b>																			
1. Client Voice in Treatment Planning: Additional chart reviews	R	R	R				R	R	R							Biannually	Chart Reviews	QUIC, The Department	Quality Assurance Manager
2. Cleint Voice in Treatment Planning												R				Annually	Chart Reviews	QUIC	Clinical Review Manager
3. Inpatient Utilization (readmission rate)		R						R						R		Biannually	PRSN Inpatient Report	QUIC	Quality Assurance Manager
4. Children's Inpatient Utilization				R												Annually	CommCare	QUIC, The Department	Quality Assurance Manager
5. Access to services (Intake)	R			R			R			R			R			Quarterly	PRSN IS Report	QUIC, The Department	Quality Assurance Manager
6. Access to services (to routine appointment)	R			R			R			R			R			Quarterly	PRSN IS Report	QUIC, The Department	Quality Assurance Manager
7. Access to services (emergent requests)	R			R			R			R			R			Quarterly	PRSN IS Report	QUIC	Quality Assurance Manager
8a and 8b. Coordination of Care (inpatient and outpatient)																Biannually	PRSN Inpatient Report	QUIC, The Department	Quality Assurance Manager
9. Coordination of Care (with PCPs): Additional chart reviews	R	R	R				R	R	R							Biannually	Chart Reviews	QUIC, The Department	Quality Assurance Manager
10a and 10b. Data Integrity Reviews					K	K		P	P		J	W				Annually	Chart Reviews	QUIC, The Department	Quality Assurance Manager
11. and 12. Data Integrity timliness			R			R			R			R			R	Quarterly	The Department	QUIC	Quality Assurance Manager/PRSN IT/IS

Activity	2nd FY/1st contract year			3rd FY/2nd contract year			4th FY/3rd contract year			1st FY/4th contract year			FY 13/ Contract year 11-12			Frequency	Data Source	Reported to:	Lead Staff
<b>Sentinel Events</b>																			
Sentinel Events Reviewed Trends reviewed at UMC/CD Meeting as needed			R													Annually	The Department's Incident Reporting System	UMC/CD	Childrens Services Coordinator
<b>Utilization Reports</b>																			
PRAT Report and Monthly Utilization Management	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	Monthly	CommCare	UMC/CD	Resource Manager
Retro and Appeals Report	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	Monthly	CommCare	UMC/CD	Resource Manager
InPt LOS Report	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	Monthly	CommCare	UMC/CD	Resource Manager
<b>Surveys</b>																			
WIMIRT Survey				R												Annually	WIMIRT	QUIC	Quality Assurance Manager
QRT Interviews and Reports	J					K								W		Biennial	QRT Interviews	Advisory Board	QRT/ Childrens Services Coordinator (as liaison)
<b>Complaint, Grievance, and Appeal Tracking</b>																			
Exhibit N Preparation and Report			R			R			R			R				six-months	Ombuds, PRSN Grievance Log	QUIC	Resource Manager
Complaints Report Preparation and analysis			R			R			R			R				Quarterly	Ombuds, Network Provider Reports	QUIC	Resource Manager
<b>PRSN Meetings</b>																			
Advisory Board Meetings	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	Monthly	n/a	n/a	Regional Administrator
UMC/Clinical Directors	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	Monthly	n/a	n/a	Resource Manager/Clinical Review Manager
Financial Directors			R			R			R			R			R	Quarterly	n/a	n/a	Resource Manager
QUIC	R			R			R					R			R	Quarterly	n/a	n/a	Quality Assurance Manager
DMHP Meetings		R			R			R			R				R	Quarterly	n/a	n/a	Clinical Review Manager
QRT	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	Monthly	n/a	n/a	Childrens Services Manager (as liaison)

Activity	2nd FY/1st contract year			3rd FY/2nd contract year			4th FY/3rd contract year			1st FY/4th contract year			FY 13/ Contract year 11-12			Frequency	Data Source	Reported to:	Lead Staff
<b>Provider Performance Summary Report</b>																			
Statistics Preparation and Analysis			R			R			R			R				Quarterly	PRSN IS	QUIC	Quality Assurance Manager
<b>Administrative and Sub-delegation Reviews:</b>																			
Annual Provider Administrative Review						K			J			P				Annually	Provider Review	Advisory Board	Resource Manager
KMHS IS Subdelegation Review																Biennial (to occur again in 2012)	Sub-delegation Review	Advisory Board	Resource Manager
CommCare Subdelegation Review																Biennial	Sub-delegation Review	Advisory Board	Resource Manager
<b>Compliance Plan</b>																			
Compliance Plan Review												R				Annually	Compliance Plan	QUIC	Resource Manager
Annual Overview of Compliance Issues	R															Annually	Compliance Log	QUIC	Resource Manager
<b>Revenue and Expenditure Reports</b>																			
Performance Improvement Projects (PIPs)																			
Healthy Living PIP Annual Measurement						K			J							Annually	PRSN IS/Chart Reviews	Advisory Board, QUIC	Quality Assurance Manager
Weight Monitoring PIP Annual Measurement																Annually	The Department /PRSN IS	Advisory Board, QUIC	Quality Assurance Manager

Activity	2nd FY/1st contract year			3rd FY/2nd contract year			4th FY/3rd contract year			1st FY/4th contract year			FY 13/ Contract year 11-12			Frequency	Data Source	Reported to:	Lead Staff
<b>Quality Management Plan Evaluation</b>																			
Quality Management Plan Evaluation										R	R	R				Annually	QUIC	Advisory Board, QUIC	Quality Assurance Manager
Quality Management Plan Revision		R														Annually	QUIC	Advisory Board, QUIC	Quality Assurance Manager

## PENINSULA REGIONAL SUPPORT NETWORK

### QUALITY INDICATORS: Contract Years 11-13

The PRSN has identified the following indicators as measures of quality performance, effective service delivery and efficiency of regional mental health systems. Progress toward achieving the standard for each indicator is regularly reported to the appropriate bodies within the PRSN who will evaluate the impact and effectiveness of the indicators. Data collected for each indicator and is tracked using the format established in this policy. Tracking and review of each indicator will assist the PRSN to identify necessary improvements and implement change to improve the overall quality of mental health services within the region.

\* **Core performance measures required and measured by The Department in 09-11 contract years**

\*\* **Submitted to The Department as Regional Performance Measures for the 09-11 contract years, and required by 11-13 contract**

**Performance-based Measure for 11-13 contract years.**

Definition of Indicator and Measurement Standard	Measurements																														
<b>A. Ensure client participation in treatment planning.</b>																															
<p><b>1. Client voice in treatment planning**</b></p> <p><u>Numerator:</u> Sum of score for presence of treatment plans written in the words of the client (or family member if the client is under 18) as evidenced by quotations on the treatment plan and treatment plan review for enrolled clients for whom a chart review was performed.</p> <p><u>Denominator:</u> Number of enrolled clients for whom a chart review was performed.</p> <p><b>Data Source:</b> Standard Intake and Reauthorization Chart Reviews and additional treatment plan reviews</p> <p><b>Current Target: 70%</b></p>	<p style="text-align: center;"><b>Reported to QUIC Semiannually in the following format:</b></p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr style="background-color: #d3d3d3;"> <th></th> <th>Region</th> <th>KMHS</th> <th>PCMHC</th> <th>JMHS</th> <th>WEOS</th> </tr> </thead> <tbody> <tr> <td style="text-align: left;"><i>Quarter 1 &amp; 2</i></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: left;"><i>Quarter 2 &amp; 3</i></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: left;"><b>Annual Measure</b></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: left;">Data notes:</td> <td colspan="5"></td> </tr> </tbody> </table>		Region	KMHS	PCMHC	JMHS	WEOS	<i>Quarter 1 &amp; 2</i>						<i>Quarter 2 &amp; 3</i>						<b>Annual Measure</b>						Data notes:					
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Data notes:																															

Definition of Indicator and Measurement Standard	Measurements					
<p><b>2. Client voice in treatment planning</b></p> <p>Problems identified by the consumer at intake or during treatment will be addressed on the treatment plan or 180-day update</p> <p><u>Numerator:</u> Number of treatments plans including problems identified at intake or during treatment.</p> <p><u>Denominator:</u> Number of charts reviewed in reporting period</p> <p><b>Data Source:</b> Standard Intake and Reauthorization Chart Reviews  <b>(Minimum Performance Standard = 90%)</b></p>	<b>Reported to QUIC annually in the following format:</b>					
		<b>Region</b>	<b>KMHS</b>	<b>PCMHC</b>	<b>JMHS</b>	<b>WEOS</b>
	<b>Annual Measure</b>					
	Data notes:					

Definition of Indicator and Measurement Standard	Measurements																														
<b>B. To ensure services are effective, efficient and appropriate.</b>																															
<p><b>3. Inpatient Utilization (readmission rate)</b>  Readmission rate to inpatient services  <u>Numerator:</u> Number re-admitted to inpatient services within 30 days from discharge.  <u>Denominator:</u> Number of individuals discharged from inpatient services during the reporting period</p> <p><b>Data Source:</b> PRSN IS  <b>(Minimum Performance Standard= Within 2 points of the State's average for previous fiscal year)</b>  State's Average for FY 11=6.3 FY 10= 6.9, FY 09 = 6.9, and FY 08= 7.4  State's Average for Medicaid Only, FY 11 = 7.2</p>	<p><b>Reported to QUIC Semiannually in the following format:</b></p> <table border="1"> <thead> <tr> <th></th> <th>Region</th> <th>KMHS</th> <th>PCMHC</th> <th>JMHS</th> <th>WEOS</th> </tr> </thead> <tbody> <tr> <td>Quarter 1 &amp; 2</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Quarter 2 &amp; 3</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Annual Measure</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Data notes:</td> <td colspan="5"></td> </tr> </tbody> </table>		Region	KMHS	PCMHC	JMHS	WEOS	Quarter 1 & 2						Quarter 2 & 3						Annual Measure						Data notes:					
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<p><b>4. Children's Inpatient Utilization **</b>  Bed Days by 1000 for children</p> <p><u>Numerator:</u> Number of days of E&amp; T or psychiatric inpatient community hospital service in a given year for Medicaid enrolled children ages 0-17 in PRSN</p> <p style="text-align: right;"><b>X 1000</b></p> <p><u>Denominator:</u> Estimate of children in the general population in the given year  <b>Data Source:</b> Authorization Records  <b>Current Target: 22.57 (This target represents a 5% decrease in admissions when the average length of stay remains constant)</b></p>	<p><b>Reported to QUIC annually in the following format:</b></p> <table border="1"> <thead> <tr> <th>Year</th> <th>Region</th> </tr> </thead> <tbody> <tr> <td>Federal Year 09</td> <td></td> </tr> <tr> <td>Federal Year 10</td> <td></td> </tr> </tbody> </table>	Year	Region	Federal Year 09		Federal Year 10																									
Year	Region																														
Federal Year 09																															
Federal Year 10																															

Definition of Indicator and Measurement Standard	Measurements																																									
<p><b>5. Access to services (to intake) *</b></p> <p>Time from the request for outpatient services to actual intake appointment.</p> <p><u>Numerator:</u> Number of actual intake appointments that occur within 14 calendar days of request for service.</p> <p><u>Denominator:</u> Number of requests that result in an intake appointment 60 days of their request.</p> <p><b>Data Source:</b> PRSN IS</p> <p><b>(Minimum Performance Standard for Region = 82.5%)</b></p> <p>Notes: Request from request to first <i>offered</i> intake may also be calculated to demonstrate capacity and contract compliance</p>	<p><b>Reported to QUIC Quarterly in the following format:</b></p> <table border="1" data-bbox="1073 256 2003 574"> <thead> <tr> <th></th> <th>Region</th> <th>KMHS</th> <th>PCMHC</th> <th>JMHS</th> <th>WEOS</th> </tr> </thead> <tbody> <tr> <td>Quarter 1</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Quarter 2</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Quarter 3</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Quarter 4</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><b>Annual Measure</b></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>Data notes: Quarter is determined by Intake date.</p>							Region	KMHS	PCMHC	JMHS	WEOS	Quarter 1						Quarter 2						Quarter 3						Quarter 4						<b>Annual Measure</b>					
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<p><b>6. Access to services (to routine appointment) *</b></p> <p>Time from Request to Service to first Routine Appointment.</p> <p><u>Numerator:</u> The number of Enrollees who receive service within 28 days of request for service.</p> <p><u>Denominator:</u> The Total number of Enrollees who receive a first routine service.</p> <p><b>Data Source:</b> PRSN IS</p> <p><b>PRSN average of 75% or a minimum of 50% for FY 10 with an increase of 20% each year after.</b></p> <p>Notes: Request from request to first <i>offered</i> routine appointment may also be calculated to demonstrate capacity and contract compliance</p>	<p><b>Reported to QUIC Quarterly in the following format:</b></p> <table border="1" data-bbox="1073 686 2003 1005"> <thead> <tr> <th></th> <th>Region</th> <th>KMHS</th> <th>PCMHC</th> <th>JMHS</th> <th>WEOS</th> </tr> </thead> <tbody> <tr> <td>Quarter 1</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Quarter 2</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Quarter 3</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Quarter 4</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><b>Annual Measure</b></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>Data notes: Quarter is determined by first routine service date.</p>							Region	KMHS	PCMHC	JMHS	WEOS	Quarter 1						Quarter 2						Quarter 3						Quarter 4						<b>Annual Measure</b>					
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<p><b>7. Access to Services (emergent requests)</b></p> <p>Time from request for emergent mental health care to face to face response to the request.</p> <p><u>Numerator:</u> The number of face to face emergent mental health care responses that occur within two hours of the request.</p> <p><u>Denominator:</u> The number of requests for emergent mental health care.</p> <p><b>Data Source:</b> PRSN IS</p> <p><b>PRSN average of 90% or 10% improvement from the last quarter</b></p>	<p><b>Reported to QUIC Quarterly in the following format:</b></p> <table border="1"> <thead> <tr> <th></th> <th>Region</th> <th>KMHS</th> <th>PCMHC</th> <th>JMHS</th> <th>WEOS</th> </tr> </thead> <tbody> <tr> <td>Quarter 1</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Quarter 2</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Quarter 3</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Quarter 4</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><b>Annual Measure</b></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Data notes:</td> <td colspan="5"></td> </tr> </tbody> </table>							Region	KMHS	PCMHC	JMHS	WEOS	Quarter 1						Quarter 2						Quarter 3						Quarter 4						<b>Annual Measure</b>						Data notes:					
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<p><input checked="" type="checkbox"/> <b>Performance-based Measure</b></p> <p><b>8a. Coordination of Care (inpatient and outpatient)*</b></p> <p>Time from discharge from hospital to first non-crisis outpatient services.</p> <p><u>Numerator:</u> First non-crisis outpatient services received 7 or fewer days after hospital discharge.</p> <p><u>Denominator:</u> Number of hospital discharges of consumers who are Medicaid enrolled.</p> <p><b>Data Source:</b> PRSN IS/Looking Glass Analytics</p> <p><b>(Minimum Performance Standard for a 6 month period= 50% with a improvement of 10% each 6 months to reach a target of 75%)</b></p>	<p><b>Reported to QUIC semiannually in the following format:</b></p> <table border="1"> <thead> <tr> <th></th> <th>Region</th> <th>KMHS</th> <th>PCMHC</th> <th>JMHS</th> <th>WEOS</th> </tr> </thead> <tbody> <tr> <td>Quarter 1 &amp; 2</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Quarter 2 &amp; 3</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><b>Annual Measure</b></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Data notes:</td> <td colspan="5"></td> </tr> </tbody> </table>							Region	KMHS	PCMHC	JMHS	WEOS	Quarter 1 & 2						Quarter 2 & 3						<b>Annual Measure</b>						Data notes:																	
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<p><b>9. Coordination of Care (with PCPs)**</b>            Coordination of Care with Primary Care Physicians  <u>Numerator:</u> Number of charts that document communication that has occurred with PCP within the last year either by sending medical notes, by documenting phone conversations, or by requesting notes from the PCP.  <u>Denominator:</u> Number of Charts reviewed that have been authorized for continued care.  <b>Data Source:</b> Standard Reauthorization Chart reviews and additional coordination of care chart reviews  <b>Current Target: 75%</b></p>	<b>Reported to QUIC semiannually in the following format:</b>					
		Region	KMHS	PCMHC	JMHS	WEOS
	Quarter 1 & 2					
	Quarter 2 & 3					
	Annual Measure					
Data notes:						
<p><b>10. Support for Employment Goals **</b>            Employment, Education or Volunteer Goals Reflected on the Treatment Plan.  <u>Numerator:</u> Number of charts in the denominator that include a treatment plan with a treatment goal addressing education, volunteering, or employment.  <u>Denominator:</u> Number Level 2 authorized, Medicaid-funded clients' charts whose intake indicates that the client is interested in pursuing education, volunteering, or employment goals  <b>Current Target: 80%</b></p>	<b>Reported to QUIC Quarterly in the following format:</b>					
		Region	KMHS	PCMHC	JMHS	WEOS
	Quarter 1					
	Quarter 2					
	Quarter 3					
	Quarter 4					
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<b>C. To ensure data is accurate and complete and timely.</b>																			
<p><input checked="" type="checkbox"/> <b>Performance-based Measure</b></p> <p><b>11a. Data Integrity *</b></p> <p>Service activity and recipient demographic (ethnicity) in the MIS system are compared with documentation in the clinical record.</p> <p><u>Numerator:</u> Number of encounters where every data element reviewed matches</p> <p><u>Denominator:</u> Total number of service encounters</p> <p><b>Data Source:</b> Encounter Data Validation Reviews  <b>(Minimum Performance Standard 90% for 2012 and 95% for 2013)</b></p>	<p><b>Reported to QUIC annually in the following format:</b></p> <table border="1" data-bbox="1073 310 2007 581"> <thead> <tr> <th></th> <th>Region</th> <th>KMHS</th> <th>PCMHC</th> <th>JMHS</th> <th>WEOS</th> </tr> </thead> <tbody> <tr> <td>Annual Measure</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Data notes:</td> <td colspan="5"></td> </tr> </tbody> </table>		Region	KMHS	PCMHC	JMHS	WEOS	Annual Measure						Data notes:					
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<p><input checked="" type="checkbox"/> <b>Performance-based Measure</b></p> <p><b>11b. Data Integrity *</b></p> <p><u>Numerator:</u> Number of encounters that are unsubstantiated (service or data element cannot be verified in clinical documentation).</p> <p><u>Denominator:</u> Total number Service encounters reviewed.</p> <p><b>Data Source:</b> Encounter Data Validation Reviews  <b>(Minimum Performance Standard 4% for 2012, and 2% for 2013)</b></p>	<p><b>Reported to QUIC annually in the following format:</b></p> <table border="1" data-bbox="1073 683 2007 954"> <thead> <tr> <th></th> <th>Region</th> <th>KMHS</th> <th>PCMHC</th> <th>JMHS</th> <th>WEOS</th> </tr> </thead> <tbody> <tr> <td>Annual Measure</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Data notes:</td> <td colspan="5"></td> </tr> </tbody> </table>		Region	KMHS	PCMHC	JMHS	WEOS	Annual Measure						Data notes:					
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<p><b>12. Data Integrity *</b></p> <p>Consumer Periodics submission timeliness</p> <p><u>Numerator:</u> Number of Consumer Periodics that were successfully submitted within 60 days of collection.</p> <p><u>Denominator:</u> Number of Consumer Periodics that were submitted.</p> <p><b>Data Source:</b> The Department  <b>Minimum performance standard: Yearly Average of 95%</b></p>	<p><b>Measures are calculated monthly and provided to PRSN on a quarterly basis by The Department. Measures are provided to QUIC quarterly.</b></p>																		

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<p><b>13. Data Integrity *</b></p> <p>Outpatient encounter submission timeliness</p> <p><u>Numerator</u>: Number of outpatient encounters successfully submitted within 60 days after the close of the month in which the services were provided (i.e. service month).</p> <p><u>Denominator</u>: Number of outpatient encounters submitted.</p> <p><b>Data Source</b>: The Department</p> <p><b>Minimum performance standard: Yearly Average of 95%</b></p>	<p><b>Measures are calculated monthly and provided to PRSN on a quarterly basis by The Department. Measures are provided to QUIC quarterly.</b></p>

**PENINSULA REGIONAL SUPPORT NETWORK  
Quality Management Organizational Chart**

