QUALITY IMPROVEMENT PROGRAMS FOR CMHSPs TECHNICAL REQUIREMENT

The State will implement the standards for internal quality assurance mechanisms as specified below. They are based upon the Guidelines for Internal Quality Assurance Programs as distributed by the Health Care Financing Administration's (HCFA) Medicaid Bureau in its guide to states in July of 1993 and HCFA's draft Standards and Guidelines for Review of Medicare and Medicaid Managed Care Organizations (December 22, 1997). These documents have been modified to reflect concepts and standards more appropriate to the population of persons served under the current waiver request; Michigan state law; and existing requirements, processes and procedures implemented in Michigan.

Michigan Standards

STANDARD I: Quality Improvement Program - The organization shall have a Quality Improvement Program (QIP) that achieves, through ongoing measurement and intervention, improvement in aspects of clinical care and non-clinical services that can be expected to affect consumer health status, quality of life, and satisfaction.

A. The organization has a written description of its QIP. The written description contains a detailed description of the structure of the QI system and a set of QI objectives that are developed annually and include a timetable for implementation and accomplishment. The plan must evaluate the QI program at least annually.

B. Scope - The written QIP plan includes a description for how the organization shall assure that all demographic groups, care settings, and types of services are included in the scope of the QIP.

C. The written plan must reflect the specific activities of the QIP, including:

1. The process for the identification and selection of aspects of clinical care and non-clinical services to be monitored and considered for process improvement projects;
2. The methods used to gather, analyze, report, and utilize customer satisfaction;
3. The mechanisms that will be used to evaluate and annually revise the QIP written plan.
4. The responsibilities of the governing body, executive director, medical director, managers, direct staff and subcontracting agencies in the QI process.
5. The structure responsible for performing QI functions and assuring that program improvements are occurring within the CMHSP. This committee or other structure must:

    a. Demonstrate that it meets or occurs with a frequency that is sufficient to demonstrate that the structure/committee is following-up on all findings and required actions.

b. Established parameters for the role, structure and function of the structure/committee.

c. Maintain records documenting the structure's/committee's activities, findings, recommendations and actions.

D. Continuous Activity - The written description provides for continuous performance of the activities, including tracking of issues over time.

E. Follow Through - The plan must delineate the mechanisms or procedures to be used for adopting and communicating process and outcome improvements.

F. Focus on Health Outcomes - The plan must address the role for mental health outcomes, of value to purchasers and individuals, to the extent possible within existing technology.

STANDARD II: SYSTEMATIC PROCESS OF QUALITY ASSESSMENT AND IMPROVEMENT - The QIP objectively and systematically monitors and evaluates the quality and appropriateness of care and service to members, through quality assessment and performance improvement projects, and related activities, and pursues opportunities for improvement on an ongoing basis.

The QIP has written guidelines for its quality-related activities, which include:

A. Specification of clinical or health services delivery areas to be monitored

1. The monitoring and evaluation of care reflects the population served by the CMHSP in terms of age groups, disease categories, and special risk status.

2. At its discretion and/or as required by the State Medicaid agency, the organization's QIP also monitors and evaluates other important aspects of care and service.

B. Use of quality indicators

1. The organization identifies and uses quality indicators that are objective, measurable, and based on current knowledge and clinical experience.

2. Indicators shall include, but not be limited to, those selected by the state agency.

3. Methods and frequency of data collection are appropriate and sufficient to detect need for program change.

C. Use of clinical care standards/practice guidelines

1. When there are nationally accepted or mutually agreed upon clinical standards/practice guidelines, QI activities monitor quality of care against those standards/guidelines.

2. When guidelines exist, a mechanism is in place for continually updating the standards/guidelines.

D. Implementation of remedial action plans

1. The QIP requires that appropriate remedial action be taken whenever inappropriate or substandard services are furnished as determined by substantiated recipient rights complaints, clinical indicators, or clinical care standards or practice guidelines where they exist.

2. Follow-up remedial actions are documented.

E. Assessment of effectiveness of corrective actions

1. As actions are taken to improve care, there is monitoring and evaluation of corrective actions to assure that appropriate changes have been made. In addition, changes in practice patterns are tracked.

2. The CMHSP assures follow-up on identified issues to ensure that actions for improvement have been effective.

F. The Quality Improvement Program describes the process of the review and follow-up of sentinel events for persons enrolled in the Children's Waiver (CW), the Children with Serious Emotional Disturbance Waiver (SEDW), and who receive services funded by these programs from CMHSPs. CMHSPs that are service providers of PIHPs, should reach agreement on how sentinel events will be handled for individuals receiving 1915(b) services or Habilitation Supports Waiver services managed by the PIHP.

1. At a minimum, sentinel events as defined in the department's contract must be reviewed and acted upon as appropriate, with root cause analyses to commence within two business days of the sentinel event.

2. Staff involved in reviewing and analyzing the sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involved death or serious medical conditions, must involve a physician or nurse.

3. All unexpected* deaths of Children's Waiver, and SED Waiver beneficiaries, who at the time of their deaths were receiving specialty supports and services from CMHSPs, must be reviewed and must include:

a. Screens of individual deaths with standard information (e.g. coroner's report, death certificate).
b. Involvement of medical personnel in the mortality reviews.
c. Documentation of the mortality review process, findings, and recommendations.
d. Use of mortality information to address quality of care.
e. Aggregation of mortality data over time to identify possible trends.

*"Unexpected deaths" include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.

STANDARD III: ACCOUNTABILITY TO THE GOVERNING BODY - Responsibilities of the Governing body for monitoring, evaluating, and making improvements to care include:

A. Oversight of QIP - There is documentation that the Governing Body has approved the overall QIP and an annual QI plan.

B. QIP progress reports - The Governing Body routinely receives written reports from the QIP describing actions taken, progress in meeting QI objectives, and improvements made.

C. Annual QIP review - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the QIP that includes: studies undertaken, results, subsequent actions, and aggregate data on utilization and quality of services rendered to assess the QIP's continuity, effectiveness and current acceptability.

D. Program modification - Upon receipt of regular written reports from the QIP delineating actions taken and improvements made, the Governing Body assures that the Executive Director takes action when appropriate and directs that the operational QIP be modified on an ongoing basis to accommodate review findings and issues of concern within the Community Mental Health Service Program (CMHSP).

STANDARD IV: QIP SUPERVISION - There is a designated senior executive who is responsible for the QI program implementation. The organization's Medical Director has an identifiable role in the QIP.

STANDARD V: Provider Qualification and Selection - The QIP contains written procedures to determine whether physicians and other health care professionals, who are licensed by the State and who are employees of the CMHSP or under contract to the CMHSP, are qualified to perform their services. The QIP also has written procedures to ensure that non-licensed providers of care or support are qualified to perform their jobs.

The CMHSP must have written policies and procedures for the credentialing process that includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, recertifying and/or reappointment of practitioners. These procedures must describe how findings of the QIP are incorporated into this re-credentialing process.

The CMHSP must also insure:

1. Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following:

    a. Educational background;
    b. Relevant work experience;
    c. Cultural competence;
    d. Certification, registration, and licensure as required by law.

2. A program shall train new personnel with regard to their responsibilities, program policy, and operating procedures.

3. A program shall identify staff training needs and provide in-service training, continuing education, and staff development activities.

STANDARD VI: ENROLLEE RIGHTS AND RESPONSIBILITIES - The organization demonstrates a commitment to treating members in a manner that acknowledges their rights and responsibilities.

A. The CMHSP monitors and assures that each individual has all of the rights established in Federal and State law.

B. The CMHSP shall have a local recipient rights office found to be in substantial compliance with the requirements of Chapter 7 of the Michigan Mental Health Code, as evidenced by a site review conducted by the state agency.

C. The CMHSP shall submit an annual report of the CMHSP's Office of Recipient Rights to the state office as required by Chapter 7 of the Michigan Mental Health Code.

D. The organization conducts periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with its services. These assessments must be representative of the persons served and the services and supports offered.

    1. The assessments must address the issues of the quality, availability, and accessibility of care.
    2. As a result of the assessments, the organization:

        a. Takes specific action on individual cases as appropriate;
        b. Identifies and investigates sources of dissatisfaction;
        c. Outlines systemic action steps to follow-up on the findings; and

d. Informs practitioners, providers, recipients of service, and the governing body of assessment results.

3. The organization evaluates the effects of the above activities.

4. The organization ensures the incorporation of consumers receiving long-term supports or services (e.g., persons receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.

STANDARD VIII: UTILIZATION MANAGEMENT

A. Written Program Description - The organization has a written utilization management program description that includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services.

B. Scope - The program has mechanisms to identify and correct under-utilization and overutilization.

C. Procedures - Prospective (preauthorization), concurrent and retrospective procedures are established and include:

1. Review decisions are supervised by qualified medical professionals.

2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate.

3. The reasons for decisions are clearly documented and available to the member.

4. There are well-publicized and readily available appeals mechanisms for both provider and patients. Notification of, a denial includes a description of how to file an appeal.

5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.

6. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures.

7. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.