WASATCH MENTAL HEALTH SERVICES
SPECIAL SERVICE DISTRICT

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPI) – C – 3.07

Purpose:

Wasatch Mental Health's (WMH) Quality Assessment and Performance Improvement Program (QAPI) represent a commitment to continuous promotion and evaluation of the statutory, ethical, contractual and professional responsibilities associated with quality mental health treatment. The Program provides oversight of all mental health center treatment to ensure all products and systems of service delivery are of the finest quality and congruent. The program achieves this through systematic performance implementation, evaluation, review, problem analysis and implementation of corrective measures.

Policy:

A. WMH shall implement a QAPI Program designed to ensure the provision of quality mental health services (see related policies at the end of this policy), and that meet the standards required by the current Utah Department of Health Prepaid Mental Health Plan (PMHP) Medicaid contract.

B. WMH shall establish a QAPI multi-disciplinary committee. The committee shall be a policy-making body under authority of WMH's executive director, and shall report its findings and recommendations to the executive director, and to WMH's authority board as required.

C. The committee chair shall be WMH's associate director over Care Management Services (CMS). The QAPI Committee shall consist, at minimum, of the chair, the executive director, administrative services associate director, medical director or medical services program manager, division directors, and the client services representative. The client services representative shall also serve as administrative assistant to the committee. Other staff members will be invited to attend when their expertise is needed or by assignment.

D. The QAPI committee shall meet quarterly to conduct its business and to review the activities of its sub-committees. The committee shall maintain written meeting agendas, minutes, an executive director's annual report, and periodically provide activity reports as needed.

E. The committee's oversight responsibilities shall include, but not limited to the following:

1. Annual establishment of WMH's QAPI plan.
2. Annual report submitted to the executive director encompassing a summary of the activities, results and findings of the committee.
3. Standards and processes associated with Peer Reviews of client clinical records.
4. Preparations for and conducting of Annual Site Reviews/Audits.
5. Consumer client satisfaction surveys and meetings.
6. Performance Improvement Projects (PIP's).
7. Client "timely access to services" data analysis and reporting.
8. Review of client grievances for improving client services.
9. Clinical record reviews and documentation of billings.
10. WMH Cultural Competency Plan.
11. Establishment of sub-committees to assist the QAPI Committee.

Procedures:

Committee Oversight Responsibilities

1. Establishment of WMH QAPI Annual Plan

The QAPI Committee shall establish its annual plan in its first meeting of each fiscal year. The formative stages of the new plan's development shall have occurred over the prior year and reflect the findings, discussions, meetings, surveys, etc., the committee or its designees has had with clients, funding partners, executive leadership, the authority board, and others.

The committee shall submit its plan to the expanded executive committee for review, modifications, and approval. Following the expanded executive committee's adoption of the plan it shall become WMH's plan by which the committee will direct its efforts over the coming year.

The plan may be modified during the year, with expanded executive committee approval, based on the circumstances.

2. QAPI Committee Shall Submit Annual Report to the Executive Director

The committee chair shall submit an annual summary report of the activities undertaken by the committee to the executive director by August 15th of each year.

3. QAPI Sub-committees

Each sub-committee shall be overseen by a QAPI committee member to facilitate coordination efforts between the sub-committee's assigned task activities and the QAPI Committee. Each sub-committee shall provide the QAPI Committee with a report at minimum annually or more frequently where required, or requested. The report shall contain a summary and analysis of activities and recommendations for improvement when needed.

4. Oversight Preparations for Annual Site Reviews

WMH acts as the host of various site reviews and audits each year. It is important that WMH ensures that the staff, and site review/audit materials needed by the auditors/reviewers are available in a timely and organized manner based on their requests. The QAPI Committee shall have oversight responsibility for ensuring preparations are organized, assignments given, etc., to ensure the agency's readiness. Ad-hoc committees shall be established when necessary to accomplish specific requirements and/or address technical issues. On the day of the audit, an appropriate staff member shall assist the auditors with the electronic clinical record navigation.

The QAPI Committee upon receiving the Utah State Division of Substance Abuse and Mental Health (USDSAMH) respective audit findings for adult and youth services shall review the findings, recommendations and corrective actions, if any, to improve the quality of WMH's quality operations.

Corrective actions shall be remediated and addressed as requested in a corrective action report within the time frames required by the USDSAMH.

5. Consumer Client Satisfaction Surveys

The QAPI Committee shall use the following processes for obtaining client and community input into the quality of WMH's services. All information obtained shall be reviewed by the

committee as part of its overall mission of evaluating and improving the quality of client care and for inclusion in WMH's various annual performance reports.

Utah State Division of Substance Abuse and Mental Health (USDSAMH) Administered Surveys

The Division Director for Adult Services and/or his/her designee shall be responsible for conducting required satisfaction surveys of adult clients. The Division Director for Child and Family Services and/or his/her designee shall be responsible for conducting required satisfaction surveys of youth clients. This will include identifying the total number of surveys needed, and by language, giving their order to USDSAMH, administering the surveys to clients, and returning the completed surveys to the USDSAMH. The USDSAMH will report survey findings to WMH's Executive Director who will provide the findings to the QAPI committee for review and agency improvement activities as needed.

WMH Internal Administered Surveys

Internally administered surveys shall be conducted at intervals by the appropriate department staff as required by the Executive Director and/or QAPI Committee.

All survey results will be documented in their original form or summarized for program improvement decision-making purposes.

6. Clinical and Non-clinical Performance Improvement Projects

WMH shall conduct formal Performance Improvement Projects (PIPs) designed to achieve, through interventions, measures and follow through with a significant and sustained level of performance improvement over time. PIP's shall be designed have an expected favorable effect on client health outcomes, functional status, and/or satisfaction using the US Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) established guidelines.

The Performance Improvement Projects shall adhere to protocols adopted by CMS entitled Conducting Performance Improvement Projects.

The QAPI Research Sub-committee shall design and implement each study including the selection of the study topic or question, the selection of the study population and relevant indicators, sampling methodology and techniques, data collection and analysis, and the development of appropriate intervention strategies necessary to achieve a sustained level of performance improvement. The Research Sub-committee shall report to the QAPI committee quarterly on its progress. The QAPI committee will review the PIPs outcome data and use any quality care, or operations information, gained from the projects to ensure the information is incorporated into the Center's operations and services.

7. Client "Timely Access to Services" Data Analysis and Reporting

The Information Technology Department (IT) Program Manager shall provide a report quarterly to the QAPI Committee of adherence to Medicaid enrollee timely access standards required by the Medicaid PMHP contract procedures for data collections and reporting). The IT Program Manager shall report whether or not WMH is in compliance, and if not the reasons and recommendations for achieving compliance. The QAPI Committee shall document compliance issues in its meeting minutes and generate reports documenting non-compliance findings and recommendations from monitoring activities. The QAPI Committee may take corrective action if there is a failure to comply with set standards (See Policy C – 3.06 Client Access to Treatment – Performance Standards)

The IT Program Manager shall use WMH's behavioral health care database "Junction" to track compliance with enrollee access to treatment standards. The IT department shall be responsible for ensuring the integrity of the pre-admit data and that all required pre-admit intake data is obtained and correctly entered for reporting purposes to PMHP Medicaid.

8. Peer Review Sub-Committee Organization and Responsibilities

Internal Provider Peer Reviews

The Peer Review Sub-committee (PRC) shall consist of the Division Director of Child and Family Services who shall act as Committee Chair (PRCC) and committee members selected from WMH therapists, case managers, program managers, and supervisors from both youth and adult service divisions. All shall be licensed or certified mental health providers, or providers practicing under the supervision of a licensed mental health provider. The Peer Review Sub-committee shall follow policy and procedures identified in policy C – 3.12 Peer and Electronic Record Review. The PRCC shall be responsible for ensuring all QAPI Committee required peer review activities are organized and carried out. The PRCC shall submit a written report to QAPI Committee quarterly.

Medical Record Peer Reviews

WMH's Medical Director and Medical Services Program Manager shall be responsible for the oversight of medical documentation audits conducted by MD's, APRN's, and Nursing staff. The Medical Director shall follow audit procedures identified in policy C – 3.12 Peer and Electronic Record Review. The Medical Director shall submit a written report quarterly of findings to the Chair of the Peer Review Committee for inclusion in its report to the QAPI Committee.

External (Outside) Provider Peer Reviews

The Outside Providers Program Manager (OPPM) shall be responsible for the oversight of outside provider audits. The OPPM shall follow outside provider auditing procedures identified in policy C – 3.12 Peer and Electronic Record Review. The OPPM shall submit a **written report quarterly** of its findings to the Chair of the Peer Review Committee for inclusion in its report to the QAPI Committee.

9. Review Client Grievances As A Mechanism For Improving Clients Services

The QAPI Committee shall quarterly review the information derived from any grievances and appeals received during the preceding three-month period as part of the quality improvement process. The Committee will use the information to determine where there are trends or systemic issues that need to be addressed at an individual, program, or center-wide level. Particular attention will be given to grievances and appeals initiated by Medicaid enrollees to ensure that WMH is in compliance with PMHP contractual requirements. In addition, all WMH actions, as defined by the PMHP contract that adversely impact Medicaid enrollees, will be reviewed.

The Committee may recommend further assessment of problem areas or corrective systemic interventions. The QAPI Committee shall maintain written documentation of meetings and reviews of appeals and grievances, including findings and recommendations. The Care Management Associate Director, Client Services Representative (CSR), and others as needed, shall act as the QAPI Grievance Sub-committee. (See Policy C – 3.08 Medicaid Enrollee Actions and Grievance System).

10. Clinical Record and Billing Reviews

The QAPI Committee shall receive minutes, and review quarterly summary reports from the Records Compliance and Quality Assurance Sub-committee who shall engage in problem identification and resolution responsibilities to ensure integration of clinical records, data management, and billing services.

11. Cultural Competency

The Cultural Competency Sub-committee shall establish and implement a cultural competency plan that encourages delivery of services in a culturally competent manner to all WMH clients including those with limited English proficiency and diverse cultural and ethnic backgrounds.

12. CFO's Financial Report

The Chief Financial Officer shall provide a quarterly summary of the centers financial report to the QAPI Committee.

13. Report to the Director

The QAPI Committee shall review program and financial information included in WMH's Monthly Briefing Reports.

Sub-Committees

The Records Compliance and Quality Assurance Sub-Committee shall:

1. Be chaired by the Adult Services Division Director. Committee members shall include but not limited to the Division Director over Child and Family Services, Director of Care Management Services, IS/IT Program Manager, Clinical Records Supervisor, and the Adult Services Division Director's Administrative Assistant.
2. Its purpose shall be to ensure the integration, coordination, and integrity of clinical records, billing services, and the IS/IT database management process to the degree possible. The sub-committee shall review the integrity of electronic record from intake through discharge. Problems and errors resulting from data entry, software upgrades and correlation problems associated with the process of moving from a paper record to an electronic record.
3. The IS/IT department shall bring or email the Attention Lists to the Records Compliance and Quality Assurance Sub-committee where they will be reviewed. These Attention Lists indicate where there are potential problems. The Division Director subcommittee members shall take the Attention Lists to their program managers for assignment and follow through. The IS/IT Department program manager will keep the sub-committee apprised of provider compliance.

   The following are currently monitored through the Attention Lists. The Records Compliance and Quality Assurance Sub-committee will continue to expand its electronic surveillance capabilities.

   a. Completeness of initial assessments
   b. Errors in database entries that hamper billing
   c. Final signatures
   d. Recorded services but no progress note
   e. Completeness of Discharge Summaries
   f. Initial Recovery/Treatment Plans – completion timeliness
   g. Recovery/Treatment Plan Reviews - completion timeliness
   h. Initial Case Management Service Plans/DLA – completion timeliness
   i. Case Management Service Plan/DLA Reviews - completion timeliness

The Grievance System Sub-Committee (GSSC) shall:

1. Consist of the Director of Care Management Services and the Client Services Representative (CSR).
2. Collect, track, monitor, and analyze all documented grievances to determine the existence and implications of possible trends or systemic performance issues associated with access, quality or other related areas
3. Submit grievances to the appropriate program manager for follow through and resolution where possible.
4. Document and submit semi-annual reports of grievances, actions and appeals to the Division of Health Care Financing.
5. Provide a written report of documented grievances, actions and appeals to the QAPI Committee quarterly.

The Research Sub-Committee shall:

1. Consist of the Director of Care Management Services and his/her administrative assistant with other members utilized as needed.
2. Design and implement Performance Improvement Projects utilizing the document entitled Conducting Performance Improvement Projects.
3. Collect and analyze data obtained from the clients initial intake data to determine timely client access to service performance standards with respect to first face-to-face contact requirements.
4. Review and analyze data obtained from client survey instruments at least annually, for overall measures of satisfaction such as service delivery, service response times, service locations, cultural competence, clinician choice, and satisfaction related to service outcomes.

The Peer Review and Record Audit Sub-Committee shall:

1. Consist of the Division Director over Child and Family Services who shall act as Committee Chair (PRCC), and identified committee members selected from therapists, case managers, program managers, and supervisors from both youth and adult service divisions. Medical Director and Medical Services Program Manager shall be responsible for the oversight of medical documentation audits conducted by MD's, APRN's, and Nursing staff. The OPPM shall be responsible for the oversight of outside provider audits.
2. Be licensed or certified mental health providers, or providers practicing under the supervision of a licensed mental health provider.
3. Follow policy and procedures identified in policy C – 3.12 Peer and Electronic Record Review.
4. The PRCC shall maintain written documentation of meetings, findings, and recommendations
5. Provide a written report to the QAPI Committee of his/her committee's activities and findings quarterly.

The Client Court Commitment Review Sub-Committee shall:

1. Be chaired by a master level clinician and designated by the OPPM.
2. Include case managers and Mental Health Providers.
3. Convene monthly to review the necessity of continuing civil court commitments.
4. Follow policy and procedures identified in policy C – 3.12 Peer and Electronic Record Review.
5. The PRCC shall maintain written documentation of meetings and recommendations of the court commitment reviews.
6. Report court commitment updates to the QAPI Committee quarterly.

The Client and Former Client Death Peer-Review Committee shall:

1. Be presided over by Care Management Services Director and his/her designee. The Care Management Services Director and his/her designee shall call the Chair of the Committee who shall be the program manager where the client was receiving, or previous to discharge was receiving their clinical services.
2. Follow policy and procedures identified in policy A – 1.01 Fatality Reporting Review.
3. Where possible, and without incurring additional risk, the Care Management Services Director will provide the QAPI Committee with consolidated information obtained from peer-reviews to assist the Committee in improving WMH's client quality care. Regardless, the Care Management Director will be aware of systemic issues needing to be addressed.

The Cultural Competency Sub-Committee shall:

1. Be Chaired by the Director of Human Resources who shall identify and maintain a team qualified to train staff in cultural diversity.
2. Develop a Cultural Competency Plan that addresses overall systems issues, including the establishment of a cultural competency committee to promote cultural competency, human resource development, including staff recruitment and retention and staff training and clinical issues.
3. Follow policy and procedures identified in policy HR – 2.30 Cultural Competency.
4. Maintain written meeting agendas and minutes.
5. Report cultural competency activities to the QAPI Committee quarterly.

The Emergency Response and Safety Preparedness Sub-Committee shall:

1. Be Chaired by the Risk Manager. Committee members are assigned from each of WMH's departments.
2. Meet quarterly to update and improve WMH's preparedness plan. The Committee shall pay particular attention to issues related to fire, flooding, earthquake, and bomb threats.
3. Provide staff training on the above topics and others.
4. Coordinate with the County disaster planner.
5. Conduct emergency fire drills in all WMH buildings.
6. Oversee employee critical incident debriefings when required.

7. Oversee and coordinates for critical incident debriefings for other community organizations and relief efforts when requested.
8. Maintain written meeting agendas and minutes and report.
9. Report disaster preparedness activities to the QAPI Committee quarterly.
10. Report Emergency Intervention Training activities to the QAPI Committee quarterly.
11. Report Employee Debriefing activities to the QAPI Committee quarterly.

Related policies around quality care:

A -1.01 Fatality Reporting Review

A -1.10 Provider Selection and Retention

C - 3.06 Client Access to Treatment – Performance Standards

C - 3.12 Peer and Electronic Record Review

C - 4.30 Intake, Recovery Planning, Discharge Services…Inhouse Provider.

C - 4.31 Intake, Recovery Planning, Discharge Services…by Outside Provider.

C - 3.08 Medicaid Enrollee Actions and Grievance System.

C - 5.01 Preferred Practice Guidelines

HR - 2.30 Cultural Competency Plan

Right to Change and/or Terminate Policy:

Reasonable efforts shall be made to keep employees informed of any changes in the policy; however, WMH reserves the right, in its sole discretion, to amend, replace, and/or terminate this policy at any time.