



Washington External Quality Review Organization



Greater Columbia Behavioral Health Prepaid Inpatient Health Plan

**External Quality Review
2006**

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Introduction and Scope

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

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

Greater Columbia Behavioral Health (GCBH) is responsible for managing mental health care and services for Medicaid consumers in Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Skamania, Walla Walla, Whitman, and Yakima counties, as well as the Yakama Nation. The PIHP is located in Kennewick, Washington and is governed by a board comprised of a commissioner from each of the member counties, the Director of Yakima County Community Services, and the Deputy Director of the Yakama Nation Department of Human Services. The PIHP Administrator reports to the Board of Directors. GCBH contracts with fourteen (14) community mental health centers and specialty providers to serve approximately 13,000 adult and child consumers annually. Average monthly enrollment in the PIHP is approximately 129,000 Medicaid-eligible individuals. In addition, the PIHP delegates utilization management to a private administrative services organization based in Nevada.

This report covers the period between January 20, 2006 and January 19, 2007 and reflects continuous improvements achieved over the previous two review periods. It should be noted that the PIHP review period has been re-defined to individual annual schedules rather than a universal calendar period.

The 2006 review included:

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

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

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

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

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

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

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

Activity	Timeline	Documents/Content
<i>Planning</i>		
1. Define 2006 review activities and determine date parameters for review year	April-May, 2006	Internal planning and meetings with MHD
2. Develop or revise review tools and procedures for: <ul style="list-style-type: none"> • Quality Assurance and Improvement 	June-August, 2006	

Activity	Timeline	Documents/Content
<ul style="list-style-type: none"> • PIHP Encounter Validation review • Subparts – to reflect 2 MHD/PIHP contracts • Review of 2004 Corrective Actions 		
3. Finalize tools and procedures	August, 2006	Internal and MHD meetings
4. Develop review schedule and communication materials	June-July, 2006	Internal and MHD meetings
5. Draft report template and data display tools	July-Sept., 2006	
6. Finalize report template	October, 2006	Internal and MHD meetings
Pre-Onsite Activities		
1. Send general information letter to all PIHPs	August 1, 2006	Overview of review year and changes in content/process
2. Send documentation request and site visit dates to PIHP	December 19, 2006	Detailed description of review topics, documents needed, instructions for submission, due date, and date of site visit
3. Send Site visit agenda to PIHP	January 5, 2007	Formal agenda/names of network providers to be visited
4. Conduct pre-onsite call with PIHP	January 16, 2007	Review attendees, logistics; confirm addresses/contact information
5. Conduct desk review of submitted materials		
Onsite Activities		
	February 6 and 7, 2007	
1. Interview PIHP staff		
2. Interview network provider staff		
3. Identify and request additional documents		
4. Provide timeline for report production		
Post Onsite Activities		
1. Phone interview with Ombuds	February 12, 2007	
2. Complete initial scoring and results documentation; construct report		
3. Draft report to PIHP	March 2, 2007	
4. Debrief conference call	March 19, 2007	Review results; answer questions; consider scores questioned
5. Final report to PIHP and MHD	March 26,	

Activity	Timeline	Documents/Content
2007		

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

2. Changes in the PIHP Environment

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

For GCBH, significant events include:

- The PIHP has greatly expanded its staffing over the last year (although some positions remain unfilled), affording the organization an opportunity to implement significant process improvements.
- The PIHP has started implementing a culture of “transparency”, bringing “all news to everyone all the time”. This new culture and operational strategy has improved collaboration among the providers and fostered more positive working relationships between the providers and the PIHP.

2006 Review Process Barriers

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

- In the 2005 CMS report, APS identified a system-wide deficiency in the understanding and conduct of Performance Improvement Projects. APS provided technical assistance to some PIHPs; however, training for all PIHPs occurred just before the beginning of the 2006 review year. Therefore, those PIHPs reviewed earlier in the year did not have time to modify their PIPs to conform with CMS protocols prior to their EQR. Many of these PIPs had not progressed since the 2005 review.
- PIHP submitted three "PIPs", none of which meet the CMS definition of a Performance Improvement Project. Documentation provided for each was lacking in one or more significant/required elements, including project summary, data reports, and evidence of process for definition and implementation of the project. The WAEQRO was therefore unable to formally validate any of the projects.
- The PIHP's sample network provider and Behavioral Health Options (BHO) contracts did not contain dated signatures of contracting parties. Thus, the WAEQRO was unable to determine if the contract references were from officially executed contracts. The sample contracts, however, were considered in scoring the Subparts.
- The policies and procedures submitted for review are approved by the Board of Directors; however, they do not contain a place holder for an official approval signature. In addition, approval dates indicate that revised policies have not been approved by the Board of Directors. Consequently, the WAEQRO was unable to determine if all the policies and procedures submitted for review had been officially adopted. They were, however, considered in scoring the subparts.
- PIHP staff did not submit a 2004 Corrective Action Plan update per the WAEQRO Document Submission Request. Therefore, the WAEQRO had limited information regarding the PIHP's accomplishments related to the implementation of their 2004 Corrective Actions Plan.

4. 2006 Review Results

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

A. STATUS OF 2004 CORRECTIVE ACTIONS

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

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
438.100(b) [Q4]	Subcontract requires providers to post client rights in public places in all prevalent languages			
	No evidence was discovered in the policy or the PIHP Provider contract requiring enrollee rights be posted "in all prevalent languages" as per 438.100(b)	Submit a corrective action plan to the MHD by 5/10/05.	Submitted by PIHP 5/09/05.	Relevant policies and procedures include all requirements of this provision. PIHP has attained a score of 4-Substantial Compliance.
438.207 [Q34]	Assurances of Adequate Capacity and Services			
	No documented evidence of Network adequacy and capacity guidelines or standards, and were not able to show evidence of a methodical quality improvement process associated	Submit a corrective action plan to the MHD by 5/10/05.	Submitted by PIHP 5/09/05.	PIHP staff acknowledged they have not established network adequacy guidelines or standards. In addition, staff recognized they have not developed systematic

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
	with access and adequate capacity that is currently being implemented.			strategies and methods of analysis for planning and identification of quality improvements associated with access, capacity, and availability of services on an ongoing basis. PIHP staff have submitted a <u>Sufficiency Strategy Project Proposal</u> to their Governing Board and are awaiting approval. PIHP has attained a score of 2-Partial Compliance .
438.230(b) [Q52] Evaluation of Subcontractor ability to perform delegated functions				
	PIHP's <u>Delegation Standard (Subcontracting)</u> applies primarily to the PIHP subcontracting the provision of mental health services rather than the subcontracting functions of the PIHP such as eligibility checks, determination of medical necessity and resource and utilization	Submit a corrective action plan to the MHD by 5/10/05.	Submitted by PIHP 5/09/05.	Revised <u>Delegation Policy</u> does not include the requirements related to the evaluation of Subcontractor ability to perform delegated functions. Policy includes list of PIHP-delegated activities. PIHP has attained a score of 1-Insufficient Compliance .

CFR/ Q#	Description of Issue	Required Action	Corrective Action Plan (CAP) Submitted to MHD	Outcome of Corrective Action Plan
	management functions. In addition, the standard does not include how it evaluates the subcontractor's ability to perform the activities delegated.			

B. SUBPART REVIEW

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

The Subparts addressed in the reviews included the following:

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

Scoring of the Subparts

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

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

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

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

Accordingly, items not reviewed in 2005 include the following.

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

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

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

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

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

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

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

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

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

Subpart Radar Charts

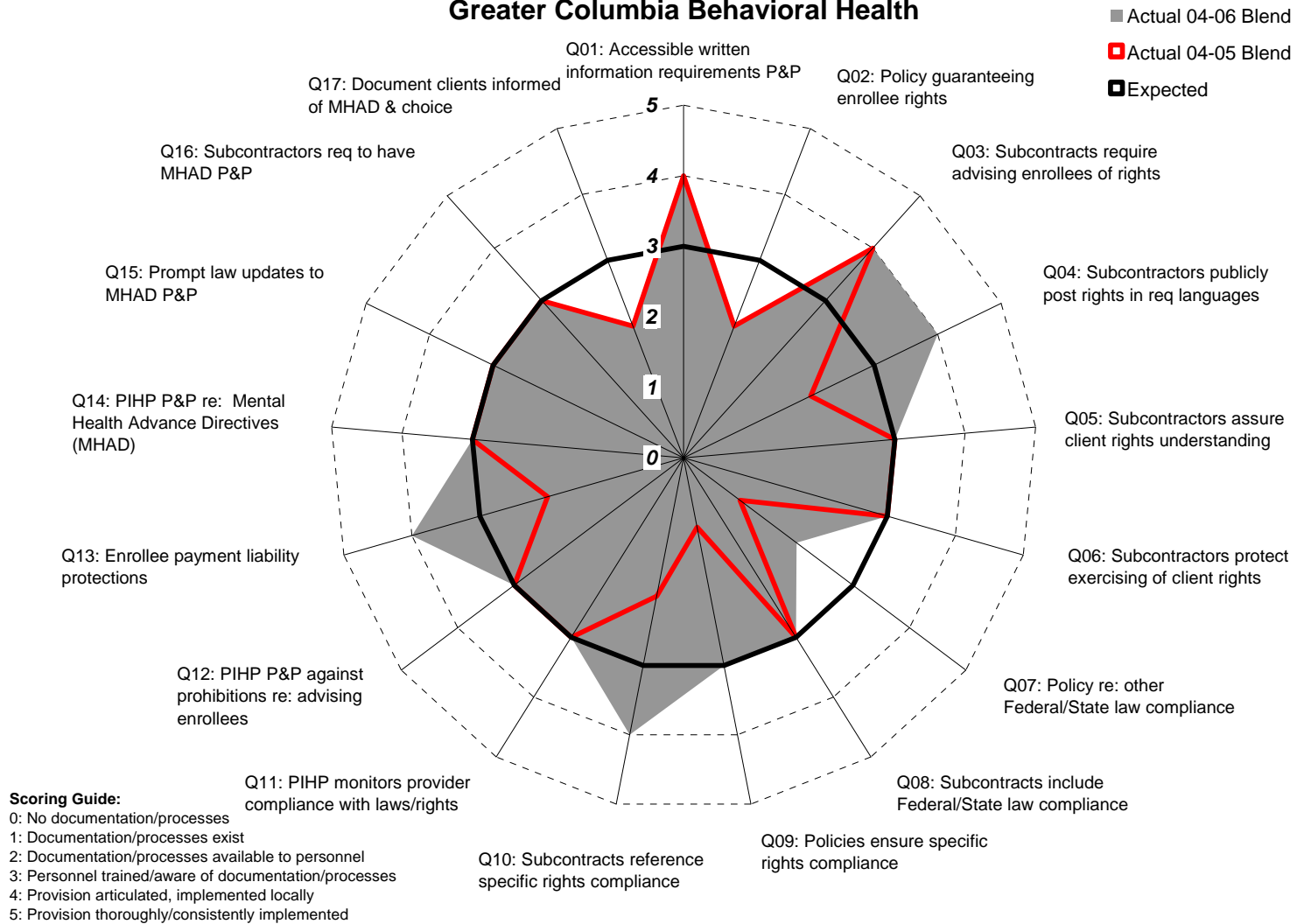
The PIHP is expected to meet independent expectations for each element reviewed. It is not appropriate to average scores across items or Subparts. Given the large number of Subpart elements, it is easier to display these scores graphically with a Radar Chart. Radar charts resemble dartboards. Each spoke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

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

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

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

Subpart C: Enrollee Rights & Protections Greater Columbia Behavioral Health



2004-2006 Subpart Scoring Trend and Detail for Greater Columbia Behavioral Health

Scoring Guide for Subparts C, D and F:

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

Subpart C: Enrollee Rights & Protections	04-05 Score	2006 Score	04-06 Blend
Q01: Accessible written information requirements P&P	4		4
Q02: Policy guaranteeing enrollee rights	2	2	2
Q03: Subcontracts require advising enrollees of rights	4		4
Q04: Subcontractors publicly post rights in req languages	2	4	4
Q05: Subcontractors assure client rights understanding	3		3
Q06: Subcontractors protect exercising of client rights	3		3
Q07: Policy re: other Federal/State law compliance	1	2	2
Q08: Subcontracts include Federal/State law compliance	3		3
Q09: Policies ensure specific rights compliance	1	3	3
Q10: Subcontracts reference specific rights compliance	2	4	4
Q11: PIHP monitors provider compliance with laws/rights	3		3
Q12: PIHP P&P against prohibitions re: advising enrollees	3		3
Q13: Enrollee payment liability protections	2	4	4
Q14: PIHP P&P re: Mental Health Advance Directives (MHAD)	3		3
Q15: Prompt law updates to MHAD P&P	3		3
Q16: Subcontractors req to have MHAD P&P	3		3
Q17: Document clients informed of MHAD & choice	2	2	2

**Greater Columbia Behavioral Health
2006 Subpart Review Results**

Subpart C – Enrollee Rights and Protections

CFR Reference	Compliance Determination Report Subpart C	Score 0-5
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438.100(b)	Specific Enrollee Rights	
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[Q2]

Policy guaranteeing the rights of enrollees

Evidence:

- Enrollee Rights Policy contains all rights listed in this provision with the exception of the enrollee’s right to request and receive a copy of their medical record. Policy only stipulates that an enrollee can review and amend their medical record. In addition, it states that an enrollee has the right to confidentiality and to have their privacy protected; however, only Washington State law is referenced. There is no reference to the privacy rule as set forth in 45 CFR parts 160 and 164. No additional policies related to HIPAA or Personal Health Information were submitted for this review element.
- No completed Clinician Attestations were submitted as referenced in the PIHP Enrollee Rights Policy. Clinician signature acknowledges that consumer has received an explanation and written copies of their rights, and understands their rights, grievance procedures, Advance Directives, and second opinions. Provider management reported that they were not required to use the PIHP Clinician Attestations. Recommend that the PIHP clarify this requirement or modify Enrollee Rights Policy to reflect desired practice and procedures.
- Provider Enrollee Notice of Rights—do not explicitly state whether the enrollee has a right to request and receive a copy of their medical record.
- Consumer Rights Training Schedule and Attendance Rosters—indicate that training occurred for the majority of network providers between 1/06 and 12/06.
- Consumer Rights Training PowerPoint—includes all rights related to this provision.
- Clinical Review Rating Tool and Results (January-June 2006)—shows “evidence consumer has received either a copy of or an explanation of rights and received this information in a language/format this person understands.”
- 05-06 Administrative Audit Results (Scoring by Provider)—reviews provider policies and procedures to ensure that provider staff take enrollee rights into account when furnishing services.
- Score remains the same as 2005 EQR due to insufficient

CFR Reference	Compliance Determination Report <i>Subpart C</i>	Score 0-5
	documentation and evidence to warrant an increase. (Partial Compliance)	2
[Q4]	<p>Subcontract requires providers to post client rights in public places in all prevalent languages</p> <p>Evidence:</p> <ul style="list-style-type: none"> • <u>05-06 PIHP Subcontract and Enrollee Rights Policy</u> include the requirement to post enrollee rights in all prevalent languages, in noticeable public locations and conspicuously marked. • Enrollee rights in required eight (8) languages were observed to be posted in the lobby at both providers. • <u>Consumer Rights Training Schedule and Attendance Rosters</u>—indicate training occurred for the majority of network providers between 1/06 and 12/06. • <u>Consumer Rights Training PowerPoint</u>—includes “Consumer rights must be posted in the prevalent DSHS languages (lists all 8 languages) in a public location within each CMHA.” • Provider direct service staff identified the languages in which the rights were translated, and where the rights are posted in their agencies. • Direct service staff did not consistently know if rights were available in Braille, large print, or on audio tape for visually impaired individuals. • <u>05-06 Administrative Audit Results (Scoring by Provider)</u>—reviews policies and procedures to ensure that enrollee rights are available in prevalent languages and alternate formats for “individuals with visual impairments or limited reading proficiency.” <p>(Substantial Compliance)</p>	4
438.100(d)	Compliance with Other Federal and State law	
[Q7]	<p>Compliance with other Federal and State laws is reflected in policies</p> <p>Evidence:</p> <ul style="list-style-type: none"> • <u>Service Provision Policy</u>—references the nondiscrimination laws related to this provision. • <u>Enrollee Rights Policy</u> and <u>Second Opinion Policy</u> do not include reference to other Federal and State laws, or the non-discrimination laws. • <u>05-06 PIHP Subcontract</u> and <u>06-07 PIHP Subcontract</u> reference compliance with other Federal and State law; specifically, the non-discrimination laws. • <u>Consumer Rights Training PowerPoint</u>—does not include reference relevant non-discrimination law. 	

CFR Reference	Compliance Determination Report Subpart C	Score 0-5
	<ul style="list-style-type: none"> • <u>Clinical Review Rating Tool and Results (January-June 2006—</u> does show evidence of monitoring for implementation of relevant non-discrimination laws. • PIHP staff and provider management reported that provider compliance with non-discrimination and other Federal and State laws is monitored during the PIHP annual provider administrative audits. No documentation of monitoring and results was submitted. <p>(Partial Compliance)</p>	2
[Q9]	<p>PIHP policies assure compliance with right to a 2nd opinion, client participation in treatment, and access to clinical records Evidence:</p> <ul style="list-style-type: none"> • <u>Enrollee Rights Policy</u> lists client rights to a second opinion, access to clinical records, and participation in decisions about their treatment. Did not include procedures related to providers' response and execution of these rights. • <u>Second Opinions Policy</u> includes procedures related to required timeframes, access within and outside of provider network, description of second opinion assessment and how it should be used, review with consumer, and monitoring of second opinions. • <u>05-06 PIHP Subcontract</u> and <u>06-07 PIHP Subcontract</u> contain references to the 3 client rights listed in this provision. • <u>Consumer Rights Training Schedule and Attendance Rosters—</u> indicate training occurred for the majority of network providers between 1/06 and 12/06. • <u>Consumer Rights Training PowerPoint—</u>includes all rights related to this provision. Training did not appear to include detailed procedures related to the 3 rights. • <u>Clinical Review Rating Tool and Results (January-June 2006—</u> shows “evidence consumer has received either a copy of or an explanation of rights and received this information in a language/format this person understands.” However, neither this statement, nor the tool reviews for provider compliance with the 3 rights. • <u>05-06 Administrative Audit Results (Scoring by Provider)—</u> reviews provider policies and procedures related to client rights to a second opinion, access to their clinical record, and participation in decisions about their treatment. • Network provider management reported that the PIHP reviews client access to a second opinion and participation in treatment decisions via regular chart reviews and by ensuring that the provider has relevant policies and procedures. • Inconsistent reports from provider management related to whether the PIHP has specifically monitored for compliance with 	

CFR Reference	Compliance Determination Report Subpart C	Score 0-5
	<p>client access to their clinical record and relevant provider processes.</p> <ul style="list-style-type: none"> • Direct service staff are able to articulate <u>basic</u> understanding of procedures related to access to a second opinion, and client involvement in treatment decisions. Reported they would contact staff responsible for medical records if client requested access to their clinical record. • Recommend that the PIHP develop, and incorporate into policy, procedures related to execution of client access to clinical record, and client participation in treatment decisions. <p>(Moderate Compliance)</p>	3

[Q10]

Subcontracts require compliance with a client’s right to a second opinion, involvement in their mental health treatment, and access to clinical records

Evidence:

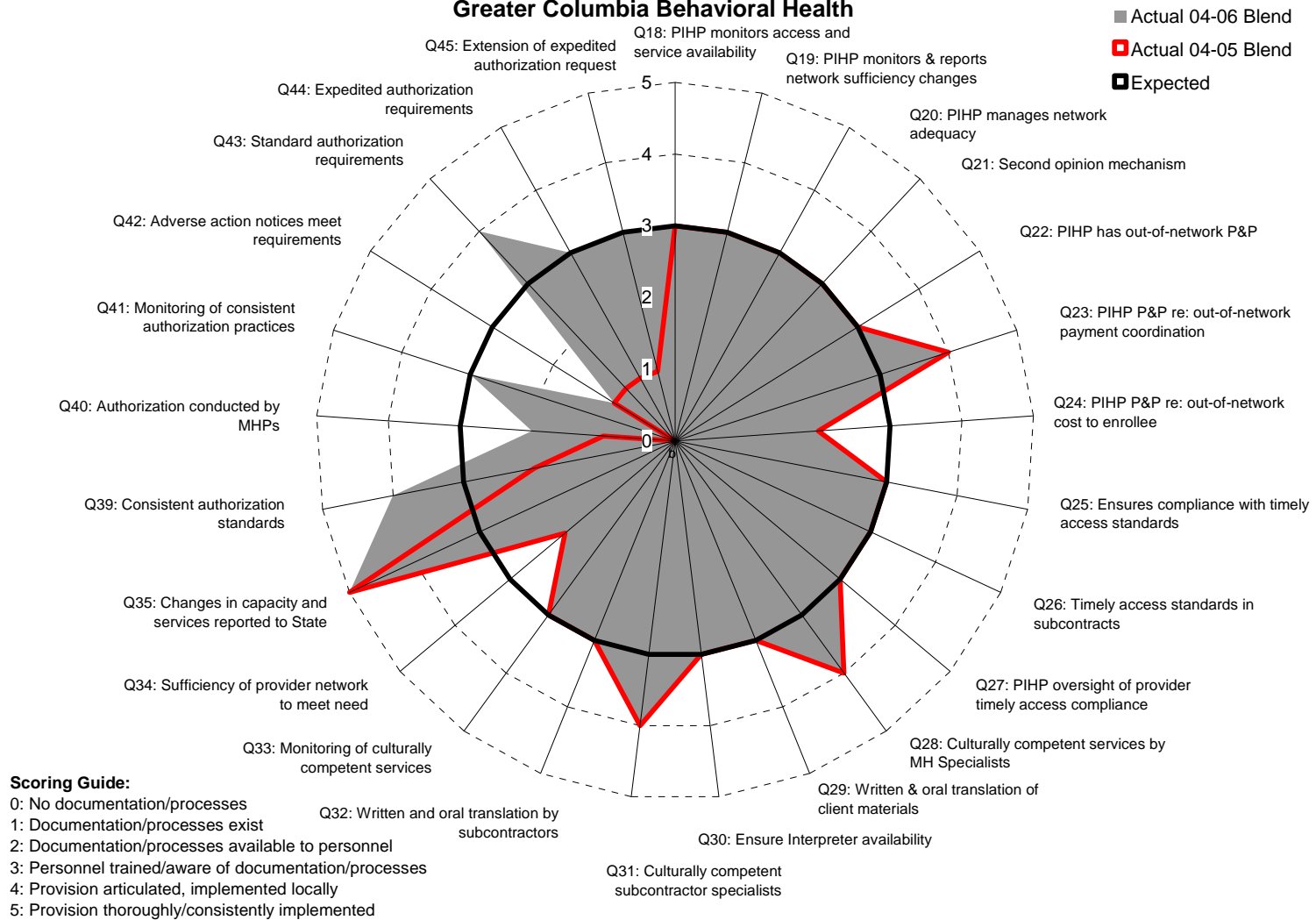
- 05-06 PIHP Subcontract and 06-07 PIHP Subcontract contain references to ensure provider compliance with a client’s right to a second opinion, involvement in their mental health treatment, and access to clinical records.
- Consumer Rights Training Schedule and Attendance Rosters—indicate that training occurred for the majority of network providers between 1/06 and 12/06.
- Consumer Rights Training PowerPoint—includes all rights related to this provision. Training did not appear to include detailed procedures related to the 3 rights.
- Clinical Review Rating Tool and Results (January-June 2006)—shows “evidence consumer has received either a copy of or an explanation of rights and received this information in a language/format this person understands.” However, neither this statement, nor the tool reviews for provider compliance with the 3 rights.
- 05-06 Administrative Audit Results (Scoring by Provider)—reviews provider policies and procedures related to client rights to a second opinion, access to their clinical record, and participation in decisions about their treatment.
- Network provider management reported that the PIHP reviews client access to a second opinion and participation in treatment decisions via regular chart reviews and by ensuring that the provider has relevant policies and procedures.
- Inconsistent reports from provider management related to whether the PIHP has specifically monitored for compliance with client access to their clinical record and relevant provider processes.
- Direct service staff are able to articulate basic understanding of

CFR Reference	Compliance Determination Report Subpart C	Score 0-5
	<p>procedures related to access to a second opinion, and client involvement in treatment decisions. Reported that they would contact staff responsible for medical records if client requested access to the clinical record.</p> <p>(Substantial Compliance)</p>	4
438.106	Liability for Payment	
[Q13]	<p>Subcontracts ensure enrollee payment liability protections</p> <p>Evidence:</p> <ul style="list-style-type: none"> • <u>05-06 PIHP Subcontract</u> and <u>06-07 PIHP Subcontract</u> includes relevant language meeting the requirements of this provision. • Revised <u>Addressing Enrollee Needs in the Event of Community Hospital Insolvency Policy</u> protects Medicaid enrollees from liability for payment in all required circumstances outlined in this provision. • <u>Inpatient Balance Billing Resolution</u>—demonstrates efforts made by the PIHP to ensure that a parent is not wrongly charged for inpatient and physician services. • <u>05-06 Administrative Audit Results (Scoring by Provider)</u>—reviews provider policies and procedures to ensure that requirements of this provision are included. • Provider management reported that the PIHP monitors to ensure Medicaid enrollees are not held liable for payment during their annual administrative audit. No documentation was submitted showing evidence of this monitoring mechanism. <p>(Substantial Compliance)</p>	4
438.10(g) 438.6(l)	Advance Directives	
[Q17]	<p>Client informed in writing of Mental Health Advance Directives, and choice is documented</p> <p>Evidence:</p> <ul style="list-style-type: none"> • Revised <u>Advance Directive Standard</u> policy and procedures contain requirements. • Blank sample copy of Consumer Advance Directive Attestation acknowledges client receipt of WA State Advance Directive information, understanding of information provided, opportunity to ask questions, and choice of whether to initiate Advance Directive. • <u>Consumer Rights Training Schedule and Attendance Rosters</u>—indicate that training occurred for the majority of network providers between 1/06 and 12/06. • <u>Consumer Rights Training PowerPoint</u>—Includes training 	

CFR Reference	Compliance Determination Report <i>Subpart C</i>	Score 0-5
	<p>related to the purpose and benefits of an Advance Directive. The training did not appear to address specific requirements related to this provision.</p> <ul style="list-style-type: none"> • Network provider management reported that the <u>Consumer Advance Directive Attestation</u> forms are not used. One provider was not familiar with the form; the other stated that the form was optional. • Each provider agency has their own unique method of documentation. Forms used at intake indicate Advance Directive information is provided to consumers; however, the forms do not reflect consumer choice related to pursuing an Advance Directive or not. • Provider direct service staff reported that they are required to document their provision of Advance Directive information to the client and whether the client already has an Advance Directive. In addition, staff stated that the client’s crisis plan should mimic what is in the Advance Directive. Direct service staff did not consistently confirm that they are required to document consumer choice as to whether client wants to execute an Advance Directive. • <u>Clinical Review Rating Tool and Results (January-June 2006)</u>— shows “The chart contains documentary evidence that the person received an explanation of, and opportunity to establish, an Advance Directive.” • <u>05-06 Administrative Audit Results (Scoring by Provider)</u>— reviews to ensure all Advance Directive requirements are included in provider policies and procedures. • Recommend that the PIHP standardize the method for documenting the provision of Advance Directive information and enrollee choice for the provider network. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. <p>(Partial Compliance)</p>	<p>2</p>

Subpart D (Part 1): Access Standards

Greater Columbia Behavioral Health



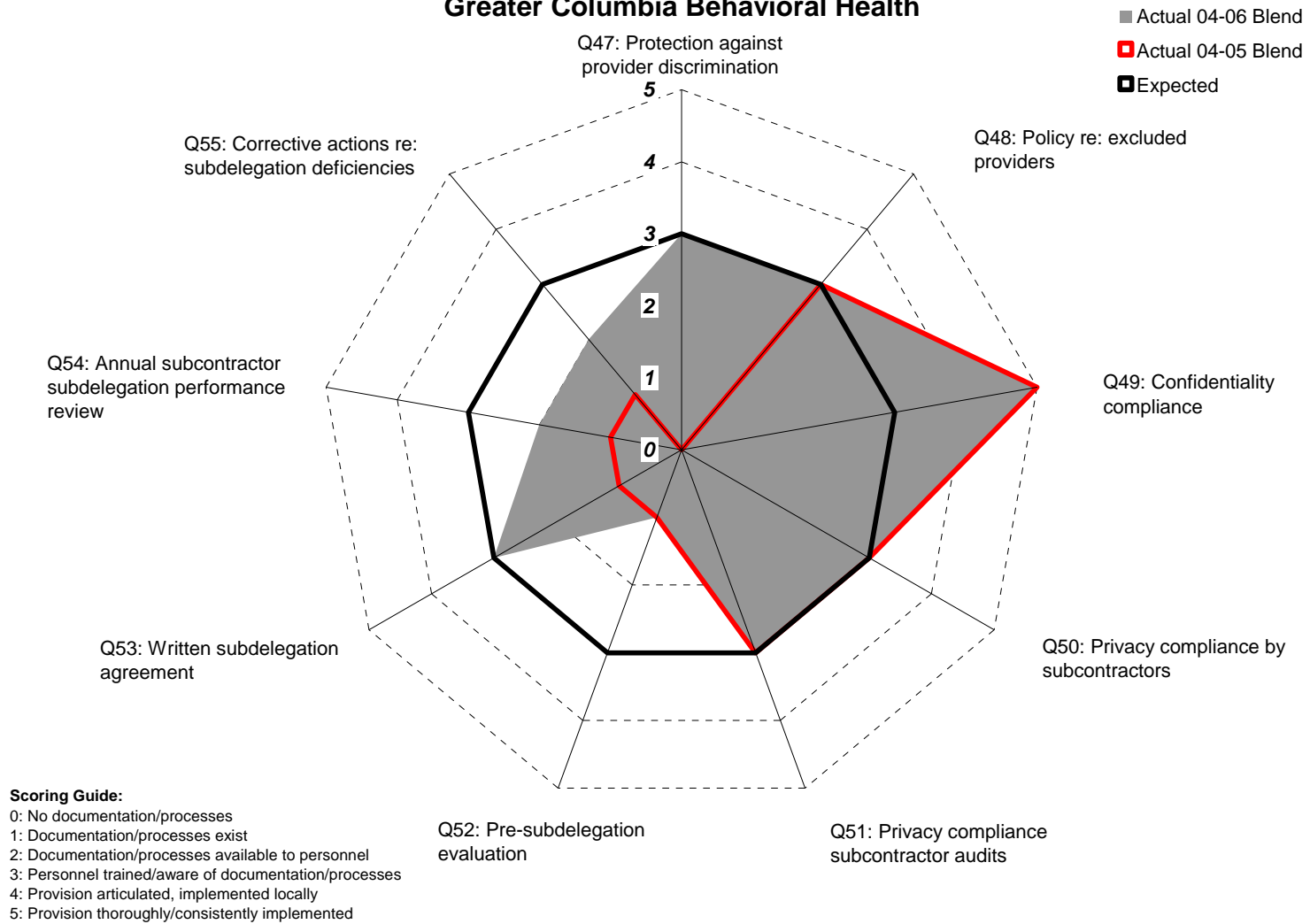
2004-2006 Subpart Scoring Trend and Detail for Greater Columbia Behavioral Health

Scoring Guide for Subparts C, D and F:

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

Subpart D (Part 1): Access Standards	04-05 Score	2006 Score	04-06 Blend
Q18: PIHP monitors access and service availability	3		3
Q19: PIHP monitors & reports network sufficiency changes	3		3
Q20: PIHP manages network adequacy	3		3
Q21: Second opinion mechanism	3		3
Q22: PIHP has out-of-network P&P	3		3
Q23: PIHP P&P re: out-of-network payment coordination	4		4
Q24: PIHP P&P re: out-of-network cost to enrollee	2	2	2
Q25: Ensures compliance with timely access standards	3		3
Q26: Timely access standards in subcontracts	3		3
Q27: PIHP oversight of provider timely access compliance	3		3
Q28: Culturally competent services by MH Specialists	4		4
Q29: Written & oral translation of client materials	3		3
Q30: Ensure Interpreter availability	3		3
Q31: Culturally competent subcontractor specialists	4		4
Q32: Written and oral translation by subcontractors	3		3
Q33: Monitoring of culturally competent services	3		3
Q34: Sufficiency of provider network to meet need	2	2	2
Q35: Changes in capacity and services reported to State	5		5
Q39: Consistent authorization standards	2	4	4
Q40: Authorization conducted by MHPs	1	2	2
Q41: Monitoring of consistent authorization practices	0	3	3
Q42: Adverse action notices meet requirements	1	1	1
Q43: Standard authorization requirements	1	4	4
Q44: Expedited authorization requirements	1	3	3
Q45: Extension of expedited authorization request	1	3	3

Subpart D (Part 2): Structure and Operation Standards
Greater Columbia Behavioral Health



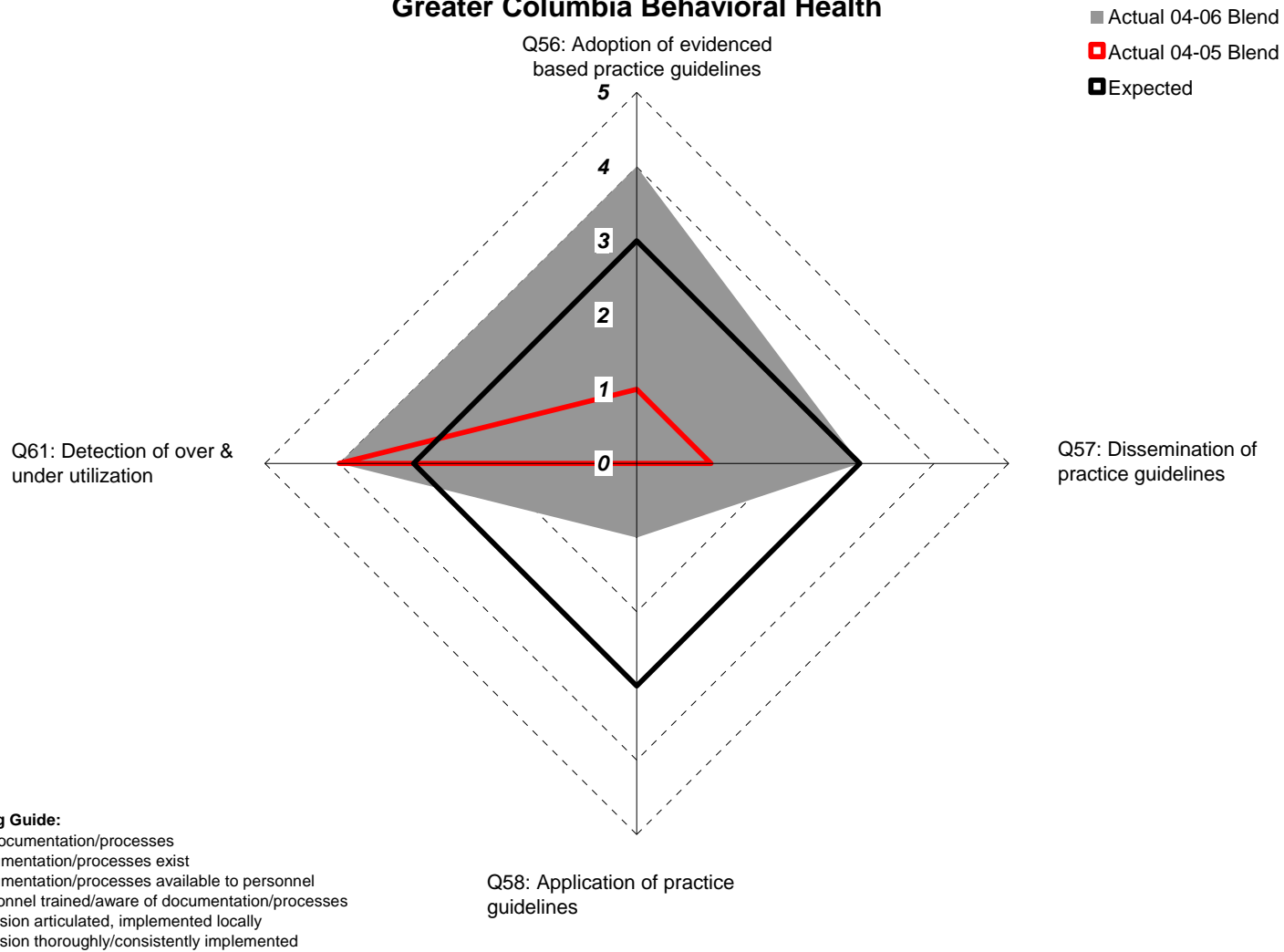
2004-2006 Subpart Scoring Trend and Detail for Greater Columbia Behavioral Health

Scoring Guide for Subparts C, D and F:

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

Subpart D (Part 2): Structure and Operation Standards	04-05 Score	2006 Score	04-06 Blend
Q47: Protection against provider discrimination	0	3	3
Q48: Policy re: excluded providers	3		3
Q49: Confidentiality compliance	5		5
Q50: Privacy compliance by subcontractors	3		3
Q51: Privacy compliance subcontractor audits	3		3
Q52: Pre-subdelegation evaluation	1	1	1
Q53: Written subdelegation agreement	1	3	3
Q54: Annual subcontractor subdelegation performance review	1	2	2
Q55: Corrective actions re: subdelegation deficiencies	1	2	2

Subpart D (Part 3): Measurement and Improvement Standards
Greater Columbia Behavioral Health



**2004-2006 Subpart Scoring Trend and Detail for
Greater Columbia Behavioral Health**

Scoring Guide for Subparts C, D and F:

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

Subpart D (Part 3): Measurement and Improvement Standards	04-05 Score	2006 Score	04-06 Blend
Q56: Adoption of evidenced based practice guidelines	1	4	4
Q57: Dissemination of practice guidelines	1	3	3
Q58: Application of practice guidelines	0	1	1
Q61: Detection of over & under utilization	4		4

Subpart D – Quality Assessment and Performance Improvement

CFR Reference	Compliance Determination Report <i>Subpart D</i>	Score 0-5
438.206 (b)(5)	Delivery Network-Out of Network Providers Coordination with PIHP with Respect to Payment	
[Q24]	<p>Cost of out-of-network provider is no greater for enrollee than services furnished within network</p> <p>Evidence:</p> <ul style="list-style-type: none"> • <u>Out of Network Referrals Policy</u> includes the provision requirements with respect to payment and coordination of care. • <u>Counseling Services Agreement</u> and related invoices with Carol Conrad, MS, LMHC (Out-of-Network Provider). • <u>Inpatient Balance Billing Resolution</u>—demonstrates efforts made by the PIHP to ensure a parent is not wrongly charged for in-network and out-of-network inpatient and physician services. • <u>Inpatient Hospital Billings Spreadsheet</u> showing 12% or \$510,000 was spent on inpatient services at hospitals outside the PIHP during FY05. Evidence of payments to additional out-of-network providers such as Columbia River Mental Health and Clark County included. • PIHP staff and provider management reported that it is the responsibility of the network providers to coordinate care and payment for out-of-network services. Reviewer noted this as a discrepancy, in that the <u>Out of Network Referrals Policy</u>, <u>Counseling Services Agreement</u>, and payment documentation show evidence of the PIHP coordinating care and paying for out-of-network services. • Reporting and tracking mechanisms outlined in the <u>Out of Network Referrals Policy</u> are limited, and are inconsistently employed. • No evidence was submitted with respect to training related to this review element. • Recommend that the PIHP clarify coordination of care and payment responsibilities in policy and trainings. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. <p>(Partial Compliance)</p>	2
438.207	Assurances of Adequate Capacity and Services	
[Q34]	Sufficient number, mix and geographic distribution of Network Providers to meet anticipated need	

CFR Reference	Compliance Determination Report <i>Subpart D</i>	Score 0-5
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Evidence:

- Network Sufficiency and Accessibility Standard Policy, Quality Management Policy, and Utilization Management Policy collectively contain the requirements that meet this provision.
- Sufficiency Strategy Project Proposal (Clegg & Associates-February 2007-June 2007)—“To develop a Sufficiency Strategy that will guide Greater Columbia Behavioral Health’s efforts to serve a broader range of adults with serious mental illness in community-based settings and thereby reduce the utilization of Eastern State Hospital. By achieving inpatient utilization reductions at a prescribed level, the Network can increase the level of state resources it receives for community-based services and continue to build the sufficiency of these services across the system.” 2006 PIHP Board Meeting Minutes provide evidence of several months of related discussions relative to this project proposal with no resolution as of this review.
- PIHP Services Analysis Table and December 2006 Agency Services Grid—lists PIHP services by network provider, and differentiates Eastern, Central, and Western provider networks.
- Inpatient Savings Reallocation Plan and related correspondence—purpose is to use funding to improve overall care and coordination of mental health services in Benton-Franklin Counties. Inpatient savings to be used for Crisis Stabilization Beds, Flexible Funding, Detox Diversion Project, and Improve Systems for Diversion Capacity.
- Access to Intake Timeline Analysis—indicates percentages per network provider of intakes offered and provided within 14 days of request for service.
- Additional Documents Submitted:
 - August and November 2006 Clinical Directors Meeting Minutes—nothing relevant to Network Sufficiency noted.
 - Executive Committee Meeting Minutes for 2006—References to the Sufficiency Strategy Project Proposal and need for the PIHP to develop a process to establish and monitor network sufficiency.
 - November and December 2006 and January 2007 Utilization Management Committee Meeting Minutes for 2006—nothing relevant to Network Sufficiency noted.
 - Out-of Network Referrals Policy
 - PACT Adhoc Memo of November 17, 2006 and PACT Adhoc Recommendation Memo of January 2, 2007
 - November 2005 Geo Mapping—completed prior to 2005 EQRO.
 - BHO Annual Executive Summary

CFR Reference	Compliance Determination Report <i>Subpart D</i>	Score 0-5
	<ul style="list-style-type: none"> ○ Inpatient Fiscal Report. • No evidence of training related to this review element. • PIHP staff acknowledged that they have not established network adequacy guidelines or standards. In addition, staff recognized that they have not developed systematic strategies and methods of analysis for planning and identification of quality improvements associated with access, capacity, and availability of services on an ongoing basis. • Recommend that the PIHP move forward with the <u>Sufficiency Strategy Project Proposal</u>. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. <p>(Partial Compliance)</p>	2

438.210(b)	Authorization of Services
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[Q39]

Authorization is consistent with Access to Care Standards and takes place in consultation with requesting provider

Evidence:

- Level of Care and Authorization Criteria Policy contains requirements to ensure that authorization is consistent with Access to Care Standards.
- PIHP delegates authorization and utilization management (UM) to Behavioral Health Options (BHO) of Nevada. Undated Sample of BHO Subcontract Amendment 01 states, "The Delegate shall ensure authorization is consistent with GCBH's Access to Care Standards and takes place in consultation with requesting provider."
- BHO Inter-Rater Reliability Report—a sample of 3 clinical vignettes was presented to 3 UM Specialists performing pre-service and concurrent reviews. A threshold of 90% compliance was established as evidence of consistent decision-making. Individual scores were 87%, 93%, 93%. One UM Specialist failed to meet the 90% compliance threshold. Results indicated opportunities for improvement in applying continued-stay criteria. "The one (1) UM Specialist who failed to meet the threshold received individualized training, and follow-up auditing will be implemented to measure ongoing compliance of criteria use."
- No training documentation related to this review element was submitted; however, network provider management reported that relevant training has been provided periodically by the PIHP and BHO. In addition, relevant agency training occurs internally through a variety of venues.
- Network provider staff have knowledge of the Access to Care Standards and how they are employed with regard to

CFR Reference	Compliance Determination Report <i>Subpart D</i>	Score 0-5
	authorization of services. (Substantial Compliance)	4
[Q40]	<p>Authorization decisions are made by Mental Health Professionals with appropriate clinical expertise Evidence:</p> <ul style="list-style-type: none"> • PIHP delegates authorization and utilization management (UM) to Behavioral Health Options (BHO) of Nevada. <u>BHO Subcontract</u> states, “Delegate shall provide RSN with documentation to confirm use of staff (that will accomplish the U/CM activities) that are properly qualified, trained and supervised. Health professionals will maintain necessary current and valid licenses and certificates.” Undated <u>Sample of BHO Subcontract Amendment 01</u> states, “The Delegate shall ensure that authorization decisions are made by Mental Health Professionals with appropriate clinical expertise.” • <u>Clinical Review Rating Tool and Results (January-June 2006—</u> reviews for evidence that “There is a complete assessment in the clinical record, conducted by a Mental Health Professional.” • No relevant policy and procedures were submitted for review. • No copies of authorizations, job descriptions, or credentials of professionals performing authorizations were submitted for review; unable to verify credentials of individuals authorizing services, and whether MHP requirement is practiced. • Recommend update of policies and procedures to consistently and accurately reflect positions responsible for conducting authorizations and denials of service, and their required qualifications. <p>(Partial Compliance)</p>	2
[Q41]	<p>PIHP audits subcontractors for consistent authorization practices and evidence of policy Evidence:</p> <ul style="list-style-type: none"> • <u>Undated Completed BHO Audit Tool</u> (no names of reviewers or participants) monitors BHO UM Plan and policies and procedures for: <ul style="list-style-type: none"> ○ “Delegate will manage, as authorized by the RSN, prior authorization related to case management activities, including that for Extended Care Benefits (ECBs). ○ Delegate will manage, as authorized by the RSN, Case Management: assessment and re-assessment, care planning and implementation, collaboration with the company in authorizations required for discharge and transfer needs. ○ Delegate shall perform its obligations under the terms and provisions of this Agreement in accordance with the 	

CFR Reference	Compliance Determination Report <i>Subpart D</i>	Score 0-5
	<p>following timeframes based upon presence of membership admitted to the Delegate's facility. The RSN timeframes for UM/Case management decisions are: 1) Approval/Denial of non-urgent pre-service decisions - 72 hours; 2) Approval/Denial of urgent pre-service decisions - 72 hours from date of request; 3) Approval/Denial of urgent concurrent pre-service decisions inpatient, intensive, outpatient, residential, behavioral health care, ongoing ambulatory care - certification serves as authorization and is completed in 12 hours, authorization number provided next business day; 4) Physician reviews of denials - within 24 hours; and 5) Notices of action - sent at time of decision.”</p> <ul style="list-style-type: none"> • <u>Undated Completed BHO Audit Tool</u> does not show evidence of PIHP monitoring BHO's performance related to the standards listed above. Purpose of audit appeared to be to ensure standards were incorporated into BHO's UM Plan and related policies and procedures. Recommend that future reviews focus on BHO's performance relevant to the PIHP's requirements, standards, and expected outcomes. • <u>BHO Inter-Rater Reliability Report</u>—a sample of 3 clinical vignettes were presented to 3 UM Specialists performing pre-service and concurrent reviews. A threshold of 90% compliance was established as evidence of consistent decision-making. Individual scores were 87%, 93%, 93%. One UM Specialist failed to meet the 90% compliance threshold. Results indicated opportunities for improvement in applying continued-stay criteria. “The one (1) UM Specialist who failed to meet the threshold received individualized training, and follow-up auditing will be implemented to measure ongoing compliance of criteria use.” • No copies of authorizations or relevant clinical record review reports were submitted for review of this element. <p>(Moderate Compliance)</p>	3

438.210(c)	Notice of Adverse Action
[Q42]	<p>Ensure that Notice of Adverse Actions meet all requirements Evidence:</p> <ul style="list-style-type: none"> • <u>Notice Requirements (Notice of Action) Policy</u> incorporates the Notice of Action (NOA) requirements with the exception of the following timeframe related to the mailing of the NOA: 438.404(c)(2) for denial of payment, at the time of any action affecting the claim. • <u>BHO Subcontract</u>—PIHP delegates authorization and utilization management (UM) and responsibility for sending

CFR Reference	Compliance Determination Report <i>Subpart D</i>	Score 0-5
	<p>Notice of Actions to Behavioral Health Options (BHO) of Nevada. Subcontract specifies that BHO will make “adverse determinations and will deliver notice of adverse determinations.”</p> <ul style="list-style-type: none"> • Undated <u>Sample of BHO Subcontract Amendment 01</u> states: <ul style="list-style-type: none"> ○ “The Delegate shall ensure that Notice of Adverse Actions (NOA) meets all State requirements. ○ Any changes to the NOA shall be made upon GCBH’s approval. ○ The Delegate must establish a procedure to track denials of medical necessity and institute NOA’s to protect enrollee rights and allow them an opportunity to exercise their right to appeal.” • <u>The BHO Utilization Management Plan</u> incorporates the required NOA content and indicates that notices are provided in writing to enrollees, and orally to providers. • Upon review of two copies of NOAs, reviewer unable to determine if the required timeframes were followed due to lack of dates for service junctures. In addition, no denial and/or NOA tracking logs detailing timeframes from request of service forward were submitted for review. • <u>Consumer Rights Training Schedule and Attendance Rosters</u>—indicate that training occurred for the majority of network providers between 1/06 and 12/06. • <u>Consumer Rights Training PowerPoint</u>—includes Timing of Notice requirements as specified in 438.404. • Providers receive notification of denials, reductions, suspensions, or terminations as part of the authorization/denial notification process. Provider management and direct service staff are familiar with NOAs and are able to articulate their basic purpose. Provider staff had differing reports as to whether the provider receives copy of NOA or are verbally informed. • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. <p>(Insufficient Compliance)</p>	1

438.210(d)	Timeframe for decisions
[Q43]	<p>Procedures for standard authorization decisions Evidence:</p> <ul style="list-style-type: none"> • Revised <u>Service Authorizations, Expedited Service Authorizations and Extension of Authorizations for Ongoing Outpatient Services Policy</u> contain procedures for standard authorization decisions. • Undated <u>Sample of BHO Subcontract Amendment 01</u> states:

CFR Reference	Compliance Determination Report <i>Subpart D</i>	Score 0-5
	<p>“The Delegate shall maintain policies and/or procedures for standard authorization decisions, expedited authorization decisions and extensions of expedited authorization requests.”</p> <ul style="list-style-type: none"> • <u>Consumer Rights Training Schedule and Attendance Rosters</u>—indicate that training occurred for the majority of network providers between 1/06 and 12/06. • <u>Consumer Rights Training PowerPoint</u>—includes requirements related to standard authorizations and extensions. • Provider management and direct service staff reported that ongoing training for authorization practices occurs in team meetings. All interviewed staff were knowledgeable and able to articulate the standard authorization practices and procedures. <p>(Substantial Compliance)</p>	4
[Q44]	<p>Procedures for expedited authorization decisions Evidence:</p> <ul style="list-style-type: none"> • Revised <u>Service Authorizations, Expedited Service Authorizations and Extension of Authorizations for Ongoing Outpatient Services Policy</u> contain procedures for expedited authorization requests. • Undated <u>Sample of BHO Subcontract Amendment 01</u> states: “The Delegate shall maintain policies and/or procedures for standard authorization decisions, expedited authorization decisions and extensions of expedited authorization requests.” • <u>Consumer Rights Training Schedule and Attendance Rosters</u>—indicate that training occurred for the majority of network providers between 1/06 and 12/06. • <u>Consumer Rights Training PowerPoint</u>—includes requirements related to expedited authorizations and extensions. • Provider direct service staff were inconsistent in accurately articulating the general purpose of an expedited authorization. <p>(Moderate Compliance)</p>	3
[Q45]	<p>Extension of expedited authorization request Evidence:</p> <ul style="list-style-type: none"> • Revised <u>Service Authorizations, Expedited Service Authorizations and Extension of Authorizations for Ongoing Outpatient Services Policy</u> contain procedures for extensions of expedited authorization requests. • Undated <u>Sample of BHO Subcontract Amendment 01</u> states: “The Delegate shall maintain policies and/or procedures for standard authorization decisions, expedited authorization decisions and extensions of expedited authorization requests.” • <u>Consumer Rights Training Schedule and Attendance Rosters</u>—indicate that training occurred for the majority of network providers between 1/06 and 12/06. 	

CFR Reference	Compliance Determination Report Subpart D	Score 0-5
	<ul style="list-style-type: none"> • <u>Consumer Rights Training PowerPoint</u>—includes requirements related to expedited authorizations and extensions. • Provider direct service staff were unable to consistently articulate the purpose of expedited authorization extensions. (Moderate Compliance) 	3
438.214(c)	Nondiscrimination	
[Q47]	<p>Protection against provider discrimination Evidence:</p> <ul style="list-style-type: none"> • New <u>Policy Provider Network Selection and Retention Policy</u> contains requirements related to protections against provider discrimination. • <u>05-06 PIHP Subcontract</u> and <u>06-07 PIHP Subcontract</u> incorporate includes requirements of this provision. • <u>05-06 Administrative Audit Results (Scoring by Provider)</u>—reviews to ensure that “Nondiscrimination. Contractor provider selection policies & procedures must not discriminate for the participation, reimbursement or indemnification of any provider who is acting within scope of his/her license or certification under applicable State Law, solely on the basis of that license or certification. If Contractor declines to include groups of providers in its network, it must give the affected providers written notice of the reason for its decision. All contracts with CMHAs must comply with 42 CFR 438.214.” • Provider network management reported that they have not experienced discrimination by PIHP. 	3
	(Moderate Compliance)	3
438.230(b)	Sub-contractual Relationships and Delegation-Specific Conditions	
[Q52]	<p>Evaluation of Subcontractor ability to perform delegated functions Evidence:</p> <ul style="list-style-type: none"> • Revised <u>Delegation Policy</u> does not include the requirements related to the evaluation of Subcontractor ability to perform delegated functions. Policy includes list of PIHP-delegated activities. • <u>BHO Pre-Delegation Audit</u> conducted by G. Lippman, MD 7/04/05-7/05/05. Conclusion: “This audit was performed by Greater Columbia RSN in preparation to delegation of UM activities to Behavioral Health Options. Behavioral Health Options was found to be in significant compliance with the UM standards. Needs to include formalization of time frames, reliability processes.” 	

CFR Reference	Compliance Determination Report <i>Subpart D</i>	Score 0-5
	<ul style="list-style-type: none"> • <u>Ombuds RFQ, Benton-Franklin Dispute Resolution Center's Response, and Comparison of Responses to RFP.</u> • Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Insufficient Compliance) 	1
[Q53]	<p>Written delegation agreement that specifies delegated functions, activities, and responsibilities</p> <p>Evidence:</p> <ul style="list-style-type: none"> • Revised <u>Delegation Policy</u> does not include the requirements related to the evaluation of Subcontractor ability to perform delegated functions. Policy includes list of PIHP-delegated activities. • <u>BHO Subcontract</u>—PIHP delegates authorization and utilization management (UM) to Behavioral Health Options (BHO) of Nevada. Subcontract specifies the activities and responsibilities delegated to BHO and provides for revoking delegation. Subcontract does not specify other sanctions if the subcontractor's performance is inadequate. • <u>05-06 Ombuds Contract</u> and <u>06-07 Ombuds Contract</u>—Contract stipulates Ombuds activities and responsibilities, and provides for revoking delegation. Contract does not specify other sanctions if the subcontractor's performance is inadequate. • Recommend that PIHP delegation subcontracts explicitly outline potential sanctions related to sub-standard performance (in addition to termination). <p>(Moderate Compliance)</p>	3
[Q54]	<p>Annually monitor subcontractor performance related to delegated functions</p> <p>Evidence:</p> <ul style="list-style-type: none"> • <u>GCBH Contract Audits Policy</u> states, "This policy applies to GCBH Member Governments and subcontractors for monitoring of delegated responsibilities from Greater Columbia Behavioral Health... Audits will be performed according to a GCBH Board approved annual audit plan. Audits will be performed to assess compliance with contractual requirements." Policy includes an effective audit process tree/flowchart. • <u>Undated Completed BHO Audit Tool</u> (no names of reviewers or participants)—desk review of BHO QI and UM Plan, contract, and policies and procedures. Purpose of audit appeared to be to ensure that standards were incorporated into BHO's UM Plan and related policies and procedures. Reviewer unable to determine if performance of BHO was reviewed and whether 	

CFR Reference	Compliance Determination Report <i>Subpart D</i>	Score 0-5
	<p>quality improvements and/or corrective actions were issued. Recommend that future reviews focus on BHO's performance relevant to the PIHP's requirements, standards, and expected outcomes.</p> <ul style="list-style-type: none"> • <u>BHO Final Administrative Audit Report</u>—Indicates that an audit was conducted onsite at BHO in Las Vegas, Nevada, April 17, 2007, by Mary Todd-PIHP Contracts Manager, with participation from the BHO Utilization Management Manager. Report Summary identifies opportunities for improvement/recommendation related to BHO's QI and UM Plan. As indicated earlier, report does not include opportunities for improvement related to BHO's performance. • No review of Ombuds performance was submitted. • Recommend that the PIHP delineate review standards for each of the delegated functions. Stipulate in each delegation subcontract the frequency and manner by which delegates will be reviewed. <p>(Moderate Compliance)</p>	3

[Q55]

Identification of subcontractor deficiencies and corrective action associated with delegated functions

Evidence:

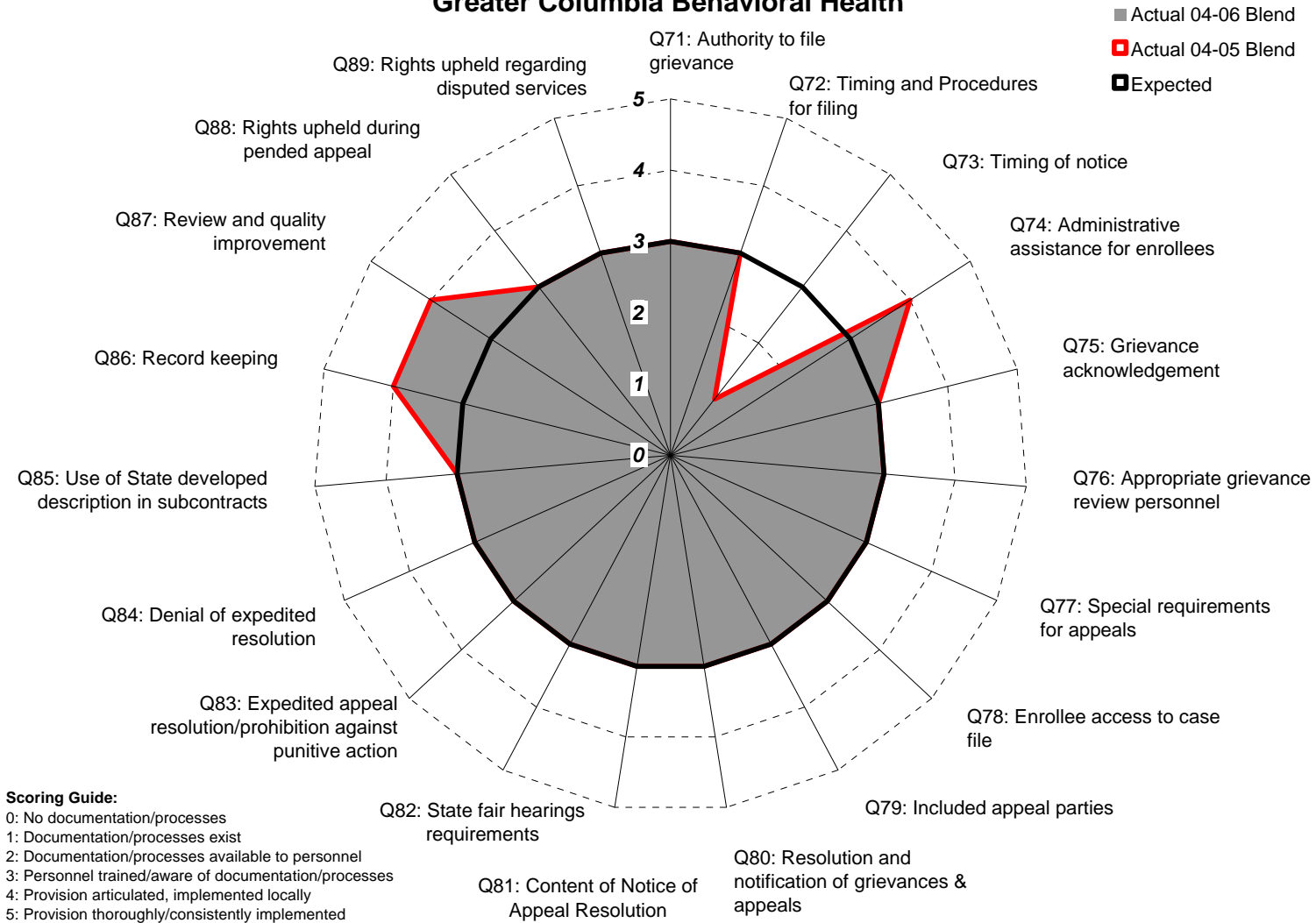
- GCBH Contract Audits Policy states, "Findings would include statements of compliance, recommendations which may be permissive, or statements of noncompliance that require coming into compliance with corrective actions within agreed upon timelines. Subcontractor shall have 10 business days to respond to the preliminary audit report. This may include face-to-face meetings between subcontractor and GCBH to discuss their rebuttal input, and as appropriate, agree on acceptable changes."
- Undated Completed BHO Audit Tool (no names of reviewers or participants)—desk review of BHO QI and UM Plan, contract, and policies and procedures. Purpose of audit appeared to be to ensure that standards were incorporated into BHO's UM Plan and related policies and procedures. Reviewer unable to determine if performance of BHO was reviewed and whether quality improvements and/or corrective actions were issued. Recommend that future reviews focus on BHO's performance relevant to the PIHP's requirements, standards and expected outcomes.
- No review of Ombuds performance submitted.
- BHO Final Administrative Audit Report—Indicates that an audit was conducted onsite at BHO in Las Vegas, Nevada, April 17, 2007, by Mary Todd-PIHP Contracts Manager, with participation from the BHO Utilization Management Manager.

CFR Reference	Compliance Determination Report <i>Subpart D</i>	Score 0-5
	<p>Report Summary identifies opportunities for improvement/recommendation related to BHO's QI and UM Plan. As indicated earlier, the report does not include opportunities for improvement related to BHO's performance.</p> <ul style="list-style-type: none"> • <u>BHO Corrective Action Plan</u>—from BHO-Executive Director of Operations, dated 7/7/06. No PIHP final approval of BHO corrective action plan was submitted for review. <p>(Moderate Compliance)</p>	3
438.236	Practice Guidelines	
[Q56]	<p>Adoption of practice guidelines meets established requirements</p> <p>Evidence:</p> <ul style="list-style-type: none"> • <u>Utilization Management Policy</u> and the <u>Quality Management Plan</u> collectively include the basic requirements of this provision. • <u>Quality Management Plan</u> states, "Practice Guidelines currently adopted for system-wide implementation include: APA Practice Guideline: Psychiatric Evaluation of Adults, Second Edition, APA Practice Guideline: Treatment of Patients with Major Depressive Disorder, Second Edition." • <u>Board of Director's Meeting Minutes</u> dated 08-24-06—provide evidence that the practice guidelines were officially adopted. • Network provider management reported that the PIHP originally distributed the proposed practice guidelines (Adult Major Depression and ADHD) during the August 2006 Clinical Directors meeting. Upon reviewing the ADHD practice guideline, providers determined that it was not a good fit. Therefore, the PIHP proposed an alternative and, ultimately, the PIHP and provider network selected the practice guidelines identified above. • No evidence of related training for PIHP or network provider staff. In addition, provider management and direct service staff reported that no practice guideline training has been provided by the PIHP. At one provider, supervisors have reviewed the guidelines with their direct service staff. <p>(Substantial Compliance)</p>	4
[Q57]	<p>Dissemination of practice guidelines to providers and enrollees upon request</p> <p>Evidence:</p> <ul style="list-style-type: none"> • <u>Utilization Management Policy</u> and the <u>Quality Management Plan</u> collectively include the basic requirements of this provision. • <u>Quality Management Plan</u> states, "Practice Guidelines currently 	

CFR Reference	Compliance Determination Report <i>Subpart D</i>	Score 0-5
	<p>adopted for system-wide implementation include: APA Practice Guideline: Psychiatric Evaluation of Adults, Second Edition, APA Practice Guideline: Treatment of Patients with Major Depressive Disorder, Second Edition.”</p> <ul style="list-style-type: none"> • <u>Board of Director's Meeting Minutes</u> dated 08-24-06—provide evidence that the practice guidelines were officially adopted. • Network provider management reported that the PIHP originally distributed the proposed practice guidelines (Adult Major Depression and ADHD) during the August 2006 Clinical Directors meeting. Upon reviewing the ADHD practice guideline, providers determined that it was not a good fit. Therefore, the PIHP proposed an alternative and, ultimately, the PIHP and provider network selected the practice guidelines identified above. • <u>Clinical Director's Meeting Minutes</u> dated 11-28-06—brief discussion of practice guidelines and need to have documented evidence that staff have been exposed to the practice guidelines. • Provider management and direct service staff are able to identify the adopted practice guidelines. • No evidence of related training for PIHP or network provider staff. In addition, provider management and direct service staff reported that no practice guideline training has been provided by the PIHP. At one provider, supervisors have reviewed the guidelines with their direct service staff. <p>(Moderate Compliance)</p>	3
[Q58]	<p>Processes of care are consistent with practice guidelines</p> <p>Evidence:</p> <ul style="list-style-type: none"> • <u>Utilization Management Policy</u> and the <u>Quality Management Plan</u> collectively include the basic requirements of this provision. • <u>Quality Management Plan</u> states, “Practice Guidelines currently adopted for system-wide implementation include: APA Practice Guideline: Psychiatric Evaluation of Adults, Second Edition, APA Practice Guideline: Treatment of Patients with Major Depressive Disorder, Second Edition.” • <u>Board of Director's Meeting Minutes</u> dated 08-24-06—provide evidence that the practice guidelines were officially adopted. • <u>Clinical Director's Meeting Minutes</u> dated 11-28-06—brief discussion of practice guidelines and need to have documented evidence that staff have been exposed to the practice guidelines. • No tools or methods of monitoring the practice guidelines were submitted for review. • PIHP and provider staff reported that the PIHP has not begun 	

CFR Reference	Compliance Determination Report <i>Subpart D</i>	Score 0-5
	<p>clinical monitoring of the adopted practice guidelines. PIHP staff reported that they are just beginning the process of creating tools and methods to monitor fidelity to ensure full utilization of the practice guidelines in clinical services. (Partial Compliance)</p>	2

**Subpart F: Grievance System
Greater Columbia Behavioral Health**



**2004-2006 Subpart Scoring Trend and Detail for
Greater Columbia Behavioral Health**

Scoring Guide for Subparts C, D and F:

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

Subpart F: Grievance System	04-05 Score	2006 Score	04-06 Blend
Q71: Authority to file grievance	3		3
Q72: Timing and Procedures for filing	3		3
Q73: Timing of notice	1	1	1
Q74: Administrative assistance for enrollees	4		4
Q75: Grievance acknowledgement	3		3
Q76: Appropriate grievance review personnel	3		3
Q77: Special requirements for appeals	3		3
Q78: Enrollee access to case file	3		3
Q79: Included appeal parties	3		3
Q80: Resolution and notification of grievances & appeals	3		3
Q81: Content of Notice of Appeal Resolution	3		3
Q82: State fair hearings requirements	3		3
Q83: Expedited appeal resolution/prohibition against punitive action	3		3
Q84: Denial of expedited resolution	3		3
Q85: Use of State developed description in subcontracts	3		3
Q86: Record keeping	4		4
Q87: Review and quality improvement	4		4
Q88: Rights upheld during pending appeal	3		3
Q89: Rights upheld regarding disputed services	3		3

Subpart F – Grievance System

CFR Reference	Compliance Determination Report Subpart F	Score 0-5
438.404	Notice of Action-Timing of Notice	

[Q73]

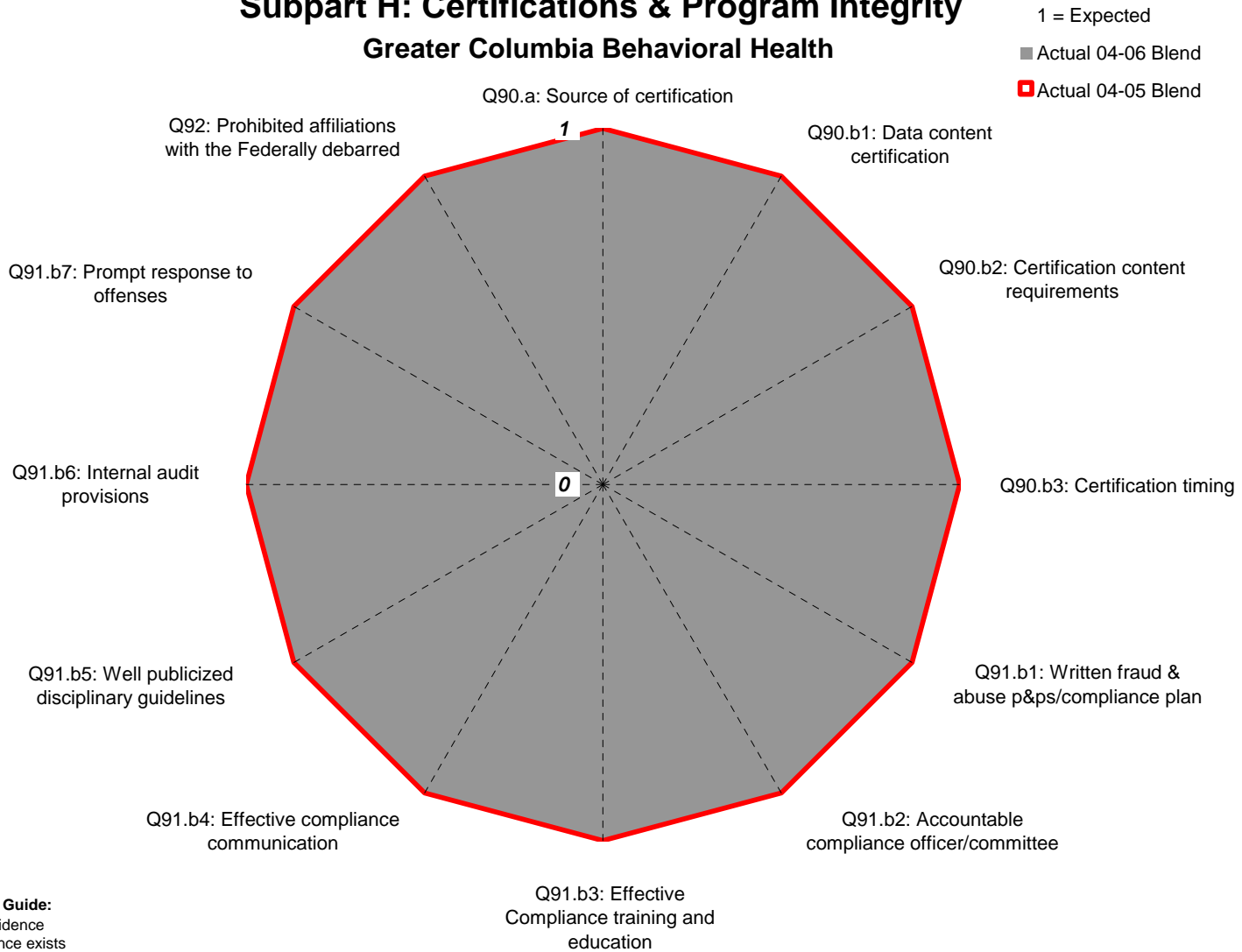
Timing of Notice of Adverse Action

Evidence:

- Notice Requirements (Notice of Action) Policy incorporates the Notice of Action (NOA) requirements, with the exception of the following timeframe related to the mailing of the NOA:
438.404(c)(2)-For denial of payment, at the time of any action affecting the claim.
- BHO Subcontract—PIHP delegates authorization and utilization management (UM), and responsibility for sending Notice of Actions to Behavioral Health Options (BHO) of Nevada. Subcontract specifies that BHO will make “adverse determinations and will deliver notice of adverse determinations.”
- Undated Sample of BHO Subcontract Amendment 01 states:
 - “The Delegate shall ensure that Notice of Adverse Actions (NOA) meets all State requirements.
 - Any changes to the NOA shall be made upon GCBH’s approval.
 - The Delegate must establish a procedure to track denials of medical necessity and institute NOA’s to protect enrollee rights and allow them an opportunity to exercise their right to appeal.”
- The BHO Utilization Management Plan incorporates the required NOA content, and indicates that notices are provided in writing to enrollees and orally to providers.
- Upon review of 2 NOAs, reviewer unable to determine if required timeframes were followed due to lack of dates for service junctures. In addition, no denial and/or NOA tracking logs were submitted for review (detailing timeframes from request of service forward).
- Consumer Rights Training Schedule and Attendance Rosters—indicate training occurred for the majority of network providers between 1/06 and 12/06.
- Consumer Rights Training PowerPoint—includes timing of notice requirements as specified in 438.404.
- Providers receive notification of denials, reductions, suspensions, or terminations as part of the authorization/denial notification process. Provider management and direct service staff are familiar with NOAs and are able to articulate their basic purpose. Provider staff had differing reports as to whether the provider receives copy of NOA or are verbally informed.

CFR Reference	Compliance Determination Report <i>Subpart F</i>	Score 0-5
	<ul style="list-style-type: none">Score remains the same as 2005 EQR due to insufficient documentation and evidence to warrant an increase. (Insufficient Compliance)	1

Subpart H: Certifications & Program Integrity
Greater Columbia Behavioral Health



**2004-2006 Subpart Scoring Trend and Detail for
Greater Columbia Behavioral Health**

Scoring Guide for Subpart H:

0: No evidence
1: Evidence exists

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

Subpart H – Certifications and Program Integrity

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

CFR Reference	Compliance Determination Report Subpart H	Score 0-1
438.606	Source content and timing of certifications	
[Q90.a]	Certification of data to State by legal authority (a) Evidence of certifications. (Compliance)	1
[Q90.b1]	Accuracy, completeness, and truthfulness of data (b) <u>Content Certification</u> (1) To the accuracy, completeness, and truthfulness of the data (Compliance)	1
[Q90.b2]	Accuracy, completeness, and truthfulness of documents specified by State (2) To the accuracy, completeness, and truthfulness of the documents specified by the State (Compliance)	1
[Q90.b3]	Certification submitted concurrently with data (3) Timing of the certification (Compliance)	1

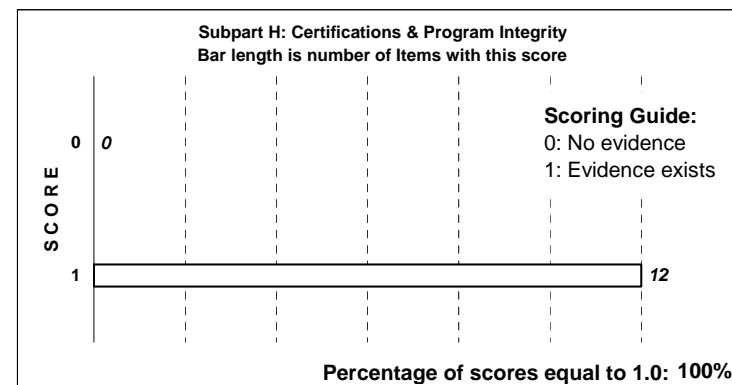
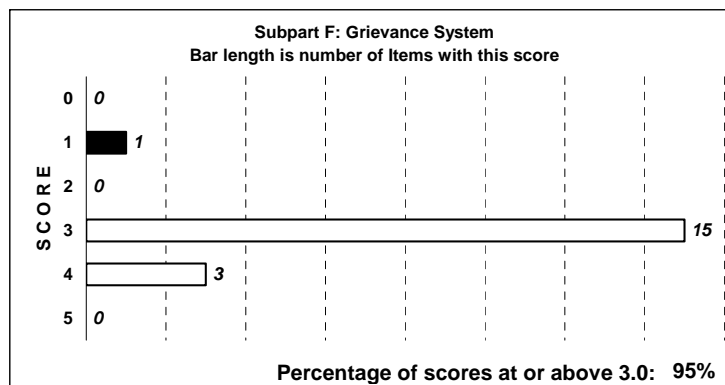
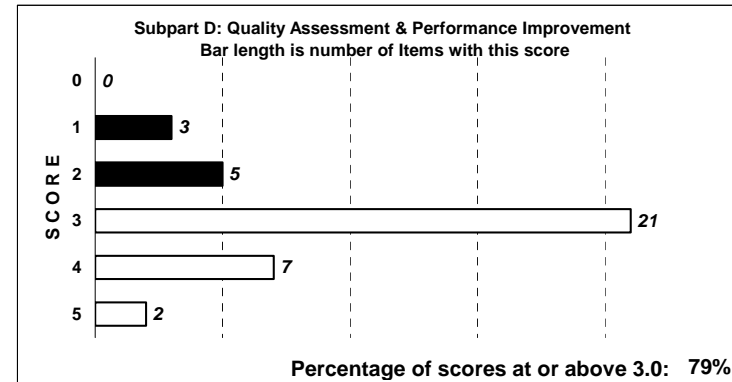
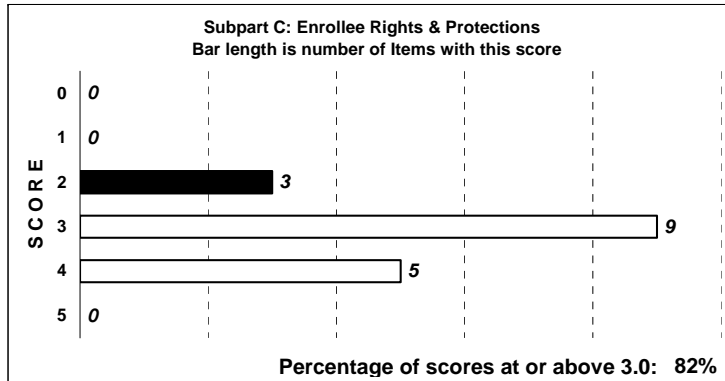
Scoring Frequency Overview

APS Healthcare EQRO (Washington State)
Scoring Frequency Overview for Greater Columbia Behavioral Health

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

Scoring Guide for Subparts C, D and F:

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



Scoring Frequency Overview Chart Discussion

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

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

Subpart C: 82%

Subpart D: 84%

Subpart F: 95%

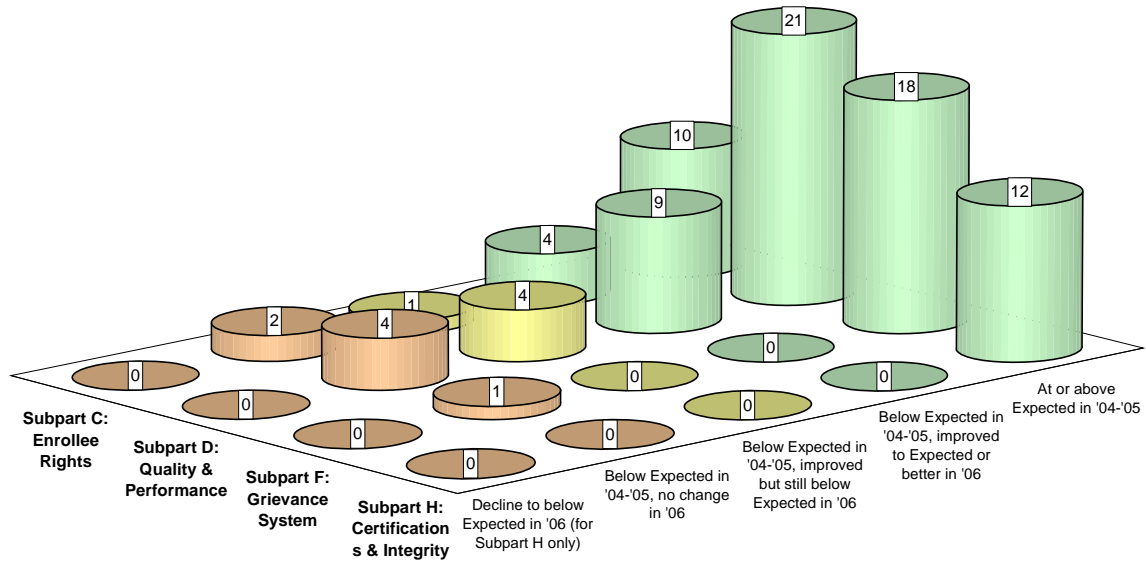
Subpart H: 100%

By prioritizing Certifications and Program Integrity, Greater Columbia Behavioral Health achieved Expected compliance for Subpart H in 2005, and again in 2006. GCBH has also achieved Expected compliance for all but one review element in Subpart F- Grievance Systems.

The PIHP continues to make progress with respect to Subpart C-Enrollee Rights and Protections, and Subpart D-Quality Assessment and Performance Improvement. However, relevant policies and procedures remain underdeveloped and are missing key requirements. Specific areas that remain a challenge include, but are not limited to, elements related to sufficiency of provider network, evaluation of subcontractor ability to perform delegated functions, requirements related to Notice of Actions, and implementation of practice guidelines. In addition, the GCBH needs to increase the knowledge and application of Subparts C and D requirements at the level of network providers and their staff.

**Score Trend Summary for:
Greater Columbia Behavioral**

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



Score Trend Category	Subpart C: Enrollee Rights		Subpart D: Quality & Performance		Subpart F: Grievance System		Subpart H: Certifications & Integrity	
	Item Count	Percent	Item Count	Percent	Item Count	Percent	Item Count	Percent
Decline to below Expected in '06 (for Subpart H only)	n/a	n/a	n/a	n/a	n/a	n/a	0	0.0%
Below Expected in '04-'05, no change in '06	2	11.8%	4	10.5%	1	5.3%	0	0.0%
Below Expected in '04-'05, improved but still below Expected in '06	1	5.9%	4	10.5%	0	0.0%	0	0.0%
Below Expected in '04-'05, improved to Expected or better in '06	4	23.5%	9	23.7%	0	0.0%	0	0.0%
At or above Expected in '04-'05	10	58.8%	21	55.3%	18	94.7%	12	100.0%
Total	17	100.0%	38	100.0%	19	100.0%	12	100.0%

Score Trend Summary Discussion

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

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

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

Prior to the 2006 review, GCBH performance relative to Subpart C (*Enrollee Rights*) showed 10 out of 17 items (58.8%) already at or above the Expected level of performance. After the 2006 review, 14 items (82.3%) are at the Expected level, reflecting improvement in 4 out of 7 elements that scored below Expected in 2005.

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

Although Greater Columbia Behavioral Health did not show improvement in Subpart F, improvement in other required Subparts reflects focused efforts on continuous quality improvement during 2006.

Subpart Strengths

- The PIHP has maintained a steady level of continuous quality improvement while recruiting for a PIHP Administrator and other positions during the review period.
- PIHP prioritized and conducted a comprehensive Consumer Rights training for their entire provider network in 2006.
- Automation of Administrative and Clinical Review Tools to electronic formats with immediate data entry, resulting in accessible, aggregated data providing the capability to identify strengths and opportunities for improvement across the PIHP provider network.

Subpart Challenges

- Delays and barriers in obtaining Governing Board approval to move forward with the Sufficiency Strategy Project Proposal.
- Revised policies and procedures were not re-approved once revisions were finalized.
- PHIP staff are challenged in effectively using the data they generate for aggregate data analysis and formulating quality improvements.
- Increased oversight of providers intensifies the communication and relationship challenges. Maintaining effective and productive communication with network providers, in conjunction with holding the agencies accountable, is critical to the success of the local public mental health system providing quality care and services.

Subpart Recommendations

1. Revise Enrollee Rights Policy to ensure the inclusion of the enrollee's right to request and receive a copy of their medical record, and enrollee's protection of privacy as set forth in 45 CFR parts 160 and 164.
2. Determine network adequacy guidelines/standards, and manage using the existing provider database. Develop a quality improvement process for evaluating capacity and network sufficiency through the use of reports and effective management practices that makes use of report information.
3. Clarify and train PIHP and provider network staff on specific procedures related to out-of-network provider referrals, and coordination of care and payment.
4. Standardize methods for documenting the provision of Advance Directive information and enrollee choice for the provider network.
5. Revise policies and procedures to consistently and accurately reflect staff positions responsible for conducting authorizations and denials of service. Include the required qualifications of relevant staff.
6. Delineate standards of application for the adopted practice guidelines relating to utilization management decisions, enrollee education, coverage of services, treatment planning, and other areas for which the guidelines are relevant. In addition, develop strategies and mechanisms to monitor fidelity of the practices and provide oversight to ensure their full utilization in clinical services.

7. Incorporate all required BBA requirements for Notice of Actions in policy and procedures. In addition, establish a procedure to accurately track and monitor all critical timeframes related to service access, denials, reductions, suspensions of service, and Notice of Actions (NOAs).
8. Clarify delegated PIHP functions and develop processes related to **all** subcontractor delegation:
 - a. Conduct a formal evaluation of subcontractor ability to perform PIHP-delegated functions prior to their delegation;
 - b. Establish written agreements that specifically outline expectations and responsibilities of the delegated functions; and
 - c. Review their related **performance** on an annual basis.
9. Clarify procedure to officially adopt and approve new and revised policies and procedures. Include dated signatures of PIHP officials or designees, date(s) of review and revisions, effective date of the policy, and motion number (if applicable).
10. Prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms. To provide a reliable record of activities, create a mechanism for documenting the dissemination of PIHP policies and procedures, as well as training events and attendance.

C. Performance Measurement

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

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

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

1. Mapping non-standard codes
The PIHP has a policy and procedure which requires all providers to submit their crosswalk on an annual basis, or whenever it changes.
2. Unique member ID
Each provider has a unique system for assigning Client IDs, and the RSN manages unique IDs for all clients within its jurisdiction. They review their client IDs for duplicates and eliminate them as needed.
3. Tracking across product lines and tracking individuals through enrollment, disenrollment and re-enrollment
The PIHP can track members, regardless of changes in status, periods of enrollment and disenrollment, or changes across product lines.
4. Calculating member months
The PIHP is using member month calculations in some management reports. The accuracy of the methodology used to generate their member months and its applicability is still being studied. Authorizing services for six (6) month periods could undermine member month calculations if breaks in eligibility during these periods are not accurately tracked.
5. Member database
The PIHP is using the data provided by MHD in a member database. They update their data monthly and use this data as a step in determining Medicaid eligibility.
6. Provider Database
PIHP staff stated that they maintain provider data in their database. They collect

more than the State requires and use this data for coordinating surveys within their provider network.

7. Data easily under-reported

The PIHP reports that the only services they use out-of-network are inpatient services. The PIHP has a policy for out-of-network services.

PM Summary

GCBH has strong pre-submission screening processes on its data and also fared fairly well in the comprehensive encounter validation exercise conducted by APS in last year's review cycle. The PIHP's efforts in this year's analysis and encounter validation review (described below) show that the PIHP made good efforts to validate its data. The overall score of Partially Met in the 2006 encounter validation review has a depressing impact on the general state of the PIHP's performance measure accuracy. The general state of the PIHP's data is evaluated as "fair". Steps are being taken to help bring their data quality up to good (using the terms "fair" and "good" as general measures, with "poor" being the worst with low confidence in the data, "fair" showing mid-level confidence, and "good" showing excellent confidence).

PM Strengths

- The PIHP's system to ensure that its data is timely, accurate, and complete is well-documented, helping the PIHP consistently apply the tools developed.

PM Challenges

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

PM Recommendations

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

D. Performance Improvement Projects

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

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

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

Non-clinical PIPs submitted for review are titled, "Community Inpatient Savings Project" and "Study and Implementation Plan to Improve Data Storage and Retrieval"; the clinical PIP is "Implementation of Family Assessment and Stabilization Team (FAST) in Benton-Franklin County". None of the submitted PIPs are developed or formulated well enough to be validated using the CMS protocol. All are descriptions of ongoing improvement activities, one reaching back five years, that have not been consistently conducted in a structured QI manner. The data storage and retrieval project is resulting in a conversion from Fox Pro to SQL, a much-needed enhancement but not related to clinical outcomes or processes of care. The other two projects relate to development of community-based alternatives to inpatient care; again, much-needed improvements. The inpatient savings project is organized around financial considerations, and the PIHP did not submit a project summary for the FAST program. Minimal documentation was provided of the structure and plan for this project.

Discussion with the PIHP at the site visit focused on their experience of the MHD PIP training in September: GCBH staff demonstrated an enhanced understanding of the protocol and requirements for conducting PIPs. The WAEQRO clarified some concepts and expectations, emphasizing that the PIHP is required to develop two of their own PIPs and recommending that they review their performance data related to clinical

outcomes and processes to identify potential study topics.

Performance Improvement Project Validation Review year 2006

Activity 1: Assess the Study Methodology

Validation was not performed for this PIHP

Activity 2: Evaluate Overall Validity and Reliability of Study Results

Validation was not performed for this PIHP

PIP Strengths

- The PIHP appears to have a more accurate understanding of the PIP protocol and the process by which study topics are most effectively considered and selected.

PIP Challenges

- The PIHP, in waiting for the MHD training and final word on the possibility of a state-wide PIP, will be starting anew in year 4 of the EQR process.

PIP Recommendations

1. Ground study topic in available data that has been analyzed and prioritized for improvement of client outcomes or processes of care.
2. Design specific and provable study questions (i.e., data is available for study indicators).
3. Design a data analysis plan that provides strong support for results of study, including assessment of reliability of data and potential bias in results.

E. Encounter Validation

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

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

Encounter Validation Review Process

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

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

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

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

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

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

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

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

Scoring

Please refer to the chart below for details on scoring.

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

PIHP Encounter Validation Process Review

<i>Item</i>	<i>Rating</i>	<i>Comments</i>
1. Data requirements		
PIHP documents data requirements, including definition of data required to be sent, by whom, to whom, when, and in what format, including any completeness standards defined.	Partially Met	The Greater Columbia Behavioral Health PIHP uses the State Data Dictionary and the MHD Service Encounter Reporting Instructions as a basis for its own data dictionary. The PIHP has items in addition to the state requirements that their provider agencies are required to submit. The PIHP's data dictionary and their trading partner agreements (TPAs) with network providers further define how and in what format providers submit data to the PIHP's database. The PIHP has a policy and procedure for making changes in their data dictionary. There was no evidence of a completeness standard for their data.
PIHP communicates data requirements to all entities responsible for data entry and submission.	Met	The State and PIHP's Data Dictionaries, MHD Service Encounter Reporting Instructions, and TPAs are communicated to the PIHP's providers when they become available. Changes are coordinated in an open forum where the providers are given opportunity to participate.

2. Network capability to produce accurate and complete encounter data		
PIHP assesses and documents the processes, capabilities, and potential vulnerabilities of the provider agencies' IT systems.	Not Met	There was no evidence to support that the PIHP has made efforts to document its provider network IT capabilities and vulnerabilities. However, their pre-submission screening process helps resolve issues that may cause errors, and they have standards in their contracts stating minimum functionality levels for software used. The PIHP has not documented and

PIHP Encounter Validation Process Review

<i>Item</i>	<i>Rating</i>	<i>Comments</i>
		evaluated its entire network to identify potential vulnerabilities in the provider agencies' IT systems.

3. Analysis of provider agencies' data for accuracy and completeness

<p>PIHP employs review processes that include analyzing the entire data set submitted by the provider agencies for accuracy and completeness.</p>	<p>Partially Met</p>	<p>The PIHP employs an array of processes to ensure that data is accurate and complete prior to submission. The various processes used are well documented. Data is screened automatically when the provider submits batches of encounters to the PIHP's database. Alerts, errors, and warnings are generated and reviewed by GCBH staff and communicated to the provider via reports and e-mails specific to that batch. Additional reports for analysis of the providers' data are generated after the provider batch is accepted and before the data is submitted to MHD. When the data is transmitted to the state, further screening generates feedback that PIHP staff address with their provider network.</p> <p>Although the PIHP creates reports of its data to validate its completeness and accuracy, it does so in monthly or smaller increments. The reports that were submitted do not provide trends, thresholds, or comments indicating what actions may have been taken based on quality of the data.</p> <p>Efforts to verify data prior to transmission are excellent. Although completeness values are generated, these values mean little without defined completeness standards, trends, and feedback indicating action is</p>
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PIHP Encounter Validation Process Review

<i>Item</i>	<i>Rating</i>	<i>Comments</i>
		being taken based on the results.
Tools are defined by the PIHP to evaluate and document their data analysis findings.	Partially Met	Tools are defined to accomplish the screening and reporting described above. Including trends and feedback from analysis of the data needs to be incorporated.
Data is evaluated in a frozen state and archived for future possible use.	Not Met	Data is not frozen for the purpose of analysis.

4. Review of medical records (encounter validation/matching exercise)

PIHP has documented a process description that meets the contract requirement for an encounter validation. At a minimum the PIHP checks the clinical records against the data for agreement in type of service, date of service, and service provider.	Met	The encounter validation conducted by GCBH met the requirements outlined in the contract between the state and the PIHP. The process is comprehensive and well-documented.
PIHP includes additional data elements in matching exercise.	Partially Met	The EV process is combined with a clinical chart review; therefore, other data elements are present. If the PIHP had a method to identify data that is seldom (if ever) verified, such data could be added to reviews on a rotating basis to ensure its eventual scrutiny.

PIHP Encounter Validation Process Review

<i>Item</i>	<i>Rating</i>	<i>Comments</i>
Effective tools are defined and used by the PIHP to capture the results of this exercise.	Partially Met	The tool used by GCBH is the primary tool for clinical chart reviews. A tool mapping data elements to processes that checks accuracy and completeness of those elements needs to be developed, as does a data completeness standard.

5. Submission of findings

PIHP reports to the State as required, detailing the encounter validation efforts and results.	Partially Met	It is unclear whether the report provided summarizing the audits conducted by GCBH is the same report provided to the state; the WAEQRO will make that assumption for the purpose of this report. The report discussed the number of records required and the time period for that requirement but does not reiterate other requirements. The overarching method of review (strength-based and partnering with provider staff) is discussed, as are summaries of accuracy found. Areas of particular note are summarized and process issues are documented. The report ends with a list of recommended areas where further emphasis may be needed. Since the process combined both data verification and clinical chart review, the report also combines elements of both. The link between the contract requirements and the report results is not obvious. It would be helpful to break out the elements more specific to data validation from those more clinical in nature. Ideally, the report covering the encounter validation activities should contain the information requested by this tool.
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PIHP Encounter Validation Process Review

Item	Rating	Comments
		At a minimum, documentation should contain: <ul style="list-style-type: none"> • A process description; • Sampling methodology; • Standards used; • Tools employed; • Summary of provider network capabilities and/or possible areas for improvement(s); • Data analysis results; • Data matching exercise results; and • Summary findings, conclusions drawn, and corrective actions requested (if any).
PIHP regularly reports to the provider agencies the findings of the studies.	Met	These reviews are conducted with provider staff. PIHP staff provided evidence demonstrating the practice of sharing review results with their providers.
PIHP regularly reports internally for quality improvement activities.	Met	Policy and procedures require the reporting and internal discussion of the results of these activities. The recommendations at the end of the report pertain to these activities.

6. Follow-up activities

PIHP has policy and procedure for	Met	The PIHP has a policy and procedure that outlines documentation and
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PIHP Encounter Validation Process Review

<i>Item</i>	<i>Rating</i>	<i>Comments</i>
documentation and oversight of follow-up activities or corrective actions required of provider agencies, based on the findings of a review activity. Evidence that PIHP maintains focus of oversight through to completion of requirements.		oversight activities for findings generated from review activities. Evidence was submitted documenting a PIHP request for a corrective action plan to address deficiencies found in an agency review. Evidence of the PIHP working with the provider agency on these issues was also submitted.
If warranted, evidence of follow-up activity was presented.	Met	Evidence was submitted related to PIHP follow-up on a request for corrective action that, a year later, had not produced measurable improvement.

Summary of Encounter Validation Findings

Score Met 43 %

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

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

Not Met = No confidence in PIHP encounter validation process

Summary of Aggregate Validation Findings



Met



Partially Met



Not Met

Summary of encounter validation findings:

The encounter validation efforts made by this PIHP met the requirements set forth in the contract between the MHD and the PIHP. The encounter validation review conducted by the GCBH is comprehensive and well documented. Their team approach and partnering with their providers while conducting these reviews helps to effectively communicate findings to the provider agency under review. The reports for data analysis need more information to be useful. Having trend data, thresholds, and brief discussion of the findings would be most helpful.

The overall finding of Partially Met was reached upon consideration of the scores in #3, 4, and 5 in the tool indicated above. To the PIHP's credit, had the entire tool been used in computing the score, the PIHP would have fared equally well, with 43% of all items meeting a score of Met, 14% at Not Met, and the remaining 43% at Partially Met.

EV Strengths

- The PIHP has designed and implemented an effective and well documented, team-based approach for reviews.
- Documentation of the processes and procedures used to verify the timely, accurate, and complete submission of data is comprehensive and detailed. The PIHP has also identified necessary improvements and is taking steps for their accomplishment.

EV Challenges

- Because the PIHP has not developed report analysis tools, identification of areas of the PIHP operation requiring improvement is hampered. The reports as currently structured do not provide the level of analysis necessary to understand system performance.
- Inclusion of EV results in Clinical and Data Verification Audit report obscures the detail of the EV results and may result in lack of attention to process that require attention.

EV Recommendations

1. Define and implement a data completeness standard against which all providers and the PIHP can evaluate performance.
2. Document the provider network's information systems to evaluate the capacity to produce accurate and complete encounter data.
3. Add trend data and analysis notes to reports to improve understanding of system performance and improvement needs.
4. Analyze the complete dataset evaluated in the review; i.e., if the review covers six months, analyze data for the entire six-month period.
5. Freeze the dataset being analyzed.
6. Separate and refine how the data verification elements are displayed in reports to provide more comprehensive views of the results.

F. Quality Assurance & Improvement

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

1. the extent to which the PIHP's quality management system is structured to ensure the regular, consistent, and useful collection and reporting of data related to management of the system, service delivery process and quality, and consumer satisfaction;
2. the extent to which the quality assurance and improvement process is fully integrated into the overall management and service delivery system of the PIHP;
3. the extent to which the PIHP follows its plan to monitor the clinical performance of its provider network, including activities related to appeals, grievances, and fair hearings; and
4. the extent to which the PIHP uses the information (data) to analyze agency and system strengths and challenges and takes effective action at the appropriate level.

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

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

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

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

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

PIHP Quality Assurance and Improvement Review 2006 External Quality Review

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

PIHP: Greater Columbia Behavioral Health				
Requirement	Met	PM	Not Met	Findings Comments
<u>Standard</u>				
1. The PIHP plans for ongoing assessment and improvement of the quality of public mental health services in its service area. (2006-7 Contract Section 7.2)				
A. PIHP has QA and I plan that is comprehensive and clearly defines structure, accountability, and process.		2		<ul style="list-style-type: none"> The QAI Plan includes most components of a comprehensive plan, such as: goals, scope, annual review, performance improvement projects, quality indicators, accountability, and responsibilities of committees. Plan includes policy and procedure references related to scope of the Plan. Plan clearly describes role of Board of Directors (BOD) as responsible for PIHP operations, including the quality management program. While the Plan states that PIHP operations and quality management are

PIHP: Greater Columbia Behavioral Health				
Requirement	Met	PM	Not Met	Findings Comments
				<p>delegated, the table identifying membership on committees and the narrative in the Plan describing committee membership and relationships to the Board are confusing on this matter.</p> <ul style="list-style-type: none"> • Monitoring and oversight of the utilization management subcontractor is not assigned or defined in the Plan. • The Chart of Subcommittees indicates a Quality Manager role; however, the duties are not defined in the Plan. • Monitoring methods and frequency of reporting are not discussed in sufficient detail to assure routine evaluation of service delivery. • The performance measures table is limited to contractual requirements and lacks calculation methods, thresholds for further action, and reporting frequency and responsibility. • In describing and diagramming the conceptual model, PI activities appear to overlap with RSN operations only partially. In a comprehensive QI process, PI activities would inform all aspects of RSN operations and hence be an overlay rather than an overlap. • Missing is:

PIHP: Greater Columbia Behavioral Health				
Requirement	Met	PM	Not Met	Findings Comments
				<ul style="list-style-type: none"> o A consumer-focused, quality of care vision; o An annual work plan of 3-4 specific quality improvement activities based on findings from the previous year and a statement of the population served.
B. Plan includes annual review of PIHP Quality Assurance and Improvement program.		3		<ul style="list-style-type: none"> • The Plan specifies that the QMOC is responsible for annually updating the written plan and providing the revised Plan to stakeholders. • The QM Plan does not specify timing of the annual review activities, nor details related to incorporating results into the following year's plan.
C. Plan includes annual work plan and process for review of associated activities and progress.			0	<ul style="list-style-type: none"> • PIHP did not provide an annual work plan that includes targeted, focused quality improvement activities to be addressed for the specific year (that are not the PIPs).
D. Plan includes routine and ad hoc provider review activities, including scope, frequency, follow-up, and use of results for system improvement.		2		<ul style="list-style-type: none"> • Plan provides for various types of reviews in description of committee structures and responsibilities. • While a degree of report frequency is specified for some monitoring functions, the frequency of reviews, reporting schedules, and use of information for <i>all</i> oversight activities is unclear. • The Plan does not reference corrective

PIHP: Greater Columbia Behavioral Health				
Requirement	Met	PM	Not Met	Findings Comments
				actions as part of a comprehensive review and follow-up process.
E. Plan includes involvement of providers and consumers and their families on regular basis in all aspects of QA and I process.		3		<ul style="list-style-type: none"> • Underlying assumptions for committee work identify the Advisory Board as a key forum for consumer, family, and stakeholder voice. • Membership of QMOC includes Ombuds and QRT. • Based on the committee membership table attached to the Plan, the consumer representative of the Regional Advisory Board sits on the QMOC and Clinical Directors committee. • Narrative Plan fails to emphasize and specify consumer involvement in QAI activities.
F. PIHP demonstrates implementation of QA and I Plan as written, including annual work plan.		3		<ul style="list-style-type: none"> • Evidence of implementation: <ul style="list-style-type: none"> o Consistent agendas, minutes, and sign-in sheets for QMOC and subcommittees. o Minutes of QMOC document review of regular reports from UM staff, Ombuds, and QRT, as well as distribution of audit schedule. o Routine minutes of Multicultural Committee include discussion of committee's work plan. o BOD 11/06 minutes discuss revisions to QAI Plan; however,

PIHP: Greater Columbia Behavioral Health					
Requirement	Met	PM	Not Met	Findings Comments	
				<p>notes do not clearly reflect adoption of the revisions.</p> <ul style="list-style-type: none"> o Provider management and staff confirmed that performance indicators are reviewed in committees. o Plan stipulates periodic, process-focused reviews as necessary. PIHP described a specific review of this nature which they conducted. o Though provider management indicated that not all providers are represented on the QMOC, they still felt there was fair representation. Due to distance, some attend by phone. <ul style="list-style-type: none"> • Evidence of annual review of the QM Program was not submitted. • No evidence was submitted indicating that BOD has officially approved Plan revision. • No evidence was submitted indicating the actual frequency/consistency of QMOC subcommittee meetings. 	
Standard 1	Count (Target 6 Met):	0	5	1	Target Points: 24 Actual: 13

PIHP: Greater Columbia Behavioral Health				
Requirement	Met	PM	Not Met	Findings Comments
<p>Standard 2. PIHP evaluates and ensures improvement in the quality and effectiveness of the regional system of care. (2006-7 Contract, Section 7.2)</p>				
A. Clinical chart reviews are conducted for each network provider, according to QI Plan, on regular basis.	4			<ul style="list-style-type: none"> • Evidence was submitted indicating that chart reviews are routinely conducted: <ul style="list-style-type: none"> ○ Policy and procedures for provider audit and chart reviews. ○ Clinical and Data Verification Audits Summary Report for 2006. ○ QMOC minutes reflecting discussion of provider audits and number of charts reviewed. ○ Clinical Directors committee minutes reflecting discussion of review of chart audits. ○ Provider management confirmation of detailed chart audit analysis. ○ Spreadsheet containing raw data relative to 417 chart reviews conducted in 2006; included were aggregated data reports depicting levels of compliance for individual PIHPs and entire system. ○ Completed annual provider audit reports for several providers. ○ Confirmation by provider management and direct service staff

PIHP: Greater Columbia Behavioral Health				
Requirement	Met	PM	Not Met	Findings Comments
				that reviews are conducted as described in the plan.
B. Review Tool is effective for measuring performance related to assessments, treatment plans, ongoing care, and required/indicated periodic review.	4			<ul style="list-style-type: none"> • CRRT Tool of 86 items with Scale 0-3 or Yes/No score is an effective monitoring tool and allows for trending. • PIHP staff reported that the automated version of the CRRT provides “tripping levels”, which are the thresholds for determining scores. However, evidence was not provided of the criteria for applying scores. • Chart review results in an Excel spreadsheet reflect simple averages of all elements scored; this methodology masks any outliers that might require attention. • PIHP described case-by-case consultation that occurs on-site during reviews. • Provider management and direct service staff confirmed the chart review process as described by the PIHP; staff also expressed value of side-by-side approach.
C. Review process incorporates training and inter-rater reliability testing of all staff conducting reviews.		2		<ul style="list-style-type: none"> • Documents submitted provide evidence of reviewer training: <ul style="list-style-type: none"> ○ 11/06 UM staff Chart Review Audit training agenda and attendance. ○ QMOC Meeting notes reflecting that

PIHP: Greater Columbia Behavioral Health				
Requirement	Met	PM	Not Met	Findings Comments
				<p>staff debrief after each review to address inter-rater reliability issues.</p> <ul style="list-style-type: none"> Review tool does not include criteria for applying scores; criteria used for training was not provided. PIHP does not conduct formal inter-rater reliability exercises.
D. PIHP maintains effective system for identifying and following up on any improvements/corrective actions required of providers.		3		<ul style="list-style-type: none"> Provider contracts include CA procedures and timelines. Chart Review Policy and pre-audit procedures sent to agencies provide details of review and CA process. Schedule of review process and timelines for reporting and follow-up on CAP requests provides detailed reference for internal compliance monitoring. PIHP submitted summary chart review reports for several providers that included requests for corrective action plans; also included one provider response with requested plan. One example of a complete process was submitted, demonstrating request for CAP through to PIHP follow-up. Dates of all activities not included. Although not supported by submitted documentation, the PIHP reported that

PIHP: Greater Columbia Behavioral Health					
Requirement	Met	PM	Not Met	Findings Comments	
				<p>corrective action decisions are based on formulas in an electronic auditing system. PIHP staff stated that they are looking for improvement in some areas and compliance in others.</p> <ul style="list-style-type: none"> • Provider management described the general framework for recommendations and corrective actions; however, because the thresholds for corrective action were identified to them after the audit was completed, providers do not know in advance the standards to which they will be held accountable. 	
Standard 2	Count (Target 4 Met):	2	2	0	Target Points: 16 Actual: 13
Standard					
3. Results of reviews are analyzed by designated committee and action taken to improve performance where needed; network, advisory board and other interested parties are informed on regular basis of findings and performance improvement activities. (2006-7 Contract Section 7.4)					
A. QI Committee (or other designated committee) regularly reviews results of provider quality oversight activities.		1		<ul style="list-style-type: none"> • QMOC met regularly through the year: reviewed reports from UM staff, Ombuds, and QRT, with infrequent “action” indicated following discussion or review of material presented. Only a few references were mentioned with 	

PIHP: Greater Columbia Behavioral Health				
Requirement	Met	PM	Not Met	Findings Comments
				<p>respect to results of clinical oversight activities from chart reviews.</p> <ul style="list-style-type: none"> • Very little evidence was submitted to confirm PIHP review and analysis of provider chart reviews.
B. PIHP analyzes and trends individual provider performance.		3		<ul style="list-style-type: none"> • Individual annual provider audit reports include a table depicting problematic review categories (based on aggregated chart review scores). The reports also provide details for each chart reviewed. • Review findings are summarized in narrative format and include strengths and weaknesses, • Capacity for this report process is fairly new; therefore, longer term analysis is not yet available. • Provider staff noted that the new electronic chart review tool, which allows for immediate feedback, is a great improvement.
C. PIHP analyzes and trends system-wide performance.		2		<ul style="list-style-type: none"> • Clinical and Data Verification Audits Summary Report for 2006 includes a summary of findings for each provider and across the system. • Longitudinal trends are not provided. • Information regarding data sources and analytic methods was not provided. • No evidence of data analysis (report is a

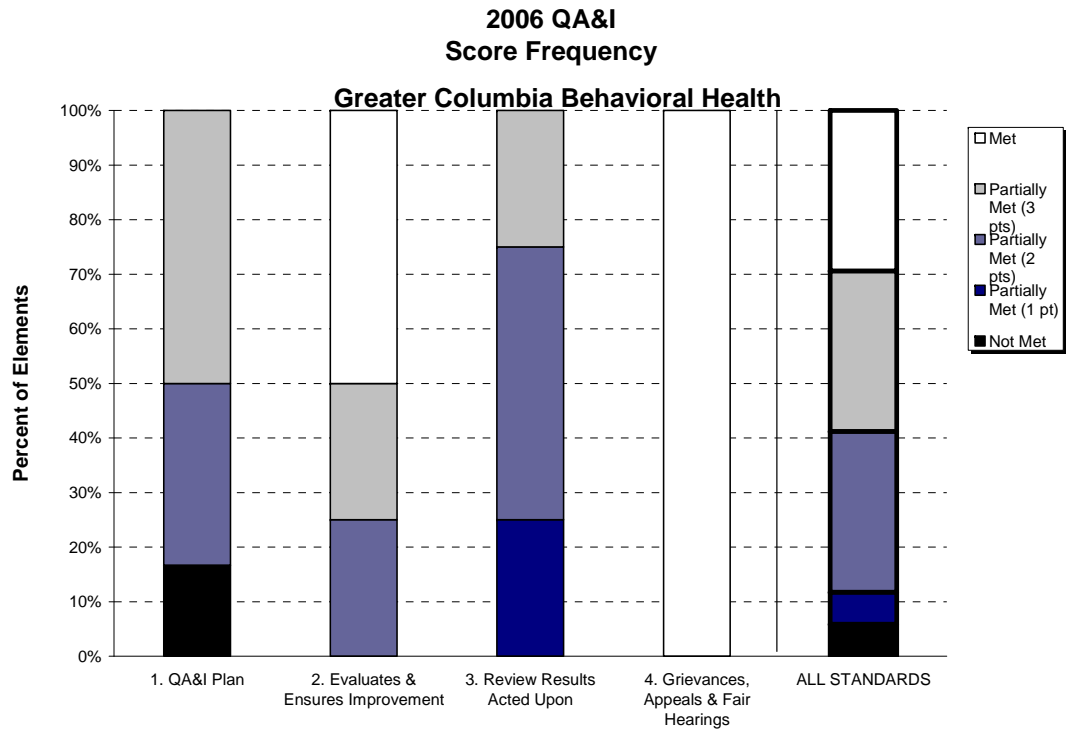
PIHP: Greater Columbia Behavioral Health					
Requirement	Met	PM	Not Met	Findings Comments	
				summary of results).	
D. PIHP communicates regularly with network, Board, and others regarding results of system-wide analyses and improvement activities.		2		<ul style="list-style-type: none"> • Discussion of results of clinical chart reviews occurs monthly at QMOC and in recent UMC meetings; however, detail regarding analysis and recommendations is limited. <ul style="list-style-type: none"> ○ Discussion based on review of upcoming schedules and reports provided to individual agencies. ○ Clinical and Data Verification Audits Summary Report for 2006 is not referenced as having been reviewed. • No evidence was submitted documenting discussion of system-wide performance related to provider chart reviews. 	
Standard 3	Count (Target 4 Met):	0	4	0	Target Points: 16 Actual: 8
Standard					
4. PIHP incorporates results of grievances, fair hearings, appeals and actions into system improvement (2006-7 Contract Section 7.3)					
A. PIHP has effective methods and systems for tracking timeliness and outcomes of actions, appeals, grievances, and fair hearings which are consistently applied.	4			<ul style="list-style-type: none"> • PIHP submitted complaints and grievances report by quarter; the report documents complaints, grievances, and fair hearings by type and provider and 	

PIHP: Greater Columbia Behavioral Health				
Requirement	Met	PM	Not Met	Findings Comments
				<ul style="list-style-type: none"> includes RSN totals. PIHP noted at site-visit that all calls are logged and tracked by the Customer Service staff, including appeals and NOA issues. The log was provided for WAEQRO review. Documentation was submitted with respect to tracking the entire process of the one grievance filed during the review year.
B. PIHP has methodology and regularly incorporates grievance and appeal activity and analyses into QA and I reviews and system improvement activities.	4			<ul style="list-style-type: none"> February 2006 QMOC meeting indicates that QRT provides a semi-annual report which includes graphic representations of types of complaints and a discussion of their possible bases. Minutes of QMOC include monthly reports from Ombuds and evidence of discussion and follow-up. Exhibit N for April-Dec 2006 was submitted for WAEQRO review; evidence that this report was submitted to QMOC. PIHP noted at site visit that complaints, grievances, and appeals data are reviewed during provider audits. Provider management confirmed receipt of reports at QMOC meetings, as well as discussion at BOD.

PIHP: Greater Columbia Behavioral Health					
Requirement	Met	PM	Not Met	Findings Comments	
				<ul style="list-style-type: none"> Ombuds stated that she reports to QMOC, RAB, MH committee, consumer voice, and DHS meetings. 	
C. PIHP ensures that network provider staff and PIHP Ombuds understand and appropriately facilitate consumer access to appeal, grievance, and fair hearing procedures.	4			<ul style="list-style-type: none"> Ombuds accurately described role relative to assisting consumers with appeals, grievances, and fair hearings. Provider management and direct service staff demonstrated sufficient knowledge of procedures and requirements when interviewed. Evidence of Ombuds, provider, and PIHP staff training related to grievances and appeals includes PowerPoint presentation and attendance rosters; training provided in person by Customer Service Staff and was made available online (confirmed by provider management and direct service staff). 	
Standard 4	Count (Target 3 Met):	3	0	0	Target Points: 12 Actual: 12
Grand Totals	Count (Target 17 Met):	5	11	1	Target Points: 68 Actual: 46

Summary Quality Assurance and Improvement Findings

Greater Columbia Behavioral Health (GCBH) achieved the highest score possible (Met = 4 points) on 5 out of 17 possible items. Another 11 items were Partially Met and, of these, 5 items scored a 3. Only 1 item was unmet: inclusion of an Annual Work Plan to direct and focus major QI activities over the course of a year. GCBH achieved a total score of 46 points (68%) for the first review of Quality Assurance and Improvement Plan and activities, indicating that the PIHP has some excellent systems in place. The WAEQRO recommends a simplified revision of the Quality Management Plan that includes (among other elements) specific responsibilities and measurable indicators to be reviewed and analyzed on a scheduled basis under the leadership of a full-time Quality Manager. Continued development of analytic and reporting tools related to data collected at the provider and system levels is encouraged to effectively trend, analyze and report well-defined indicators. Accomplishing these tasks will produce consistent focus on critical performance measures and desired improvements.



QAI Strengths

- PIHP provided needed supports to the quality assurance and improvement system: extensive training across the system of providers; leadership of the Multi-cultural Committee; and information system enhancements for the Ombuds and QRT reporting processes.
- PIHP took effective action to include consumer voice by funding consumer representation on committees and initiating a consumer voice group.
- Quality Management team developed an effective and efficient clinical chart review process that actively involves provider staff through use of an electronic clinical chart review tool with an immediate feedback option at site visits.

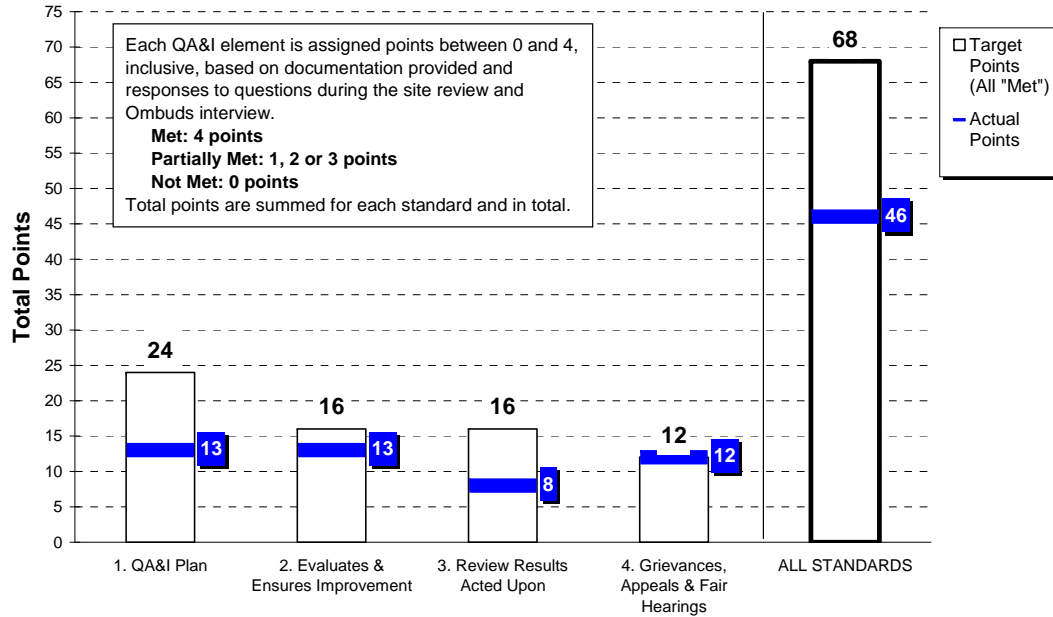
QAI Challenges

- The Quality Management Plan does not provide an effective roadmap to accomplish the required oversight and improvement activities.
- While considerable data is becoming available to the PIHP, use of the data for long-term

I. Frequency of Scores

Standard:	Total Number of Elements	Number of "Met" Elements	Number of "Partially Met" [3 points] Elements	Number of "Partially Met" [2 points] Elements	Number of "Partially Met" [1 point] Elements	Number of "Not Met" Elements
1. QA&I Plan	6	0	3	2	0	1
2. Evaluates & Ensures Improvement	4	2	1	1	0	0
3. Review Results Acted Upon	4	0	1	2	1	0
4. Grievances, Appeals & Fair Hearings	3	3	0	0	0	0
ALL STANDARDS	17	5	5	5	1	1

**2006 QA&I
Cumulative Points
Greater Columbia Behavioral Health**



II. Cumulative Points

Standard:	Target Points (All "Met")	Actual Points
1. QA&I Plan	24	13
2. Evaluates & Ensures Improvement	16	13
3. Review Results Acted Upon	16	8
4. Grievances, Appeals & Fair Hearings	12	12
ALL STANDARDS	68	46

trending and analysis is not yet evident.

- An annual review of the quality assurance program is necessary to evaluate effectiveness of the QAI Plan and process and to analyze system-wide performance on key indicators. The PIHP did not submit evidence that this review has been conducted.

QAI Recommendations

1. Develop data analysis tools and methods to better understand results on all key performance indicators.
2. Prioritize hiring a full-time Quality Manager to assure that necessary functions of the QM program are implemented.
3. Create an Annual Work Plan that includes 3-5 improvement activities identified through data analysis. Reflect those projects in a document attached to the QM Plan and include responsible committees, details of goals, and reporting schedule. These QI activities would be in addition to the PIPs.

4. Expand Performance Measures/Indicators matrix to include detail of reporting responsibility and frequency, measurement protocol, targets for achievement, and thresholds for further action or investigation.
5. Increase detail of discussions in meeting minutes, particularly related to analysis of reports and decisions about further action or follow-up.
6. Consider redesign of quality management structure to create an oversight hierarchy that supports a clear distinction between governance and management/operations of the PIHP.

Recommendations

Subpart Recommendations

1. Revise Enrollee Rights Policy to ensure the inclusion of the enrollee's right to request and receive a copy of their medical record, and enrollee's protection of privacy as set forth in 45 CFR parts 160 and 164.
2. Determine network adequacy guidelines/standards, and manage using the existing provider database. Develop a quality improvement process for evaluating capacity and network sufficiency through the use of reports and effective management practices that makes use of report information.
3. Clarify and train PIHP and provider network staff on specific procedures related to out-of-network provider referrals, and coordination of care and payment.
4. Standardize methods for documenting the provision of Advance Directive information and enrollee choice for the provider network.
5. Revise policies and procedures to consistently and accurately reflect staff positions responsible for conducting authorizations and denials of service. Include the required qualifications of relevant staff.
6. Delineate standards of application for the adopted practice guidelines relating to utilization management decisions, enrollee education, coverage of services, treatment planning, and other areas for which the guidelines are relevant. In addition, develop strategies and mechanisms to monitor fidelity of the practices and provide oversight to ensure their full utilization in clinical services.
7. Incorporate all required BBA requirements for Notice of Actions in policy and procedures. In addition, establish a procedure to accurately track and monitor all critical timeframes related to service access, denials, reductions, suspensions of service, and Notice of Actions (NOAs).
8. Clarify delegated PIHP functions and develop processes related to **all** subcontractor delegation:
 - a. Conduct a formal evaluation of subcontractor ability to perform PIHP-delegated functions prior to their delegation;
 - b. Establish written agreements that specifically outline expectations and responsibilities of the delegated functions; and
 - c. Review their related **performance** on an annual basis.
9. Clarify procedure to officially adopt and approve new and revised policies and procedures.

Include dated signatures of PIHP officials or designees, date(s) of review and revisions, effective date of the policy, and motion number (if applicable).

10. Prioritize training for provider network management and direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms. To provide a reliable record of activities, create a mechanism for documenting the dissemination of PIHP policies and procedures, as well as training events and attendance.

PM Recommendations

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

PIP Recommendations

1. Ground study topic in available data that has been analyzed and prioritized for improvement of client outcomes or processes of care.
2. Design specific and provable study questions (i.e., data is available for study indicators).
3. Design a data analysis plan that provides strong support for results of study, including assessment of reliability of data and potential bias in results.

EV Recommendations

1. Define and implement a data completeness standard against which all providers and the PIHP can evaluate performance.
2. Document the provider network's information systems to evaluate the capacity to produce accurate and complete encounter data.
3. Add trend data and analysis notes to reports to improve understanding of system performance and improvement needs.
4. Analyze the complete dataset evaluated in the review; i.e., if the review covers six months, analyze data for the entire six-month period.
5. Freeze the dataset being analyzed.
6. Separate and refine how the data verification elements are displayed in reports to provide more comprehensive views of the results.

QAI Recommendations

1. Develop data analysis tools and methods to better understand results on all key performance indicators.

2. Prioritize hiring a full-time Quality Manager to assure that necessary functions of the QM program are implemented.
3. Create an Annual Work Plan that includes 3-5 improvement activities identified through data analysis. Reflect those projects in a document attached to the QM Plan and include responsible committees, details of goals, and reporting schedule. These QI activities would be in addition to the PIPs.
4. Expand Performance Measures/Indicators matrix to include detail of reporting responsibility and frequency, measurement protocol, targets for achievement, and thresholds for further action or investigation.
5. Increase detail of discussions in meeting minutes, particularly related to analysis of reports and decisions about further action or follow-up.
6. Consider redesign of quality management structure to create a hierarchy that supports a clear distinction between oversight and management of QAI activities.

Attachments

Attachment 1 – 2006 Review Information Letter

Attachment 2 – Document Submission Information

Attachment 3 – 2006 PIHP Information Request Update

Attachment 4 – Roadmap to PIP

Attachment 5 – Subpart Review Tools

Attachment 6 – Subpart Scoring Guides

Attachment 7 – Performance Improvement Project Review Information

Attachment 8 – Instructions for Submission of PIP Materials

Attachment 9 – Quality Assurance and Improvement Review Instructions

Attachment 10 – 2006 Encounter Validation Document Request

Attachment 11 – Subpart Documentation Request

Attachment 12 – Site Visit Agenda

Attachment 13 – Site Visit Letter

Attachment 14 – QAI Plan Requirements Tool

Attachment 15 – QAI Review Scoring Criteria

Attachment 16 – List of Site Visit Attendees