
Document Type: ¹	<input type="checkbox"/> Policy & Procedure	<input type="checkbox"/> Process Guideline	Adopted:	04/27/00
	<input checked="" type="checkbox"/> Plan	<input type="checkbox"/> System Description	Last Reviewed:	04/03/08
			Retired:	_____

Revisions: 10/26/01; 09/26/02; 08/02/05; 11/07/05; 11/30/06

Document Scope: (applies to Policy & Procedure only)

- The requirements herein apply only to the GCBH Central Office and its functions.
 - The requirements herein apply, verbatim, to GCBH and its network providers².
 - The requirements herein apply both to GCBH and its network providers². Additionally, network providers must have internal documents outlining their processes for implementing the requirements, insofar as they relate to actions for which network providers are responsible.
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SEE ATTACHED PLAN

TABLE OF CONTENTS

I.PURPOSE.....	3
II.GOVERNANCE & STRUCTURE	3
III.PROGRAM SCOPE	4
A. The Conceptual Model	4
B. Care Management	5
C. Utilization Management.....	7
D. Performance Improvement.....	9
E. QM Program Review	11
IV.GENERAL BOARD SUBCOMMITTEE RESPONSIBILITIES	11
A. Participating Subcommittees.....	11
B. Committee Membership	11
C. General Committee Processes and Responsibilities.....	12
D. Underlying Assumptions for Committee Work.....	12
V.FUNCTIONS OF THE BOARD COMMITTEES	12
A. Quality Management Oversight Committee.....	12
B. Clinical Directors Committee	14
C. Funding and Fiscal Operations (FFO) Committee.....	14
D. Management Information Services (MIS) Committee.....	15
E. Multi-Cultural Competence Committee	15
VI.GCBH STAFF & PROVIDER FUNCTIONS	16
A. GCBH Staff	16
B. Provider Network Members.....	16
VII.Appendices/Attachments:	18
Appendix A. 2008 Goals for Greater Columbia Behavioral Health Quality Management.....	19
Appendix B. Greater Columbia Behavioral Health Performance Improvement Projects Abstracts.....	20
1. Nonclinical	20
2. Clinical	20
APPENDIX C: Performance Indicators/Measures	21
APPENDIX D: Quality Management Oversight Committee Workplan Schedule	23
APPENDIX E: The PDSA Cycle for Performance Improvement.....	25
APPENDIX F: Membership of the Board Subcommittees and QM Team†.....	26
APPENDIX G: Sources of Noted Requirements.....	27

I. PURPOSE

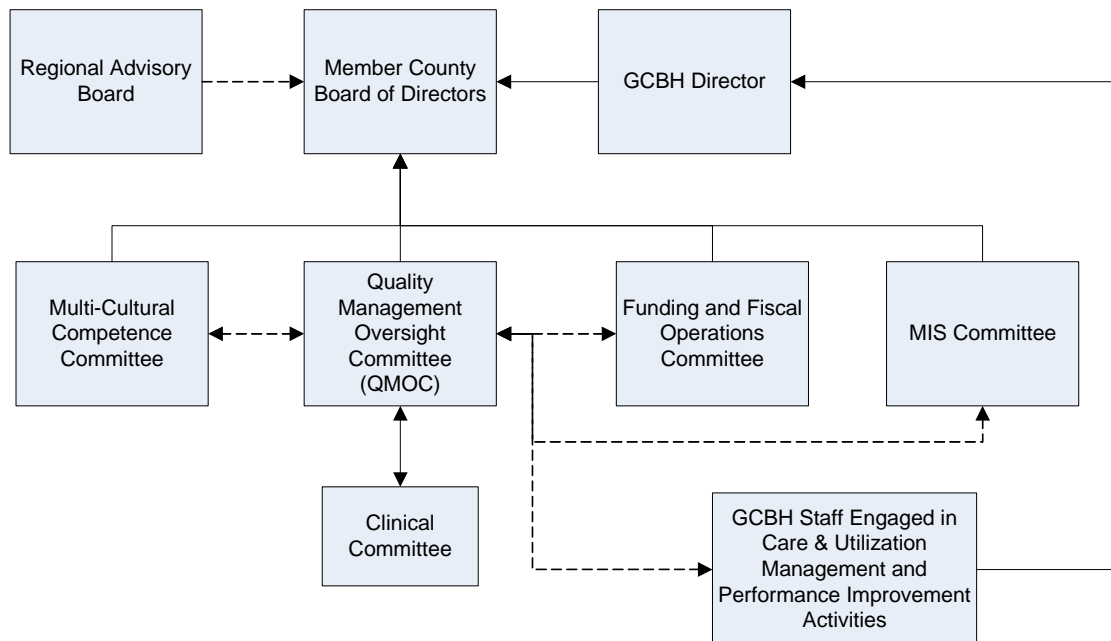
The Greater Columbia Behavioral Health Quality Management (QM) Program is founded on the GCBH vision:

Greater Columbia Behavioral Health is committed to the development, implementation, and maintenance of a model mental health system of care that incorporates principles and practices of managed care and maintains the public trust.

The purpose of this Plan is to outline the program by which Greater Columbia Behavioral Health (GCBH) establishes, deploys, monitors, and improves services provided under agreements with the State of Washington Department of Social and Health Services, in accord with Chapters 71.05 and 71.24 RCW and Chapter 388-865 WAC.

II. GOVERNANCE & STRUCTURE

As indicated by the diagram below, the GCBH Board of Directors oversees the Quality Management Program. As the governing body, the Board of Directors is responsible for promoting the activities of the Quality Management Program, for holding all Network Providers accountable for ongoing participation in its processes, and for ensuring its effectiveness. The Board authorizes the Program via its approval of this Plan.



To ensure that Quality Management is an active consideration in all aspects of GCBH business, and that members of the GCBH Provider Network and consumers of public mental health services are involved in the Program's processes, the Board carries out its responsibility for Program oversight via the activities of its subcommittees and the Regional Advisory Board. The Board charges the Quality Management Oversight Committee (QMOC) with the responsibility for assuring that the various activities of the Quality Management Program are appropriately

focused and cohesive, and designates it the entity by which recommendations concerning the management of quality are made to the Board.

The Board delegates responsibility for day-to-day Program operations to the GCBH Executive Director, who ensures that the Program is adequately staffed and effectively responsive to its mandates. The roles and responsibilities of specific Board subcommittees, GCBH staff, and members of the GCBH Provider Network, as they pertain to supporting the GCBH QM Program, are described in later sections of this Plan.

III. PROGRAM SCOPE

A. The Conceptual Model

The GCBH Quality Management Program encompasses three domains—Care Management, Utilization Management, and Performance Improvement. The diagram to the right reflects the reality that these domains are highly interdependent relative to service delivery, performance monitoring, and the implementation of systemic change.

Perhaps because these domains so often overlap, the terms used in Washington State law and by the Mental Health Division to describe them are inconsistent. Given this, the language used by GCBH to describe its approach to managing and improving service quality varies in some particulars from the State's language. The three domains represented by the diagram are viewed by GCBH as described below.



Care Management (CM) includes both system-oriented and consumer-oriented activities relating to the delivery of care.

System-oriented CM activities focus on:

- Establishing a provider network capable of meeting the network sufficiency standards established by MHD, and assuring the coordination of resources both within that network and between the network and other community agencies providing services to mental health consumers.
- Establishing the criteria upon which decisions regarding consumers' access to care are based and by which service delivery is evaluated, and assuring consistent application of these criteria across the provider network; and
- Assuring that feedback from consumers, allied service systems, community providers, Ombuds and the Quality Review Team is considered when planning and evaluating the delivery of care.

Consumer-oriented CM activities are focused on:

- Assuring that each consumer receives care on the basis of an individual service plan that meets his/her unique needs, and

- Assuring that specific consumers (e.g., those at high risk and/or requiring complex care; those with special needs arising from age, gender, cultural differences or physical condition; those with concerns relating to their care) receive the specialized services designed to address and coordinate issues relating to their care.

In the Care Management domain, quality is evaluated via review of: (1) demographic data regarding the distribution of services and populations, (2) feedback data from the stakeholders identified above, and (3) findings of audits focusing on clinical decision-making and service delivery, as documented in consumers' records.

Utilization Management (UM) focuses upon assuring that the most appropriate services are delivered in the most efficient manner. UM includes processes for:

- Authorizing the provision of services to individual consumers,
- Evaluating the appropriateness of authorized services, and
- Monitoring system-wide and provider-specific performance relative to the volume (i.e., under/over utilization) and timeliness of service delivery.

The evaluation of quality in this domain is based primarily upon trended data arising from ongoing measurement. The majority of measures for which data are collected reflect standards of service delivery established by contract.

Performance Improvement (PI) involves focused activity occurring within the framework of a structured, measurement-driven change process which has as its goal "significant improvement, sustained over time, in clinical care and operational areas that are expected to have a favorable effect on health outcomes and consumer satisfaction."¹

The identification of opportunities for improvement arises from activity in the Care and Utilization Management domains, as a product of routine activities of the various committees comprising the QM Program structure, from feedback offered by consumers and consumer advocacy organizations, and/or in response to the findings of external audits.

Specific goals addressing quality management processes are developed annually (see Appendix A) to ensure continual improvement in the organizations' capacity for managing quality in each of the above domains.

B. Care Management

Care Management, as defined by GCBH, includes the activities briefly described below and addressed in detail via separate policy and procedure, as noted.

1. Establishing the Service Delivery Network. The processes by which GCBH establishes its provider network and assures provider qualifications are outlined in the following policies:
 - a. QM503 – "Network Sufficiency and Accessibility Standards"
 - b. QM507 – "Network Management"
 - c. CL308 – "Children's Service Delivery Protocol"

- d. CL322 – “Service Provision Policy”
 - e. AD109 – “Provider Network Selection and Retention”
 - f. AD101 – “Credentialing of Mental Health Providers”
 - g. AD102 – “Delegation Policy (Subcontracting)”
2. Coordinating Services. GCBH strives to assure that care is coordinated both within the network, and between the network and other agencies providing services to mental health care consumers. The Allied System Plans describe activities undertaken toward this end:
- a. AS1000 – “Tribal Collaboration Plan”
 - b. AS1001 – “Community Integration Assistance Program Coordination Plan”
 - c. AS1002 – “K-12 Education System Coordination Plan”
 - d. AS1003 – “Aging and Disability Services Administration Coordination Plan”
 - e. AS1004 – “Children’s Administration Coordination Plan”
 - f. AS1005 – “Chemical Dependency and Substance Abuse Services Coordination Plan”
3. Establishing Criteria for Accessing Services. GCBH maintains Level of Care Guidelines which incorporate the State of Washington’s Access to Care Standards establishing eligibility requirements for authorization of services for Medicaid enrollees, and include criteria for determining the appropriateness of continued stay in, or discharge from, service. See:
- a. CL301 – “Level of Care and Authorization Criteria.”
 - b. CL319 – “Best Practices”
 - c. Practice Guidelines – GCBH adopts practice guidelines designed to facilitate appropriate decision-making regarding the prevention, diagnosis, treatment, and management of clinical conditions. The degree of Provider adherence to these Guidelines is evaluated via on-site audit. Practice Guidelines currently adopted for system-wide implementation include:
 - i. APA Practice Guideline: Psychiatric Evaluation of Adults, Second Edition
 - ii. APA Practice Guideline: Treatment of Patients With Major Depressive Disorder, Second Edition
4. Coordinating Care for Individual Consumers. GCBH employs Care Coordinators to facilitate treatment planning and service delivery for consumers at high risk for frequent inpatient/institutional care and/or with high potential for relapse or emergence of disabling symptoms. These Care Coordinators collaborate with network providers, to whom is delegated the responsibility for all other care coordination, including that for special populations (i.e., children, older adults, ethnic minorities, individuals with

disabilities in addition to mental illness) and for individuals receiving inpatient and community care. Network providers are also responsible for coordinating their care activities with those of primary care providers and hospital-based emergency services. See:

- a. CL310 – “Local Application Process for Children’s Long-Term Inpatient Treatment”
 - b. CL327 – “Ensuring Care Coordination for High Risk Consumers”
 - c. CL328 – “Care Coordination With Primary Care and Emergency Rooms”
 - d. CL331 – “Early Periodic Screening and Diagnostic Treatment for Children”
 - e. CL332 – “Ensuring Care Coordination Complex Care Consumers”
 - f. CL333 – “Inpatient and Community Care Coordination”
 - g. CL336 – “Special Population Care Coordination”
 - h. QM505 – “Coordination of Mental Health Services With Other Systems of Care”
5. Assessing Network and Service Delivery Quality – In addition to stressing the need for network providers to continually evaluate their services for opportunities for improvement, GCBH assures the regular conduct of formal reviews of system and care quality, as described in:
- a. AD103 – “Contract Audits”
 - b. CL338 – “Clinical Review”
 - c. CL341 – “Monitoring of Residential and Inpatient Provider System Performance”
 - d. QR902 – “Quality Review Team”

Additionally, GCBH surveys network provider satisfaction annually and periodically requests feedback from allied service partners.

6. Providing an Ombuds Services – GCBH assures the availability of an independent Ombuds service to respond to consumer complaints and to assist consumers with processes associated with the resolution of complaints and grievances. See:
- a. QR901 – “Ombuds Policy”

C. Utilization Management

The goal of Utilization Management is timely access to appropriate care, as defined by the Level of Care and Authorization Criteria.

1. Service Authorization – Essential to the successful implementation of this goal is a standardized process for authorizing residential and community support services based on medical necessity. The GCBH authorization process involves both the network providers and an external utilization management organization, as described in policy CA405 – “Enrollee Service Authorization Notices and Appeals”. Additionally, processes for managing

utilization of services in specific situations are described in the following policies:

- a. CL313 – “Consumer Loss of Medicaid Eligibility”
 - b. CL314 – “Out of RSN Network Referrals”
 - c. CL335 – “Psychiatric Inpatient Service Policy”
 - d. CL339 – “Children’s Care Manager”
2. Routine Assessment of Network Performance – GCBH staff are responsible for assessing network performance and for identifying trends relating to the utilization of resources and timeliness of access to those resources. Aspects of performance assessed include at least the following:
- a. Timeliness of service authorization processes.
 - b. Timeliness of access the services.
 - c. Consistency in the application of the Level of Care criteria during the service authorization process (see Policy CL330 – “Assuring Reliability of Utilization Decision Making”), and the appropriateness of the level of care authorized.
 - d. Consumer movement through and across levels of care, including measures designed to evaluate over or under-utilization of resources.

These assessments are accomplished via the review of data relating to standards established by the Mental Health Division and other parameters determined by GCBH to be necessary to the evaluation of network sufficiency (see Appendix A), and/or by retrospective audit of consumer records. Collection of data relating to service authorization and access is an ongoing process in which both the external utilization management organization and the network providers participate. Trends identified as a result of these assessment activities are reviewed by GCBH management and by the QMOC for evidence suggesting opportunities for system or provider improvement, and for implications relating to network sufficiency.

3. Concurrent Review – GCBH staff conduct concurrent reviews of authorizations for cases in which a grievance regarding the authorization is raised or when CMHA staff request a review. Such reviews are carried out primarily for the identifying opportunities to improve accurate and consistent application of the Level of Care criteria, but may also be used to monitor provider progress when toward correcting issues identified as a result of other review activities. To support consistent, accurate service authorization practices, GCBH provides training to GCBH and CMHA staff relating to the use of global assessment of functioning scale, the use of the Level of Care and Authorization Criteria, and other criteria adopted by GCBH to assure appropriate, high quality care.
4. Grievances and Appeals – Processes established by GCBH for service challenging authorization decisions or denials of payment, and for addressing issues relating to service quality and rights violations are described in the following policies:

- a. CA401 – “Consumer Rights”
- b. CA402 – “Fair Hearing”
- c. CA403 – “Consumer Grievances”
- d. CA405 – “Enrollee Service Authorization Notices and Appeals”

D. Performance Improvement

As stated above, activity in this domain is focused and data-driven, which typically occurs in response to opportunities for improvement identified via evaluative activities in the Care and Utilization Management domains, including (1) systematic, ongoing data collection, (2) periodic, process-focused assessment, and (3) periodic provider auditing. Each of these activities yields information regarding opportunities to improve performance—indicating opportunities unique to given Providers and/or suggesting trends requiring a broad response.

1. Systematic, Ongoing Assessment – This form of assessment focuses on statistical analysis of quantitative data as a means of understanding performance relative to selected indicators of quality. These indicators are typically measured across the entire system and monitored over extended periods of time, in order to confirm sustained levels of acceptable performance and/or identify problematic trends.
 - a. The selection of indicators for ongoing monitoring is guided by organizational priorities and the external requirements to which the organization responds. These indicators/measures are identified in Appendix C, and the review schedule is outlined in Appendix D.
2. Periodic, Focused Assessment – This form of assessment is used primarily to achieve an in-depth understanding of the processes underlying the indicators of quality addressed by ongoing monitoring, particularly when performance relative to those indicators is determined to fall short of acceptable thresholds. It may also be used to study the efficiency and/or effectiveness of key processes that are identified, by means other than the ongoing measures, as high volume, problem prone, and/or high risk.
 - a. Focused assessment generally involves both quantitative (i.e., statistical analysis of data) and qualitative (e.g., Root Cause Analysis, Failure Modes and Criticality Analysis) methodologies.
 - b. Because it is resource intensive, focused assessment is undertaken by GCBH QM Program staff only when analysis of routinely collected data indicates intractable problems relating to a specific key process impacting the delivery or quality of care.
3. Periodic Provider Auditing – This form of performance assessment is based on requirements established by GCBH via its contracts with the members of its Provider Network, and occurs via both desk and onsite audits. As noted in the Care Management section, provider compliance with contractual requirements is audited annually, and findings from these audits are analyzed for implications at both the provider-specific and systemic levels.

Performance Improvement Projects (PIP's)

1. Performance Improvement Projects are improvement initiatives conducted via processes reflecting the requirements of CMS Protocols for such projects.
2. Because of the expertise and commitment of resources required for such initiatives, PIP's are initiated only for system-wide projects. Issues identified by the Mental Health Division for statewide PIP's have first priority for resource commitment. When GCBH-specific issues potentially warranting this kind of initiative are identified as a result of other Quality Management activities, PIP's may be chartered by the Board on the basis of the following priorities, indicated in descending order:
 - a. The number and nature of PIP's needed in order to satisfy State requirements.
 - b. Improving the design and outcomes of service delivery and operational processes, system-wide.
 - c. Improving the perception of care and the strategic alliances with other providers in the community.
3. Appendix B provides a brief description of the PIP's currently in progress or planned for the implementation during the coming year. The progress of each PIP is closely monitored to ensure that it is completed in a reasonable time period so as to produce new information on quality of care each year.²
4. Measures established as part of a PIP, to evaluate the degree to the PIP accomplished its goals, are monitored for at least 12 months after its conclusion to evaluate for sustained improvement.

Ongoing Quality Improvement Processes

1. As needed, in response to data generated via activity in the CM/UM domains, GCBH initiates improvement processes and/or small projects that do not warrant the commitment of resources associated with the large scale PIP's designed to reflect CMS protocols. These smaller processes/projects are conducted via the PDSA (Plan, Do, Study, Act) Cycle. (See Appendix C for specific information relating to activities typically included in the PDSA Cycle.)

Performance Improvement Activity Conducted by Providers

1. Network providers are required to carry out improvement activities as described by Policy QM502, "Provider Quality Improvement," using the PDSA Cycle as a structure for achieving and sustaining improved performance.
2. Providers are expected to develop sufficient internal expertise in the use of processes and statistical tools commonly employed within the PDSA Cycle to participate effectively in PIP's chartered by the QMOC.

E. QM Program Review

1. The GCBH QM Program quality indicators/measures and the outcomes of its processes are reviewed annually. The product of this review is a written report assessing the QM Program's relevancy and effectiveness, and offering for Board action recommendations regarding its improvement. The annual report must address at least the following:
 - a. An assessment of the organization's performance relative to the standard indicators/measures required by the State, with a corrective action plan for indicators/measures where an opportunity for improvement is evident.³
 - b. A summary of the activities and outcomes, and an evaluation of effectiveness, for each PIP engaged in during the past year.⁴
2. The QM Program Plan is updated to reflect the findings of the annual review process.

IV. GENERAL BOARD SUBCOMMITTEE RESPONSIBILITIES

A. Participating Subcommittees

1. The ongoing activities of the GCBH QM Program are carried out by the Program staff, by contracted resources, and by the members of the GCBH Provider Network. These activities are reviewed and informed by the following Board subcommittees:
 - a. Quality Management Oversight Committee (QMOC) and its subcommittee, the Clinical Directors Committee.
 - b. Funding and Fiscal Operations Committee
 - c. Management Information Services Committee
 - d. Multi-Cultural Committee
2. The full scope of the Quality Management Oversight Committee's responsibility is addressed in the next section of this Plan. Because their charters are broader in scope than their responsibilities relating to Quality Management, only the functions they perform in support of the QM Program are described for the other Board subcommittees.

B. Committee Membership

1. In addition to Board members, the membership of each committee includes, as appropriate, consumers, advocates appointed from the GCBH Regional Advisory Board, members of the GCBH Provider Network, and GCBH staff. A table showing the membership of the various committees is included in Appendix F.
 - a. When requested, consumer participation in these committees is supported financially via an honorarium and mileage reimbursement. See FM823 – "Honorariums."
2. Committee membership is constituted to accomplish two purposes: (a) to ensure that the committee has the necessary information/expertise available

to fulfill its responsibilities; and (b) to ensure sufficient communication between the committees regarding QM-related issues. Non-member, non-voting participants are invited to committee meetings, as appropriate, based on their ability to contribute to the issues under consideration.

3. Committee members and Chairs are appointed by the GCBH Board Chair, with input from the committees. Committee Chairs are authorized to invite non-member participants to meetings, on an as-needed basis, in order to accomplish their mandates.

C. General Committee Processes and Responsibilities

1. All committees meet as often as necessary to fulfill their obligations, and not less than three times per year. Members are expected to participate regularly in committee meetings, either in person or via teleconference.
2. Each committee establishes the quorum necessary for decision-making. Each committee seeks to make its decisions via a consensus-building process, but when consensus proves impossible, may make decisions via a majority vote, after which it may issue a majority/minority report if such is deemed likely to be useful to the Board.
3. Minutes including all committee decisions are kept for each committee meeting and distributed as appropriate to facilitate adequate communication regarding quality-related findings and issues.

D. Underlying Assumptions for Committee Work

1. As it relates to their responsibility for supporting the GCBH QM Program, each committee's work is founded upon the following assumptions :
 - a. Consumers are entitled to timely access to the correct level of high quality care regardless of their location within the GCBH region.
 - b. The recipient's, family member's and other stakeholders' voices are genuinely reflected in policy decisions and provision of services. The Regional Advisory Board is a key participant in this process.
 - c. Committees are responsible for fostering a culture that learns via objective, data-driven assessment of *what is done and how well it is done*, uses the knowledge gained to inform its efforts to improve performance, and recognizes that the expert use of QM processes and methodologies is vital to achieving both ends.

V. FUNCTIONS OF THE BOARD COMMITTEES

A. Quality Management Oversight Committee

As the organization's QM Committee, the Quality Management Oversight Committee (QMOC) oversees and coordinates the QM-related activities of all other committees and performs the following functions:

1. Ensures that the activities of the QM Program are sufficiently comprehensive to satisfy State requirements and GCBH priorities, and are described via a written plan that is updated at least annually and is made available to community stakeholders. Ensures that the Program is

evaluated annually and that a written report of that evaluation is submitted to the Board of Directors, accompanied by recommendations based on the findings of the evaluation.⁵

2. Identifies and recommends the measures of performance for which members of the GCBH Provider Network are expected to supply data; reviews interpretations of that data provided by QM Program staff, and makes recommendations to based on those interpretations.
3. Regularly reviews findings related to all required measures, as shown in Appendix C of this Plan. Refers these findings for review by other committees as appropriate; assures that quality improvement processes/projects occur, when warranted.
4. Reviews all PIP's prior to their implementation, and recommends them for Board approval as appropriate. Charters and monitors the progress of all PIP's.
5. Ensures that training and technical support are provided to members of the GCBH Provider Network relative to their participation in quality improvement processes/projects and PIP's.
6. Defines the GCBH processes for investigating and reporting incidents related to the provision of mental health services that are likely to result in news coverage. Reviews the findings of investigations; if possible, identifies interventions designed to prevent or lessen the possibility of future similar events, and makes recommendations accordingly.⁶
7. Ensures the organization's readiness for annual monitoring reviews of its Encounter Data Validation and PIP's by DSHS or its External Quality Review Organization (EQRO) contractors.
8. Ensures that the Quality Review Team (QRT) has access to the information and expertise necessary to carry out its mandates. Reviews the QRT's biennial reports; ensures that input from the QRT is integrated into the GCBH QM Program.⁷
9. Oversees processes relating to the annual on-site audits of Provider compliance with contractual requirements. Considers system improvements based on recommendations from all on-site monitoring, evaluation and accreditation/certification reviews.⁸
10. Oversees investigation of allegations of fraud and abuse, ensuring that other Board subcommittees are involved as appropriate. Ensures that allegations are reported to the Mental Health Division as required, and that all necessary follow-up is completed.⁹
11. Reviews the biennial reports and formalized recommendations provided by the Ombuds service for their implications for the GCBH QM Program; ensures that these inputs are reflected in the Program's activities.¹⁰
12. Reviews Grievance and Appeal summary reports on a quarterly basis, and, if changes in appeal or grievance patterns are detected, requests and receives a more in-depth review of the appeal and grievance information to determine if any procedural or programmatic changes are indicated. As

needed, reviews Grievance and Appeal information received from the GCBH Ombuds service. Identifies trends indicating opportunities for improvement; makes recommendations regarding measures needed to address undesirable patterns¹¹.

13. Regularly reviews utilization data, issues, and recommendations submitted by RSN staff and/or the contracted UM organization. Assures that, when data indicate potential issues relating to service utilization, such issues are evaluated and addressed, as appropriate.¹²
14. Reviews critiques of GCBH/Provider Network Member performance relative to participation in community-based disaster drills and actual disasters. Oversees any follow-up activity needed to improve performance.¹³
15. Participates in the annual review of the 7.01 Plan to enhance coordination with the tribes in the GCBH area as it pertains to improving service delivery and cultural sensitivity.¹⁴
16. Publicizes performance improvement successes and effects within and outside the organization.

B. Clinical Directors Committee

As a subcommittee of the QMOC, the Clinical Directors Committee serves as a forum for the coordination of clinical performance improvement efforts affecting the members of the GCBH Provider Network. Functions the Committee include, but are not limited to the following:

1. Reviews the annual audits of subcontracted Providers' contract compliance relative to (1) the quality of care, (2) Intake Evaluations and Individual Service Plans, (3) Practice Guidelines, and (4) all other audit findings relating to consumers' Medical Records; makes recommendations for improvement based on their findings.
2. Participates in the development, implementation and review of all clinical PIP's.
3. Interprets and communicates Practice Guidelines.¹⁵ At least annually, reviews and make recommendations regarding the organization's use of Best Practices and Practice Guidelines.

C. Funding and Fiscal Operations (FFO) Committee

The FFO Committee provides oversight of the organization's financial and contracting processes. Relative to its participation in the QM Program, the committee performs the following functions:

1. Collects and analyzes sufficient financial and cost information regarding the organizations capacity to manage its resources and services to enable effective decision-making; ensures that findings, as they pertain to the quality of the services delivered, are reflected in the activities of the QM Program.¹⁶
2. Reviews the findings of the annual reviews of subcontracted Providers' contract compliance relative to liability for payment and the pursuit of third party revenue; recommendations corrective action as needed.¹⁷

3. Reviews the annual audits of subcontracted Providers' contract compliance relative to fiscal practices; makes recommendations for improvement based on their findings.
4. Monitors GCBH staff and GCBH subcontracted providers for Fraud and Abuse as outlined in GCBH plan CO201 – "Fraud and Abuse Compliance Plan".
5. Ensures that the Corporate GCBH Compliance Plan is maintained and adhered to as the means of avoiding issues of Fraud and Abuse within the RSN and the Provider Network.

D. Management Information Services (MIS) Committee

The MIS Committee provides oversight and direction related to the development and integration of the computerized information systems throughout the organization. Relative to its participation in the QM Program, the committee performs the following functions:

1. Review management information system data accuracy, validity, completeness, integrity, and security as outlined in GCBH procedures,
 - a. IS706 – "Data Importing"
 - b. IS707 – "Data Integrity"
 - c. IS708 – "Data Integrity and Processing".¹⁸
2. Ensures that means are established by which to electronically collect data relative to the clinical and operational indicators/measures monitored via the QM Program, insofar as feasible.
3. Ensures that QM-related data collected via MIS processes are readily available to participants in the QM Program.
4. Establishes processes to ensure the integrity of data produced by the information system.¹⁹
5. Reviews the annual audits of subcontracted Providers' contract compliance relative to the management of electronic information; makes recommendations based on their findings.
6. Assures the maintenance of the GCBH Disaster Recovery Plan.

E. Multi-Cultural Competence Committee

The Multi-Cultural Competence Committee is tasked with promoting an environment within GCBH and its Provider Network that values and respects the differences of its staff, consumers, and communities, and utilizes their collective abilities and experiences to ensure organizational growth and service improvement. Relative to its participation in the QM Program, the committee performs the following functions:

1. Establishes and monitors indicators/measures to assess need and performance relative to key cultural competence and diversity issues. At a minimum this process should assess issues within the:
 - a. Staff of Member Government/Provider Agencies,

- b. Consumers, and
 - c. Communities being served by the organization.
2. Participates in designing and implementing PIP's for which multi-cultural competence is identified as a key dimension.

VI. GCBH STAFF & PROVIDER FUNCTIONS

A. GCBH Staff

1. The staff of the GCBH QM Program supports its ongoing activities and provides the QMOC and the Board of Directors with information and recommendations that facilitate decision-making relative to improving operational and service delivery performance throughout the organization, including its Provider Network.
2. The staff is tasked with providing the organization with expertise in data collection, statistical analysis and performance improvement processes and methodologies commonly recognized as critical to viable QM Programs. This includes assisting members of the GCBH Provider Network to develop or enhance their own expertise in the use of these processes and methodologies to whatever degree is necessary to ensure that GCBH is able to fulfill its responsibility for maintaining an active, productive QM Program.
3. The GCBH QM Program is staffed to support the following functions:
 - a. Care Coordination for special populations,
 - b. Ongoing review and analysis of utilization data,
 - c. Provider Network auditing, and
 - d. Participating in statewide PIP's, and/or conducting regional PIP's in collaboration with the members of the GCBH Provider Network.

B. Provider Network Members

1. The members of the GCBH Provider Network are advisors to and participants in the GCBH QM Program.
 - a. As advisors, Provider Network members are represented on the Board subcommittees and consulted relative to the focus, design and implementation of quality indicators/measures and PIP's.
 - b. As participants, Provider Network members ensure that their internal quality management processes (1) result in progress toward more effective and efficient age and culturally competent services and improved consumer satisfaction and outcomes; and (2) include objective measures of progress toward rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices. Providers are required to have written plans describing, at a minimum, the mechanisms by which their quality management processes:

- i. Review the services offered and provided to improve the treatment of consumers, including the quality of intake evaluations and the effectiveness of prescribed medications;
- ii. Review the work of persons providing mental health services at least annually; and
- iii. Continuously collect, maintain and use information to correct deficiencies and improve services.²⁰

Approved:

/S/ William Wilson
William Wilson, DrPH
Director

04/03/08
Date

VII. APPENDICES/ATTACHMENTS:

Appendix A. 2008 Goals for Greater Columbia Behavioral Health Quality Management

1. Identify, develop and implement one nonclinical and one clinical performance improvement project.
2. Develop and implement quality improvement project to study and, if necessary, make recommendations for improving the process of contacting the inpatient unit by the CMHA within 3-days of admission.
3. Review CRRT/PDV audit & report process.
 - a. *Action Plan:* Revise report structure and content to include active communication between CMHA staff and GCBH Quality Manager. Perform analysis of CRRT data. Collaborate with IS on PDV analysis. Involve clinical group on revisions of CRRT wording and evaluation scale.
4. Establish reporting procedure for periodic performance indicators.
 - a. *Action Plan:* Create PIHP Performance Indicator definitions and data sources document. Work with IS to develop reporting procedure.
 - b. *Action Plan:* Design processes for collecting data elements specific to the four contractual measures noted in Appendix D for which there is no current means of generating performance data.

Appendix B. Greater Columbia Behavioral Health Performance Improvement Projects Abstracts

1. Nonclinical

Good clinical care for individuals with serious mental illnesses involves providing rapid follow-up care after discharge from an inpatient facility (e.g., community psychiatric hospital or evaluation and treatment facility). Ideally, for individuals with mental illnesses, the timing of aftercare would be within seven days of discharge from an inpatient psychiatric facility. Offering and scheduling an outpatient follow-up appointment after discharge are critical steps toward ensuring service provision occurs, but they may not be enough to secure true engagement. Statewide the rate of patients seen in non-crisis outpatient services within seven days of discharge from a community hospital or evaluation and treatment facility has been declining in recent years.

The MHD has set a benchmark of 80% of (Medicaid) patients discharged from a psychiatric hospital (community hospital or evaluation and treatment facility) must be offered non-crisis services within seven days of discharged. A recent review of follow-up outpatient appointments by the Washington State Department of Social and Health Services, Mental Health Division (MHD), has shown that many Medicaid patients served by Washington State Regional Support Networks/Prepaid Inpatient Health Plan (RSN/PIHP) are not receiving timely follow-up care after hospitalization. In 2006-2007 fiscal year, for example, MHD determined all RSNs were performing below the 80% benchmark. State-wide RSNs were had a 51% adherence rate, and Greater Columbia Behavioral Health had a 62% adherence rate during this period. Thus, we propose to study the effects of [[[TBD Intervention]]] on the rate of patients seen in non-crisis outpatient services within seven days of discharge from a community psychiatric hospital or evaluation and treatment facility.

2. Clinical

A recovery-based mental health system embraces self-determination, empowering relationships based on trust, understanding and respect, meaningful roles in society and the elimination of stigma and discrimination. Unlike the Medical model system, which is deficit focused and expert not consumer based, the recovery model focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals and families. The strengths-based recovery model is based on a self-directed approach to outpatient care. When the consumer's strengths are identified to help overcome existing deficits, they are much more likely to have significant recovery. The process of recovery moves forward through interaction with others in supportive, trust-based relationships. Research indicates that consumers who experience a rootedness to the community and participate in consumer-directed services are more likely to thrive. Recovery is not a linear process but based on continual growth and setbacks, possibly including hospitalization. Specifically, consumers with *housing* (group home, or house), *meaningful activities* (going to get medications everyday, or full-time employment), and *support* (members of group home, or an extended family) are less likely to require hospitalization, and in the event of a hospitalization, there is typically a shortened length of stay. Thus, we propose to support a recovery-based outpatient mental health system through educating agency staff, consumers and the community to ensure adequate understanding of recovery concepts.

APPENDIX C: Performance Indicators/Measures

Identification of the specific data elements needed to facilitate meaningful analysis for a given indicator/measure, the means by which the data are collected, and the scope of data collection is the joint responsibility of the QMOC and GCBH staff, with input from other committees, as appropriate.

GCBH staff is responsible for the initial statistical analyses of the data, for gathering information from Providers that helps them interpret and relate the statistics to the everyday processes they reflect, and for presenting their findings in a manner that facilitates understanding and action.

The purpose of QMOC review is to identify trends suggesting opportunities for improvement. The frequency of reporting for a given measure is established by the QMOC, based on the nature of the measure and the volume of data available. The performance indicators/measures are detailed in the *Greater Columbia Behavioral Health Performance Indicators Definitions and Data Sources* document.

Focal Areas
The degree to which mental health services and planning are driven by and incorporate enrollee and family voice. ²¹
The degree to which mental health services are age, culturally and linguistically competent. ²²
The degree to which mental health services are provided in the least restrictive environment. ²³
The degree to which provided mental health services assist enrollees' progress toward recovery and resiliency. ²⁴
The continuity in service and integration with other formal/informal systems and settings. ²⁵
Under and over-utilization of services ²⁶
Network Provider Satisfaction (QRT) ²⁷
Allied Service Provider Satisfaction (QRT) ²⁷
Consumer Feedback (QRT) ²⁷
Performance Indicators
*** These values will be calculated quarterly by MHD for the 2007-2009 PIHP and State contracts. ***
The % of Medicaid eligible hospital (community and E&T) discharges for which non-crisis outpatient services were provided with 7 days of discharge. ²⁸
The % of requests for routine services for which services were provided within 28 calendar days of request for mental health services. ²⁹
The % of Intakes for which Telesage Outcome Assessment was initiated at time of intake. ³⁰
The % of consumers for whom there is a Telesage Outcome Assessment attempted/completed during the 90 days follow-up. ³¹
The % of consumers for whom there is a Telesage Outcome Assessment attempted/completed during the subsequent 180 days follow-up. ³¹

Performance Measures

The % of intake evaluations initiated within 10 working (14 calendar) days of the consumer's request for mental health services. ³²
The % of authorizations for initial routine services that occur within 14 calendar days of the date the intake evaluation was initiated. ³³
The % of consumers aged 13 and above, for which there is a completed GAIN-SS. ³⁴
The % of requests for a second opinion from a mental health professional for the appointment for a second opinion occurred within 30 days of the request. ³⁵
The % of grievances resolved within 30 days from statement of grievance. ³⁶
The % of appeals resolved within 45 days from receipt of notice of the appeal. ³⁶
The % of written notifications pertaining to a denial or limiting of (outpatient) services that occurred within 14 working days of the decision. ³⁷
The % of authorizations for psychiatric inpatient care occurring within 12 hours of the initial request. ³⁸
The % of inpatient admissions for which contact was made by GCBH and/or responsible CMHA within 3 working days of the admission. ³⁹
The % of denials for certification of a psychiatric inpatient stay that reviewed by a psychiatrist within 3 days of the initial denial. ⁴⁰
The % of Emergent requests for which care occurred within 2 hours of the request. ⁴¹
The % of Urgent requests for which care occurred within 24 hours of the request. ⁴²
State Hospital Bed Utilization rate. ⁴³
The average length of stay in inpatient services. ⁴⁴
Readmission to inpatient treatment within 30 days of discharge. ⁴⁴

APPENDIX D: Quality Management Oversight Committee Workplan Schedule

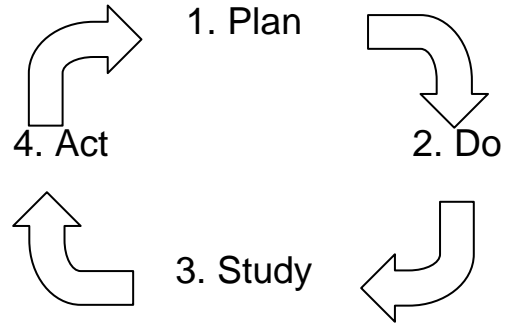
Focal Areas	
Network Provider Satisfaction (QRT)	The QRT will report to QMOC once study data has been analyzed and summarized.
Allied Service Provider Satisfaction (QRT)	
Consumer Feedback (QRT)	
Performance Indicators	
*** These values will be calculated quarterly by MHD for the 2007-2009 PIHP and State contracts. ***	
The % of Medicaid eligible hospital (community and E&T) discharges for which non-crisis outpatient services were provided with 7 days of discharge.	Monthly & Quarterly Summary
The % of requests for routine services for which services were provided within 28 calendar days of request for mental health services.	
The % of Intakes for which Telesage Outcome Assessment was initiated at time of intake.	
The % of consumers for whom there is a Telesage Outcome Assessment attempted/completed during the 90 days follow-up.	
The % of consumers for whom there is a Telesage Outcome Assessment attempted/completed during the subsequent 180 days follow-up.	
Performance Measures	
The % of intake evaluations initiated within 10 working (14 calendar) days of the consumer's request for mental health services.	Quarterly (Month/Quarter calculation)
The % of authorizations for initial routine services that occur within 14 calendar days of the date the intake evaluation was initiated.	Quarterly (Month/Quarter calculation)
The % of consumers, aged 13 and above, for which there is a completed GAIN-SS.	Quarterly (Month/Quarter calculation)
The % of requests for a second opinion from a mental health professional for the appointment for a second opinion occurred within 30 days of the request.	*
The % of grievances resolved within 30 days from statement of grievance.	Quarterly
The % of appeals resolved within 45 days from receipt of notice of the appeal.	
The % of written notifications pertaining to a denial or limiting of (outpatient) services	Quarterly (Month/Quarter calculation)

that occurred within 14 working days of the decision.	
The % of authorizations for psychiatric inpatient care occurring within 12 hours of the initial request.	Quarterly (Month/Quarter calculation)
The % of inpatient admissions for which contact was made by GCBH and/or responsible CMHA within 3 working days of the admission.	*
The % of denials for certification of a psychiatric inpatient stay that reviewed by a psychiatrist within 3 days of the initial denial.	<i>na</i> **
The % of Emergent requests for which care occurred within 2 hours of the request.	*
The % of Urgent requests for which care occurred within 24 hours of the request.	*
The # of persons who are authorized for State-funded mental health services.	Quarterly (Month/Quarter calculation)
State Hospital Bed Utilization rate.	Quarterly (Month/Quarter calculation)
The average length of stay in inpatient services.	Quarterly (Month/Quarter calculation)
Readmission to inpatient treatment within 30 days of discharge.	Quarterly (Month/Quarter calculation)

* The GCBH data collection system is not currently structured to provide the data elements necessary to these measures. See Appendix A, Item 4, for plans to address this deficit.

** BHO Medical Director reviews 100% - only M.D. can deny claim for inpatient services.

APPENDIX E: The PDSA Cycle for Performance Improvement



<p style="text-align: center;">1. Plan</p> <ul style="list-style-type: none"> • Define a realistic scope and establish measurable goals for the project. • Review existing data relevant to the process(es) upon which the project is focused. If no data are available, define the measures needed to demonstrate improvement and collect baseline performance data. • Gather qualitative assessments of the process(es), and ideas for improvements from staff involved in them and from consumers who experience them. • Generate possible courses of action likely to achieve the project goals, and select a course of action that appears feasible and likely to result in measurable improvement. • Plan the process for <u>piloting</u> the chosen course of action. Planning should include the following: <ul style="list-style-type: none"> ➢ Developing the guidelines or procedures staff will need in order to successfully implement the pilot project. ➢ Identifying any additional measures that will be needed to evaluate the effectiveness of the pilot and/or the achievement of the project goals, and establishing the means for collecting the necessary data. ➢ Identifying potential barriers to implementation of the pilot project and developing strategies to address them. ➢ Developing clear stages and timelines for implementation and evaluation of the pilot project. • Identify potential “champions” or organizational strengths that can support the project and develop a plan for capitalizing on these. 	<p style="text-align: center;">2. Do</p> <ul style="list-style-type: none"> • Introduce the pilot project to affected staff, providing them a final opportunity to influence its design. Introduction of the project includes: <ul style="list-style-type: none"> ➢ Presenting the data and other information that indicated a need for this PIP, ➢ Presenting the project goals and clarifying what will be measured to determine whether those goals have been met. ➢ Presenting the timelines for implementing the project and assessing its success. ➢ Providing training relative to their roles in implementing the pilot project, including instructions relating to any unfamiliar forms, procedures or techniques. • Make any last minute adjustments to the implementation plan. • Implement the pilot project and monitor its progress, assisting staff as needed to ensure that implementation goes as planned and adheres to established timelines. • Ensure that data are collected as planned. <p style="text-align: center;">3. Study</p> <ul style="list-style-type: none"> • Review the data collected during the “Do” phase of the cycle. • Involve staff, consumers, and external sources as needed in the data review. (They may see something you missed or overlooked.) • Look for trends, improvements, surprises, and collateral or unexpected impacts. • Determine whether the proposed solution worked as planned and achieved measurable progress toward achieving the project goals.
<p>4. Act</p> <ul style="list-style-type: none"> • If progress toward the goal is satisfactory, take the necessary steps to formalize the change. This may involve publicizing your success, getting new policies approved, providing training for staff not involved in the pilot project, establishing mechanism for ongoing measurement to ensure sustained improvement, etc. • If progress toward the goal is not satisfactory, share the outcomes of the pilot project, gather feedback from staff and consumers, and use the lessons learned to drive a second PDSA Cycle. Remember, it’s called a “cycle” and you may have to tweak your plan or even go “back to the drawing board” in order to achieve the desired level of performance. 	

APPENDIX F: Membership of the Board Subcommittees and QM Team†

The membership of the Board subcommittees and of the GCBH QM Team is designed ensure that there will be adequate expertise and communication for these bodies to address their responsibilities relative to participation in the GCBH QM Program.

	QMOC	Funding/Fiscal Operations Committee	Clinical Directors Committee	MIS Steering Committee	Multi-Cultural Competence Committee
GCBH Board of Directors	Board Chairman, Clinical Committee Chair, UM Committee Chair	3 representatives	3 representatives	3 representatives	3 representatives
GCBH Executive Director	Yes	Yes	Ad hoc ^{††}	Ad hoc ^{††}	Ad hoc ^{††}
Chief Clinical Officer	Yes				
Chief Financial Officer	Ad hoc ^{††}	Yes		Ad hoc ^{††}	
Quality Director	Yes	Ad hoc ^{††}	Yes	Yes	Yes
GCBH Medical Director	Yes		Yes		
Grievance & Appeals Manager	Ad hoc ^{††}		Ad hoc ^{††}		
Customer Services/Satisfaction Manager	Yes		Yes		Yes
MIS Director	Yes		Ad hoc ^{††}	Yes	
UM Staff			Yes	Yes	
Advisory Board Representative	Yes, a consumer member		Yes, a consumer member		
Ombuds Representative	Yes				Yes
Quality Review Team	2 representatives				
Representatives of Provider Organizations	At least 3, 2 with clinical expertise and 1 with non-clinical operations expertise	1 representative	All Clinical or Medical Directors	2 with MIS expertise, and 2 with clinical expertise	4 staff members
Multi-Cultural Committee Representative	Yes		Ad hoc ^{††}		

[†] A given committee member may fill more than one membership role. For example, a Board member may also represent a Provider agency. Accordingly, this table does *not* establish the *number* of members required for each committee, nor is it intended to limit committee membership.

^{††} Ad hoc members are kept informed of meeting dates and agendas, and elect whether to participate in a given meeting unless specifically asked to attend.

APPENDIX G: Sources of Noted Requirements

- ¹ 42 CFR 438.240 (b)(1)
- ² 42 CFR 438.240 (d)(2)
- ³ 42 CFR 438.240 (e)(1)(i)
- ⁴ 42 CFR 438.240 (e)(1)(ii)
- ⁵ WAC 388-865-0280
- ⁶ WAC 388-865-0280, par. (2)(c); PIHP Contract, 3
- ⁷ WAC 388-865-0282, par. (4)
- ⁸ WAC 388-865-0280, par. (1)
- ⁹ WAC 388-865-0280, par. (2)(e); PIHP Contract 18.7
- ¹⁰ WAC 388-865-0250, par. (13); PIHP Contract 10.5
- ¹¹ WAC 388-865-0250, par. (12); WAC 388-865-0280, par. (2)(c); PIHP Contract 13
- ¹² WAC 388-865-0320
- ¹³ State Contract
- ¹⁴ PIHP Contract, 15
- ¹⁵ WAC 388-865-0280, par (2)(h); PIHP Contract 8.10
- ¹⁶ WAC 388-865-0280, par. (2)(a)(i)
- ¹⁷ PIHP Contract, 6.15.3; 9.3.16
- ¹⁸ WAC 388-865-0280, par. (2)(b)
- ¹⁹ PIHP Contract, 12
- ²⁰ WAC 388-865-0450
- ²¹ PIHP Contract, 8.1.2.7
- ²² PIHP Contract, 8.1.2.8
- ²³ PIHP Contract, 8.2.1.9
- ²⁴ PIHP Contract, 8.1.2.10
- ²⁵ PIHP Contract, 8.1.2.11
- ²⁶ PIHP Contract, 42CFR 438.240 (b)(3); 11.1.1.4
- ²⁷ WAC 388-865-0282
- ²⁸ PIHP Contract, 8.7.1.1
- ²⁹ PIHP Contract, 8.7.1.4
- ³⁰ PIHP Contract, 8.7.1.2
- ³¹ PIHP Contract, 8.7.1.3
- ³² PIHP Contract, 7.1.1.1
- ³³ PIHP Contract, 7.2.2.2
- ³⁴ PIHP Contract, 7.2.6.1
- ³⁵ PIHP Contract, 14.2
- ³⁶ PIHP Contract, 13.8.1.1
- ³⁷ PIHP Contract, 7.2.2.2.2; 13.6.3.3
- ³⁸ PIHP Contract, 11.3.2
- ³⁹ PIHP Contract, 14.5.2.1
- ⁴⁰ 7.2.2.6; 11.3.2.1

⁴¹ PIHP Contract, 7.2.1.3

⁴² PIHP Contract, 7.2.1.4

⁴³ State Contract – Exhibit D

⁴⁴ Measure not specifically named by MHD contracts, but considered important by the RSN and/or required by law.