COMMUNITY MENTAL HEALTH SERVICES OF MUSKEGON COUNTY

POLICY

Prepared by: No. 01-006 Effective: January 27, 2006
Revised: April 6, 2011

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Corporate Compliance Advisor

Approved by: Subject: Corporate Compliance

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David R. Parnin
Chief Operating Officer

I. POLICY

It is the policy of Community Mental Health Services of Muskegon County to conduct itself as a good organizational citizen with the utmost of professional integrity, ethics and honesty.

II. PURPOSE

To establish and maintain a Corporate Compliance Program in strict conformance with laws and regulations governing administrative, business, clinical, financial and marketing practices to prevent violations of any law, whether criminal or non-criminal for which CMHS of Muskegon County is, or would be, liable.

III. APPLICATION

All employees, volunteers, contractual employees or vendors of CMHS of Muskegon County.

IV. DEFINITIONS:

A. Covered Individuals: Except as otherwise provided within the Corporate Compliance Plan, the term "Covered Individuals" refers to all of CMHS of Muskegon County's employees and all of its contractors and individuals with responsibilities pertaining to the ordering, provision, marketing, documentation, coding or billing of services payable by a Federal or State program for which CMHS of Muskegon County seeks reimbursement.

B. Off-Site Contractor Providers: Individuals/entities that contract with CMHS of Muskegon County (or who are employed by or sub-contract with a person or entity that contracts with CMHS of Muskegon County) to provide services at locations that are not owned or leased by CMHS of Muskegon County.

C. Pre-Existing Contractors: Covered Individuals who are independent contractors with whom CMHS of Muskegon County has an existing contract on the effective date of any revisions to the Corporate Compliance Plan. Once CMHS of Muskegon County renegotiates, modifies, or renews a contract with an existing contractor, that contractor ceases to be a Pre-Existing Contractor and CMHS of Muskegon County will have full responsibility for the certification and training compliance obligations as pertains to that contractor.

D. Corporate Compliance Plan: Procedural framework established to provide assurances that CMHS of Muskegon County is in compliance with all billing, collection, and medical records and other documentation requirements of all Federal or State programs with which the Agency does business. The Plan provides avenues for errors/problems in the system to be appropriately and timely identified and corrected.

E. Corporate Compliance Advisor: Senior staff member selected by the Board of Directors to manage CMHS's Corporate Compliance Plan. The Corporate Compliance Advisor has necessary access to legal counsel, Board of Directors, and Director in order to enforce the Plan.

F. Risk Management Committee: Senior staff members of the Agency with the responsibility to review risk management and other compliance issues and activities.

G. Abuse: Payment for items or services when there is no legal entitlement to that Payment, and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

H. Fraud: Knowingly and willfully executing or attempting to execute a scheme or artifice to defraud any Federal or State program or to obtain, by means of false or fraudulent pretenses, representations or promises any of the money or property owned by, or under custody or control of, any Federal or State program.

V. PROCEDURE

A. The Community Mental Health Services Board of Directors will designate a Corporate Compliance Advisor, who is responsible for oversight of the Corporate Compliance Program.

B. The Corporate Compliance Advisor in conjunction with the Risk Management Committee will develop, implement, and revise the Corporate Compliance Plan as needed.

C. The Code of Ethics will be reviewed on an annual basis and revised as necessary to meet any changes in regulations that would result in a change in the Corporate Compliance Plan.

D. The Corporate Compliance Advisor/Designee will train the employee using the Corporate Compliance Plan and other pertinent information when they are first employed by CMHS of Muskegon County with updates on an as needed basis. The Executive Director/Designee will assure the Corporate Compliance Advisor is trained to perform his/her duties.

E. The Corporate Compliance Advisor will continuously review all health care fraud alerts and other pertinent information for integration into the ongoing training program for CMHS of Muskegon County employees.

F. The Corporate Compliance Advisor will distribute the Code of Ethics to "Covered

Individuals" and "Off-Site Contractor Providers" and ensure by certification that such individuals and providers have received, read, understood, and will abide by the Code of Ethics.

G. The Corporate Compliance Advisor will ensure that CMHS of Muskegon County employees have the opportunity to report any wrongdoing in several ways: telephone, internal mail, voice mail and electronic mail.

H. Once a complaint is received, the Corporate Compliance Advisor, in conjunction with legal counsel (if necessary) will investigate the complaint. The Corporate Compliance Advisor will either substantiate or not substantiate the complaint as a result of the investigation. If the complaint is substantiated, recommendations will be made and a plan of correction will be required.

I. The Corporate Compliance Advisor will monitor the Plan of Correction. If the Plan of Correction is not implemented; the Executive Director will be notified for subsequent action to prevent future occurrences of the offense.

J. Depending upon the nature of the complaint, the Board of Directors of CMHS will be informed and if appropriate, the Executive Director shall make a timely and thorough report to the appropriate governmental authorities on behalf of CMHS.

K. No retribution will be taken against any employee for merely reporting what the employee reasonably believed to be a violation of the Program.

L. Adherence to and promotion of the Corporate Compliance Program will be a specific criterion used in performance evaluations of all levels of CMHS employees.

M. The Corporate Compliance Advisor will continuously review the effectiveness of the Corporate Compliance Plan.

N. The Corporate Compliance Advisor will present a report to the Board of Directors on an annual basis, and more frequently, if necessary relative to the adherence to the Corporate Compliance Plan.

VI. REFERENCES

- Definitions of Fraud and Abuse – 42 CFR § 455.2
- False Claims Act 31 U.S.C. § 3729
- DOJ Guidance on the Use of the False Claims Act in Civil Health Care Matters
- Federal Anti-Kickback Statute 42 U.S.C. § 1320a-7b (b)
- False or fraudulent representation in connection with health care benefits program 18 U.S.C. § 1035
- Office of Inspector General Compliance Guidelines

/jec

Attachment A

COMMUNITY MENTAL HEALTH SERVICES OF MUSKEGON COUNTY

ACKNOWLEDGEMENT STATEMENT

I hereby acknowledge that I have received and read the Community Mental Health Services of Muskegon County's Corporate Compliance Plan and agree to participate fully in the Compliance Program. I have also received and read the Code of Ethics and agree to fully comply.

In accordance with the procedures described in the Corporate Compliance Plan, I have reported, and/or will report to Community Mental Health Services of Muskegon County any wrongdoings and potential compliance problems of which I become aware.

Employee's Signature: _____

Employee's Printed Name: _____

Employee's Position: _____

Date Signed: _____

(Please return to Human Resources Secretary within one (1) week of receipt.)

Community Mental Health Services of Muskegon County

Attorney-Client Privileged
Attorney Work Product

Corporate Compliance Telephone Report

Case Identification Code: _____

Date Report Initially Filed: _____

Staff Completing Report: _____

Instructions:
Complete information above. Leave Case Identification Code blank. The Corporate Compliance Advisor will assign this number after reviewing the report. Describe details of the report in the space below. Encourage the caller to be as specific as possible concerning names, dates, description of the problems, etc. Attach additional sheets of paper as necessary. When completed, sign your name at the bottom of the report and send to Corporate Compliance Advisor. If the report involves the Corporate Compliance Advisor, the report should be submitted to the Director.

Staff Filing the Complaint:

Employee(s) the Complaint is in Regards:

Dates/Period Incidents(s) Occurred:

How the Complaint was Identified:

Signature: _____ _____
Staff Completing the Report Date

COMMUNITY MENTAL HEALTH SERVICES OF MUSKEGON COUNTY

CORPORATE COMPLIANCE CHECK

Multiple Choice: Please circle the correct answer and return to the Corporate Compliance Advisor.

1. The purpose of the Corporate Compliance Program is to:

   A. Avoid illegal, unethical and improper conduct

   B. Find illegal, unethical and improper conduct

   C. Stop illegal, unethical and improper conduct

   D. A and B

   E. All of the above

2. The Community Mental Health Services of Muskegon County reporting hotline is:

   A. 1-800-rat–u–out

   B. 1-231-724-6575

   C. 1-800-9-Notify

   D. 1-800-CallCCA

3. The person responsible for reporting possible fraud or illegal activities that happens in one of the CMHS programs to the Corporate Compliance Advisor is:

   A. The Program Supervisor

   B. The Assistant Director

   C. The Client Services Manager

   D. Each employee

4. Some of the improper or fraudulent activities the Compliance Program is intended to prevent include:

   A. Placing misleading or inaccurate information regarding diagnosis, treatment or cause of consumer's condition into the medical record or chart.

   B. Reporting consumer complaints about services to the supervisor.

   C. Billing for services or services not rendered, not documented or not provided as claimed.

   D. B and C

   E. A and C

5. The following are methods in which the employee can report wrongdoing to the CMHS of Muskegon County Corporate Compliance Advisor:

   A. Telephone – Corporate Compliance Advisor number (1-231-724-6055)

   B. Mail marked to the "Attention of the Corporate Compliance Advisor."

   C. Voice Mail – hotline number (1-231-6575)

   D. Electronic Mail – internal mailbox entitled, "Corporate Mail."

   E. All of the above

True / False

6. I am responsible to report concerns about fraudulent or illegal acts directly to the Corporate Compliance Advisor or in the variety of ways available to report.

   A. True
   B. False

7. If an employee, be it a direct care worker, billing agent, social worker, therapist, coding specialist and/or management staff is found guilty of fraud or illegal activities on the job, he/she could lose their job, be fined or be put on trial.

   A. True
   B. False

8. If I tell my supervisor that I suspect a criminal or other wrong act, I have done everything that I need to do:

   A. True
   B. False

9. Telling friends, family or others about consumer problems or issues could be illegal:

   A. True
   B. False

10. There are several ways to report potential fraud and abuse: a) to my own Corporation's Corporate Compliance Program; b) to the CMHS of Muskegon County Corporate Compliance Advisor; and c) to the Office of Inspector General, HHS.

   A. True
   B. False

11. The Organization shall not take disciplinary action against an employee for merely reporting what the employee reasonably believes to be a violation of the Organization's Corporate Compliance Program.

   A. True
   B. False

I have read the Corporate Compliance Plan and completed the Corporate Compliance Comprehension check.

_____ _____

Employee Signature Date

Community Mental Health of Muskegon County

UM PLAN 2010-2011

Goals and Objectives:

- To provide ongoing monitoring and evaluation activities which address over-utilization, under-utilization, and inefficient coordination of behavioral health resources.
- To ensure that guidelines, standards, and best practice criteria are adhered to.
- To respond to member and provider grievances by coordinating timely investigations associated with utilization issues
- To ensure that services provided are within the guidelines of the member's health plan and are authorized as requested by the primary worker.
- To facilitate and care manage "high risk" members by ensuring timely access to continuum of services
- To ensure consistency of application of service selection guidelines across all reviewers.
- To ensure that members have a network of competent providers in accessible locations
- To develop and maintain Um policies and procedures; annually review and revise as necessary
- To maintain a strong link with other management functions including, but not limited to, quality improvement, network, and customer services.
- To monitor member and stake holder/provider satisfaction with the UM processes and identify areas of concern
- To monitor the utilization of high cost services and monitor usage trends
- To target Um reviews around current priority areas (capacity, quality, high cost, high utilization)
- To ensure that services are charged to the appropriate fund source.
- To maintain individuals in the least restrictive treatment setting available.

1. **To ensure timely access to supports and services:**

Indicators for timeliness will be monitored with standards as follows:

a. Face to Face meeting, usually a screening or assessment will occur within 14 days of the request.
b. Days between a non-emergency assessment and the start of ongoing services will not exceed 14 days.
c. Preadmission screenings will be completed within three hours of initial request.
This data is aggregated by division quarterly and shared with management staff.

2. To provide concurrent review of all active cases to determine Medical Necessity/appropriate service needs.

a. At the time of re-authorization it will be determined if the consumer still meets Medical necessity criteria for the requested services and supports.
b. Access staff will also ensure that the consumer is in the correct level of care, and that they are maintaining stability with the current scope, and frequency of services.

c. Clinical information will be obtained from the record as well as consultation with treatment team including psychiatrists and clinical staff to assist with decision making.
d. If it is determined that the level of care provided is not meeting the individual's needs a formal chart review with recommendations will be completed and forwarded to the supervisors.

3. To conduct Retrospective reviews on discharged cases, and determining Medical Necessity for inpatient cases which require CMH financial authorization.

a. If there are significant findings these will be forwarded to the program or responsible manager
b. Trends will be noted especially in the areas of inadequate discharge planning, or poor follow up.
c. On inpatient cases where there is a disagreement with the admitting psychiatrist, the final reviews will be completed by a psychiatrist who will review the chart of both the hospital and pertinent CMH documentation to make a decision.

4. Individual concurrent review will occur when there is suspected under or over utilization of services.

a. This will occur during the authorization process when the case is discussed with the primary worker.
b. This may not necessarily result in a formal chart review process, and will be documented on the Access call log.
c. Results of the review will determine the amount and scope of services authorized.
d. Special emphasis will be on OP cases that have been open longer than one year to determine if they continue to meet medical necessity criteria. (reference service selection guidelines)

5. To monitor changes of the consumer's movement within the continuum.

a. Clinical review will occur to ensure that the step-down is clinically appropriate and will not put the consumer at risk. Persons who have utilized inpatient or crisis residential will not be considered for step down unless there is evidence to suggest why an exception should be made.
b. When the primary worker requests a consumer be moved into a more intensive level of care, the chart will be reviewed to ensure that the transfer is medically necessary, least restrictive, and that every effort was made by the primary worker to attempt to maintain them in the current level of care.
c. Findings will be forwarded to the primary worker. A formal chart review may not be necessary, owever, if one was completed the supervisor will receive a copy of the completed form.

7. To trend all gate keeping activity and track costs and demand over time.

a. Diversion rate will be tracked and trended by month
b. Length of stay will be tracked and trended by hospitalization, and by child or adult
c. Costs will be kept track of in real time by looking at days authorized, and separated by child and adult admissions.

8. Focus resource Utilization Management efforts on high cost, intensive services, and services with limited capacity, and termination reviews.

a. Access managers are assigned to the high cost areas of adult and child inpatient, specialized residential (children and adult MI)
b. Random reviews of terminated cases will occur each quarter in order to determine whether services are terminated appropriately and if the individual was connected to community services.
c. Reports will be run at least monthly to monitor usage of services such as residential , inpatient, and community living supports.

9. Individuals who are identified on the MMBIS report as meeting the criteria for recidivism will receive a concurrent review to determine if the current service array is sufficient to maintain stability.

10. A Utilization Management Committee , which is comprised of clinical management staff will develop and review key reports to control costs, create efficiencies , and establish oversight over this process.

a. Will meet once monthly
b. This group will use data available to identify areas which are vulnerable and require cost control measures
c. Will also focus on medical necessity as defined by minimum and maximum number of units within key programs, and reviewing outliers.

COMMUNITY MENTAL HEALTH SERVICES OF MUSKEGON COUNTY
QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN
2011/2012

I. PURPOSE

To provide a structure and a set of practices which facilitate planning, measurement, assessment and improvement of processes and systems. Community Mental Health Services of Muskegon County is committed to planning for and supporting a formal continuous improvement structure and a planned systematic, organization-wide approach to process design and redesign, performance measurement, analysis, and improvement of important governance, management, clinical, and support functions to improve care and outcomes. This is accomplished in a comprehensive, coordinated, collaborative manner that considers internal and external consumer and stakeholder needs and expectations, and focuses on important functions and processes. The overall approach to continuous improvement is a continuum from daily problem solving to interdisciplinary continuous improvement to process and system design and redesign. The Quality Assessment and Performance Improvement policy (#09-001), plan and other supporting formal working procedures comprise the structure for Quality Assessment and Performance Improvement. Practice standards provide detailed processes.

II. APPLICATION

All Agency staff will participate in Quality Assessment and Performance Improvement activities. Contracted services include contract language that reflects their adherence to established Quality Assessment and Performance Improvement strategies and quality standards.

III. PERFORMANCE IMPROVEMENT PROGRAM GOALS

A. Target improvement at all levels including the Board, management, administration, and programs. Clinical care and non clinical dimensions of care such as access, efficiency, coordination of services, timeliness, safety, respect and caring, effectiveness, appropriateness, continuity and outcomes are included.
B. Maintain a formal process to identify areas of improvement.
C. Involve consumers and providers in assessing and improving consumer satisfaction with services delivery and outcomes.
D. Involve consumer, family members and providers in quality improvement activities and representation on quality improvement committees.
E. Develop key performance indicators to assure services are effective and efficient.
F. Use analysis of reliable and valid data for decisions.
G. Track and compare the agency's performance on key indicators to statewide and/or national data to assess the agency's performance over time and in comparison to industry standards.
H. Monitor the QI structure, including activities of standing committees and workgroups.
I. Assure providers of service fulfill contractual or employment obligations in accordance with applicable regulatory and accreditation standards.
J. Assure providers of service are competent and capable of providing services through a system of competency evaluation, credentialing and privileging.
K. Assure that providers of services are culturally competent, and make accommodations to consumers, as needed.
L. Assure that performance indicators and QI activities impact all populations served by the agency, including longer term consumers.
M. Review all sentinel events and take action based on reviews.
N. Assure coordination and integration of QAPIP and Utilization Management activities.
O. Carry out performance improvement projects as required State and Federal Guidelines.

IV. CONFIDENTIALITY AND CONFLICT OF INTEREST

All Quality Assessment and Performance Improvement Activities take place in a manner consistent with State and Federal confidentiality regulations and agency policy. All member information is kept strictly confidential. No written reports, records or any work product or communication related to Quality Assessment and Performance Improvement (PI) activities are identifiable except when specific reference to an individual provider, program or clinician is necessary to meet the goals of the PI program.

The procedures and minutes of PI Committees and PI data and analysis, will be open to review by the Department of Community Health, accrediting bodies, state and federal regulatory agencies, when applicable.

V. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT MODEL

A. The Quality Assessment and Performance Improvement program spans across all internal operational areas as well as external clinical operations that affect consumer members. .

B. Community Mental Health Services of Muskegon County functions according to a Continuous Quality Improvement (CQI) philosophy. A four-step process improvement model developed by Shewhart has been adopted for PI initiatives. The cycle of CQI begins with careful examination of data collected from monitoring mechanisms. As data indicates a need for Quality Assessment and Performance Improvement, the Plan – Do – Check – Act (PDCA) process begins.

C. Planning incorporates response to the development, implementation and monitoring of internal plans and methodologies integrated through the following administrative plans:
   1. Strategic Plan
   2. Risk Management Plan
   3. Utilization Plan
   4. Information Management Plan
   5. Safety Plan
   6. Procurement/Network Plan
   7. Corporate Compliance Plan
   8. Cultural Competency Plan
   9. Accessibility Plan
   10. Training Plan
   11. Human Resources Plan

   The planning step defines topics of study or measurement through data collection and analysis and stakeholder and consumer input. The planning step identifies the type of information and data that are necessary for development of the measurement methodology using research of literature to establish benchmarks based on best practices, when possible. The planning step results in the establishment of a team of knowledgeable individuals to lead the PDCA processes. Individuals may include employees, contracted providers, consumer members and/or community members.

D. Doing includes:

The identification of specifically what data is required and the individual(s) responsible for data collection and report development. The individual(s) responsible assure data is reliable and valid for analysis compared to benchmarks and develops a report of recommended improvements based on the data, trending and established requirements for corrective actions. Implementation of improvements occurs during this step.

E. Checking includes:
Review of the findings from the data collection and monitoring to assure that improvement processes. On-going measurement and monitoring occurs to assess the effectiveness of the improvement strategy to achieve sustained improvement.

F. Acting involves:
Monitoring of the needed action is taken to assure adequate follow up. Measurement of the action taken is to assure that the intended effect of the change has happened as planned or redesign of improvement strategy occurs if effectiveness is not demonstrated. Results are disseminated to internal and external providers, consumers and stakeholders.

VI. STRUCTURE/ROLES (Please Reference Policy # 09-001)

The formal organization is designed to provide a consistent process through which quality can be defined, pursued, achieved and monitored. The formal mechanisms are expressed through the functions and activities of the Quality Council, standing committees and performance improvement teams. The QI Structure is graphically depicted in the attachment to the plan.

VII. PRACTICE GUIDELINES

The Board of Directors approves the adoption of practice guidelines. Performance Improvement committees are responsible for overseeing the development, implementation and continuous monitoring and evaluation of practice guidelines related to core processes within the scope of the committee. Guidelines may be adopted by adherence to State contract requirements or developed internally based on data analysis and research of evidence based best practices. The Medical Director participates in the review of practice guidelines related to outcomes of care. The Improving Practices Leadership Team oversees the adoption, development, implementation and continuous monitoring and evaluation of practices guidelines, evidence-based practices, practice-based evidence, best practices and promising practices relevant to the person served.

VIII. PERFORMANCE ANALYSIS

The organization utilizes compliance indicators and quality improvement measures established by the Department of Community Health in the areas of access, efficiency and outcomes. Monitoring measures in the area of access/penetration, continuity of care, denial/appeals, supported employment and quality of life is collected and analyzed. Data is reported to the Department of Community Health. An internal Michigan Mission Based Performance Indicator System (MMBPIS) Report Card is utilized to monitor on-going adherence to established standards and to benchmark the organization compared to the performance of neighboring regions.

Agency Performance Indicators are developed, monitored and reported in the Outcome Management Summary (Attached) for both service delivery and business functions. Indicators focus on effectiveness, efficiency, access and satisfaction.

IX. BEHAVIOR TREATMENT REVIEW

The Behavior Support Committee reviews behavior treatment plans on a quarterly basis. The Behavior Support Committee reports quarterly to the Quality Council an analysis of data where intrusive or restrictive techniques have been approved. Only techniques that have been approved during person-centered planning by the individuals or his/her guardian, and supported by a current peer reviewed psychological and psychiatric literature may be used. Data shall include numbers of interventions and length of time the interventions were used. The use of physical management is reviewed by Recipient Rights and/or the Behavioral Support Committee through data obtained from critical incidents reports. In responding to and incorporating the philosophy of Gentle Teaching, use of physical management is not allowed in behavior plans. Any use of physical management is considered emergency use and reported with an incident report.

The Behavior Support Committee reports quarterly to the Quality Council additional critical events that put individuals at risk of harm. The analysis is used to determine what actions need to be taken to remediate the problems or situation and to prevent the occurrence of additional events and incidents.

Risk Event Monitoring

Service	Harm to Self	Harm to Others	Police Calls	Physical Management	Hospitalization
Supports Coord	•	•	•	•	•
Case Management	•	•	•	•	•
ACT	•	•	•	•	•
Homebased	•	•	•	•	•

X. SENTINEL EVENTS & UNEXPECTED DEATHS

Adverse incidents and Sentinel Events are defined in the organization's policy number 04-024 Peer Review and Root Cause Analysis. Network providers are responsible to report sentinel events to the Agency's Office of Recipient Rights and are reviewed by the Recipient Rights workgroup. A Peer Review process is utilized to review agency procedures, evaluate actions taken and make recommendations for further training, procedures change, or interventions that will improve care for individuals served. Staff involved in reviewing and analyzing sentinel events must have appropriate credentials to review the scope of care. The Medical Director is consulted as needed. Sentinel events are reported to the Recipient Rights office. Within 48 hours of a sentinel event occurrence, the Quality Manager convenes a Root Cause Analysis workgroup. Within 20 days the Root Cause Analysis workgroup conducts an evaluation and prepares a report containing full documentation of the Root Cause Analysis. The report is forwarded to the Executive Director and PIHP Regulatory Management Supervisor. The Executive Director accepts or revises the recommendations and assigns responsibility to the appropriate supervisor(s) who are responsible to provide quarterly reports to the Risk Management Committee who evaluates the effectiveness of the improvements.

The Agency Office of Recipient Rights is responsible to ensure that the Department of Community Health and CARF International are informed of all reportable events.

The critical incident reporting system captures information on reportable events. Community Mental Health Services of Muskegon County will report to MDCH the following events within 60 days after the end of the month in which the event occurred for individuals who, at the time of the event, were actively receiving services:

Reporting of Critical Incidents to MDCH

Service	Suicide	Death	EMT	Hospital	Arrest
CLS	•	•			
Supports Coord	•	•			
Case Management	•	•			
ACT	•	•			
Homebased	•	•			
Wraparound	•	•			
Hab Waiver	•	•	•	•	•
SED Waiver	•	•	•	•	•
Child Waiver	•	•	•	•	•
Any other Service	•				
Living Situation					
Specialized Resid	•	•	•	•	•
CCI	•	•	•	•	•

All unexpected deaths of individuals who at the time of their death were receiving specialty supports and services are reviewed. The review includes:

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

XI. CUSTOMER SATISFACTION

The assessment of consumer satisfaction with services and outcomes occurs through qualitative and quantitative methods and throughout an individual's involvement with the agency and post discharge. The assessments address issues of quality, availability, accessibility and respect. At the program level, individuals are asked for feedback about their satisfaction with services quarterly and annually at the time of the Person Centered Plan development. Every consumer also has the opportunity to complete a satisfaction survey and/or participate in a focus group, at least once a year. Additionally, "How are We Doing" satisfaction survey cards are placed at each CMH location for completion as often as an individual would like to provide feedback. All survey instruments provide an opportunity for an individual to request a follow-up contact. Quality Improvement staff forwarded requests for follow-up to Customer Services staff or Program Managers who conduct and document the outcome of the follow-up. Quality Improvement staff aggregated results by program internally and by provider for contracted services and are reported through the Quality Improvement structure including the Consumer Advisory Council, Quality Advisory Council and to the Board of Directors. Satisfaction Survey results are posted to the CMH website and distributed through CMH/PIHP publications such as newsletters and annual reports

to community partners and Family Resource Centers. Results can also be obtained through the CMH/PIHP customer services department.

XII. PROVIDER SATISFACTION

To give consumers, family members, advocates, and other interested parties an opportunity for completion of a satisfaction survey, a Satisfaction Questionnaire for Community Partners is conducted annually. The initial survey was developed and distributed in 2002. The objective of the provider satisfaction survey is to determine provider's satisfaction with Community Mental Health of Muskegon's benefits management functions. Both qualitative and quantitative measures are used. The Customer Satisfaction Workgroup reviews the results of the survey and report to the Board of Directors and leadership groups, Customer Services and the provider network.

XIII. PERFORMANCE IMPROVEMENT PROJECTS

Community Mental Health Services of Muskegon County conducts clinical and non-clinical quality studies in accordance with the Quality Improvement System for Managed Care (QISMC) standards. Performance Improvement projects are out-come-oriented, demonstrate improvement and sustained improvement in care and services. For the current fiscal year 2011/2012 these studies will include:

- Increasing the proportion of Medicaid Eligible individuals with a mental illness who received at least one peer delivered service or support.
- Increasing the percentage of Medicaid Eligible individuals served with integrated behavioral and physical health care.

Over increments of one year intervals, performance improvement projects are added to the Quality Assessment and Performance Improvement program such that each of the following areas is addressed:

Clinical Focus

- Primary, secondary, and/or tertiary prevention of acute conditions
- Primary, secondary, and/or tertiary prevention of chronic conditions
- Care of acute conditions
- Care of chronic conditions
- High – volume services
- High – risk services
- Continuity and coordination of care

Non-clinical Focus

- Availability, accessibility and cultural competency of services
- Interpersonal aspects of care
- Appeals, grievances, and other complaints

XIV. CLINICAL CHART REVIEWS

The agency has had a chart review process in place since 1994. Since 1999 a comprehensive effort has been made to integrate program specific chart reviews into a common comprehensive review. In January, 2004 a revised Clinical Chart Review procedure was implemented. Data is aggregated quarterly and reviewed by the Chart Review Coordination Committee with recommendations made to the Quality Improvement Council. In October 2001, Documentation Standards procedures were developed and implemented to strengthen the inter-rater reliability on the Clinical Chart Review form and the validity of results.

XV. CREDENTIALING, PRIVILEGING AND COMPETENCY

The agency maintains a complete system for credentialing, privileging and competency assessment for staff and contractual providers. Procedures are in place to ensure criminal background checks and source verification of educational and State licensing status occur at the time of hire/contract. Job descriptions are available for all county employees with a detailed scope of responsibility specifying expectations, and cultural competence, for each position. Annually, all staff receives a performance/competency evaluation by their supervisor. Applicable policy and procedures and additional supporting documentation are noted in the Reference section.

XVI. CULTURAL COMPETENCE

A. The agency evaluates access and treatment trends of ethnic and minority groups through the annual Cultural Competency and Accessibility Plans.
B. All new hires are required to attend a Cultural Competency class and external providers are required to ensure staff receives initial and on-going training in Cultural Competence.
C. On-going information and training is made available, as defined in the Cultural Competency and Accessibility Plans.
D. On-line training course(s) are available to staff and external providers through Netsmart University.

XVII. VERIFICATION OF SERVICES PROVIDED TO MEMBERS

Community Mental Health Services of Muskegon County verifies that services claimed by providers have been provided. A policy titled "Claims Verification" covers all claims for the entire CMH network, whether from CMH service divisions or from contracted providers. The policy ensures that the Agency shall review a sample of claims to determine that payments for services are properly made. This includes determining that the service claimed was provided, is eligible for payment from the claimed funding source, is identified in a person-centered plan and is properly documented.

A procedure titled "Billing Audit" covers only services provided by CMH directly. This policy is approved and is being implemented.

XVIII. COMMUNICATION AND TRAINING

Training and information about Quality Improvement is provided at the time of new hire orientation and on an on-going basis. Information and activities are communicated in a number of ways:

A. A systematic means for staff to make suggestions related to any quality issues is provided through the use of agency suggestion form and procedure.
B. A quality improvement newsletter is distributed via the CMH website monthly.
C. Minutes of standing quality improvement committees are available via the Intranet.
D. Information and activities about quality improvement efforts are included in the Director report to the Board each month.
E. Quality Improvement reports including satisfaction and service outcomes are posted to the CMH website.
F. Quality Improvement communications are a standing item for the external Provider meetings.

XIX. LINKAGE TO UTILIZATION MANAGEMENT

Quality Assessment and Performance Improvement philosophy and methodology is central to Utilization Management's procedures for identifying, analyzing and correcting under utilization as well as over utilization. To achieve the Utilization Management goals, a number of UM functions are used:

- Eligibility Screening, including Psychiatric Hospitalization pre-evaluation;
- Service Authorization
- Utilization Review
- UM Committee: Prospective (eligibility determinations, medical necessity and level of care determinations), concurrent and/or retrospective procedures are established based on the principles of quality improvement.
- Development and Maintenance of Standards and Guidelines

These utilization management activities and operating processes are detailed in the UM Plan.

XX. EVALUATION OF THE QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN

The Quality Assessment and Performance Improvement policy is reviewed annually and revised as needed to keep pace with the changing needs and input of the CMH/PIHP stakeholders. The Quality Assessment and Performance Improvement Plan is valuated annually and ongoing methods of evaluation include:

- Periodic review of specific goals of QAPIP related to organizational performance improvement.
- Ad Hoc studies, surveys and informally gather data related to the above.
- Review of quality, outcomes and other data on an ongoing basis, to identify trends and new issues requiring attention.
- Feedback from CMH/PIHP Network providers and Consumer Councils.
- Review of Satisfaction surveys related to the quality of care review process, and other qualitative/quantitative measure of satisfaction and input.
- Auditing for continuous improvement in the provider network.

The annual evaluation of Quality Assessment and Performance Improvement effectiveness includes a workgroup/committee self-assessment, which cover such aspects as:

- Do the performance indicators cover the key dimensions relevant to best practice performance standards?
- Does problem resolution result in long term improvement?
- Is the mission and composition of workgroups conducive to meeting the agency Strategic Plan objectives?
- What are the Process Improvement Accomplishments?
- Are reports effective and timely?
- Has the QA&PI program improved the efficacy, appropriateness and cost-effectiveness of managing consumer benefits, outcomes and satisfaction?
- Have stakeholders participated in the design, delivery and evaluation of the CMH/PIHP through quality improvement processes.

The Director and the Quality Manager are responsible to present findings and recommendations to the Board of Directors.

XXI. PERFORMANCE IMPROVEMENT PROGRAM FISCAL YEAR 2011/2012 OBJECTIVES:

- Participate in collaborative work with academic researchers, and other mental health programs on the implementation and statistical measurement of existing evidence based practices, emerging treatments, and innovative interventions.
- Conduct a Community Needs Assessment with individuals served and stakeholders.
- Ensure full implementation and adherence to the expected 95% accuracy and completion benchmark for Health & DD Proxy Measures.
- Refine methods to aggregate and analyze the health conditions of individuals receiving services for future program planning and integration of health care services.
- Explore the use of health condition, proxy measure, and other available data to aid in identifying and monitoring the most vulnerable individuals served.
- Identify benchmarks for quality/performance indicators, when possible.
- Explore additional qualitative and quantitative measures of feedback on focus areas (i.e. Recovery, Trauma, Welcoming etc.)
- Implement measures of outcomes and quality of life for all persons receiving services, using standardized measures when possible.
- Increase the participation of stakeholder, non-management staff, and individuals receiving services in performance improvement committees, workgroups, and activities.

XXII. REFERENCES:

- CARF International Standards
- Policy Quality Assessment and Performance Improvement
- Policy Peer Review and the Root Cause Analysis of Sentinel Events
- Implementation and Monitoring of CMH Satisfaction Surveys
- Policy Claims Verification
- Procedure- Billing Audit
- Policy Clinical Chart Review
- Person- Centered Planning Best Practice Guideline
- Provider Orientation & Implementation of Person Centered Planning
- Procedure New Hire process
- Policy Verification of Registration and/or Licensure of CMH Professional Employees and Contracted Professional Providers.
- Contract Boiler Plate
- Strategic Plan
- Risk Management Plan
- Utilization Plan
- Information Management Plan
- Corporate Compliance Plan
- Human Resources Plan
- QISMC Guidelines
- MDCH Contract Attachment
- Lakeshore Behavioral Health Alliance QAPIP and Utilization Plan
- Balanced Budget Act, 1997