



*Creating solutions, **One** person at a time*

**CONTINUOUS QUALITY  
IMPROVEMENT (CQI) PROGRAM  
DESCRIPTION  
2010-2011**

# Table of Contents

	<b><u>Page</u></b>
Introduction.....	3
Purpose.....	4
Goals .....	5
Objectives .....	6
CQI Structure and Accountability .....	7
Organizational Chart.....	9
Committee Structure.....	10
Scope of the Continuous Quality Improvement Program .....	16
Collaboration with Other PBH Departments.....	22
Collaboration with External Stakeholders.....	25
System Resources .....	26
Communication of CQI Information .....	27
CQI Program Documents .....	28
Confidentiality .....	29

## **Introduction**

Partnerships with recipients with mental health, developmental, and substance abuse conditions and their families, stakeholders, and provider network are essential to meet the changing needs and choices with service provision. This important aspect of recipient empowerment and choice drives Piedmont Behavioral Healthcare's (PBH) Continuous Quality Improvement (CQI) program. PBH is committed to providing quality services to recipients in the five county areas: Cabarrus, Davidson, Rowan, Stanly, and Union. This commitment mandates an interactive system that involves recipients and their families, providers in the network, LME staff, and stakeholders. This quality system must work collaboratively to set quality standards, identify system problems, require corrective action, and recommend solutions.

## **Purpose**

PBH is a system manager of services for consumers with mental health, developmental, and substance abuse conditions over a five county region. PBH directly manages multiple funding streams that include state, federal block grant, county, and Medicaid funding. Under a contract with the North Carolina Department of Health and Human Services, PBH operates two sub state Medicaid waivers. PBH is a prepaid health insurance program (PHIP) that operates a 1915b/c waiver, called the NC MH/DD/SAS Health Plan. The NC MH/DD/SAS Health Plan covers mental health and substance abuse services (State Plan for Mental Health Services). The NC Innovations Waiver, a 1915 C Home and Community based waiver, covers developmental disabilities services. PBH aims for continuous improvements in the quality of health care services and the health status of the population served. A comprehensive Continuous Quality Improvement (CQI) program directs PBH's efforts.

The scope of the CQI program is designed to ensure the accessibility of services, availability of the network and the quality and appropriateness of behavioral health services. Input and feedback into the CQI process from various stakeholders are valuable components of the quality improvement program.

The CQI program encompasses all aspects of care delivered by providers. This includes mental health, substance abuse, and developmental disabilities services which are provided in outpatient, inpatient hospital, and community based settings. In addition to continuous assessment of the clinical elements of health care, the CQI program looks at administrative and service issues that affect the delivery of care.

The CQI program outlines the scope of activities in the following functional areas:

- Continuous Quality Improvement (CQI) is focused on improving the care and service enrollees receive from the health plan and its providers.
- Utilization Review (UR) is structured to both manage the appropriateness and the effectiveness of care and services provided to enrollees.
- Care Coordination (CC) is designed to coordinate and ensure access to health care services resulting in optimal, cost effective outcomes for enrollees identified as high-risk, high-cost, and special needs.
- Disease Management (DM) is a multi-disciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions. Disease management supports the practitioner-consumer relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and consumer empowerment strategies such as self-management. It continuously evaluates clinical, humanistic and economic outcomes with the goal of improving overall behavioral health.

The CQI Program description is designed to describe the efforts of PBH to meet state and federal regulations, and national accreditation standards.

## Goals

- To develop a comprehensive, meaningful, and soundly executed quality improvement, utilization, and care coordination management strategy.
- To integrate a quality improvement approach in all aspects of the behavioral health plan management.
- To implement a standardized and comprehensive CQI program which will address and be responsive to the behavioral health needs of the enrollee population.
- To create an effective and responsive CQI program that allows for early detection and resolution of issues that affect the plan's enrollees, families, practitioners or providers.
- To measure, monitor, and improve performance of behavioral health care in key aspects of clinical and service quality for enrollees, providers, and practitioners.
- To demonstrate improved outcomes in behavioral health care and services to its enrollees.
- To foster a supportive environment to assist practitioners and providers to improve the safety and outcome of their clinical practice.
- To continually monitor, evaluate and optimize behavioral health care resource utilization in collaboration with contracted practitioners and providers.
- To ensure that state and federal regulatory requirements are met and that policies and procedures support the requirements.
- To ensure that cultural competence is integrated through the accessibility, availability, appropriateness and quality of care given to persons of all cultures, races and ethnicities.

## Objectives

The following objectives were designed to assist the plan in meeting its goals:

- Develop an annual CQI work plan that outlines activities, objectives, responsible person(s), and timeframes. Monitor the work plan on a quarterly basis.
- Develop, implement, and monitor action plans to improve behavioral health care. Integrate mechanisms for evaluating consumer safety into existing CQI activities.
- Initiate clinical and service performance improvement projects (PIPs) that are relevant to the populations served by PBH; NC MH/DD/SAS Health Plan and NC Innovations waivers.
- Identify and implement disease management programs relevant to the chronic populations served by PBH.
- Identify enrollees who would benefit from care coordination or disease management programs.
- Develop and distribute enrollee information that improves knowledge regarding consumer safety as it relates to self-care and clinical practice guidelines.
- Include network practitioners and providers in the development, monitoring, and evaluation of performance improvement projects, practice guidelines, standards, and interventions to improve outcomes.
- Facilitate continuity of care between providers and state hospitals to promote exchange of information, appropriate diagnosis, treatment, and referral for services for behavioral health disorders.
- Develop, implement and monitor processes that ensure culturally competent care to all persons.
- Complete a comprehensive analysis of all CQI studies, consumer and provider surveys or monitoring results against performance goals, benchmarks when available, and previous performance.
- Identify barriers to improvement, opportunities to pursue and take action when performance goals are not met.
- Monitor and improve compliance with accreditation standards and regulatory requirements governing managed care organizations.

## **CQI Structure and Accountability**

### ***Governing Body***

Ultimate accountability for the management and improvement of the quality of clinical care and service provided to enrollees rests with PBH Board of Directors. The PBH Board is comprised representatives from all five counties. Membership is established in state law and includes elected officials, consumer and families, professionals, and other community stakeholders. The Executive staff is responsible for ensuring the implementation of all aspects of the CQI program. The PBH Board delegates day-to-day operational responsibilities for the CQI program to the Medical Director.

On an annual basis, the PBH Board at a minimum reviews and approves the CQI Program Description, Work Plan, and Program Evaluation. CQI updates are presented monthly to the Executive Cabinet. The Executive Cabinet makes recommendations that are operationalized by the CQI committee.

### ***Designated Health Care Practitioner***

The day-to-day implementation of the continuous quality improvement program is under the direction and leadership of the Medical Director. The PBH Medical Director, a board certified psychiatrist provides direction and support for the behavioral health and substance abuse, and developmental disabilities aspects of the CQI program through participation on the CQI Committee. The Medical Director's primary responsibilities include:

- Working with the Quality Management (QM) Director and staff to monitor the implementation and progress of the CQI Work plan.
- Chairing the Matrix/CQI Committee and Credentialing committee.
- Supporting CQI committee(s) in developing and conducting activities and achieving their objectives.
- Ensuring that quality of care and service activity results have been thoroughly analyzed by appropriate staff/ committees; that opportunities for improvement have been identified and prioritized, and approved interventions have been implemented.
- Conducting or facilitating peer review of potential clinical quality of care issues and ensuring that validated quality issues have been addressed.
- Working with the Quality Management Director to ensure compliance with Federal and State standards/requirements.

### ***QM Director***

The QM Director is a Licensed Professional Counselor (LPC) who works collaboratively with the Medical Director, committee participants and departments to integrate coordinate and facilitate the activities of the CQI program through out the organization.

***Other Staff***

All PBH departments have representation on the CQI Committee. The departments are as follows:

Information Technology

Community Relations

Consumer Affairs

Finance

Utilization Management/Access

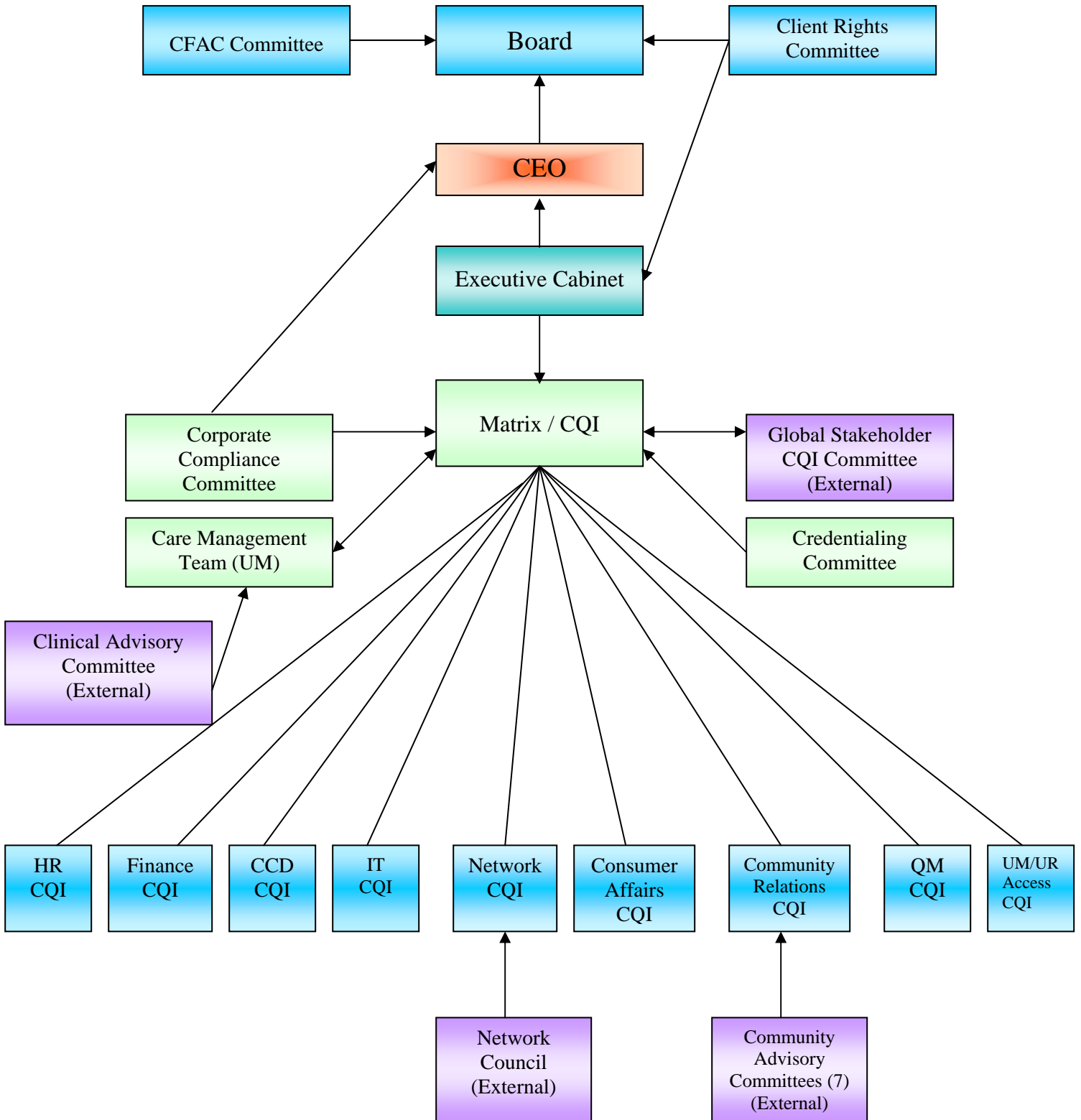
Human Resources

Care Coordination

Network Operations

Quality Management

# Organizational Chart



## **Committee Structure**

### **Executive Cabinet**

#### **Reporting Structure:**

PBH Board

#### **Membership:**

Chief Executive Officer  
Chief Operating Officer  
PBH Medical Director  
PBH General Counsel  
PBH Department Directors

#### **Frequency of meetings:**

Bi-Monthly

#### **Responsibilities:**

- Executive Cabinet reviews CQI program description, work plan and annual evaluation and recommends approval to the Board of Directors.
- Provides oversight for the CQI process through review and analysis of CQI activity reports.
- Recommends interventions for opportunities to improve for identified quality system issues.

### **Matrix Management/CQI Committee (MMCQI)**

This committee is comprised of representatives from all PBH internal departments. The purpose of the MMCQI committee is the management and oversight of the PBH system of care and continuous quality improvement, including internal operations as well as the Provider network. The MMCQI Committee conducts routine performance monitoring, identifies barriers and solutions for improvement, develops the annual CQI plan as well as monitoring its implementation across the agency and provider network, review and evaluate the results of CQI activities, ensure that interventions and recommendations for improvements are operationalized throughout the departments and agency and ensure follow-up, as appropriate.

#### **Reporting Structure:**

Executive Cabinet

#### **Membership:**

- Chair Medical Director
- QM Director

- QM representative
- Finance representative
- UM&UR representative
- Access representative
- Provider Network representative
- Community Relations representative
- Consumer Affairs representative
- IT representative
- HR representative
- Care Coordination representative

**Frequency of Meetings:**

Monthly and as needed

**Responsibilities:**

1. Monitors performance for trends, patterns, and adverse effects; determine need for further study and CQI actions to address problems. Monitors performance against identified targets.
2. Monitors the quality of care, provider performance, performance improvement projects and indicators through analysis of CQI activity reports.
3. Monitors CQI plan.
4. Monitors the use of coercive interventions and ensure consumer health and safety.
5. Monitors UM delegated functions and recommends actions to correct identified deficiencies.
6. Monitors the Network Provider indicators.

**The Care Management Committee**

The purpose of the Care Management Committee is the oversight for the management of consumer care including access to and utilization of both clinical and support services. This oversight includes utilization, demographics, and overall penetration by identified target populations. The Care Management Committee develops the Clinical Plan and provides an annual report on its implementation and effectiveness as well as monitoring performance targets for access to care.

**Reporting Structure:**

Matrix/CQI Committee

**Membership:**

- Chair: Medical Director
- UM Director
- UM&UR representative
- Community Relations representative
- Finance representative
- Provider Network representative

- Credentialing representative
- QM representative
- Director Consumer Affairs

**Frequency of Meetings:**

Every Other Week and as needed

**Responsibilities:**

1. Research and identify evidenced based practices.
2. Work in collaboration with the Clinical Advisory Committee. Develop clinical protocols related to treatment of specific conditions and make recommendations to the Clinical Advisory Committee for approval.
3. Identify need for education and training on clinical protocols.
4. Monitor activities for the following:
  - Timeliness of access to care
  - Consumer demographics related to utilization and diagnosis
  - Service encounter data, penetration, and utilization patterns
  - Under and over utilization patterns
  - Service completion rates
  - Identify outliers and high end system users; determine whether Care Coordination was provided as needed
  - Performance on Utilization Management Plan indicators
  - Outcomes of Utilization review activities
  - Authorizations and denial of care
  - Medicaid Appeals and level resolved related to clinical issues and practices
  - Waitlist across all disabilities groups for non Medicaid services

**The Global Continuous Quality Improvement Subcommittee (GCQI)**

The GCQI Committee collaborates with the internal PBH CQI Committee to assure continuous quality improvement for the PBH Network. The GCQI Committee and the PBH internal CQI Committee work collaboratively to identify solutions and interventions to improve overall satisfaction, care and services. GCQI focuses on systems and processes that will promote incremental improvements and generate better products and services for consumers, families, stakeholders and providers. The GCQI committee is a team-oriented approach between PBH staff, providers, practitioners, consumers and stakeholders who work together to analyze data, identify barriers and implement interventions to improve quality processes through continual planning, design, implementation, review and actions. The GCQI Committee makes recommendations for addressing quality issues and shares the information with the internal PBH CQI Committee.

**Reporting Structure:**

Matrix/CQI Committee

**Membership:**

- Provider, Chair
- LME QM Director
- LME Quality Monitoring Manager
- Comprehensive Community Providers
- Network Provider Council representative
- Specialty practitioners
- Consumer representative(s)
- LME Consumer Affairs representative
- Mental Health/Developmental Disability/Substance Abuse providers

**Frequency of Meetings:**

Quarterly

**Responsibilities & Objectives:**

1. To review and advise PBH regarding the provider network in the following areas: development of the annual GCQI plan, goals, performance improvement projects, best practice and quality initiatives.
2. To evaluate Network performance in accordance with established goals.
3. To provide a mechanism for oversight of the performance of the network on key quality indicators.
4. To identify quality system issues.

**Goals:** In order to meet stated objectives, the continuous quality improvement goals for GCQI activities are as follows:

1. Review of aggregate data and analysis on complaints and grievances.
2. Review satisfaction survey results in aggregate from PBH and provider specific survey results reported by GCQI members.
3. Review access to care standards and performance in order to implement activities to improve care and services.
4. Assist in developing preventative health programs to improve consumer care.

**Clinical Advisory Committee**

The Clinical Advisory Committee is comprised of clinical staff representing various disciplines and disabilities from PBH and network providers and practitioners. Consumer and family members also participate as full committee members. The purpose of this committee is to work collaboratively to review evidenced based practices, identify training needs, evaluate utilization in relation to clinical guidelines and assist with the development of community standards of care. This body reports to the Care Management Team that is chaired by the Medical Director. The Medical Director reports any identified concerns on behalf of Clinical Advisory to Care Management and Matrix/CQI committees. This advisory committee reviews and makes recommendation on identified accessibility issues, service gaps in the service continuum, diversity and cultural issues impacting clinical approach to treatment, training needs pertaining to best practice, and identify prevention concerns in the community.

**Reporting Structure:**

Care Management  
Matrix/CQI Committee

**Membership:** Network Providers, Consumer, family members and PBH department representatives

**Frequency of meetings:**

Every other month.

**Responsibilities:**

- To review quarterly reports on referrals made/referrals accepted per service per provider; review number and demographics of consumers receiving services per provider; discharges from providers and reasons; annual review of trend analysis.
- To recommend new service initiatives to address service gaps.
- To assess and recommend provider education and training needs.
- To assess community prevention needs and cultural issues impacting service delivery.
- To approve Clinical Guidelines (protocols) and establish community standards of care.

**Credentialing Committee**

The Credentialing Committee is comprised of practicing practitioners from the PBH network as well as clinical staff from PBH departments. The committee reviews and ensures that practitioners are qualified to provide clinical services to PBH consumers. The Credentialing committee functions as the PBH's peer review subcommittee.

**Reporting Structure:**

Matrix/CQI Committee

**Membership:**

- Chair Medical Director or designee
- Three (3) Provider Network representatives
- Representatives by all major Mental Health disciplines to include MR/DD
- QM representative
- Network Operations representative (ex-officio)
- Community relations representative
- Credentialing staff (ex-officio)
- UM/Access representative

**Frequency of Meetings:**

Quarterly and as needed.

**Responsibilities:**

1. Review and propose credentialing policies and procedures to Executive Cabinet.

2. Credential and recredential licensed clinical practitioners in its network according to state regulations, NCQA accreditation standards, CMS requirements, and prevailing community standards.
3. Communicate and incorporate peer review findings in the credentialing decisions.
4. Review practitioner quality of care issues presented by the Medical Director.
5. Recommend follow-up action on practitioner quality of care issues through the review of medical records, results of care and service monitoring and evaluation of quality of care issues identified by the QM Department.
6. Monitor corrective action plans submitted by practitioners not meeting PBH quality standards.

## Scope of the Continuous Quality Improvement Program

Key indicators (measurements) are identified, collected and reviewed at least annually so that clinical and service quality is monitored and evaluated and opportunities for improvement are identified.

Issues selected for special studies or ongoing monitoring reflect the population served, satisfaction data, service data, high volume services and conditions, high risk conditions, and areas that may be amenable to actions for improvement that will result in system-wide improvements in the PBH behavioral health service delivery system.

### CQI Model

PBH's quality improvement philosophy is an approach based on W. Edwards Deming Continuous Quality Improvement model. This model commands a strong commitment from management, allocation of appropriate resources, and sufficient time to develop a successful CQI process. CQI includes discovery, remediation, and improvement. This model includes:

- A process for implementing appropriate remedial action for continuous quality improvement;
- A structured and systematic approach to identify quality improvement opportunities;
- A common language for problem solving techniques;
- Facilitation of communication among groups;
- Provides supports for the basic quality value of managing by data;
- An increase in the credibility of data and reproducibility.

The discovery, remediation and improvement model is a process to identify and implement strategies and improvement activities.

- **Discovery:** Evaluate data, identify opportunities to prevent/improve behavioral health problems or occurrences, and identify appropriate intervention strategies based on best practices and known barriers.
- **Remediate:** Implement program(s) to address identified needs and barriers.
- **Improvement:** Measure the effects of the improvement program and assess its effectiveness. Continue intervention if effective. Adjust as necessary to achieve goal targets. Repeat cycle if intervention does not achieve desired result.

### ***Clinical Performance Improvement Projects (PIPs)***

The Care Management Committee will recommend to the Matrix/CQI Committee and Clinical Operations, clinical activities (also known as Performance Improvement Projects {PIPs}) based on the results of the NC MH/DD/SAS Health Plan and the NC Innovations waivers performance data in areas such as:

- Healthcare Effectiveness Data & Information Set (HEDIS) and clinical indicators
- Clinical practice guideline monitoring
- Under and over utilization
- Disease management conditions
- Care management

- Quality of care reviews
- Continuity and coordination of care

### ***Service Performance Improvement Projects (PIPs)***

All other departments outside of Clinical Operations will develop and implement Service PIPs and report these to the Matrix/CQI Committee. PIPs will be developed and implemented related to performance data in areas such as:

- Barriers identified by the network with service provision
- Enrollee satisfaction
- Medical Record Audits results
- Network availability issues
- Network performance issues related to identified targets.

### ***Consumer Safety***

PBH's role in improving consumer safety involves fostering a supportive environment to assist practitioners and providers in ensuring consumer safety by:

- Distributing information to enrollees, providers, and facilities that improves knowledge regarding safety as it relates to consumer self-care.
- Focusing on improving consumer safety through existing CQI activities.
- Monitoring of Clinical and Preventive behavioral health guidelines.
- Ensure that evidence based guidelines are adopted and implemented to improve behavioral health outcomes throughout the network.
- Provide in service training on improving treatment documentation.
- Provide in service training on improving knowledge of safe practices when implementing restrictive interventions.
- Distribute information to consumers annually that helps them to make informed decisions about their treatment, based on safety and performance records of the provider organization through agency newsletter and the provider performance profile card via the PBH web site.
- Review results from health and safety site visits to identify and improve safe practices through follow up with critical incident reporting to identify abuse/neglect/exploitation, failure to provide a safe environment, and patterns that indicate consumers are not receiving appropriate care and supervision.
- Review reports and make improvements based on complaints and satisfaction data that impact the safety of consumers.
- Improve continuity and coordination of care between behavioral health practitioners and settings such as hospitals to outpatient care to avoid miscommunication that can lead to poor outcome.

- Inform consumers of their rights to make informed decisions, and the procedure to report and/or voice concerns about the quality and safety of the service they are receiving in the network via the consumer handbook, newsletters, complaint line, Consumer and Family Advisory Committee(CFAC), Client Rights Committee, etc.
- Others

### ***Clinical Practice Guidelines (CPG)***

The Clinical Advisory Committee reviews and approves evidence-based CPGs that address the clinical areas most relevant to the populations served by PBH. The Clinical Advisory Committee advises the Care Management Committee on the CPGs. The guidelines are used in utilization management to guide and direct appropriate care. They are also used by practitioners and consumers for direction and education of care for various disease states. Guidelines are reviewed, updated, and redistributed at least every two years or sooner, if indicated, based upon new scientific evidence. The goals for the establishment of a CPG include the following:

- Reduction of variation in the provision of clinical care to enrollees.
- Documentation and incorporation of current scientifically based clinical knowledge.
- Provision of decision support tools to participating physicians and providers.
- Standardization of processes that support clinical care.
- Monitoring of compliance.
- Fidelity to model in implementation of Evidenced Based Practices.
- Improved opportunities to achieve clinical outcomes.

### ***Preventive Health Guidelines (PHG)***

The Care Management Committee developed guidelines for the prevention and early detection of incidence, emergence, or worsening of behavioral health disorders. These guidelines cover the target populations served by PBH. The guidelines are developed in cooperation with providers who have appropriate knowledge specific to those guidelines through their involvement on the Clinical Advisory Committee. The guidelines are based upon scientific evidence as documented in professional literature or by professional medical societies and associations. The Clinical Advisory Committee reviews and revises, if necessary guidelines biennially or when new scientific evidence or national standards are updated.

### ***Disease Management Program***

PBH works collaboratively with the Southern Piedmont Community Care Plan, a Primary Care/Case Management program for Medicaid enrollees. The approach to disease management is characterized by three steps:

- 1) Identification of consumers with chronic mental health conditions: Identification of enrollees with specific chronic illness occurs through concurrent review of inpatient cases, physician referrals, and analysis of claims and encounter data.

- 2) Institution of a disease management intervention based upon severity: The interventions vary from program to program but generally emphasize education and counseling.
- 3) Evaluation of the effectiveness of the program: Relevant outcomes include analysis of changes in hospitalization rates and emergency encounters, enrollee satisfaction with the program, quality of life or functional status, and cost savings.

Disease management activities include:

- Identification of enrollees with chronic health conditions that are at risk for co morbid mental health disorders and arrange for screening, assessment and treatment as needed.
- Provide education for identified enrollees on self management activities.
- Collaborative activities between mental health, case managers, and nurse case managers including staffings, treatment planning and joint home visits.
- Psychiatric consultation to nurse case managers on clinical indicators of mental health conditions and strategies to improve care.

### ***Accessibility and Availability***

Standards, established by the Division of Medical Assistance, ensure that all covered services including additional or supplemental services contracted for or on behalf of enrollees are available and accessible during normal business hours to the same extent available to non-Medicaid enrollees.

Annually, PBH monitors its network capacity using one or more of the following mechanisms:

- Geo Access or mapping
- Enrollee to practitioner ratios
- Enrollee and provider satisfaction surveys
- Grievances
- Site visits
- Membership data
- Provider and facility data

### ***Satisfaction Surveys***

The monitoring, evaluation, and improvement of enrollee and provider satisfaction are important components of the CQI program. This is accomplished through the use of surveys as well as through the aggregation, trending, and analysis of enrollee grievance data. A number of surveys are conducted annually including:

- PBH's Consumer Satisfaction Survey was approved by the Division of Medical Assistance (DMA). Annually, an external vendor conducts this population-based enrollee satisfaction survey. All enrollees are identified from a data file and sent to the vendor. PBH receives the results of the survey from the vendor for review. The survey also provides information on enrollee satisfaction with UM processes; accessibility; and availability of PBH's provider network.

- **Provider Satisfaction Survey:** All providers in PBH's network receive either a mail or electronic survey annually. The survey includes questions on behavioral health plan performance in the areas such as claims payment, quality, notification, authorization, care/case management and disease management.

### ***Medical Record Audits***

PBH requires that practitioner and provider records are maintained in a current, detailed, organized and comprehensive manner that demonstrates effective consumer care and conformity to standards of professional medical practice and appropriate behavioral healthcare management. A sample of medical records is audited by QM based on the Gold Star Performance Profile. Any practitioner or provider receiving a score of less than 100% requires a corrective action and/or follow up audit with additional records reviewed.

### ***Delegation***

PBH delegates the following function:

Back up telephone response when Access staff is unable to pick up calls during business hours, the evening, at night, and on the weekends.

The Director of Clinical Operations has the responsibility for the contractual oversight of the delegation arrangement and reports to the Medical Director.

At a minimum, the following requirements are needed to establish and monitor a delegated entity performance including:

- Mutually agreed upon agreement that describes the responsibilities of the organization and the delegated entity, describes the delegated activities, reporting, annual evaluation, and the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.
- Precapacity assessment prior to delegation to determine if the delegate has devoted sufficient resources and appropriate qualified staff to perform the function(s).
- Routine reporting.
- Annual comprehensive evaluation of the delegated entity.

The Matrix/CQI Committee will be responsible for performing delegation oversight and ensure compliance with CMS and compliance related contractual requirements. The Compliance Officer, QM Director or designee, and Director of Clinical Operations will perform the annual audits, review routine reports, and follow-up when necessary on any corrective action issues/concerns. The CQI subcommittees will review and analyze any clinical and service results.

### ***Monitoring Activities***

Clinical and service indicators of quality are established and monitored on a regular basis by PBH Cross Functional Teams in order to assess PBH performance. Indicators are designed to reflect the demographic characteristics, prevalence of incidence of mental health, developmental disability and substance abuse conditions, and/or utilization of services of its membership. The indicators have targets established and are measured on a periodic basis with the frequency appropriate to the indicator. Benchmark information from HEDIS and the State of North Carolina Department of Health and Human Services will be used in setting goals or thresholds, when available. All indicators are trended for change over time and are included in the annual program evaluation. Indicators, which are outside established control limits, may provide the basis for quality improvement projects.

## **Collaboration with Other PBH Departments**

**Executive Cabinet:** The Executive Cabinet is responsible for the overall management and oversight of the agency's continuous quality improvement initiatives and efforts, direction of the network toward best practices, performance outcomes, and direction of financial resources to achieve desired outcomes.

**Office of Medical Affairs:** PBH Medical Director is the Chief Medical Officer. The Medical Director is a board certified psychiatrist. The Office is responsible for the overall clinical management of services to consumers, including authorization of services and utilization management as well as oversight for quality of care and consumer health and safety initiatives. Other activities include collaboration with medical providers in the community and health care organizations such as State and Community hospitals.

**Quality Management (QM) department:** The Quality Management department has oversight for quality throughout the network. The QM department supports a continuous Quality improvement system that includes network providers. This unit provides training to the provider network on standards, requirements, quality improvement, indicators and targets, client rights, advocacy and protections, health and safety and other critical areas of performance. The department manages the tracking and evaluation of all critical incidences and complaints. The Quality Management department also implements a system of review, monitoring, and investigation that serves as the foundation for quality of services.

**Finance department:** The Finance department manages the financial resources of the agency. This is inclusive of allocation of resources, financial accountability, financial authorizations, availability of funds, claims processing and payment. The Finance department is responsible for ensuring compliance with General Statute 159 and other general accounting requirements. The Finance department supports providers through training and Customer service representatives. PBH's claims are processed by the claims section of the Finance department. Routine reports such as timeliness of claims processing, accuracy, prompt payment, provider appeals, to name a few, are shared with the Matrix/CQI Committee. A Finance representative participates on the Matrix/CQI committee.

**Compliance department:** This internal department is responsible for coordinating, facilitating, and ensuring that all state and regulatory requirements have been met or in full compliance within all PBH's departments. The agency General Counsel serves as the PBH Compliance Officer and reports to the CEO. The department is staffed with an attorney. The Directors of QM, Clinical Operations, and the Compliance Officer share the responsibilities for ensuring delegation oversight of PBH's delegated entities. The Compliance Officer participates in the CQI activities when corporate compliance issues are identified.

**Access department:** PBH's Call Center is responsible for handling all enrollee and provider calls and enrollee applications. Routine reports such as telephone average speed to answer, abandonment rate and service levels; enrollee inquires and grievances, and enrollee satisfaction reports are shared with the Matrix/CQI committee and GCQI committee. Routine

reports such as Inpatient Hospital, and Access to Care and are shared with the Care Management and Matrix/CQI committees.

**Network Management:** The Network Operations department is responsible for the development of the network to meet the needs of consumers and to manage the scope and size of the network to ensure choice of providers. This department has four distinct functions including assisting with the credentialing of practitioners, provider recruitment and enrollment, network data management and provider relations. The department works with providers individually and at large in order to promote best practices in service delivery. Each provider has a Network manager assigned as their point of contact for questions, problems, and assistance. New service development and the recruitment of qualified providers is also a responsibility. Routine reports including provider enrollment, provider satisfaction, accessibility and availability are shared with the Matrix/CQI, Care Management committee, and Network Council. Network staff participates on the Matrix/CQI, Network Council and Care Management.

**Community Relations:** The Community Relations department is responsible for collaboration and community relations with local organizations, public agencies and advocacy groups. The department coordinates communication with key stakeholders and supports the responsible Community Advisory Councils and the Consumer Family Advisory Committee. This unit is responsible for the development of consumer friendly and culturally sensitive materials and information for consumers, families and the public at large which is available in a variety of medias. Routine reports are shared with Matrix/CQI and Clinical Management committees. The Community Relations representative participates on the Matrix/CQI and Care Management committees.

**Clinical Operations:** Clinical Operations manages the LME Access, including a call center, authorization, and care management system, utilization management functions, and crisis response network. The unit defines review gates, completes concurrent and retrospective reviews, and responds to Medicaid appeals. Additionally the unit researches utilization trends, identifies areas for further study and review, and develops Clinical Guidelines and written protocols which are reviewed annually. Care managers provide clinical review, support, and follow up to ensure consumers receive the care that they need. This unit supports the Clinical Advisory Committee. The Office of Medical Affairs is involved in all aspects of the operation of this department. Clinical management and utilization review are handed by the UM department. Routine reports such as timeliness of processing requests and enrollee satisfaction with UM processes are shared with the Matrix/CQI and Network Council; denial and appeal rates, under and over utilization and inter rate reliability results are reported to the Network Council. UM representatives participate on the Matrix/CQI and Network Council. The Access Unit is responsible for the operation of a 24 hour call center. PBH call center is responsible for handling all enrollee and provider calls regarding information and requests for and referrals for services. The call center conducts both telephonic and screening and arranges face to face screening, triage, and referral of consumers requesting services. This center includes qualified licensed professionals that respond to the telephone calls. Calls range from informational, to screening and referral and may respond to crisis and emergencies.

**Office of Consumer Affairs:** The Office of Consumer Affairs works to develop and identify consumer leaders and to encourage consumer led initiatives. The director serves as ombudsman and advocate for individual cases and assists consumers as requested with grievances and appeals. The director assists in the development of consumer operated services and assists in activities that promote and support the empowerment of consumers. The department provides advocacy and support for the Client Rights Committee.

**Information Technology:** The Information Technology department maintains information systems to support the operations of the agency and connectivity to providers and state agencies. This includes the management of hardware, software and connectivity functions. The information technology department is responsible for critical software for state reporting, submission of claims and shadow claims authorization tracking and encumbrance data, care management, and clinical system functions, CQI data on targets and quality indicators, management of demographics, utilization patterns, and penetration data and other data requirements. The information system is fully HIPAA compliant and secure. This internal department supports the CQI program through HEDIS reporting and the development and reporting of CQI projects.

**Care Coordination Dept. (CCD):** The PBH Care Coordination department provides Care Coordination to individuals enrolled in the NC Innovations Waiver, individuals enrolled in the B3-DI Program, and to individuals in identified special needs populations. Care Coordination is focused on the individual as part of a population and in relationship to the overall system. Care Coordinators manage care across the continuum of care, throughout various care settings, and work in conjunction with the person, providers, and others to improve outcomes for the individual and make the best use of resources. This is both a risk management and quality management function which has a significant impact on both the management of resources and the quality of care for an individual.

## Collaboration with External Stakeholders

### PBH Stakeholder and Advisory Committees

#### **Client Rights Committee (CRC):**

The CRC is a subcommittee of the Area Board. The CRC is comprised of six members who are either direct consumers of services, family members of consumers or professionals in Behavioral Healthcare. One member is also a member of the Area Board. The CRC reviews information regarding incidents, investigations and measures of consumer care. The CRC makes recommendations to PBH regarding matters under review. The CRC may hear concerns from members of the community in accordance with their by-laws.

#### **Clinical Advisory Committee:**

The Committee is composed of clinical staff representing various disciplines and disabilities as well as consumers, family members and LME staff. The purpose is to review evidence based practices, identify training needs, and evaluate service utilization as related to clinical guidelines, as well as to, develop community standards of care and clinical guidelines.

#### **Community Advisory Committees:**

Committees at the county level involving local stakeholders especially focused on involving public partners and advocates. These forums have local co-chairs and convene to discuss LME activities, community needs and to provide feedback to the LME.

#### **Consumer/Family Advisory Committee (CFAC):**

The committee is comprised of up to 21 members who are all direct consumers of services or family members of a consumer. One member is also a member of the Area Board. The committee must be represented of at least 50% consumers. The members represent various disabilities, and also each of the five counties. The CFAC advises and collaborates with PBH to improve services for consumers.

#### **Credentialing**

The credentialing committee is composed of representatives of licensure categories that include both PBH staff and practicing members of the PBH network. The committee reviews and approves applications from licensed practitioners to join the PBH network.

#### **Cultural Competency Oversight Committee**

A committee comprised of PBH staff, a representative from the Consumer Family Advisory Committee and the PBH Network Council is responsible for oversight of the implementation of the PBH and Provider Cultural Competency Plans.

#### **Global CQI Committee**

The GCQI Committee collaborates with the internal PBH CQI Committee to assure continuous quality improvement for PBH Network. The GCQI Committee and the PBH internal CQI Committee work collaboratively to identify solutions and interventions to improve overall satisfaction, care and services. GCQI focuses on systems and processes that will promote incremental improvements and generate better products and services for consumers, families, stakeholders and providers. The GCQI committee is a team-oriented approach between PBH staff, providers, practitioners, consumers and stakeholders who work together to analyze data, identify barriers and implement interventions to improve quality processes through continual planning, design, implementation, review and actions. The GCQI Committee makes recommendations for addressing quality issues and shares the information with the internal PBH CQI Committee.

## System Resources

System resources currently available for supporting the CQI program include

Functional Area	General Purpose
<b>Enrollment:</b> NC MH/DD/SAS Health Plan and NC Innovations waivers.	<ul style="list-style-type: none"> <li>• Identifying enrollees for studies, monitoring indicators, and case management. Disease management programs</li> <li>• Implementing targeted enrollee interventions</li> </ul>
<b>Provider Network:</b> CI	<ul style="list-style-type: none"> <li>• Identifying practitioners &amp; facilities in network</li> <li>• Determining high-volume practitioners</li> <li>• Credentialing and recredentialing</li> <li>• Implementing targeted practitioner or facility interventions</li> </ul>
<b>Claims:</b> CI system and Crystal reporting  BH DD	<ul style="list-style-type: none"> <li>• Identifying enrollees with specific conditions/treatments</li> <li>• Evaluating practitioners &amp; facilities quality and utilization of services</li> <li>• Data collection for QI projects</li> </ul>
<b>Customer Service</b> Inquiries Grievances Complaints	<ul style="list-style-type: none"> <li>• Generate reports by reason codes</li> <li>• Identify top reasons for enrollee and provider dissatisfaction</li> </ul>
<b>Quality Improvement</b> Quality of Care (QOC)	<ul style="list-style-type: none"> <li>• Tracking and trending of monitoring by QM</li> <li>• Follow-up recommended by GCQI/CQI Committees</li> </ul>

## **Communication of CQI information**

PBH will communicate results from the CQI activities to enrollees, practitioners, and providers using any of the following avenues: written reports, presentations, educational forums, published articles, direct mail, provider manual, and/or PBH web site.

Annually, PBH distributes the provider manual to all new providers in the network and annual updates to current providers. The provider manual includes:

- An overview of the CQI Program
- Pertinent policies and procedures for obtaining authorization, notification of specific services approved by the primary care practitioner, pharmacy management, and technology assessment
- Enrollee appeal process
- Practitioner rights in the credentialing and recredentialing process
- The availability of information on the CQI program, clinical practice guidelines and/or medical necessity criteria used by Utilization Management department
- Enrollee rights and responsibilities
- Billing procedures

## **CQI Program Documents**

### ***Program Description***

The QM department and Matrix/CQI Committee reviews and revises the CQI program description at least annually and as needed.

### ***Work Plan***

The QM Department and Matrix/CQI Committee annually formulate the CQI Work Plan with input from GCQI and Clinical Advisory subcommittees and PBH departments. The CQI Work Plan is monitored and updated quarterly. The CQI Work Plan includes the following:

- Activity/ Populations
- Objectives for the year and program scope,
- Goals,
- Tasks,
- Person(s) responsible for each activity,
- Monitoring Frequency, and
- Planned evaluation of the CQI program.

### ***Program Evaluation***

The Matrix/CQI Committee formally evaluates the CQI program. The assessment includes the following:

- Description of completed and ongoing CQI activities,
- Trending of measures to assess performance in the quality of clinical care and quality of service,
- Analysis of whether there have been demonstrated improvements in the quality of clinical and quality of service to enrollees,
- Evaluation of the overall effectiveness of the CQI program, and
- Evidence that quality and service activities have contributed to meaningful improvement in the quality of clinical care and quality of services provided to enrollees.

### ***Committee Minutes***

The Office of the Medical Director maintains minutes for each Matrix/CQI committee meeting. The minutes will be dated and signed by the chair of the committee following the committee's review and approval.

## Confidentiality


Confidentiality will be observed throughout the Continuous Quality Improvement Program. Internal staff and external participants and consultants to the program are made aware of the confidential nature of the proceedings as they occur. It is the responsibility of the CQI program to develop and monitor the overall confidentiality policy. Confidentiality is observed as follows:

- Committee members sign confidentiality statements annually and all guests must sign confidentiality statements.
- Enrollees, prospective enrollees, and providers are informed of PBH's policies regarding the use and release of identifiable information.
- The Matrix/CQI has been designated as the committee to assess and oversee corporate confidentiality policies and practices.
- Contracts with providers outline standards for confidentiality and providers are reviewed for the standards in the credentialing and re-credentialing process.
- To prevent conflict of interest, no person may participate in a review, evaluation or final disposition of any issue/case in which he/she is or has been professionally involved or where judgment may be compromised.
- All policies and procedures and Business Associate Agreements meet the standards regarding HIPAA and confidentiality and privacy of health information.

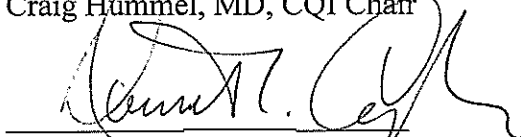
## Signatures

The 2010-2011 CQI Program Description was reviewed and approved by the chair of the Matrix/CQI Committee, the Chief Executive Officer of the Executive Cabinet and the Chair of the PBH Board of Directors.


### Approved by:

  
Craig Hummel, MD, CQI Chair

8/19/2010  
Date

  
Daniel Coughlin, CEO

8/19/10  
Date

  
Bill Burgin, PBH Board Chair

8/19/10  
Date