



Current Status: Active

PolicyStat ID: 3273485



Origination: 04/2017
Last Approved: 04/2017
Last Revised: 04/2017
Next Review: 04/2018
Owner: Starlit Smith: Quality Management Administrator
Policy Area: Quality Improvement
References:

CASE RECORDS MAINTENANCE AND REVIEW

POLICY

It is the policy of Detroit Wayne Mental Health Authority (DWMHA) that Managers of Comprehensive Provider Networks (MCPN) and Contracted Providers, including Substance Abuse provider agencies, establish a process to ensure case records are maintained for all clients who are the responsibility of DWMHA. Case records shall be maintained according to these standards for protection, completeness, accuracy, legibility, timeliness and clinical pertinence to assure availability of reliable documentation of services provided and client response.

PURPOSE

The purpose of this policy is to:

1. To establish and define the responsibilities for the DWMHA and contract service providers in the maintenance of case records consistent with contractual guidelines, state and federal laws and regulations.
2. To ensure a medical record will be maintained for every individual who is receiving or has received behavioral health services from contractual providers of DWMHA.
3. To validate funding of services through case record documentation.
4. To improve quality of care along with managing risk.
5. To assure the existence of a reliable source for Quality Improvement and Utilization related data.

APPLICATION

1. The following groups are required to implement and adhere to this policy: DWMHA Board, DWMHA Staff, Contractual Staff, Access Center, MCPN Staff, Network Providers, Crisis services vendor and Credentialing Verification Organization (CVO)
2. This policy serves the following populations: Adults, Children, I/DD, SMI, SED, SUD and Autism
3. This policy impacts the following **contracts/service lines** : MI-HEALTH LINK, Medicaid, SUD, Autism, Grants and General Fund

KEYWORDS

1. Case Record Review

2. Clinical Pertinence
3. Health Information Technology for Economic and Clinical Health (HITECH) Act
4. Individual Plan of Service/Person-Centered Plan/Family-Centered Plan (IPOS/PCP)
5. Managers of Comprehensive Provider Networks (MCPN)
6. Medical Record
7. Mental Health Professional (MHP) (MCL 330.1100b(14))
8. Record Keeping
9. Service Provider
10. Utilization Management
11. Utilization Review

STANDARDS

1. MCPNs and Contracted Providers, including Substance Abuse provider agencies, must maintain in English and in a legible manner, records necessary to fully disclose and document the extent of services provided to clients.
2. The primary clinical case record is held by the clinically responsible provider which may consist of electronic documentation, paper documentation or a hybrid thereof. The clinically responsible provider is responsible for assuring that there is a complete and accurate medical record for every patient.
 - a. At the request of a Federal, State or DWMHA representative, access to a complete medical record must be made available immediately. Access to the record shall be produced within 30 minutes of the request.
 - b. Providers must also ensure that sufficient staff are properly trained to ensure the medical record information is available during all operating hours.
 - c. Backup and retrieval systems must be in place and operational in case of power outages and failures.
3. The clinical record is confidential and is protected from unauthorized disclosure by law. The use and disclosure of confidential medical record information is regulated by DWMHA policies, HIPAA, the State of Michigan Mental Health Code 42 CFR Part II, state and federal laws, rules and Recipient Rights. The provider agrees to maintain an accounting of disclosures as required by the HIPAA and HITECH Act.
4. MCPNs and Contracted Providers shall develop policies for case record organization and maintenance that includes but is not limited to privacy and confidentiality, program oversight, responsibility designation, legal and protective measures to foster data integrity, record reconstruction and safeguards to prevent unauthorized access, and address the following:
 - a. Similar information will be found in the same place for all case records. Material must be affixed in a binder, electronic record or case file folder and arranged so that information can be found quickly and easily.
 - b. Abbreviations that have been approved for use in case records by the provider administration and clarification that no other abbreviations may be used.
 - c. Time frames specifying when reports and documents must be entered in the record. It is the DWMHA's expectation that all progress note documentation be submitted into the clinical record

- within 24 business hours.
- d. Description of how case records will be stored and protected from damage such as fire or breach of confidentiality, i.e., records must be returned to their secure storage location at the close of business each day. It is required that all providers implement a process that complies with DWMHA's Record Retention and HIPAA policies.
 - e. Description of how corrections may be made in case records by drawing a single line through the entry to be corrected, entering the correction, initialing and dating the entry. "White-out" may not be used.
 - f. All entries must be legible and provisions for alternative methods for record entry when individuals are not able to write legibly. The name of the person signing the entry must be clearly identified if the signature is not legible.
 - g. Accurate dating of reports or entries.
 - h. Accuracy of information and use authenticating signatures.
 - i. Blank spaces may not be left between entries and when they exist, a line must be drawn through.
 - j. Notification to the DWMHA of the need to manage case records in the event the provider goes out of business.
 - k. Provisions for release of information contained within the record and protection of second-party materials.
5. Archiving: If the provider archives portions of the record, the current treatment documents must remain in the active record, specifically the assessments completed in preparation for the current plan of service/ treatment and all documentation entered toward the implementation, review and revision of that plan.
 6. Contents: Case record documentation must be compliant with payer specific requirements i.e., the Michigan Medicaid Manual, CMS, Medicare or third party payer requirements. The record shall contain, at a minimum, complete client identifying information including information on services provided by other community agencies. It must contain documentation of all treatment including, at a minimum, intake assessments, demographic information, treatment plans, progress notes, medical orders, prescriptions and termination reports/discharge summaries. All entries must be authenticated with dated signatures and credentials of the person making the entry.
 7. Record Storage: Records must be stored and monitored in a way as to protect the confidentiality of the information and to protect them from fire and other hazards. The provider must develop an indexing system and method for monitoring the location of records when they are removed from the primary storage area and must assure by policy that records may not remain out of the storage area after closing hours.
 8. "Primary" Record: When the provider offers services at a location other than the primary clinic site and, therefore, more than one version of a record is created, one of the records must be identified as the "primary" record and must contain all the information. The record located in the program or residential site must contain enough information to assure appropriate and quality care at the program site.
 9. Retention: Case records must be retained for ten years following the last service rendered to the individual client or following the client's eighteenth birthday. This requirement also extends to any subcontracted providers.
 10. Case Record Reviews: There shall be on-going reviews of case records to ensure they contain current, accurate and complete information. Case record reviews shall be conducted according to the DWMHA's

written monitoring plan to assure consistency. The plan describes the scope of the review, how the review is performed, sample size and selection of records, frequency of reviews, assurances of confidentiality, how the findings will be protected, and reported, how problems will be corrected. Aggregate results of case record reviews shall be incorporated into the provider's Quality Improvement Plan and opportunities to improve identified.

11. Records will be released from the provider organization in accordance with the provisions of DWMHA policies, the Michigan Mental Health Code, HIPAA, 42 CFR Part II, state and federal laws, rules and regulations.
12. Utilization Review: The provider shall conduct ongoing reviews to assure appropriateness of care according to a written plan and using a written level of care criteria. Results shall be addressed for individual cases and shall be reported in the aggregate as part of the provider's Quality Improvement Plan.
13. Peer Review: Care provided by qualified professionals shall be reviewed by peer professionals to assure that care is being provided according to professional standards of practice and results should affect provider standards of care. This is particularly required for psychiatric services.
14. Integration of Care: It is the DWMHA's expectation that clinical information will follow the client through the system of care and be made readily available at the point of service. Based on Michigan Attorney General Opinion # 5709 (5/20/1980), DWMHA and its subcontractors are considered one entity for the purpose of sharing confidential case records. All providers are required to obtain a Release of Information according to DWMHA policy, HIPAA, 42 CFR Part II, the Mental Health Code; however, treatment may not be withheld from a client due to the lack of a signed release.
15. Confidentiality: Case records must be protected as defined by, 42 CFR Part II, HIPAA, the Mental Health Code and DWMHA policy on Confidentiality. They may be accessed only as stipulated in DWMHA policy and relevant laws, rules and regulations. Research projects must be approved by the DWMHA prior to having access to client record information.
16. Electronic Medical Record (EMR) Guidelines:
 - a. All Protected Health Information (PHI) from an outside facility will be scanned into the provider's Electronic Medical Record (EMR) according to the MCPN/provider scanning procedures. Once the record has been scanned into the EMR, it is the official record and the paper record can be destroyed using the approved protocol.
 - b. A provider utilizing an EMR must ensure confidentiality, integrity and availability of its electronic health information. The provider must also protect against reasonably anticipated threats, hazards or misuse of electronic health information
 - c. Providers utilizing an EMR agree to abide by all requirements of the HIPAA Security Rule and its progeny.
 - d. Providers utilizing an EMR health record shall have all appropriate administrative, physical and technical safeguards in place for the protection of protected health information.
 - e. Providers utilizing an electronic health record shall document compliance with all Security Rule implementation specifications, both required and addressable.
 - f. All providers shall perform regular risk analysis for their operations as the privacy and security of health information whether in paper or electronic form. See Exhibit A: Guidance on Risk Analysis Requirements Under the HIPAA Security Rule.
 - g. Providers:

1. May maintain individual medical records with electronic signatures in a computerized environment as long as the provider has a written policy describing the clinical record and authentication policy in force. These include, but are not limited to, privacy and confidentiality issues, program oversight, responsibility designation, legal and protective measures to foster data integrity, record reconstruction and safeguards to prevent unauthorized access. Implementing, at a minimum, the following procedures may alleviate objections to the use of electronic signatures in medical records.
2. Delineate those categories of personnel who are authorized to access, modify and authenticate medical records using electronic signatures/computer entry.
3. Use a unique ID number, code, password or some other measure (such as a fingerprint/voice activation code) to identify each authorized user of an electronic signature. This ID number, code or password should be confidential and known only to the user and complex enough so that others cannot employ it.
4. Keep a signed statement authorizing that the user's electronic signature can only be applied to specific types or sections of the record they have authored. System managers must have the ability to revoke this authorization at any time.
5. Establish a system to place responsibility for verifying the accuracy of dictated information. A statement regarding this responsibility could be incorporated into the authorization for use of the electronic signature.
6. Include a method for "flagging" records with blanks, incomplete information and/or questions prior to their authentication. Records must be reviewed prior to signing. For systems in which the electronic signature is assigned at the time of transcription, there must be the ability for staff to verify the record is accurate and the signature has been properly recorded before it is considered complete.
7. Ensure that a security system is established that prohibits changes to a record after it has been authenticated.
8. Establish and enforce penalties for anyone who discloses their ID number, code or password to others or for anyone using an ID number, code or password without authorization.

QUALITY ASSURANCE/IMPROVEMENT

The DWMHA shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives. The MCPNs, their subcontractor's and direct contractor's quality improvement program must include measures for both the monitoring of and the continuous improvement of the program or process described in this policy.

DWMHA shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

The quality improvement programs of MCPNs, their subcontractors, and direct contractors must include measures monitoring that include use of DWMHA standardized monitoring tools. Reference the attached exhibit: **2016-2017 Case Record Monitoring Plan**

COMPLIANCE WITH ALL APPLICABLE LAWS

DWMHA staff, MCPNs, contractors, and subcontractors are bound by all applicable local, state and federal

laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

1. Michigan Mental Health Code, P. 258 of 1974, Sections 330.1746 and 330.1748.
2. HIPAA Security Guide
3. DWMHA Record Retention Storage Retrieval and Scheduled Disposal Policy
4. Michigan Attorney General Opinion #5709, (5/20/1980)
5. Medicaid Clinic Service Manual, Chapter III.
6. RELATED DEPARTMENTS

RELATED POLICIES

1. DWMHA Record Retention Storage Retrieval and Scheduled Disposal Policy

RELATED DEPARTMENTS

1. Administration
2. Children's Initiative
3. Claims Management
4. Clinical Practice Improvement
5. Compliance
6. Customer Service
7. Information Technology
8. Integrated Health Care
9. Legal
10. Managed Care Operations
11. Quality Improvement
12. Recipient Rights
13. Substance Use Disorders

CLINICAL POLICY

NO

INTERNAL/EXTERNAL POLICY

EXTERNAL

Attachments:

[2016-2017 Case Record Monitoring Plan.docx](#)

Approval Signatures

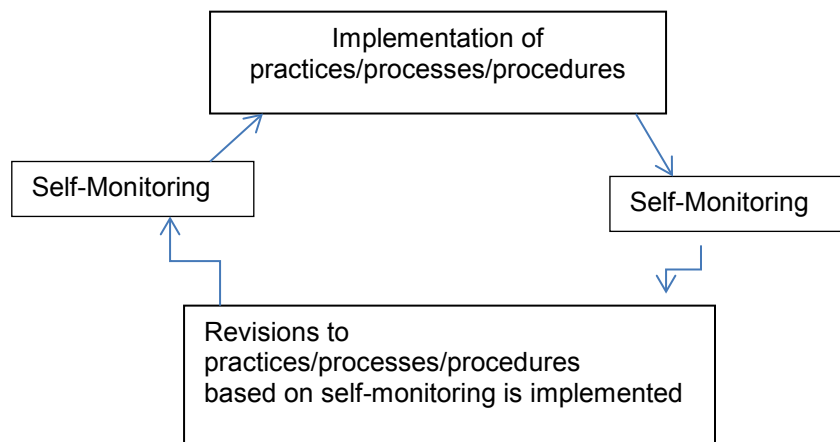
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**Detroit-Wayne County Community Mental Health Agency
Monitoring Plan
Managed Care Provider Network MCPN**

The Detroit Wayne Mental Health Authority (DWMHA) has developed standardized self-monitoring tools to be utilized throughout the system. The implementation of this self-monitoring plan is a component of the Continuous Quality Improvement (CQI) process. The CQI is designed to provide an organized, documented process for assuring that eligible Wayne County residents are receiving the medically necessary and appropriate services for mental health, substance use disorders and/or developmental disabilities. In addition, these services must conform to accepted standards of care, while achieving the consumers' desired outcomes.

The goal of the self-monitoring plan is to support a CQI process. This involves ongoing monitoring efforts to improve services through continuous and consistent evaluation and change thus resulting in a process/procedure that creates program refinements.

The CQI process is iterative.



Four main principles of quality improvement include:

1. Focus on the client: Services should be designed to meet the needs and expectations of consumers. An important measure of quality is the extent to which customer needs and expectations are met.
2. Understanding of and system processes: Providers need to understand the service system and its key processes in order to improve them. Using process-

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Network Monitoring Plan FY 2016-2017**

engineering tools provides simple visual images of these processes and systems.

3. Teamwork: Because work is accomplished through processes and systems in which different people fulfill different functions, it is essential to involve stakeholders in the improvement process. This brings their insights to the understanding of changes that need to be made and to the effective implementation of the appropriate process. It also ensures ownership of the improvement processes and systems.

4. Focus on the use of data: Data is needed to analyze processes, identify problems and measure performance. Changes can then be tested and the resulting data analyzed to verify that the changes have actually led to improvements.

Monitoring and contractual responsibilities:

DWMHA contracts with Managers of Comprehensive Provider Networks (MCPN) who then contract with service providers to manage and deliver a full array of supports and services to consumers within Wayne County. DWMHA also has direct contracts with sixty Substance Abuse Agencies to oversee and manage Medicaid and MI Health Link substance abuse services. In addition, DWMHA maintains a three-way contract with five Integrated Care Organizations and Community Mental Health (CMS) to serve both Medicaid and Medicare (dual-eligible) individuals.

Delegation:

Delegation is a formal process by which a Prepaid Inpatient Health Plan (PIHP) gives another organization the authority to perform certain functions on its behalf, such as, but not limited to, customer services, utilization management or quality improvement. Although DWMHA can delegate the authority to perform a function, the ultimate responsibility, for assuring the quality and appropriateness of care rests with DWMHA. DWMHA must ensure all contractual obligations between the Michigan Department of Community Health (MDCH) and all other regulatory bodies are met. It is DWMHA's responsibility to ensure that the MCPN delivers the provision of Medicaid services consistent with the applicable sections of the Social Security Act, the Code of Federal Regulations (CFR), the Center for Medicare and Medicaid (CMS) Medicaid & State Operations Manuals, Michigan's Medicaid State Plan, and the Michigan Medicaid Provider Manual and Mental Health-Substance Abuse requirements.

This monitoring plan is geared to improve quality, measure our performance in the delivery of service and ensure compliance with required standards. The plan requires the involvement, skills, expertise and input from the service providers, MCPNs and DWMHA staff. This approach is a partnership between the DWMHA, the MCPNs, providers, professionals and consumers.

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Goals, Objectives and Strategies:

Improving the quality and consistency of services is an important part of improving the provision of services to Wayne County consumers. The goals of DWMHA are to ensure providers maintain high standards and offer reliable supports and services within all programs.

To accomplish this goal, DWMHA needs to achieve the following three objectives.

- Objective 1: Continuously improve the overall standards of clinical care.
- Objective 2: Reduce unacceptable variation in clinical practice.
- Objective 3: Ensure the best use of resources so that consumers receive the greatest benefits.

Strategies to meet the above objectives require that supports and services be:

- Appropriate to the consumer needs
- Effective by utilizing the best practices based on available clinical evidence
- Efficient and cost effective to maximize mental health gains for the maximum number of consumers.

Implementation of a Multilevel Approach:

This multi-level monitoring approach begins at the service provider level and cascades up to the DWMHA Quality Improvement Team.

Standardized Tools:

Standardized monitoring tools were developed to promote inter-rater reliability, sound and cost-effective self-regulation and data driven outcomes. Mental health professionals will be able to assess the care they provide against established standards.

Standardized tools are necessary to ensure:

- Actions and/or process requirements are not open to different interpretations
- The process is made easier to understand
- Non-value added steps are eliminated
- An increase in effectiveness and efficiency
- The process can be benchmarked to determine if it is proficient or that new performance goals are needed
- Authority and MCPN staff can collect evidence relying on process conformity to increase validity and reliability in findings.

Review Process:

Providers receive a DWMHA-generated random sample of cases to be reviewed. Providers with greater than \$250,000 in revenue receive 35 case records to review. Providers with less than \$250,000 are grouped together and then 35 cases are

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sampled between those providers. Providers complete their reviews using the **Clinical Record Review Tool** identified for that specific quarter. The case record findings are to be aggregated by the providers using the Combined Record Review process in MHWIN which can provide immediate feedback on the provider's overall performance. On-going review will identify trends, areas for improvement and corrective action plans as needed.

MCPNs will:

Monitor provider self-record reviews (in MH-WIN) on a monthly basis to: 1) ensure they are being completed 2) begin identifying patterns and trends.

On a quarterly basis the MCPN will complete an aggregate report comprised of the information in MHWIN on the case record reviews for providers in their network. From the findings the MCPN will analyze the data looking for patterns and trends. Providers scoring below 95% plans of corrections are expected.

MCPNs will complete a validation review of 5% of the total sample of case records selected during the quarter for their provider network. The validation reviews will be completed using the case record review tool in MHWIN. The MCPNs may validate the providers' findings at their discretion but ensuring that no less than a 5% sample of the cases are being validated.

The MCPNs will implement "revisions to practices/processes/procedures" based on their monitoring results. In addition to requesting a CAP of all providers scoring below 95%, the MCPN is also required to provide technical assistance and supports geared toward improving outcomes. Findings from the validation reviews will also be reported as part of their quarterly reporting.

The MCPN Quarterly report must include at a minimum, information on the overall findings from both the provider self-reviews and the MCPN validation reviews. Included in this report are:

- Number of providers receiving plans of corrections
- Identified trends/patterns
- Possible barriers to improving outcomes
- Where improvements are needed
- Action steps that will be taken to improve outcomes.

Quarterly reports are due on the 7th business day of each quarter (see attached schedule)

MCPN and DWMHA Monitors will validate the provider outcomes.

Level I: The beginning of the review process occurs at the provider level with the clinician delivering the service and documenting it in the clinical

record. Staff is expected to self-regulate their clinical activities under the direction of the supervisor.

Level II: The service provider's Quality Improvement staff is responsible for evaluating their program's use of self-monitoring tools.

Level III: The MCPN is required to review 100% of their contracted service providers including the specialized residential homes during the fiscal year. The reviews can be either on-site, desk audits validated reviews from another MCPN or DWMHA quality unit.

The MCPN will report their monitoring results to the providers. This data is critical to implementing a systematic process for improvement.

Level IV: The DWMHA Performance Monitoring staff will be responsible for validating the information submitted by MCPNs and providers. On a monthly basis DWMHA Performance Monitoring staff will generate aggregated reports of their assigned MCPNs and providers.

Steps of the Review Process:

Step I: Clinician, Clinical Supervisor and or Quality Improvement Supervisor:

Clinicians will deliver the services, document the findings in the case record, review case record documentation based on clinical record requirements and consult with the supervisor in areas of concern.

Training and technical assistance can be provided through a number of venues: peer reviews, increased supervision, technical assistance, in-service training, and practice-specific conferences. To ensure skills are updated the service provider organization should create an organizational learning culture that encourages staff to continually update their skills through such arenas as University or VCE offered trainings and other educational forums. All completed trainings must be submitted into the VCE for monitoring purposes.

Step II: Provider Quality Improvement Supervisor:

The service provider's Quality Improvement (QI) staff is responsible for evaluating provider compliance using self-monitoring tools.

On a monthly basis providers are required to analyze data on completed case record reviews by completing a combined report in MHWIN. The findings must be reviewed

with the supervisor(s) who will then review with staff and if needed, implement corrective action.

Each quarter all providers will review at 100% of the randomly selected case records provided by DWMHA. At the end of each quarter, the QI supervisor will complete an Aggregate report of the randomly selected Case Record Review tools.

The findings shall be used to assess program compliance and plan continuous quality improvement activities. The QI supervisor will aggregate the scores from the standardized review tool to assess patterns/trends, areas of weaknesses and strengths. The results will be shared with supervisors, clinical staff and MCPNs as part of the continuous quality improvement process. It is the responsibility of the QI supervisor and staff to implement a plan to achieve and maintain no less than 95% compliance.

At this level, the reviewers are able to determine the employee or supervisor's level of understanding, skill set and strengths. If problems are found, the QI supervisor should take the lead to provide direction, guidance and technical assistance. It is imperative that problem areas are addressed and corrected. Evidence of these corrections should be demonstrated in the clinical record progress notes and/or a revised IPOS, as appropriate.

Step III: MCPN Quality Director:

The MCPN is still required to review 100% of their contracted service providers including Specialized Residential homes during the fiscal year. The DWMHA expects the MCPN to ensure all dimensions of the programs are being fully implemented and that there is a process for providing continuous quality improvement. The MCPN's Quality Improvement staff must ensure quality outcomes as evidenced by compliance scores of no less than 95%.

MCPN monitoring will continue to occur through currently established venues:

- a. Review of the MH-WIN data
- b. Review of the randomly selected clinical records
- c. Site visits, desk audits or shared reviews between MDHHS, MCPNs, and or fidelity reviews.

Step III involves the MCPN implementing a CQI process through on-going evaluations using standardized review protocols and guidelines to analyze the findings. If problems are identified, the provider and MCPN are to work to understand the problem and develop a hypothesis about the changes needed to correct the problem.

MCPNs are expected to validate a sample of the case records submitted by each provider. On a monthly basis, using the Case Record Review Tool in MHWIN, the MCPN will validate the provider records. On a quarterly basis, the MCPN shall compile

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reports using the electronic Combined Report in MHWIN. For all providers whose total score on the Combined Report falls below 95%, the MCPN shall create a written plan of correction to be submitted to the DWMHA Quality Performance Monitor for the MCPN.

Step IV: DWMHA

On a monthly basis, the Performance Monitoring staff will review and validate the MCPN and provider Case Record Reviews and Combined Reports in MH-WIN. The Performance Monitoring staff will submit:

- a. Monthly reports to the Performance Monitoring Administrator on the first working day of the month following the end of a month. Monthly reports shall include:
 - i. Updates on the outcomes of the Provider Plans of Correction.
 - ii. Results of continuous monitoring from desk audits, internal Agency reporting and on-site reviews.
- b. Quarterly reports will be submitted to the Performance Monitoring Administrator on the first working day of the month following the end of a quarter. The quarterly reports are:
 - i. Quarterly narrative reports along with bar charts displaying the overall MCPN/provider performance to include significant findings: improvements/deficiencies and plans of correction for providers below the 95% compliance threshold.
 - ii. Recommendations for technical assistance that the Authority can offer to the providers as a group to ensure compliance with the standards of care to continue to be a “high performing PHIP”.
- c. Annually, Performance Monitoring staff is responsible for completing site reviews for each assigned MCPN and Direct Contract Provider.
 - i. MCPN site review entails:
 1. An Administrative site review
 2. Randomly selected sample of their contracted providers/programs will be reviewed. Special attention will be given to providers on plans of correction from previous reviews by Authority staff or from MDHHS.

Inter-DWMHA Review of the MCPN Process for Continuous Improvement

DWMHA Performance monitoring staff will work in conjunction with staff from other Authority units in monitoring identified standards. These units will include but are not limited to the following:

1. Contract Management

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2. The Office of Recipient Rights
3. Customer Services
4. Evidence-Based Medicine
5. Children's Initiative

Coordinating with the various units will improve our ability to monitor health and welfare issues by way of recipient complaints, sentinel events, Medicaid Fair Hearing requests as well as monitoring the use of restrictive or aversive behavioral interventions.