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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 beneficiaries 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 beneficiary response.

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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

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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.

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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, HIPPA, 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:

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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.

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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: **2017-2018 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 Initiatives
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

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CLINICAL POLICY

NO

INTERNAL/EXTERNAL POLICY

EXTERNAL

Attachments:	2017-2018 Case Record Monitoring Plan (3262018)_ma_.pdf

Approval Signatures

Approver	Date
Dana Lasenby: Acting Chief Executive Officer	03/2018
Allison Smith: Project Manager, PMP	03/2018
Michele Vasconcellos: Director, Customer Service [AS]	03/2018
Bessie Tetteh: CIO [AS]	03/2018
Lorraine Taylor-Muhammad: Director, Managed Care Operations [AS]	03/2018
Maha Sulaiman: Director of Utilization Management [AS]	03/2018
Andrea Smith: Director of Clinical Practice Improvement [AS]	03/2018
Michael Rangos: Director of Procurement [AS]	03/2018
Crystal Palmer: Director, Children's Initiatives [AS]	03/2018
Darlene Owens: Director, Substance Use Disorders, Initiatives [AS]	03/2018
Corine Mann: Chief Strategic Officer/Quality Improvement [AS]	03/2018
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Julia Kyle: Director of Integrated Care [AS]	03/2018
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Stacie Durant: CFO Management & Budget [AS]	03/2018
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Jean Alce: Interim Medical Director [AS]	03/2018
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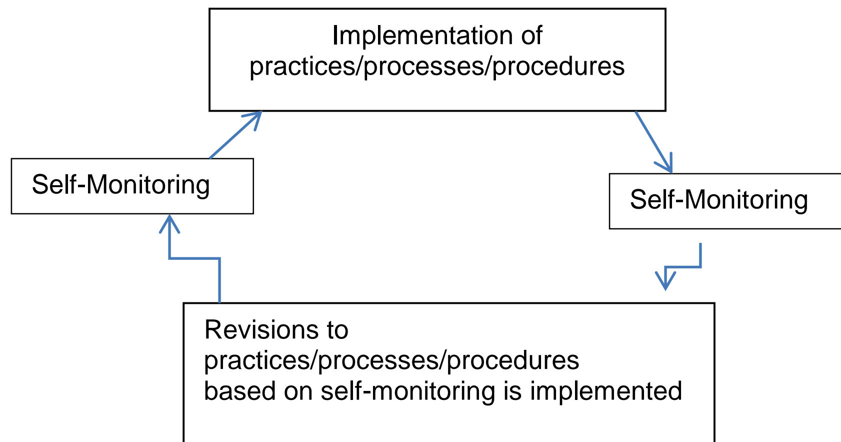
The Detroit Wayne Mental Health Authority (DWMHA) has developed standardized self-monitoring tools to be utilized throughout the system. The implementation of this self-monitoring plan is a component of the Continuous Quality Improvement (CQI) process. The CQI is designed to provide an organized, documented process for assuring that eligible Wayne County residents are receiving the medically necessary and appropriate services for mental health, substance use disorders and/or intellectual/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 repetitive.



Four main principles of quality improvement include:

1. *<u>Focus on the beneficiary</u>*: Services should be designed to meet the needs and expectations of the person being served. An important measure of quality is the extent to which beneficiary needs and expectations are met.

2. *<u>Understanding work and system processes:</u>* Providers need to understand the service system and its key processes in order to improve them. Using process-engineering tools provides simple visual images of these processes and systems.

3. *Teamwork*: 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 is responsible for managing specialty services for Consumers with or at risk for serious emotional disturbance (SED), severe mental illness (SMI), intellectual/developmental disabilities (I/DD), and substance use disorders. DWMHA manages a full array of specialty mental and substance use disorders services through contracts with Managers of Comprehensive Networks (MCPNs), SUD Providers and Direct Contractors.

What encompasses the DWMHA Network?

DWMHA network is a comprehensive group of contracted organizations to provide services for the SMI, SED, SUD and I/DD eligible populations in Wayne County. The network is comprised of:

- 5 Managers of Comprehensive Provider Networks and their subcontracted providers
- Direct Contractors which includes Substance Use Disorder providers, MI Health Link Dual Eligible providers, Autism Spectrum Disorders Benefit and Children's Waiver providers

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 Health and Human Services (MDHHS) and all other regulatory bodies are met. DWMHA must ensure effective and efficient operation of the various programs and agencies in a manner consistent with the provision of Medicaid services, sections of the Social Security Act, the Code of Federal Regulations (CFR), the Center for Medicare and Medicaid (CMS) Operations Manuals, Michigan's Medicaid State Plan, 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, SUD providers, Direct Contract providers and DWMHA staff. This approach is a partnership between the DWMHA, the MCPNs, SUD providers, Direct Contract providers, professionals and beneficiaries.

Goals, Objectives and Strategies:
The success of this plan is measured by our ability to meet and exceed the sets of outcome specifications in the beneficiary's individual plan of service, developed through the person-centered planning process or, for substance abuse services, the individualized treatment plan. Ensure providers maintain high standards and offer reliable supports and services within all programs.

To accomplish this goal, DWMHA will need 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 beneficiaries 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 beneficiaries.

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. Clear quality standards and the use of standardized tools will promote clinical effective self-regulations and monitoring for frontline staff.

These tools will allow staff to look at what they are doing against agreed upon standards and, where necessary, make changes to their current practice. Supervisors may identify

a need for increased supervision for staff in making clinical and service decisions about consumer care.

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
- DWMHA, MCPN, SUD and Direct Contract staff can collect evidence relying on process conformity to increase validity and reliability in findings.

Review Process:

On a quarterly basis, 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 sampled between those providers. Providers complete their reviews using the **Clinical Case 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 MH-WIN 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, subcontracted providers, SUD providers and Direct Contract Providers, quality staff will:

Monitor self-record reviews (in MH-WIN) on a monthly basis to: 1) staff are completing the monitoring review tools 2) begin identifying patterns and trends.

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 Improvement unit.

The MCPN will report their monitoring results to the providers and to the DWMHA Quality Improvement Unit. This data is critical to implementing a systematic process for improvement.
The SUD providers and Direct Contractors will report their monitoring results to DWMHA Quality Improvement Unit. This data is critical to implementing a systematic process for improvement.

Level IV: The DWMHA Quality Improvement staff will be responsible for validating the information submitted by MCPNs, SUD providers and Direct Contractors. On a monthly basis DWMHA Quality Improvement staff will generate aggregated reports of their assigned MCPNs, SUD providers and Direct Contractors.

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 Detroit Connect Wayne and other educational forums. All completed trainings must be submitted into Detroit Connect Wayne 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. The findings must be reviewed with the supervisor(s) who will then review with staff and if needed, implement corrective action if needed.

Each quarter all providers will review 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, SUD providers, Direct Contractors 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 100% 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: Quality Director:

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

MCPN, SUD providers and Direct Contractors monitoring will continue through currently established venues:

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

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

MCPN, SUD providers and Direct Contractors are expected to validate a sample of the case records submitted. On a monthly basis, using the Case Record Review Tool in MH-WIN, the MCPN will validate the provider records. The SUD providers and Direct Contractors using the Case Record Review Tool in MH-WIN, will validate their staff records. On a quarterly basis, the MCPN, SUD providers and Direct Contractors shall compile reports within their respective organizations using the electronic Combined Report in MH-WIN. For all providers whose total score on the Combined Report falls below 100%, the MCPN shall create a written plan of correction to be submitted to the DWMHA Quality Improvement staff for the MCPN. For all SUD providers or Direct Contractor staff whose total score on the Combined Report falls below 100%, they shall

create a written plan of correction to be submitted to the DWMHA Quality Improvement staff for their organization. Standards showing repeat non-compliance over two quarters will require the Quality Director to conduct a systematic process for identifying "**root causes**" for the problem(s) or events and an approach for responding to them. This Root Cause Analysis (RCA) is based on the idea that effective management requires more than merely "putting out fires" for problems that develop, but finding a way to prevent them. A **root cause** is a factor that caused a nonconformance and should be permanently eliminated through process improvement.

The MCPN, SUD providers and Direct Contractors will implement "revisions to practices/processes/procedures" based on their monitoring results. In addition to requesting a CAP of all providers or staff scoring below 100%, the MCPN, SUD providers and Direct Contractors are 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, SUD providers and Direct Contractors monthly report must include at a minimum, information on the overall findings from both the provider or staff self-reviews and the MCPN, SUD providers and Direct Contractors validation reviews. Included in this report are:

- Number of providers or staff 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.

MCPN, SUD providers and Direct Contractors and DWMHA Quality staff will validate the outcomes.

Step IV: DWMHA QI Staff

On a monthly basis, the Quality Improvement staff will:

- Review and validate the MCPN, SUD providers and Direct Contractors Case Record Reviews in MH-WIN.
- Review POC's and RCA submitted from the network and provide feedback.
- Conduct on-going monitoring of their assigned network providers, through a host of venues no less than monthly:
    - On-site reviews
    - Electronic medical records (EMR)
    - Web Support Application (WSA)
    - MH-WIN

- Training and Personnel (TAP) located in Detroit Wayne Connect (DWC)

The degree to which quality is measured is based on our network providers meeting or exceeding the sets of outcome specifications in the beneficiary's individual plan of service, developed through the person-centered planning process or, for substance abuse services, the individualized treatment plan.

DWMHA Quality Improvement staff will **submit**:

- Monthly
  a. Quality Improvement Team Report
     i. Submitted on the 15th of the month.
- Monthly and Quarterly Provider Monitoring Report
  a. Narrative Report
     The Narrative report will include:
  i. Line, bar, or pie charts, or pivot tables visualizing the monitoring data elements MH-WIN, WSA).
  ii. Significant findings, areas requiring improvements, POCs generated for the quarter, etc.
     iii. Highlight providers with on-going POCs, these providers should have identified factors that caused the non-compliance, established tools to permanently eliminated the problem and improve the deficiency. (**Root cause analysis** is a collective term that describes a wide range of approaches, tools, and techniques used to uncover **causes** of problems).
     iv. Recommendations for technical assistance that DWMHA can offer to providers to improve compliance.
     v. Utilization of process-engineering techniques to provide simple visual image of the processes used to improve the system. I.e. Flow charts, graphs etc.
     vi. Claims verification data.

- Annually
  a. Complete site reviews for assigned MCPN selected contractors and sub-contractors, SUD providers, and Direct Contract Providers.
  b. MCPN, SUD providers and Direct Contractors on-site review involves the following:
     i. Administrative
     ii. Mission Statement
     iii. Community Education
     iv. Improvement of Program Quality
     v. Randomly selected sample of contracted providers/programs as well as a sample of sub-contractors for review.

1. Special attention will be given to providers on plans of correction from previous reviews by MDHHS, DWMHA, MCPN, SUD providers and Direct Contractors and or other regulatory bodies.

c. Direct Contract reviews involves:
An annual on-site review of the following:

i. Administrative (Governance)
ii. Community Education
iii. Personnel and Resource Management (MH-WIN, TAP)
iv. Physical/Therapeutic Environmental
v. Case Record (either electronic or paper record)
vi. Claims Verification/Data review
On-going monitoring throughout the year which may involve:
Monitoring POC
Desk audits

d. SUD Provider reviews involve:

An annual on-site review of the following:

i. Administrative (Governance)
ii. Community Education
iii. Personnel and Resource Management (MH-WIN, TAP)
iv. Physical/Therapeutic Environmental
v. Case Record (either electronic or paper record)
vi. Claims Verification/Data review
On-going monitoring throughout the year which may involve:
Monitoring POC
Desk audits

DWMHA-Inter Department Collaboration

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

1. Provider Network
2. The Office of Recipient Rights
3. Customer Services
4. Integrated Health Care
5. Clinical Practice Improvement
6. Children's Initiatives
7. Utilization Management

Coordination and collaboration is key to improving of the network.

Focused Reviews:
Focused reviews can be prompted by a number of situations. They could be conducted in response to a request or complaint from staff, consumers, family member or other stakeholders, or based on unresolved systemic problems.

MCPN, SUD providers and Direct Contractors will be notified to obtain a mutually agreed upon date, time and place to the extent that it is feasible for DWMHA obligations.

1. A confirmation letter will be sent to the provider with details about the review and what is needed to facilitate the review.

Unannounced Reviews:

Unannounced reviews may occur to assess a critical or unusual problem within the provider system. MCPN, SUD providers and Direct Contractors may or may not be notified by phone prior to the arrival to ensure their presence at the designated location.

Except in cases where there is an unannounced visit, the guidelines, protocols and/or instruments to be used to review the contracted service provider shall be provided to the MCPN, SUD providers and Direct Contractors at least 15 days prior to the review, or a detailed agenda if no protocol exists.

Where problems are identified, the assigned Quality Improvement staff may choose to convene a meeting between units and decide on the best way to address the concerns i.e., increased desk audits or an on-site review.

At the conclusion of the review, DWMHA Quality Improvement staff shall conduct an exit interview with the MCPN, SUD providers and Direct Contractors. The purpose of the exit interview is to allow DWMHA Quality Improvement staff to present the preliminary findings and recommendations.

The MCPN, SUD providers and Direct Contractors shall have 30 days to provide a Plan of Correction (POC) for achieving compliance for all its contracted providers where areas of non-compliance have been identified. The MCPN, SUD providers and Direct Contractors may also present new information to the DWMHA that demonstrates it was in compliance.

DWMHA Responses for Consistent Non-compliance:

DWMHA will utilize a variety of means to assure compliance with contract requirements and with the provisions of Section 330, 1232(b) of Michigan's Mental Health Code, regarding Specialty Prepaid Inpatient Health Plans. The DWMHA will pursue possible remedial actions and sanctions as needed to resolve outstanding contract violations and performance concerns. The application of remedies and sanctions shall be a matter of public record. If action is taken under the provisions of Section 330, 1232(b) of the Mental Health Code, an opportunity for a hearing will be afforded the MCPN, SUD providers and Direct Contractors, consistent with the provisions of Section 330, 1232(b)(6).

The DWMHA will utilize actions in the following order:

1. Notice of the contract violations and conditions will be issued to the MCPN, SUD providers and Direct Contractors with copies to the Board.
2. Require a POC and specified status reports that become contract performance objectives.
3. If the above-mentioned actions have not worked, impose a direct dollar penalty, make it a non-match able MCPN, SUD providers and Direct Contractors administrative expense, and reduce earned savings from that fiscal year by the same dollar amount.
4. For sanctions related to reporting compliance issues, DWMHA may delay up to 25% of the scheduled payment amount to the MCPN, SUD providers and Direct Contractors until after compliance is achieved. DWMHA may add time to the delay on subsequent uses of this provision. (Note: DWMHA may apply this sanction in a subsequent payment cycle and will give prior written notification to the MCPN, SUD providers and Direct Contractors.)

The implementation of any of these actions does not require a contract amendment to implement. The sanction notice to the MCPN, SUD providers and Direct Contractors is sufficient authority according to this provision. The use of remedies and sanctions will typically follow a progressive approach, but DWMHA reserves the right to deviate from the progression as needed to seek correction of serious or patterns of substantial non-compliance or performance problems. The MCPN, SUD providers and Direct Contractors can utilize the dispute resolution provision of the contract to dispute a contract compliance notice issued by DWMHA

The following are examples of compliance or performance problems for which remedial actions including sanctions can be applied to address repeated or substantial breaches, or reflect a pattern of non-compliance or substantial poor performance. This listing is not meant to be exclusive, but only representative.

1. Untimely, poor quality and inaccurate reporting
2. Failure to consistently meet Performance Indicator Standards

3. Repeated site review non-compliance (repeated failure on same item)
4. Failure to complete or achieve contractual performance objectives
5. Substantial inappropriate denial of services required by contract or substantial services not corresponding to conditions. Substantial can be a pattern, large volume or small volume but severe impact
6. Repeated failure to honor appeals/grievance assurances
7. Substantial or repeated health and/or safety violations

Supervision of DWMHA Monitoring Plan:

This Plan is under the authority of the Director of Quality Improvement in the DWMHA. It is the responsibility of the Quality Improvement Manager to supervise the implementation of this Plan.