NORTH COUNTRY COMMUNITY MENTAL HEALTH
ADMINISTRATIVE MANUAL

CHAPTER: Two – Quality Improvement
PLAN: QUALITY IMPROVEMENT PROGRAM PLAN
EFFECTIVE DATE: December 1, 2021

PURPOSE

PURPOSE OF A CONTINUOUS QUALITY IMPROVEMENT PROGRAM

North Country Community Mental Health's Quality Improvement Program is designed to achieve improvement in clinical and non-clinical services that impact the overall health, quality of life, and satisfaction of persons served in keeping with NCCMH's mission:

> *To provide behavioral health services that inspire hope and promote recovery, resilience, and wellness to eligible residents.*

NCCMH maintains an administrative and organizational structure that supports a high quality, comprehensive managed behavioral health program. The organizational structure ensures effective linkages between administrative areas including provider network services; customer services, service area network development; quality improvement and utilization review; grievance/complaint review; financial management; and management information systems. Effective linkages are determined by outcomes that reflect coordinated management and are evidenced in this Quality Improvement Program Plan.

PURPOSE OF THE QUALITY IMPROVEMENT COUNCIL

The Quality Improvement (QI) Council supports the ongoing advancement and implementation of a comprehensive plan for improving the performance of the organization; oversees that process in order to give guidance and ensure that it is properly implemented through coordination with standing committees; and facilitates the dissemination of performance information throughout the organization.

North Country CMH is committed t the LEAN Culture of Continual Process Improvement. LEAN can be defined as an operational strategy that enables people and organizations to change for the better, by being persistent in the pursuit of excellence and elimination of waste. LEAN places emphasis on processes and improvement, and it is a people-based system that strives for value for all customers, internal and external.

SCOPE OF QUALITY IMPROVEMENT PROGRAM

The Quality Improvement Program Plan is intended to address those activities and processes that are particular to operations within the six-county service area. All demographic groups, care settings and types of services are included in its scope. An emphasis will be placed on behavioral health and physical health outcomes and the use of information technology to facilitate and improve care coordination for the people served.

The QI Council will work closely with the Northern Michigan Regional Entity's (NMRE) Quality Oversight Committee on issues related to regional performance improvement projects as described in its annual work plan.

A profile of the organization describing its geographic area, demographics of populations served, and types of services is found in Attachment A.

STRUCTURE OF THE QUALITY IMPROVEMENT COUNCIL

Council Membership

North Country CMH has several standing committees tasked with meeting administrative and clinical needs of the organization. The QI Council will include representatives from the standing committees.

Each committee chairperson shall select the representative in consultation with the Chief Executive Officer (CEO) and/or the Chief Clinical Officer (CCO) It is intended that representatives be from various programs and job functions. Terms shall be for two years. Members may serve consecutive terms. Committees to be represented include:

- ► Risk Management Committee
- ► Infection Control/Safety Committee
- ► Credentialing and Privileging Committee
- ► Behavioral Health Home/Health Services Committee
- ► Behavior Treatment Committee
- ► Office of Recipient Rights
- ► Utilization Management Committee
- ► Data Management Committee
- ► Consumer Council

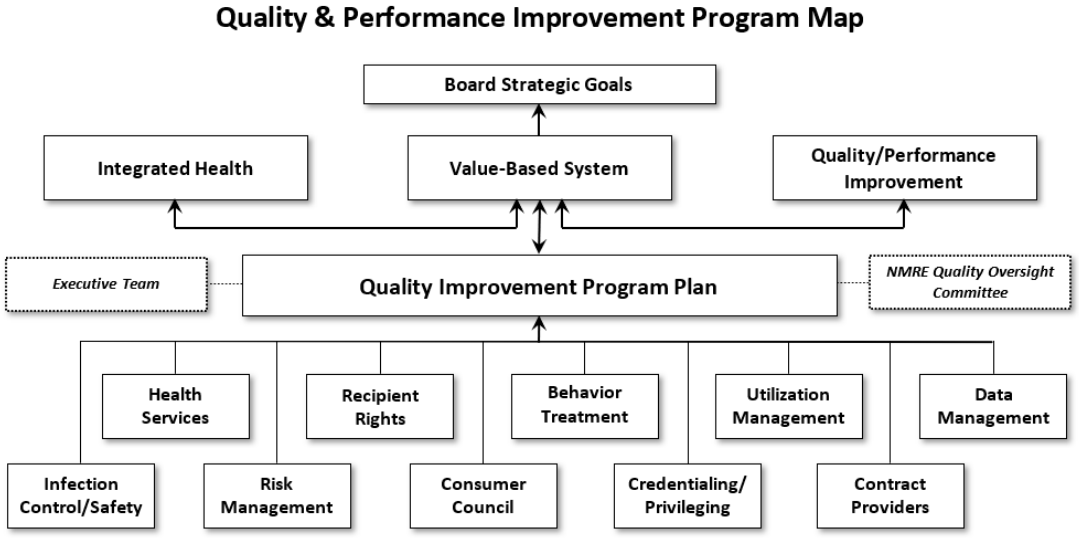
Additionally, the Council shall consist of three "At Large" staff members and a representative from a contract provider agency. Future standing committees that may be initiated will be represented as deemed appropriate by the CEO and/or CCO. The Medical Director, one Board Member and Chief Operating Officer (compliance leader) shall also be members of the Council, as consultative members.

Relationship to Organizational Structure

The Quality Improvement Council will take a lead role in the coordination of all quality improvement activities and participate in the development of the Board's strategic goals. Each standing committee of the organization will work with the QI Council to ensure coordination of efforts and to avoid duplication of activities.

The QI Council, as depicted in Figure 1 below, will bridge functional, population, and geographical boundaries. It will work with the Executive Team to provide coordination, data interpretation, and feedback, and with the NMRE's Quality Oversight Committee to support regional initiatives.

Figure 1. QI Council Structure



GOALS AND OBJECTIVES

QI PROGRAM GOALS

- Use of continuous quality improvement and Lean process improvement methodologies to monitor and improve the agency's performance in the delivery of services to its customers.
- Ensure the quality of services provided to persons served by other organizations under contract with NCCMH.
- Accurately assess the outcome of services provided in terms of improved functioning levels, improved quality of life, and symptom reduction.
- Improve customer and stakeholder satisfaction as evidenced by satisfaction surveys and stakeholder survey input.
- Improve the performance, structure, and consistency of quality Action teams.
- Increase consumer involvement in the quality improvement process and Lean process improvement teams..
- Monitor performance measures on access to services, and the effectiveness and efficiency of services.

BOARD STRATEGIC GOALS

The QI Council will align its activities with the Board's strategic goals. The strategic goals for 2021-2022, as noted in Figure 1 above, are as follows:

- Demonstrate Value of CMH Services
- Enhance Clinical Services and Improve Client Outcomes
- Enhance Continuum of Crisis Services through Community Partnerships
- Be an Employer of Choice
- Maintain Stability of Provider Network

PERFORMANCE IMPROVEMENT OBJECTIVES

Annual performance objectives are established based on data gathered throughout the year, including but not limited to: utilization management data, clinical standards compliance, LEAN process improvement team recommendations, quality assurance measures, safety and infection control findings, service outcome data, customer satisfaction data, staff and consumer recommendations, and changing regulatory requirements.

Upon reviewing all appropriate and available information, the QI Council will develop a list of potential performance improvement objectives. This list will be shared with the Executive Team and management. Upon receipt and review of feedback, the QI Council will reduce the list to a workable number of appropriate objectives with interventions for improvement and timeframes for the upcoming year. Board approval will be sought in the first quarter of each fiscal year. Active Performance Improvement Projects are listed in Attachment B.

In addition to annual performance improvement objectives, the QI Council monitors trends in quality assurance measures established by the standing committees and leadership, or as required by stakeholders, such as the Michigan Department of Health and Human Services. Quality measures must be objective, measurable, and based on current knowledge and clinical experience. These are tracked over time for sustainability. Quality assurance measures are found in Attachment C.

USE OF CLINICAL STANDARDS AND PRACTICE GUIDELINES

North Country CMH has adopted clinical care guidelines and evidence-based practices in the areas of Trauma Focused Cognitive Behavioral Therapy (TF-CBT), parent management training Oregon model (PMTO), and integrated dual diagnosis treatment (IDDT), Eye Movement Desensitization and Reprocessing (EMDR), and Motivational Interviewing (MI) The organization uses standardized assessment tools, such as LOCUS, CAFAS, PECFAS, and SIS.

The QI Council monitors quality of care against both internally established and nationally accepted clinical standards/guidelines and the technical requirements in its MDHHS Contract. The QI Council is responsible for ensuring that clinical guidelines are regularly reviewed and updated.

Technical Requirements contained in the MDHHS Contract may be assigned to an individual or specific standing committee for implementation and monitoring or may fall to the QI Council to fulfill this purpose. The QI Council is responsible for the following MDHHS Technical Requirements:

ACCESS TO CARE
The QI Council will review access standards and measures including telephone answering rates, call abandonment rates, timeliness of appointments and referrals, and inpatient hospital recidivism. Review of these standards are documented in the meeting minutes. Any resulting performance issues will be addressed through the Lean quality/performance improvement process.

PERSON CENTERED PLANNING:
The QI Council assures that best practices for supporting individuals through person-centered planning (PCP) are identified and implemented (what is working and what is not working in supporting individuals). Expectations and standards are in place to assure the individual directs the PCP process and that PCP is consistently done well. Results from qualitative record reviews, MDHHS site reviews, and CARF reviews, among others, are used to drive quality improvement efforts.

ANNUAL REVIEW OF GOALS AND OBJECTIVES
The QI Council will review established goals and objectives annually, as noted in committee minutes, to assess their continuing applicability and appropriateness. This will be done in conjunction with the annual assessment of the effectiveness of the quality improvement process as described in this Plan.

ROLES AND RESPONSIBILITIES

To be successful, quality improvement must be a culture which is pervasive in the organization. Thus, individuals at all levels, from governing body to part-time staff have a role in the quality improvement process.

BOARD
As the governing body, the Board must approve the Quality Improvement Program Plan and annual performance objectives. Regular progress reports will be made to the Board regarding outcomes on performance objectives, action teams established, progress made, and results realized.

The Board periodically reviews, but no less than annually, a written report on the QI Program that includes studies undertaken, results, subsequent actions, and aggregate data on utilization and quality of services rendered to assess the QI Program's continuity, effectiveness, and current acceptability. The Board assures that the Chief Executive Officer (or his/her designee) acts when appropriate and directs the Plan be modified on an ongoing basis to accommodate review findings and issues of concern.

Chief Executive Officer
The Chief Executive Officer (CEO)Executive Director must demonstrate a commitment to the principles of quality improvement and Lean process improvement by establishing a vision for the organization that has quality services as its center and by creating an environment in which quality is

valued. The CEO, either directly or through the QI Council, establishes goals and objectives for the overall quality effort.

Acting on behalf of the CEO, the Chief Clinical Officer is responsible for oversight of the Quality Improvement Program Plan and will support the quality improvement and Lean processes through personal involvement. This participation will include involvement in improvement efforts, council meetings, communications, and recognition of successes.

MEDICAL DIRECTOR

As a member on the QI Council, the Medical Director represents the medical and clinical aspects of NCCMH operations. The Medical Director is responsible for the review and approval of clinical care guidelines (by way of membership on the Health Services Committee) and the review of all sentinel events (by way of membership on the Risk Management Committee).

MANAGEMENT

The management of the organization plays a critical role in determining the success of quality improvement activities. It is incumbent upon all management staff to learn and fulfill several responsibilities that include:

- Ensure the readiness of their program/department for the implementation of quality improvement efforts by coaching staff, participating in Lean process teams, and ensuring open and safe communication.
- Assist in identifying opportunities for improvement, using data analysis and business analytics.
- Assist in the implementation of new or revised systems and/or processes.
- Monitor the results of quality improvement activities and ensure proper and timely communication of these results.

STAFF

The success of this plan will be directly related to the involvement of staff in the quality improvement and Lean processes. A properly designed quality improvement program places additional responsibilities on the staff of the organization. These responsibilities include:

- Identifying opportunities for improvement, using the established systems of Lean to identify wastes in the current value streams, recommend review for process improvement, and participate on Lean process improvement teams as core team members or subject matter experts. Quality improvement has a solution focus. Staff must be committed not only to identifying problems, but to developing solutions.
- Reporting progress in their efforts. This includes identifying barriers to progress and exploring solutions to these barriers. Lean teams and individuals working within the quality improvement process will be asked to report to the QI Council on a regular basis. This is an important step in the communication and coordination of efforts and results.
- Seeking skill level improvement, i.e., demonstrating initiative in learning the tools of quality improvement and the skills particular to their own job performance, piloting new processes, and monitoring processes for necessary updates or changes.

QUALITY IMPROVEMENT COUNCIL

The QI Council serves as the leadership for the quality improvement process. Empowered by the Board and the CEO, the QI Council guides all quality improvement activities. The QI Council ensures that all levels of the organization are trained in Lean and thequality improvement process, tools and resources. The QI Council assists in identifying opportunities for improvement, as well as reviewing and prioritizing all suggested activities. The Council supports training, guidance and resources for Lean process improvement and other quality improvement teams.

The QI Council takes a lead role in monitoring progress toward obtaining and maintaining CARF accreditation. Programs accredited by CARF include: Assertive Community Treatment (ACT), case management/supports coordination, clubhouse (community integration), emergency services (crisis intervention), , and outpatient treatment. The QI Council assures that program plans meet CARF standards; monitors programs' performance measures on access, efficiency, effectiveness and satisfaction; reviews triennial CARF survey results, and works with programs to implement performance improvement activities, as needed.

The QI Council assists in planning and data collection for the MDHHS Annual Needs Assessment, including conducting stakeholder satisfaction surveys and/or focus groups, and assures this information is reported back to stakeholders, leadership, the Board, and staff. An open meeting is publicized and held to review findings with the public.

The QI Council also plays a lead role in ensuring compliance with all auditing bodies, such as the MDHHS, the NMRE, and the Office of Recipient Rights. To this end, the QI Council assists the Training Coordinator as needed, with planning for staff education. The QI Council assures that findings from audits are communicated to staff and that corrective actions are implemented, as needed. A schedule of audits, reviews and surveys is found in Attachment D.

It is incumbent upon the QI Council to monitor all quality improvement activities. The QI Council receives reports from standing committees and action teams on a regular basis and monitors their performance goals for improvement. When necessary, the QI Council and/or the Quality and Data Management Coordinator provide assistance in implementing and following the quality improvement process. This information is used in establishing priorities and identifying needs. Appropriate information is communicated to the CEO, the Board, the staff, and to other stakeholder groups.

STANDING COMMITTEES

As illustrated in Figure 1 on page 3, standing committees play an essential role in the quality improvement process. As stated above, each group will be responsible for reporting to the QI Council on a regular basis through its representative member. This coordination is needed to avoid redundancy and to ensure a constancy of purpose throughout the organization. Each group is responsible for identifying opportunities for improvement within the area they represent. Similarly, they are responsible for reporting progress and results to the QI Council. Each group must assist in communication and feedback activities as well.

Each standing committee has written Committee Guidelines which describe its purpose, membership, meetings, responsibilities, goals, reporting requirements, and compliance references. These are presented in Attachment E. Some committees are charged with meeting specific Quality Improvement Program or other Technical Requirements of the MDHHS contract, as noted in Attachment F.

BEHAVIOR TREATMENT COMMITTEE

The Behavior Treatment Committee's role is to review and approve, or disapprove, any plans that propose to use restrictive or intrusive interventions with individuals who exhibit seriously aggressive, self-injurious or other challenging behaviors that place the individual or others at imminent risk of physical harm.

CONSUMER COUNCIL

Consumer input and involvement in the development, implementation, review and use of technology, processes, and outcome measures, and is a critical part of quality improvement and a specific goal of this Plan.

CREDENTIALING/PRIVILEGING COMMITTEE

The Credentialing and Privileging Committee assures that written policies and procedures are in place to determine whether physicians and other health care professionals, who are licensed by

the State and who are employees of NCCMH or under contract, are qualified to perform their services. Further, the Committee assures that non-licensed providers of care or support are qualified to perform their job duties, reviewing experience and competencies as compared to State guidelines

The Credentialing and Privileging Committee also assures there are written policies and procedures for credentialing and re-credentialing providers every two years, and for monitoring providers and sanctioning providers who are out of compliance. In conjunction with the Human Resource Manager, the Committee assures that staff possess the appropriate qualifications as outlined in job descriptions including: educational background, relevant work experience, cultural competence, and certification, registration, and licensure as required by law.

DATA MANAGEMENT COMMITTEE

The Data Management Committee directs the collection of data obtained from various sources in the agency and assures verification of data integrity. The committee ensures all contractual reporting requirements are met and supports and expands the use of data driven decisions within all programs.

BEHAVIORAL HEALTH HOME/HEALTH SERVICES COMMITTEE

The Behavioral Health Home/Health Services Committee assures that psychiatry and health services are aligned with best practices that promote and support integrated health care coordination. The committee develops and implements staff education to ensure a high quality, well integrated treatment team.

INFECTION CONTROL & SAFETY COMMITTEE

The Infection Control and Safety Committee's role is to identify and reduce the risks of acquiring and transmitting infections among consumers, visitors, healthcare providers, students, volunteers and other staff within the agency; and to identify and reduce the number of injuries and illnesses to an absolute minimum.

RISK MANAGEMENT COMMITTEE

The Risk Management Committee's role is to identify and mitigate risk exposure and reduce the severity of a loss if one were to occur; to improve the quality of services and mitigate the effects of any potential loss; and to reduce or prevent the potential for harm to consumers, employees, and visitors by assuring that all preventive or corrective actions are identified and taken.

RECIPIENT RIGHTS ADVISORY COUNCIL

The Recipient Rights Officer (RRO) and Recipient Rights Advisory Council assure that the organization meets federal, state and contractual requirements as described in the organization's Recipient Rights System policies and procedures. The RRO provides an analysis of complaint, investigation, and outcome data semi-annually to the QI Council.

UTILIZATION MANAGEMENT COMMITTEE

The Utilization Management Committee is responsible for maintaining and implementing the utilization management plan including processes to identify and correct over-and-under-utilization, guidelines for decision-making, and a well-publicized local dispute resolution process.

CONTRACT AGENCIES

Contract agencies play a vital role in the service delivery system for NCCMH. As such, their involvement in the quality improvement process is beneficial. A representative of the contract agencies selected by the provider network manager, will participate on the QI Council. Additionally, contract agency staff will be invited to participate in action teams, as appropriate. Information pertinent to the contract agencies will be shared on a regular basis.

CONFIDENTIALITY

Protection of the identity of the persons receiving care and services and the identity of internal and external consumers is essential. NCCMH will comply with all federal, state and local laws, rules, regulations and statues in ensuring the privacy of protected health information. Individual data will be used only when necessary, and in such cases, all reasonable measures will be taken to respect the confidentiality and integrity of the individual(s) involved.

The QI Council recognizes that at times individuals and programs may need to be identified specifically enough that some members will be able to recognize the individual referenced. All QI Council members will be held to the highest standard of confidentiality. Violation of this standard may result in removal from the QI Council and other disciplinary action as appropriate.

IDENTIFYING STAKEHOLDERS AND STAKEHOLDER SATISFACTION

Understanding and examining customer relationships, both internal and external to the organization, is helpful in applying quality improvement principles. The level of satisfaction experienced by a customer (stakeholder) is an important determinant to the continued relationship with that customer.

North Country has many stakeholders including, but not limited to, persons served, employees, referral sources, other health and human service agencies, funding sources, primary care providers, courts, schools, MDHHS, the state legislature, and the taxpayers or general community.

The organization conducts periodic quantitative and qualitative assessments of consumers' experience with its services. These assessments are representative of persons served and the services and supports provided and include issues of quality, availability, and accessibility of care. As a result of these assessments, North Country does the following:

- Takes specific action on individual cases as appropriate
- Identifies and investigates sources of dissatisfaction
- Outlines systemic action steps to follow up on findings
- Informs practitioners, providers, recipients of service, and the governing body of the assessment results.
- Ensures the incorporation of consumers receiving long-term supports or services (persons receiving case management or supports coordination) into this review process.

THE QUALITY IMPROVEMENT PROCESS

INFORMATION GATHERING

It has been repeatedly stated that quality improvement must be pervasive throughout the organization. This includes not only the commitment to the principles of quality improvement, but also the application of these principles to processes. Quality improvement efforts must be based upon objective information. It is imperative that the QI Council supports the organization's evolution in becoming a data-driven, value-based organization.

Objective data are drawn from several sources, including but not limited to: consumer and stakeholder satisfaction surveys; state, affiliation and organization performance measures; statewide benchmarking measures; clinical program outcome measures; peer review; claims audits; clinical record reviews; and review of current literature or research. Subjective information and suggestions for improvement may also come from suggestion boxes, consumer focus groups, contract provider meetings, satisfaction surveys or through staff Quality Improvement Input forms.

DATA INTEGRITY

Accurate and consistent data are paramount to effective business operations and the quality improvement process. Therefore, quality improvement projects must address the fundamental elements of reliability, validity, completeness, and accuracy of the data collected and reported.

SELECTION OF PROCESSES

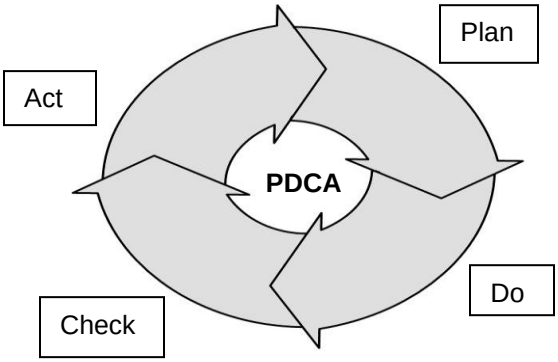
Selection of specific quality improvement projects/Lean process improvement demands attention to both complexity and relevance of a particular project. Projects/teams may be recommended either through data identification needs or through employee Lean suggestions or customer suggestions. Items selected for quality improvement studies or Lean process improvement teams must represent realistic opportunities for meaningful improvement. In selecting projects, the QI Council shall consider the following criteria:

- Frequency of request or suggestion
- Age groups, disease categories and special risk status
- Risk or existing situation
- Impact on services or funding
- Consumer generated requests
- Consumer impact
- Feasibility of project
- Consensus of QI Council
- Scope of impact on the organization as a whole
- Focused on health outcomes

Projects may be handled either through single purpose action teams or through standing committees, depending upon the nature of the process to be addressed. In order to monitor performance improvement over time, quality assurance measures will be identified and tracked.

QUALITY IMPROVEMENT MODEL

Plan - Do - Check - Act, also known as the Shewhart Model, forms the basis for the quality improvement program. It is a strategy used for facilitating Rapid Cycle Improvement by identifying, implementing, and measuring changes in an efficient and cyclical (continuous) manner:



Plan:

Identify area for potential improvement
Assemble and charge an action team or Lean Process Improvement team

Do:

Document current process and all related data inputs and outputs
Identify perceived difficulties or barriers
Identify improvements, recommendations, and map out the process

Check:

Analyze data from pilot to determine impact
Present data

Act:

Act on what was learned
Implement changes organizationally *or* Adjust plan and try again
Provide feedback on lessons learned
Pilot new process on a small scale
Collect/Organize data regarding pilot activities

The quality improvement process will generally be implemented through Lean Process Improvement teams or quality Action teams. Action teams may be initiated by the QI Council, standing committee, or program. The QI Council chairperson will be notified when Lean or Action teams are established.

IMPLEMENTATION OF CORRECTIVE ACTION PLANS

The QI Council is responsible to ensure that appropriate corrective action is taken whenever inappropriate or substandard services are furnished as determined by substantiated recipient rights complaints, clinical indicators, or clinical care standards or practice guidelines. This includes corrective actions from, among others, MDHHS and NMRE site reviews, Medicaid claims audits, CARF reviews, External Quality Reviews, and Recipient Rights reviews. Follow up on corrective actions are documented.

COMMUNICATIONS AND FEEDBACK

Timely communication and feedback are vital parts of the quality improvement process. Information must be shared in formats that are useful to the persons served, staff and other stakeholders.

First and foremost, there must be a commitment by the leadership to improve and maintain communication throughout the organization. This level of communication is dependent upon each individual manager.

The QI Council will communicate through a variety of vehicles. Communications will include regular reports to the governing Board, minutes of meetings, and reports to staff. These reports, combined with appropriate memorandums and announcements, will effectively communicate and solicit input and feedback.

TRAINING

North Country Community Mental Health is committed to properly training all employees and Board members in the principles of quality improvement, Lean Process Improvement, and other relevant topics. Training will also be delivered at new employee or board member orientation and through continuous staff development. To this end, the Human Resource department will be responsible for developing, implementing, and monitoring an agency-wide training program that includes standard and special topics.

Training is also vital to the implementation of changes resulting from action team efforts. Each team or committee responsible for a quality improvement project will, as part of their recommendations, address necessary training for staff. Standing committees will also include recommendations for staff training as part of its annual report to the QI Council.

DOCUMENTATION

The QI Council chairperson will assign an administrative assistant to take and maintain meeting minutes, and records documenting the council's activities, findings, recommendations, and actions, including those of Lean process improvement teams. Lean teams will keep process improvement files and summaries on the Intranet.

ANNUAL REVIEW AND EVALUATION OF QI PROCESS

Each year the QI Council shall conduct an evaluation of the QI process and activities for the past year. This evaluation shall be based upon the stated goals and objectives of the program in comparison to the actual activities and outcomes. Further, the information will be used to review the implementation of the mission and core values of the organization.

The effectiveness review will include analysis of whether there have been improvements in the quality of health care and services for recipients as a result of quality assessment and improvement activities and interventions carried out by the organization. The analysis should take into consideration trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives

The method of evaluation shall be consistent with sound quality improvement and Lean principles. Activities should include, at a minimum: survey of appropriate parties, review of data collected, and assessment of progress.

The results of this evaluation shall be submitted to the CEO and the Board for input and comments. Following Board approval, the evaluation and revisions will be shared with all staff, and to network providers and consumers upon request

REFERENCE: MDHHS/CMHSP Managed Mental Health Supports and Services Contract, C.6.8.1 Quality Improvement Program Technical Requirements; Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program; CARF Behavioral Health Standards Manual

REVIEWED: 11/15/2021

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APPROVED BY SIGNATURE:

Amy Christie	*December 1, 2021*
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