NORTH COUNTRY COMMUNITY MENTAL HEALTH ADMINISTRATIVE MANUAL

CHAPTER: Two – Quality Improvement
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EFFECTIVE DATE: March 1, 2024

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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 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 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

<u>Council Membership</u>

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 (or designee) shall represent their standing Committees to be represented include:

- ► Risk Management Committee
- ► Credentialing and Privileging Committee
- ► Behavior Treatment Committee
- ► Utilization Management Committee
- ► Data Management Committee
- ► Residential Sustainability Committee
- ► Executive Committee
- ► Lean Advisory Group

Additionally, the Council may include additional 'at large' members, including the Director of Recipient Rights. Future standing committees that may be initiated will be represented as deemed appropriate by the CEO and/or QI Council. The Medical Director shall also be a member 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 through review of information presented by standing committees and recommendations to the Lean Advisory Group. QI activities will align with the Board's strategic plan. Each standing committee of the organization will work with the QI Council and Lean Advisory Group 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 and other standing committees to provide coordination, data interpretation, and feedback, and with the NMRE's Quality Oversight Committee to support regional initiatives.

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 improvement teams.
- Increase client 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 2024-, are as follows:

- Develop the sustainable capacity to serve everyone that requests services regardless of severity of illness, insurance, or ability to pay.
- Drive policy and program development from a rural

- Build the reputation of the organization on the value it adds to the community it serves. Demonstrating value based on outcomes requires measuring outcomes that highlight tangible, positive results.

- Develop a culture of operational excellence emphasizing a collective commitment to the people we serve through continuous improvement, streamlined processes, and a focus on eliminating waste.

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 advisory group recommendations, quality assurance measures, risk management 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, which includes the Medical Director. Upon receipt and review of feedback, the QI Council and Lean Advisory Group 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 on the Lean Advisory Group SharePoint.

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 B.

USE OF CLINICAL STANDARDS AND PRACTICE GUIDELINES

North Country CMH supports the use of practice guidelines that are evidence-based and supported by the NMRE. The practice guidelines comprise of the American Psychiatric Association (APA) practice guidelines, other practice guidelines reviewed and made available bgy the APA, MDHHS practice guidelines and region-specific practice guidelines.

Region specific practice guidelines include Integrated Dual Diagnosis Treatment (IDDT), Home-Based, Family Psychoeducation (FPE), Assertive Community Treatment (ACT), and Parent Management Training Oregon model (PMTO). North Country CMH has adopted clinical care guidelines and evidence-based practices in the areas of Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Eye Movement Desensitization and Reprocessing (EMDR), and Motivational Interviewing (MI) The organization uses standardized assessment tools, such as LOCUS, CAFAS, and PECFAS.

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 is documented in the meeting minutes. Any resulting performance issues will be addressed through the Utilization Management and/or the Lean Advisory Group.

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 the 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 quality assurance measures/ performance objectives. Regular progress reports will be made to the Board regarding outcomes on performance objectives, Lean process improvement teams established, progress made, and results realized.

The Board and/or Board Program Committee 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 their designee) acts when appropriate and directs the Plan to be modified on an ongoing basis to accommodate review findings and issues of concern.

Chief Executive Officer

The Chief Executive Officer (CEO) 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. This participation will include involvement in improvement efforts, council meetings, communications, and recognition of successes.

MEDICAL DIRECTOR

As a member of the Executive Team and QI Council, as requested, 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 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 quality improvement activities. The QI Council ensures that all levels of the organization are trained in Lean Process Improvement and the quality improvement process, tools and resources. The QI Council assists in identifying opportunities for improvement, as well as reviewing and prioritizing all suggested activities in coordination with the Lean Advisory Group. 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 E.

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 aid 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

Standing committees play an essential role in the quality improvement process. 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 committee goals, progress, and results to the QI Council. Each group must assist in communication and feedback activities as well.

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

QI Standing Committees with Individual Charters:

- Behavior Treatment Committee
- Credentialing and Privileging Committee
- Data Management Committee
- Executive Team
- Lean Advisory Group
- Risk Management Committee
- Recipient Rights Advisory Council
- Utilization Management Committee
- Residential Sustainability Committee

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 CMH 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 clients receiving long-term supports or services (persons receiving case management/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 and Lean Process 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 to become a data-driven, value-based organization.

Objective data are drawn from several sources, including but not limited to client 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, client focus groups, contract provider meetings, satisfaction surveys, Lean suggestions, or directly by staff.

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

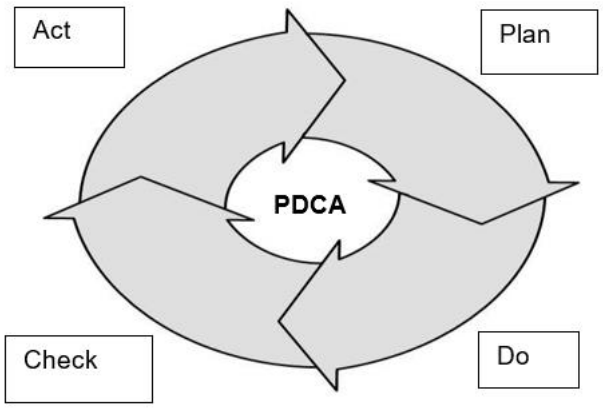
Selection of specific quality improvement projects/Lean process improvement requires review of the waste determined/value added details of the process being suggested for improvement. Process improvement teams may be recommended either through data identification needs, through employee Lean suggestions or client/stakeholder suggestions. Items selected for quality improvement or Lean process improvement teams must represent realistic opportunities for meaningful improvement. In selecting projects, the QI Council will refer needs/suggestions to the Lean Advisory Group, who will consider criteria including, but not limited to:

- Frequency of request or suggestion
- Age groups, disease categories and special risk status
- Risk or existing situation
- Impact on services or funding
- Client generated requests
- Client impact
- Value adds
- Scope of impact on the organization as a whole
- Focused on outcomes

When identified initiatives may be assigned through different process improvement methods, including 'just do its', Lean process improvement teams, or larger scale project management/development. To monitor process improvement over time, the Lean Advisory Group will post the status of those initiatives identified.

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 within the process of Lean process improvement by identifying, implementing, and measuring changes in an efficient and cyclical (continuous) manner:



Plan:

- Identify area for potential improvement
- Assemble and charge a Lean Process Improvement team

Do:

- Document current process and all related data inputs, outputs, and 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 organization 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 project development teams. Teams may be identified to the Lean Advisory Group by the QI Council, standing committee, or program. The QI Council will be updated when Lean Process Improvement teams are established.

IMPLEMENTATION OF CORRECTIVE ACTION PLANS

The QI Council is in part, 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, and actions for correction are facilitated and monitored by standing committees and reported to QI Council.

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 CMH 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. In conjunction with Human Resources and Operations, the Training Department will oversee the development, implementation, and monitoring of an agency- wide training program that includes standard and special topics.

Training is also vital to the implementation of changes resulting from process improvement 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 share any recommendations for staff training as part of its report to the QI Council.

DOCUMENTATION

The QI Council will request a support staff to take and maintain meeting minutes, and records

documenting the council's activities, findings, recommendations, and actions, including those of Lean process improvement teams. The Lean Advisory Group will keep process improvement files and summaries.

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. Review should be facilitated by the Lean Advisory Group and should include, at a minimum: survey of participating Lean teams, review of data collected, and assessment of processes.

The results of this evaluation shall be submitted to the CEO and the Board for input and comments. Following Board presentation, the review and additional input obtained, will be shared with all staff, and to network providers and clients 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

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APPROVED BY SIGNATURE:

Amy Christie *2/20/2024*

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Chief Executive Officer **Date**