HEALTHWEST

Policy and Procedures

No: 09-001

Prepared by:

Effective: April 22, 1983
Revised: March 14, 2018

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Approved By:

Subject: Quality Assessment and Performance Improvement

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I. POLICY

It is the policy of HealthWest that all staff participate in formal Performance and Quality Improvement activities to assist the Agency in attainment of the stated mission/vision and values. This includes the monitoring of all Network activities.

II. PURPOSE

To describe the Quality Assessment and Performance Improvement Program (QAPIP) whose plan it is to give structure and a set of practices that facilitates planning, measurement, assessment, and improvement of service delivery and support processes and systems. The scope of the program is comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service. Clinical improvement activities will minimally address prevention, acute, chronic, high volume, high risk services, continuity and coordination of care, ensuring fidelity to evidence-based practices, and person-centered, recovery-oriented care. Non Clinical improvement activities will minimally address availability, accessibility, and cultural competency of services, quality of providers, and processes regarding appeals, grievances and complaints. The Plan for Quality Assessment and Performance Improvement provides the formal Board approved structure and systems to carry out QAPIP initiatives.

III. APPLICATION

All HealthWest staff will participate in performance quality improvement activities. Contracted services include contract language which reflects their adherence to established performance/quality standards.

IV. DEFINITIONS

None

V. CONFIDENTIALITY AND CONFLICT OF INTEREST

All consumer and/or individual provider-specific information will be kept in a confidential manner in accordance with applicable federal, state laws and agency policy. Information will be used solely for the purposes of quality oversight and/or directly related activities. Disclosing confidential

consumer and/or provider information, internally or externally, may be grounds for immediate dismissal from the committee.

The contents of clinical records and provider credentialing files are confidential. Access to confidential quality improvement or quality oversight information (i.e. clinical information, consumer history, credentialing information) shall be restricted to those individuals and/or committees charged with the responsibility/accountability for the various aspects of the program. Individual provider information may be utilized and/or evaluated at the time of re-credentialing or contracting. Procedures and/or minutes posted for general information will be without identifiers.

## VI. AUTHORITY AND ACCOUNTABILITY

A strong quality assurance and performance improvement process requires consistent accountability across the organization. This means that the Quality Council has the ability to recommend to the Executive Team that opportunities for improvement are prioritized and specific actions to address these improvement opportunities are taken. Ultimate authority for Quality Assurance / Performance Improvement rests with the Board of Directors, who vests responsibility for all operations of the organization with the Executive Director. The Executive Director places responsibility for the leadership, implementation, and overall organizational coordination of Performance Improvement / Quality Assurance Activities with the Chief Operating Officer.

A. The Pre-Paid Inpatient Health Plan (PIHP), Lakeshore Regional Entity (LRE) Board of Directors is accountable for quality assessment and performance improvement activities across the seven (7)-county affiliation. The LRE Board will annually review and evaluate the written Regional Quality Assessment and Performance Improvement Plan. The Board will regularly receive specific reports of affiliation-wide performance indicators, quality oversight activities, and corrective actions as requested. The LRE is responsible for implementation of Quality Oversight at the PIHP Level and is responsible for facilitation of the affiliation-wide Quality Oversight Committee. HealthWest staff are participating members of the LRE Regional Quality Advisory Team and support affiliation-wide Quality Oversight Functions.

   As part of the contractual arrangement between the LRE and HealthWest, Quality Assurance/Performance Improvement is a delegated function, whereby the affiliation ensures compliance with federal and state requirements for a functioning quality improvement system but HealthWest is responsible for implementation and timely required reporting including unexpected events, critical incidents and risk events. All Community Mental Health Service Programs, as part of this arrangement, develop, implement and maintain quality improvement programs and will report results of monitoring and improvement activities to the Regional Quality Advisory Team as requested.

B. The HealthWest Board of Directors is accountable for Quality Assurance and Performance Improvement activities across HealthWest's programs and services. The Board will review and evaluate the Quality Assurance and Performance Improvement Plan annually. They will receive reports on the performance of HealthWest on State, Accrediting Body, and PIHP site visits (annually), contractual performance improvement indicators, and day-to-day Quality Assurance and Performance Improvement activities.

C. The Executive Director is ultimately responsible for Quality Assurance and Performance Improvement activities of the organization. The Executive Director has the authority to require providers, departments, and teams within the organization to comply with all contractual and organizational requirements.

D. The Executive Team includes the Executive Director and all department Directors. The Director of Quality Improvement is responsible for sharing all recommendations of the committee with the Executive Team for review. The Executive Team is responsible for evaluating recommendations, evaluating plans of correction, and prioritizing critical organizational activities. Recommendations regarding Quality Assurance and Performance Improvement

E. The Medical Director actively participates in QI activities as appropriate and provides medical and clinical expertise relative to the QA/PI activities of the organization.

F. Consumer and Provider Representative(s) are expected to be involved in quality improvement and performance committees, with the same responsibilities as all members of the committee.

## VII. STRUCTURE/PROCEDURE

### A. Director of Quality Improvement

The Director of QI is responsible for development and supervision of the Agency QI Program. This may include: Maintaining all PI records, understanding and communicating the intent of regulatory standards, conducting an annual evaluation of the QI program and communicating the results to the stakeholders, providing technical assistance to PI committees.

### B. Quality Improvement Specialist/Coordinator

1. An individual, from the Agency's Quality Improvement Unit responsible to:

    a. Maintain/update knowledge of regulatory standards, compliance expectations, audit and reporting requirements.

    b. Educate leadership/staff regarding those standards, expectations, and reporting requirements. Monitor compliance to agency QI procedure;

    c. Provide technical assistance in the development and updating of goal/objective statements;

    d. Acts as a Performance and Quality Improvement process technical resource and support;

    e. Assist as requested in the orientation of new group members.

## VIII. PROCESS IMPROVEMENT METHODOLOGY

A. The Performance and Quality Improvement Plan methodology is based on the Plan-Do-Study-Act (PDSA) model and provides for review of clinical and non-clinical care provided by the organization. Committees and workgroups will develop and implement process or outcome indicators based on aspect of services that are high risk, high volume, and problem prone, or critical to customer satisfaction.

B. Performance and Quality Improvement priorities are established annually by the Quality Improvement department and the organization's leadership. The agency will incorporate stakeholder expectation for performance/quality improvement measurement, including but not limited to the Department of Health and Human Services Department, and other regulatory bodies and consumer input.

C. Organizational elements selected for study will be identified through the committee structure based on leadership established priorities.

D. The duration of studies undertaken, including follow up, will be sufficient to ensure both validity and reliability of the findings.

E. Committees and work groups will develop a system of data collection and reporting for each indicator consistent with system norms. Baselines will be established. Data collection is conducted using concurrent and/or retrospective methods. Integrity of data will be assured throughout the process.

F. Committees, work groups, and change teams aggregate and analyze data and make recommendations to the oversight body.

G. Committees, work groups, and change teams use benchmarks or practice standards, when possible, in data analysis with statistical measurements and development of recommendations and action steps.

H. As actions are taken to improve care, it is the responsibility of the assigned group to document issues identified, the corrective action taken, to track the results of these interventions over time and to evaluate if the interventions have been effective. These may be reported in the group's formal kept minutes or in their quarterly reports.

## IX. TRAINING AND EDUCATION

A. Each new employee will be given an overview of the Performance Improvement principles and PDCA methodology during the orientation process.

B. On an annual basis, all employees will receive Performance Improvement education based on the identified needs.

## X. REFERENCES

Quality Assurance and Performance Improvement Plan (QAPIP)

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