QAPI Team

REQUIRED POLICIES AND PROCEDURES

- ☐ Quality Assessment and Performance Improvement
- ☐ Quality Assessment and Performance Improvement Plan

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Policies & Procedures

DAVIS BEHAVIORAL HEALTH

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Policy

In order to foster excellence in comprehensive, community-based behavioral health, Davis Behavioral Health will assure that continuous quality assessment and performance improvement (QAPI) processes are conducted routinely, and involve all staff at all levels of the organization.

Purpose

Performance assessment and continual improvement efforts require a systematic analysis of key data, focused studies of areas of concern, and defined efforts to improve service delivery and business practices. A centralized committee and annual plan is the foundation of these efforts.

Procedures

I. Quality Assessment Performance Improvement Committee

A. The Quality Assessment Performance Improvement Committee (QAPIC) is responsible for coordinating centralized quality improvement efforts of the agency.

i. The QAPIC will be multi-disciplinary and representative of key areas of the operations of DBH. For effective functioning as an executive committee, however, QAPIC members may represent multiple programs or units.

ii. The QAPIC consists of, but is not limited to :

1. A designated senior official responsible for administration of the program
2. Clinical Director and service providers from the adult and children's teams
3. Representatives from HR & UM
4. Ad hoc members as required

B. The QAPIC will function by developing an annual Quality Assessment Performance and Improvement Plan that includes:

i. Policy making body that oversees the Quality Assessment and Performance Improvement Program (QAPIP)
ii. Provide a general description of our peer review program and implement policies and procedures detailing this.
    1. The composition of the peer review committee (may be the QAPIC or a subcommittee)
    2. The frequency of the peer reviews, which must be conducted no less than two times per year.
    3. The requirement that the peer review committee makes recommendations for improvement based on review findings
    4. The requirement that the peer review committee maintains written documentation of meetings, peer review findings, and recommendations
    5. Developing scoring standards and the process of selecting records.

iii. Written procedures to detect both under-utilization and over-utilization of services provided to enrollees. (Reviews may be included in the peer review or conducted as separate utilization reviews.)
iv. Requirement that documentation is maintained of the assessment strategies used for the year, findings and how information was or is to be used to improve accessibility, and quality of Covered Services or aspects of center
v. Use the information derived from Appeals and Grievances to determine whether there are trends or systemic issues that need to be addressed at an individual, program, or center-wide level.
vi. integration of agency-wide activities to improve organizational performance
vii. The means to evaluate and ensure enrollees have timely access to covered services.
viii. Monitoring reports from The Division of Licensing, and the Division of Mental Health and Substance Abuse.
ix. Special studies to be initiated during the year.
x. Development and/or review, evaluation and monitoring of practice guidelines.
xi. Development and implementation of a cultural competency plan.
xii. Development of annual satisfaction surveys collected from clients and how this data is used to ensure quality improvement.
xiii. Conducting PIPs in accordance with CMS protocol.

C. The QAPIC provides study issues, analysis, and recommendations to administration and Program Supervisors. Supervisors are expected to show responsiveness to the QAPIC by reviewing recommendations and communicating supervisory decisions to their Operations Committee representative, who will then bring recommendations to the Committee. The QAPIC may initiate follow-up studies to determine if program quality has improved in identified target areas.

D. The QAPIC will:

i. Meet quarterly at a minimum;
ii. Maintain written minutes of the meeting;
iii. Make evaluative decisions based on a balancing of the need for treatments based on individual client needs and the need for providing the optimal service as defined by practice guidelines and the consensus of national standard-setting organizations.

Policies & Procedures

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Quality Assessment and Performance Improvement Plan

Introduction

This Quality Assessment and Performance Improvement Plan (QAPIP) is written as required by the Davis Behavioral Health (DBH) QAPI Policy. The QAPIP has two components: Operational Guidelines, which are typically consistent from year to year, and the Annual Improvement Work Plan, which is modified on an annual basis according to the improvement needs of the organization. This QAPI Plan is to be reviewed and updated annually by the DBH Clinical Director, QAPI Committee, and the Chief Executive Officer.

Operational Guidelines

A. QAPI Oversight

1. Compliance Officer
    a) Oversight of all QAPI activities
    b) Seeks consultation from the QAPI Committee
    c) Serves as the chair of the QAPI Committee
    d) Reports directly to the Chief Executive Officer

B. Quality Assessment and Performance Improvement Committee (QAPIC)

1. The QAPIC is created and defined by the Quality Assessment and Improvement policy of DBH
2. The QAPIC is the body responsible for oversight of all quality assessment and performance improvement activities

C. Monitoring and Data Analysis

1. The QAPIC will monitor performance processes and quality of outcomes through the following mechanisms:
    a) Standard and customized queries of operational, utilization and clinical data stored in the electronic database
    b) Peer review (see below)
    c) Appeals and grievances (see below)
    d) Surveys of clientele
    e) Outcomes data, including standard measures specified by the State
2. The QAPIC is responsible for monitoring DBH's compliance with practice guidelines, performance standards relating to client access, service utilization, staff utilization, client outcomes, and cultural competency.
    a) The QAPIC will specifically monitor:

(1) Timeliness of in-person contacts between DBH personnel and clients with emergent, urgent, and non-urgent service needs
(2) Compliance with all practice guidelines
(3) Utilization trends of high cost resources
(4) Results of the internal audit conducted by the cultural competency committee as described in the Cultural Competency Plan

3. Practice Guidelines

a) The Clinical Director is responsible for the processes by which practice guidelines are identified, adopted and implemented. These guidelines will also be periodically reviewed and updated.
b) The QAPIC identifies those practices where practice guidelines would be needed and determines if external practice guidelines will meet DBH standards for adoption.
c) If external guidelines cannot be identified, the QAPIC will draft internal guidelines according to the Practice Guidelines Policy.
d) Practice guidelines proposed for adoption are submitted to ELT for approval.
e) The QAPIC then develops and implements a plan for disseminating and education providers regarding the newly adopted guidelines.
f) QAPIC will periodically review internal guidelines to ensure that they continue to meet the needs of the agency, client care, and coverage of services.

D. Peer Review
See Peer Review Policy

E. Performance Measures and Standards for Timely Access

1. Ensure compliance with all other performance standards for the department
2. Contractors agree to take corrective action if there is a failure to comply (access to care and other)
3. Develop written reports documenting findings from monitoring activities

F. Appeals and Grievances

1. The QAPIC is responsible for monitoring trends in consumer appeals and grievances and their resolutions. This will be reported to the committee quarterly.
2. The QAPIC will analyze this information to identify any patterns in consumer appeals and grievances. This synthesized information will be used by the QAPIC to develop targeted actions at the staff, program area, or organizational level to remedy any systemic causes of patterns in consumer appeals and grievances.

G. Surveys of Clientele

1. The QAPIC will conduct an annual survey for client feedback regarding services.
2. Procedure

a) During the specified time period, the feedback survey will be available at the reception desk.
b) Each client, parent or guardian will be asked upon arrival to complete a survey if they have not already done one during the survey period, and assured that the survey and responses are anonymous.
c) All surveys will be gathered at the end of the survey period and forwarded to the State Division of Substance Abuse and Mental Health or contracted entity for aggregation and reporting.

d) The aggregated report, provided by the state or contracted entity will be reviewed in QAPIC.
e) Survey comments will be compiled and distributed to key staff for possible improvements.

3. The QAPIC responds to issues identified by the survey as described in the Performance Improvement section below.

H. Performance Improvement

1. The QAPIC will analyze data from the sources and mechanisms described above to determine improvement opportunities.
2. The QAPIC will prioritize and select opportunities to be focused on for intervention.
3. The QAPIC will define and initiate Performance Improvement Projects in order to implement improvement strategies. The QAPIC will define:

a) Measurement of improvement
b) Implementation of interventions to achieve improvements
c) Evaluation of the effectiveness of interventions
d) Planning and initiation of activities

I Cultural Competency

4. See Cultural Competency Policy