Washington State
Mental Health Division
Health and Recovery Services Administration
Department of Social and Health Services

Quality Strategy

UPDATED

April 21 2007

I. Introduction

Objectives

The Balanced Budget Act of 1997 requires states that contract with a Prepaid Inpatient Health Plan for mental health services to develop and implement a written strategy for assessing and improving the quality of public mental health services (42 CFR, 438.202). The quality strategy will be updated whenever significant contractual or system changes are made.

This document is the Washington State Mental Health Division (MHD) Quality Strategy. It is a revision of the Quality Strategy that was submitted and approved by The Center for Medicare and Medicaid Services (CMS) in December 2003. The strategy summarizes a systematic approach to assessing and improving the quality of Medicaid mental health care, and sets a course for promoting ongoing, systematic quality assessment and performance improvement within a recovery-based public mental health care delivery system.

The MHD Quality Strategy incorporates both quality assurance and quality improvement activities. The following definitions will be used throughout this document to refer to quality, quality assurance and quality improvement:

A. Quality – The Degree to which services for clients increase the probability of desired outcomes and are consistent with current knowledge and best practices within the field.

B. Quality Assurance – An ongoing process that constantly assures that all policies, procedures, standards, and process requirements are updated with the most recent changes. We want to determine if we did it right the first time, and if not, why not.

C. Quality Improvement – A systematic approach to the continuous study and improvement of the processes by which MHD provides services to meet the needs of clients. The goal of quality improvement activities is to improve the overall functioning of MHD and to increase quality outcomes for our clients. We want to determine if we are doing the right things the right way.

History of the State's Medicaid Mental Health Managed Care Program

Escalation of health care costs led the MHD to transition from block grant and fee-for-service payment models to managed care strategies. This transition occurred in three phases.

The first phase involved the creation of the Regional Support Networks (RSNs). These networks are made up of one or more counties. MHD purchases services from the RSNs. RSNs then contract with mental health agencies that directly provide mental health services.

MHD began the second phase of its movement toward managed care in 1993 with the implementation of outpatient managed mental health care services for people covered by Medicaid under a 1915b federal waiver. Washington State began purchasing outpatient services through capitated payments to the RSNs. RSNs began operating Prepaid Health Plans (PHPs) by assuming financial risk to provide all medically necessary outpatient community mental health rehabilitation services to people in their geographic region.

The third phase was implemented in October of 1997 when the Mental Health Division included community psychiatric hospital services within the managed care contracts with RSNs. This change was approved by the federal government in October 1997. As a result, the RSNs assumed full financial risk for the management and provision of all medically necessary mental health services. MHD currently contracts with 13 Regional Support Networks (RSNs) as Prepaid Inpatient Health Plans (PIHPs).

The goals and objectives that were targeted during the development of the Washington managed care waiver program included:

- Cost containment;
- Utilization management;
- Quality assurance and improvement;
- Increased administrative efficiencies;
- Making more effective use of data to adapt quickly to changes in the environment; and
- Development of integrated, collaborative delivery systems.

Performance Objectives

MHD expects that all PIHPs will be compliant with contract standards, and all External Quality Review (EQR) standards. MHD's performance expectations for the PIHPs at this time are for all PIHPs to meet the minimum standards outlined in the Balanced Budget Act (BBA). The most recent External Quality Review Organization (EQRO) results show that the PIHPs are demonstrating improved compliance with the standards listed in the Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs) Subparts. Results from the June 2006 Technical report are listed below.

- Subpart C – Enrollee Rights and Protections
    - Subpart C includes elements addressing such requirements as client understanding of their rights, incorporation of advance directives, and availability of written information.
    - There was noticeable statewide improvement with respect to the requirements on this subpart. In the 2004 review, 49% of the Subpart C items met performance standards. In the 2005 review, 80% of the items met performance standards.

- Subpart D – Quality Assessment and Performance Improvement
    - Subpart D addresses a wide variety of requirements related to service access, network availability, cultural accommodations, authorization processes, and quality of care.

  - In the 2004 review, 47% of the Subpart D items met performance standards. In the 2005 review, 63% of the items met performance standards.

- Subpart F – Grievance System
  - Subpart F includes requirements regarding administration of the grievance and appeal system as well as supports and protections for consumers as they engage with that system.
  - PIHPs improved statewide in meeting the requirements of this Subpart. In the 2004 review, 40% of the Subpart F items met performance standards. In the 2005 review, 74% of the items met performance standards.

- Subpart H – Certifications and Program Integrity
  - Subpart H sets forth requirements associated with prevention of fraud and abuse and compliance with privacy laws.
  - In the 2004 review, 75% of the Subpart F items met performance standards. In the 2005 review, 87% of the items met performance standards.

Additional Objectives:

MHD has also implemented provider training and certification programs to produce a large number of qualified mental health providers trained in the newer state plan services (e.g. peer support, clubhouse, supported employment). These services are specialized and relatively new in Washington State, and therefore were not previously covered in the professional curriculum. As a result, there were few existing providers with experience or specialization in these types of services. By providing training and certification directly to providers, MHD improves and augments the provider pool available for PIHP networks. By directly influencing the training of the providers, MHD is improving the quality of care received by enrollees.

The objectives that MHD has set for itself regarding provider training are below:

-The state will increase the number of certified peer specialists.
-The state will develop clubhouse certification standards.
-The state will increase the number of providers trained in Trauma-focused CBT.
-The state will increase number of providers trained in Supported Employment.

MHD has a dedicated program administrator working to increase the number of certified peer counselors in the state. In addition, MHD partners with educational affiliates such as the Washington Institute of Mental Illness Research and Training (WIMIRT) to refine and develop other promising practices and evidence-based practice guidelines. MHD also uses its various grants and block grant funding to provide training and other cross system collaboration opportunities with social service agencies such as local employment, mental health, nursing homes, boarding homes and government agencies such as Division of Vocational Rehabilitation (DVR), Division of Developmental Disabilities (DDD), and Home & Community Services (HCS) for long term care service recipients.

As a result of newly passed legislation, MHD will be working with stakeholders this year to develop clubhouse certification standards.

II. Assessment

Responsibility for quality is diffused throughout MHD and its service system in a manner that facilitates and holds each level accountable for discovery, remediation of problems, and system improvements. The following areas represent the primary areas of quality assessment in MHD:

Certification Reviews and Contract Monitoring

MHD monitors PIHP contracts through receipt and review of contract deliverables, on-site visits conducted by MHD staff, and record reviews. MHD has implemented a new contract monitoring system this year. This system documents and tracks the receipt, review, acceptance or Corrective Action request of each contract deliverable required by MHD. This system will decrease response times, improve continuity in monitoring, and increase consistency in MHD responses. In addition, MHD has monitors conducting annual fiscal reviews of RSN Revenue and Expenditure (R & E) reports; information technology specialists reviewing data submission errors, data timeliness and data certifications; and is building a system to track critical incident reporting.

EQRO Review

MHD contracts with APS Midwest as the External Quality Review Organization that conducts extensive on-site reviews of each PIHP using the requirements listed in each of the following CMS protocols:

- Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)- Subparts C, D, F, H;
- Validating Performance Indicator protocol;
- Validating Performance Improvement Projects protocol; and
- Encounter Validation protocol.

Results from the EQRO are reviewed by MHD within 10 days of publication of the final report for each PIHP. MHD requests Correct Action Plans for those PIHPs not meeting the minimum standards of the protocols, and PIHPs are re-reviewed the following year. For those EQRO findings which indicate a significant health and safety risk, follow-up reviews are scheduled by MHD immediately upon discovery. The EQRO Statewide Technical Report is reviewed to identify areas for a quality improvement focus in the next year's PIHP contracts and EQRO review.

Contract Requirements

PIHP contract requirements include compliance with applicable Federal and State statutes and 42 CFR 438 including:

- Availability of services;
- Continuity and coordination of care;
- Provider selection;
- Enrollee information;

- Enrollee rights;
- Confidentiality and accuracy of enrollee information;
- Subcontractual relationships and delegation;
- Practice Guidelines;
- Health information systems;
- Mechanisms to detect both under and over utilization of services;
- Quality improvement;
- Utilization management; and
- Data reporting.

MHD contracts with the PIHPs include the standards listed below. MHD assesses those standards in a variety of ways, each described below:

1. Access to care:
   MHD requires the PIHPs to make available crisis mental health services and medically necessary mental health services on a 24-hour, 7 days per week basis.

   - A request for mental health services occurs when mental health services are sought or applied for through a telephone call, EPSDT referral, walk-in, or written request for mental health services.
   - An intake evaluation must be initiated within 10 working days of the request for mental health services.
   - Emergent mental health care must occur within 2 hours of a request for mental health services from any source;
   - Urgent care must occur within 24 hours of a request for mental health services from any source; and
     - Urgent and emergent medically necessary mental health services (e.g. crisis mental health services, stabilization mental health services) may be accessed without full completion of intake evaluations and/or other screening and assessment processes.
   - Routine mental health services must be offered to occur within 14 calendar days of a decision to authorize mental health services. The time from request for mental health services to first routine appointment must not exceed 28 calendar days unless the Contractor documents a reason for the delay.

   MHD has recently begun to track the length of time between a request for service and the next emergency or routine service encounter. This data will be reviewed as part of contract monitoring. Anomalies will be reviewed by on-site reviewers.

2. Structure and Operations:
   Standards for provider selection and retention, delegation, subcontracts, and documentation requirements to ensure confidentiality and other requirements are detailed in the PIHP contracts:

   - Prohibiting contracting with individual practitioners or providers with ownership or controlling interests in an MCO or convicted of crimes;

- Compliance all Federal non-discrimination laws and regulations, including non-discrimination against providers servicing high risk populations or specializing in conditions that require costly treatment (42 CFR 438.214)

- Consider provider training, experience and specialization to ensure experience in treating enrollee conditions (42 CFR 438.206 (b) (1) (iii).

- Limit the activities that can be delegated to a subcontract and require that prior to any delegation of responsibility or authority to a subcontractor, the Contractor shall use a formal delegation plan, consistent with the requirements of 42 CFR §438.230, to evaluate the subcontractor's ability to perform delegated activities. Submit its delegation plan to the MHD for approval.

- Eligibility for Medicaid is determined by the Community Services Offices (CSOs). The information is entered into a client eligibility system. All Medicaid eligible clients are eligible for mental health services if they meet the access to care standards for medical necessity.

- MHD produces and distributes the Medicaid enrollee handbook related to PIHP services. Contract requirements and specifications related to enrollee information are found throughout the PIHP Contract. These contract requirements include:
  - Providing to MHD the information necessary to update the Benefits Booklet for Medicaid Enrollees.
  - Inform every enrollee at the time of an intake evaluation that the Benefits Booklet produced by MHD is available anytime upon request. If requested the booklet must be provided.
  - Provide interpreter services for enrollees with a primary language other than English for all interactions between the enrollee and the Contractor including, but not limited to, customer service, all appointments for any covered service, crisis services, and all steps necessary to file a grievance or appeal.
  - Post a multilingual notice that advises consumers that all written materials are available in Cambodian, Chinese, Korean, Laotian, Russian, Spanish and Vietnamese.
  - Provide translations of the mental health consumer rights identified in section 3.1 readily accessible in public areas and conspicuously marked.
  - Provide information that clearly explains to enrollees how the enrollee can request and be provided written materials in alternate formats. Information explaining to the enrollee how to access these materials must be provided prior to an intake evaluation in an easily understood format.
  - Identification of individual Mental Health Care Providers (MHCP) who are not accepting new enrollees;
  - Community Mental Health Agency (CMHA) licensure, certification and accreditation status; and
  - Information that includes but is not limited to, education, licensure, and Board certification and/or re-certification of mental health professionals and MHCPs.

- Confidentiality requirements in the contract govern disclosure of medical records and other health information that individually identifies an enrollee in accordance with HIPAA regulations and 42 CFR 438.224.
- MHD requires each PIHP to have a grievance system that meets 42 CFR 438.228. Comprehensive standards in the contract include:
    - Enrollee right to file a grievance or appeal, receive assistance, and contribute to and participate in appeal hearings;
    - Specified timelines for enrollee appeals and PHIP response;
    - Individuals making decision have appropriate clinical expertise and are not involved in previous levels of review;
    - Easily understood enrollee communication written in the enrollee's primary language, giving clear explanation of the action and reasons, circumstances for and to request expedited resolution, right to continue benefits pending appeal resolution, how to request it, circumstances under which enrollees may be required to pay, and written notice of resolution and completion date;
    - Enrollee right to request a fair hearing after exhausting all levels of the grievance and appeal system. The entire appeal process, including fair hearing, must be completed within 90 calendar days of the date the enrollee filed the appeal;
    - Maintain a record of all actions, grievances, and appeals and submit a complete report to MHD twice a year

PIHPs Structure and Operations are reviewed by the EQRO. These reviews include review of the PIHP's policies and procedures, provider interviews, and other documentation used within the PIHP network. MHD reviews the EQRO reports and requires corrective action plans for those PIHPs who do not meet minimal standards. PIHPs not meeting minimal standards are reviewed again the following year. MHD is informed immediately by the EQRO of any health and safety, or client rights or abuse issues. The MHD conducts an immediate assessment of the issues, and follows up on all correct action required.

- In addition, the PIHP must submit the following deliverables to MHD for review and approval:
    - Advisory Board Membership Roster
    - Governing Body Membership Roster and By-laws
    - Level of Care Guidelines
    - Revenue and Expenditure Reports
    - Data Certifications
    - Delegation Plans

These deliverables are submitted to MHD for review and approval per the process described above in the Certification and Contracts Monitoring section of the Quality Strategy.

3. Quality Measurement and Improvement:

MHD requires PIHPs to use collected data, monitoring results, and services verification activities to assess their ongoing quality management program. The Contractor shall engage in ongoing assessment and improvement of the quality of public mental health services in its service area, as well as evaluate the effectiveness of the overall regional system of care. At a minimum, the Contractor shall:

- Assess the degree to which mental health services and planning is driven by and incorporates enrollee and family voice;
- Assess the degree to which mental health services are age appropriate, and culturally and linguistically competent;
- Assess the degree to which mental health services are provided in the least restrictive environment;
- Assess the degree to which mental health services assist enrollees' progress toward recovery and resiliency; and
- Assess the continuity in service and integration with other formal/informal systems and settings;
- Incorporate the results of grievances, fair hearings, incidents, appeals and actions into system improvement;
- Provide quality improvement feedback to providers, the advisory board, and other interested parties; and
- Invite enrollees and enrollees' families that are representative of the community being served, including all age groups, to participate in planning activities and in the implementation and evaluation of the public mental health system.

The PIHPs Quality Management system is reviewed by the EQRO. These including review of policies and procedures; provider and QI member interviews; and review of reports, meeting minutes and work plans. The MHD reviews the EQRO reports and requires corrective action plans for those PIHPs who do not meet minimal standards. PIHPs not meeting minimal standards are reviewed again the following year.

4. Practice Guidelines:
The MHD requires the PIHPs to adopt and implement a minimum of two Practice Guidelines. The PIHPs provide documentation describing the chosen guidelines to the MHD within 90 days of the execution of this Agreement. The Practice Guidelines must:

- Be based on valid and reliable clinical evidence or a generally accepted practice among the mental health professionals in the community;
- Consider the needs of the enrollees;
- Be adopted in consultation with mental health professionals in the contracted network of CMHAs, when applicable;
- Be disseminated to all affected providers and, upon request, to enrollees; and
- Be chosen with regard to utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply.

PIHPs practice guidelines are reviewed by the EQRO. These reviews include review of the PIHP's policies and procedures, provider interviews, and other documentation of the practice guidelines in use within the PIHP network. The MHD reviews the EQRO reports and requires corrective action plans for those PIHPs who do not meet minimal standards. PIHPs not meeting minimal standards are reviewed again the following year.

MHD Quality Assurance and Monitoring

The chart below outlines where assessment occurs within MHD regarding the following key quality areas:

1. The quality and appropriateness of care and services delivers to enrollees;
2. The level of contract and regulatory compliance of the PIHPs; and
3. The level of impact of Health Information Technology changes/evolution.

This chart identifies staff responsible for various assessment activities, lists the activities performed, and lists information that is available based on the assessments. Each unit reviews its own assessment information and conducts quality improvements on its own business processes and results.

	HRSA/MHD Office/Contractor	Activities Performed	Assessment Information Produced
Quality and Appropriateness	Office of Mental Health Services	• Manage Grievance and Appeals system • Represent State at Fair Hearings • Develop training curriculum • Manage Peer Certification process	• Grievances and Appeals reports • Call logs
	MHD Office of Decision Support	• Produce Performance Indicator reports o includes data reports on race, ethnicity, and primary language • Contract for Consumer Surveys • Contract for Provider Surveys • Contract for Provider Trainings	• Performance indicator reports • Consumer survey reports • Provider surveys reports • training attendance rosters
	MHD Operations Office	• Write PIHP Contracts • Write & manage EQRO contract • Contract for PIP training and technical assistance	• Quality and appropriateness standards • EQR reports
	External Quality Review Organization	• Review RSN Policies and procedures • Reviews PIHP subcontracts and delegation plans • Review PIHP Network Rosters • Review PIHP's PIPs and quality management structures	• EQR reports (include subparts C,D,F,H; validating PIPs; validating Performance Indicators; encounter validation) • ISCA reports
	External Quality Review Organization Committee (EQRO-C)	• Develop MHD standards for EQR • Review EQRO reports • Identify PIHP non-compliance and weaknesses on EQRO review • Develop and monitor PIHP corrective actions	• Summary of statewide issues identified by EQR • Summary of PIHP compliance with EQR standards
	HRSA Medical and Dental committee	• Review questionable provider behavior o Service anomalies and complaints, Provider license infractions, and DOH corrective actions against providers	• List of sanctioned, dropped or barred providers.
	MHD Quality Committee	• Review recommendations, develops and prioritizes statewide quality improvement initiatives	• Quality Strategy • Statewide Quality Improvement Proposals
Contract Compliance	MHD Compliance Office	• Maintain and review PIHPs contract deliverables • Conduct PIHP reviews • Collect and review PIHP reports of critical incidents • Conduct licensing reviews of provider agencies	• Contract compliance reports • Reviews of critical incidents • Summary of licensing results • List of licensed providers
	Division of Rates and Finance	• Receives and reviews PIHP R & E reports • Conducts fiscal reviews of PIHPs	• PIHP Revenue and Expenditure reports • Results of HRSA Fiscal audit • Additional DSHS and CMS Financial audit results

	HRSA/MHD Office/Contractor	Activities Performed	Assessment Information Produced
	HRSA Division of Systems and Monitoring	• Designs contract terms for encounter data submission and other data deliverables. • Oversees and monitors encounter data submissions • Manages and monitors encounter data certifications • Reviews and provides written evaluation of the IT disaster recovery plans • Facilitates Information System Data Evaluation Committee (ISDEC)	• Monthly summaries of encounter data submissions • Data submission Error Reports • Data submission certification summaries • Summaries of Disaster Recovery Plans
	MHD Office of Decision Support	• Develops Performance Indicators for contract • Produces performance indicator reports • Contracts and facilitates consumer survey administration	• Data Quality Reports • Performance Indicator Reports • Consumer Survey Reports
Health Information Technology Changes	Provider One Project Staff and CNSI	• Develop new MMIS for HRSA o Includes both claims/encounter reporting and payment processes • Communicate changes to provider community, including PIHPs	• Design Documents • Provider awareness campaigns • Staff awareness campaigns • Documentation of business process changes
	HRSA Division of Systems and Monitoring	• Serve on design and system review workgroups to ensure that MH data needs are represented • Integrate existing MHD-CIS with new Provider One MMIS • Facilitates Information System Data Evaluation Committee (ISDEC)	• Planning documents • Design documents • ISDEC minutes
	MHD Office of Decision Support	• Serve on design and system review workgroups to ensure that MH data needs are represented • Prepare PIHPs for MMIS changes • Maintain code sets for Medicaid service benefit • Review PIHP encounter validation reports	• Provider One fact sheets • Service Encounter Reporting Instructions • Summaries of Encounter validation results
	HRSA Division of Rates and Finance	• Serve on design and system review workgroups to ensure that PIHP payments meet current needs • Prepare PIHPs for payment changes	• Provider One fact sheets
	External Quality Review Organization	• Review existing IT structure within the PIHPs o Includes ISCA and encounter validation	• ISCA results • RSN encounter validation reports

Quality Improvement Processes

MHD has developed a robust Quality Assurance program. The addition of a system to track receipt and review of PIHP contract deliverables, the addition of 2 contract monitors, 1 fiscal monitor, and an additional focus on data quality and certification have all improved the ability of MHD provide increased oversight and accountability within the PIHPs.

However, quality improvement activities remain siloed within individual units. While it is important that each unit maintain its individualized quality assurance activities, there is also need for a forum to identify statewide trends, issues, and quality improvement opportunities within the entire managed care system. Each participant at each level of the service delivery system must be integrated into the Quality Improvement process. Within MHD, leadership, program managers, contract writers, program reviewers and auditors must have access to the same information. Leadership sets the direction, program managers and contract writers implement the direction and reviewers and auditors correct course as necessary.

MHD has implemented a series of quality structures in the past in an effort to promote consistency, and cohesiveness in the service delivery system. The current effort attempts to take a more long-range strategic approach while also recognizing the need to attend to immediate and urgent needs. This refined quality structure hopes to address past failings by broadening participation within MHD to include MHD leadership; program, compliance, operations, IT and decision support staff into a Quality Committee (QC); and by incorporating results and statewide concerns identified by multiple units within the MHD. The MHD Quality Committee is described below.

MHD Quality Committee:
The MHD Quality Committee maintains membership that includes:

- Waiver Management;
- Program/Policy;
- Decision Support;
- Office of Consumer Affairs;
- Compliance, licensing, contract monitoring;
- Fiscal; and
- Information Technology.

The MHD Quality Committee meets 6 times per year and performs the following activities:

- Reviews information/recommendations from MHD staff and the EQROC on statewide trends and issues needing quality improvement;
- Develops quality improvement initiatives and updates the annual Quality Improvement Work Plan, to include timelines and responsible staff;
- Engages stakeholders and plans for implementation;
- Monitors implementation efforts and measures progress;
- Evaluates effectiveness of quality initiatives;
- Develops and perform an annual self-evaluation; and
- Reviews and updates the MHD Quality Strategy.

External Quality Committees:

In addition to the internal MHD workgroup, MHD includes stakeholders in its statewide quality initiatives. Because managed care system services are managed and delivered in local communities, quality initiatives must be designed in ways that improve local communities' ability to implement them. Because communities have the best ideas for successful implementations of improvement initiatives in their systems of care, it is important that that they be actively involved in the planning, implementation and evaluation of statewide quality initiatives.

MHD is fortunate to have several existing external committees that focus on differing aspects of the care delivery system. These external groups are described below. They will be asked to provide input on statewide quality initiatives that are proposed by MHD, and be involved in implementation and evaluation as appropriate.

1. Regional Support Networks Administrators Meeting- Monthly meeting between MHD and the 13 RSN-PIHP Administrators.

2. Washington Community Mental Health Council (WCMHC) – Monthly meetings between community mental health center directors who are members of WCMHC. MHD attends these meetings by invitation in relation to specific topics. MHD would attend these meetings to discuss quality improvement initiatives.

3. Performance Data Group (PDG) – Monthly standing committee consisting of MHD, RSN, provider and consumer members that review performance indicators, consumer outcomes, and data quality reports to develop reports for all levels of the Mental Health system.

4. Information System Data Evaluation Committee (ISDEC)—Monthly standing committee consisting of MHD and RSN members that review IT and data submission issues between the RSNs and MHD.

5. Mental Health Planning and Advisory Council (MHPAC)—a Governor-appointed Advisory Committee advises MHD on a variety of public policy and practice issues. This committee has multiple subcommittees that focus on specific sub-populations of those receiving public mental health services (e.g. children, adults, older adults, ethnic minorities, sexual minorities)

III. Improvement

Planned Quality Improvement Interventions

MHD will continue to implement the quality structure described in this document. The MHD Quality Committee will review QA findings and recommendations from MHD staff for statewide quality improvement initiatives. The MHD will develop an annual Quality Improvement plan during this year.

MHD is also working with PIHPs to develop a statewide Performance Improvement Project (PIP) that all 13 RSNs will implement. MHD is in discussions with the PIHPs now to develop a study topic. The plan for implementation will include:

1. Development and justification of a study topic;
2. Selection of the study population;
3. Definition of indicators;
4. Data collection and analysis plan;
5. Documentation of the interventions used by the PIHPs;
6. Presentation and interpretation of results; and
7. Generation of a report and plans for follow-up.

By partnering with the 13 PIHPs and focusing on one statewide PIP MHD anticipates the ability to effect a significant and meaningful change in the service delivery system.

IV. Review of Quality Strategy

Frequency of Assessments of Strategic Performance

The Quality Committee will conduct an annual self-evaluation of the committee and the current quality structure. The Quality Committee will review the Quality Strategy annually, and will develop an Annual Quality Improvement Work Plan. This review will be done at the end of the state fiscal year to assure that the EQRO and contract compliance reports are completed and available to inform the next year's work plan.

Updates to the Quality strategy, including the development of the Annual Quality Improvement Work Plan will be submitted to CMS for review within 30 working days of completion. This review process will be built into the implementation plans of all quality improvement initiatives.

Assessment of individual PIHPs and the service delivery system may be done more frequently depending upon the topics and projects selected. MHD has the capacity for monthly or quarterly reporting many of the performance indicators currently reviewed.

In addition, the EQRO will review the Quality Strategy once every three years and provide feedback and technical assistance to the MHD regarding the content, structure and function of the Quality Strategy.

V. Achievements and Opportunities

The in-depth reviews conducted by the EQRO have given MHD a much broader view of the structure and functioning of the 13 PIHPs. Results from these reviews have lead to changes in contract language, monitoring activities, and MHD business functions regarding PIHP compliance. There has been significant improvement in the PIHPs' adoption and compliance

with BBA requirements and improvements in the quality of care being delivered to Medicaid enrollees.

Over the past several years MHD has achieved significant improvements in data collection, data integrity and data analysis. MHD has developed both a web-based consumer outcome reporting system, and a web-based performance indicator reporting system. Work is currently underway to construct a web-based incident reporting system and an improved grievance and appeals reporting system.

In addition to improvements in mental health specific quality activities, MHD is also partnering with HRSA on many quality improvement projects. Several are listed below.

- **Integrated EQRO RFP.** MHD is partnering with the Managed Care Services Division of HRSA to create a single Request For Proposals (RFP) that will be used to solicit the EQRO for both the PIHPs and the MCOs. The RFP will be structured so that vendors can apply for parts or the whole RFP.

- **Medication review.** MHD is working with the Medical Director and Managed Care Services Division of HRSA to assess the quality of prescribing practices and psychotropic medication use in Medicaid enrollees. While PIHPs do not directly manage the pharmacy benefit, this project does have significant impact on the quality of care received by Medicaid enrollees, especially those enrollees with mental illness. As this project moves forward, MHD will develop specific performance objectives for these projects.

- **Return On Investment.** The Managed Care Services Division of HRSA has received a small Center for Health Care Strategy (CHCS) grant to test a tool designed to calculate Return On Investment (ROI) for innovative Medicaid service delivery programs. One of the targeted populations for this project is individuals with Depression. MHD is working with HRSA to pilot the tool.

- **HRSA Steering Committees.** HRSA has developed a number of targeted steering committees to address issues of quality among the different service sectors covered by Medicaid. The steering committees are: Outpatient Services, Inpatient Services, Pharmacy, Durable Medical Equipment, Cost and Utilization, and Efficiencies and Customer Service. MHD has representatives on each of these committees, and is exploring the experience of enrollees with Mental Illness in each of these areas.

- **Provider One,** HRSA is designing a new payment and claims/encounter reporting system to replace the current MMIS. MHD and the PIHPs will be included in this new system, as will the medical MCOs and other administrations with DSHS. The target start date for the new system is February, 2008. MHD anticipates that the full implementation of Provider One will significantly change how MHD does business by allowing for integration of data sets across physical health, mental health and chemical dependency. This new system paves the way for other cross-system interventions and collaborations to improve the quality of care for Medicaid enrollees. Because Provider One changes business processes impacting staff, RSNs, providers and leadership, they will be extremely disruptive initially. Clear planning, ongoing communication, and staff and provider training will be crucial to a successful transition.

Now that state programs for mental health, chemical dependency, and medical care are all now housed within one administration, MHD stands at the threshold of an incredible opportunity to integrate systems of care. Even in its infancy, several collaborative programs have begun, and others are being planned for the future. While this move toward integration brings both opportunity and challenges, MHD will need to support the transition of PIHPs into this new system in a planned and measured way. Improving the quality of care for all Medicaid recipients through improvement and integration of services is becoming a strong focus of the Medicaid mental health managed care program. MHD's Quality Strategy sets the framework to drive these system changes. Implementation of this Quality Strategy will give MHD a mechanism for the planning and development of a mental health delivery system that serves the multiple, varied, and complex needs of Medicaid recipients.

Appendices

Appendix A: MHD Quality Group Membership List

Appendix B: MHD Quality Group Charter

Appendix C: External Groups' Membership Lists

Appendix D: Quality Initiative Template

Appendix A

MHD QUALITY COMMITTEE

Name	Position on Committee	Title
Cheryl Strange	Committee Chair	Assistant Director
Judy Hall	Facilitator	Office of Research and Decision Support
Fran Collison	Member	Operations Office Chief
Rhonda Kenney	Member	Waiver Program Manager
Steve Norsen	Member	Program Support Office Chief
Rene Ulam	Member	Data Quality
Brian Coolidge	Member	HRSA IT
Sweden DeMatas	Member	Compliance Officer
Pete Marburger	Member	Licensing Supervisor
Judy Gosney	Member	EQRO Contract Manager
Mary Wendt	Member	Fiscal
Travis Sugarman	Member	Contracts

Appendix B

MHD Quality Committee
Charter

The charter of the Quality Committee is as follows:

Purpose:
This committee is chartered as the Mental Health Division quality workgroup. This committee is charged with the development of quality initiatives to improve the performance of Medicaid managed mental health care plans and state funded mental health services in Washington State. The committee serves as the Quality Improvement Committee for the Mental Health Division, and will make recommendations to Mental Health Division management regarding quality improvement initiatives.

Membership:
The MHD Quality Committee maintains membership that includes:

- Waiver Management
- Program/Policy
- Decision Support
- Office of Consumer Affairs
- Compliance, Licensing, Contract Monitoring
- Fiscal
- Information Technology

Each of these functional areas shall have a designee and an alternate. It is the members' responsibility to educate any alternate and to assure that the views of the area are represented. Any alternate shall have the same speaking and decision-making authority as the primary member for their functional area.

Meeting Schedule:
The full committee will meet every other month starting in March 2007. It is expected that the committee—and any subcommittees convened for focused work—will continue to meet at the discretion of the MHD Director.

Goals:
Primary Goals of the Committee

1. To serve as the Quality Improvement Committee for the MHD
2. To develop an annual Quality Work Plan that includes initiatives to improve the quality of mental health care delivered to Medicaid enrollees
3. To develop and review the MHD Quality Strategy annually

Expected Outcomes:

1. 2007 MHD Quality Strategy completed by June1, 2007
2. 2007 Quality Work Plan finalized by August 1, 2007.
3. Work Plan Implementation begins September 1, 2007.

Appendix C

EQRO-Committee

Name	Position on Committee	Title
Judy Gosney	Facilitator	EQRO Contract Manager
Karie Castleberry	Member	Program Support
Rene Ulam	Member	Data Quality
Sweden DeMatas	Member	Compliance Officer
Judy Hall	Member	Office of Research and Decision Support
Cheryl Strange	Committee Chair	Assistant Director
Rhonda Kenney	Member	Operations

MENTAL HEALTH PLANNING AND ADVISORY COUNCIL ROSTER

February 2007

	NAME/ADDRESS	REPRESENTATION
1.	Thressa Alston	Advocate; Ethnic Minority Subcommittee
2.	Dan Clement	Emergency Service Center Provider
3.	Cindy Ashley-Nelson	Consumer
4.	Rebecca Bates	Consumer, parent advocate
5.	Roger Bauer	Co-occurring disorders provider: Community Mental Health Council
6.	Cheri Dolezal	Regional Support Network (RSN) Representative,
7.	Russ Hammond	Office of Superintendent Public Instruction (OSPI)
8.	B.J. Cooper	Consumer
9.	Rick Crozier	Older adult service provider Chair, Older Adult Subcommittee
10.	Tom Saltrup	Department of Corrections (DOC)
11.	Danny Eng	Vocational Rehabilitation representative, DSHS
12.	Marie Jubie	Consumer/Advocate Adult Consumer Subcommittee
13.	Joann Freimund, Chair	Advocate
14.	Michael Haan	Consumer
15.	Diana Jaden-Catori	Consumer
16.	Douglas Johnson	Consumer Advocate; Sexual Minority Subcommittee Representative
17.	Brett Lawton	State Medicaid agency representative: DSHS/HRSA
18.	Vanessa Lewis	Parent of minor with SED
19.	Cathii Nash, Vice-Chair	Parent advocate, Consumer
20.	Steve Norsen	HRSA Mental Health Division
21.	Eleanor Owen	Family Advocate
22.	Joanne Groves	Ethnic Minority Subcommittee (EMAC)
23.	Barbara Putnam	State Children’s Administration representative
24.	Annie Conant	State Housing agency representative
25.	Mary Christine	Parent of a minor child with SED
26.	Ron McCoy	Parent of minor child with SED
27.	Lenora A. Warden	Consumer; Program and Planning Subcommittee Adult Consumer Subcommittee
29.	JoEllen Woodrow	Consumer Advocate; Legislative Subcommittee
30.	Traci Adair	DSHS/Adult and Disability Services Administration/Home and Community Services
32.	Nanette Baker	Mental Health Division staff to MHPAC

PERFORMANCE DATA GROUP

Ann Christian	Washington Community Mental Health Council
Bill Voss	University of Washington
Bob Short	Washington State University
Can Du	Mental Health Division
Carolyn Glover	Pierce RSN
Casey Jackson	Washington State University
Cathii Nash	Mental Health Planning and Advisory Council, family member
Chris Foster	Clark RSN
Christina Carter	Mental Health Division
Barb Hawkins	Western State Hospital
Deb Srebnik	King RSN
Dennis McBride	University of Washington
Diana Striplin	North Sound RSN
Donald Montaine	Southwest RSN
Gino Aisenberg	University of Washington
Hank Balderrama	Mental Health Division
Jessica Ahrens	Southwest RSN
JoEllen Woodrow	Consumer
Judy Hall	Mental Health Division
Kali Henderson	Valley Cities Counseling
Kathy Latimer	Chelan Douglas RSN
Katie Weaver Randall	Washington State University
Linda Smythe	Thurston Mason RSN
Rene Ulam	Mental Health Division
Lisa Cordova	GM Health Care
Marianne Neff-Daniels	Mental Health Division
Mary Sarno	Mental Health Division
Natasha Chung	Western State Hospital
Robin McIllvaine	Mental Health Division
Sela Barker	Clark RSN
Traci Crowder	Behavioral Health Resources
Tracy Thompson	Kitsap Mental Health
Ronda Kenney	Mental Health Division
Douglas Johnson	Greater Columbia RSN
Lyn Gordon	Clark RSN
John Roll	Washington State University
Carolyn Glover	Pierce RSN, consumer advocate

INFORMATION SYSTEM DATA EVALUATION COMMITTEE

NAME	Representing
Austin, Christine	Raintree Systems, Inc North Sound RSN
Barton, Joe	HRSA, Division of Systems and Monitoring
Beilstein, Kurt	IT manager, Spokane RSN
Boyus, Jeff;	IT manager, Greater Columbia
Burbridge, Dwayne	IT Manager, Pierce RSN
Cameron, Brian	IT Manager, SW RSN
Carver, Sherrie	IT manager, TM RSN
Clay, Dana	TM RSN- Jet Computing
Coolidge, Brian D.	HRSA, Division of Systems and Monitoring
Cummings, William (Bill)	IT Manager, SW RSN
Dolezal, Jerry	IT Manager, Clark County
Foster, Chris	IT Manager Clark RSN
Frady, John;	IT Manager, Harborview MHS
Hall, Judy	HRSA, Mental Health Division
Jennings, Ron	HRSA, Division of Systems and Monitoring
Kero, Patty	IT Manager, SW RSN
Kline, Greg A	HRSA ,Division of Systems and Monitoring
Langill, Amy	Raintree Systems, Inc
Latimer, Kathy	IT Manager, Grays Harbor & Chelan Douglas RSN
Legel, Susan	Spokane Mental Health
Lyen, Judy	Pierce RSN
McDowell, Gerene	Clark & Timberlands RSN
Mikhlin, Mark	IT Manager, King RSN
Miller, MaryAnne	Peninsula RSN
Murray, Marsha	Mental Health Council
Nguyen, Diep	IT Manager, King County
Priest, Pam	Clark RSN
Robbins, Ty	IT Manager, NC RSN
Schneider, Jerry	IT Manager, Pierce RSN
Summerlund, Melinda	Greater Columbia
Swayze, Mary	Okanogen BHC
Thompson, Tracy	IT Manager, Peninsula RSN
Ulam, Rene C)	HRSA, Mental Health Division
Vine, Ann;	Spokane Mental Health
Weaver-Randall, Katie	HRSA, Mental Health Division
Wade, Kristin;	Clark RSN
White, Michael	IT Manager, North Sound

Appendix D

SAMPLE WORK PLAN OUTLINES

Statewide Quality Improvement Initiative

What is a statewide Quality Improvement Initiative?

A project that results in demonstrated improvement in public mental health processes, products, and outcomes. For a statewide QII to be considered it must have statewide relevance/impact/significance that prevents a problem or improves the system.

a) I. PROPOSAL DATA		
1. Contact Person 2. Email	3. Address:	4. Contact Numbers: Work: Cell: Fax:
5. Alternate Contact 6. Email	7. Address:	8. Contact Numbers: Work: Cell: Fax:
9. Proposed Project Name (name by which you want the project known)		
II. PROJECT PROPOSAL		
1. Statement of need (problem statement, quality improvement need):		
2. Overall objective/goal of the proposed project:		
3. Proposed project's statewide relevance/impact/significance. Must include: a. The perceived short-term and long-term importance/value/outcome of the proposed. b. How the proposed project will prevent a problem or improve the system. c. How the proposed project will have an impact on the statewide mental health system.		

4. How does the proposed project promote the mission and system principles of the public mental health system?

5. Resources needed for successful completion of this proposed project.

   a. Possible funding sources (private, grants, federal, state, regional, etc):

   b. Participants and/or skills needed:

6. Proposed timeline for starting and completing this project:

III. ADDITIONAL CONSIDERATIONS

1. Has this project or a similar project been initiated or piloted before?

   a. What were the successes?

   b. What were the challenges?

   c. What can be built upon?

2. If available, provide a cost-benefit analysis/statement:

3. Describe potential consequences of inaction if proposal is not pursued.

4. List potential barriers (any regional/state/federal mandates or potential delays, system or organizational non-readiness, measurement issues, availability of timely data, quality of data, or data analysis issues).

5. How would you know this proposed project has succeeded (i.e., evaluation criteria, qualitative indicators, quantitative indicators)?