

*State of Hawaii  
Department of Human Services  
Med-QUEST Division  
601 Kamokila Boulevard, Room 518  
Kapolei, Hawaii*

# ***QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT WORK PLAN***

# *Med-QUEST*

## *QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT WORK PLAN*

### **I. PURPOSE**

**The purpose of the Quality Strategy Work Plan is to support the Strategy goals and objectives and describe an organized schedule of quality improvement (QI) activities during 2003–2004.**

### **II. SCOPE**

The scope of the Work Plan includes PIHP and State activities related to CAMHD provided crisis management, outpatient behavioral health services, intensive family intervention services, crisis residential services, intensive outpatient hospital services, therapeutic living supports and therapeutic foster care supports, residential treatment in a hospital setting, and administrative support services.

### **III. POPULATION DEMOGRAPHICS**

The demographic and epidemiological data are the basis for selection of the Strategy activities and studies. As the population fluctuates and new information becomes available, the Work Plan will be updated to facilitate the health care needs of the Medicaid/CAMHD recipients. The following represents current knowledge as of June 30, 2002 and is based on the most recent data reported by CAMHD.

#### **Glossary**

**Population** The present analysis was all QUEST involved youth (N = 875) registered in the Child and Adolescent Mental Health Management Information System (CAMHMIS) for one or more days during the period from July 1, 2001 through June 30, 2002 as of October 31, 2002. A youth was defined as QUEST involved if the youth was recorded in the CAMHD QUEST Eligibility database as eligible for QUEST on one or more days during the reporting period. QUEST eligibility is determined through a daily transaction that examines the list of QUEST eligible youth published by Med-QUEST Division and identifies those youth actively registered in CAMHMIS on that day. In the fiscal year 2003 services for youth with Pervasive Developmental Disorders were transferred to the Department of Education. Since there were so few Recipients with this diagnosis, the numbers will not be affected.

**Age** was defined as the difference between each youth's date of birth and the end of the fiscal year, June 30, 2002 truncated to years. Therefore, the age variable represents how old the youth would be at the end of the reporting period, not at the time they were QUEST enrolled or received services. Therefore, this variable will tend to overestimate each youth's age at the time of service to the extent that services were received prior to the end of the year (up to a one-year with a one-half year bias expected).

**Diagnostic Status** was defined based on Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994) codes entered into CAMHMIS. Youth registered with CAMHD receive annual diagnostic evaluations from the Department of Education, DOE providers, or occasionally CAMHD staff. Children and youth may receive multiple diagnoses on the first two axes of the DSM system, but only the primary diagnoses are reported here.

**Number of Youth** for the service table represents the count of youth that received each level of care for one or more days during the year. This count is unduplicated within a single level of care (i.e., row) but duplicated across levels of care. For example, 44 different youth received Hospital Residential care at some point during the year, and each of these 44 may have received another level of service.

**Percent of Registered** represents the number of youth receiving each service divided by the total number of QUEST youth registered during the period. Because the number of youth is duplicated across levels of care, the sum of these percentages may exceed 100%.

**Receipt of Services** was calculated based on records that were accepted as payable during billing adjudication for the Hospital Residential, Community Residential, Therapeutic Group Home, Therapeutic Family Home, Respite Home, Intensive Day Stabilization, Intensive In-Home, and Less Intensive (i.e., all other low-end assessment and treatment services) levels of care. Service information for the Out-of-State, Community High Risk, Multisystemic Therapy, Flex, and Respite is based on the CAMHMIS service authorization database augmented by information based on manual billing collected by the Fiscal Office and weekly provider census data collected by the Clinical Services Office. A youth is identified as receiving a service if there was a record of payment for the service on at least one day during the quarter. Thus, the service receipt counts are unduplicated within a level of care, but are duplicated across levels of care. For example a youth who received one month of Hospital Residential and two months of Intensive In-Home services would be recorded as receiving both of these levels during the quarter.

**Total Cost of Services** was the sum of all expenditures (US\$) recorded for a specific level of care.

**Cost per Level of Care (LOC)** was calculated as the sum of all expenditures (US\$) for services at a given level.

**Cost per Youth per Level of Care (LOC)** was calculated as the total cost of services for a given level of care divided by the unduplicated count of youth receiving services at that level of care (i.e., the arithmetic mean of cost per level of care and number of youth served at that level of care).

**Total Cost** was calculated as the sum of all services dollars recorded in CAMHMIS as expended during FY 2002 that are allocated to level of based on youth counts duplicated across levels of care. For example, the average Out-of-State cost per youth includes total expenditures for youth that received any Out-of-State service. If a youth receive two weeks of Out-of-State services and two months of Multisystemic Therapy for a total quarterly expenditure of \$20,000, this amount would be included in calculating the sum for both the Out-of-State and Multisystemic Therapy levels of care.

**Total Cost per Youth** represented the average cost for all services received by youth during the quarter allocated to level of care based on youth counts duplicated across levels of care. For example, the average Out-of-State cost per youth includes total expenditures for youth that received any Out-of-State service. If a youth receive two weeks of out-of-state services and two months of Multisystemic Therapy for a total quarterly expenditure of \$20,000, this amount would be included in calculating the averages for both the out-of-state services and Multisystemic Therapy levels of care.

**Summary of Statewide Age Group and Gender Cross-Tabulation for QUEST Youth  
For the Period from July 1, 2001 to June 30, 2002  
as of October 31, 2002**

Age (Years)	Gender	Number of Youth (Unduplicated)		Age (Years)	Gender	QUEST Plan
<1	M	0		45-49	M	
	F	0			F	
1-4	M	8		50-54	M	
	F	1			F	
5-9	M	97		55-59	M	
	F	36			F	
10-14	M	237		60-64	M	
	F	74			F	
15-17	M	240				
	F	110		Subtotal:	M	
18-19	M	47		45-64	F	
	F	23			Total	
Subtotal:	M	629		65-69	M	
0-19	F	244			F	
	Total	873		70-74	M	
					F	
20-24	M	2		75-79	M	
	F	0			F	
25-29	M			80-84	M	
	2				F	
30-34	M			85-89	M	
	F				F	
35-39	M			90 and over	M	
	F				F	
40-44	M					
	F			Subtotal:	M	
				65 and over	F	
Subtotal:	M	2			Total	
20-44	F	0				
	Total	875		Age		
				Unknown		-
				<b>Total</b>		875

**Summary of Statewide Behavioral Health Diagnoses for QUEST Youth  
For the Period from July 1, 2001 to June 30, 2002  
as of October 31, 2002**

(a) 10 Most Common Primary Diagnoses	(b) DSM Code	(c) Number of Youth (Unduplicated)	(d) Percent of Registered	(e) Total Cost (\$)	(f) = (e) / (c) Total Cost Per Youth
1. ADHD, Combined Type	314.01	182	20.8	2,994,670	16,454
2. Oppositional Defiant Disorder	313.81	86	9.8	1,519,082	17,664
3. Conduct Disorder	312.8	72	8.2	2,569,504	35,688
4. Posttraumatic Stress Disorder	309.81	62	7.1	2,205,088	35,566
5. Dysthymic Disorder	300.4	56	6.4	1,161,415	20,740
6. Adjustment Disorder With Mixed Disturbance Of Emotions and Conduct	309.4	43	4.9	463,526	10,780
7. ADHD, Predominantly Inattentive Type	314.00	39	4.5	417,290	10,700
8. Pervasive Developmental Disorders Not Otherwise Specified	299.80	31	3.5	821,413	26,497
9. Disruptive Behavior Disorder Not Otherwise Specified	312.90	22	2.5	367,338	16,697
10. Anxiety Disorder Not Otherwise Specified	300.00	22	2.5	344,265	15,648

Note: This table only presents the 10 most common primary diagnoses. Not all registered youth receive one of these diagnoses; therefore the percent of registered youth (column d) will sum too less than 100%.

**Summary of Statewide Behavioral Health Services for QUEST Youth  
For the Period from July 1, 2001 to June 30, 2002  
as of October 31, 2002**

Any Receipt of Services	(a) Number of Youth (Duplicated)	(b) = (a) / 875 Percent of Registered (Duplicated)	(c) Total Cost (Duplicated \$)	(d) = (c) / (a) Total Cost per Youth	(e) Cost per Level of Care (Unduplicated \$)	(f) = (e) / (a) Cost (\$) per Youth per Level of Care
out-of-state	1	0.1	112,516	112,516	7,003	7,003
Hospital Residential	44	5.0	4,473,547	101,672	2,676,250	60,824
Community High Risk	3	0.3	542,025	180,675	542,025	180,675
Community Residential	72	8.2	5,305,485	73,687	4,266,009	59,250
Therapeutic Group Home	54	6.2	3,570,466	66,120	2,249,924	41,665
Therapeutic Family Home	90	10.3	5,028,694	55,874	2,914,303	32,381
Partial Hospitalization	9	1.0	971,442	107,938	91,000	10,111
Day Treatment	10	1.1	460,477	46,048	138,447	13,845
Multisystemic Therapy	91	10.4	2,274,181	24,991	641,410	7,048
Intensive In-Home	341	39.0	7,961,158	23,347	2,670,961	7,833
Flex	114	13.0	6,466,413	56,723	104,213	914
Respite	48	5.5	930,103	19,377	80,123	1,669
Less Intensive	239	27.3	8,754,588	36,630	2,180,634	9,124

Note: The Community High Risk level of care provides services to juvenile sex offenders over extended periods of time with relatively little change in population. Therefore, the average cost per youth tends to be higher than other levels of care with a higher daily rate but shorter lengths of service such as Hospital Residential services.

#### **IV. GOALS AND STRATEGIES**

Specific goals and tactics to achieve the goals and objectives for 2003-2004 include the following:

**A. Support and maintain an information system that collects, analyzes, integrates, and reports data.**

Med-QUEST will establish a monitoring process that is consistent with CMS guidelines to examine the information systems of the PIHP. The EQRO will do a partial review of the information system through performance measures validation. This will be conducted in March or April of each year. A more complete review of the information systems will be performed by the PIHP using an edited version of the CMS tools and protocols. The PIHP will conduct an annual claims validation study comparing provider medical records to submitted claims. CAMHD must collect data on recipients and providers and on services furnished to recipients through an encounter data system. The review will validate the accuracy and completeness of CAMHD data received from providers; the completeness, logic, and consistency of the data; and the use of standardized formats. CAMHD's information system is essential to effectively and efficiently validate encounter data, calculate or validate performance measures and manage the health care of its enrollees. The purpose of this assessment is to identify areas that require improvement with respect to those capabilities.

- a. Information systems used to collect and identify race, ethnicity, and primary language spoken for each QUEST recipient will be examined in the 2003-2004 Strategy. A thorough review of the current policies and procedures for collecting data will be compiled and assessed. The State methodology of enrollment and enrollee rights will be reviewed to assure that disclosure of these facts by enrollees is not used in any potentially adverse way.

Once the current situation is reviewed, assessed and strengths and weaknesses are identified, Med-QUEST can develop action steps to implement, and assure that race, ethnicity, and primary languages spoken are collected in an improved process. Improvements will lead to delivery of services in a culturally competent manner.

- b. Information systems used to identify access to care delivery networks, utilization services, number and types of providers, and geographic locations of providers will be assessed in the 2003-2004 strategy as part of the EQRO annual PIHP review.

**B. Monitor and support behavioral health services activities and develop action plans for deficiencies when indicated.**

- C.** Use standardized national methodology to measure some compliance rates of Behavioral Health Care Services provided to its recipients annually. At least two measures a year will be audited by the EQRO. These measures may be rotated. The audits are followed by corrective action plans when appropriate. Other measurements may be necessary for data compilation and measurement in specific areas.

**PERFORMANCE MEASURES CONDUCTED BY PIHP**

**EXAMPLES**

Topic	Rationale	Study Population	Type	Methodology	Measurable Objective	Contract Years	Accountability	Jul 2003	Aug 2003	Sept 2003	Oct 2003	Nov 2003	Dec 2003	Jan 2004	Feb 2004	Mar 2004	Apr 2004	May 2004	Jun 2004	
Percentage of consumers linked to physical health services	↑ Risk Coordination of Care	P	C	PIHP Documents	90% Benchmark ↑ Rate to 10% of GAP	7/2003	PIHP/EQRO							X	X	X				R
Percentage of available school days attended in the last 30 days	↑ Risk Child status	P	C	PIHP Documents	TBD Benchmark Baseline Measurement	7/2003	PIHP/EQRO							X	X	X				R
CAFAS 8-scale Total Score	↑ Risk Child status	P	C	CAMHIS	↓ to 10% of Gap ≥ 30 point Difference between New Admission and Average Scores Baseline Measurement	7/2003	PIHP/EQRO	X	X	X	X	X	R							
CAFAS – School Role Performance Score	Child status	P	C	CAMHIS	↓ to 10% of Gap ≥ 10 point Difference between New Admission and Average Scores Baseline Measurement	7/2003	PIHP/EQRO	X	X	X	X	X	R							

2003-2004 goals will be to measure performance against previous years' performance and set performance goals. Selected measures that have been validated will be published in the annual open-enrollment packets mailed to members.

R = Report  
P = Population Measurement Monitor  
FS = Focus Study on Select Members  
C = Clinical Study

S = Service Study  
I = Intervention period  
X = Data collection period  
PS = Performance Improvement Project

**F. Monitor chronic mental illness or other related services and develop action plans for Strategy when indicated. Services related to chronic pediatric mental illness will be selected as Performance Improvement Project.**

Med-QUEST and the PIHP will use methodology to measure the care provided to members enrolled in Medicaid/CAMHD. THE PIHP must pick at a minimum one study of its own choosing. If more than one studies are performed, the EQRO will examine whichever study is chosen by CAMHD.

Topic	Rationale	Study Population	Type	Methodology	Measurable Objective	Contract Years	Accountability	Jul 2003	Aug 2003	Sept 2003	Oct 2003	Nov 2003	Dec 2003	Jan 2004	Feb 2004	Mar 2004	Apr 2004	May 2004	Jun 2004
CAMHD Selected	As Defined by PIHP	PS	C	As Selected by Plan	Performance Improvement Project	7/2003	PIHP/ EQRO									X			R

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**H. Monitor health services for access to care.**

Continuous monitoring of key indicators will be essential to ensure compliance with the standards.

Topic	Rationale	Study Population	Type	Methodology	Measurable Objective	Contract Years	Accountability	Jul 2003	Aug 2003	Sept 2003	Oct 2003	Nov 2003	Dec 2003	Jan 2004	Feb 2004	Mar 2004	Apr 2004	May 2004	Jun 2004	
Registration Date to 1 <sup>st</sup> receipt of non-emergent, non-urgent services	Access to Care	P	S/C	CAMHMIS PIHP records	≤ 42 days Baseline Measurement	7/2003	PIHP/EQRO	X	X	X	X	X	X	X	X	X	X	X	X	R

R = Report

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**I. Conduct consumer and provider satisfaction surveys and analysis of grievances.**

Monitor recipient grievances to assure enrollees are receiving benefits based upon the CAMHD MOA and rendered within quality parameters.

**GRIEVANCES AND APPEALS**

Topic	Rationale	Study Population	Type	Methodology	Measurable Objective	Contract Years	Accountability	Jul 2003	Aug 2003	Sept 2003	Oct 2003	Nov 2003	Dec 2003	Jan 2004	Feb 2004	Mar 2004	Apr 2004	May 2004	Jun 2004
Grievances /1000	Care and Service Dissatisfaction	P	S	Quarterly Grievance	≤10/1000	7/2003	PIHP/MQD	X	R	X	X	R	X	X	R	X	X	R	R
Grievance Turnaround Time	Consumer of Perception Service Satisfaction	P	S	Quarterly Grievance	100% ≤ 30 days ↑10% of gap	7/2003	PIHP/MQD/EQ RO	X	R	X	X	R	X	X	R	X	X	R	R
Grievances about Access to Care	Consumer perception Service	P	S/C	Quarterly Grievance	≤ 5/1000	7/2003	PIHP/MQD/EQ RO	X	R	X	X	R	X	X	R	X	X	R	R

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### CONSUMER SATISFACTION SURVEY

Consumer satisfaction surveys will be conducted using standardized, validated methodology as scheduled to assess satisfaction with the access, quality of care and quality of service provided to the recipients.

Topic	Rationale	Study Population	Type	Methodology	Measurable Objective	Contract Years	Accountability	Jul 2003	Aug 2003	Sept 2003	Oct 2003	Nov 2003	Dec 2003	Jan 2004	Feb 2004	Mar 2004	Apr 2004	May 2004	Jun 2004
General Satisfaction With CAMHD	Consumer perception	P	S	TBD Survey	80% Baseline Measurement ↑10% of GAP	7/2003	PIHP/EQRO							X	X	X	R		R
Consumer perception of active participation in decision making regarding treatment	Consumer perception	P	S	TBD Survey	80% Baseline Measurement ↑10% of GAP	7/2003	PIHP/EQRO							X	X	X	R		R
Consumer perception of access	Consumer perception Compliance by providers and PIHP	P	S	TBD Survey	80% Baseline Measurement ↑10% of GAP	7/2003	PIHP/EQRO							X	X	X	R		R
Consumer perception of quality/appropriateness	Consumer perception Compliance by Providers	P	S	TBD Survey	80% Baseline Measurement ↑10% of GAP	7/2003	PIHP/EQRO							X	X	X	R		R

### PROVIDER SATISFACTION SURVEY

Provider satisfaction surveys of both individual providers and agencies will be scheduled every other year to assess satisfaction with CAMHD, reimbursement, PIHP utilization management and quality of care. The first survey will be conducted in 2004-2005.

**J. Conduct annual contract structure and operations compliance audits to determine CAMHD's compliance with the standard set forth in the agreement between the State and the PIHP. This audit will be conducted by the EQRO. The audit will be followed by corrective action as an improvement plan and/or sanctions. The improvement plan will be monitored by the EQRO or/and Med-QUEST Division.**

**STANDARD I: WRITTEN QAP DESCRIPTION** – The Contractor has a written description of its QAP. This written description meets the following criteria:

**STANDARD II: SYSTEMATIC PROCESS OF QUALITY ASSESSMENT AND IMPROVEMENT** – The QAP objectively and systematically monitors and evaluates the quality and appropriateness of care and service to participants, through quality-of-care studies and related activities, and pursues opportunities for improvement on an ongoing basis.

**STANDARD III: ACCOUNTABILITY TO THE GOVERNING BODY** – The Governing Body of the Contractor is the Board of Directors or, where the Board's participation with quality improvement issues is not direct, a designated committee of the senior management of the PIHP is responsible for the PIHP QAP review. Responsibilities of the Governing Body for monitoring, evaluating and making improvements to care include:

**STANDARD IV: ACTIVE QA COMMITTEE** - The QAP delineates an identifiable structure responsible for performing QA functions within the contract. This committee or other structure has:

**STANDARD V: QAP SUPERVISION** – There is a designated senior executive who is responsible for program implementation. The PIHP's Medical Director has substantial involvement in QA activities.

**STANDARD VI: ADEQUATE RESOURCES** – The QAP has sufficient material resources and staff with the necessary education, experience, or training to effectively carry out its specified activities.

**STANDARD VII: PROVIDER PARTICIPATION IN QAP**

**STANDARD VIII: DELEGATION OF QAP ACTIVITIES** – The Contractor remains accountable for all QAP functions, even if certain functions are delegated to other entities. If the Contractor delegates any QA activities to contractors:

**STANDARD IX: CREDENTIALING AND RE-CREDENTIALING** – The QAP contains the following provisions to determine whether physicians and other health care professionals, who are licensed by the State and who are under contract to the PIHP, are qualified to perform their services.

**STANDARD X: PARTICIPANT RIGHTS AND RESPONSIBILITIES** – The PIHP demonstrates a commitment to treating participants in a manner that acknowledges their rights and responsibilities.

**STANDARD XI: STANDARDS FOR AVAILABILITY AND ACCESSIBILITY** – The PIHP has established standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice; and recipient service lines). Performance on these dimensions of access is assessed against the standards.

**STANDARD XII: MEDICAL RECORD STANDARDS**

- i. Accessibility and Availability of Medical Records
- ii. Record Keeping Record Review Process

**STANDARD XII: UTILIZATION REVIEW**

- A. Written Program Description
- B. Scope
- C. Pre-Authorization and Concurrent Review Requirements

**STANDARD XIV: CONTINUITY OF CARE SYSTEM** – The PIHP has put a basic system in place, which promotes continuity of care and case management.

**STANDARD XV: QAP DOCUMENTATION**

- A. Scope
- B. Maintenance and Availability of Documentation

**STANDARD XVI: COORDINATION OF QUALITY ASSURANCE ACTIVITY WITH OTHER MANAGEMENT ACTIVITY** – The findings, conclusions, recommendations, actions taken and results of the actions taken as a result of QA activity, are documented and reported within the PIHP’s organization and through the established QA channels.

**STANDARD XVII: DATA COLLECTION** – The PIHP must provide Med-QUEST with uniform utilization, cost, quality assurance, and recipient satisfaction/complaint data on a regular basis.

**STANDARD XVIII: DISPUTE RESOLUTION** – The PIHP must staff a provider services unit to handle provider questions and disputes.

**K. Conduct periodic surveys of recipient access to health care services.**

The annual member satisfaction survey listed above address consumer satisfaction with access to health care. Also, the PIHP conducts audits of provider sites to determine handicap accessibility, and the availability of appointments for emergent, urgent, routine, and periodic services. The PIHP’s facility site audit will be reviewed by the EQRO at the time of the annual plan audit to determine the validity of the methodology.

**L. Monitor Over-and Under-Utilization of health care services.**

The PIHP will monitor both the over-utilization and under-utilization of health care services. They will develop a system that will identify practice patterns by diagnosis and treatment. Action plans will be developed for improvement and will assure appropriate access to services.

**M. PIHP profiling will be conducted based upon a combination of all measures, audits and studies.**

**N. An intermediate sanction system will be further developed based upon the 2003 MOA with the PIHP and results of profiling.**

- O. **The Annual Quality Assessment and Improvement Evaluation will be conducted for the previous calendar year following receipt of the performance data, consumer satisfaction survey, and EQRO reports. The annual Work Plan will be built from the Evaluation.**

## V. CONFIDENTIALITY

Patient information documents created because of this Quality Assessment and Performance or Work Plan will be maintained as confidential.

## VI. OVERSIGHT AND DIRECTION

- A. The Med-QUEST Division meets regularly and is the body in which responsibility for the overall Strategy resides.
- B. The PIHP/Med-QUEST quarterly meeting is held and exercises oversight through a standing agenda item of the overall Strategy and Work Plan.
- C. The PIHP maintains internal control of the processes and will be responsible to resolve issues identified through the survey, service complaints, provider changes, and activities related to operations, claims, information system, customer service, marketing, and contracting and clinical departments. Activities conducted by Med-QUEST will be coordinated with the PIHP and input will be received to assure that all systems affected are involved in the improvement process.
- E. Other committees and multi-disciplinary bodies are formed to meet on a temporary or permanent basis to fulfill the quality improvement needs of the State.

## VII. REVIEW AND APPROVAL

The stakeholders, recipients and public exercise oversight by reviewing and providing feedback to the State on the Strategy and Work Plan.

Dates of Stakeholder meetings July 8 & July 9 2003

Approval

Dates of Recipient Input July 5, 6, 8, 9, 2003

Date of Public Information Disclosure \_\_\_\_\_

Date of Approval by Med-QUEST Division  
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