

## COLORADO HEALTH NETWORKS

### QUALITY IMPROVEMENT STEERING COMMITTEE FRIDAY, MAY 20, 2005 9:30 – 2:30 BUENA VISTA – VISTA INN

## HIGHLIGHTS

### INTERNAL OUTCOMES DATA TASK GROUP UPDATE

Data was pulled from 1996 and compared to data from 2002. A comparison was conducted of the members that were in treatment during both time frames. The goal was to look at the changes from the two time frames. The task group met and reviewed the draft audit tool. The audit tool needed clarification.

A sample of 10 clients was pulled to pilot the audit tool and to ensure that the audit tool is pulling information that is needed for this audit.

### EXTERNAL ADHD AUDITS UPDATE

The QOCC suggested to send a letter to the participants in the audit and give them a general summary and compared the data to the audit from 2002. The letters were sent out and in the letter the provider was given the option to get individual results. The results have been posted the CHN website.

### CCAR UPDATE

It was noted that many committee representatives and other mental health center staff participated in a meeting to give suggestions and recommendations for changes to the CCAR. The recommendations were sent to Nancy Johnson-Nagel at the State. There is going to be a pilot study conducted on the CCAR. The plan is to have the new format complete and distributed before July 1, 2006. E. Arnold-Miller stated that a hold will be put on the work that this group was looking at on the CCAR until the new form is in circulation. Much discussion ensued regarding training staff.

### COMPLIANCE COMMITTEE

N. Henjum created an audit tool based on the contract requirements. The audit tool will be sent to the mental health centers when it is completed. A suggestion was made to have 1 or 2 staff from the mental health centers participate in monitoring other mental health centers. The results of the audits will be presented to the Class A Board. If there is an item that is out of compliance; a corrective action plan will need to be implemented. The results will be presented to the QISC as the Compliance Committee wants the QISC to be in charge of this process. The audit will be called the CHP Contract Compliance audit. This process will start in the fall.

### MHC RESPONSIBILITIES

The draft audit tool will be sent out and welcome any input on the tool. The Class B Board will then need to approve the tool.

### INDICATOR TRENDING REVIEW

On the Satisfaction Survey, compared to a year ago are you feeling better, worse or about the same? The "worse" answer has decreased. It was also noted that the complaints have increased, which shows that mental health centers are reporting more complaints to CHN. H. Grublak noted that training will happen on June 14 with PPMHC regarding complaints process and getting the advocates involved. There is an on-going conference call with the advocates that allows time for questions about complaints and give each other feedback. During this conference M. Denman provides updates from the Advocates meeting with HCPF. There is a plan to have training on the West Slope as well. The committee asked for the break out of complaints after the fiscal year data is available.

### REVIEW OF PROGRAM DESCRIPTION AND WORKPLAN

The committee reviewed the program description and requested changes to the committee members in attendance and their discipline. Minor grammatical changes were noted in the Population Analysis.

Approved: The committee reviewed and approved the QM Program Description pending the suggested changes.

## **QM WORK PLAN**

The committee suggested many changes to the goals. Under Goal #10 there was much discussion ensued regarding the Cultural Competency Plan and lack of support of going forward with a plan. The goal states "QISC will implement, review and/or evaluate Cultural Competency Plan. Because Cultural Competency activities vary by mental health center, QISC determined having an overall plan is not effective. The QISC/CAUMC recommended removing this goal from the QISC goals and suggested adding the goal to the OCFA work plan goals. It was also suggested that this item be added to the compliance review.

(E. Arnold-Miller noted that the additional goals listed would be incorporated into the EQRO goal.

- 1) Complete provider site visits/audits to evaluate compliance with contract requirements (CMHC & non-CMHC providers)
- 2) Initiate new Performance Improvement Project(s) based on system performance or other measurement activities.

The committee reviewed and approved the Quality Management goals pending the suggested changes

## **PERFORMANCE MEASURES HCPF**

E. Arnold-Miller noted since that there are unresolved questions regarding the performance measures this item is deferred to the June 7, 2005 QISC conference call.

## **PERFORMANCE IMPROVEMENT PROJECT**

E. Arnold-Miller noted that we must develop Performance Improvement Projects. She noted that this would be more effectively discussed in a task group. The task group will look at requirements for the performance improvement projects and some ideas and timelines. The task group shall bring the recommendation backs to the QISC/CAUMC at the next meeting for discussion. The proposal will be due early June. A task group was formed. A conference call will be scheduled.

## **ACCESS AND CORRECTIVE ACTION PLANS**

E. Arnold-Miller asked the committee if each mental health center would monitor their routine access data on a monthly basis. If the data is not meeting standard, the mental health centers will need to initiate their own corrective action plan. Much discussion ensued regarding what would constitute a corrective action plan. The committee agreed that the standard should be if the mental health centers are at or below 95% for two consecutive months a corrective action plan will need to be submitted. SyCare representatives expressed some concerns regarding reporting monthly. This item will be presented to the Class B Board to notify the Executive Directors that this data is needed on a monthly basis.

## **QUALITY MANAGEMENT POLICY AND PROCEDURE REVIEW**

The Committee reviewed the changes made the Quality Management Policies and Procedures. It was asked that in the future, if there are policies that pertain to the mental health centers to flag it so they can make changes to their internal policies. It was suggested to add the Quality and Clinical policies and procedures to the CHN website. The committee accepted the changes to the policies.

## **AMBULATORY FOLLOW-UP**

It was noted the reports were sent to the Mental Health Centers for feedback on cases where the person was not available for follow-up. All information had not been received at the time the report was generated. The overall CHN score may change once the information is included.

## **PIKES PEAK PRESENTATION ON CCAR AND GAF**

There is training be setup in the first week in June on GAF. They want to have it up and running in September. There will be a train the trainers session scheduled as well. S. Dixon noted that there is also a system being worked on to have re-training staff to make sure that they are completing the forms correctly.

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