

**NORTHPOINTE BEHAVIORAL
HEALTH SYSTEMS**

**QUALITY ASSESSMENT AND PERFORMANCE
IMPROVEMENT PROGRAM
(QAPIP)
FY19**

I. INTRODUCTION

Northpointe Behavioral Health Systems' (NBHS) Quality Assessment Performance Improvement Program (QAPIP) is dedicated to serving our Strategic Plan and Mission. The QAPIP is structured to facilitate and assure an objective and systematic performance improvement program that monitors and evaluates the quality of care provided to individuals with mental illness, developmental disabilities, and/or co-occurring disorders, both adults and children.

The QAPIP provides a system-wide method that pursues identified opportunities to improve care and outcomes. The QAPIP also provides direction in our efforts to achieve and maintain compliance with accreditation and regulatory requirements. The QAPIP may be amended at any time if it is determined by the Quality Improvement Team that it is not in compliance with national, state, accreditation, or local laws and mandates, or because it is either incomplete or ineffective.

II. PROGRAM GOALS

The mission of NBHS is to improve the well being of individuals and families through the delivery of excellent person-centered health services. To accomplish this goal, NBHS is committed to implementing a system-wide continuous quality improvement process that will ensure high quality clinical and administrative services. To support this effort the following goals are identified:

Goals

1. Conduct a comprehensive, ongoing, and coordinated Quality Assessment and Performance Improvement Program (QAPIP) that:
 - Identifies areas for improvement
 - Designs, measures, and objectively evaluates effective performance of clinical and support processes.
2. *Oversight of Vulnerable Individuals* - NBHS will utilize various reporting mechanisms and data sets to identify vulnerable individuals and events that can put them at risk of harm, including required health measures and health assessments. Such events and data will be used to determine opportunities for improving care and outcomes.
3. Maintain a program that targets processes that impact directly or indirectly on service recipient function and evaluates performance with respect to meeting key aspects of service delivery including:
 - Access to care
 - Person-centered Planning
 - Coordination of services
 - Health and Safety
 - Continuity of overall care
 - Assurance of high level of service recipient satisfaction
 - Compliance with the Michigan Department of Health and Human Services(MDHHS) mandatory performance improvement projects and other regulatory and accrediting standards
 - Development of other projects as indicated through data collection and analysis
4. Conduct appropriate follow-up, with corrective actions based on results and continuing efforts to improve the quality of clinical care.
5. Create and foster an organizational culture that encourages employee and other stakeholder recommendations and participation in quality improvement processes through ongoing training, discussions, and program evaluation.

6. Assure needed assistance and resources are available for quality improvement activities and that the activities are supported by the executive authority of NBHS.
7. Conduct ongoing satisfaction surveys with service recipients/guardians, contract providers, and other community stakeholders. Assure that information derived from the satisfaction process is utilized in the improvement and planning processes and is shared with service recipient/stakeholder group(s).
8. Conduct monthly Clinical Record Quality Assurance Reviews (QRC) to ensure compliance with documentation standards and to verify the delivery of Medicaid and all other services from internal providers. (The delivery of services by external and contract providers is verified through our contract management site review process.)
9. In keeping with accrediting and regulatory mandates, NBHS will identify and respond appropriately to all Critical, Risk, and Sentinel Events (as defined by NBHS *Event Reporting and Notification* policy) occurring in the organization or associated with services that the organization provides, or provides for. Appropriate response includes conducting a timely, thorough and credible root cause analysis as needed, implementing improvements to reduce risk, and monitoring the effectiveness of those improvements.
10. Develop organizational Performance Indicators and report as appropriate. The Performance Indicators identify and measure vital functions of the organization while consolidating employees' efforts in the continuous improvement process. Performance Indicators can be established in one of the following ways:
 - Written in response to the Strategic Plan as a method of verifying organizational effectiveness and efficiency
 - Derived from data collection, trending, and/or analysis of that data
 - Developed in response to a suggestion for improvement, implementation of an initial quality improvement project or planned change initiative, and/or upon recommendation of Quality Improvement (QI) or Operations Teams
11. Quarterly reports on quality/performance improvement and outcomes activities will be provided to management, Board of Directors, and stakeholders and are available to the general public via the NBHS website www.nbhs.org.
12. Maintain an active multi-disciplinary committee structure (QI Team) utilized to identify, evaluate, and establish a plan for resolving problems.
13. Institute standards and performance goals aimed at improving clinical and administrative functions, with particular emphasis on core processes that directly or indirectly impact the delivery of services.
14. Utilize Performance Indicators to pinpoint risks from a medical, legal, or financial perspective and recommend targeted actions for their current resolution and future prevention.
15. Provide quality improvement training to all new staff.
16. Maintain a Behavioral Treatment Committee (BTC) to review and approve or disapprove any plans that propose restrictive or intrusive interventions. The BTC will be developed according to the guidelines in the MDHHS technical guidelines.

17. Continue active involvement with relevant committees, such as QI Team, Operations Team, Stakeholder Advisory Committee, Member Services Committee, and Safety and Risk Management Committee.

III. AUTHORITY AND RESPONSIBILITY

The QI Manager develops the QAPIP and Annual Performance Improvement Plan with input from staff, service recipients/guardians, management and Board of Directors. The QAPIP is reviewed annually and modified as necessary. The Performance Improvement Plan is reviewed and updated as applicable. The Quality Improvement Team, who makes recommendations for final approval to the Board of Directors, reviews both documents.

In carrying out their duties, the Chief Executive Officer (CEO) has the ultimate responsibility for the implementation of the QAPIP and provides oversight during the QAPIP's development stages, monitoring of progress as the plan is implemented, and a detailed post-implementation review to evaluate the plans' efficacy at least annually. The CEO delegates responsibility to the QI Manager for developing and implementing NBHS's QI Program.

NBHS's Medical Director is a member of the QI Team and has involvement in the QI and Utilization Management (UM) activities, provides consultation, leads the peer review process with medical staff and participates in the review and follow-up of sentinel, critical or risk events that require a root cause analysis and all deaths.

IV. COMMITTEE STRUCTURE

NBHS's committee structure is designed to oversee the QI process, and committee members participate in activities including reviewing, analyzing, and enhancing the QAPIP.

1. Northpointe Behavioral Health Systems Board of Directors

- **Membership:** Members of the NBHS Board of Directors are appointed by their respective County Boards of Commissioners.
- **Meetings:** The NBHS Board of Directors meeting semimonthly on the 2nd and 4th Thursdays of each month. Meeting minutes are recorded by the Board Secretary and approved by the Board.
- **Role:** The NBHS Board of Directors is accountable for reviewing the operations and outcome of the QAPIP and Performance Improvement Plan.
- **Function:** The Board of Directors provides general oversight of NBHS clinical services delivery. Members provide input into the annual evaluation of the QAPIP and the Performance Improvement Plan and makes recommendations for approval.
 - a. Oversight of the QAPIP. There is documentation that the Board has approved the overall QAPIP and an annual Performance Improvement Plan.
 - b. QAPIP Progress Reports. The Board routinely receives written reports from the QI Manager describing performance improvements projects undertaken, the actions taken, and the results of those actions. These are generally in the form of the Quarterly Outcomes report but may include other reports as needed.
- **Reporting Accountability:** Ultimately, the Board is charged with ensuring the quality of care and services provided to individuals. The County representatives on the Board are responsible for reporting to their respective County Board of Commissioners and the public at large.

2. Quality Improvement Team

- **Membership:** Membership of the QI Team consists of the QI Manager, who serves as chair, CEO, County Director from each County or designee, Community Housing Supervisor, Director of Community Inclusion, Emergency Services Manager, Medical Records Manager, Recipients Rights Officer, Director of Nursing or designated RN, IT Manager or designee, and clinical representatives.
- **Meetings:** The QI Team meets at a minimum bimonthly on the third Thursday of each month. Meeting minutes are recorded by the Board Secretary and approved by the QI Team.
- **Role:** The QI Team helps establish a corporate culture based on continuous quality improvement philosophies and techniques. The QI Team assesses the effectiveness and efficiency of the QAPIP and makes recommendations regarding development of programs and activities to improve quality of care and service. Additionally, the QI Team manages specific quality improvement efforts and serves as a mechanism for communication and integration across all areas of quality improvement throughout the organization. This is accomplished by:
 - a. Review, comment, recommendations, and approval of a Quality Improvement/Outcomes Report submitted by the QI Manager
 - b. Formal review and recommendation regarding approval of the QAPIP
 - c. Submission of the QAPIP and Performance Improvement Plan to the Board of Directors annually
 - d. Assurance that adequate resources are available to effectively carry out the QAPIP
- **Function:** Functional responsibility is assumed for assuring appropriate action is taken when opportunities for improvement become evident within members' respective departments. Specific functions include:
 - a. Development of practice guidelines and standards, oversight of QI studies and initiative, and review of quality of care issues, as necessary.
 - b. Analysis of summary data including quality indicators, QI study results, population demographics and morbidities, service recipient complaints and appeals, service recipient satisfaction survey results, provider satisfaction survey results, and clinical record reviews.
 - c. Approval of QI program policies and procedures.
 - d. Ensuring organizational improvement activities are consistent with current accrediting body and other regulatory mandates.
 - e. Ensuring that improvement efforts measure and objectively evaluate the timely and effective performance of clinical and support processes throughout the organization.
 - f. Ensures that the methodology includes a variety of activities from tracking and trending Performance Indicators, to data collection and analysis, to quality improvement teams.
 - g. Review of performance improvement activities, Performance Indicators, and monthly/quarterly reports; troubleshoot problem areas and requests/implements corrective action plans, as appropriate.
 - h. Establishes a detailed administrative policy and procedure for the reporting, review, root cause analysis, and follow-up for critical incidents and sentinel events; documenting that the policy and procedure were appropriately followed; and outlining the precise methods for reporting, reviewing, analyzing, and documenting compliance. Sentinel events are reviewed and acted on as appropriate by individuals possessing the appropriate credentials to review the scope of care (e.g. participation by a physician or nurse in reviewing sentinel events that involved a serious medical condition or death of a service recipient).
 - i. Review of incident reports for performance improvement opportunities.
 - j. Review of Recidivism reviews for performance improvement opportunities.
- **Reporting Accountability:** The QI Manager reports to the Board of Directors at least quarterly.

3. Stakeholders Advisory Committee

- **Membership:** Membership consists of 12 members, applications are given to the Board of Directors by the QI Manager and appointments are then made. Members will represent primary and secondary service recipients, community agencies, service recipient advocacy groups, and the communities at large. The QI Manager, CEO, and Clinical Directors also participate on this committee.
- **Meetings:** The Stakeholder Committee meets at a minimum bimonthly on the first Tuesday of each month. Meeting minutes are recorded by the Board Secretary and approved by the Stakeholder Committee.
- **Role:** The Stakeholder Advisory Committee acts in an advisory role and provides input into policy, printed materials used to educate service recipients and the public, reviews quarterly quality improvement reports, critical incidents and suggestions for improvement.
- **Function:** Reviews and provides input into agency policy, major changes in service and/or programs, stakeholder satisfaction, QAPIP and Performance Improvement Plans, handbooks, brochures, and other advertising materials and quality improvement efforts.
- **Reporting Accountability:** The Stakeholders Advisory Committee Chair reports to the Board of Directors via SAC minutes.

4. Behavioral Treatment Committee

- **Membership:** BTC shall be comprised of a minimum of three individuals, at least two of who meet the following criteria:
 - One member must be a fully licensed or limited licensed psychologist with formal training or experience in applied behavior analysis;
 - One member must be a licensed physician or psychiatrist;
 - One representative from the Office of Recipient Rights shall be in attendance at all meetings
- **Meetings:** BTC meets as necessary. Meeting minutes are recorded by the Board Secretary and approved by the BTC; the signature page of the meeting minutes is scanned into the chart.
- **Role:** BTC will review and approve or disapprove any plans that propose to use restrictive or intrusive interventions with individuals served by Northpointe who exhibit seriously aggressive, self-injurious or other behaviors that place the individual at risk of physical harm. The BTC shall substantially incorporate the standards and procedures as listed in the Behavioral Treatment Review Committee Guidelines. The Recipient Rights officer will report quarterly to the QI Team a summary of all emergency physical interventions and intrusive and restrictive techniques used in the previous three months.
- **Function:**
 - a. Review and approve, or disapprove, in light of current research and prevailing standards of practice, all behavioral programs utilizing the generalized use of token economies. If the removal of tokens is a planned part of the program and those techniques requiring special consent by the recipient (Level II and III), such reviews shall be completed as expeditiously as possible.
 - b. Review and approve all program plans involving the use of psychoactive medications where they are applied for behavior control purposes and where target behavior is not due to acute psychotic process.

- c. Categorize behavioral treatment techniques approved by NBHS into a hierarchy along the parameters of intrusiveness and restrictiveness. When either of these are a component of a service recipient's behavior plan, the plan itself will reflect when the proposed component will be decreased or discontinued. Using this hierarchy, the committee shall determine the frequency of reviews necessary for program plans using approved behavior treatment techniques.
- d. Set a specific date for each approved program when it will re-examine the continuing need for approved procedures by BTC.
- e. Be familiar with all litigation involving the use of behavior modification at the agency and to the extent it is commonly made available by the Michigan Department of Health and Human Services (MDHHS).
- f. Keep all Behavior Treatment Committee Meeting forms and/or minutes, and clearly define the actions of the Committee.
- g. Provide decisions, in writing, to the responsible staff person and a copy to the individual's file, with an indication of appropriate appeal process of the agency in the event of continuing dispute.
- h. BTC members should abstain from decision making with respect to programs prepared by them or under their specific direction.
- i. Program data should be reviewed by the care manager and psychologist monthly; BTC will provide a formal committee review on or before 90 days.

V. **QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROCESS**

Northpointe's quality assessment and performance improvement process seeks to ensure that individuals receive quality services by continually improving the organization's clinical, management, administrative, and support areas. Improving performance in organizational areas positively impacts service recipient's outcomes and establishes credibility related to the quality and value of services. Michigan Department of Health and Human Services (MDHHS) directives – from assimilating Person-centered Planning into agency culture, to achieving or exceeding benchmarks for the State's Performance Indicators – contribute to Northpointe's ability to ensure a high caliber of services.

1. Establishment of the Performance Improvement Plan

NBHS quality improvement process involves careful design and planning, performance measurement and analysis, intervention strategies, and outcome evaluation.

NBHS Performance Improvement Plan provides for the monitoring, evaluation and continuous improvement of behavioral health services. quality improvement issues identified through the previous year's performance improvement program and issues raised through feedback from service recipients, staff, contract providers, the PIHP, accrediting body, and MDHHS are incorporated.

The QI Outcomes Report identifies measurable objectives and defines responsibility for completing the tasks involved.

NBHS recognizes that a primary ingredient for success in any performance improvement system is the involvement of employees and service recipients. With this in mind, employees and service recipients have the opportunity to submit ideas/suggestions for improvement to the QI Manager utilizing: the Suggestion for Improvement form; the Satisfaction Survey process; Suggestion boxes in each lobby of main sites; or by filing a Customer Service Complaint/Grievance. All ideas are reviewed by the QI Data Analyst and forwarded to the appropriate committee/department. The QI Data Analyst will bring these ideas to the QI Team for discussion and implementation of new or improved processes, if appropriate. Persons submitting an idea, who identify themselves, will receive acknowledgement of receipt and a prompt response pending the review of the suggestion or complaint.

2. Use of Quality Indicators

Performance Indicators employed are objective, measurable, and based on current knowledge and experience in order to monitor and evaluate key aspects of care and service. Performance goals and/or a benchmarking process are utilized for the development of each indicator.

A *performance goal* is defined as the desired level of achievement of the standard of care. A *benchmark* is the measure of the field's best performance for a particular indicator. In instances where NBHS's performance exceeds the industries standard, the attained level of performance will become the benchmark for future performance goals. It is expected that as NBHS, MDHHS and/or NorthCare fine-tune processes for delivering care and service, performance goals and benchmarks will progress upward toward the optimal level. Indicators are activities, events, occurrences, or outcomes for which data is collected to allow the tracking of performance and improvement over time.

Data Collection and Analysis:

The data collected from each indicator are organized in a way that quality or risk issues are readily identified. Evaluations can be prompted by single events, trends, comparisons with other similar benchmarking, or when there is a desire to improve overall performance. This data is the basis for NBHS managerial and operational decisions, as well as for choosing performance improvement activities around service recipient's care.

Each identified indicator requires specified data sources, collection methods, and time schedules for data collection. Aggregated data are then compared to the corresponding goals for evaluation. The data for problem-solving may be collected from, but not limited to, the following internal and external sources:

- Claims data
- Encounter data
- Clinical records
- Denial and appeal documents and reports
- Complaints and grievance documents and reports
- Credentialing and re-credentialing information
- Utilization management reports
- Service Recipient incident reports
- Service Recipient satisfaction surveys and focus groups
- MDHHS Michigan's Mission Based Performance Indicator System (MMBPIS) reports

A crucial part of the data collection involves maintaining and striving to surpass the benchmarks set for Performance Indicators established by MDHHS in the areas of access, efficiency, and outcomes. Indicators are continually monitored and analyzed. Anything less than full compliance shall be addressed using a multi-step correction plans that:

- Takes specific action on individual cases as appropriate
- Identifies and investigates sources of dissatisfaction
- Outlines systemic action steps to follow-up on the findings
- Informs providers, stakeholders, and the Board of assessment results

3. Performance Improvement Projects: Standards published by the Centers for Medicare and Medicaid Services (CMS) require that the Pre-paid Inpatient Health Plan (PIHP i.e. Northcare) conduct performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and satisfaction. NBHS, through their regional work with Northcare, must engage in at least two affiliation-wide projects during the waiver renewal period. Project topics are either mandated by MDHHS or selected by Northcare in a manner that takes into account the prevalence of a condition among, or need for a specific service by, the organization's service recipients, demographic characteristics and health risks, and the interest of individuals in the aspect of service to be addressed.

4. Service Recipient Satisfaction

The wisdom of one who has experienced the "way it is" and sees the "way it could be" is integral to shaping a QI vision that works for service recipients. Northpointe views service recipient's satisfaction measurement as critical to ensuring quality ongoing service delivery that meets or exceeds individual expectations. The thread that ties all individual data collection efforts into a usable whole includes identification of service recipients' wants and needs, understanding service recipient's expectations and perceptions, and the communication of both the service delivery parameters and quality improvement efforts.

5. Monitoring and Evaluation of Care

NBHS systematically collects, assembles, analyses, and utilizes information as a means of improving organizational and program quality, and demonstrates its responsiveness to the individuals served and other stakeholders on an ongoing basis.

An important indicator in this area is the Clinical Record Quality Assurance Review (QRC) Process, which is outlined in the Clinical Record Quality Assurance Review policy and procedure. The process entails monthly reviews of clinical documentation.

6. Regional Verification of Services:

MDHHS requires that the PIHP implement a process for the verification of the delivery of Medicaid services. The purpose of the process is to verify that adjudicated claims are Medicaid billable services and that the services are sufficiently supported in clinical record documentation.

NBHS will participate in the verification of the delivery of Medicaid services during the site reviews conducted by NorthCare. NorthCare typically completes this review in conjunction with other reviews such as the Clinical Documentation Review and/or the Quality Monitoring Review by NorthCare's Documentation Review Team, on an annual basis at minimum. All findings will be recorded on a regional form and submitted to NorthCare's QI Coordinator.

Data will be compiled and analyzed by NorthCare's Quality Council and will also be reviewed by the regional Compliance Committee. NBHS is expected to submit a corrective action plan to NorthCare, who will either accept and monitor or require additional action.

A summary report is submitted to MDHHS by October 31 of each year and is also made available to various stakeholder groups.

7. Use of Clinical Care Standards/Best Practice Guidelines

NBHS endorses and utilizes Practice Guidelines published by NorthCare . NBHS has also adopted a policy outlining the procedures for the screening, assessment and treatment of service recipients who may have co-occurring mental health and substance abuse disorders. The NBHS CEO participates in

the regional Improving Practices Leadership Team which continues to oversee new and current Evidence Based Practice activities. Best Practices that NBHS has initiated, include:

- Cognitive Behavioral Therapy (CBT)
- Dialectic Behavioral Therapy (DBT)
- Assertive Community Treatment (ACT)
- Medication Management
- Supported Employment
- Parent Management Training
- Motivational Interviewing
- Peer Supports Specialists
- WRAP
- Family Psycho-education
- Integrated Dual Diagnosis Treatment (Co-Occurring)
- Supported Housing
- Home Based
- Infant Mental Health
- Trauma Informed Care
- Applied Behavioral Analysis

8. Utilization Management

NBHS maintains a written Utilization Management (UM) Plan that is reviewed at least annually and updated as necessary. The Utilization Review Committee meets quarterly or as often as needed, to review, discuss, and monitor trends to promote cost effective, least restrictive individual care. The UM committee is made up of: CEO, CFO, Director of Nursing (DON), County Clinical Directors, Director of Community Inclusion, Community Housing Supervisor, Emergency Services Manager, and QI Data Analyst. The Medical Director, Recipient Rights Officer, and practitioners, shall be called upon on an ad hoc basis.

9. Contract Monitoring

A. Contracts for Services off site:

1. The NBHS Recipient Rights Officer and other staff as deemed appropriate to the services offered, will conduct an annual site review.
2. Monitoring will consist of clinical record reviews, staff qualifications, training and credentialing, environmental safety, the recipient rights system, licensing review, financial billing and accounting for service recipient's funds. The report will include an overall compliance score with a Plan of Correction to be submitted to the Recipient Rights Officer.
3. Consultation with the appropriate State Licensing Division will occur on an as needed basis to ensure quality services.
4. Quarterly reports will be submitted to the Safety-Risk Management Team and annually to the NBHS Board of Directors.

B. Clinical Contracts for Services conducted off site, through Single Case Agreement or Self Determination:

1. Monitoring will consist of the specifications in the contract, credentialing, background checks, training, and verification of licensure, clinical documentation review and consistency with billing and support of authorizations, timeliness, and overall satisfaction.
2. Quarterly reports will be submitted to the Safety-Risk Management Team and to the NBHS Board of Directors.

10. Implementation of Quality Improvement Interventions/Corrective Action Plans

Each department assesses their performance on each of the indicators by aggregating and analyzing the data they have collected. Reports are generated by each department and reviewed by the appropriate committees within the organization. Each department manager also presents reports to the QI Team for further discussion and receives recommendations from the Team for additional action to be considered by the department.

Recommendations sometimes include a determination that a multi-disciplinary quality improvement task force be formed to address an issue. A task force for this purpose is comprised of staff that has the expertise necessary to understand the process under study. When necessary to accomplish its purposes, the task force utilizes resources at its disposal and draws upon the expertise of Northpointe and regional staff.

Systematic follow-up is used to assess effectiveness and improve quality within the organization. Once the information has been analyzed and the barriers to meeting performance goals have been identified, a corrective action plan is developed by the respective department/team. At a minimum, action plans include:

- What corrective action should be undertaken?
- How will the corrective action be accomplished?
- Who is responsible for the corrective action?
- When will the corrective action be completed?

Corrective actions are based on the problem's cause, scope, and severity. Corrective action plans are submitted on the *Plan of Correction* form QI.141 and are approved and monitored by the QI Team.

Following corrective action, the QI Data Analyst will monitor performance to determine if a corrective action has been effective. QI Analyst relays results to the QI Team, and if performance has not improved, may assist in developing additional interventions. It is the responsibility of the Department and/or Program Manager to ensure that follow-up actions have been implemented and identified problems are successfully resolved and reported to the QI Team.

Alternatives to forming a task force or implementing corrective action include, but are not limited to:

- Implementing a focused study or audit;
- Applying a specific quality improvement intervention;
- Requesting additional data or information.

Methods of problem solving create a common language that provides a degree of precision and clarity needed to identify, analyze, and resolve important health care or administrative issues. This process keeps staff focused on concrete improvement opportunities.

VI. RISK MANAGEMENT

Risk Management promotes the minimization of the adverse effects of accidental loss at the least possible cost by its identification, measurement and control of risks. It is also meant to protect the physical, financial, and human assets of the organization.

Northpointe monitors the quality of service and risk issues using the following methodologies:

1. Clinical Record Quality (QRC) Assurance Reviews are conducted monthly.
2. Credentialing/Re-credentialing provides a means for selecting and evaluating providers to ensure quality of care (written procedures can be found in the NBHS *Credentialing Program Policy*)

3. Satisfaction Surveys allow Northpointe to receive direct feedback from service recipient's and/or their guardians regarding their quality of care.
4. Complaints, Appeals, and Grievances are monitored to ensure that no trends have developed.
5. Corporate Compliance Standards are established and implemented to assist in reducing risks.
6. Review of incident reports, medication error reports, and accident reports to monitor for trends and improve safety standards.
7. Critical Incidents, Sentinel Events and Risk Events are reviewed by the QI Data Analyst and ad hoc representatives through the Root Cause Analysis (RCA) process to determine what actions, if any, need to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents.
8. In addition to other reporting requirements, MDHHS Contract (Section P7.7.1.1) requires Northcare to immediately notify them of specific Risk events. These events include:
 - Service recipient's death that occurs within 12 months of the individual's discharge from a state facility; or a death that occurs as a result of suspected staff member action or inaction within 48 hours of the death or the notification of the death. NBHS will notify Northcare within 24 hours of receipt of notification of the death.
 - Relocation of a service recipient's placement due to licensing issues.
 - An occurrence that requires the relocation of a Northpointe service site, governance, or administrative operation for more than 24 hours.
 - The conviction of a Northpointe employee for any offense related to the performance of their job duties or responsibilities.

VII. SERVICES FOR RECIPIENTS

NBHS takes an active role in assuring improvement in the well-being of its service recipients, with the following identified as priority areas:

1. Recipient Rights – provided by all employees and through the NBHS Office of Recipient Rights, as outlined in Recipient Rights policies/procedures
2. Stakeholder/Community Involvement
3. Person Centered Planning Policy Implementation
4. Service recipient Satisfaction

Individuals are educated about the services available to them and the method to access them through:

1. NorthCare Customer Handbook
2. NBHS Customer Service staff
3. Providers through the Person Centered Planning process
4. A coordinated regional effort with NorthCare
5. Stakeholder Advisory Committee
6. Recipient Rights Advisory Committee
7. Northpointe Services brochure
8. Northpointe's Web site - www.nbhs.org

Outreach to individuals may take the form of written communication through newsletters, focused mailings, direct telephone contact, educational meetings or focus groups.

VIII. CONFIDENTIALITY

Confidentiality is a cornerstone in any QI program. Individuals engaged in quality improvement activities must maintain the confidentiality of the information. Reference to individual providers or members shall be impersonal, in that those individuals are referred to by numbers or initials only, except when a specific reference is essential to meeting the goals of the Quality Assessment and Performance Improvement Program.

All written records, reports or any work product or communication related to quality improvement activities are to be considered privileged and confidential information. Any release of information is subject to legal approval (Pursuant to Michigan Statutes, Act No. 168 of 1972.).

NBHS standard operating procedures and committee minutes and service recipient's clinical records are open to review by accrediting bodies and to state and federal regulatory agencies, when applicable (Members are notified of this via the "Privacy Notice."). Information sharing is strictly limited to the specific purposes of the reviewing party. Confidentiality of NBHS documents and use of our electronic medical record (EMR) is governed by the NBHS confidentiality policies, in accordance with applicable promulgated HIPAA standards and within legal time frames for compliance.

IX. CONFLICT OF INTEREST

The provision of mental health services is a public trust that requires integrity, compassion, dedication to truth, belief in the dignity, worth, and right to self-determination of all human beings, and respect for individual and group differences. Mental health workers are dedicated to service for the welfare of humanity through disciplined practice at the highest level of competence, without partiality. Standards of behavior related to conflict of interest follow the principles set forth in the NBHS Code of Ethical Practice Policy.

X. EFFECTIVENESS OF THE PROGRAM

An effective Quality Assessment and Performance Improvement Program will demonstrate that its activities have resulted in significant improvements in the care and/or service delivered to its service recipients. Improvements are evident by the outcomes of care and the satisfaction of service recipients.

NBHS evaluates the overall effectiveness of the QAPIP annually. The evaluation reviews all aspects of the program with emphasis on determining whether the program has demonstrated improvement in the quality of care and services. The QI Data Analyst develops the Outcomes Report which shows the trending of clinical and service indicators and other performance data and demonstrated improvements. This report is reviewed quarterly by the QI Team, Stakeholder Advisory Committee and the Board of Directors. Measurements in the Outcomes Report shall be made available and presented to various stakeholder groups and are available to the general public via the website www.nbhs.org in the Annual Report.

XI. SUMMARY

Northpointe believes that QI is the foundation upon which the quality of care is built. This foundation is based upon the highest standards of care. The QAPIP expands the scope to include interdisciplinary improvement in systems and key processes as well.

Northpointe is a quality organization that maximizes its efforts to achieve these goals and the mechanisms for implementing self-improvement. NBHS is committed to self-examination and improvement. NBHS seeks to be successful in its mission of improving the well being of individuals and families through the delivery of excellent person-centered behavioral health services.

Board Approval: 1/10/19

QI Team Review and approval: 11/15/18