Quality Management Improvement and Accountability (QMIA) Plan

Jeff D Agreement

DHW
Falsetti, Candace - CO 3rd

Quality Management Improvement and Accountability Plan
Version 13, March 31, 2016

Table of Contents

Quality Management Improvement and Accountability Plan
Version 13, March 31, 2016

Overview of the Quality Management Improvement and Accountability (QMIA) Plan

The Quality Management, Improvement, and Accountability Plan (QMIA) Plan describes the development of a collaborative, cross-system, practice, performance monitoring and clinical quality improvement system. The QMIA Plan explains how Idaho's child serving systems will monitor, assess, and report on the progress toward the execution of the commitments set forth in the Jeff D. Settlement Agreement.

The QMIA Plan is founded upon the following definition of quality of care by the Institutes of Medicine (IOM):

> "The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

The QMIA Plan was developed by a workgroup (the QMIA Plan Development Workgroup) which included representatives from the Division of Behavioral Health, Medicaid, Family and Children's Services (FACS), Idaho Department of Juvenile Corrections (IDJC) and Dept. of Education, as well as families and mental health providers. The QMIA Workgroup met between September 2015 and March of 2016. Agencies designated representatives for the QMIA Workgroup who were knowledgeable about quality assurance, quality improvement, or quality review processes. The Plaintiffs asked for and were included on the workgroup as their time permitted.

The QMIA Plan addresses the goals, objectives, tools, resources and feedback mechanisms that will be used. Implementation of the QMIA Plan will begin in the month following acceptance of the Implementation Plan by the Court. All of the core components of QMIA Plan will be completely in place by approximately March of 2022.

The child serving agencies agree that the QMIA Plan is crucial to the successful implementation of the required elements of the Settlement Agreement. Parties to the Settlement Agreement intend that this QMIA Plan will adapt and change over time to meet the challenges of the approved Implementation Plan. Any and all revisions to the QMIA Plan will be consistent with the Settlement Agreement and Implementation Plan.

Quality Management, Improvement, and Accountability Plan
Version 13, March 31, 2016

Quality Management, Improvement, and Accountability Plan Description:

The Quality Management, Improvement, and Accountability Plan (QMIA) Plan describes the development of a collaborative, cross-system, practice, performance monitoring and clinical quality improvement system. The QMIA Plan addresses the specific requirements for monitoring, assessing and supporting clinical providers, programs and the system as set forth in paragraph #'s 52-58 of the agreement (See Attachment 1). The QMIA Plan establishes the core components of the monitoring system for those involved in the children's systems of care to identify and address performance issues at critical points in care which will serve to improve outcomes for children, youth and families, and reduce unnecessary and potentially serious variation in healthcare processes.

There are four primary components at the core of the QMIA Plan:

- Quality: An enhanced Quality Assurance (QA) infrastructure,
- Management: The use of performance metrics to monitor and assess the system,
- Improvement: Quality improvement through management action plans (MAP) and performance improvement projects (PIP), and
- Accountability: Monitoring the progress toward implementation and completion of the outcomes required by the Settlement Agreement.

The four core components are described as follows.

Quality: Enhanced QA Infrastructure

The QMIA Plan establishes an enhanced QA infrastructure. The plan is for the existing QA infrastructure in child serving services in Idaho to be built on and enhanced. Each child serving agency will continue to utilize their existing specialized internal systems for QA monitoring and quality improvement. In addition the goal for the child serving agencies is to develop an enhanced, effective and collaborative QA infrastructure to support the development of a coordinated practice, performance monitoring and clinical quality improvement system.

The primary component of this enhanced infrastructure will be the QMIA Council. The QMIA Council will be a collaborative made up of executive level staff and children's mental health stakeholders with chartered responsibilities specific to meeting the terms of the Settlement Agreement. The QMIA Council will provide reports and recommendations to the Interagency Governance Team (IGT). The Council will meet regularly to review reports, set goals for improvement, monitor progress, and communicate outcomes. The QMIA Council will be supported by the development of specialized QA subcommittees to address various aspects of care. QA subcommittees will identify gaps, characterize areas of improvement, set targets for improvement, develop and refine cross-system indicators, and recommend practice and policy changes. All of the QA Committees will work collaboratively with the Project Team and any implementation workgroups.

This new QA infrastructure will include participation from clients and their families, providers and communities through membership on QA subcommittees. This enhanced infrastructure will provide stakeholders opportunities to meaningfully participate in quality monitoring and improvement.

The QA infrastructure will be based on a concept of a data to action feedback cycle. Each of the QA subcommittees will be required to monitor and report on their targeted, specialized areas of expertise. The QA subcommittees will develop recommendations for improvements based on their review of reports

and data and will forward their recommendations to the QMIA Council. Items that are identified as requiring improvement will be addressed through Performance Improvement Projects (PIPs) and/or Management Action Plans (MAPs). As needed Ad Hoc QA subcommittees will be developed and implemented.

Management: Use of Performance Metrics

The QMIA Plan sets out the initial set of key quality performance metrics that were identified by the QMIA Workgroup. The performance metrics include, but are not limited to, access to care, engagement, provision of appropriate and effective services, and linkage to other community services. The proposed measures provide a picture of the quality of services provided, and how those services result in child, youth and family outcomes.

The development of performance metrics will continue to evolve over time. The proposed set of initial metrics will be reviewed by the QMIA Council and the Interagency Governance Team (IGT). Additional measures may be recommended by the QMIA Council, IGT, Project Team, or other stakeholders. The QA Committees will bring in a variety of subject matter experts, such as Dr. John Lyons, as well as other internal and external experts to ensure that the metrics utilized target the most critical aspects of care and client and family outcomes.

The QMIA Workgroup which met during the Implementation Plan period created a framework for identifying the key performance metrics based on indicators related to processes, outcomes and system impact. These are identified in the QMIA plan as the Key Quality Performance Management Indicators.. As further work is done to develop the performance metrics within the QA committees there will be performance metrics at all levels including client/family, provider, program, regional, agency and statewide.

The measures and indicators will be both quantitative and qualitative, and will support decision making, outcome monitoring, and quality improvement. A primary component of quantitative data will be data and reports generated by the Child and Adolescent Needs and Strengths (CANS) assessment. The data entry and reporting system for the CANS will be designed to provide real-time feedback to clinicians, as well as supervisors, agencies, and system administrators for quality improvement purposes. As an element in the development of the QMIA data sets consideration will be given to implementing the Transformational Collaborative Outcomes Management (TCOM) which utilizes CANS data for describing, rating and guiding development of core system and cross system administration and management competencies.

The following are examples of the ways the CANS data may be used to support decision making, quality improvement and system transformation;

	Youth & Family	Provider, Program	System
Decision Support	Setting goals for care plans	Fit for level of care	Assessing system capacity
Outcome Monitoring	Transitions in care	Evaluation of care	Identification of effective practice
Quality Improvement	Clinical supervision	Performance contracting	Systemwide transformation

The QMIA Plan includes the utilization of Quality Review (QR) processes to objectively assess and improve clinical practice and program effectiveness system wide. The elements of the QR process may include, but are not limited to, a representational sampling of cases, evaluation of the case sampling by a team of reviewers that will include at least one independent, neutral monitor, and interviews with Class Members and their families that agree to participate in the process, CFT members, and others associated

with the Class Members who might have relevant information about the Class Members' experience of care. The plan for QR will be developed jointly with plaintiffs in the first 6 months to 1 year after the completion of the Implementation Plan.

In addition to the key quality management indicators each party in the children's system of care will also continue to produce reports using data captured by their own data and record keeping systems. A goal of the QMIA will be to collaboratively develop methods for combining data from each agency into merged reports.

Improvement: Quality Management Improvement Projects

The QMIA Plan specifies that child serving agencies utilize results of the QMIA monitoring to support continuous quality improvement in clinical practice, program, and system performance. Quality Management Improvement Projects (QMIP) will be implemented as indicated when findings that result from monitoring indicate needed system improvements. The quality management improvement projects may be implemented by individual agencies (Performance Improvement Projects) or as cross-system collaborative work (Management Action Plans).

QMIPs will be based on continuous quality improvement models, such as "Plan, Do, Check, Act". Involvement in QMIPs will be supported by management in each child serving system. QMIPs will have clear roles and responsibilities assigned. Approaches to quality improvement will be founded on effective methods such as coaching, technical assistance, root cause analysis, Six Sigma.

Accountability: Monitoring the Progress of the Implementation

The QMIA Plan addresses the requirement for on-going monitoring of the implementation of the Settlement Agreement based on the outcomes, commitments, exit criteria, and demonstration of sustainability. The progress toward implementation of the Settlement Agreement will be publically reported quarterly. The items that will be reported have been identified in the QMIA plan as high priorities. The work to develop the data and reports will begin once the court has agreed to the Implementation Plan.

Quality Assurance Committee Structure and Responsibilities

The QMIA Plan includes the development of cross-system QA committees that will strengthen interagency collaboration. To monitor, assess and support the management of the child serving agencies will need to be working together to define terminology, collect data, create meaningful reports.

Quality Assurance (QA) Committee Structure:

- There will be a QMIA Council. The QMIA Council will work closely with the Project Team and report up to the Interagency Governance Team (IGT) .

- There will QA Subcommittees that will be implemented to address specific aspects of the child serving system of care. QA Subcommittees will work collaboratively with each other, and with other implementation workgroups.

- The QMIA Council will meet at least quarterly to review management and monitoring reports at the program and system level, and make recommendations for system improvement.

- Each agency in the child serving system will designate a lead person/s for the QMIA Council and as needed for the QA Subcommittees that are implemented and will deliver reports to support the goal of the respective committees.

- QMIA Council and QA Subcommittees membership will include clients, families and other stakeholders.

- The QMIA Council and QA Subcommittees will establish loop back processes for information to ensure that stakeholders are informed of quality issues and quality improvement plans.

- Training on CANS, Wraparound, Principles of Care and Practice Model, Access Model and other targeted topics will be provided to QA committees as needed.

- Additional technical assistance will be sought from local, state and other recognized subject matter experts.

Goals and Objectives of the QA Committees:

During the first year after the Implementation Plan has been approved Idaho will initiate the QMIA Council. This oversight committee will finalize plans for QA subcommittees which will initially be the committees listed below or may vary based on needs that are identified by the QMIA Council. The following QA committees are proposed as the initial QA committees for the QMIA.

QMIA Council- QMIA Council will oversee the development and implementation of an actionable quality improvement process. QMIA Council will review quarterly and annual quality data and reports to assess agency, regional and statewide performance, develop and refine cross system indicators and measures, make recommendations to the Interagency Governance Team (IGT) including changes to policy and practice. The membership of the QMIA Council is proposed to be executive level staff of each child serving agency and will also include representation of youth and families. To be implemented in the summer of 2016.

QMIA, Data, and Reports Development Committee- The QMIA, Data, and Reports Development Committee will select or develop metrics and refine measurement strategy and plan for the dissemination of results Designated committee to develop working definitions for the Quality Review process, standardize terms for data and establish framework for stakeholder's reports. Facilitated by DBH. To be implemented after Court Approval of the Implementation Plan., Spring or Summer of 2016.

Implementation Plan Monitoring Committee – Designated Committee to monitor and report on progress toward meeting Outcomes in the Settlement Agreement. Facilitated by DBH. To be implemented in Spring of 2016 after court approval of the Implementation Plan.

Provider Partnership Committee - Committee to encourage partnership with all child mental health serving providers and State, review reports to assess statewide performance, recommend QA/QI activities. Facilitated by DBH and Medicaid to be implemented after July 2016.

Youth and Family Partnership Committee –Committee to provide a collaborative forum for open discussion of issues related to children's mental health, including outreach and consumer education. Committee may recommend QA/QI activities, review quarterly and annual reports to assess statewide performance, submit concerns to the QMIA Council and to the IGT when no improvement is noted. Facilitated by DBH and Medicaid. To be implemented after July 2016.

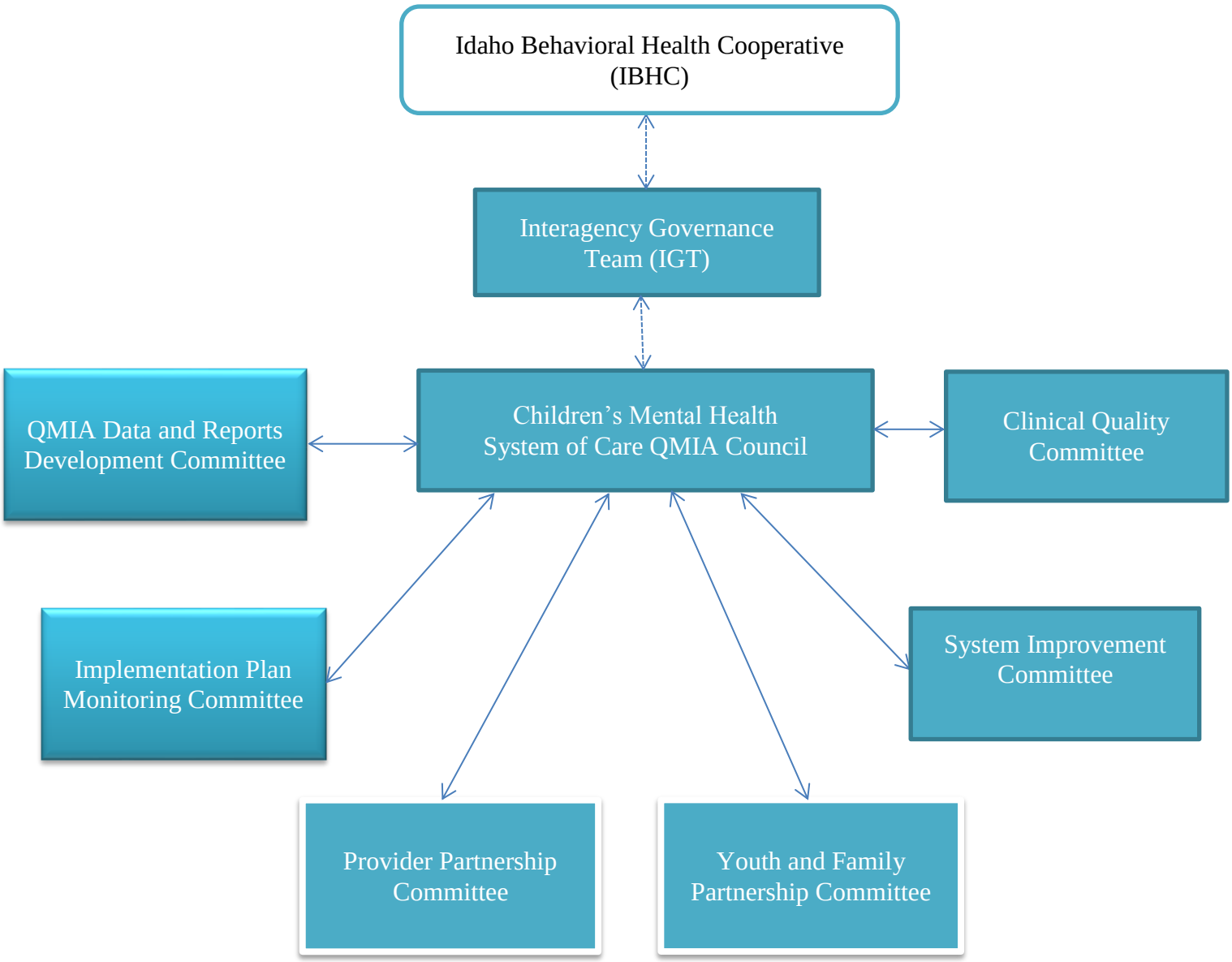
System Improvement Workgroup- Multiagency workgroup to review complaints and appeals, results of QR, notices of action that reflect adverse decisions, child, youth and family feedback on service effectiveness. The System Improvement Workgroup may recommend QA/QI activities

such as PIP, investigation, new QA subcommittees, or action plans. To be implemented by July 2018.

Clinical Quality Committee – Committee to oversee interventions and monitor progress , review Wraparound fidelity results, compliance with the Access to Care and Principles of Care and Practice Model results of chart reviews, Quality Review Grand Rounds, and other reviews of clinical quality measures. To be implemented by July 2018.

Ad Hoc Committees- To be developed as needed.

Proposed QA Committee Structure



Overview of Key Quality Performance Management Indicators:

The QMIA Workgroup which met during the Implementation Planning process identified the key performance metrics that will be monitored, assessed and utilized in planning system improvement. The key performance metrics form the basic framework of the QMIA and are based on critical points in the care process, such as services and supports, the Access Model, or the Principles of Care and Practice Model.

The Key Quality Performance Management Indicators have been organized in to the following categories:

1 - Process: Interactions between children, youth and families and providers, this includes diagnosis, treatment, and the quality of care delivered.

Examples: referrals, screening, assessment, eligibility, service delivery, provider performance, and safety

2 - Child, Youth and Family Outcomes: The effects of mental health care on children, youth and families.

Examples: Engagement, effectiveness, child, youth and family perception of care, changes in strengths and needs (CANS scores).

3 - System Impact: The context in which care is delivered.

Examples: Access to and availability of resources, provider training, expenditures, development of core system and cross system administration and management competencies

The indicators and data that are specifically required by the agreement are noted by being underlined in the following tables. These required indicators will be prioritized for collection and reports. All other measures and indicators (noted as Additional Key Quality Performance Management Indicators) are proposed as possible concepts about how to measure performance in the coming years. The QMIA Council will review all the proposed indicators and may add or change the priorities based on system changes or direction from child serving agencies or the IGT.

See Key Quality Performance Management Indicators Tables #'s 1 - 3 for more detail

Key Quality Performance Management Indicators:

1) Process Indicators

The QMIA Plan identifies the indicators that will be monitored to assess quality factors related to planned changes in children's mental health services processes, including services and support, the Access Model, and the Principles of Care and Practice Model. Process indicators measure interactions between children, youth and families and providers. This includes diagnosis, treatment, and the quality of care delivered. The planned quality performance measures and indicators will assess if processes are improving, how processes are getting better, and what processes need continued efforts to improve the quality of care. At the client, provider and program level this information will be used to inform training and supervision efforts. At the regional and statewide level this information will be used to identify areas for training and PIP. Reports on process indicators will be shared with QA committees such as the Clinical Quality Committee and Provider Partnership Committee.

The processes that parties to the Agreement plan to monitor include:

- Referrals - The number of referrals and types of referral sources will be tracked and reported to identify any barriers to the referral process. Monitoring will include identification of referral source types (such as schools or primary care) with high or low volume, or a high or low volume of referrals that meet criteria for class membership.

- Screening - The number and characteristics of children and youth who were screened will be monitored and compared to the number estimated as needing services to assess the effectiveness of the screening allow the state to assess the possibility that there may a systematic screening out of youth who would have benefitted from services. Characteristics will include socio- demographics such as age, race/ethnicity, and presenting issues. Monitoring will also assess the penetration and/or effectiveness of communication materials.

- Assessment - The number and characteristics of children and youth who received an assessment and are found eligible for services will be monitored and compared to the number estimated as needing services. Assessment results (recommendations for outpatient CFT services, ICC, residential placements, other out of home placements as an example) will be tracked and reported. Characteristics may include CANS scores, BH diagnoses, psychiatric medications.

- Care Planning – The match of identified needs and strengths with planned interventions will be assessed as well as involvement of cross-system membership and participation in care planning.

- Service delivery - The number and types of services delivered to Class Members, and variations in service delivery are monitored. Other aspects of care that will be monitored are changes in CANS scores, BH diagnoses, psychiatric medications, scope, duration and intensity of services delivered, and cross system involvement.

- Provider Performance –Providers are certified in CANS, and are able demonstrate to mastery in providing CFT and WRAP, utilization of CANS outcome scores at the client and provider level, fidelity measures for EBPs, audit and compliance reviews. Services are individualized, strength based culturally sensitive, needs driven and trauma informed. Supervisors are trained to effectively support and coach staff. Training is evaluated and improved based on participant feedback.

Table #1: Process Indicators:

Information about the successes and issues related to interactions between children, youth and families and providers, this includes diagnosis, treatment, and the quality of care delivered and use the information to make changes to service delivery.		
Proposed Initial Key Quality Performance Management Questions		**Proposed Measures/Indicators Initial Set of Indicators are underlined**
1A	Are children and families being referred, screened, assessed and identified as eligible for services in accordance with their need?	Number estimated to need services Number referred, screened, assessed and determined eligible Types of referrals Age, race/ethnicity, Dx, presenting issues CANS scores
1B	Are mental health services being delivered in accordance with care plans?	Number receiving services by scope, intensity, duration, Quality Review - Sample record review
	Additional Key Quality Performance Management Questions	**Proposed Measures/Indicators** TBD Indicators
1C	Do care plans match identified needs?	Quality Review on Care Planning
1D	Is provider performance assessed and monitored?	Impact of Wrap Training WRAP fidelity Quality Review on Provider Performance
1E	Are providers using the CANS to improve their own performance?	Quality Review on Provider Performance

Key Quality Performance Management Indicators:

2) Child, Youth and Family Outcomes Indicators

The QMIA will assess quality factors related to client and family outcomes. Outcomes denote the effects of care on the mental health and quality of life of clients and families. The planned measures and indicators will assess if clients and families are engaged in care, getting better as a result of care, how they are getting are getting better, and what issues need continued efforts to improve the quality of care so that they will get better. Reports on outcomes indicators will be shared with QA committees such as the System Improvement Committee, Child, Youth and Family Partnership Committee.

Child, youth and family outcomes that will be monitored include engagement, appropriateness, effectiveness, satisfaction, complaints, grievances and appeals.

Engagement – Number of children and youth who do receive treatment after the assessment, satisfaction with services and involvement in treatment planning, as well as retention in services. Additionally the number who screen as needing an assessment but do not receive a full CANS in comparison to those who do. Monitoring will assess if children, youth and families are engaged in screening, assessment, and if services are useful, and collaborative.

Service Appropriateness – Monitor the outcomes of those screened and those not screened, and those receive services compared to those who don't. Number of children who receive psychotropic meds who also receive therapy services. Monitoring to assess if treatment plans and placement decisions are made based on CANS scores and if care provided is consistent with child, youth and family goals and needs.

Service Effectiveness- Assess the effectiveness at the client, provider, program, regional and statewide level of the mental health services in improving the quality of life for children, youth and families. Monitoring will provide information at all levels to ensure continuous identification and promotion of effective practices

- Changes in CANS scores to gauge change over time
- Transitions in care
- Movement to more restrictive levels of care
- Cross system involvement

Child, Youth and Family Perception of Care– Child, youth, and family ratings on standardized satisfaction instruments to assess child, youth and family perception of care.

Complaints, Grievances and Appeals - Number, type and disposition of all complaints and grievances will be tracked and reports. Notices of Action will be assessed for variations between client and providers perception of services appropriateness.

Table #2: Child, Youth and Family Outcomes Indicators

Information about child, youth and family outcomes regarding the effects of care on the mental health and quality of life of clients and families to make qualitative change in the delivery of care.		
Proposed Initial Key Quality Performance Management Questions		**Proposed Measures/Indicators Initial Set of Indicators are underlined**
2A	How is the children's mental health system experienced by clients and families?	CANS indicators Wrap indicators Quality Review of: Youth and family ratings of engagement Perception of care
2B	How are families' complaints and appeals reflected in quality improvement efforts?	Number, basis and outcomes of complaints and appeals
2C	How are children and families showing improvement in functioning?	CANS scores Other possible indicators: Kids are staying in their homes Placements are shorter in durations Days attending school, special ed placement Days suspended Contacts with Law Enforcement Changes in caregiver strain
	Additional Key Quality Performance Management Questions	**Proposed Measures/Indicators** TBD Indicators
2D	Are children provided services in the least restrictive environment appropriate for their care?	Transitions in levels of care Hospitals, readmission, ER, Residential IDJC involvement (including number and type of offenses, recidivism)
2E	Are planned Wraparound outcomes being achieved?	CANS Wraparound Graduation rates

Key Quality Performance Management Indicators:

3) System Impact Indicators

The QMIA will assess quality factors related to the impact on the child serving systems. The focus of System Impact is on the context in which care is delivered. The planned measures and indicators will assess the development of core system and cross system management and competencies and evaluate system and infrastructure strengths and needs. Information gathered will assist in identifying and prioritizing actions necessary to improve the system. Reports on system impact indicators will be shared with QA committees such as the Implementation Plan Monitoring Committee.

Availability of resources, training, expenditures, development of core system and cross system administration and management competencies

- Access and availability of resources – The number, type, geographic distribution, capacity, and timeliness of service delivery and unmet needs caused by service gaps will be monitored and reported by region.

  Examples of targeted areas for review may include:
  - assessment of capacity to meet the needs and changes over time,
  - timeliness measured by number of days from referral to screening, and screening to completion of CANS,
  - linkage to services,
  - patterns of unmet need,
  - number and types of trainings offered and number of providers trained.

- Systemic changes - Changes to rules, standards and contracts, addressing barriers to care.

- Expenditures – Expenditures are tracked by agency, region, and key demographics to identify successes and barriers

- Cross system administration and management competencies - Evidence of cross system communication and collaboration at the beginning of treatment, during treatment and at transition. Children, youth and families experiences with linkages and transition planning. Administration of the Children's System of Care (SOC) Self-Assessment, repeated a various intervals during implementation.

Table #3: System Impact Indicators

Information about the system impact regarding the context in which care is delivered to make changes in the system of care.		
Proposed Initial Key Quality Performance Management		**Proposed Measures/Indicators Initial Set of Indicators are underlined**
3A	How do services available in urban, rural and underserved areas across Idaho to meet the needs of children and families, including training for providers?	Access to Services by age, race/ethnicity, Dx, presenting issues Service delivery by funding sources, program and provider Availability of services Geographic utilization Timeliness Service Array Providers Trained
3B	How have core system and cross system management and competencies been enhanced?	Children's System of Care Assessment
3C	Do child serving agencies analyze expenditures by regions, key demographics, and services and supports and how do they utilize the information to make system improvements?	Expenditures by agency, region, key demographic characteristics
	Additional Key Quality Performance Management Questions	**Proposed Measures/Indicators** TBD Indicators
3D	How has youth and family involvement at the system / policy level been enhanced?	Organizations, Workgroups, advisory bodies, training
3E	In what way are systems working together to reduce barriers to care?	QA Committees Performance Improvement Projects (PIPs) Management Action Plans (MAPs) Complaints, appeals, commitments, use of higher levels of care related to lack of coordination across systems

Quality Review (QR) Process

The QMIA Plan will utilize a Quality Review (QR) process to objectively assess and improve clinical practice and program effectiveness system wide. The elements of the QR process may include, but are not limited to, a representational sampling of cases, evaluation of the case sampling by a team of reviewers that will include at least one independent, neutral monitor, and interviews with Class Members and their families who agree to participate in the process, CFT members, and others associated with the Class Members who might have relevant information about the Class Members' experience of care.

The proposed plan will likely include consultation with subject matter experts, use of an external review entity, use of standardized survey tools, and the development of a protocol for reviewing records. The QMIA Workgroup also suggested the use of a QR model that is based on the healthcare "Grand Rounds" methodology. Other approaches that may be considered are team observation and use of tools developed by other states or recognized subject matter experts.

The expected results from the QR may include:

- Detailed stories of practice, results, and themes
- Deeper understanding of factors that effect practice
- Emerging problems, issues, and system barriers.

The plan for QR will be developed jointly with plaintiffs in the first 6 months to 1 year after the completion of the Implementation Plan. There is a QA subcommittee that is designated to develop a proposal for the QR process, the QMIA, Data and Reports Committee. Results of the QR process will be reviewed by the Clinical Quality Committee and the QMIA Council, as well as other QA Committees

Monitoring Progress of the Implementation

The QMIA Plan is required to include the methods that will be utilized to measure and track progress toward completing Implementation Plan, meeting the commitments, and achieving the outcomes in the Settlement Agreement.

The following high level crosswalk demonstrates the section of the QMIA Plan that addresses each of the required outcomes from the Settlement Agreement:

Outcome	QMIA Plan
71 a-e Services Outcomes	Process and Client and Family Outcomes
72 a-b Principles of Care and Practice Model	Process and Client and Family Outcomes
73 a-I Access Model	Process and Client and Family Outcomes
74 a-e Workforce Training & Development Outcomes	System Impact
75 a-g Due Process Outcomes	System Impact
76 a-c Governance & Integrity	System Impact
77 a-g QMIA	System Impact
78 a-c Implementation Plan	System Impact

There is a designated QA Subcommittee, the Implementation Plan Monitoring Subcommittee (IPMS), that will responsible for monitoring and reporting on the progress of implementation. The subcommittee will further develop the crosswalk with details to indicate each outcome and identify each key management indicator. The IPMS will have the responsibility also for addressing commitments, exit criteria, and sustainability.

Planned Reports:

All of the child serving agencies involved in the Jeff D agreement will publish and distribute quality monitoring reports. Reports will support decision making and identify effective performance and performance needing improvement. System level reports will be developed based on the various quality committees and on expert consultation as needed.

The QMIA monitoring reports will be developed or modified as needed to meet the needs of the QA committee or stakeholder group. Stakeholders will include, but are not limited to:

Youth and Families
Providers and Community stakeholders
Boards
Administration
Legislation

To the extent possible reports will be posted on-line. Some reports will be high-level; one page style while others will be an in-depth analysis of specific targeted topics. All reports will be vetted to ensure that they contain no identifiable personal health information.

Initially the following reports will be prioritized:

- An annual update of the range of expected class members
- Compliance with the complaint and due process systems
- Data re notices of action, complaints, fair hearing requests, and the outcomes

A full set of initial reports will be identified in year 1 of QMIA.QA committees will be involved in developing the initial reports and for identifying additional reports. As new reports are developed they will be added to the QMIA Reports list and will be included in reports to the court.

QMIA Proposed timeline:

Year 1	
Implement the QMIA, Data, and Reports Subcommittee	**April or May**
Work on norming definitions and terms, and clarifying measures and indicators	**May- Dec**
Define baseline of current QA state for children's mental health services- for all parties	**May – Sept**
Implement the QA Subcommittee (IPMS) to monitor implementation progress	**May**
Establish QMIA Council	**July or August**
Administer Self-Assessment for Children's System of Care survey	**Sept**
Plan for development of QA processes to address required QMIA	**Sept – Feb**
Implementation of priority methodology for data collection for QMIA	**April- Oct**
Prepare and deliver quarterly QMIA reports	**1st Q FY 2016-2017 Nov delivery**
Implement other targeted QA subcommittees	**As needed**
Years 2-4	
Initiate additional QA committees and advisory groups	
Continue implementation of methodology for data collection for QMIA	
Monitor the Implementation Plan progress	
Re-administer Self-Assessment for Children's System of Care	
Prepare and deliver quarterly and annual QMIA reports	
Years 5-7	
Re-administer Self-Assessment for Children's System of Care	
Evaluate the fidelity of treatment interventions	
Monitor the Implementation Plan progress	
Prepare and deliver quarterly and annual QMIA reports	
Year 8	
Prepare and deliver quarterly and annual QMIA reports	

Glossary- includes acronyms

Agencies	Child serving agencies including DBH, FACS, Medicaid, IDJC, and Dept. of Ed.
agency	Legal entity providing direct services
Agreement	Jeff D. Settlement Agreement
BH	Behavioral Health
CANS	Child and Adolescent Needs and Strengths
CFT	Child Family Teams
DBH	Division of Behavioral Health
DHW	Department of Health and Welfare
Duration	Length of stay in services
Dx	Diagnosis
EBP	Evidence Based Practice
FACS	Family and Community Services
ICC	Intensive Care Coordination
IDJC	Idaho Department of Juvenile Corrections
IGT	Interagency Governance Team
Intensity	Amount of care delivered
IWG	Interagency Workgroup
MAC	Management Action Plan
QA	Quality Assurance
QI	Quality Improvement
QMIA	Quality Management Improvement Accountability
QR	Quality Review
Parties	Parties in the Jeff d. Settlement Agreement- see agencies
PIP	Performance Improvement Project
Program	Type of service, such as ICC
Provider	Individual clinical provider
Region	DBH regional
Scope	Level of care such as inpatient, residential, outpatient
System	Statewide children's programs and services
System of Care (SOC)	Standard definition of child serving systems working together to form a system of care
TCOM	Transformational Collaborative Outcomes Management (TCOM)
WRAP	Wraparound

Attachment #1

QMIA Requirements- Page 15 of Agreement

G. Quality Management, Improvement and Accountability

53. Defendants shall develop and implement a Quality Management, Improvement and Accountability (QMIA) plan for monitoring and reporting on Class-Member outcomes, system performance, and progress on implementation of this Agreement, as well as for ensuring continuous quality improvement at the clinical, program and system levels. The QMIA plan shall include goals, objectives, tools, resources, and feedback mechanisms needed to:
    a. Measure, assess and report on progress on meeting this Agreement's Commitments, achieving the Outcomes, sustaining performance, and satisfying the Exit Criteria; and
    b. Build on existing quality assurance and improvement processes to achieve a collaborative QMIA system for mental health programs and services across Defendants' child-serving systems.

54. The QMIA System shall develop system-wide capabilities to:
    a. Consistently, routinely, and accurately monitor progress implementing this Agreement, and document the achievements or satisfaction of Commitments, Outcomes, sustained performance requirements and Exit Criteria;
    b. Determine and measurably improve core-system and cross-system program administration and management competencies necessary for successful implementation of the Agreement;
    c. Monitor, measure, and evaluate multi-level (e.g., clinical, provider, program, system) information on access, performance, outcomes, service quality, and cross-system collaboration;
    d. Regularly communicate the information developed in subsections a-c with managers, decision-makers, supervisors, clinicians, young people and families, the public, and the parties**;**
    e. Improve clinical and program quality by (i) providing feedback of clinical and program experience and data to clinicians, supervisors, and managers; (ii) identifying effective treatment practices and teaching those practices to clinicians, supervisors, and managers;
    f. Make CANS data available in real time; and
    g. Set goals for improving system accessibility, performance, outcomes, service quality, and cross-system collaboration over time in order to comply with the Agreement's Commitments and sustained performance requirements, and achieve the intended Outcomes and Exit Criteria.

55. Defendants shall complete development of and begin to implement the QMIA plan within nine (9) months after the District Court gives final approval of the Agreement. Defendants agree to implement the QMIA plan consistent with its terms.

56. In order to accurately measure and report on progress implementing the Agreement, Defendants shall routinely measure, analyze, and publicly report (not less than quarterly or as determined in the QMIA planning process) on regional and statewide QMIA indicators and data that include, but are not limited to:
    a. The number and characteristics of potential Class Members estimated, screened, assessed, and determined eligible for services and supports under this Agreement;
    b. The number and characteristics of Class Members that receive any mental health services and supports;

c. The quality, scope, intensity, duration, type, funding source, and program provider of services and supports provided pursuant to this Agreement to Class Members;
d. Service quality, satisfaction, and outcomes for Class Members and their families;
e. Expenditures on each service and support segregated by agency that provides them, by region, and by key demographic data utilizing a reporting format and content uniform across systems; and
f. Number, basis, and outcomes of complaints and appeals;

57. The Parties will jointly develop, and Defendants will initiate on a jointly agreed date, a Quality Review (QR) process to be used to objectively assess and improve clinical practice and program effectiveness system wide. The QR process is an effective tool for identifying program strengths and needs and providing critical information on how to improve practice. The components of the QR process shall include, but are not limited to:
    a. Quality and outcome measures at the clinical and program levels;
    b. A representational sampling of cases, as agreed to by the Parties;
    c. Evaluation of the case sampling by a team of reviewers that will include at least one independent, neutral monitor. The evaluation includes:
        i. Interviews with Class Members and their families that agree to participate in the process, CFT members, and others associated with the Class Members who might have relevant information about the Class Members' experience of care; and
        ii. File reviews.
    d. A QR instrument and rating system to be used by the reviewing team when evaluating the case sampling; and
    e. Use of QR results to help identify best practices and support quality improvement in clinical practice and program performance.

58. Defendants shall conduct QRs on a periodic basis, as agreed upon by the Parties, but not less than annually, beginning after the start of the implementation period on the date specified in paragraph 57 and throughout the sustained performance period.

59. Defendants shall publicly report the QR results on an annual basis. As part of the annual reports, Defendants will identify "lessons learned" from the QRs with recommendations regarding steps to be taken, if any, to improve clinical and program quality.