



# Arizona Department of Health Services Children's Rehabilitative Services

## Annual Quality Management Plan

Contract Year Ending (CYE) 2008  
(July 1<sup>st</sup>, 2007 – June 30<sup>th</sup>, 2008)



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# Arizona Department of Health Services Children's Rehabilitative Services

## Quality Management Plan

**CYE 2008**

**(July 1<sup>st</sup>, 2007 – June 30<sup>th</sup>, 2008)**

### **I. Introduction**

Children's Rehabilitative Services (CRS) started as Crippled Children's Services in 1929 as a private, charitable organization caring for poor children suffering from the effects of poliomyelitis and other conditions such as clubfeet. It began through the efforts of a nurse named Ruth Wendell who was concerned about the need for treatment of these children. Medical services were provided by the first orthopedic-surgeon in Phoenix, Dr. James Lytton-Smith, who volunteered his time.

As other specialists arrived in Arizona and offered their services, additional crippling conditions were included into the program. CRS currently offers a full range of services to Arizona children from birth to age 21, who met the financial and medical eligibility requirements to be enrolled in the program. CRS has four regional contractors, Yuma Medical Center, St. Joseph's Hospital, Flagstaff Medical Center, and the Tucson Children's Clinic. These four regional clinics offer a medical home to CRS enrolled members throughout the state of Arizona.

CRS is currently administered by the Arizona Department of Health Services (ADHS)/Office for Children with Special Health Care Needs (OCSHCN), Children's Rehabilitative Services (CRS). The functions include monitoring of service delivery, ensuring contractual compliance, quality improvement initiatives, education and support/consultation.

The OCSHCN operates under the authority of A.R.S. 36-132 for the Arizona Department of Health Services (ADHS), A.R.S. 36-261 for Children's Rehabilitative Services, Title V of the Social Security Act for Maternal and Child Health services and intergovernmental agreements with the Arizona Department of Education (ADE), Arizona Department of Economic Security (ADES) and the Arizona Health Care Cost Containment System (AHCCCS).

The OCSHCN has a fiduciary responsibility to monitor CRS Regional Contractor performance and quality standards of providers while maintaining a partnership/collaborative approach to improvement in service delivery. The OCSHCN/CRS Quality Management (QM) Section is composed of both professional and administrative support staff dedicated to enhancing service delivery for CRS members and their families.

## II. Program Goals & Objectives

The mission of Children's Rehabilitative Services (CRS) is to improve the quality of life for children by providing family-centered medical treatment, rehabilitation, and related support services to enrolled individuals who have certain medical, handicapping, or potentially handicapping conditions.

It is the objective of CRS that all children and youth with special health care needs have the opportunity to reach their full potential.

It is the objective of Children's Rehabilitative Services Administration (CRSA) to provide oversight and technical support to its contractors to meet all compliance and regulatory standards as delineated by AHCCCS, The Center for Medicare and Medicaid Services (CMS), and other regulatory and compliance bodies as are necessary.

In July 2002, administration at Arizona Department of Health Services (ADHS)/Office for Children with Special Health Care Needs (OCSHCN) published twelve Guiding Principles. These Principles continue to be core components in the development of the Quality Management Plan. These principles are:

### ***Principle 1: Informed Decision Making***

*When children and families are fully informed and understand the options available, better decisions can be made regarding individual treatment and services. When key stakeholders such as the children, families, public policy makers, community leaders, and program personnel are fully informed and empowered, decisions lead to more effective systems of care.*

### ***Principle 2: Easy Access to Care and Services***

*Promoting early diagnosis and timely, continuous, available care leads to optimal use of resources and more children and families receiving the most appropriate services.*

### ***Principle 3: Parent and Child Involvement***

*Meaningful involvement of children, youth and their families is promoted in all aspects of care and in the development, planning, implementation and evaluation of programs and policies of the system of care.*

**Principle 4: State of the Art Medical Care and Support Services**

*Through research, education, training, and evaluation, children and families are provided a choice of state-of-the-art medical and support services that can lead to the best outcomes and highest quality of life.*

**Principle 5: Accountability**

*A System of Care, which is accountable to the child and family as primary stakeholders, along with communities, providers of service and other stakeholders, leads to the highest quality of care through communication, monitoring and publishing of measurable outcomes, performance standards, and cost data..*

**Principle 6: Diversity**

*Service delivery which is respectful of the lifestyle, environment and strengths of the individual and family, their ethnic and cultural perspectives and their economic condition provides a system that is responsive to the individual needs as well as community abilities.*

**Principle 7: Partnership and Collaboration**

*Effective policy and service delivery systems are best developed through action, learning, relationship development and building on the strengths of the existing systems and communities. Partnerships and collaborations within the Department of Health Services and external to the Department will be defined in all our work with families, agencies, communities, providers and other systems of care.*

**Principle 8: Family Centered System of Care**

*Children, youth and their families are better able to meet their needs when they are supported within a system of care built on parent and professional partnerships, cultural competency, and community based approaches.*

**Principle 9: Marketing and Information Sharing**

*Providing leadership in raising the awareness of children, families, community members, providers, public policy decision makers and the general public about the needs and strengths of children with special health care needs and the system of care results in better outcomes and responsive systems of care and communities.*

**Principle 10: Comprehensive Approach to Service Delivery**

*Children and families have the ability to reach their full potential when they have access to a comprehensive array of service and supports designed to meet the individual special needs of the child and their family in the context of their community and their natural environment.*

**Principle 11: Enhanced System of Care**

*The coordination and integration of OCSHCN services and supports with other service delivery systems will result in the most effective, comprehensive system of care for children and families. Partnership driven OCSHCN initiatives leading to system-wide improvements in care delivery have the greatest potential for improving outcomes for children and their families.*

**Principle 12: Cost Effective**

*Delivery of care services will be based on providing the most quality, cost effective and efficient services that provide the greatest benefit for the largest number of children and families.*

Activities outlined in this Plan involve implementation of action plans and strategic initiatives designed to improve quality. This Plan includes efforts undertaken by ADHS as well as Contractors to comply with Federal, State and AHCCCS requirements.

The following sections more specifically describe the structure and process of the Division's Quality Management (QM) Program.

**III. Scope of Program**

CRSA' QM Plan encompasses activities of CRSA, along with those of its Contractors that are designed to improve the quality of services delivered through Arizona's activities for children with special health needs. This Plan incorporates ongoing performance improvement activities and identifies new initiatives through data analysis and evaluation, national best practices, and feedback from stakeholders. The Plan describes both internal (Division) and external (Contractor) monitoring and evaluation activities.

The QM Plan will be evaluated at least on an annual basis. During this evaluation process a summary of all QM and Performance Improvement activities will be described. This description

will include a title, goal and/or objective(s), responsible person(s), analysis and description of the data, statement of performance outcome, and actions for improvement.

The QM plan will include information based upon trends identified through QM/PI activities and resulting actions taken for improvement.

A rationale will be given for all changes to the QM program and plan. All modifications to the QM program and plan will be approved by the Quality Management Committee prior to their implementation. Targeted completion dates will be included to ensure full implementation of revisions made to the QM plan.

#### **IV. Structural Framework & Communication**

##### ***The CRSA Division of Quality Management***

CRSA has established a quality management team of experienced professionals to conduct the activities of an efficient and effective quality management program. The structure of the quality management team allows for each professional to assist with oversight of the quality of the program.

The CRSA quality management team is building processes and systems to ensure improved quality outcomes, efficiency, and safety for CRS members.

The CRSA QM staff communicates and collaborates with other functional areas to improve and ensure high quality of care, including but not limited to, Utilization and Medical Management, Clinical Programs, Consumer Rights and Member Services, and Compliance. Communication and collaboration is achieved through sharing of data, internal forms, and cross participation within committee structures.

##### ***CRSA Medical Director***

An Arizona licensed physician with medical knowledge in caring for children with special health care needs as well as experience with operational aspects of managed care. This position reports to the OCSHCN Office Chief and is responsible for:

- Collaborating with the OCSHCN Office Chief, CRS Regional Contractor Medical Directors, physician providers and other professionals in development and review of procedures, guidelines of care, protocols and other regulatory policies that affect the medical services being provided to CRS members;
- Functioning as a Medical Director representative at AHCCCSA meetings;
- Providing consultation to CRS Regional Medical Directors and other physicians within Arizona regarding care of children with special health care needs;

- Providing review and consultation to CRSA QM staff to ensure appropriate medical implications have been considered;
- Implementation of the Quality Management Plan and substantial involvement in assessment and improvement of quality management and performance improvement activities;
- Guides and ensure high standards and best practices are being met through the quality management/performance improvement program; and
- Chairing of the QM and UM Committees. If unavailable, the CRSA Medical Director will designate an ADHS Medical Director to act as a temporary chairperson.

### ***CRSA Division Chief of Quality Management***

An Arizona licensed Registered Nurse with experience in quality management and knowledge of children with special health care needs. The CRSA Division Chief for Quality Management is responsible for:

- Overseeing CRS Regional Contractor compliance with Federal/State regulations/statutes and CRS contractual agreements;
- Providing administrative, clinical input, and support to CRS Regional Contractors;
- Development, review and maintenance of CRS QM policies and procedures;
- Identifying issues/concerns/compliance problems and formulating corrective action plans for problem resolution;
- Ensure that care concerns are addressed in accordance with Federal/State regulations/statutes and CRS contractual agreements from both an individual and program standpoint;
- Working with OCSHCN Office Chief in developing RFP requirements, contracts, and collaborative agreements;
- Collaboration with the CRSA Medical Director for the oversight of development of CRSA Quality Management /Performance Improvement Plans/Workplans/Evaluations;
- Collaboration with the CRSA Medical Director in the implementation, assessment and evaluation of the CRSA QM/PI Plan;
- Collaboration with other section managers within the OCSHCN on CRS activities;
- Overseeing the creation, review and evaluation of quality improvement projects; and
- Leading annual on-site reviews of CRS Regional Contractors compliance with contractual requirements.

### ***CRSA Quality Management Coordinator(s)***

CRSA Quality Management Coordinator must have graduated from an accredited nursing program and be currently licensed as an RN in Arizona, or have a Bachelors Degree in a health

related field. The managers must have experience in quality management. CRSA Quality Management Coordinators are responsible for:

- Providing clinical and operational consultative support to CRS Regional Contractors;
- Identifying quality of care issues/concerns that require further investigation;
- Researching and resolving care concerns in accordance with Federal/State regulations/statutes and CRS contractual agreements from both an individual and program standpoint;
- Assisting in the design of CRSA Quality Management Plan;
- Providing direct oversight to CRS Regional Contractors to ensure their compliance with Federal/State regulations/statutes and CRS contractual agreements;
- Functioning as leads for projects assigned by Division Chief for Quality Management;
- Performing on-site reviews of CRS Regional Contractors to assess provision of covered services and compliance with State/Federal and CRS contractual requirements.

### ***CRSA Quality Management Project Specialist II***

CRSA Quality Management Project Specialist II is an individual with skills in project management, systems development, and organization. CRSA Quality Management Project Specialist II is responsible for:

- Functioning as lead for projects assigned by the Division Chief for Quality Management, including quality management/performance improvement database development
- Ensuring that the Division Chief for Quality Management is aware of concerns/issues with assigned projects.
- Providing support to other CRSA quality management staff.

### ***CRSA Quality Management Project Specialist I***

CRSA Quality Management Project Specialist I is an individual with excellent organization and communication skills. They are responsible for:

- Coordinates retrieval of records, scheduling of events and time management.
- Development of a system maintaining records, meeting minutes, plans, and important documents.
- Taking, revising and editing minutes, memos, and reports.
- Anticipating and problem solving conflicts in meeting schedules for the Medical Director and the Division Chief for Quality Management.
- Providing support to other CRSA Quality Assurance staff.

### ***Performance Improvement Manager***

The Performance Improvement Manager ensures the development, implementation, organization, analysis, and reporting of performance improvement projects. Additional responsibilities include: the retrieval, evaluation, analysis, and presentation of the various data elements in support of quality improvement.

### ***Data Analyst***

The Data Analyst supports the Performance Improvement Manager through ensuring appropriate, valid, and reliable data is used for analysis. They may also assist in the development of data presentation and building of data analysis tools to improve the quality management system.

### ***Parents of Children with Special Health Care Needs enrolled in the CRS Program***

ADHS/OCSHCN/CRS provides services to members based on a Medical Home Model that has a family centered focus. As part of this building of partnerships between families and professionals, the families are encouraged to be active participants in the CRS Program. Participation can be through any of the following:

- Participating in their child's care coordination conferences;
- Participating in the State Parent Action Council (SPAC) and Regional Parent Action Council (PAC);
- Responding to surveys regarding care and services;
- Participating as representative to CRS Administrator meetings;
- Participating as representative to CRS Medical Director meetings;
- Participating as team members on special projects; and
- Participating in the CRSA Quality Management Committee

## ***CRSA Committees /Team Descriptions***

CRSA QM activities and communications are conducted through various mechanisms. Committees are utilized for internal and external communication, involving stakeholders, consumers and families in decision-making and guiding performance improvement. The following information identifies the committee structure of CRSA in relation to QM function.

### ***CRSA Executive Committee***

The CRSA Executive Management Team is the decision making body for the administration of the CRS Program. It retains the primary responsibility of oversight and administration of the

program. It oversees the operations of the Program, reviews Arizona Health Care Cost Containment System (AHCCCS) deliverables and requirements, and ensures contract compliance.

Membership

- OCSHCN Office Chief (Chairperson)
- CRSA Medical Director
- CRSA Division Chief of Quality Management
- CRSA Division Chief of Utilization & Medical Management
- CRSA Division Chief of Clinical Programs
- CRSA Division Chief of Compliance
- CRSA Division Chief of Consumer Rights
- CRSA Finance Officer
- Cultural Competency Officer
- OCSHCN Office Manager-minutes
- Selected staff as appropriate

Meeting Frequency: A minimum of nine times a year

***CRSA Quality Management Committee***

The QMC operates under the direction of the CRSA Executive Management Team. The CRSA Medical Director is the chairperson of the CRSA Quality Management Committee; if unavailable, the CRSA Medical Director will designate an ADHS Medical Director to act as a temporary chairperson. The Chairperson of the CRSA QMC is responsible for the implementation of the Quality Management Plan and substantial involvement in assessment and improvement of quality management and performance improvement activities. The Quality Management Committee operates under the protections granted it through Arizona Revised Statute and federal protections respectively, ARS 36-441, ARS 36-445, ARS 36-2401 through 2404, ARS 36-2917, and 42 CFR 434.34. Each participant of the committee signs a confidentiality agreement prior to participation within the committee. The role of this Committee is to:

- Review the quality management and performance improvement (QM/PI) program objectives, policies and procedures at least annually and modify or update them as necessary;
- Develop procedures for QM/PI responsibilities and clearly document the processes for each QM/PI function/activity;
- Develop and implement procedures to ensure that CRSA staff, CRS Regional Contractors and providers are informed of the most current quality management and performance improvement requirements, policies and procedures;
- Develop and implement procedures to ensure that CRS Regional Contractors are informed of information related to their performance (i.e., results of studies, performance measures, profiling data, etc.)
- Serve as the focal point for review and dissemination of CRS quality assurance policies, procedures, reports and information;

- Ensure completion of recommendations for improvement, up to and including corrective action, based upon data analysis, trends and stakeholder input.
- Ensure achievement of minimum performance measures.
- Ensure the quality and safety of the clinical service delivery system.
- Evaluate, approve, and monitor a performance improvement project on at least an annual basis.

The annual QM Plan & Evaluation as well as recommendations for performance improvement activities from other committees are reviewed and approved by this Committee prior to presentation to the CRSA Executive Management Team.

The QMC enters executive session to conduct confidential investigative reviews of significant quality of care concerns. Parents, CRS members, and those without direct interest or with conflicts of interest will be excused from attendance. The cases discussed in the meetings are generated through, but not limited to, grievances, contacts by outside agencies, audit activity, and review of medical records. Cases include those of immediate jeopardy to the member; abuse and neglect; inadequate or inappropriate care of a CRS covered condition; denial of services that are deemed medically necessary by a CRS member/provider; unexpected deaths; potential provider misconduct; or the potential for adverse media coverage or a lawsuit.

In addition to providing immediate action relative to a member's care, system issues are identified and corrective action is requested of the CRS Regional Contractors by the QMC as found necessary. Cases may be referred to the CRSA Peer Review Committee. Aggregate data is used to identify trends.

### Membership

CRSA Medical Director (Chairperson)  
CRSA Division Chief of Quality Management  
CRSA Division Chief of Utilization & Medical Management  
CRSA Division Chief of Compliance  
CRSA Division Chief of Consumer Rights  
CRSA Quality Coordinators  
PAC (Parent Action Council) Parent Nominated Member

Meeting Frequency: Monthly

### ***CRSA Peer Review Subcommittee***

This Committee is responsible for conducting peer reviews of credentialed providers. Peer review involves the review of particular quality of care concern which is evaluated to the standard of care and facts of law by a select peer group.

The Peer Review Committee will produce a Recommendation Report to be reviewed by the Executive Team for further action. This Committee is a subcommittee of the QMC and operates under the protections granted it through Arizona Revised Statute and federal protections respectively, ARS 36-441, ARS 36-445, ARS 36-2401 through 2404, ARS 36-2917, and 42 CFR 434.34.

### Membership

CRSA Medical Director (Chairperson)  
CRSA Division Chief for Quality Management  
At least one CRS Regional Contractor Medical Director  
Selected specialty physicians as appropriate

Meeting Frequency: Quarterly (minimally)

### ***CRSA Performance Improvement Project (PIP) Subcommittee***

This Subcommittee is responsible for the study design, methodology, data collection, analysis, and report format of all Program Improvement Projects under the direction of the QMC.

### Membership

CRSA Medical Director (Chairperson)  
CRSA Division Chief for Quality Management  
Performance Improvement Manager  
At least one CRS Regional Contractor Medical Director  
At least one CRS community provider  
Selected specialty physicians as appropriate

Meeting Frequency: Bi-annually (minimally)

### ***Medical and Utilization Management Committee***

The MM/UM Committee operates under the direction of the CRSA Executive Management Team. The CRSA Medical Director is the chairperson and has substantial involvement in the assessment and improvement of MM/UM activities. Medical Director or his/her designee runs MM/UM meeting in his/her absence.

The MM/UM Committee reviews and evaluates MM/UM Program objectives, policies and procedures annually, supplying modifications and updates as necessary. The Committee assures that the CRS Regional Contractors are notified of MM/UM policies and procedures, and when

any subsequent modifications to them occur. The Committee ensures that modifications are submitted to AHCCCS prior to implementation.

The MM/UM Committee is responsible for monitoring progress on utilization management activities and required actions. Issues related to reporting (to CRSA from regional contractors, and from CRSA to AHCCCS), delegated services, over and under utilization, provider/contractor variance in high risk/high cost services, pharmacy, DME and readmission within 30 days are presented and discussed in this committee for feedback and recommendations.

Recommendations from this committee are forwarded to CRSA Executive (Governing Body) committee for further recommendations and/or approval.

The MM/UM Committee develops and implements procedures to ensure that providers are informed of their performance. For example, sites receive a formal written site-visit report from the MM/UM Division after each site visit. The provider network gap analysis is shared with regional contractors' Administrators and Medical Directors in the quarterly Provider Network Taskforce Meeting. Corrective actions are implemented as required to reinforce compliance with the contract and with standards.

This committee also provides a platform to discuss issues regarding denials, appeals, and issues related to compliance. The annual MM/UM Plan and the annual MM/UM Evaluation; as well as recommendations for MM/UM activities are reviewed and approved by this Committee prior to presentation to the CRSA Executive Management Team.

Membership:

CRSA Medical Director (chairperson)  
Division Chief, Medical Management/Utilization Management  
CRSA MM/UM nursing and data management staff  
Division Chief, Compliance  
CRSA Contract Monitoring Officers (2)  
Division Chief, Clinical Programs  
Division Chief, Quality Management  
Division Chief, Consumer Rights.  
CRSA Consumer Rights, Division Chief or designee

Meeting Frequency: Monthly

***Pharmacy & Therapeutics Subcommittee***

The main responsibility of this subcommittee is to have focused discussions on issues related to pharmacy and durable medical equipments (DME); or any major material change at a regional contractor's service site specific to pharmacy or DME. Recommendations from this subcommittee are forwarded to the MM/UM Committee for further recommendations and follow-up.

Membership:

CRSA Medical Director (Chairperson)  
Division Chief, Medical Management/Utilization Management  
DME Coordinator, MM/UM Division,  
Chief, Research and Statistical Analysis, MM/UM Division  
UM Specialist, MM/UM Division,  
Division Chief, Compliance  
Division Chief, Quality Management  
Division Chief Finance/designee

Meeting Frequency: Quarterly

***Provider Network Taskforce Subcommittee***

This subcommittee provides a forum for the CRSA Medical Director and the CRS Regional Medical Directors, to review and comment on network gaps, issues related to provider capacity and scheduling patterns, as well as current and new member referral issues, and concerns related to DME and pharmacy utilization. Recommendations from this subcommittee are forwarded to the MM/UM Committee for further recommendations and follow-up.

Membership

CRSA Medical Director (Chairperson)  
CRS Regional Contractor Medical Directors  
CRS Regional Contractor Administrators  
Division Chief, Medical and Utilization Management  
MM/UM Provider Network Coordinator  
Division Chief, Quality Management  
Division Chief, Compliance

Meeting Frequency: Quarterly

***CRS Data Subcommittee***

This committee was established on 10/19/06. Its main responsibility was to maintain a health information system that collects, integrates, analyzes the utilization data necessary to implement the MM/UM program, as specified by AHCCCS in Chapter 1000; as well as to review processes that support the infrastructure of the CRSA encounter system and recommend enhancements to the system.

Initial committee tasks were to identify existing documentation of data flow within the encounter system, understand the details of data submission from regional sites, develop data information

for encounter processing; as well as to identify the process for updating and modifying data, enhance documentation, or other aspects of the system.

The merger of BHS and CRSA finance and encounter system expanded the role of the MM/UM data subcommittee. The BHS Finance group became the data owner for CRSA encounter data in May 2007. BHS partners were included in the Subcommittee; both partners effectively worked together in reconciling priorities and work efforts, with a new focus of activity planned for our efforts going forward.

The name of committee was changed to OCSHCN/CRSA data subcommittee. In FY2008, the Subcommittee has been reorganized to better match the roles and functions of the merged groups. Subcommittee participants will represent the full range of CRSA Divisions as well as the ITS and BHS Office of Program Support to ensure that data issues are visible and have involvement of all necessary parties. In addition, there is an informal weekly meeting between the IT group and BHS/CRS staff to discuss progress and status of feature development. The MM/UM Research and Statistical Analysis Chief will attend those meetings on regular basis.

Membership:

- Chief, MM/UM Research and Statistical Analysis (Chair)
- Manager, Performance Improvement (Co-Chair)
- Manager, Office of Program Support
- Project Manager, Information Technology CRS/BHS Application Services
- Division Chief, Medical Management/Utilization Management
- Finance Representative
- Manager, Policy
- Division Chief, Quality Management
- Clinical Program Division Representative
- Division Chief, Compliance (ad hoc)
- Medical Director (ad hoc)

Meeting Frequency: Bimonthly, or as necessary

***Medical Directors' Meeting***

The CRS Medical Directors' meeting provides a forum via teleconference for the CRSA Medical Director and the CRS Regional Medical Directors, to review and comment on proposed policies and procedures, clinical guidelines, new medical technologies and drug uses and issues of quality of care. Performance improvement and utilization management issues are forwarded to the CRSA QMC or Utilization/Medical Management Committee if they require formal review and resolution.

Membership

CRSA Medical Director (Chairperson)  
CRS Regional Medical Directors

Meeting Frequency: Monthly

***CRS Medical Directors' and Administrators' Meeting***

The CRS Medical Directors' and Administrators' meeting provides a forum for CRSA, the CRS Regional Administrators, and member representatives to review and comment on proposed policies and procedures, issues having statewide impact, and to discuss other contractual, programmatic and operational issues. Performance improvement and utilization management issues are forwarded to the CRSA QM/PI Committee if they require formal review and resolution.

Membership

OCSHCN Office Chief (Chairperson)  
CRSA Medical Director  
CRS Regional Medical Directors  
CRS Regional Contractor Administrators  
CRSA Division Chief of Quality Management  
CRSA Division Chief of Utilization & Medical Management  
CRSA Division Chief of Clinical Programs  
CRSA Division Chief of Compliance  
CRSA Division Chief of Consumer Rights  
CRSA Finance Officer  
Cultural Competency Officer  
CRS Regional Parent/Guardian Representatives

Meeting Frequency: Quarterly

***State Parent/ Youth Action Council (PAC & YAC)***

These are active committees comprised of youth, parents of CRS members, and CRSA/CRS Regional Contractors' social workers. The Committee members provide input into the quality improvement program, policies, and documents such as the member handbook, and satisfaction surveys. Parent representatives from this committee attend the quarterly Medical Directors/ Administrators meeting to provide current information on their regional PAC and or YAC discussions. Each June 1st, a parent representative and an alternate from the statewide PAC (Parent Action Council) is nominated to participate on the CRSA Quality Management Committee (See tab: PAC Parent Nomination Process).

Membership

CRSA Social Worker  
CRS Regional Contractor Social Workers  
Parents of CRS Members / CRS Members and/or graduates

Meeting Frequency: Quarterly

### ***Cultural Competency Committee***

This advisory committee was established in February 2005 to strategize and discuss implementation of culturally effective initiatives related to training, the provision of family centered culturally competent care and translation/interpretation services. It meets monthly through video conferencing technology to focus on specific issues.

#### Membership

Flagstaff CRS Social Services  
CRS Parent Representative  
Administrative Assistant CRSA  
Tucson CRS Social Services  
Phoenix CRS Social Services  
Cultural Competence Officer  
Yuma CRS Social Services Representative(s)  
CRS Graduate  
Sickle Cell Program Manager  
Flagstaff CRS Parent Representative  
CRSA Executive Coordinator (Chairperson)  
CRSA Administrative Assistant  
Flagstaff CRS Parent Representative  
ADHS/OCSHCN Division Chief of Clinical Programs

Meeting Frequency: Monthly

Meeting Frequency: Quarterly

## **Quality Management Plan Activities**

### **I. Introduction**

This section describes activities and processes undertaken by CRSA quality program. These activities serve as the direction and focus of CRSA QM program. The CRSA Work plan activities include the title of the activity, objective/goals, responsible position(s), and interventions. Initiatives are evaluated on a quarterly basis with the results of the annual evaluation being used to inform activities for the upcoming year.

### **II. Monitoring and Evaluation Activities**

CRSA utilizes internal review of data provided by the contractor and external on-site reviews, to ensure reliability and validity of compliance to standards and quality within contractor services. External reviews are both on a planned, annual review, and unplanned, random or ad hoc, basis.

#### **Data Integrity**

Data integrity is a priority within the QM/PI program. Quality Management participates in conjunction with the utilization management and the financial departments through the CRSA/OCSHCN Data Committee to seek means to improve the validity and reliability of our data. Additionally, the quality management department utilizes the Annual Administrative Review and focused reviews to ensure the integrity of quality of care, grievance, and performance measures data.

#### **Audits**

##### ***Annual Administrative Review Audit***

Staff from all functional areas within CRSA completes an annual on-site review to assess Contractor compliance with contractual requirements and standards and perform data validation activities related to performance measures. CRSA establishes a minimum compliance/performance threshold for each standard and Contractors are required to develop performance improvement activities when their performance is rated below the established minimum threshold. Administrative review findings and corrective action plans for each Contractor are reviewed through the appropriate CRSA Committee to ensure performance improves and compliance is achieved. Ultimate oversight responsibility is with the CRSA Executive Committee.

### ***Focus Review (Quarterly and Ad Hoc) Audits***

During the contract year, CRSA will perform quarterly audits of the regional CRS contractors reviewing one contractor each quarter. The intent of the quarterly focused reviews will confirm the successful implementation of QOC corrective actions. In addition to the quarterly audits, ad hoc focus review audits will be conducted as necessary. Ad hoc audits are random on-site audits due to variance within a specific process, significant risk to CRS members, or data validation purposes. Staff from a functional area within CRSA will review a defined process or system to ensure compliance and or performance to acceptable standards. If the contractor's process, system, or performance is below acceptable standards CRSA will require corrective action. Corrective actions will be monitored through the CRSA Division of Compliance and the applicable functional area.

### ***Peer Review***

Peer Review is the evaluation of the necessity, quality or utilization of care/service provided by a health care professional/provider. Peer review is conducted by other health care professionals/providers from the same discipline or with similar or essentially equal qualifications who are not in direct economic competition with the health care professional under review. The process compares the health care professional/provider's performance with that of peers or with community standards of care/service. (See tab: QM 1.1 Peer Review Policy).

### ***Medical Record Review***

CRSA audits medical records as part of its review for peer review, quality of care concerns, and unexpected mortality. Additionally, medical record reviews are completed as a validation process for prior authorization, emergency, and retrospective reviews. If quality of care concerns are identified by the utilization review auditor these potential issues and records are input into the quality of care database and evaluated by the QM Coordinator. Quality of care concerns are then taken to the QMC for evaluation, monitoring, and intervention.

### **Performance Measures**

AHCCCS has established within the CRSA contract performance measures with minimum requirements and performance goals. Contractors are required to incorporate monitoring of performance measures into their provider monitoring process, and take actions, as necessary, to improve performance. CRSA reports performance within the CRSA QMC, the Medical & Administrative Committee, and the QM/UM Committees by regional contractor on rolling quarters and as an aggregate of overall CRS performance.

Performance Measure	How Measured	CYE 08 Minimum Standard	CYE 08 Performance Goal
<b>Annual Measures</b>			
Preliminary Determination of Medical Eligibility (14 Calendar Day Standard) Eligible	Contractor Data	75%	90%
Preliminary Determination of Medical Eligibility (14 Calendar Day Standard) Ineligible	Contractor Data	75%	90%
Preliminary Determination of Medical Eligibility (14 Calendar Day Standard) Incomplete	Contractor Data	75%	90%
Timeliness of Initial Evaluation (30 Calendar Day Standard)	Contractor Data	75%	90%
First Appointment with CRS Specialty Provider (45 Calendar Day Standard)	Contractor Data	75%	90%

**Corrective Action Plans**

Corrective action plans are requested by CRSA of its regional contractors when contractor compliance to contract, policy, or procedure does not meet the standard for performance. Corrective action plans consist of achievable, measurable, time limited, and outcome driven results. The regional contractor will specify within the plan a responsible party or parties who are accountable to follow through on the delineated corrective actions. CRSA approves and maintains oversight of the plans completion within its various functional areas. Ultimately the CRSA Executive Team is responsible for plan compliance and taking further corrective measures when necessary.

### **III. Performance Improvement Activities**

Through careful evaluation and analysis, such as the use of a Failure Modes Effect Analysis tool (FMEA), of quality concerns and or system issues, CRSA identifies areas in which to focus performance improvement efforts. These activities include performance improvement projects, consumer surveys, and consumer complaint and quality of care trending.

#### **Performance Improvement Projects (PIPs)**

CRSA has identified the need to implement several performance improvement projects to utilize structured methodology as established by AHCCCS and target specific areas for improvement. Minimally, CRS will initiate one PIP annually unless relieved of such requirement by the request and approval of AHCCCS. Project topics are determined through the use of data collection and analysis and include both clinical and non-clinical topics. Information and data evaluated within the quality management program (e.g. quality of care issues) will be utilized to determine potential future performance improvement projects (See tab: QM 1.2 PIP Policy). Projects are considered complete when a year of sustainable improvement has been demonstrated.

Contractors are required to participate in any and all activities, including interim monitoring, related to the completion of the PIPs. During CY 2008, CRSA will continue to implement interventions and monitor progress for the two PIPs discussed below:

#### ***Improving Pediatric-to-Adult Transition Services***

The purpose of the CRSA PIP entitled “Improving Pediatric-to-Adult Transition Services” is to improve transition services for youth enrolled in the CRS program, with the overall goal of improving successful transition to adulthood. This project was initiated in FY2004, and was designed to assess and increase the proportion of CRS members who have a transition plan initiated and documented by their 15<sup>th</sup> birthday. Providing transition planning allows young people to optimize their ability to assume adult roles and functioning. Beginning the transition process early in adolescence allows youth and their family time to plan and address the complex issues involved during transition. The project will measure whether transition planning is initiated and documented for youth enrolled in CRS, as is required by contractual agreement.

The baseline measurement period for this PIP was July 1, 2003 through June 30, 2004. A sample of continuously enrolled CRS members turning 15 during the time period was used, and medical records for sampled members were requested by CRSA. Data abstraction was then performed by CRSA staff. A total of 347 CRS members statewide were sampled for data collection. No members in the sample frame had a documented transition plan in the medical record. Further communication with sites revealed that transition planning was taking place, but was not documented in a standardized format and was not kept in the medical record. Therefore, interventions focused on general transition guidelines and issues, as well as documentation of transition planning. Sites were instructed to keep documentation of transition planning within the members’ medical records. Four training sessions were held, with the final session held in April 2006.

During CY 2007, re-measurement data was collected for CRS members turning 15 between July 1, 2006 and June 30, 2007. Data collection for the re-measurement year was completed in two phases. An interim sample for members who turned 15 during the first quarter of the re-measurement period was collected during the winter of 2007. The interim measure was conducted in an effort to determine if the interventions which had been implemented were having the desired effect on the outcome. Of the 82 charts audited for the interim re-measurement, 26 (32 percent) contained documentation of transition related discussions before the member turned 15 years old. While this was a vast improvement from the baseline measure, the results clearly demonstrated that CRS sites still needed to improve documentation of their transition services for members turning 15. In response to this need, CRSA held three more training sessions in late February and early March of 2007. The purpose of the training was to provide technical assistance for improving performance on this PIP. In response to this training, CRS sites made revisions to their transition services policies and procedures and the manner in which they document transition services in member's charts.

Phase two of data collection for the re-measurement year was completed in August, 2007. Preliminary analysis of the re-measurement data indicate that none of the CRS sites met the goal of initiating transition discussions with 80 percent of members by their 15th birthday. However, it appears that policies and procedures implemented during the spring of 2007 have had a positive effect on the desired outcome. A report with results for the re-measurement will be submitted to AHCCCS by October 1, 2007. Projects are considered complete when a year of sustainable improvement has been demonstrated. CRSA anticipates extending the Transition PIP for an additional contract year and expects to see improvements for this PIP as a result of the interventions implemented in the spring of 2007.

### ***Non-Utilization among CRS Members***

The purpose of CRSA PIP entitled “Non-Utilization Among CRS Members” is to identify opportunities to promote proper utilization of needed services and discharge members who should no longer be enrolled in CRS. This project was initiated in FY2007 and was designed to assess and decrease the proportion of continuously enrolled members who did not receive services for 12 consecutive months. Historically, this figure has ranged from 33% to 45% within the CRS system. Non-utilization is a concern to CRSA for two reasons; 1) members may not be receiving services which are needed, or 2) members may not need additional services and should be discharged from the program and removed from capitation payments.

Data for the baseline measurement was taken from claims data for dates of service between January 1, 2005 and December 31, 2005. Encounters were summed for all Title XIX/XXI members with at least 335 days of enrollment during this time period. Members with no encounters, or non-utilizers, were compared to members with one or more encounter, or utilizers, on several characteristics, using z-tests for statistical significance where appropriate. A total of 13,307 CRS members statewide met the criteria for inclusion, of which 3,933, or 29.6%, had no encounters. Gender and ethnicity were not major factors in non-utilization; however, rates did vary by CRS site, age, and enrollment diagnosis. The lowest rate of non-utilization by site

(23.6%) was seen among Yuma CRS members, while the highest rates were seen among members with the Flagstaff and Tucson sites (33.4% and 32.5%, respectively). Non-utilization rates were found to increase with members' age, with the highest proportions seen among members between 18 and 21. Diagnostic categories with the highest proportions of non-utilization included musculoskeletal, circulatory, sensory and genitourinary conditions.

To obtain a more in-depth understanding of non-utilization patterns, CRSA conducted a medical records review on a sample of members identified as non-utilizers. The sample was randomly drawn from members who had 335 days of enrollment between 10/01/2005 and 10/1/2006 and were identified as non-utilizers. Half (49.6 percent) of non-utilizers had a history of repeated no-shows or canceling appointments. Appropriate follow-up actions were taken by clinic staff for just over half of the members with histories of repeated no-shows suggesting that non-utilization rates could be improved through improved follow up with members who cancel appointments.

Interventions are being implemented during the current contract year, and include data sharing of non-utilization patterns, collaboration with regional contractors to establish utilization improvement plans, educational materials to targeted populations, exploring of telemedicine alternatives, and the production and distribution of social marketing materials. Re-measurement data will be extracted in July 2008 for submission of the first re-measurement data report on October 1st, 2008.

### **Satisfaction Surveys**

Satisfaction Surveys are used to monitor the areas noted above. For 2008, the following surveys will be offered to members:

#### ***Family Satisfaction Survey***

Annually CRSA completes a Family Satisfaction Survey to determine member satisfaction related to the Children's Rehabilitative Services Program. Results are analyzed and compared to other monitoring mechanisms to determine areas for improvement.

#### ***Telehealth Satisfaction Survey***

Providers and families participating in the telehealth program complete an evaluation after each experience evaluating the quality, accessibility and satisfaction of their telemedicine visit. Annually this information is summarized, analyzed, and compared to expand and improve the quality and access to care through the use of telemedicine.

## **IV. Delegated Functions**

CRSA delegates a number of functions to Contractors as outlined within the QM/PI Monitoring of Delegated Functions table (see below). Although delegated, CRSA provides oversight and has

ultimate accountability for all delegated functions. The Annual Administrative Review serves as the mechanism for monitoring delegated functions.

**Quality Management/Performance Improvement Monitoring Activities of Delegated Function**

<b>Contract Task</b>	<b>Task Name</b>	<b>Responsible Party</b>	<b>Methodology for Oversight</b>
1	Adaptive Wheelchair and Ambulation Assistive/ Adaptive Aid Devices	QM Coordinator	Administrative Review
4	Appointment System	QM Analyst & QM Coordinator	Administrative Review; Referral Report and New Enrollment Report; Family Satisfaction Survey
5	Audiology	QM Coordinator	Administrative Review
6	Care Coordination	QM Coordinator	Administrative Review; grievances; Family Satisfaction Survey
8	Dental/Orthodontia Services	QM Coordinator	Administrative Review
12	Family Centered Care Services	QM Research Analyst & QM Coordinator	Administrative Review; Family Satisfaction Survey
17	Laboratory Services	UM staff	Medical Record On-Site Review
19	Medical Record Services	QM/UM staff	Administrative Review
20	Nursing Services	QM/UM staff	Administrative Review
21	Nutrition Services	Office of Nutrition	Administrative Review
22	Orthotic and Prosthetic Services	QM/UM Staff; QM Research Analyst	Administrative Review
28	Physical and Occupational Therapy Services	QM Coordinator	Administrative Review
29	Physician Provider Services	Medical Director	Quality Review & Peer Review

**Quality Management/Performance Improvement Monitoring Activities of Delegated Function (continued)**

<b>Contract Task</b>	<b>Task Name</b>	<b>Responsible Party</b>	<b>Methodology for Oversight</b>
32	Quality Management	QM Coordinator	Administrative On-Site Review
			Enrollment Reports
			Review of grievance/appeal/claims dispute logs
33	Radiology	QM Coordinator	Administrative Review
34	Regional Outpatient Clinic	QM Coordinator	Administrative Review
36	Special Diagnostic Testing	QM Coordinator	Administrative Review
37	Speech-Language Pathology	QM Coordinator	Administrative Review
38	Telehealth	QM Research Analyst	Provider and Member Satisfaction Surveys
39	Translator/Signer Services	QM Coordinator	Administrative Review

Contractors are allowed to delegate certain responsibilities in the CRSA contract. The Regional Contractor must obtain CRSA approval prior to delegation and ensure that the following activities occur for delegated functions:

- A written agreement must be executed that specifies the delegated activities and reporting responsibilities of the entity and provides for revocation of the delegation or other remedies for inadequate performance;
- The Contractor must evaluate the entity's ability to perform the delegated activities prior to delegation;
- The performance of the entity and the quality of services provided are monitored on an ongoing basis and formally reviewed by the Contractor at least annually;
- The Contractor must maintain, for CRSA' review, evaluation reports and corrective action plans, as necessary, to ensure quality for all delegated activities.

CRSA requires each Contractor to identify delegated functions, and their oversight of the subcontractor's performance during the Annual Administrative Review.

## **V. Consumer Rights & Responsibilities**

CRSA produces the Member Handbook, which contains consumer rights and responsibilities, grievance, and fraud & abuse reporting information. Regional contractors are responsible to disseminate the Member Handbook at enrollment, and annually thereafter if requested by the consumer, and when significant changes are made to the handbook. CRSA posts the Member Handbook on the ADHS, CRS webpage. Each regional contractor website has a link to the ADHS, CRS webpage and the Member Handbook. CRS Contractors have created Orientation Packets for the new enrollee which is approved annually by CRSA. The Member Handbook is one component of this Orientation Packet. Validation of contractor compliance with distribution and components of the Member Handbook is achieved through the Annual Administrative Review.

## **VI. Medical Records & Communications**

The Regional Contractors Policy & Procedure Manual, Chapter 70 establishes the standards for medical records. CRSA conducts validation during Focus Audits, Medical Record Reviews, and Annual Administrative Review to oversee compliance of the Contractor/provider medical record and its contents. If problems with medical records or communications are identified, CRSA provides technical assistance and or corrective action until such issues are resolved.

To protect the confidentiality of member information and ensure compliance with HIPAA requirements, CRSA requires its contractors to ensure compliance to The Regional Contractors Policy & Procedure Manual, Chapter 70. Contractors and their subcontractors are expected to adhere to these mandates for releasing confidential member information. Oversight is achieved during on-site reviews.

## **VII. Non-Quality of Care**

The non-quality of care process is defined in policy GS 1.1: CRSA Non-Quality of Care/ Grievance Process (See Attached: GS 1.1 policy). Additionally, CRS regional contractors must comply with the Regional Contractors Policy and Procedure Manual (RCPPM) Chapter 60 (See attached: Chapter 60). CRSA Quality Management performs an investigation of all non-quality of care issues, which includes an investigation, resolution, intervention, reporting, and closure process as well as oversight of the process for grievances received by the CRS Regional Contractors. CRSA maintains a non-quality of care database which tracks and trends grievance of members and providers specifically evaluating the delivery of care system and the provider network.

### **VIII. Quality of Care**

The quality of care process is defined in policy QM 1.5: CRSA Quality of Care Process (See attached: QM 1.5 policy). Additionally, CRS regional contractors must comply with the Regional Contractors Policy and Procedure Manual (RCPPM) Chapter 80 Section 302 (See attached: RCPPM 80.302). CRSA maintains a quality of care database which tracks and trends quality of care concerns of members and providers specifically evaluating the delivery of care system and the provider network.

### **IX. Credentialing & Re-credentialing**

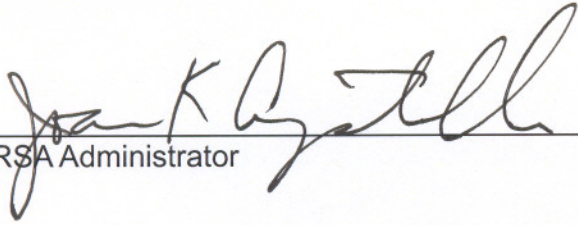
The Credentialing and Re-credentialing process is a delegated function to Contractors. Compliance will be considered met if the facility has deemed status by demonstrating accreditation by The Joint Commission for Accreditation of Healthcare Organizations (JCAHO) or National Committee for Quality Assurance (NCQA) within the last 3 years. If a facility has not obtained deemed status monitoring will occur through the Annual Administrative Review process. Requirements for credentialing, re-credentialing, and privileging are found in Regional Contractors Manual Chapter 80. Contractors must appropriately credential its contracted providers prior to the delivery of services, and every three years. The credentialing process must include a mechanism for providers to appeal and to inform the provider of the appeal process.

### **X. Annual Evaluation**

An appraisal of the QM Plan and work plan activities is conducted on an annual basis. Findings from this evaluation are reviewed by the QMC and serve to provide direction for the QM system for the up-coming year. The CRSA Executive Team grants final approval of the QM evaluation, plan, and work-plan. CRSA will submit any substantial changes within the QM/PI Plan to AHCCCS for approval prior to implementation.

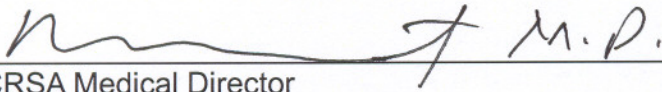
Approved:

Date:



CRSA Administrator

9/13/2007



CRSA Medical Director

9/12/2007