Behavioral Health
a division of Lakeview Center, Inc.

2018 Quality Improvement Program Description

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Access Behavioral Health (ABH) Background, Historical Information, and Overview

From September 2001 to July 2015, Access Behavioral Health (ABH) operated the prepaid mental health plan for Area 1 and the Department of Children and Families substance abuse and mental health funding for Circuit 1. AHCA Area 1 and DCF Circuit 1 comprise the same four Florida Panhandle counties, Escambia, Santa Rosa, Okaloosa and Walton. The Quality Management Plan covered both of these contracts, providing consistency for members and providers throughout the area.

In August 2014, as a result of Medicaid Managed Assistance, AHCA selected the Health Plans Humana Health Plan and Integral Quality Care to be the HMO and PSO, respectively for Region 1. ABH contracted with both of these Health Plans to manage the Behavioral Health Services for the MMA Contracts for Region 1. The requirements for member management were expanded under the MMA plans to cover Substance Abuse diagnoses, and the SIPP. On August 1, 2014, the member population of ABH doubled, from 45,000 to 90,000 members. In November 2015, Integral Quality Care assigned their Medicaid contract to Molina, who in turn contracted with ABH to manage the Behavioral Health Services for Molina Health Care of Florida.

The Quality Management Operations Plan outlines the methodology used for the continuous assessment and management of a quality management system inclusive of quality assurance, quality improvement, and risk management techniques from January through July 2014 when ABH operated under the PMHP, and beginning in August 2014 when the Medicaid Managed Assistance Plans moved into Region 1. New methods of operation were added at that time to meet needs of the new member population as well as to meet compliance with National Council on Quality Accreditation (NCQA) Standards.

This document is an overview of how priorities for improvement are identified and chosen, the role of the Quality Management Committee as well as its structure, and the tools and methodologies employed on a regular basis for provider evaluation. Also included is a description of how these activities changed in August 2014 and how they continue to drive the continuous Quality Improvement activities of ABH under the MMA plans.

The Quality plan remains comprehensive, and includes all outcomes and performance measures for Quality, Utilization Management, Member Satisfaction, Clinical Practice Guidelines, and other operation and tasks of ABH. Quality Improvement Activities are ongoing, opportunities for improvement identified, and interventions applied. The Quality Improvement Work Plan is evaluated annually.

The Quality Improvement Program at Access Behavioral Health (ABH) provides a formal mechanism whereby ABH can systematically and objectively monitor, evaluate, improve, and impact the quality, efficiency, safety, and effectiveness of care to our members. Through this

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process ABH is able to identify and focus on opportunities for improving the quality of clinical service delivery by our network of providers. The Quality Improvement plan helps ensure accountability of staff and network providers for the quality of care and services provided to ABH members. Access Behavioral Health maintains a network of contracted behavioral healthcare providers. The Quality Improvement Department governs the quality assessment and improvement activities of our network providers and spans the system to any function that impacts the quality of service delivered to our members. The ABH QI Department accomplishes this governance via internal and external monitoring of care management, utilization management, the development and maintenance of a provider network, member safety, and monitoring of clinical services to ensure that all members receive the highest quality care and service.

In November 2016, ABH acquired Full NCQA Acreditation as a Managed Behavioral HealthCare Organization (MBHO).

Purpose of Quality Improvement Program Description

The purpose of the ABH QI Program Description is to serve as a comprehensive summary of the activities, tasks, goals, objectives, performance measures, and oversight structure of the ABH Quality Improvement; more detailed descriptions of program components and processes can be found in the ABH Manual of Operations and Policies and Procedures.

Goals and Objectives of the ABH Quality Improvement Program

The ABH Quality Improvement Program is responsible for the timely availability and access of quality Behavioral Health Care Services to our members.

Goal: Monitor and evaluate the quality of care to ABH members by participating network providers.

Objectives:

- Maintain an adequate provider network through the credentialing and re-credentialing process;
- Maintain an organized and effective framework for Quality Improvement functions;
- Monitor quality of care to members by the ABH Provider Network;
- Ensure coordination of care between behavioral health care providers and medical providers;
- Assess compliance with medical records documentation standards;
- Monitor member safety;
- Monitor member satisfaction;
- Monitor HEIDIS and other provider performance measures;

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- Ensure that behavioral health services are culturally and linguistically diverse as required to meet the needs of our membership.

Goal: Ensure timely member and provider access to Utilization Management processes.

Objectives:
- Ensure that available, appropriate, accessible, and timely services fully meets or exceeds standards;
- Monitor Utilization Management outcomes based on HEIDIS and other national benchmarks;
- Ensure coordination of care between behavioral and medical healthcare providers
- Ensure coordination of care between behavioral and behavioral healthcare providers
- Ensure effective care coordination exists to meet the needs of consumers with complex health needs via the Complex Case Management program.
- Educate providers about ABH policy regarding utilization review, medical necessity, medically recommended, clinical care criteria, quality of care, peer review and practice guidelines;
- Provide a structure for the sharing of information and the collaboration of knowledgeable parties in the improvement efforts of the organization via the ABH Quality Management Committee and subcommittees.

Goal: Maximize Satisfaction of ABH members and providers through continuous quality improvement.

Objectives:
- Ensure timely access to services through ABH helpline, ABH Website, and geographic access monitoring.
- Resolve Member Inquiries and Complaints within 24 hours;
- Ensure Provider compliance with HIPAA and other local, state, and federal regulations;
- Conduct annual Provider Satisfaction Survey;
- Identify Opportunities for Improvement in Member and Provider Satisfaction and apply Interventions.

Goal: Maximize the safety and quality of behavioral healthcare delivery to ABH members through continuous quality improvement.

Objectives:
- Conduct annual Member Satisfaction Surveys;
- Address member safety issues at Quality Management Committee meetings and Safety and Privacy Sub-Committee meetings when appropriate;
- Identify Opportunities for Improvement and apply Interventions;
- Review service utilization data to identify over- and under-utilization patterns;
- Ensure timely access to emergency appointments;
- Offer members Self-Management Tools in print and on ABH website;
- Assist network providers with establishment of safe clinical practices.

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Program Scope

The Quality Improvement Program is to provide a means whereby all functions of ABH, both clinical and non-clinical, can be tracked, trended, and reviewed by the oversight body, opportunities for improvement identified, and interventions to address those opportunities applied. All activities and tasks of ABH Program Components flow through the Quality Improvement Process.

The Quality Improvement program is designed to monitor, evaluate, and continually improve the care and services to all ABH consumers and encompasses services delivered in both outpatient and inpatient settings. ABH integrates quality improvement into all functional areas. Participation in the QI program is required of all contracted network providers. All staff, network providers, and members are asked to participate in the quality management process through satisfaction surveys, committee meetings, and corrective action plans which are implemented as part of the overall quality plan whenever barriers and opportunities for improvement are identified.

The Quality Improvement Program encompasses both clinical quality outcomes and service utilization measures. The range of clinical activities includes monitoring for urgent, emergent, and routine appointment times and quality of care. The program includes provider credentialing and re-credentialing, HEIDIS and other performance outcomes, Behavioral Health screening programs, Clinical Practice Guidelines, and medical record documentation. The service component of the program includes utilization management, accessibility of care, member/provider satisfaction, and member inquiries, member complaints, Member Self-Management Tools, Fraud/Waste/Abuse Prevention, and Coordination of Care

Organizational Structure

The Quality Management Committee (QMC) is the governing body of the ABH QI Program and is responsible for oversight of the Quality Improvement program, along with its subcommittees. The QMC is responsible for ensuring the quality improvement processes outlined in this plan are implemented and reviewed. The QMC also serves as an advisory group and communication forum for all ABH Quality Improvement components and sub-committees. The QMC is the decision making body ultimately responsible for implementation, coordination, and integration of all QI activities for ABH. The QMC reviews and approves the QI Program Description, Work Plan, and Annual Evaluation.

The Quality Management Committee meets at a minimum bi-annually. Ad hoc meetings may be called if necessary. The Director of Quality Management and Improvement is responsible for conducting the meeting.

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The authority to implement the ABH Quality Improvement Program plan is held by the QMC. The QMC is assigned oversight responsibilities to all ABH quality improvement efforts. ABH is accountable to the QMC, where quarterly reports, pertinent reports, data analysis, and recommendations or actions are put forth for consideration. This process allows ABH to routinely monitor the activities and effectiveness of the Quality Improvement program. This monitoring includes, but is not limited to:

- Reviewing data and reports to identify trends that may require corrective action;
- Ensuring practitioner participation in the QI process;
- Monitoring the implementation and effectiveness of corrective actions;
- Determining the need for ad hoc committees ;
- Reporting conclusions and actions as appropriate to meet the goals of ABH QI.

The QMC is comprised of all components and committees of ABH which work together as a whole to achieve program goals and objectives. The QMC's focus is on key quality outcome areas designed to improve overall system effectiveness of service delivery to ABH consumers. Although each component and subcommittee operates to achieve specific objectives and processes that are operationalized through the ABH QI Program, all components operate as a whole to create the ABH Quality Program.

Quality Management Committee Members and Roles

The members and the ABH Quality Management Committee and their roles are as follows**:**

The Director of Access Behavioral Health Care is responsible for the overall operations of Access Behavioral Health. The Director of Access Behavioral Health Care ensures that the ABH network has the capacity and capability of meeting the behavioral healthcare needs of members.

The ABH Medical Director is the **designated Physician** who provides supervision and oversight to the Quality Improvement program, the Quality Management Committee, and all sub-committees. The Medical/Clinical Director reports to the Director of Access Behavioral Health Care. The Medical/Clinical director oversees the utilization review functions for the Care Management Department and the ABH Utilization Management Plan. The Medical/Clinical Director provides support and consultation to ABH and provider staff.

The Director of Quality Management and Improvement is the senior level quality staff person responsible for and with the authority to manage the Quality Management

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Operations Plan. This role reports directly to the Director of Access Behavioral Health Care. The Director of Quality Management and Improvement coordinates the Quality Management Committee, compliance and quality monitoring activities, and other activities related to quality management of the ABH network.

The Director of Network Management and Reporting reports directly to the Director of Access Behavioral Health Care. The Director of Network Management and Reporting is responsible for ensuring that the reporting needs of the Quality Management program and the care Management program are met. The Director of network Management and Reporting collects data from a variety of sources and outs it into a meaningful format for review and analysis.

The Director of Care Management is responsible for the functions and operations of the Care Management Department. This position reports directly to the Director of Access Behavioral Health Care. The Director of Care Management oversees the utilization review, utilization management and claims authorization processes for ABH. The Director of Care Management works closely with the Medical/Clinical Director in coordination of care and outreach to primary care physicians.

Provider Representative(s) is the **Designated Behavioral Health Practitioner** responsible for aiding the network in participation in the ABH QI plan.

Claims Representative: Staff responsible for processing claims and reporting on any issues or concerns identified.

Information Systems Representative: Team representative(s) responsible for key outcome performance tracking systems/software, data reports and other issues as identified.

Consumer Representative: Member that is a current/past recipient of behavioral health services.

Call Center Representative: Responsible for reporting on all call center activities and reports.

QI Specialist/Incident Coordinator: Tracks, trends incidents from the district. Reviews any pertinent issues or trends. Reviews internal quality assurance activities to include Care management department record reviews, enrollee satisfaction with services.

ABH Care Coordinator: Network care coordination activities.

ABH Office Manager: Completes and distributes minutes.

Minutes are recorded at each meeting using a standardized format which includes topic, discussion, recommendations, follow up, and applicable graphs or associated reports. Follow up items become topics for the next meeting. All minutes are maintained in a confidential manner.

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The minutes are reviewed and approved at the beginning of the subsequent meeting with any changes or corrections noted.

All members of the QMC annually sign a confidentiality attestation.

Sub-Committees of QMC

Following are the Sub-Committees of the QMC and a description:

A. Quality Management

Function & Accountability: The Quality Sub-Committee reports directly to the QMC. The Committee is responsible for oversight of provider and facility adherence to HEIDIS measures and other performance measures. The committee identifies improvement opportunities and develops interventions to address deficits, including monitoring of individual occurrences of poor quality service and clinical care leading to potential quality of care issues. The Quality Committee is responsible for ensuring the conclusions and recommendations for improvement are communicated in confidence to the QMC committee, and for monitoring applied interventions.

The Quality Sub-Committee is Responsible for:

- Compliance with HEDIS Performance measures;
- Approval of Annual QI Work Plan;
- Approval Annual QI Plan Evaluation;
- Oversight of Provider Monitoring ;
- System Improvement & Effectiveness;
- IS Functions (Data Collection and Data Reporting).

The Committee's members include the ABH QMI Director, the ABH Care Management Director, he Quality Specialist, and one network provider.

The Quality Subcommittee meets on an ad hoc basis.

B. Credentialing

Function & Accountability: The Credentialing Sub-Committee reports directly to the QMC. The Credentialing Sub-Committee is responsible for reviewing applications from potential network providers for compliance with ABH Credentialing standards, and approving or denying admission to the network. The Credentialing Sub-Committee has the authority to pend an

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application and ask for more information, or to Provisionally approve an applicant. The Credentialing Sub-Committee has the authority to terminate a provider

The Credentialing Sub-Committee is responsible for:

- Oversight of the ABH Provider Network;
- Ensuring adequate network capacity;
- Approving, denying, pending, or terminating providers from the network.

Committee members include: ABH Medical Director, Director of ABH, Director of Network Management, Director of Care Management, Director of QMI, two provider representatives.

Provider representatives must recuse themselves from voting if they have a conflict of interest in the outcome of a credentialing sub-committee decision.

The Credentialing Sub-committee meets on an ad hoc basis.

C. Clinical

Function & Accountability: The Clinical Sub-committee reports directly to the QMC.

The Clinical Sub-committee is responsible for:

- Oversight of the Clinical Practice Guideline studies;
- Self-management Tools;
- Behavioral Health Screening Tools management.

The committee members include: ABH Medical Director, Director of QMI, Quality Specialist, two provider representatives.

The Clinical Sub-Committee meets on an ad hoc basis.

D. Utilization Management

Function & Accountability: The Care Coordination Sub-Committee reports directly to the QMC.

The Care Coordination Sub-Committee is responsible for:

- Utilization Review and Management to Care Management;
- Care Coordination between Behavioral Healthcare Providers;
- Care Coordination between Behavioral Healthcare and Medical Providers;
- Continuity of Care of ABH members.

The members of the UM Sub-committee include the Director of Care Management, the Director of QMI, and a provider representative. The UM Sub-Committee meets on an ad hoc basis.

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E. Rights and Responsibilities

Function & Accountability: The Safety & Privacy Sub-Committee reports directly to the QMC.

The Safety & Privacy Sub-Committee is responsible for:

- HIPAA Compliance;
- Quality of Care Concerns;
- Environment of Care Concerns;
- Confidentiality of Members.

Sub- Committee members include: QMI Director, Quality Specialist, Provider Representative,

ABH Medical Director. The R&R Sub-Committee meets on an ad hoc basis.

Quality Improvement Process

ABH uses a variety of monitoring systems, both qualitative and quantitative, for identifying barriers or gaps in service, identifying opportunities for improvement, and for applying interventions in order to maintain continuous quality improvement. The monitoring of specific outcomes is designed, measured and assessed on a monthly basis by the Quality Management Committee. Trends are identified and tracked, and performance improvement opportunities identified.

The outcome and performance measures used by ABH are objective, measurable, and based on national benchmarks.

Methodologies used for tracking outcomes and performance include:

- Review and selection of benchmarks for each HEIDIS measure;
- Tracking and trending of data;
- Identification of opportunities for improvement based on available data;
- Implementation of interventions or corrective actions for identified opportunities for
- Improvement;
- Re-measurement to determine the effectiveness of the interventions based on available data;
- improvement and/or reaching a goal or benchmark.

DATA SOURCES

ABH organizes and analyzes the following broad data sources, when available, for identification of improvement opportunities:

- HEDIS Measures;
- Member Satisfaction Surveys;
- Provider satisfaction surveys;

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- Medical records review data;'
- Geographic Access and Availability of Providers, including specialty;
- Continuity and coordination of care processes and data;
- Level of Care Criteria;
- Credentialing and Re-Credentialing data;
- Pharmacy data;
- Lab data;
- Quality of care concerns;
- Member complaints;
- Provider complaints;
- Complex Case management data;
- Utilization management data;
- Feedback from external regulatory and accrediting agencies;
- Office site visits reports;
- Provider background screenings.

Outcome Measures

Access Behavioral Health has developed a data system that adequately supports the collection, tracking, and analysis of data necessary to perform utilization management activities, reviews of clinical/administrative performance related to levels of care, clinical outcomes, and adherence to Medicaid clinical/administrative standards.

Additional outcomes that ABH monitors on a monthly basis include but are not limited to:

- **HEIDIS Measures**
  - ADD
  - F/U Care for Children Prescribed ADHD Medications
  - Adherence to Anti-Psychotics for Members with Schizophrenia
  - Diabetes Screening Among People With Bipolar Disorder and Schizophrenia Who Are on an Antipsychotic Medication
- **Utilization Measures**
  - Enrollments
  - Members Receiving Services
  - Members Receiving Services/1000 Members
  - IP Admits/1000 Members
  - IP Days/1000 Members
  - Median LOS
  - Discharges w/re-admit in 7 days
  - Discharges w/re-admit in 30 days
  - MH IP 30 Day Re-Admit Rate (%)
  - MH IP 7 Day Re-Admit (%)

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- UM Timeliness
- Claims Processing Times
- Call Center Statistics
- Call Abandonment Rates

- **Quality Measures**
  - Number of Reported Quality of Care Incidents
  - Number of Confirmed Quality of Care Incidents
  - Number of Site Visits Related to Member Complaints
  - Number of HIPAA Disclosures
  - Provider Satisfaction
  - Member Satisfaction
  - Coordination of Care Between Behavioral Health Providers
  - Coordination of Care Between Behavioral Health and Medical Providers
  - Quality of ABH Care Management
- **Access to Services**
  - Emergent
  - Urgent
  - Routine
  - Provider Network Adequacy
- **Call Center**:
  - Number of Calls Received
  - ASA
  - Abandonment Rate
  - Blocked Rate
  - Average Call Wait Time in Queue
  - Monthly Quality Monitoring
- **Claims Processing:**
  - Number of Clean Claims Processed
  - Percent of Clean Claims Processed within 7 days
  - Percent of Clean Claims Processed within 10 days
  - Percent of Clean Claims Processed within 20 days
  - Number of Adjustments
  - Claim Denial Rate
  - Number of Pended Claims
  - Number of Backlog Claims
  - Claims Financial Accuracy
  - TAT on Paper Claims
  - TAT on Electronic Claims
- **Utilization Management**
  - Number of Authorizations Received
  - TAT for Authorizations Processed within 7 Days
  - Percent of Authorization Processed within 14 Calendar Days
  - Number of Authorizations Received
  - TAT for Authorization Requests within 2 Days
  - Percent of Authorization Requests Processed within 3 Business Days
  - Number of Denials Issued
  - Members Receiving OP Services/1000 Members

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- Members Receiving CM Services/1000 Members
- Members Receiving MD Services/1000 Members

➢ **CLINICAL PRACTICE GUIDELINES**

Access Behavioral Health adopts evidence-based clinical practice guidelines for at least three behavioral health conditions. Access Behavioral Health measures performance annually against at least two important aspects of three practice guidelines for behavioral health conditions.

The three Clinical Practice Guideline Studies ABH conducts are:

1) **Are members with a schizophrenia diagnosis receiving services as indicated by the APA guidelines,**

2) **Are members with a ADHD diagnosis receiving services as indicated by the APA guidelines**.

3) **Are members diagnosed with Major Depression, single episode, newly diagnosed, treated as indicated by the APA guidelines**.

Quality Improvement Program Components

Additional components of the ABH Quality Improvement Program are outlined below. For a full description of the program's elements please see the document referenced in the description.

Care Coordination

Access Behavioral Health monitors the continuity and coordination of care that members receive across the behavioral healthcare network and takes action, as necessary, to improve and measure the effectiveness of these actions.

Access Behavioral Health uses information at its disposal to facilitate and measure the effectiveness of improvement actions related to continuity and coordination of care.

Please refer to the ABH 2014/2015 Coordination of Care Plan.

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Fraud, Waste, and Abuse

The ABH Corporate Compliance Program is intended to establish methods for consistent adherence to applicable laws, regulations, and requirements governing Corporate Compliance as well as for preventing, detecting, and investigating fraud, abuse, and overpayment. ABH has established a centralized mechanism via the Corporate Compliance Program, the Anti-Fraud Unit, and the Quality Management Committee, to track compliance and achieve the goal of preventing fraud and abuse. These mechanisms have created a corporate culture of strict adherence to federal, state, and local laws. To demonstrate our commitment to the highest standards of ethical conduct, to prevent and deter criminal activity, and to encourage employees to report potential problems that will allow for appropriate internal inquiry and corrective action, the following Compliance Plan has been structured to meet the guidelines as set forth by the Health Plans, Florida Statute 409.91212, 42 CFR 438.608, and the Deficit Reduction Act.

Please refer to the ABH Corporate Compliance Plan and Fraud/Waste/Abuse Plan.

Behavioral Health Screening Programs

ABH has established behavioral health screening programs based on evidence and distributes program Information to practitioners and providers. Access Behavioral Health Maintains two screening programs at all times, one of which is focused on the identification of co-occurring mental health and substance use disorders. (Defined as any combination of two or more mental health and substance use disorders). Each program has a description that contains the following:

A. Identifies how eligible members are identified.

B. Planned screenings and their recommended frequency.

C. Conditions where screening is Indicated or required.

The ABH Behavioral Health Screening Programs are:

1) Identification of Co-Occurring Disorders using the PHQ-9 and the CAGE-AID
2) Screening Protocol for Metabolic Syndrome.

Please refer to the ABH Behavioral Health Screening Programs.

Self-Management Tools

ABH offers self management tools that have been derived from evidence based materials. This information is available on at least the following health promotion areas:

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- Healthy Weight (BMI) maintenance
- Smoking and Tobacco use cessation.
- Encouraging physical activity.
- Healthy eating.
- Managing stress.
- Avoiding at risk drinking
- Identifying psychiatric symptoms through self-assessment.
- Recovery and resiliency.
- Treatment monitoring.

The self management tools are available on the ABH website, in print (upon request) or over the telephone.

Cultural Competence

Cultural competence is about adapting mental health care to meet the needs of consumers from diverse cultures. One key aim is to improve their access to care. Others are to build trust and to promote their engagement and retention in care.

Above all, cultural competence aims to improve the quality of care and to help consumers recover quicker and better. Its broader societal purpose is to reduce or eliminate mental health disparities affecting disenfranchised groups.

ABH Objectives:

- **Ensure adequate service to culturally and linguistically diverse membership:**
    - A language bank service is offered and the language line to ensure that language is not a barrier.
    - Approximately 5% of the membership in Region 1 speaks Spanish; Spanish speaking therapists will be made available.
    - ABH Help Line has a Spanish Speaking Option
    - Provider Profiling to ensure adequate cultural and linguistically diverse providers to match the membership .
- **Ensure adequate services to members with Complex Health Needs**
    - Implement ABH Complex Case Management Plan
    - Monitor provider office sites to ensure wheelchair and other disability access to physical locations

Please refer to the ABH Cultural Competence Plan.

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Provider Training

ABH conducts annual Provider training on medical records documentation, fraud/waste/abuse, utilization management, and other pertinent topics.

HIPPA/Corporate Compliance

ABH staff routinely deals with Protected Health Information. All documents that are created, obtained, or viewed as a part of the Quality or Utilization management process are considered confidential and privileged information . All protected information is maintained in compliance with applicable federal and state regulations. Medical information systems including email, claims, medical records, and other PHI is password protected. All medical record documentation obtained in the course of clinical review is considered strictly confidential and is retained in a secured environment.

Annual QI WorkPlan & Evaluation

An annual Quality Improvement Work Plan is developed and approved by the QMC. The purpose of the QI Work Plan is to identify goals, objectives, deadlines, persons responsible, and target dates for the upcoming year. The annual work plan serves as a correction action plan for previously identified opportunities for improvement and applied interventions, if any.

Additionally, the Quality Improvement Committee annually presents an evaluation of the QI Work Plan and the Quality Improvement Program to the Quality Management for approval at the end of the calendar year. Updates to the work plan are presented quarterly if available based on data collection, tracking and trending of identified issues, and gaps in effectiveness of the QI Work Plan identified.

The program evaluation includes information about the following:

- Review of status of annual goals.
- Monitoring of previously identified issues.
- Evaluation of the effectiveness of each quality improvement activity.
- Review of trends of clinical and service quality indicators.
- Evaluation of the improvements occurring as a result of quality improvement efforts.
- Evaluation of the overall effectiveness of the Quality Improvement Program.
- Evaluation of adequacy of staff resources.
- Evaluation of program structure and processes.
- Goals and objectives for the work plan for the following year.

Policies and procedures supporting the Quality Improvement Program are reviewed and approved annually by the QMC and updated as needed. Based on the annual program evaluation, the prior year's QI Work Plan is revised, and a new QI Work Plan for the coming year is developed.

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