



CAHC Continuous Quality Improvement & Peer Review

Content Relevant to: Clinical and Alternative Clinical Models

MPR #12, part a:

The health center shall implement a continuous quality improvement plan.

Components of the plan shall include, at a minimum:

- a) Practice and record review shall be conducted at least twice annually by an appropriate peer and/or other staff of the sponsoring agency, to determine that conformity exists with current standards of health care. A system shall also be in place to implement corrective actions when deficiencies are noted. A CQI Coordinator shall be identified. CQI meetings, that include staff of all disciplines working in the health center, shall be held at least quarterly. These meetings shall include discussion of reviews, client satisfaction survey and any identified clinical issues.
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The CAHC Program has some specific **requirements for CQI and performance review** as defined in Minimum Program Requirement #12, part a (above). The elements of the MPR are specific to the goals of the model and do not necessarily “match up” with CQI measurements across different fiduciary types. It has been our experience that **bringing the quality improvement down to the health center level is the best way to monitor and improve care specific to our model**. For example, we know that involving all disciplines in center based CQI, (breaking down silos) improves both office processes and client outcomes.

Regarding peer review, because most fiduciaries include “mid-level providers” in organizational performance review, we have modified our definition of a “peer” to include those reviewers who may not be “true peers.” Peer review is done best by a “true peer,” but often this is not possible or does not work well organizationally.

Although we know that our CQI requirements are often “extra work” for the health centers, we have found the outcomes are worth the efforts.

Please see the resources included her to help you meet the requirements for MPR #12, part a. Among the resources, you will find a sample agenda and an example of a chart review topic. (We have many examples to share. Of course the fiduciary format can also be used.)

NPs and PAs: Collaboration and Practice Review

NURSE PRACTITIONERS

Scope of Practice:

The Michigan Public Health Code does not define the scope of practice of advanced practice registered nurses (APRN) which includes Nurse Practitioners (NP). All nurses are responsible and accountable for recognizing the limits of their knowledge and skill. Therefore, in Michigan, APRNs practice within a scope of practice defined by their specialty education and training, and as outlined by their respective certification boards and professional organizations. The Board of Nursing issues a specialty certification to a RN who has advanced training beyond that required for initial licensure and who has demonstrated competency by examination or other evaluative process (R 338.10401-10406).

Supervision:

Public Health Code Act 368 of 1978 states: RNs are licensed to practice independently under the definition "Practice of Nursing," including the dispensing of non-scheduled prescription drugs. Supervision or delegation does not apply for those acts performed within the scope of nursing practice. However, the Public Health Code further states if an APRN prescribes a controlled substance (schedules 2 to 5), both the APRN's name and DEA number, as well as the physician's name and DEA number, shall be used, recorded or otherwise indicated in connection with that prescription.

Collaborative Practice Agreement:

A Collaborative Practice Agreement (CPA) with a physician **is required** for Michigan APRNs to receive Medicaid (& Medicare) reimbursement (other third party payers may require it).

The CPA defines the relationship between the NP and the physician to deliver health services. The CPA should be appropriate to the individual practice of the NP.

PHYSICIAN ASSISTANTS

Scope of Practice and Required Practice Agreements:

A Physician Assistant (PA) is licensed to “practice medicine” in Michigan. The Medical Board in Michigan regulates licensure. A “PA-C” is certified, and in compliance with the regulations of the national certifying organization. This certification is required for licensure. PAs have their own medical license and do not work under a physician license.

The PA scope of practice is outlined in their PA-Physician Practice Agreement and they cannot practice in a manner other than prescribed in their practice agreement with a collaborating physician. The PA must have a formal agreement on file with a collaborating physician in order to practice in the state. The agreement must include:

- A process between the PA and participating physician for communication availability and decision-making when providing medical treatment to a patient. The process must utilize the knowledge and skills of the PA and participating physician based on their education, training and experience.
- A protocol for designating an alternative physician for consultation in situations in which the participating physician is not available for consultation.
- The signature of the PA and the participating physician.
- A termination provision that allows the PA or participating physician to terminate the practice agreement by providing written notice at least 30 days before the date of termination.
- The duties and responsibilities of the PA and participating physician. The practice agreement shall not include as a duty or responsibility of the PA or participating physician an act, task or function that the PA or participating physician is not qualified to perform by education, training or experience and that is not within the scope of the license held by the PA or participating physician.
- A requirement that the participating physician verify the PA’s credentials.

The Public Health Code: ACT 368 of 1978 and Public Act 210 of 2011 include specific language governing PAs.

PRACTICE REVIEW FOR NPs and PAs

Practice review of medical providers is most often dictated by the fiduciary as part of ongoing credentialing, practice privilege requirements or other similar processes. For the majority of our program sites, NPs and PAs are included in these processes.

The CAHC program strongly recommends performance review of NPs/PAs by their Medical Director/collaborating physician.

Please see below for **Sample Nurse Practitioner/PA-Physician Collaborator Review Meeting**. This is an example of what a NP/PA-Physician collaborator meeting may include. In this sample chart review, CQI, clinical concerns and other issues are reviewed and documented.

We have samples of chart review indicators. Of course the organizational review criteria can also be used.

Sample Nurse Practitioner/PA – Physician Collaborator Review Meetings

It is important to document your review by your collaborator. On the following two pages, you will find a sample meeting agenda and form for chart review.

Important Points:

1. Develop a schedule for meetings
2. Develop an agenda for each meeting
3. Review your quality data- show what you do in the health center
4. Discuss your risk assessment findings and work you are doing with your GAS (goals and outcomes)
5. Maintain ongoing communication with your collaborator.

Schedule for NP/PA-Physician Collaborator Meetings:

Frequency: Biannual (each center determines if greater frequency is needed)

Purpose:

- Review of 10 charts or 10% of visits from quarter for documentation of competency and quality (see chart review form)
- Follow up on deficiencies
- Review CQI
- Discuss clinical concerns.
- Open discussion of any issues

Sample Meeting Documentation:

NP/PA AND PHYSICIAN - SIGN AND DATE, INDICATING PROCESS

	May/June	Nov/Dec
CHART REVIEW DONE?		
# OF CHARTS:		
CQI		
CLINICAL CONCERNS		
OPEN DISCUSSION		

Sample Meeting Agenda

MD Collaborator Biannual Chart Review and Meeting Agenda

NAME OF ORGANIZATION:

DATE:

QUARTER REVIEWED:

MD:

NP/PA:

1. CHART REVIEW (see next page)

Document results – *determine your thresholds if management is less than optimal (e.g., <100%)*

- a) What did you do?
- b) How will you improve?

2. CQI REVIEW: Review your quarterly CQI:

3. CLINICAL CONCERNS:

4. OPEN DISCUSSION: Any center issues, reporting, fiduciary communication:

5. FOLLOW-UP needed on any items

Sample Chart Review Form

DATE:

CENTER:

NP/PA:

PHYSICIAN:

Chart Record #	Collected Critical Data for CC Yes/No	Diagnosis (ICD-10) Consistent w/ Data Collected Yes/No	Includes Mental Health Dgx if appropriate Yes/No/NA	Appropriate Management Yes/No	Comments

Sample Nurse Practitioner / Physician Assistant

Peer Review Meetings

Peer Review is important as it provides a means for clinical review to identify clinical conditions, issues in management, potential risk management concerns.

Definition of a Peer

The CAHC Program defines a peer as someone doing “same work in a comparable environment or someone with knowledge of that work and environment.”

Important Points for Developing the Peer Review Process

1. Develop a schedule for meetings with peers in your area
2. Develop an agenda for each meeting
3. Define your reviews- what are you going to discuss, how will you review, how will you report this?
4. Are you looking at evidenced based and clinical practice guidelines?
5. What follow-up is/will be needed?

Schedule for Peer Review

Frequency: Twice annually (at minimum per MPR #12)

Purpose: Ensure that clinical staff (NP's or PA's) are practicing within their scope of practice and providing quality care. Discussion among peers allows for performance improvement and mentoring.

Sample Quality Assurance Management / Continuous Quality Improvement Policy

TITLE: QUALITY MANAGEMENT

PURPOSE and OBJECTIVE: To ensure quality care is provided at the CAHC

POLICY STATEMENT: The CAHC will develop and implement a quality assurance management program that monitors and evaluates the medical and behavioral health record documentation and specific clinical performance measures.

PROCEDURES:

1. The CAHC Quality Committee will consist of all health center staff at the CAHC. An identified CQI Coordinator will coordinate this committee.
2. The CAHC Quality Committee will meet on a quarterly basis and submit reports to the health center management and designated organizational Quality Committee quarterly, or as needed.
3. Components of the record review and clinical performance measures will be discussed and selected based on current organization indicators, pediatric and adolescent health best practices in medical and behavioral health care, as well as review of current needs assessment, and client satisfaction survey results. Target goals will be set at health center staff meetings.
4. Indicators shall include both medical and behavioral health measures targeted for improvement based on the above criteria.
5. All indicators which do not meet an acceptable level of compliance will be individually scrutinized and a corrective action plan will be developed by the health center to improve care.

Subsequent to problem definition and implementation of a corrective action plan, to ensure that acceptable performance standard is met, the indicator shall be reviewed until the CQI Coordinator and health center management are satisfied that the quality of care is meeting the acceptable performance standard.

6. Annually, the indicators will be evaluated for necessity of continued monitoring. Indicators may be removed from monitoring when the appropriate performance standard has been met three consecutive times. However, if an indicator is important to the program or has a significant impact on patients, then it should be continued.
7. Results of the needs assessment data will be reviewed every three years to determine the health needs of the populations.
8. Results of the client satisfaction surveys will be reviewed annually.

Alternatives:

3. The CQI Committee will review health center clinical performance indicator data, organizational CQI indicators, client satisfaction survey data and current needs/risk assessment data. All indicators will have a target/threshold for improvement. Annually, the CQI Committee will evaluate indicators and their thresholds/targets for continued necessity of monitoring and/or revision of the threshold.
5. CQI initiatives may be identified and a PDSA process initiated any time throughout the year.
7. The health center shall complete or acquire access to a needs assessment at least every three years.
8. The health center shall conduct client satisfaction surveys at least annually.

Sample Quality Management Plan

Indicators with “Meaningful Use”

These are examples that can be tailored to each center’s CQI plan.

INDICATOR	CRITERIA REQUIRED
Demographics are entered in record (MU 50%)	Gender, race, ethnicity, language, DOB entered
Barriers to learning documented (JACHO)	Barriers to learning noted in medical history
Medication Log & Reconciliation (QA/MU 80%)	Patient’s medication is recorded and verified at every visit.
Allergy Status (QA/MU 80%)	Allergy status is documented in record Note must have allergy status verified or no known allergies
Up to Date Problem List (QA/MU 80%)	Maintain an up to date problem list of diagnosis based on ICD-10 When charting assessments be sure to check PL so your assessment will be recorded on Problem List Use for all chronic diagnosis and significant acute
Current CPE documented (QA/MDHHS)	CPE visit is documented annually Will count if done by PCP within last 12 months- must document date in chart
Risk assessment current (MDHHS)	Use age-appropriate risk assessment Review, sign and date and time by provider and scanned into EMR
Appropriate referrals complete (post-risk assessment)	Review of risk assessment MH referral complete if needed due to at risk for questions which screen for anger/violence/depression/self-harm

INDICATOR	CRITERIA REQUIRED
Smoking status noted with cessation assistance offered All patients over 13 years of age must have smoking status recorded (MU) (MU 50%)	Age 13 and up (MU) Discuss risks of smoking, and ask regarding cessation plans Use motivational interviewing
BMI V code noted on Problem List (MU-BMI growth chart /MDHHS	Check height and weight on each visit Record vitals in EMR Note BMI code on Diagnosis/Problem List If addressing BMI during visit add codes for nutrition and physical activity counseling
BMI >85%ile nutrition and physical activity counseling are completed (MDHHS)	BMI counseling done at visits when BMI>85%
BMI>85% refer to RD for individual counseling	If patient is not interested, must document
Blood Pressure recorded (MU 50%)	Check BP at each visit Record in vitals If BP noted to be orange or red- indicates over normal range Indicate pre, stage 1 or stage 2 with management plan
Immunizations reviewed at each visit	Assess current MCIR for immunizations Document any immunizations recommended or required Send letter to parent with VIS advising of immunizations needed
Adolescent vaccination schedule (ACIP Guidelines) up to date	Vaccination schedule reviewed with parent/guardian Provider recommends/orders vaccines needed

Sample Quality Action Plan

<p>INDICATOR:</p> <p><i>List Indicator you are working on:</i></p> <p><i>Write down plan, steps needed to improve your results ~</i></p> <p><i>Note progress or lack of progress in each quarter ~</i></p> <p><i>Review your Plan and revise if necessary ~</i></p>	<p>ACCOUNTABLE MEMBERS:</p> <p><i>List all members that will help with reaching this goal:</i></p>																		
<p>YEAR TARGET / MEASURE OF SUCCESS:</p> <table border="1" style="margin-left: auto; margin-right: auto; border-collapse: collapse; text-align: center;"> <tr> <td style="padding: 5px;"><i>FY 2016</i></td> <td style="padding: 5px;"><i>FY 2017</i></td> </tr> <tr> <td style="padding: 5px;"><i>RESULTS</i></td> <td style="padding: 5px;"><i>TARGET</i></td> </tr> <tr> <td style="height: 40px;"></td> <td style="height: 40px;"></td> </tr> </table>	<i>FY 2016</i>	<i>FY 2017</i>	<i>RESULTS</i>	<i>TARGET</i>			<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td style="padding: 5px;">1st Quarter</td> <td style="padding: 5px;">2nd Quarter</td> <td style="padding: 5px;">3rd Quarter</td> <td style="padding: 5px;">4th Quarter</td> </tr> <tr> <td style="padding: 5px;">FY 2017</td> <td style="padding: 5px;">FY 2017</td> <td style="padding: 5px;">FY 2017</td> <td style="padding: 5px;">FY 2017</td> </tr> <tr> <td style="height: 60px;"></td> <td style="height: 60px;"></td> <td style="height: 60px;"></td> <td style="height: 60px;"></td> </tr> </table>	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	FY 2017	FY 2017	FY 2017	FY 2017				
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