2017 QMR OPR Scoring Descriptors

INPATIENT

STANDARD	REFERENCES	SUPPORTING EVIDENCE & SCORING
SECTION 1 - GENERAL ADMINISTRATIVE OVERSIGHT		
1.1 The provider has adequate policy and/or procedure to protect confidential and individually identifiable information from unauthorized use or disclosure, including: 1. Protections for physical facility access. 2. Protections for electronic access. 3. Media and device controls. 4. Physical safeguards for workstations. 5. Procedures for allowing and removing access according to role-based employment	*HIPAA/HITECH* *42 CFR Part 2* *MH Code 330.1748*	**Supporting Evidence:** Computer safeguards (e.g., screen locks, password use, and regular password expiration), paper file safeguards (locking paper files when not in use), IT policies and/or procedures, policies and/or procedures around verbal/written sharing of customer information with others (such as with family members, law enforcement and/or other health professionals). **Scoring: 2** - No concerns. Ample precautions to protect confidential information are in place. **1** - One or two minor suggestions for improvement. **0** - Improvement needed in several areas; or potential for serious violation of privacy was noted.
1.2 The organization has developed and adopted a "Code of Conduct" (or its equivalent) for its employees regarding ethical and legal practice expectations. A provider may choose to comply with the SWMBH Code of Conduct in lieu of developing its own code of conduct (must have written certification that they have received, read and will abide by SWMBH's Code of Conduct).	*PIHP Policy 10.1*	**Supporting Evidence:** A copy of the organization's Code of Conduct or acknowledgement of use of the SWMBH Code of Conduct. For evidence of "adoption" of the code of conduct - training records, policy and/or procedure regarding dissemination of the code, employee handbook with the code, posting of ways to report fraud, waste, and abuse. **Scoring: 2** - Code of conduct is in place and evidence supports its adoption in the organization. **1** - Code of conduct has been developed or accepted from SWMBH, but efforts are not being made to make staff aware of its content or purpose. **0** - No code of conduct in place.
1.3 Staff know what to do if they suspect Medicaid fraud or abuse within the organization.	*Deficit Reduction Act; Patient Protection & Affordable Care Act of 2010; HealthCare & Education Reconciliation Act of 2010*	**Supporting Evidence**: Interviews with staff members. Scoring: **2** - Staff consistently know who to report possible Medicaid fraud and abuse to, various ways to report (phone, email, etc.). **1** - Not all staff interviewed knew who or how to report possible Medicaid fraud and abuse. **0** - Staff appear to be unaware of Medicaid fraud and abuse reporting.
SECTION 2 - QUALITY IMPROVEMENT		
2.1 Plan(s) for Improvement in response to citations / recommendations from the most recent reviews (licensing, MDHHS, PIHP or accrediting body, etc.) has been submitted to the appropriate agency.	*Provider Contract requirement*	**Supporting Evidence:** Plan(s) for improvement submitted to monitoring agencies complete with dates and corrective action plans. **Scoring: 2** - Plan(s) complete and submitted within time frames, or no recommendations or citations from recent reviews. **1** - Plan(s) does not address all items for correction or not completed within time frames. **0** - No response has been implemented to citations/recommendations from recent reviews.
2.2 Program can demonstrate effort to implement proposed corrective actions of Improvement Plan (document status of implementation).	*SWMBH-Provider contract XV 325.14113*	**Supporting Evidence:** Documentation of trainings conducted, repairs made, changes made to policies, forms, procedures, etc., as identified in corrective action plan(s). **Scoring: 2** - Follow up complete and done within time frames, or no recommendations or citations from recent reviews. **1** - Improvements address most, but not all, items cited for correction, or not completed within time frames. **0** - No response or very limited response implemented to address citations/recommendations and due date is past.

2017 QMR OPR Scoring Descriptors

INPATIENT

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SECTION 3 - CUSTOMER SERVICES		
3.1 Communication Accommodations: program has developed resources and incorporated features to overcome barriers for persons who have limited ability to communicate in standard English (i.e., LEP resources; bi-lingual staff; communication resources in alternative languages/formats [Braille, Spanish, audio enhancements, sign language communication; TDI; communication enhancement devices; signs; person served-specific communication techniques, etc.); interpreters]).	*MDHHS Contract Attachment P.4.1.1 Access System Standards; MDHHS Contract Attachment P.6.3.1 Customer Service Requirements; DHHS Site Review Protocol B.4.5.1; PIHP policy 6.5 (Communication Accommodations for Limited English Proficiency and Visual Impairment)*	**Supporting Evidence:** Contract for interpretation services. Translations of key documents into different languages. Accommodations for individual customers' language styles and abilities. The reviewer(s) will verify through a review of materials, policies, staff training and interviews that there are resources available to assist persons who have limited ability to communicate in standard English. **Scoring: 2** - Program has appropriate communication accommodations in place to address needs and staff are familiar with accommodations. **1** - Program has a need for communication accommodations and has made some movement toward this, but there is still a gap. **0** - Program has a need for communication accommodations but there has been no movement toward this.
SECTION 4 - FACILITY & MAINTENANCE (If applicable - when customers are served at a provider-owned location)		
4.1 Adequate parking is provided, including handicap accessible spaces.	*DHHS Site Review Protocol D.3*	Supporting Evidence: The site review team will verify through a tour of the facility. Scoring: 2 - Facility and premises are barrier free. 1 - Facility and premises are not barrier free but adequate planning exists to address physical accessibility needs as they arise. 0 - Facility and premises are not barrier free and adequate planning does not exist to address physical accessibility needs as they arise.
4.2 Handicap access to facility, therapy/exam rooms, and restrooms is provided	*DHHS Site Review Protocol D.3*	Supporting Evidence: The site review team will verify through a tour of the facility. Scoring: 2 - Facility and premises are barrier free. 1 - Facility and premises are not barrier free but adequate planning exists to address physical accessibility needs as they arise. 0 - Facility and premises are not barrier free and adequate planning does not exist to address physical accessibility needs as they arise.
4.4 Exits, corridors and hallways are free of obstruction.	*DHHS Site Review Protocol D.3*	**Supporting Evidence:** The site review team will verify through a tour of the site that exits, corridors, and hallways are free of obstruction to allow for safe ambulation for the occupants and emergency evacuation. **Scoring: 2** - Exits, corridors, and hallways are free of obstruction. **1** - Exits, corridors, and hallways have an obstruction that can be permanently corrected while review team is on site (example - moving a laundry basket). **0** - Exits, corridors, and hallways have multiple areas of obstruction, or at least one obstruction that requires planning by the facility for permanent correction (example - moving a Hoyer lift to a more practical location).
4.5 Facility Interior/Cleanliness - safe and sanitary environment is maintained throughout the facility (furnishings, flooring, walls, smells, cleanliness, housekeeping standards, etc.).	*DHHS Site Review Protocol D.3*	**Supporting Evidence:** The site review team will verify through a tour of the inside of the site that the facility is structurally sound and maintained in a safe condition for the occupancies. **Scoring: 2** - The interior is well-maintained and clean. **1** - The interior is in need of minor repairs, maintenance or cleaning (e.g., repairs/maintenance <~$1000, minor cleaning/housekeeping needs that could be alieved in an hour or less). **0** - The interior is in need of major repairs, maintenance or cleaning (e.g., repairs/maintenance >~$1000, cleaning/housekeeping needs that would take more than an hour to accomplish).

2017 QMR OPR Scoring Descriptors

INPATIENT

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4.6	Maintenance of Facility - there is evidence that maintenance issues are being appropriately addressed (invoices for repair / inspection / replacement of equipment, utilities, evidence of facility improvements, etc.).	*DHHS Site Review Protocol D.3*	**Supporting Evidence:** The site review team will verify through a review of maintenance records and site tour that facility and equipment upkeep is being adequately addressed. **Scoring: 2** - Equipment and appliances on the site are in good repair; fire alarms are tested and batteries replaced bi-annually, fire extinguishers are replaced when expired. **1** - One or two minor maintenance issues identified. **0** - More than two minor maintenance issues were identified, or one or more substantial issue.
SECTION 6 - EMERGENCY RESPONSE (If applicable - when customers are served at a provider-owned location)			
6.2	Emergency evacuation maps/routes are displayed in prominent locations at the facility (when customers are served at a provider-owned location)	*DHHS Site Review Protocol D.3*	**Supporting Evidence:** Posted evacuation routes with exiting route specified. **Scoring: 2** - Map(s) posted prominently with specified exiting route(s) marked. **1** - Map(s) not posted prominently or do not clearly mark exiting route(s). **0** - No map(s) posted.
SECTION 7 - TRAINING			
A - All Direct Service Staff			
7.A.1	Recipient Rights Protection (including confidentiality, mandatory reporting requirement for incidents, abuse & neglect) (within 30 days of hire; annual update thereafter).	*MH Code: 330.1755(5)(f)*	**Supporting Evidence:** For all training and personnel items, the review team will verify by a review of staff personnel files or training records. **Scoring: 2** - 95-100% of staff selected completed each required training item within the stated timeframes. **1** - 75-94.4% of staff completed the required training item within the stated timeframes. **0** – Less than 75% of staff have completed the training within the stated timeframes.
7.A.2	Person-Centered Planning (aka Individualized Service Planning) (within 60 days of hire; annual update thereafter).	*MDHHS Master Contract Attachment P.4.4.1.1*	**Supporting Evidence:** For all training and personnel items, the review team will verify by a review of staff personnel files or training records. **Scoring: 2** - 95-100% of staff selected completed each required training item within the stated timeframes. **1** - 75-94.4% of staff completed the required training item within the stated timeframes. **0** – Less than 75% of staff have completed the training within the stated timeframes.
7.A.3	Cultural Diversity / Competency / Awareness (within 6 months of hire; annual update thereafter).	*MDHHS Master Contract Part II(A); 4.5* *42 CFR 438.206*	
7.A.4	Blood borne Pathogens (Preventing Disease Transmission, Infection Control) (within 30 days of hire; annual update required).	*MIOSHA R 325.70016*	
7.A.5	Limited English Proficiency (LEP) (within 6 months of hire).	*MDHHS Master Contract Part I; 18.16* *Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination*	
7.A.6	HIPAA (within 30 days of hire).	*45 CFR 164.308(a)(5)(i) &* *45 CFR 164.503.(b)(1)*	
7.A.7	Corporate Compliance (within 30 days of hire; annual update thereafter).	*Medicaid Integrity Program (MIP)* *Deficit Reduction Act (DRA)*	
7.A.9	Non-Aversive Techniques for Prevention and Treatment of Challenging Behavior (MDHHS approved curriculum if restricted interventions included) (within 30 days of hire and annual updates, if working with individuals with challenging behavior)	*MDHHS Master Contract Attachment P.1.4.1 and R 330.1806*	

2017 QMR OPR Scoring Descriptors

INPATIENT

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SECTION 8 - CREDENTIALING AND PERSONNEL MANAGEMENT REQUIREMENTS			
CAFAS/PECFAS training (prior to administering and booster every two years - CMHPs)			
8.2	Individuals have been credentialed prior to providing services that require credentialing. Re-credentialing occurs at least every 2 years or as required by accreditation, and includes: -updated attestation to credentialing application questions and any other updates to credentialing application information, -verification of valid and current licensure to practice in the State of Michigan, -verification of current malpractice insurance, -review of any quality concerns (if applicable), -verification that the practitioner has not been excluded from participation in Medicaid through OIG check, -verification of licensure limiations or malpractice suites reported through LARA or other issuing state database, or NPDB check	*MDCH Contract attachment P.6.4.3.1 PIHP Policy 2.2 & 2.3*	**Supporting Evidence:** The review team will verify by a review of staff personnel files. **Scoring: 2** - 95-100% of staff selected meet criteria and have required documentation. **1** - 75-94.4% of staff selected meet criteria and have required documentation. **0** – Less than 75% staff selected meet criteria and have required documentation.
8.3	Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following: A. Educational background (Primary source verification required) B. Relevant work experience C. Certification, registration, and licensure as required by law. (Primary source verification required)	*MDCH Contract attachment P.6.4.3.1 PIHP Policy 2.2*	**Supporting Evidence:** The review team will verify by a review of staff personnel files. **Scoring: 2** - 95-100% of staff selected meet criteria and have required documentation. **1** - 75-94.4% of staff selected meet criteria and have required documentation. **0** – Less than 75% staff selected meet criteria and have required documentation.
8.4	Criminal Background Checks: there is evidence that provider conducts verification of criminal background checks prior to hire using the protocol required by SWMBH policy 2.16, including documentation of approval of waiver for employees with exclusionary convictions.	*Contract Requirement; Public Act 59 (PA 218 400.734a); 5) AFC Licensing Rules: R.400.14201.13 (SGH); R.400.1404.6 (FH); PIHP Policy 2.16*	**Supporting Evidence:** The review team will verify by a review of staff personnel files that AFCs and hospitals are using the Michigan Workforce Background Check System and that each employee was registered prior to hire. For other services, it will be verified through a review of files that criminal background checks were completed prior to hire and bi-annually thereafter. Documentation of approved waiver must be present for employees with exclusionary convictions. If the Michigan Workforce Background Check System is being used, annual checks are not needed. **Scoring: 2** - 95-100% of staff selected meet criteria and have required documentation. **1** - 75-94.4% of staff selected meet criteria and have required documentation. **0** – Less than 75% staff selected meet criteria and have required documentation. Note: For AFCs and inpatient, if hired prior to 2001, there was no criminal background check requirement prior to hire; however, annual checks were required from 2001 forward unless exempt. Finger printing became required in 2006.
8.7	Monitoring for Exclusion from Participation in Federal Healthcare Programs. Each employee is to be run through OIG and SAM exclusion databases prior to hire and annually thereafter.	*PIHP Policy 10.13*	**Supporting Evidence:** The review team will verify by a review of staff personnel files that monitoring for exclusion from federal healthcare programs occurs prior to hire and annually thereafter. (Note - individuals with controlling interests in the organization may have ongoing OIG exclusion checks run through SWMBH's compliance dept. If it's confirmed that SWMBH has been supplied with all necessary information to run the checks, full credit should be given for those individuals for OIG screening). **Scoring: 2** - 95-100% of staff selected meet criteria and have required documentation. **1** - 75-94.4% of staff selected meet criteria and have required documentation. **0** – Less than 75% staff selected meet criteria and have required documentation.