



QUALITY MANAGEMENT POLICY  
ASSURANCE & IMPROVEMENT

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## Quality Management Policy

Adopted by the Membership

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The content of this manual does not constitute nor should it be construed as a promise of employment or as a contract between NEFHSC and any of its partners nor staff members of collaborating organizations.

NEFHSC at its option, may change, delete, suspend, or discontinue parts or the policy in its entirety, at any time without prior notice.

## INTRODUCTION

The purpose of this plan is to provide the Coalition with a systemic continuance of quality assurance and improvement activities. These activities are designed to ensure compliance with contractual requirements and to provide a framework for improving the health system serving women, infants and families.

**Scope: This policy applies to the implementation and management of the state Healthy Start program.**

### Quality Management Goals

According to the mission of the Northeast Florida Healthy Start Coalition, the following goals have been established:

- A) To promote and protect the health and well-being of all pregnant women and their children in Northeast Florida through the provision and accessibility of health care programs to meet the health requirements of this population;
- B) To establish a partnership between the private and public sector, state and local government, community alliances and maternal and child health care providers to provide coordinated community-based care for pregnant women and infants;
- C) To enhance communication, information gathering and sharing among public and private sectors on needs and services required by mothers and their infants to reduce risks that contribute to adverse outcomes in Northeast Florida;
- D) To evaluate the community's use of resources for the health and welfare of mothers and their infants in Northeast Florida;
- E) To plan for new and expanded services for women, infants and families in Northeast Florida to address gaps and avoid duplication and fragmentation of existing services.

### Quality Management Objectives

The following objectives and activities will direct the Coalition in working toward meeting these goals:

**Objective I: To conduct Coalition operations and activities in accordance with its bylaws and contractual obligations and to encourage overall quality assurance and quality improvement.**

- 1) HSMN Annual Self-Assessment Form: The Coalition will complete the self-assessment form on years that they are not receiving a site monitoring by HSMN. The Coalition will check the appropriate boxes attesting to its understanding and compliance with the referenced contract requirements. This form must be signed by the Coalition designee and returned to the HSMN Contract Manager. An executed copy will be returned to the Coalition and placed within the program files. The original, executed form will be maintained in the Coalition's contract file, and is valid for the specified contract period shown. Minutes of Coalition Board meetings are sent to the DOH Coalition Contract Manager as requested.
- 2) Stakeholder Survey: A survey of community stakeholders, health care providers, elected leaders and other community groups will be completed as needed serving as an update of the Strategic Plan. The results of the survey will be collected by the Coalition staff and reviewed by the Contracts & Quality Improvement Committee.
- 3) By-Laws: Coalition bylaws will be reviewed at least biannually by an Ad Hoc Committee established by the Chair for this purpose.

- 4) Grievance Procedure: The Coalition will review any grievances by service recipients monthly to identify trends and opportunities for improvement.
- 5) Quarterly Review of Healthy Start Standards & Guideline and Performance/Outcome Measures: The Coalition will review the most recently available data for its service delivery catchment area. The Coalition may develop a Performance Improvement Plan (PIP) or a Corrective Action Plan (CAP) for any Healthy Start Standards and Guidelines (HSSG), Performance Measures (PM), Outcomes and Outputs Measures (OOM), or any non-compliance with contract provisions that does not achieve contract specified goals, objectives, and requirements.
- 6) Annual Action Plan: The Coalition will submit the Annual Action Plan Update along with required appendices to the DOH Contract Manager. The update will note progress on all goals in the Action Plan and will also indicate activities planned for the upcoming year. Any proposed changes or revisions to the Annual Action Plan will be noted as well.

**Objective II: To monitor and evaluate external contracted providers of maternal and child health services to ensure that the needs of women, infants and families are being met.**

- 1) Providers' Annual QA Plan: The Coalition will develop and provide an annual QA/QI Plan for all funded providers (internal and external) and will review those plan objectives and activities monthly through the digitized reporting as specified in the Coalition's Reporting System.
- 2) Providers' Monthly QA-QI Report (Log): Funded providers (internal; and external) are required to submit to the Coalition a Monthly QA-QI Report reviewing Coalition funded services. The Coalition requires all Provider Monthly QA Reports to include the following standardized activities:
  - a. Chart Review Findings & Summary Report  
Healthy Start client chart reviews quarterly. The Coalition recommends that Providers review approximately 10 percent of the number of participants, depending on the size of their total open client caseload. Providers must use the Coalition's specified review tools for Healthy Start. Providers must also submit copies of each completed chart review form to the Coalition via the digitized Coalition Reporting System process. Additionally, providers must create a plan with objectives and activities to address issues identified through the chart review process. Providers should summarize other issues reviewed that affect the delivery of services to Healthy Start clients and describe a plan to address them.
  - b. Performance Measures & Outcomes and Outputs Measures  
Providers must include a review and summary of contract identified performance and outcome measures; creating a plan of objectives and activities to address performance and outcome measures not meeting contract requirements.
  - c. Client Satisfaction Surveys  
Both internal and external providers must include a report of the client satisfaction results and a plan of objectives and activities to address any identified concerns. Providers must utilize the Coalition specified survey provided via file format or at the identified survey link.
  - d. Data Dashboard and Provider Meetings  
Providers will engage regularly and monthly in the Provider/Program Manager's meeting convening to discuss integral programmatic best practices, technical assistance, and catchment area needs. Within the meetings,

Providers will be afforded the opportunity to review and discuss the data dashboard updates that capture the review and completion of contract deliverables.

- 3) Annual Site Visits. The Coalition will conduct annual site visits to all funded providers (internal and external). Site visits will include the following components:

- Site Visit Preparation (Pre Site Visit Materials)
- Site Visit Presentation
- Review of Client Charts
- Review of Financials (FDOH Base Funds and HSMN Medicaid Earnings)
- Review of Contractual Compliance
- Review of Adherence to Healthy Start Standards & Guidelines (HSSG)
- Review of FDOH Performance Measures (PM)
- Review of HSMN Outcomes and Outputs Measures (OOM)
- Provider Interviews (Administration, Finance, Program Staff)

After completion of the site visit, the Coalition will generate and prepare a written Site Visit Report summarizing findings and providing recommendations and the Site Visit Checklist indicating **MET** or **NOT MET** criteria.

The report will be sent to provider and the Contracts & Quality Improvement Committee. Response to any questions and/or concerns from either party will be addressed after this time. The Coalition at its sole and absolute discretion has the ability to engage a provider in either a Performance Improvement Plan (PIP) after identifying any contractual or service performance discrepancies. If the provider continues to perform inadequately following the engagement of a PIP period, the Coalition will assess the implementation of a Corrective Action Plan (CAP).

Coalition staff will review and monitor reports and if Providers are not meeting performance measures (PMs and OOMs) and/or meeting program standards according to Healthy Start Standard and Guidelines (HSSGs). The Coalition will additionally utilize site visits and data collection to monitor Providers in program performance and standards. Through this monitoring and review, the Coalition will utilize the following criteria to engage in additional communication, a Performance Improvement Plan (PIP), or Corrective Action Plan (CAP).

Coalition staff will communicate with Providers:

- Monthly and Ongoing
  - Providers will provide an explanation and a plan to address the item(s) that are not being met.
- Site Visit Process
  - If findings are noted during the Monitoring/Site Visit, a preliminary monitoring report that summarizes the onsite monitoring visit will be completed and returned within 30 days of the monitoring visit. The report will identify program findings and/or deficiencies. Findings and/or deficiencies are conditions that are not in compliance with contractual or statutory requirements.

After two consecutive quarters and/or following the completion of a site visit, if the issue has not been resolved the following steps will be taken:

The Provider will be placed on a Performance Improvement Plan (PIP) and a notice will be sent to the Healthy Start Program Manager and to the Provider's Administrator. The Performance Improvement Plan (PIP) at a minimum will include the following:

- Addresses issues identified during the monitoring process and explains how the Provider must resolve it within a specified timeframe;

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- Strategies on how to improve performance;
- Description of how the Provider will monitor performance and identify whether the issue has been resolved;
- Baseline data (when available) and a specific goal measurement to be achieved and maintained;
- The status of performance achievement;
- The status of progress toward full implementation of strategies and their impact on the performance outcome;
- Discussion of additional strategies that will be attempted or of strategies found to be ineffective that will be discontinued.

The Provider will be required to conduct the following as it relates to the Performance Improvement Plan:

- Submit a copy of an executed performance plan, signed by the Provider to the Coalition's Healthy Start Director (Contract Manager) with the QA/QI Monthly Activity Report.
- Submit performance plan updates each month with the QA/QI Monthly Activity Report until the issue has been resolved.
- Coalition staff will report on the Provider's PIP to the NEFHSC Contracts & Quality Improvement Committee. The Provider may be required to report updates to the committee as requested. A summary of the monitoring and performance improvement plan will be presented at a regularly scheduled meeting. One important focus of these presentations will be to highlight strengths and best practices utilized by Coalitions and their service providers.

The Coalition will provide technical assistance for the Performance Improvement Plan.

If after the plan's identified performance period, if the Provider does not make adequate progress on their PIP then:

- Coalition staff will schedule a meeting with the Healthy Start Team Administrator(s) and Program Manager(s) to discuss other options including but not limited to:
  - The commencement of a Corrective Action Plan (CAP)
  - Coalition staff and Contracts & Quality Improvement Committee will discuss whether or not to impose financial consequences as identified in the standard agreement.

If the determination from Coalition staff and the Contracts and Quality Improvement Committee is for the Provider to be engaged in a Corrective Action Plan (CAP). The CAP is based on a program's repeated failure to meet performance specifications, failure to meet the goals set in previously placed PIPs, and significant signs that the program is not functioning effectively and/or efficiently. The Coalition is responsible for developing a CAP that is mutually agreed upon by the Provider and the Coalition. In the event a mutual agreement cannot be reached, the Coalition shall have final determination of the CAP requiring conformance with the contract.

If the Provider fails to achieve compliance with the CAP within the specified time frame, the Coalition has the authority to terminate the contract for cause in the absence of any extenuating or mitigating circumstances. Additionally, if a Provider does not make improvement as mutually identified, the Coalition Contracts and Quality Improvement Committee will discuss if the contract should be discontinued.

It is critical, that all technical assistance steps needed to prevent this scenario. The Healthy Start program in the region is jeopardized if one Provider is defunded.

**Objective III:** To ensure all direct services provided by the Coalition are delivered in accordance with adopted policies, procedures and protocols.

- 1) Programmatic Policies, Procedures and Protocols: All community-based programs implemented by the Coalition shall establish and adhere to program-specific policies, procedures and protocols to guide service delivery.
- 2) Personnel Policies & Procedures: All Coalition employees, including community-based program staff, shall be provided with and adhere to a copy of the agency's Personnel Policies and Procedure Manual.
- 3) Administrative Management and Fiscal Policies & Procedures: Expenditure of all funding received by the Coalition shall adhere to adopted policies and procedures outlined in the agency's adopted Financial Policies & Procedures.

**Objective IV: To monitor and evaluate services directly provided through Coalition special projects and programs to ensure that the needs of women, infants and families are being met.**

- 1) Reporting to the Coalition
  - a. All community-based programs implemented by the Coalition shall be evaluated once a year to identify areas of need and best practices. The evaluation will be based on what they are being measured by their grantor. Programs and providers that receive subcontracts or serve as subrecipients to the Coalition will be engaged in Coalition led monitoring and evaluation. Programs that function independently and receive annual site visits and monitoring from their grantors/funders will report findings and recommendations from their respective activities to the Contracts and Quality Improvement Committee as requested.

**Objective V: To have a Florida Medicaid Compliance Program in place, providing a mechanism for preventing and detecting violations of law and/or policy.**

Federal and state law requires that Medicaid providers ensure that the claims they submit are correct and properly reimbursed. Federal and state law also requires that providers ensure that they are operating their businesses in compliance with governing laws.

Medicaid providers are required to perform services in accordance with Medicaid policy, while appropriately documenting the service. This includes certifying compliance with regulations when a claim is submitted. Provider documentation must demonstrate compliance or non-compliance with Medicaid policy. A self-audit is a review of claims submitted to Medicaid for a specified period and includes a detailed evaluation of submitted claims. Non-compliance may occur if documentation does not support the billed service, if unqualified staff have performed the service, if there is an incorrect date of service, if there is an incorrect recipient name documented, etc.

A Coalition Consultant conducts regular desk audits of Medicaid claims to identify potential non-compliance issues. Participation in a self-audit does not eliminate the possibility of further review by AHCA and does not affect the Agency's or other regulatory or law enforcement agencies' ability to pursue criminal, civil, or administrative remedies.

The Providers should conduct a self-audit review of Medicaid claims on a monthly basis to evaluate submitted claims or unpaid claims as part of their internal quality assurance plan.

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The Coalition's Management Team shall be responsible for ensuring all agency activities are consistent with this internal quality management plans and policies.

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**Compliance:** To ensure internal compliance with the activities and processes outlined in this document, Coalition staff and Contracts and Quality Improvement Committee members will annually review the Quality Management Plan.

### Changes in Procedures

While every effort is made to keep the contents of this document current, NEFHSC reserves the right to modify, suspend, or terminate any of the policies, procedures, and/or benefits described in the manual with or without prior notice to staff members.

We receive and respect all recommendations to the operating manual and ask that all request be submitted for final approval to the Chief Operating Officer and Chief Executive Officer.