Southwest Michigan Behavioral Health

Quality Assurance and Performance Improvement Program

All SWMBH Business Lines

Year 2017 (October 1, 2016 - September 30, 2017)

Final Version 2/10/2017

- Approved by SWMBH Board: 2/10/2017
- Reviewed by SWMBH Quality Management Committee: 1/26/17
- Reviewed by SWMBH MI Health Link Committee: 2/9/17
- Customer Service Advisory Committee: 1/11/17

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I. Introduction

The Michigan Department of Health and Human Services (MDHHS) requires that each specialty Prepaid Inpatient Health Plan (PIHP) has a documented Quality Assessment and Performance Improvement Program (QAPIP) that meets required federal regulations: the specified Balanced Budget Act of 1997 as amended standards, 42 CFR § 438, requirements set forth in the PIHP contract(s), specifically Attachment P.6.7.1.1.

Southwest Michigan Behavioral Health ("SWMBH") uses its QAPIP to assure it is meeting all contractual and regulatory standards required of the Regional Entity, including its PIHP responsibilities. The QAPIP describes the organizational structure for the SWMBH's administration of the QAPIP; the elements, components and activities of the QAPIP; the role of service recipients in the QAPIP; the mechanisms used for adopting and communicating process and outcome improvement, and to implement improvement strategies to meet and exceed best practice performance levels. SWMBH is a learning region where quality and cost are measured and improved.

SWMBH QAPIP is approved annually by the Southwest Michigan Behavioral Health (SWMBH) Board. The authority of the Quality Management (QM) department and the QM Committee is granted by the SWMBH EO and SWMBH Board. Additionally, more information related to the QAPIP standards can be found in SWMBH policies and procedures, SWMBH Strategic Guidance Document, QMC Committee Charter and other departmental plans.

II. Purpose

The QAPIP delineates the features of the SWMBH QM program. This QAPIP serves to promote quality customer service and outcomes through systematic monitoring of key performance elements integrated with system-wide approaches to continuous quality improvement.

The SWMBH QAPIP spans across clinical service delivery within the network as well as benefit management processes within SWMBH. The program addresses access, quality and cost for services delivered, inclusive of administrative aspects of the system, service delivery and clinical care. Populations served by the SWMBH include persons who experience mental illness, developmental disabilities and substance use disorders.

Additional purposes of the QAPIP are to:

- continually evaluate and enhance the regional Quality Improvement Processes and Outcomes.
- monitor, evaluate, and improve systems and processes for SWMBH.
- Provide oversight and data integrity functions.
- develop and implement efficient and effective processes to monitor and evaluate service delivery, quality and integration of care and customer satisfaction.
- improve the quality and safety of clinical care and services it provides to its customers.
- promote and support best practice operations and systems that promote optimal benefits in service areas of service *accessibility, acceptability, value, impact,* and *risk-management* for all members.
- conduct and report the results of ongoing performance monitoring and structure accountabilities for meeting performance standards and requirements.
- promote best practice evaluation design and methodology in performance monitoring and outcomes research and push process improvement techniques throughout the system.
- promote timely identification and resolution of quality of care issues.
- conduct performance monitoring and improvement activities that will result in meeting or exceeding all external performance requirements.
- meet the needs of external and internal stakeholders and provide performance improvement leadership to other departments.

III. Guiding Principles

Mega Ends

1. **Quality of Life.** Persons with Intellectual Developmental Disabilities (I/DD); Serious Mental Illness (SMI); Serious Emotional Disturbances (SED) and Substance Use Disorders (SUD) in the SWMBH region see improvements in their quality of life and maximize self-sufficiency, recovery and family preservation.
2. **Improved Health.** Individual mental and physical health status and population health are measured and improved.
3. **Exceptional Care.** Persons served are highly satisfied with the care they receive.
4. **Mission and Value-Driven.** CMHSPs and SWMBH fulfill their agencies' missions and support the values of the public mental health system.
5. **Quality and Efficiency.** The SWMBH region is a learning region where quality and cost are measured and improved.

IV. Core Values

Core Values: customer driven, person-centered**,** recovery-oriented**,** evidenced-based**,** integrated care system**,** trust**,** integrity**,** transparency**,** inclusivity**,** accessibility, acceptability, impact, value, culturally competent & diverse workforce, high quality services and risk management.

1. **Quality healthcare will result from a benefit management system embracing input from all stakeholders**
   - Educating all customers of SWMBH on continuous improvement methodologies including providing support to other SWMBH departments and to providers as requested. Inclusion of customers, families, stakeholders, and providers in the performance improvement design will promote optimal results.
   - Promoting a person-centered philosophy will promote customer satisfaction as well as optimal treatment outcomes.
2. **Poor performance is costly**
   - Performance improvement initiatives will be consistent with metrics as established by the SWMBH Board and prioritized in accordance to potential risk.
   - Quality Improvement projects are best approached systemically; best practice improvement planning should promote elements of systematic monitoring, evaluation, feedback and follow-up.
   - Valid, acceptable, accurate, complete and timely data is vital to organizational decision-making.
   - Making data accessible will impact value and reduce risk to SWMBH.
3. **Data Collection Values**
   - Data that is consistently complete, accurate, and timely will lead to consistent measurement and over time ensure data integrity.
   - Providers submitting data to SWMBH shall certify data integrity and have available for review the process used to collect the data.
   - Performance that has demonstrated instability or significant variance to comparison performance on an on-going basis will be monitored closely. Significant variation in results will indicate the need for a corrective action/performance improvement plan.

V. Authority and Structure

The SWMBH Board retains the ultimate responsibility for the quality of the business lines and services assigned to the regional entity. The SWMBH Board annually reviews and approves the QAPIP, receives periodic QAPIP reports and the QAPI & UM Effectiveness Review/Evaluation throughout the year.

In addition to review by the SWMBH Board and SWMBH EO, the QAPIP and QAPI & UM Effectiveness Review/ Evaluation will be taken to the SWMBH Operations Committee to facilitate the development and management of quality assurance and improvement. The SWMBH Operations Committee consists of the EO, or their designee, of each participating CMHSP.

The general oversight of the QAPIP is given to the SWMBH's QAPI Department, with a senior management officer, the Director of QAPI, being responsible for the oversight of QAPIP Implementation. *(Please see attachment A – SWMBH*

organizational chart for more details)

Internal Staffing and Resources of the QAPI Department

The SWMBH QAPI Department is charged with the purpose of developing and managing its program. This program plan outlines the current relationships and structures that exist to promote the performance improvement goals and objectives.

The QAPI Department is staffed with a Director of Quality Assurance and Performance Improvement which oversees the QAPI Department including the 3 Full-Time staff and one external contract position. The QAPI Director collaborates on many of the QAPI goals and objectives with the SWMBH Senior Leadership team and SWMBH Regional Committees, such as the; Quality Management Committee (QMC), Regional Information Technology Committee (RITC), Regional Utilization Management Clinical Protocol Committee (RUMCP) and the Consumer Advisory Committee (CAC).

The QAPI Department staff will include a Business Data Analyst. The Business Data Analyst will play a pivotal role in the QAPIP providing internal and external data analysis, management for analyzing organizational performance, business modeling, strategic planning, quality initiatives and general business operations including developing and maintaining databases, consultation and technical assistance. In guiding the QAPI studies, the Business Data Analyst will perform complex analyses of data including statistical analyses of outcomes data to test for statistical significance of changes, mining large data sets and performs factor analyses to determine causes or contributing factors for outcomes or performance outliers; correlates analyses to determine relationships between variables. Based on the data, the Business Data Analyst will develop reports, summaries, recommendations and visual representations.

SWMBH staff will include a designated behavioral health care practitioner to support and advise the QAPI Department in meeting the QAPIP deliverables. This designated behavioral health care practitioner will provide supervisory and oversight of all SWMBH clinical functions to include; Utilization Management, Customer Services, Clinical Quality, Provider Network, Substance Abuse Prevention and Treatment and other clinical initiatives. The designated behavioral health care practitioner will also provide clinical expertise and programmatic consultation and will collaborate with QAPI Director to ensure complete, accurate and timely submission of clinical program data including Jail Diversion and Behavioral Treatment Committee. The designated behavioral health care practitioner is a member of the Quality Management Committee (QMC).

Adequacy of Quality Management Resources

The following chart is a summary of the positions currently included in the QAPI Department, their credentials and the percentage of time devoted to quality management activities. Additional departmental staff are listed with the percentage of their time devoted to quality activities.

Title	Department	Percent of time per week devoted to QM
Director of Quality Assurance and Performance Improvement	QAPI	100%
QAPI Specialist	QAPI	100%
Business Data Analyst I	QAPI	100%
Business Data Analyst II	QAPI	80%
Consulting Statistician	QAPI and PN	75%
Director of Utilization Management	UM	40%
Director of Provider Network	PN	20%

Chief Information Officer	IT	30%
Senior Software Engineer	IT	30%
Member Engagement Specialist	UM	20%
Waiver and Clinical Quality Manager	PN	20%
Applications and Systems Analyst	IT	30%
Designated Behavioral Health Care Practitioner	UM/PN	40%

QAPI = Quality Assurance and Performance Improvement
PN = Provider Network
UM = Utilization Management
IT = Information Technology

SWMBH will have appropriate staff to complete QAPI functions as defined in this plan. In addition to having the adequate staff, the QAPI Department will have the relevant technology and access to complete the assigned tasks and legal obligations as a managed benefits administrator for a variety of business lines. These business lines include Medicaid, Healthy Michigan Plan, MiChild, Autism Waiver, MI Health Link (MHL) & Duals, SUD Block Grant, PA 2 funds and other grant funding. To complete these functions needed resources include, but are not limited to:

- Access to regional data
- Software and tools to analyze data and determine statistical relationships

The QAPI Department is responsible for collecting measurements reported to the state and to improve and meet SWMBH's mission. In continuing the development of a systematic improvement system and culture, the goal of this program and plan is to identify any needs the organization may have in the future so that performance improvement is effective, efficient and meaningful. The QAPI Department monitors and evaluates the overall effectiveness of the QAPIP, assesses its outcomes, provides periodic reporting on the Program, including the reporting of Performance Improvement Projects (PIPs), and maintains and manages the Quality Management Committee (QMC) and MI Health Link QM Committees.

The QAPI Department collaborates with the Quality Management Committee (QMC) and SWMBH Board in the development of an annual QAPI plan. QAPI Department also works with other functional areas and external organizations like Streamline to review data collection procedures. These relationships are communicated with the EO and the SWMBH Board as needed. Other roles include:

- Reviewing and submitting data to the state
- Creating and maintaining QAPI policies, plans, evaluations and reports
- Implementation of regional projects and monitoring of reporting requirements
- Assisting in the development of Strategic Plans and Tactical Objectives
- Assisting in the development of the Boards Ends Metrics and other Key Performance Indicators

VI. Committees

Quality Management (QM) Committee

SWMBH has established the QMC to provide oversight and management of quality management functions, and providing an environment to learn and share quality management tools, programs, and outcomes. SWMBH values the input of all stakeholders in the improvement process and QMC is one method of participant communication, alignment, and advice to SWMBH. QMC allows regional input to be gathered regarding the development and management of processes and policies related to quality. QMC is responsible for developing Committee goals, maintaining contact with other committees, identifying people, organizations or departments that can further the aims of both the QAPI Department and the QMC. Cooperation with the QMC Program is required of all SWMBH staff, participants, customers and providers.

CMHSPs are responsible for development and maintaining a performance improvement program within their respective organizations. Coordination between the participant and provider performance improvement programs and SWMBH's program is achieved through standardization of indicator measurement and performance review through the QMC.

In order to assure a responsive system, the needs of those that use or oversee the resources, (e.g. active participation of customers, family members, providers, and other community and regulatory stakeholders) are promoted whenever possible. Training on performance improvement technology and methods along with technical assistance is provided as requested, or as necessary.

Quality Management Committee (QMC) Membership

The QMC shall consist of an appointed representative from each participating CMHSP, representative(s) from the SWMBH Customer Advisory Committee (CAC) and SWMBH QAPI Departmental staff. All other ad hoc members shall be identified as needed and include: provider representatives, IT support staff, Coordinating Agency staff and the SWMBH medical director and clinical representation. All QMC members are required to participate; however alternates will also be named in the charter and will have all same responsibilities of members when participating in committee work.
QMC Committee Commitments include:

1. Everyone participates.
2. Be passionate about the purpose
3. All perspectives are professionally Expressed and Heard
4. Support Committee and Agency Decisions
5. Celebrate Success

Decision Making Process

Quality Management is one of the core functions of the PIHP. The QMC is charged with providing oversight and management of quality management functions and providing an environment to learn and share quality management tools, programs and outcomes. This committee allows regional input to be gathered regarding the development and management of processes and policies related to quality. On a quarterly basis, QMC collaborates with the Regional Utilization Management Clinical Practices Committee (RUMPC) on clinical and quality goals and contractual tasks.

The committee will strive to reach decisions based on a consensus model through discussion and deliberation. Further information on decision making can be found in the QMC charter. *(Please see Attachment B – QMC Charter for more details)*

QMC Roles and Responsibilities

- QMC will meet on a regular basis (at a minimum quarterly) to inform quality activities and to demonstrate follow-up on all findings and to approve required actions, such as the QAPIP, QAPI & UM Effectiveness Review/Evaluation, and Performance Improvement Projects (PIPs). Oversight is defined as reviewing data and approving projects.

- Members of the committee will act as conduits and liaisons to share information decided on in the committee. Members are representing the regional needs related to quality. It is expected that QMC members will share information and concerns with SWMBH QAPI staff. As conduits, it is expected that committee members attend all meetings by phone or in person. If members are not able to attend meetings, they should notify the QMC Chair Person as soon as possible. QMC members should be engaged in performance improvement issues, as well as bringing challenges from their site to the attention of the SWMBH committee for deliberation and discussion.
- Maintaining connectivity to other internal and external structures including the Board, the Management team, other SWMBH committees and MDHHS.
- Provide guidance in defining the scope, objectives, activities, and structure of the PIHP's QAPIP.
- Provide data review and recommendations related to efficiency, improvement and effectiveness.
- Review and provide feedback related to policy and tool development.
- The primary task of the QMC is to review, monitor and make recommendations related to the listed review activities with the QAPIP.
- The secondary task of the QMC is to assist the PIHP in its overall management of the regional QAPI functions by providing network input and guidance.

MI Health Link Committee

On March 1, 2015, SWMBH became part of the Center for Medicare and Medicaid Services project titled the "MI Health Link (MHL) demonstration project" for persons with both Medicare and Medicaid. SWMBH contracts and coordinates with two Integrated Care Organizations within the region. The two ICOs identified for Region 4 are Aetna Better Health of Michigan and Meridian Health Plan. As such SWMBH will be held to standards that are incorporated into this QAPIP that are sourced from The Michigan Department of Health and Human Services (MDHHS) , CMS Medicare rules, NCQA Health Plan standards, and ICO contract arrangements. In addition to the MHL demonstration contract, it is required that each specialty PIHP have a documented QAPIP that meets required federal regulations: the specified Balanced Budget Act of 1997 as amended standards, 42 CFR § 438, requirements set forth in the PIHP contract(s), specifically MDHHS Attachment P.7.9.1, Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans, and MI Health Link (MHL) demonstration project contracts, Medicaid Provider Manual and National Council on Quality Assurance (NCQA). SWMBH will maintain a QAPIP that aligns with the metrics identified in the MHL ICO contract. SWMBH will implement BH, SUD and I/DD-oriented Health Care Effectiveness Data and Information Set (HEDIS) measures enumerated in the contract. This may include the implementation of surveys and quality measures, ongoing monitoring of metrics, monitoring of provider performance, and follow-up with providers as indicated.

The MHL Committee is charged with providing oversight and management of quality management functions, and providing an environment to learn and share quality management tools, programs, and outcomes. This committee allows regional input to be gathered regarding the development and management of processes and policies related to quality. The committee is one method of participant communication, alignment, and advice to SWMBH.

The committee tasks are determined by the SWMBH EO, committee chair and members, member needs, MI Health Link demonstration guidelines including the Three-Way Contract, ICO-PIHP Contract and NCQA requirements. The MHL QMC is accountable to the SWMBH EO, and is responsible for assisting the SWMBH Leadership to meet the Managed Care Benefit requirements within the MHL demonstration, the ICO-PIHP contract, and across all business lines of SWMBH. The MHL QMC must provide evidence of review and thoughtful consideration of changes in its policies and procedures and work plan and make changes to its policies where they are needed. Analyzes and evaluates the results of QM activities to identify needed actions and make recommendations related to efficiency, improvement, and effectiveness. The MHL QMC will meet on a regular basis (at a minimum quarterly) to inform quality activities and to demonstrate follow-up on all findings and to approve required actions, such as the QAPI Program, QAPI Effectiveness Review/Evaluation, and Performance

Improvement Projects. Oversight is defined as reviewing data and approving projects.

MI Health Link Committee Membership

The MHL Committee shall consist of the QAPI Department staff, a designated behavioral health care practitioner and ICO representatives. This designated behavioral health care practitioner shall have oversight of any clinical metrics and participates in or advising the MHL Committee or a subcommittee that reports to the MHL Committee. The behavioral healthcare provider must have a doctorate and may be a medical director, clinical director or, participating practitioner from the organization or affiliate organization. All other ad-hoc members shall be identified as needed and could include: provider representatives, IT support staff, Coordinating Agency staff, and medical director and clinical representation.

Members of the committee are required to participate; however alternates will also be named in the charter and will have all same responsibilities of members when participating in committee work.

Members of the committee will act as conduits and liaisons to share information decided on in the committee. Members are representing the regional needs related to quality. It is expected that members will share information and concerns with SWMBH QAPI staff. As conduits it is expected that committee members attend and are engaged in Performance Improvement issues, as well as bringing challenges from their site to the attention of the SWMBH committee for possible project creation.

Decision Making Process

The committee will strive to reach decisions based on a consensus model through discussion and deliberation. Further information on decision making can be found in the MHL QMC charter. *(Please see Attachment D – MHL Committee Charter for more details)*. The MHL Committee is responsible for maintaining contact with other committees as well as identifying people, organizations, or departments that can further the aims of both the QAPI Department and the Committee. The MHL QAPI section of the Committee coordinates with the UM and Provider Network MHL Committees. The QAPI Director is a member of both the UM and Provider Network MHL Committees. The QAPI Director may call on other QAPI team members or CMHSP partners to participate in MHL Committee meetings as necessary.

---*See Attachment A, "Southwest Michigan Behavioral Health Committee Structure."*

Functional Area	Objectives	Lead Staff	Review Date
Committee	Approve last month's MHL Committee Meeting minutes.	All Committee Members	Monthly
UM	Grievances and Appeals	Member Engagement Specialist	Quarterly
Credentialing	Review and approval of MI Health Link policies and procedures.	Director of Provider Network	As needed
	Medical Director, Clean File Review Approvals Four clean file reviews since last meeting	Provider Network Specialist, or Director of Provider Network	Monthly
	Credentialing Applications for Committee Review	Provider Network Specialist, or Director of Provider Network	Monthly
	Practitioner Complaints	Provider Network Specialist, or Director of Provider Network	Quarterly
Quality	Policy and Procedure Review and Updates**.**	Director of QAPI or designated QAPI Specialist	As needed
	Annual Work plan Review (Quarterly).	Director of QAPI or designated QAPI Specialist	Quarterly, as indicated by QAPI work plan

Functional Area	Objectives	Lead Staff	Review Date
	Annual Reviews/Audits (Recommendations for Improvement).	Director of QAPI or designated QAPI Specialist	As needed
	Practitioner Participation and Clinical Practice Guideline Review.	Director of QAPI or designated QAPI Specialist	Quarterly
	Performance Measures for Site Audit	Director of QAPI or designated QAPI Specialist	As needed
	Causal Analysis	Director of QAPI or designated QAPI Specialist	Quarterly
	Call Center Monitoring	Director of QAPI or designated QAPI Specialist	Monthly
	Timeliness Monitoring	Director of QAPI or designated QAPI Specialist	Monthly
	NCQA Reports	Director of QAPI or designated QAPI Specialist	Quarterly
UM/Clinical	Collaborative Initiatives Meridian ICT Update	Director of Utilization Management or Integrated Care Specialist	Monthly
	Complex Case Management	Director of Utilization Management or Integrated Care Specialist	Monthly
	NCQA Measures	Director of Provider Network or Director of Utilization Management	Monthly
	Policy and Procedure Review and Updates.	Director of Utilization Management or Manager of Utilization Management	As needed

MI Health Link Committee Roles and Responsibilities:

- Maintaining connectivity to other internal and external structures including the Board, the Management team, other SWMBH committees and MDHHS.
- Provide guidance in defining the scope, objectives, activities, and structure of the QAPIP.
- Provide data review and recommendations related to efficiency, improvement, and effectiveness.
- Review and provide feedback related to policy and tool development.
- The secondary task of the Committee is to assist the PIHP in its overall management of the regional QAPI functions by providing network input and guidance.
- The primary task of the Committee is to review, monitor and make recommendations related to the listed review activities with the QAPI Program.
- Ensures follow-up as appropriate. Ensures practitioner participation in the QAPI program through planning, design, implementation or review. Ensures discussion (and minutes) reflects:
    - Appropriate reporting of activities, as described in the QM program description.
    - Reports by the QM director and discussion of progress on the QM work plan and, where there are issues in meeting work plan milestones and what is being done to respond to the issues.
- Ensures the organization describes the role, function and reporting relationships of the QM Committee and subcommittees.

- Ensures all MHL required reporting is conducted and reviewed, corrective actions coordinated where necessary, and opportunities for improvement are identified and followed-up.
- Ensures member and provider experience surveys are conducted and reviewed, and opportunities for improvement are identified and followed-up.
- Ensures the organization approves and adopts clinical practice guidelines and promotes them to practitioners. The appropriate body to approve the clinical practice guidelines may be the organization's QM Committee or another clinical committee.
- Ensures the organization approves and adopts preventive health guidelines and promotes them to practitioners in an effort to improve health care quality and reduce unnecessary variation in care. The appropriate body to approve the preventive health guidelines may be the organization's QM Committee or another clinical committee.
- The organization annually:
    - Documents and collects data about opportunities for collaboration.
    - Documents and conducts activities to improve coordination between medical care and behavioral healthcare.
- Ensures the ICO and PIHP identify shared quality improvement measurement requirements and develop and implement related processes sharing results and undertaking correction and quality improvement activities.
- Ensures a care management quality control program is maintained at all times.
- Ensures Call Center quality control program is maintained and reviewed, which should include elements of internal random call monitoring.

VII. Standards and Philosophy

The SWMBH's QAPIP functions according to a Continuous Quality Improvement (CQI) methodology to provide sound benefits management strategy that will yield higher satisfaction for all stakeholders. The regional quality management system combines traditional aspects of quality assurance with quality improvement using a variety of process and improvement strategies including:

- ✓ Develop measures that are reliable, and meet related standards
- ✓ Establish thresholds/benchmarks,
- ✓ Achieve target performance levels,
- ✓ Identify and analyze statistical outliers
- ✓ Implement Performance Improvement Projects
- ✓ Evaluate effectiveness (e.g. QAPI Effectiveness Review/Evaluation)
- ✓ Develop a system that is replicable and adaptable (appropriate scalability of program)
- ✓ Promote integration of QAPI into PIHP management and committee activity
- ✓ Promote coordination internally and externally throughout the region
- ✓ Incorporate relevant process and quality improvement methodologies
- ✓ Predefined quality standards
- ✓ Formal assessment of activities
- ✓ Measurement of outcomes and performance
- ✓ Strategies to improve performance

Other methodologies are used to control process include:

- ✓ ***Define*** the project, process, and voice of the customer.

- ✓ ***Measure*** the current process performance.
- ✓ ***Analyze*** to determine and verify the root cause of the focused problem.
- ✓ ***Improve*** by implementing countermeasures that address the root causes.
- ✓ ***Control*** to maintain the gains

VIII. Review Activities

The QAPI Department is responsible for a wide range of activities and monitoring contract requirements. The QAPI assessment consists of a variety of strategically planned activities that help to identify the actual practices, attitudes, performance, and conformance to standards. Reviews could be at a systematic, programmatic, or individual level. Some of the observed review activities include:

Review Activity	Activity Description
1. Annual QAPI Plan	The QAPI plan is a document that reflects the ongoing progress on QAPI activities throughout the year. The QAPI plan is developed by the QAPI Department with guidance from the QMC and RUMCP. The Plan is reported annually to the EO, Operations Committee the SWMBH Board, and to customers and other stakeholders. The plan consists of the quality improvement, performance and outcome goals to be achieved throughout the year and addresses: • Yearly planned QI objectives/goals for improving: – Quality of clinical care. – Safety of clinical care. – Quality of service. – Members' experience. • Time frame for each objective/goal's completion. • Lead staff responsible for each objective/goal. • Monitoring of previously identified issues. • Evaluation of the QAPIP. ***--See Section XI, "2017 Quality Assurance Improvement Plan"***
2. Annual QAPI & UM Effectiveness Review & Evaluation	Monitoring, evaluation and reporting occurs on an on-going basis. Evaluation results will be shared annually with the EO, Operations Committee, the SWMBH Board, relevant Committees, customers and other stakeholders. The QM department will on an annual basis will do an effectiveness review/evaluation of the QAPIP that will include: • A description of completed and ongoing objectives/goals that address quality and safety of clinical care and quality of service. • Trending of measures to assess performance in the quality and safety of clinical care and quality of service. • Analysis and evaluation of the overall effectiveness of the QI program, including progress toward influencing safe clinical practices throughout the organization. • Identification of any performance improvement needs or gaps in service. • Adequacy of QAPIP resources and staff including practitioner participation and leadership involvement in the QAPIP. • Remediation and corrective action plans.
3. *Annual Goals and Objectives* – Reports,	• Annual Goals and Objectives are discussed, monitored, and reported as defined by the objective scope. All goals should align with SWMBH

Dashboards, Outcome monitoring	Strategic Guidance Document, which is the overarching tool to maintain strategy and tactical objectives, as defined by the Board. • Key Performance indicators will be compared and monitored with reports created. (Board Ends Metrics, Dept. Goals, Regional Committee Goals) • Training and monitoring of best practice standards will be completed as necessary. ***see attachment (G) – "2017-2018 Board Ends Metrics"***
4. Access Standards	• SWMBH will monitor that customers will have a face-to-face level 2 assessment completed within 15 days. • Contracts with providers will be monitored to assess customer access to services within Medicare and Medicaid standards on geography and type. • Assessments against standards related to regular and routine appointments, urgent/emergency care, after-hours care, and call center rates. o Behavioral Health will meet the following standards: 1. Routine Non-Life Threatening Emergency within 6 hours 2. Urgent Care within 48 hours 3. Routine Office Visits within 10 business days 4. Call Center calls will be answered by a live voice within 30 seconds 5. Telephone call abandonment rate is within 5%
5. Key Administrative Functions	In keeping with the need to provide performance oversight across a broad array of PIHP administrative functions, key areas of performance are reviewed by the identified functional committee(s): • *Provider Network* • *Compliance* • *Customer Services* • *Utilization Management* • *Administrative Support* Performance measures for respective functional areas are further described in functional documents, which provides description of associated plans, performance measures, and tracking processes
6. Credentialing	SWMBH will ensure that services and supports are consistently provided by staff (contracted or direct operated) who are properly and currently credentialed, licensed, and qualified. The SWMBH Credentialing and Re-Credentialing policy outlines the guidelines and responsibilities for credentialing and re-credentialing for SWMBH. Credentialing activities will be completed and monitored through the Provider Network functional area in conjunction with QAPI and Provider Network departmental staff, QMC, MHL Committee and the Provider Network Committee.
7. Provider Monitoring Reviews	SWMBH Provider Network department in conjunction with QAPI Department will monitor its provider network to ensure systematic and comprehensive approaches to monitoring, benchmarking, and implementing improvements.

<table>
<tr><td>8. External Monitoring Reviews</td><td>The QAPI department will coordinate the reviews by external entities, including MDHHS, HSAG, NCQA review organization, and any accreditation organization as identified by the SWMBH Board. The QAPI department will also be available to assist affiliates in their external reviews.</td></tr>
<tr><td>9. Performance Improvement Projects (PIPs)</td><td>Every year at least two projects are identified as PIPs. This is done by the QMC as directed by MDHHS and is based on identified gaps in service quality, penetration, or other performance improvement functions. The PIPs are aimed at impacting error reduction, improving safety and quality. Reported to EO, the Operations Committee, customers, relevant other committees, and to other stakeholders according to MDHHS reporting requirements, and/or according to project plan.

Every year at least three projects are defined as PIPs for MHL.

The following are a list of current PIPs that have been selected for each business line:
<table>
<tr><th>MDHHS – Medicaid PIPs:</th><th>MI Health Link PIPs:</th></tr>
<tr><td>Improvement Project #1: (EQR evaluated): “Improving Diabetes Treatment for Consumers with a Co-morbid Mental Health Conditions”.

Improvement Project #2: “Improving Medication Management for persons with Intellectual and Developmental Disabilities”.</td><td>1. (NQF 1879): “Adherence to Antipsychotic Medications For Individuals with Schizophrenia” – National Quality Strategy Domain: Patient Safety
2. (NQF 1932) : “Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications”
3. (NQF 0576) “Follow-Up after Hospitalization for Mental Illness (FUH)”.</td></tr>
</table></td></tr>
<tr><td>10. Customer and Provider Assessments</td><td>Surveys are collected throughout the year; and are reviewed by the QMC and MHL Committee and required by PIHP/MDHHS contract. Results are Reported to EO, the CAC, the Operations Committee, the SWMBH Board, customers, and other stakeholders annually. This data is used to identify trends and make improvements for the customer experience. The MHSIP survey is used for adult participants 17 years of age and over and the YSS survey is used for Youth under the age of 17.</td></tr>
<tr><td>11. Customer and Provider Assessments</td><td>Surveys are collected throughout the year; and are determined by the QMC and MHL Committee and required by PIHP contract. Reported to EO, the CAC, the Operations Committee, the SWMBH Board, customers, and other stakeholders annually. This data is used to identify trends and make improvements for the customer experience.</td></tr>
<tr><td>12. Michigan Mission Based Performance Indicators (MMBPIS)</td><td>A collection of state defined indicators that are aimed at measuring access, quality of service, and provide benchmarks for the state. Data is reported to Michigan Department of Health and Human Services (MDHHS), results are additionally communicated to the EO, the Operations Committee, the SWMBH Board, customers, and other stakeholders. The SWMBH maintains a dashboard to monitor the progress on each indicator throughout a year.</td></tr>
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13. Critical Incidents/Sentinel Events/Risk Events	The state has provided definitions for three categories of events that the SWMBH monitors through the QAPIP. For further information see SWMBH Policy (3.5) Critical Incidents/Sentinel Events/Risk Events.
14. Customer Grievances and Appeals	Collected and monitored by the SWMBH and analyzed for trends and improvement opportunities. Categories will be used for reporting including: Quality of Care Complaints, Access, Attitude and Service, Bill/Financial, and Quality of Practitioner Office Site. These trends will be reviewed quarterly and annually.
15. Behavior Treatment Review Data	Collected by the SWMBH from the affiliates and available for review. For more information see SWMBH Policy Behavior Treatment Review Committee. The PIHP shall continually evaluate its oversight of "vulnerable" people in order to determine opportunities for improving oversight of their care and their outcomes.
16. Utilization Management	An annual Utilization Management (UM) Plan is developed and UM activities are conducted across the Affiliation to assure the appropriate delivery of services. Utilization mechanisms identify and correct under-utilization as well as over-utilization. UM data will be aggregated and reviewed by the Regional UM Committee as well as QMC for trends and service improvement recommendations. To ensure that the UM program remains current and appropriate, QM will do an annual evaluation of the UM program.
17. Jail Diversion Data	Collected by the SWMBH from the participants and available for review. Collaborative program between participant CMHSPs and their County to provide mental health treatment and assistance, if permitted by law and considered appropriate, to people with serious mental illness who are considered at risk for 1 or more of the following; entering the criminal justice system; not receiving needed mental health services during incarceration in a county jail; not receiving needed mental health treatment services upon release or discharge from a county jail; and being committed to the jurisdiction of the Department of Corrections. SWMBH collects and reports the number of jail diversions (pre-booking, and post booking) of adults with mental illness (MI), adults with co-occurring mental health and substance abuse disorders (COD), adults with developmental disabilities (DD), and adults with developmental disabilities and co-occurring mental health and substance abuse disorders (DD & COD).
18. Emergent and Non-Emergent Access to care	Emergent and non-emergent cases are periodically monitored to ensure compliance with standards. Standards: i. All crisis/emergent calls are immediately transferred to a qualified practitioner without requiring an individual to call back. ii. For non-emergent calls, a person's time on-hold awaiting a screening must not exceed three minutes without being offered an option for callback or talking with a non-professional in the interim. iii. All non-emergent callbacks must occur within one business day of initial contact. iv. For individuals who walk in with urgent or emergent needs, an intervention shall be immediately initiated. v. Those individuals with routine needs must be screened or other arrangements made within thirty minutes.
19. Medicaid Verification	Managed by compliance department with report to the QM department for analysis and process evaluation.

20. Business Line Management	Manage quality improvement activities as required by different business lines of the SWMBH including Medicaid, Healthy Michigan, Coordinating Agency, and MME as required in the appropriate contract.
21. Call Center Monitoring Plan	The QM Department in collaboration with UM Department is responsible for ensuring a call center monitoring plan is in place. The monitoring plan includes elements such as: providing routine quality assurance audits through random call monitoring and tracking call center service lines (crisis, emergent, immediate and routine) calls for timely responses. Call center performance measures may include: a. A 96.25% performance criteria scoring rate. b. A call abandonment rate of 5% or less. c. Average call center answer time of 30 seconds or less. d. Service level standard of 75% or above.
22. Serving members with Complex Health Needs	The SWMBH is committed to serving all customers including those with complex health needs. The QM Department will work with The UM Department to use process and outcome measurement, evaluation and management tools to improve quality performance. Program effectiveness, processes, member satisfaction data and quality improvement measures will be reviewed and revised each year based on the population assessment and all quantitative and qualitative measures available regarding the program.
23. Activities for serving a culturally and linguistically diverse membership	The SWMBH is committed to serving all customers including those with complex health needs. The QM Department will work with The UM Department to use process and outcome measurement, evaluation and management tools to improve quality performance. Program effectiveness, processes, member satisfaction data and quality improvement measures will be reviewed and revised each year based on the population assessment and all quantitative and qualitative measures available regarding the program.
24. Patient Safety	To improve the safety of clinical care and services provided to customers, safety initiatives are provided to providers and customers to help reduce, avoid and prevent adverse events or injury. To develop and evaluate the effectiveness of regional safety initiatives, the QM department and Committee analyzes data from various sources including customer surveys, audits, reported incidents and member or provider complaints. Collaborate and discuss findings with Provider Network, Regional Utilization Management, MHL and Clinical Committee meetings.
25. Collaborative Activities	In an effort to improve outcomes, the QM Department collaborates with multiple functional areas on a quarterly basis to provide quality updates and data reviews. Many of the QM Department functions overlap with Technology, Utilization Management and Clinical objectives/goals. The QM Department has an active present throughout all functional area's to enhance communication and feedback mechanisms between collaborative groups and Committee's. The QM Department also collaborates with other quality organizations, physical health organizations and venders to share information, to improve overall member outcomes.

IX. 2017 Quality Assurance/Utilization Management Departmental Goals

2017 QAPI Departmental Goals:

1. Managed Information Business Intelligence (MIBI) Conversion of remaining dashboards into Tableau data visualization/analysis system. (by: 9/30/17)
2. Improve and streamline internal report request, tracking and follow-up process. (by: 9/30/17)
3. Perform annual evaluation and analysis of required Utilization Management Department functions. (by: 12/30/17)
    a. 2017 UM Program Description & Plan
    b. Policies and Procedures in compliance with contractual, state and regulatory and. accreditation requirement.
    c. Department Compliance with Established UM standards.
    d. Adequate Access
        i. Telephone Access to Services and Staff.
    e. Timeliness of UM Decisions
        i. Services
        ii. Appeals
    f. UM Decision-Making
        i. Clinical Criteria
        ii. Availability of Criteria
        iii. Consistency of Applying Criteria
        iv. Inter-rater reliability (IRR audit)
    g. Coordination of Care
    h. Quality of Care
    i. Outlier Management
    j. Over or under utilization
    k. Hospital Follow-Up
    l. Behavioral Healthcare Practitioner Involvement

2017 Utilization Management Departmental Goals:

1. Publish a region wide community event calendar on the SWMBH Website. (by: 12/30/17)
    a. Customer Services to work with web site committee to develop a calendar
    b. Customer Services to work with each CMH to provide quarterly updated for the calendar and ensure calendar is updated

2. Develop processes to ensure consistent application of medical necessity and service determination. (by: 12/30/17)
    a. Quarterly inter-rater reliability testing which results in 85% accuracy rating across clinical staff
    b. 85% accuracy score for call monitoring for all clinical staff
    c. Development of an internal process to evaluate the appropriateness of medical necessity denials through Smartcare record audits

3. Create a release of information management process. (by: 12/30/17)
    a. Provide onsite pick up of release of information for MHL members from highly utilized Inpatient Psychiatric Units (i.e. Borgess, Bronson Battle Creek)
    b. Work with IT to develop a report out of Smartcare indicating expiring releases of information

c. Determine a method for provider notification of expiring releases in Smartcare (i.e. Dashboard for SUD providers/messages and alerts)
d. Restructuring MHL record/release/authorization processes in Smartcare to require the development of separate Provider Records, based on the presence of a Release of Information (parallel system to SUD records)

X. 2017 QMC Regional Commitments & Goals

Goals are in alignment with SWMBH and QMC Regional leadership principles and MDHHS contract reporting requirements:

1. Develop a standardized call data reporting and monitoring process for CMHSPs.
2. Evaluation and Analysis of 2016 Customer Satisfaction Survey process. Evaluation of Consumer responses will be used to promote best practice interventions and improve Consumer outcomes.
3. The QMC will evaluate and offer improvement strategies on Regional Critical Incident and Event Reporting.

XI. Data Management

As part of a productive and active Quality Improvement system it is critical that data integrity and collection is systemically monitored and improved. As such it is important to review the system for errors and ensure that the data is correct, accurate, and timely.

1. System Reviews- the QM Department along with IT is responsible for ensuring that there are:
   - Data Reviews before information is submitted to the state
   - Random checks of data for completeness, accuracy and that it meets the related standards.
   - Source information reviews to make sure data is valid and reliable.
2. The QMC and QM Department will address any issues identified in the system review.
3. Processes should be clearly defined and replicable with consistently applied methods of tracking to assure measurability in data collection. Re-measurements should happen as often as determined necessary for the identified project(s).

XII. Communication

The QAPI Department interacts with all other departments within SWMBH as well as the participant Community Mental Health Services Programs (CMHSPs). The communication and relationship between SWMBH's other departments and CMHSPs is a critical component to the success of the QAPI Department. The QAPI Department works to provide guidance on project management, technical assistance and support data analysis to other departments and CMHSPs. The sharing of information with internal and external stakeholders through our Managed Information Business Intelligence system and through the SWMBH SharePoint site is key. The site offers a variety of interactive visualization dashboards that give real time status and analysis to the end user. At least annually, the QAPI department shares with relevant stakeholders and the SWMBH provider network in newsletter articles and on the SWMBH website its QAPI program information and results such as member survey and QAPI & UM evaluation results.

SWMBH acknowledges the importance of disseminating quality-related information and improvement outcomes. Communication of findings will be made to the following groups:

- Stakeholders (Including providers inside the provider network), Customers and family members of customers (when appropriate)
- SWMBH Board

- CMH staff and SWMBH staff
- Others - State representatives

These groups and others may be provided information through a variety of methods including but not limited to:

- ✓ Newsletters
- ✓ SWMBH Website
- ✓ SWMBH SharePoint Site
- ✓ Tableau Dashboards
- ✓ SWMBH QM Reports
- ✓ Meetings
- ✓ External Reports

XIII. 2017 Quality Assurance and Performance Improvement Plan

(October 2016- September 2017)

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
1. Michigan Mission Based Performance Improvement System (MMBPIS)	➢ MMBPIS Performance Standards will meet or exceed the State indicated benchmark, for each of the (17) Performance Measures.	✓ Maintain a dashboard tracking system to monitor progress on each indicator throughout the year (located on SWMBH Portal). ✓ Report indicator results to MDHHS on a Quarterly basis. ✓ Status updates to relevant Committees such as: QMC; RUMCP; CAC and Operations Committee. ✓ Ensure CMHSPs are using approved template to submit Indicators on a monthly schedule to SWMBH.	October 2016 – September 2017	Aradhana Gupta, Jonathan Gardner, Heather Sneden Moira Kean Rhea Freitag	Quarterly Submissions to MDHHS CMHSPs submit monthly reports

2. Event Reporting (Critical Incidents, Sentinel Events and Risk Events)	➢ Event Reporting- trending report Adhere to MDHHS and ICO reporting mechanisms and requirements for qualified events as defined in the contract language. ➢ Ensure CMHSPs are submitting monthly reports.	✓ Event Reporting Quarterly reports to QMC; RUMCP, CAC and MHL committees as part of process. ✓ Quarterly Reports of any qualified events to MDDHS including: ▪ Suicide ▪ Non Suicide Death ▪ Emergency Medical Treatment Due to medication error ▪ Hospitalization due to injury or medication error ▪ Arrest of a consumer that meets population standards	October 2016 – September 2017	Heather Sneden Jonathan Gardner Moira Kean	Quarterly
3. Uniformity of Benefits	➢ Implement and perform analysis on the consistency of functional assessment tools. ➢ Ensure reliable use of selected tools.	✓ Perform analysis on tool scores relative to medically necessary level of care. ✓ Identify and schedule reports on functional assessment tool scores.	October 2016 – September 2017	Aradhana Gupta Jonathan Gardner Heather Sneden Paula Ongwela	Quarterly
4. Behavioral Treatment Review Committee Data	➢ Information is collected by SWMBH from CMHs and available for review. ➢ The PIHP will continually evaluate its oversight of "vulnerable" people to identify opportunities for improving care.	✓ The QMC Committee will review the data collected from CMHs on a quarterly basis. ✓ The QMC Committee will formulate methods for improving care of "vulnerable" people.	October 2016 – September 2017	Heather Sneden Jonathan Gardner Moira Kean Kim Rychener	Quarterly

5. Jail Diversion Data Collection	➢ Information is collected by SWMBH from CMHSPs and available for review.	✓ The QMC will evaluate data trends and specific CMHSP results. ✓ Jail Diversion data is shared at QMC/RUMCP regional committees.	October 2016 – September 2017	Heather Sneden Jonathan Gardner Moira Kean Kim Rychener	Annually

6. External Monitoring Reviews	➢ Ensure that the participant has achieved each Quality element, as identified in the site tool and contracts with satisfactory results.	✓ Participant written Quality Improvement Plan for the fiscal year. ✓ Review participants Sentinel event and Critical Incident policy. ✓ Ensure participant has a BTRC that meets MDHHS requirements. ✓ The participants Jail Diversion Policy is compliant. ✓ Participants that are found to be deficient, with reviewed elements will be required to submit a Corrective Action Plan to outline improvement strategies.	October 2016 – September 2017	Heather Sneden Jonathan Gardner Moira Kean Kim Rychener Rhea Freitag	Annually

7. Review of Provider Network Audits, Clinical Guidelines, and Medicaid Verification	➢ Review audits and reports from other SWMBH departments for continuous improvement opportunities.	✓ Annual report to QMC Committee on any findings or opportunities for improvement. ✓ Corrective Action Plans (CAP) developed, issued and tracked as needed. ✓ QAPI dept. will monitor its provider network on an annual basis to ensure systematic approaches to monitoring are occurring. Results are included in the QAPI annual Evaluation report. ✓ NCQA Clinical Practice Guidelines measure performance against at least (2) aspects of the (3) guidelines. three clinical practice guidelines.	October 2016 – September 2017	Jonathan Gardner Heather Sneden Aradhana Gupta Paul Ongwela Moira Kean Kim Rychener Nancy Wallace Rhea Freitag Mila Todd Sackett	Annually

8. Monitor the Complaint tracking system for Providers and Customers	➢ Monitor Grievance, Appeals and Fair Hearing Data ➢ Monitor denials and UM decisions for trends related to provider complaints	✓ At a minimum quarterly reports on customer complaints to the QMC Committee; MHL Committee; RUMCP Committee and CAC Committee are reviewed. ✓ Ensure proper reporting, monitoring and follow-up resolution of Grievance and Appeals data including: ➢ Billing or Financial Issues ➢ Access to Care ➢ Quality of Practitioner Site ➢ Quality of Care ➢ Attitude & Service	October 2016 – September 2017	Heather Sneden Ashley Esterline Moira Kean Kim Rychener	Quarterly
9. External Monitoring, Audits and Reviews	➢ The Quality Management Department will coordinate the reviews by external entities, including MDHHS, HSAG, NCQA and other organizations as identified by the SWMBH board. ➢ The Quality Department will make sure that SWMBH achieves the goal/score established by the Board Ends Metrics, or meets the reviewing organizations expectations.	✓ The Quality Department will ensure all documentation is returned to the external monitoring agency in a timely manner. ✓ The Quality Department will notify other functional areas of reviews and ensure all arrangements and materials/documents are ready for review. ✓ The Quality Department will use effective communication with affiliates and make sure all Corrective Action Plans are distributed to the entity or functional area and returned in a timely manner.	October 2016 – September 2017	Jonathan Gardner Heather Sneden Aradhana Gupta Moira Kean Kim Rychener Mila Todd Sackett Tim Dubois Robert Schleichert	Annually

10. Utilization Management	➢ UM data will be aggregated and reviewed by the Regional UM Committee and Quality Management Committee for trends and service improvement recommendations. ➢ Identify Best Practice Standards and Thresholds to ensure valid and consistent UM data collection techniques.	➢ Report development and production. Identify software needs to track outlier management. ➢ MDHHS required initiatives. Identify reports necessary to review current utilization patterns. ✓ Work with committees to analyze data by population and level of care. ❖ **Annual UM Evaluation:** o Department Compliance with Established UM standards o Adequate Access/Telephone Access to Services & Staff o Timeliness of UM Decisions: Service & Appeal o UM Decision-Making: Clinical Criteria; Availability of Criteria; Consistency of Applying Criteria; Inter-rater reliability (IRR audit) o Coordination of Care o Quality of Care o Outlier Management o Over or under utilization o Hospital Follow-Up	October 2016 – September 2017	Kim Rychener Jonathan Gardner Heather Sneden Natalie Tenney	Some components are monitored Monthly. All results are included in the QAPI annual Evaluation.

11. Emergent and Non-Emergent Access	➢ Emergent and non-emergent cases are periodically monitored to ensure compliance with standards.	✓ All crisis/emergent Calls are immediately transferred to a qualified practitioner. ✓ Non emergent time on-hold must not exceed three minutes. ✓ All non-emergent call backs should occur within one business day. ✓ Individuals with emergent needs, shall be provided an immediate intervention.	October 2016 – September 2017	Jonathan Gardner Kim Rychener Natalie Tenney Moira Kean	Monthly
12. Call Center Monitoring (SWMBH reporting) for MI Health Link Business Line	➢ Ensure that a call center monitoring plan is in place ➢ Provide routine quality assurance audits. ➢ Random (live) Monitoring of calls for quality assurance. ✓ Tracking and monitoring of all service lines (crisis, emergent, immediate and routine)	✓ A review of (live) calls and agent performance to meet a scoring criteria of 96.25% performance rate is completed on approved template/form. ✓ Achieve a call abandonment rate of 5% or less. ✓ Monitor number of calls received for each service line. ✓ Average answer time is confirmed as; 30 seconds or less. ✓ Service level standard of 75% or above. ✓ Other performance indicators may be requested by the Integrated Care Organizations.	October 2016 – September 2017	Jonathan Gardner Heather Sneden Tim Dubois Paul Ongwela Kim Rychener Natalie Tenney	Monthly

13. Management of Information Systems and Data Reporting	✓ Quality Department; QMC and MHL Committee to review quality and timeliness of data reporting. ✓ Ensure Reports are timely and accurate for internal/external stakeholders.	✓ Claims Payment and tracking systems accuracy. ✓ Ensure timeliness and accuracy of Quality Indicator submissions to MDHHS. ✓ Grievance and Complaint tracking analysis. ✓ Data Security tracking. Reporting any breaches to ICO's and contract agencies. ✓ Tracking and analyzing services, cost by population groups and special needs categories. ✓ Access to care tracking (Level II Timeliness report). ✓ Tracking and adherence to encounter reporting requirements. ✓ Credentialing Reports. ✓ A minimum acceptance rate of 98% of Encounters are accepted by (MDHHS). ✓ A minimum acceptance rate of 90% of BH TEDS records are accepted by (MDHHS).	October 2016 – September 2017	Jonathan Gardner Heather Sneden John Holland Robert Schleicher t Paul Ongwela Tim Dubois Business Analyst	Monthly

14. Coordination of Care	✓ Monitors for continuity and coordination of care members receive across the network and actions improve. ✓ Demonstrate re-measurement for selected interventions. ✓ Quantitative and causal analysis of data to identify improvement opportunities. ✓ Collaboration with health plans to coordinate BH treatment for members.	✓ Use of Care Management Technology (CMT) and CC360 to measure: Exchange of information across the continuum of BH services. ✓ Access and follow-up with appropriate BH practitioners in the network. ✓ Help create and implement a Provider Survey on collaboration and coordination of care between behavioral healthcare and medical care. ✓ Measure and analysis of appropriate use of psychotropic medications. ✓ Measure and analysis of services/programs for consumers with severe and persistent mental illness.	October 2016 – September 2017	Jonathan Gardner Heather Sneden Moira Kean Kim Rychener Nancy Wallace	Quarterly

15. Quality of Clinical Care	➢ Provide Qualitative analysis for the identified opportunities. ➢ Re-measure identified opportunities and determine if interventions were effective.	✓ Create a procedure describing how the organization assists pediatric members with transition to adult practitioner. ✓ Implementation and analysis of electronic based technologies, such as: o E-visits o E-Appointment scheduling o E-prescribing o E-referrals o E-enrollment in case management or wellness programs o Online record access o Healthwise Patient Education System o My Strength Program	October 2016-September 2017	Jonathan Gardner Tim Dubois Kim Rychener Moira Kean Cathy Hart	Quarterly
16. Safety of Clinical Care	➢ Track patient safety activities and make recommendation for regional improvement. ➢ Provide a comparative report using current year and previous year's data to identify safety concerns and trends.	✓ Complete an annual analysis of patient safety activities. ✓ Track and provide analysis on patient safety concerns, risk incidents including Adverse incidents, Critical Incidents or Sentinel Event that are reported by CMHSPs on a monthly basis. ✓ Monitoring/Discussions and collect minutes during the BRTC meetings. ✓ Cover and identified network-wide safety issues during Regional Clinical and Quality meetings. ✓ ICO Case Management ✓ Review of I & A's ✓ Background checks for Providers during Credentialing/Recredentialing process ✓ Case Management Review Sessions	October 2016-September 2017	Heather Sneden Moira Kean Rhea Freitag Scott	Monthly

17. Member Experience	➢ To develop and evaluate the effectiveness of programs and initiatives, the QM department and QMC and MHL Committee analyzes data and customer input from various sources including customer surveys, audits, reported incidents and member or provider complaints. ➢ Data is used to identify trends and make improvements for the customer experience and improved outcomes.	✓ Distribution and analysis of an annual customer satisfaction survey for members who have received multiple services during the survey time period. ✓ Medicaid Member Service Satisfaction Surveys ✓ Medicare Member Service Satisfaction Surveys ✓ Complex Case Management Member Experience Survey ✓ Distribution and analysis of MH and Physical Health provider satisfaction surveys. ✓ Causal analysis of grievance and appeal data broken into categories including: Quality of care, access, attitude and service, billing and financial issues and quality of practitioner office site. ✓ Member Grievance and Appeals data Complex Case Management Grievance and Appeals data. ✓ Results are presented to the EO, Customer Advisory Committee, Operations Committee, QMC, MHL Committee, RUMCP, SWMBH Board and other stakeholders annually.	October 2016-September 2017	Jonathan Gardner Heather Sneden Moira Kean Mike Vincent Paul Ongwela Kim Rychener	Annually

18. Sharing and Communication of Information	➢ The Quality Department will demonstrate Sharing of information and communication through various internal and external resources to its membership and providers.	✓ Ensure availability of information about QI program and results through newsletter, mailings, web-site, and member handbook and practitioner agreements. ✓ Provide newsletter articles communicating QI performance results and satisfaction results for members and practitioners. ✓ Provide access to QMC and MHL meeting minutes and materials to internal customers.	October 2016 - September 2017	Jonathan Gardner Heather Sneden Aradhana Gupta Tim Dubois Kim Rychener Kimberly Whittaker	Quarterly

19. Serving Culturally and Linguistically Diverse Members	➢ The Quality Department will work with other SWMBH Departments to address the Cultural and Linguistic needs of its membership.	✓ Ensure that Cultural Competency policies are being followed. ✓ Review Cultural Competency Plan on an annual basis to address any identified barriers to care. ✓ Work with Clinical Team and RUMCP Committee to reduce health care disparities in clinical areas. ✓ Work with Provider Network to improve network adequacy to meet the needs of underserved groups. ✓ Improve Cultural Competency materials and communication. ✓ Review Annual Cultural Competency Policies and Plan.	October 2016-September 2017	Jonathan Gardner Achelles Malta?? Kim Rychener Joel Smith Moira Kean	Annually

20. Serving Members with Complex Health Needs	➢ The Quality Management Department will work with the Utilization Management Department to use process and outcome measures to improve quality and performance.	✓ Measure program effectiveness, process, member satisfaction data and outcomes to help improve the Complex Care Management Program. ✓ Population Assessment ✓ Complex Case Management Member Satisfaction Survey ✓ Causal Analysis of Complex Case Management Grievance and Appeal Data ✓ Monitor and Evaluate Access to care standards to ensure members are receiving timely services. ✓ Help to identify population health trends and plan programs and services accordingly. ✓ Qualitative and Quantitative Analysis	October 2016 – September 2017	Moira Kean Kim Rychener Nancy Wallace Natalie Tenney Ashley Esterline	Quarterly

21. State Mandated Performance Improvement Projects (PIP)	➢ Identify (2) PIP projects that meet MDHHS and NCQA standards: *Improvement Project #1:* (EQR evaluated): "Improving Diabetes Treatment for Consumers with a Co-morbid Mental Health Conditions". *Improvement Project #2:* "Improving Medication Management for persons with Intellectual and Developmental Disabilities".	✓ HSAG report on PIP interventions and baseline ✓ PIP Status updates to relevant SWMBH Committees such as: QMC; RUMCP; CAC, Operations and MHL Committees ✓ QMC to consider selection of PIP projects aimed at impacting error reduction, improving safety and quality. NCQA PIPs to be considered: 1. (NQF 1879): "*Adherence to Antipsychotic Medications For Individuals with Schizophrenia"* – National Quality Strategy Domain: Patient Safety 2. (NQF 1932) **:** *"Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications"* 3. (NQF 0576) "*Follow-Up after Hospitalization for Mental Illness (FUH)".* *4.* (NQF 0004): "*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)".*	October 2016 – September 2017	Mike Vincent Moira Kean Jonathan Gardner Paul Ongwela	Quarterly

XII. Evaluation

On at least an annual basis, the QAPIP is evaluated. The QAPI & UM Effectiveness Review/Evaluation document is a companion document to the annual QAPIP and will be completed at the end of the fiscal year, or shortly thereafter. The QAPI & UM Effectiveness Review/Evaluation assesses the overall effectiveness of the QAPI and UM Programs including the effectiveness of the committee structure, the adequacy of the resources devoted to it, practitioner and leadership involvement, the strengths and accomplishments of the program with special focus on patient safety and risk assessment and performance related to clinical care and service. Progress toward the previous year's project plan goals are also evaluated. The SWMBH QM department completes the evaluation and identifies the accomplishments and any potential gaps during the previous year's QM activities. When a gap is identified and addressed during that year it will be reported in the QAPI Effectiveness Review/Evaluation, other gaps may be incorporated into the next year's QAPI plan. The findings within the QAPI Effectiveness Review/Evaluation will be reported to the QM Committee, Operations Committee, SWMBH EO, and SWMBH Board.

A Performance Improvement/Corrective Action Plan may be required for any area where performance gaps are identified. This describes a project improvement plan of action (including methods, timelines, and interventions) to correct the performance deficiency. A corrective action/performance improvement plan could be requested of a SWMBH department, CMHSP, or Provider Organization. When a provider within the network is required to complete such a plan, the Provider Network department will be involved and a notification of the needed action and required response will be given to the provider. A sanction may be initiated based on the level of deficiency and/or failure to respond to a Performance Improvement/Corrective Action Plan request.

References:

BBA Regulations, 42 CFR 438.240

MDHHS –PIHP Contract Attachment P 6.7.1.1 et al

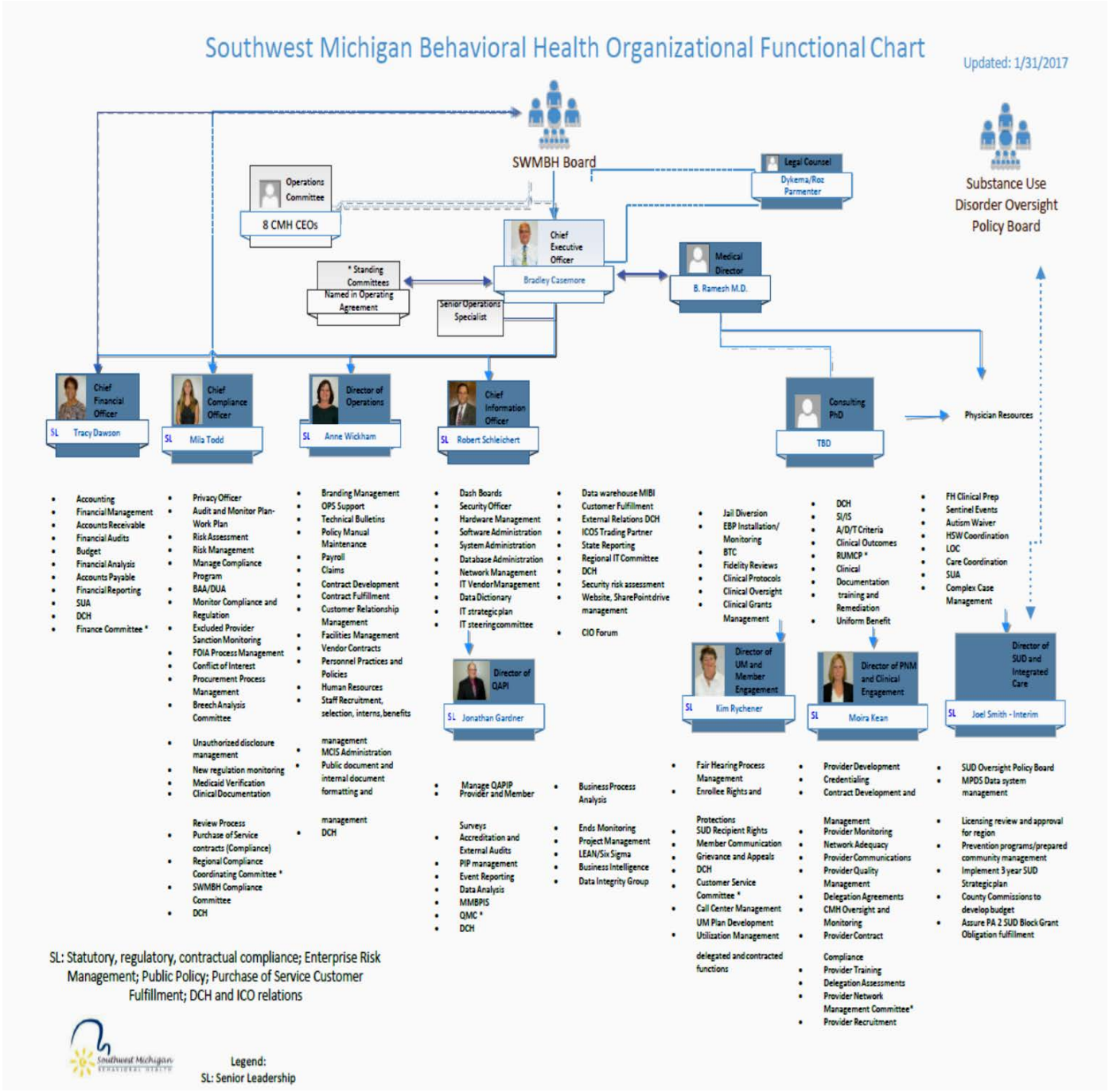
SWMBH Quality Management Policies

NCQA – 2017 MBHO Accreditation Standards

Quality Management Committee Charter

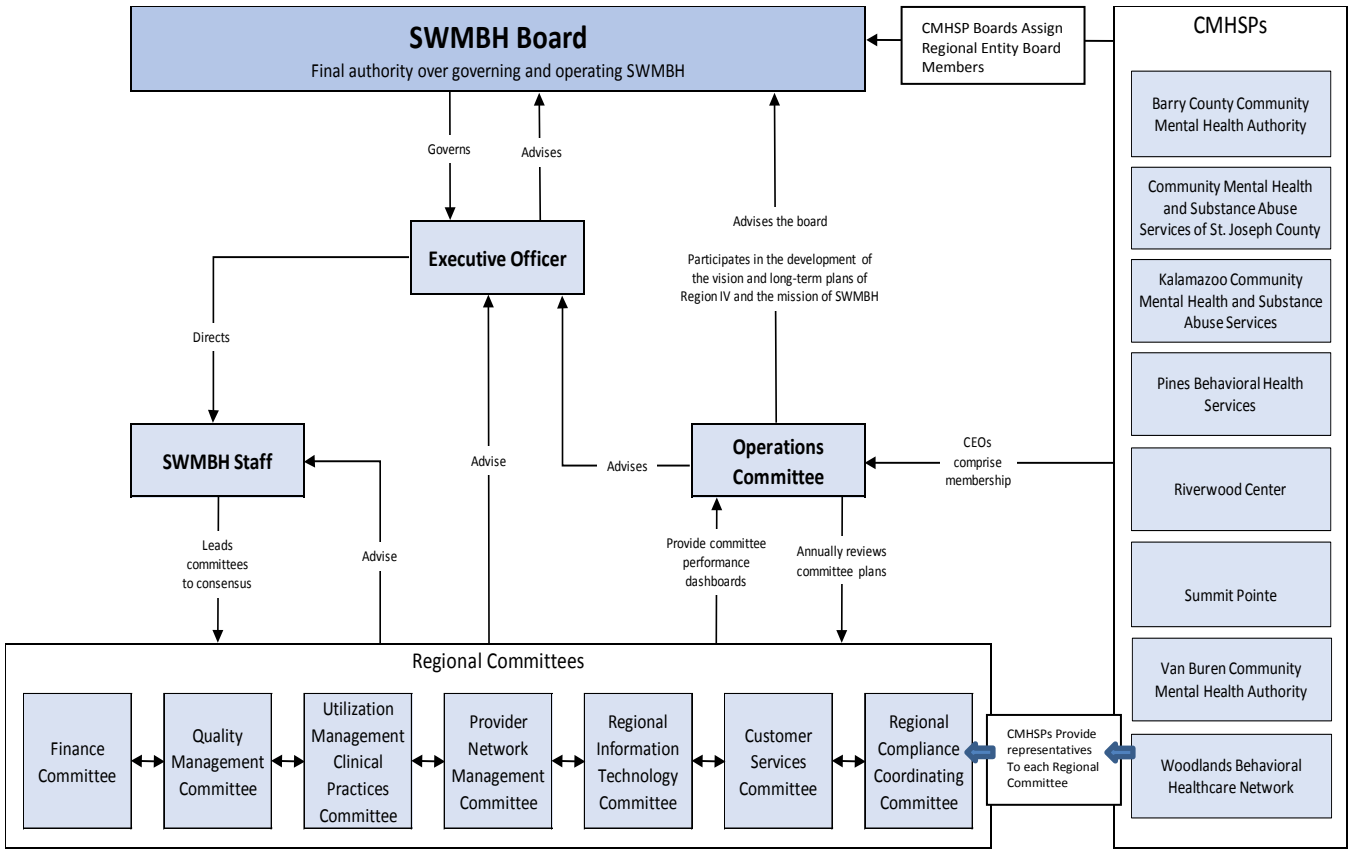
Attachment A

Southwest Michigan Behavioral Health Organizational Chart



Attachment B

Southwest Michigan Behavioral Organizational and Committee Structure Chart



Attachment C

Quality Management Committee Charter

☒ **SWMBH Committee** **Quality Management Committee (QMC)** ☐ **SWMBH Workgroup:** _____
Duration: ☒ **On-Going** ☐ **Deliverable Specific**

Date Approved: **5/1/14**

Last Date Reviewed: **4/28/16**

Next Scheduled Review Date: **4/28/17**

Purpose:	Operating Committees can be formed to assist SWMBH in executing the Board Directed goals as well as its contractual tasks. Operating Committees may be sustaining or may be for specific deliverables.
Accountability:	The committee is one method of participant communication, alignment, and advice to SWMBH. The committee tasks are determined by the SWMBH EO with input from the Operations Committee. Each committee is accountable to the SWMBH EO, and is responsible for assisting the SWMBH Leadership to meet the Managed Care Benefit requirements within the Balanced Budget Act, the PIHP contract, and across all business lines of SWMBH. The committee is to provide their expertise as subject matter experts.
Committee Purpose:	• *The QMC will meet on a regular basis to inform quality activities and to demonstrate follow-up on all findings and to approve required actions, such as the QAPI Program, QAPI Effectiveness Review/Evaluation, and Performance Improvement Projects. Oversight is defined as reviewing data and approving projects.* • *The QMC will implement the QAPI Program developed for the fiscal year.* • *The QMC will provide guidance in defining the scope, objectives, activities, and structure of the PIHP's QAPIP.* • *The QMC will provide data review and recommendations related to efficiency, improvement, and effectiveness.* • *The QMC will review and provide feedback related to policy and tool development.*

	• *The secondary task of the QM Committee is to assist the PIHP in its overall management of the regional QM function by providing network input and guidance.* • *The primary task of the QM Committee is to review, monitor and make recommendations related to the listed review activities with the QAPI Program/Plan*
Relationship to Other Committees:	At least annually there will be planning and coordination with the other Operating Committees. • Finance Committee • Utilization Management Clinical Practices Committee • Provider Network Management Committee • Health Information Services Committee • Customer Services Committee • Regional Compliance Coordinating Committee
Membership:	The Operating Committee appoints their CMH participant membership to each Operating Committee. The SWMBH EO appoints the committee Chair. • Members of the committee will act as conduits and liaisons to share information decided on in the committee. This includes keeping relevant staff and local committees informed and abreast of regional information, activities, and recommendations. • Members are representing the regional needs related to Quality. It is expected that members will share information and concerns with SWMBH staff. As conduits it is expected that committee members attend and are engaged in issues, as well as bringing challenges from their site to the attention of the SWMBH committee for possible project creation and/or assistance. Membership shall include appointed participant CMH representation, a member of the SWMBH Customer Advisory Committee with lived experience, SWMBH staff as appropriate, and the CA Director.
Decision Making Process:	The committee will strive to reach decisions based on a consensus model through research, discussion, and deliberation. All regional committees are advisory with the final determinations being made by SWMBH. When consensus cannot be reached a formal voting process will be used. The group can also vote to refer the issue to the Operations Committee or another committee. Referral elsewhere does not preclude SWMBH from making a determination and taking action. Voting is completed through formal committee members a super majority will carry the motion. This voting structure may be used to determine the direction of projects, as well as other various topics requiring decision making actions. If a participant fails to send a

	representative either by phone or in person they also lose the right to participate in the voting structure on that day.
Deliverables:	• Annual Committee Work Plan The Committee will support SWMBH Staff in the: • *QAPIP* • *QAPI Evaluation* • *Michigan Mission-Based Performance Indicator System (MMBPIS) regional report* • *Event Reporting Dash Board*

Attachment D
MI Health Link Quality Management Committee Charter

☒ **MI Health Link**

☒ **SWMBH Committees: Quality Management (QMC); Provider Network Credentialing (PNCC); Clinical and Utilization Management (CUMC)**

Duration: ☒ **On-Going** ☐ **Deliverable Specific** **Charter Effective Date: 6/1/15**

Last Review Date: 1/30/2017

Approved By:

Signature:

_____

Date:

_____

Purpose:	SWMBH Mi Health Link Committees are formed to assist SWMBH in executing the Mi Health Link demonstration goals and requirements, NCQA requirements, as well as its contractual obligations and tasks.
Accountability:	The committee is one method of participant communication, alignment, and advice to SWMBH. The committee tasks are determined by the SWMBH EO, committee chair and members, member needs, MI Health Link demonstration guidelines including the Three-Way Contract, ICO-PIHP Contract and NCQA requirements. Each committee is accountable to the SWMBH EO, and is responsible for assisting the SWMBH Leadership to meet the Managed Care Benefit requirements within the MI Health Link demonstration, the ICO-PIHP contract, and across all business lines of SWMBH. The committee is to provide their expertise as subject matter experts.
Committees Purposes:	**Quality Management Committee:** • The QI Committee must provide evidence of review and thoughtful consideration of changes in its QI policies and procedures and work plan and make changes to its policies where they are needed. *NCQA, MBHO, QI 1:*

	Program Structure; Quality Improvement Program Structure, Element A (Factor 4) & QI 2: Program Operations; QI Committee Responsibilities, Element A (Factor 1-4). • Analyzes and evaluates the results of QI activities to identify needed actions and make recommendations related to efficiency, improvement, and effectiveness. Ensures follow-up as appropriate. *NCQA, MBHO, QI 2: Program Operations, QI Committee Responsibilities Element A (Factor 1, 2 & 5)* • Ensures practitioner participation in the QI program through planning, design, implementation or review. *NCQA, MBHO, QI 2: Program Operations, Element A QI Committee Responsibilities, Element A (Factor 3).* • Ensures discussion (and minutes) reflects: o Appropriate reporting of activities, as described in the QI program description. *NCQA, MBHO, QI 1: Program Structure, Quality Improvement Program Structure, Element A (Factor 1).* o Reports by the QI director and discussion of progress on the QI work plan and, where there are issues in meeting work plan milestones and what is being done to respond to the issues. *NCQA, MBHO, QI 1: Program Structure, Quality Improvement Program Structure, Element A (Factor 7). QI 1: Annual Evaluation, Element B (Factor 3).* • Ensures the organization describes the role, function and reporting relationships of the QI Committee and subcommittees. *NCQA, MBHO, QI 1: Program Structure, Quality Improvement Program Structure, Element A (Factor 1 & 4).* • Ensures all Mi Health Link required reporting is conducted and reviewed, corrective actions coordinated where necessary, and opportunities for improvement are identified and followed-up. *NCQA, MBHO, QI 2: Program Operations, QI Committee Responsibilities, Element A.* • Ensures member and provider experience surveys are conducted and reviewed, and opportunities for improvement are identified and followed-up. *NCQA, MBHO, QI 9: Complex Case Management, Member Experience with Case Management, Element I (Factor 1).* • Ensures the organization approves and adopts clinical practice guidelines and promotes them to practitioners. The appropriate body to approve the clinical practice guidelines may be the organization's QI Committee or another clinical committee. *NCQA, MBHO, QI 2: Program Responsibilities, QI Committee Responsibilities, Element A.* • Ensures the organization approves and adopts preventive health guidelines and promotes them to practitioners in an effort to improve health care quality and reduce unnecessary variation in care. The appropriate body to approve the preventive health guidelines may be the organization's QI Committee or another clinical committee. *NCQA, MBHO, QI 10: Clinical Practice Guidelines, Adopting Relevant Guidelines, Element A.* • The organization annually: o Documents and collects data about opportunities for collaboration. *NCQA, MBHO, CC 2: Collaboration Between Behavioral Healthcare and Medical Care, Data Collection, Element A.* o Documents and conducts activities to improve coordination between medical care and behavioral healthcare. *NCQA, MBHO, CC*

	2: Collaboration Between Behavioral Healthcare and Medical Care, Data Collection, Element A. Aetna Contract-Attachment C.2 • Ensures the ICO and PIHP identify shared quality improvement measurement requirements and develop and implement related processes sharing results and undertaking correction and quality improvement activities. *Aetna Contract p. 33 (9.22)* • Ensures a care management quality control program is maintained at all times. *Aetna Contract Attachment C.2* • Ensures Call Center quality control program is maintained and reviewed, which should include elements of internal random call monitoring. *NCQA, MBHO, QI 5: Accessibility of Services, Assessment Against Telephone Standards, Element B. Aetna Contract* **Credentialing Committee:** • Uses a peer review process to make credentialing and recredentialing decisions and which includes representation from a range of participating practitioners. *NCQA, MBHO, CR 2: Credentialing Committee, Element A (Factor 1). Meridian Contract. Aetna Contract-Attach C4.* • Reviews the credentials of all practitioners who do not meet established criteria and offer advice which the organization considers. *NCQA, MBHO, CR 2: Credentialing Committee, Element A (Factor 2). Meridian Contract.* • Implements and conducts a process for the Medical Director review and approval of clean files. *NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A (Factor 10); CR 2: Credentialing Committee, Element A (Factor 3). Meridian Contract.* • Maintains meeting minutes. *NCQA, MBHO, CR 2: Credentialing Committee, Element A (Factor 2).* • Reviews and authorizes policies and procedures. *NCQA, MBHO, CR 1: Credentialing Policies; CR 2: Credentialing Committee. QI 2: Program Responsibilities, QI Committee Responsibilities, Element A. Aetna Contract-Attach C4.* • Ensures that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the committee's decision. *NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A: (Factor 9). Meridian Contract* • Ensures reporting of practitioner suspension or termination to the appropriate authorities. *NCQA, MBHO, CR 7: Notification to Authorities and Practitioner Appeal Rights, Actions Against Practitioners, Element A (Factor 2); NCQA, MBHO, CR 7: Notification to Authorities and Practitioner Appeal Rights, Reporting to the Appropriate Authorities, Element B. Aetna & Meridian Contracts.* • Ensures practitioners are informed of the appeal process when the organization alters the conditions of practitioner participation based on issues of quality or service. *NCQA, MBHO, CR 7: Notification to Authorities and Practitioner Appeal Rights, Element A (Factor 4); CR 7: Notification to Authorities and Practitioner Appeal Rights, Practitioner Appeal Process: Element C (Factor 1). Meridian Contract.*

	• Ensures the organization's procedures for monitoring and preventing discriminatory credentialing decisions may include, but are not limited to, the following: o Maintaining a heterogeneous credentialing committee membership and the requirement for those responsible for credentialing decisions to sign a statement affirming that they do not discriminate when they make decisions. *NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A: (Factor 7)* o Periodic audits of credentialing files (in-process, denied and approved files) that suggest potential discriminatory practice in selections of practitioners. *NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A: (Factor 7).* • Ensures annual audits of practitioner complaints to determine if there are complaints alleging discrimination. *NCQA, MBHO, CR 6: Ongoing Monitoring, Ongoing Monitoring and Intervention: Element A (Factor 3). Aetna Contract.* **Clinical/Utilization Management Committee:** • Reviews and authorizes policies and procedures. *NCQA, MBHO, UM 1: Utilization Management Structure, UM Program Description Element A.* • Ensures the PIHP and ICO conduct regular and ongoing collaborative initiatives that address methods of improved clinical management of chronic medical conditions and methods for achieving improved health outcomes. *NCQA, MBHO, CC 2: Collaboration Between Behavioral Healthcare and Medical Care, Opportunities for Collaboration, Element B. Aetna Contract, p. 22 (9.22)* • Is involved in implementation, supervision, oversight and evaluation of the UM program. *NCQA, MBHO, UM 1: Utilization Management Structure, UM Program Description Element A. UM 1: Utilization Management Structure, Behavioral Healthcare Practitioner Involvement, Element B.* • Ensures Call Center quality control program is maintained and reviewed, which should include elements of internal random call monitoring. *NCQA, MBHO, QI 5: Accessibility of Services, Assessment Against Telephone Standards, Element B. Aetna Contract* • Maintains meeting minutes and ensures review of tools/instruments to monitor quality of care are in meeting minutes. *NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria, Element A. Aetna Contract-Attachment C.2* • Ensures annual written description of the preservice, concurrent urgent and non-urgent and postservice review processes and decision turnaround time for each. *NCQA, MBHO, UM 5: Timeliness of UM Decisions, Timeliness of UM Decision Making, Element A & Notification of Decisions, Element B. Meridian Contract-Attach C.* • Ensures a care management quality control program is maintained at all times. *Aetna Contract-Attach C.2* • Ensures at least annually the PIHP review and update BH clinical criteria and other clinical protocols that ICO may develop and use in its clinical case reviews and care management activities; and that any modifications to such BH clinical criteria and clinical protocols are submitted to MDCH annually for

	review and approval. *NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 5). Aetna Contract, p. 33-34 (9.27).* • Ensures PIHP shall render an authorization and communicate the authorized length of stay to the Enrollee, facility, and attending physician for all behavioral health emergency inpatient admissions in authorized timeframes. *Aetna Contract, p. 33 (9.25.3). Meridian Contract-Attachment C.* • Ensures the organization: o Has written UM decision-making criteria that are objective and based on medical evidence. *NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 1). Meridian Contract-Attachment C.* o Has written policies for applying the criteria based on individual needs. *NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 2).* o Has written policies for applying the criteria based on an assessment of the local delivery system. *NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 3).* o Involves appropriate practitioners in developing, adopting and reviewing criteria. *NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 4). Meridian Contract-Attachment C.*
Relationship to Other Committees:	These three committees will sometimes plan and likely often coordinate together. The committees may from time-to-time plan and coordinate with the other SWMBH Operating Committees.
Membership:	The SWMBH EO and Chief Officers appoint the committee Chair and Members. Members of the committee will act as conduits and liaisons to share information decided on in the committee. This includes keeping relevant staff and local committees informed and abreast of regional information, activities, and recommendations. Members are representing the regional needs related to Provider Network Credentialing; Quality Management and Clinical/Utilization Management as it relates to Mi Health Link. It is expected that members will share information and concerns with the committee. As conduits it is expected that committee members attend and are engaged in issues, as well as bringing challenges to the attention of the SWMBH committee for possible project creation and/or assistance.
Decision Making Process:	The committee will strive to reach decisions based on a consensus model through research, discussion, and deliberation. All regional committees are advisory with the final determinations being made by SWMBH. When consensus cannot be reached a formal voting process will be used. The group can also vote to refer the issue to the Operations Committee or another committee. Referral elsewhere does not preclude SWMBH from making a determination and taking action. Voting is completed through formal committee members a super majority will carry the motion. This voting structure may be used to determine the direction of projects, as well as other various topics requiring decision making actions. If a participant fails to send a representative either by phone or in person they also lose the right to participate in the voting structure on that day.

Attachment 1: - Credentialing

Membership Name	***Organization/County***	***Type of member (Ad hoc, standing, voting, alternate)***
Dr. Bangalore K. Ramesh (Medical Director/Practitioner/Provider)	Western Michigan University	*Voting*
Nancy Wallace	SWMBH	*Voting*
Jonathan Gardner	SWMBH	*Voting*
Moira Kean	SWMBH	*Voting*
Kim Rychener	SWMBH	*Voting*
Natalie Tenney	SWMBH	*Voting*
Scott VanKirk	SWMBH	*Voting*
Bethany Viall, RN (Practitioner)	SWMBH	*Voting*
Daniel Spencer Price, LLP, CAADC (Practitioner and Provider)	St. Joe CMH (SUD)	*Voting*
Stephanie Lagalo, LMSW (Practitioner and Provider)	Interact of Michigan (MH/SUD)	*Voting*

Attachment 2: - Quality/UM/Clinical

Membership Name	***Organization/County***	***Type of member (Ad hoc, standing, voting, alternate)***
Dr. Bangalore K. Ramesh (Medical Director/Practitioner/Provider)	Western Michigan University	*Voting*
Nancy Wallace	SWMBH	*Voting*
Jonathan Gardner	SWMBH	*Voting*
Moira Kean	SWMBH	*Voting*
Kim Rychener	SWMBH	*Voting*
Natalie Tenney	SWMBH	*Voting*
Scott VanKirk	SWMBH	*Voting*
Bethany Viall, RN (Practitioner)	SWMBH	*Voting*

Attachment E

SWMBH Strategy and Future Directions Map

Attachment F
QMC Regional Committee Goals

ESTABLISH S.M.A.R.T. GOALS	
Directions:	Complete goals collaboratively using the S.M.A.R.T. goals process (Specific, measurable, achievable, realistic, time-bound). Goals include applicable departmental or individual objectives. Periodically during the year (i.e., monthly quarterly, or annually) and complete the "Results" section stating the outcomes for each.

Ends Metric:		Adhere to MDHHS Contract Requirements.	
Goal Description:		Develop a standardized call data reporting and monitoring process for CMHSPs.	
	Specific: What is the desired specific result?	Receive CMHSP call answer rates on a quarterly basis, via the SWMBH Portal.	
	Measurable: How will you measure success?	95% of CMHSP incoming access calls are answered within 30 seconds. Access calls are defined as: First initial phone contact to CMH or access center. Transferred calls are not evaluated for timeliness component.	
	Achievable: What are the potential obstacles to success?	CMHSPs not having access to their answer rates or other call system data. Dependent on CMHSP budget requests and phone system upgrades. Filtering calls that come through front desk may be a barrier.	
	Relevant: Is it in alignment with the Charter?	This goal is in alignment with SWMBH and QMC Regional leadership principles and MDHHS contract reporting requirements and accepted plan of correction (2016).	
	Time-Based: What is the timeline?	Target date of systems in place by October 31, 2016. Testing of data submission completed by December 1, 2016. First completed data submission for Q1 FY 16-17 by January 31, 2017.	
	How will you track progress?		**Result:**
	Step 1	Complete gap analysis of current CMHSP call system capabilities.	February 2016
	Step 2	Discuss process and requirement at QMC meetings.	April 2016
	Step 3	Formulae a consistent process for all CMHSPs to submit call data via the SWMBH portal on a quarterly basis.	Sept-Oct 2016
	Step 4	Allow CMHs time to resolve any technical issues and submit budget requests for phone system upgrades to capture required data elements.	Oct-Nov 2016

	Step 5	CMHs test reporting system and work out any glitches.	October 31, 2016 through December 1, 2016
	Step 6	First completed data submission for Q1 FY 16-17.	January 31, 2017

ESTABLISH S.M.A.R.T. GOALS	
Directions:	Complete goals collaboratively using the S.M.A.R.T. goals process (Specific, measurable, achievable, realistic, time-bound). Goals include applicable departmental or individual objectives. Periodically during the year (i.e., monthly quarterly, or annually) and complete the "Results" section stating the outcomes for each.

Ends Metric:		Adhere to MDHHS Contract Requirements.	
Goal Description:		Develop a standardized call data reporting and monitoring process for CMHSPs.	
	Specific: What is the desired specific result?	Receive CMHSP call answer rates on a quarterly basis, via the SWMBH Portal.	
	Measurable: How will you measure success?	95% of CMHSP incoming access calls are answered within 30 seconds. Access calls are defined as: First initial phone contact to CMH or access center. Transferred calls are not evaluated for timeliness component.	
	Achievable: What are the potential obstacles to success?	CMHSPs not having access to their answer rates or other call system data. Dependent on CMHSP budget requests and phone system upgrades. Filtering calls that come through front desk may be a barrier.	
	Relevant: Is it in alignment with the Charter?	This goal is in alignment with SWMBH and QMC Regional leadership principles and MDHHS contract reporting requirements and accepted plan of correction (2016).	
	Time-Based: What is the timeline?	Target date of systems in place by October 31, 2016. Testing of data submission completed by December 1, 2016. First completed data submission for Q1 FY 16-17 by January 31, 2017.	
	How will you track progress?		**Result:**
	Step 1	Complete gap analysis of current CMHSP call system capabilities.	February 2016
	Step 2	Discuss process and requirement at QMC meetings.	April 2016
	Step 3	Formulae a consistent process for all CMHSPs to submit call data via the SWMBH portal on a quarterly basis.	Sept-Oct 2016
	Step 4	Allow CMHs time to resolve any technical issues and submit budget requests for phone system upgrades to capture required data elements.	Oct-Nov 2016
	Step 5	CMHs test reporting system and work out any glitches.	October 31, 2016 through

			December 1, 2016
	Step 6	First completed data submission for Q1 FY 16-17.	January 31, 2017
	Step 7	Collect data and present during accreditation reviews/audits as necessary.	As scheduled

ESTABLISH S.M.A.R.T. GOALS	
Directions:	Complete goals collaboratively using the S.M.A.R.T. goals process (Specific, measurable, achievable, realistic, time-bound). Goals include applicable departmental or individual objectives. Periodically during the year (i.e., monthly quarterly, or annually) and complete the "Results" section stating the outcomes for each.

Ends Metric:	SWMBH Tactical Objectives and MDHHS Contract Requirements.	
Goal Description:	The QMC will evaluate and offer improvement strategies on Regional Critical Incident and Event Reporting.	
Specific: What is the desired specific result?	Identify opportunities for improvement in regards to collection of data, reliability of data and focus on building consistency throughout the Region.	
Measurable: How will you measure success?	Improvement in data reporting, accuracy and analysis.	
Achievable: What are the potential obstacles to success?	Many CMHSPs collect and report data in different ways. CMHSPs being on different systems.	
Relevant: Is it in alignment with the Ends Metrics?	Pre-Eminence	
Time-Based: What is the timeline?	By August 2017	
How will you track progress?		**Result:**
Step 1	Identify problem areas within Critical Incident and Event Reporting. Each CMHSP to report on current methods.	January 2017
Step 2	Look at current processes and provide education	February 2017
Step 3	Identify standardized data collection and report methods	March 2017
Step 4	Identify and perform analysis on current reporting strategies	April 2017
Step 5	Are policies and procedures in place to support identified reporting process?	May 2017

Attachment G
SWMBH 2017-2018 Board Ends Metrics
Board Approved on: 1/13/17

Quality of Life Persons with Intellectual Developmental Disabilities (I/DD); Serious Mental Illness (SMI); Serious Emotional Disturbances (SED) and Substance Use Disorders (SUD) in the SWMBH region see improvements in their quality of life and maximize self- sufficiency, recovery and family preservation.		**Improved Health** Individual mental and physical health status and population health are measured and improved.	
PROOFS	**STATUS**	**PROOFS**	**STATUS**
Regional Hab Waiver slots are full at 99% though out the year. (October 16 - September 17) **Measurement:** (%) of waiver slot (months) filled x 12 (#) of waiver slot (months) available		Improve Population Health efforts and patient outcomes in our Region by; Increasing My Strength program usage by 50% over 2016 baseline measure (By September 30, 2017) **Measurement:** (#) of new users registered – Sept 2017 (338) Baseline Users – Sept 2016	New Metric
Increase the use of recovery coaches by 20% over the 2016 baseline measure. (by October 31, 2017) **Measurement:** (%) of recovery coach usage during measurement period (10.12%) baseline recovery coach contacts in 2016 CPT Code for Recovery Coach = (H0038HF) FY 2016 baseline is: 684/6758 = 10.12%	New Metric	70% of members (6) to (20) years of age and 58% of members (21) and older; who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner will receive follow-up within 30 days. (by December 31, 2017) **Measurement:** Total number of members 6 -20 and 21 and older who were hospitalized for selected mental illness diagnosis Number of members in each age group who received follow-up within 30 days after hospitalization	New Metric

Fully implement contractually obligated assessment tools for persons with Intellectual Developmental Disabilities (I/DD); Substance Use Disorders (SUD); Mental Illness (SMI) and Serious Emotional Disturbances (SED).

A. 90% of eligible members will receive the appropriate qualified assessment (beginning 1/1/17)
   1. SIS – Supports Intensity Scale Tool
   2. CAFAS – Child and Adolescent Functional Assessment Scale Tool
   3. LOCUS – Level of Care Utilization System Assessment Tool
   4. ASAM – American Society of Addiction Medicine Assessment Tool
B. Further analysis of data will be completed.

(By: December 31, 2017)

Measurement:

Total number of eligibles who received an assessment
Total eligible population who received services

Exceptional Care: Persons served are highly satisfied with services they receive.		**Mission and Value Driven:** CMHSPs and SWMBH fulfill their agencies' missions and support the values of the public mental health system.	
PROOFS	**STATUS**	**PROOFS**	**STATUS**
90% of persons with Autism Spectrum Disorders that have an Individual Plan of Service (IPOS), which includes ABA services, receive a billable ABA encounter. (by November 30, 2017) **Measurement:** (%) of Autism consumers that received a billable ABA encounter Total number of Autism consumers with a (IPOS) FY18 – When we reach 90% by November 30, 2017 SWMBH will have developed measurements with analysis to show improvements in population served.	New Metric	A. Regional Committees establish (2) new collaborative goals to achieve (by March 31, 2017) B. Regional Committees shall contribute to 1115 waiver transition work plan goals. (by March 31, 2017) C. The Regional Committees have developed and achieved 100% of their collective approved CY17 goals, as indicated by the SWMBH Regional Committee Goal tracking matrix. (by December 31, 2017) **Measurement:** Committee Goal Tracking Matrix % of Committee Goals Met	New Metric

Customer Satisfaction Surveys collected by SWMBH are at or above the SWMBH 2016 results; for the *Improved Functioning* (MHSIP survey) and *Improved Outcomes* (YSS survey) measurement categories, utilizing the following survey tools: *a.* Mental Health Statistic Improvement Project Survey (MHSIP) tool. *(Improved Functioning)* b. Youth Satisfaction Survey (YSS) tools. *(Improved Outcomes)* (by December 31, 2017) **Measurement: (MHSIP)** 2017 MSHIP Improved Functioning Score / 2016 MSHIP Improved Functioning Score **Measurement: (YSS)** 2017 YSS Improved Outcomes Score / 2016 YSS Improved Outcomes Score	Metric Adjustment	92% of MMBPIS Indicators will be at or above the State benchmark for 3 quarters for FY 17. (October 16 – September 17) **Measurement:** Total number of indicators that met State Benchmark / Total number of indicators measured (51)	Metric Adjustment
100% of required Home and Community-Based Service (HCBS) Provider corrective action plans are completed and submitted to MDHHS by SWMBH for review. (by December 31, 2017) **Measurement:** Number of corrective action plans completed and submitted to MDHHS / Total number of provider corrective action plans issued	New Metric	1115 Waiver Transition Achieve successful 1115 waiver transition across the Region A. Complete a gap analysis of 1115 waiver/contract analysis (by April 28, 2017) B. Develop a 1115 waiver transition work plan (by July 31, 2017) C. Execute 1115 waiver transition work plan (by September 30, 2017) **Measurement:** Complete transition steps identified above by indicated target dates; on metric tracking matrix.	New Metric
73.8% of consumers receiving an SUD assessment, will receive a minimum of (3) outpatient services within a (45 day) period; following their date of initial assessment. (by November 30, 2017) **Measurement:** Total # of consumers who received 3 outpatient services in 45 days following SUD assessment / Total # of consumers receiving an SUD assessment	New Metric	A. Apply for NCQA Accreditation by 12/31/2016. B. Achieve NCQA-MBHO accreditation (by April 28, 2018) **Measurement:** a. Confirmation from NCQA that our accreditation process has started. b. Confirmation from NCQA that SWMBH has achieved accreditation.	

Quality and Efficiency:

SWMBH is a learning region, where quality and cost are measured and improved.

HSAG Performance Measure Validation Passed with (95% of Measures evaluated receiving a score of "Met") (by September 30, 2017) **Measurement:** Number of Critical Measures that achieved "Met" Total number of Critical Measures Evaluated	
FY 2017 Medicaid Administrative Loss Ratio for the region is (≤ 10.0%) (by February 2018) **Measurement:** (Medicaid) Administrative and other Costs Total Medicaid Revenue	2016 Current status: 9.6%
FY 17 Medicaid Medical Loss Ratio meets standards as set by the Board. (85% - 87%) (by February 2018) **Measurement:** Total Medicaid Healthcare Cost Total Medicaid Revenue	2016 Current Status: 85.6%

Attachment H
2017 Board Member Roster

Southwest Michigan BEHAVIORAL HEALTH

Barry County
- Robert Nelson
- Robert Becker (Alternate)

Berrien County
- Edward Meny
- Nancy Johnson (Alternate)

Branch County
- Tom Schmelzer -- Vice-Chair
- Vacant (Alternate)

Calhoun County
- Kathy-Sue Dunn
- Jim Blocker (Alternate)

Cass County
- Robert Wagel
- Mary “May” Myers (Alternate)

Kalamazoo County
- Moses Walker
- Patricia Guenther (Alternate)

St. Joseph County
- Barbara Parker- Chair
- Matie James (Alternate)

Van Buren County
- Susan Barnes - Secretary
- Angie Dickerson (Alternate)