Southwest Michigan Behavioral Health
Quality Assurance and Performance Improvement Program
All SWMBH Business Lines

Year 2020 (October 1, 2019 - September 30, 2020)

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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 outlined in the PIHP contract(s), specifically AttachmentP.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 SWMBH EO and SWMBH Board grant the authority of the Quality Management (QM) department and the QM Committee. 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 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

During the November 8, 2019 Board Meeting, the SWMBH Board approved the 2020-2020 Board Ends Metrics and revised Mega Ends. The Mega Ends serve as the guiding principles for the development of annual Board Ends Metrics, Regional Committee Goals, SWMBH Department Goals, and Regional Strategic Objectives set forth by the SWMBH Board. Please see attachment (*Please see Attachment G - Strategic Alignment and Annual Goal Setting*)

Mega Ends

1. **Quality of Life.** Persons with Intellectual Developmental Disabilities (I/DD); Serious Mental Illness (SMI); Serious Emotional Disturbances (SED); Autism Spectrum Disorders (ASD) 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, physical health, and functionality are measured and improved.
3. **Exceptional Care.** Persons and families 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, improved, and reported.

IV. Strategic Imperatives

Strategic Imperatives: During the May 10, 2019 Board Retreat and Board Meeting, the Board voted on and established a new set of Strategic Imperatives. It is critical to the success of SWMBH and the Region that these Strategic Imperatives are tracked and monitored for success. The following are the approved 2019-2020 Strategic Imperatives:

1. Public Policy and Legislative initiatives
2. Uniformity of Benefit
3. Population Health Management
4. Revenue Maximization
5. Improved Analytics and Business Intelligence tools
6. Managed Care Functional Review
7. Use of Level of Care Guidelines
8. Cost reduction efforts for Medical Loss Ratio (MLR) and Administrative Loss Ratio (ALR)
9. Proof of Value and Improved Outcomes
10. Consistent use of Assessment tools and Authorization Process

V. Core Values of Quality Assurance and Improvement

1. **Quality healthcare will result from a benefit management system embracing input from all stakeholders**
    a. Educating all customers of SWMBH on continuous improvement methodologies, including providing support to other SWMBH departments and providers as requested. The inclusion of customers, families, stakeholders, and providers in the performance improvement design will promote optimal results.
    b. Promoting a person-centered philosophy will promote customer satisfaction as well as optimal treatment outcomes.
2. **Poor performance is costly**
    a. Performance improvement initiatives will be consistent with metrics as established by the SWMBH Board and prioritized in accordance with potential risk.
    b. Quality Improvement projects are best approached systemically; best practice improvement planning should promote elements of systematic monitoring, evaluation, feedback, and follow-up.

c. Valid, acceptable, accurate, complete, and timely data is vital to organizational decision-making.
    i. Making data accessible will impact value and reduce risk to SWMBH.

3. Data Collection Values

a. Data that is consistently complete, accurate, and timely will lead to consistent measurement and over time ensure data integrity.
b. Providers submitting data to SWMBH shall certify data integrity and have available for review the process used to collect the data.
c. Performance that has demonstrated instability or significant variance to comparison performance on an ongoing basis will be monitored closely. Significant variation in results will indicate the need for a corrective action/performance improvement plan

VI. 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, 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 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 2 Full-Time Quality Assurance Specialists. The QAPI Department also may utilize an outside contract consultant for special projects and preparation for accreditation reviews. 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 Committee (RUM), and the Regional Clinical Practices Committee (RCP).

As the primary data user, the QAPI Department works very closely with the IT Department to review and analyze data. In guiding the QAPI studies, the Business Data Analyst is tasked with performing 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 the Behavioral Treatment Committee. The designated behavioral health care practitioner is a member of the Quality Management

Committee (QMC).

Adequacy of Quality Management Resources

The QAPI Department works collaboratively with many different functional areas. Although each position identified below is not assigned to the QAPI Department, they maintain an active role in quality related activities. The following grid provides a representation of what percentage of total time is spent on quality related activities.

Title	Department	Percent of time per week devoted to QM
Director of Quality Assurance and Performance Improvement	QAPI	100%
(2) QAPI Specialist	QAPI	100%
Business Data Analyst I	QAPI	50%
Business Data Analyst II	QAPI	30%
Clinical Data Analyst	QAPI and PNM	20%
Manager of Utilization Management	UM	20%
Director of Clinical Quality	PNM	20%
Chief Information Officer	IT	30%
Senior Software Engineer	IT	20%
Member Engagement Specialist	UM	15%
Waiver and Clinical Quality Manager	PNM	10%
Applications and Systems Analyst	IT	20%
Designated Behavioral Health Care Practitioner	UM/PN	20%
Chief Compliance and Operations Officers	Com/Ops	15%

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

SWMBH will have appropriate staff to complete QAPI functions as defined in this plan. In addition to having 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. Completion of these functions require resources that 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 the SWMBH Board in the development of an annual QAPI plan. QAPI Department also works with other functional areas and external organizations/venders like Streamline Solutions and the Health Service Advisory Group (HSAG) 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
- Communications and Reporting to our Integrated Care Organizations
- Analysis of reports and data; to determine trends and recommendations for process improvements

VII. 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 the development and maintenance of 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.

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, which may include; provider representatives, IT support staff, Coordinating Agency staff, and the SWMBH medical director and clinical representation. The QMC will make efforts to maintain consumer representation, assist with review of reports/data, and provide suggestions for Regional process improvement opportunities. All QMC members are required to participate; however, alternates will also be named in the charter and will have all the 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. Quarterly, QMC collaborates with the Regional Clinical Practices (RCP) and Regional Utilization Management (RUM) Committees 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 regularly (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 guidance and make suggestions for process improvement opportunities, with the goal of improving consumer outcomes.

2020 Quality Management Committee Goals (2020-2021)

1. **Implementation of a Consumer Satisfaction Survey Performance Improvement Project (By: 6/30/20)**
    i. Review consumer feedback from MHSIP and YSS annual consumer satisfaction survey project
    ii. Identify common denominators and classify into strategic categories
    iii. Perform analysis on feedback and prioritize in order of importance (by number of comments identified for each category)
    iv. Develop and target interventions to improve (3) identified problem areas
    v. Determine tracking mechanisms and targets goals for each identified area
    vi. Share results with Operations Committee and other relevant committees

2. **Formulate a series of instructional videos/tutorials, which live on the SWMBH SharePoint Portal for SWMBH and CMHSP access (By: 12/30/2020)**
    i. Perform a gap analysis to identify Regional Education needs, based on current contractual/oversight obligations
    ii. Identify Training resources and software/tools we will use to create educational resources.
    iii. Initial trainings will include: MMBPIS Indicator documentation, Jail Diversion documentation, Critical Incident tracking and documentation and SWMBH Poral navigation tutorial
    iv. Form sub-groups within QMC to review trainings and present trainings to their providers
    v. Test Access to the trainings/tutorials and ensure all CMHSP/SWMBH users have access to them
    vi. Present trainings to relevant Regional Committees or Internal SWMBH/CMHSP departments

3. **2020 Quality Management Committee Quarterly Review and Analysis Categories**
    I. Review of Regional Critical Incident Reporting Procedures and Requirements
    II. Review of Risk Event tracking, analysis and monitoring for consistency across all CMHSPs
    III. Review of Regional Jail Diversion processes, training and State reporting measures
    IV. Review of Regional Grievance and Appeals tracking, notices, letters against HSAG and Managed Care guidelines
    V. Review and analysis of Hospital Follow-up (FUH) Timeliness Metric
    VI. Review of HSAG and MDHHS selected Performance Improvement Measures

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 outlined 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 regularly (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 C, "MHL Charter – Decision Making."* ---

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
	Annual Reviews/Audits (Recommendations for Improvement and review of results).	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 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 always maintained.

The MI Health Link Committee and QAPI Department is also responsible for reporting and achieving all quality withhold performance measures identified in the Integrated Care Organization (ICO) and Michigan Department of Health and Human Services (MDHHS) three – way contracts. The quality performance measure data will be collected by the QAPI Department and a report analysis will be performed in collaboration with the UM Department, Provider Network Management Department and with the Integrated Care Specialist. The identified quality withhold measures will be used to reconcile payments between the SWMBH and the ICO on an annual basis via a calendar year schedule identified in the contract.

Quality Performance Withhold Measures:

Each year, a set of Quality Performance Measures are reviewed and negotiated between the PIHP and the Integrated Care Organizations (ICO's). Pursuant to Section 3.4.3 of the Agreement, the quality-withhold measures and corresponding point values that will apply to PIHP in Demonstration Year 4 are as follows:

Domain	Measure	Source	Maximum Point Value	Benchmarks
Encounter Data	Encounter Data submitted timely, accurately, and completely in compliance with requirements in this Agreement	Encounter data file submissions	5-Timely 5-Complete 5-Accurate	-90% of paid claim encounters submitted by 15th of the month following payment -80% of paid claim encounters submitted within 180 days of the date of service -95% CMS initial acceptance rate of PIHP encounters
Assessments	Percentage of Enrollees with Level II assessments completed within 15 days of the Plan	Monthly assessment status reports	30	95%+ - 30 90-94% - 25 85-89% - 20 80-84% - 15 75-79% - 10

	referral for Level II assessment			
Care Transition Record Transmitted to Health Care Professional	Percentage of Enrollees with an inpatient psychiatric admission discharged to home or any other site of care for whom a transition record was transmitted within twenty-four (24) hours of discharge to the facility or behavioral health professional designated for follow-up care	Care transition audit	10	80%+ - 10
Documentation of Care Goals	Percentage of Enrollees with documented discussions of care goals	Documented care plans in ICBR	20	95%+ - 20 90-94% - 10
Follow-up after Inpatient Admission	Percentage of Enrollees with a follow-up visit with a behavioral health practitioner within 30 days of BH inpatient discharge	HEDIS 2019 data (FUH)	20	56%
Governance board	Participation of members appointed by PIHP on the ICO's advisory board	Advisory Board meeting minutes	5	2 participating advisory board appointments

VIII. 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 current process performance**.**
- ✓ ***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

IX. 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, RCP, and RUM. 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, "2020 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. • Analysis of overall results for MDHHS quality & UM reporting metrics, such as: • MMBPIS Performance Indicators, Critical Incidents, Jail Diversion, Call Center Performance Metrics, Inter-Rater Reliability testing, Consumer Satisfaction Survey Results, RSA-r Survey Results, Program and Service Audit results and more.
3. Annual Goals and Objectives – Reports, Dashboards,	• Annual Goals and Objectives are discussed, monitored, and reported as defined by the objective scope. All Department and Regional Committee goals should align with SWMBH Board Ends Metrics and SWMBH Strategic Guidance

Outcome monitoring	• 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) – "2020-2021 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. • 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. External Monitoring Reviews	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.
7. Customer Provider Assessments	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.

8. Customer and Provider Assessments (MIHL)	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. When available; results are compared to State and National values, to provide performance benchmarks.
9. Michigan Mission Based Performance Indicators (MMBPIS)	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. The SWMBH QAPI Department reviews and approves plans of correction that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate and documented interval time.
10. 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.
11. 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.
12. 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.
13. 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. The Utilization Management (UM) Plan Evaluation Components include: a) 2020 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 a. Telephone Access to Services and Staff. e) Timeliness of UM Decisions a. Services b. Appeals f) UM Decision-Making a. Clinical Criteria

	g) Availability of Criteria h) Consistency of Applying Criteria i) Inter-rater reliability (IRR audit) j) Coordination of Care k) Quality of Care l) Outlier Management m) Over or under utilization n) Hospital Follow-Up o) Behavioral Healthcare Practitioner Involvement
14. 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).
15. 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 National Quality Standards (NCQA) 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 call abandonment rate of 5% or less. b) Average call center answer time of 30 seconds or less. *c)* Service level standard of 75% or above. (*meaning 75% of calls are answered in 30 seconds or less and not abandoned)*
16. 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 areas 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.
17. Active Participation of providers and consumers in the QAPIP process	SWMBH QI Policy 3.2- III.D: Indicates that: "*Member feedback on QAPI activities will be sought and incorporated into the QAPI plan*". On a quarterly schedule, data is brought to Customer Service Committee by QAPI team members for presentation and feedback. Some of the reports that are shared with the Customer Service Committee and MI Health Link Committee's include: MMBPIS Performance Indicator reports; Customer Satisfaction survey planning and results; Grievance and Appeals reports; Critical Incident reports and the annual QAPI evaluation

	report. Lots of great feedback comes from these Regional Committees and it gives the QAPI department the opportunity to receive consumer feedback on opportunities for improvement. QAPI Key Performance Indicators are also reported to consumers through quarterly newsletters and on the SWMBH website. The QAPI department actively seeks out consumer involvement and feedback to proactively improve programs, services and ultimately improved outcomes for our customers.

X. 2020 Quality Assurance/Utilization Management Department Goals

QAPI Departmental Goals:

As indicated previously in the Plan, SWMBH is taking a different approach to Department and Committee goal setting in 2019. Each Department and Regional Committee will now work together to achieve the overarching Strategic Imperatives that were identified during the Board of Directors retreat on May 10, 2019. The following represent a list of those Strategic Imperatives: (***Please see attachment E for more details on completion of Strategic Imperatives***)

1. Public Policy and Legislative Initiatives
2. Uniformity of Benefit
3. Population Health Management
4. Revenue Maximization
5. Improved Analytics and Business Intelligence
6. Managed Care Functional Review
7. Use of Level of Care Tools and Guidelines
8. Cost Reduction Strategies (MLR and ALR)
9. Proof of Value and Outcomes

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.

a. System Reviews- the QM Department along with IT is responsible for ensuring that there are:
    i. Data Reviews before information is submitted to the state
    ii. Random checks of data for completeness, accuracy and that it meets the related standards.
    iii. Source information reviews to make sure data is valid and reliable.
b. The QMC and QM Department will address any issues identified in the system review.
c. 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).
d. The Health Service Advisory Group (HSAG) and Michigan Department of Health and Human Services (MDHHS) complete annual audits on SWMBH data sources, to measure and validate the accuracy of all data transactions.
e. Maintaining and organization of the SWMBH portal and reports.
f. Maintaining and organization of reports in the Tableau Data Visualization system.

XII. Data Management Continued

In May of 2019, the Managed Information Business Intelligence (MIBI) Steering Committee was formed.
The purpose of the committee is to oversee Business Intelligence strategy, resources and priorities, including report development and maintenance, taxonomies, data dictionaries, data model development, and integrity of incoming data, to ensure organizational needs are met. The Directors of QAPI, IT and Clinical Quality meet on a monthly schedule to review prioritized and relevant data issues and policies. Since each department works cross functional with all available data sources, this meeting is a great way to minimize overlap and ensure identified tasks stay on track. The secondary purpose of the committee is to ensure all data sources are reports are in alignment with contractual requirements and exceeding metric benchmarks.

(Please see attachment J "*SWMBH Managed Information Business Intelligence Department Roles*")

XIII. 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

XIV. 2020 Quality Assurance and Performance Improvement Plan

(October 1, 2019- September 30,2020)

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 reported to State.	➢ 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; RUM; RCP and Operations Committee. ➢ Ensure CMHSPs are submitting the approved template to the SWMBH FTP site on the 25th of each month. ➢ Ensure each CMHSP receives a Corrective Action Plan for any indicators that missed the State indicated bench mark. ➢ Ensure CMSHP Corrective Action Plans are achieved and improvements are recognized. ➢ Participate in MDHHS Performance indicator workgroup and communicate any changes with indicator measurement or reporting to internal and external stakeholders.	January 2020 – December 2020	QAPI Director QAPI Specialist Clinical Quality Director SUD Manager	Quarterly Submissions to MDHHS: *Q1 - 3/31/20 *Q2 - 6/30/20 *Q3 - 9/30/20 *Q4 - 12/30/20 CMHSPs submit monthly reports on the 25th of each month Via the FTP site. Annual on-site reviews for all (8) CMHSPs beginning in June 2020.

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
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. ➢ Development of educational materials and guidance on Sentinel and Immediate Event reporting.	➢ Event Reporting Quarterly reports to QMC; RUM, RCP 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 2019 – September 2020	QAPI Director QAPI Specialist	Monthly Report Submission to QAPI Specialist with Sentinel and Immediate Events being reported within 48 hours to the event reporting email address: eventreporting@swmbh.org Annual on-site reviews for all (8) CMHSPs occur in June. Select Critical Incidents are selected for review.
3.Uniformity of Benefits Cross functional Goal	➢ Perform analysis on the consistency of Inter-rater Reliability Testing to ensure uniformity of benefit. ➢ Complete analysis on Level of Care Guidelines and examine outliers/trends.	➢ Perform analysis on tool scores relative to medically necessary level of care (LOC). ➢ Identify and schedule reports on functional assessment tool scores. ➢ Ensure functional assessment data related to the LOCUS, SIS, CAFAS and ASAM are being received in the SWMBH data warehouse.	October 2019 – September 2020	Utilization Management Director Clinical Quality Manager Data Analyst Director of QAPI QAPI Specialist	Quarterly

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
4.Behavioral Treatment Review Committee Data Cross Functional Goal	➢ Information is collected by SWMBH from CMHs and available for review. ➢ The PIHP will continually evaluate its oversight of "vulnerable" consumers to identify ➢ opportunities for improving care.	➢ The QMC Committee will review the data collected from CMHs for trends and outliers on a quarterly basis. ➢ If trends are identified the QMC will collaborate with the Operations Committee and Regional Clinical Practices Committee to identify improvement strategies. ➢ The QMC Committee will formulate methods for improving care of "vulnerable" people.	October 2019 – September 2020	QAPI Specialist QAPI Director Data Analyst Director of Clinical Practices Regional Operations Committee	Quarterly
5.Jail Diversion Data Collection	➢ 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	➢ The QMC will evaluate data trends and specific CMHSP results. ➢ Jail Diversion data is shared at QMC, RUM, and RCP regional committees. ➢ Identified Trends and suggestions for policy change are share with Regional Entities through the Operations Committee and Utilization Management Committee as needed.	October 2019 – September 2020	QAPI Specialist QAPI Director Director of Clinical Practices Director of Utilization Management	Annually or as needed

	and co-occurring mental health and substance abuse disorders (DD & COD).				

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
6.External Monitoring Reviews	➢ Ensure that the participant has achieved each Quality element, as identified in the 2020 site review tool with satisfactory results. ➢ Help to formulate Corrective Action Plans for any Quality Review Elements scored out of compliance.	➢ 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. ➢ Review of MMBPIS Performance Indicators, primary source verification documentation and protocols. ➢ Call Data Reports are submitted on a quarterly schedule (*i.e., call abandonment rate, average answer time in seconds and total incoming call volume*)	October 2019 – September 2020	QAPI Specialist QAPI Director	Annually or as needed

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
7.Review of Provider Network Audits, Guidelines, and Medicaid Verification Cross functional Goal	➢ 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. (3) Clinical practice guidelines.	October 2019 – September 2020	QAPI Specialist QAPI Director Chief Compliance Officer Director of Clinical Quality	Annually

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
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 for all business lines ➢ Work through Regional Committees if trends are identified to improve outcomes	➢ At a minimum, quarterly reports on customer complaints to the QMC Committee; MHL Committee; RUM Committee and RCP 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 2019 – September 2020	QAPI Specialist QAPI Director Chief Compliance Officer Customer Service Manager Chief Operations Officer Director of Clinical Quality	Quarterly

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
9.External Monitoring, Audits and Reviews	➢ The Quality Management Department will coordinate the reviews by external entities, including MDHHS, HSAG, ➢ ICO's, NCQA and other organizations as identified by the SWMBH board. ➢ The Quality Department will ensure that SWMBH achieves the goal/score established by the Board Ends Metrics or meets the reviewing organizations expectations. ➢ The Quality Department will collect changes to contracts, managed care regulations and other contractual standards and provide education and resources to SWMBH and CMHSPs.	➢ 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 SWMBH QAPI Department reviews and approves plans of correction (CAPs) that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate and documented interval time. The QAPI Department may increase level of monitoring/oversight for Regional performance indicators that are consistently out of compliance.	October 2019 – September 2020	All Functional Area Senior Leaders QAPI Specialist QAPI Director Chief Compliance Officer Customer Service Manager Chief Operations Officer Director of Clinical Quality	Annually or audits as scheduled

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
10. Utilization Management Cross functional Goal	➢ 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 (FY 2020):** 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 o Level II Assessments o Customer Satisfaction on service experienced with UM Department	October 2019 – September 2020	QAPI Specialist QAPI Director Chief Compliance Officer Customer Service Manager Chief Operations Officer Utilization Manager Director of Clinical Quality	Some components are monitored Monthly. All results are included in the QAPI annual Evaluation.

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
11. Emergent and Non – Emergent Access Cross functional Goal	➢ 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 2019 – September 2020	QAPI Specialist QAPI Director Director of Clinical Quality Chief Operations Officer Utilization Manager	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 internal service lines (crisis, emergent, immediate and routine) ➢ Collect and analyze quarterly call reports submitted by CMHSPs	➢ A review of calls and agent performance to meet a scoring criteria of 96.25% performance rate is completed and evaluated. (*not required)* ➢ 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. ➢ A minimum of 12 internal (UM) calls will be evaluated per month *(calls selected randomly across all available agents)*	October 2019 – September 2020	QAPI Specialist QAPI Director Customer Service Manager Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant	Monthly

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
13. Management of Information Systems and Data Reporting Cross functional goal	➢ 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). ➢ Monitor Data Quality, Timeliness and Completeness: ➢ Volume: Encounters submitted at 85% of monthly rolling average. ➢ Completeness: 99.8% of encounters are submitted and accepted by MDHHS (CMHSP to supply the num/denom. ➢ Timeliness: 95% of encounters adjudicated through submission cycle within 30 days or less. ➢ Assessments: 90% of consumers received the appropriate	October 2019 – December 2020	QAPI Director Chief Information Officer Chief Operations Officer Senior Systems Architect Applications and systems Analyst	Monthly

		assessment ➢ 98% of Encounters have a BH TEDs match or close match			
Objective	**Goal**	**Deliverables**	**Dates**	**Lead Staff**	**Review Date**
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. ➢ Monitors and tracks analysis of communication 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. ➢ Administration and analysis of 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. ➢ Develop and implement a procedure for Complex Care Management community Outreach to improve member engagement and coordination. ➢ Increase outreach and care coordination with regional ED to improve BH	October 2019 – September 2020	QAPI Specialist QAPI Director Customer Service Manager Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant Chief Compliance Officer	Quarterly

		prescreening process and reduce IP admissions. ➢ Increase outreach to Veteran and Military Families that are not currently receiving services.			
Objective	**Goal**	**Deliverables**	**Dates**	**Lead Staff**	**Review Date**
15. Quality of Clinical Care Cross functional goal	➢ Provide Qualitative analysis for the identified opportunities . ➢ Re-measure identified opportunities and determine if interventions were effective.	➢ Create a procedure describing ➢ 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 My Strength Program ➢ Assist with Clinical Quality Site Reviews with monitoring the following categories: o Physician Coordination o Assessment Case files and Scoring o Progress Notes/Goals/Object	October 2019 - September 2020	QAPI Specialist QAPI Director Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant	Quarterly

		ive s ○ Care Transitions Analysis/Reports ○ TEDS and Customer Discharge/Transfer			
Objective	**Goal**	**Deliverables**	**Dates**	**Lead Staff**	**Review Date**
16. Safety of Clinical Care Cross functional goal	➢ Track patient safety/risk events and make recommendation for regional improvement. ➢ Provide a comparative report using current year and previous year's data to identify safety/risk concerns and trends. ➢ Analysis of reported risk events to identify 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/Discussi on s 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/Re-credentialing process ➢ Case Management Review Sessions	October 2019 - September 2020	QAPI Specialist QAPI Director Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant	Quarterly or as needed

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
17. Member Experience	➢ 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. ➢ Distribution, collection and analysis of annual Person in Recovery Survey (RSA-r). ➢ Medicaid Member Service Satisfaction Surveys. ➢ Medicare Member Service Satisfaction Surveys. ➢ MI Health Link – Dual Eligible Member Satisfaction Surveys. ➢ Complex Case Management Member Experience Survey. ➢ Distribution and analysis of MH and Physical Health provider communication 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.	October 2019 - December 2020	QAPI Specialist QAPI Director Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant All Senior Leadership	Annually

		➢ 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, RCP, RUM, SWMBH Board and other stakeholders annually.			
Objective	**Goal**	**Deliverables**	**Dates**	**Lead Staff**	**Review Date**
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, website, 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. ➢ Access to the SWMBH website for various publications and Provider Directory. ➢ Access to the SWMBH SharePoint Portal	January 2019 - December 2020	QAPI Specialist QAPI Director Chief Operations Officer Utilization Manager News Letter Editor Chief Information Technology Officer	Quarterly

		for internal and external stakeholders, as a collaborative information sharing resource and report delivery system.			
Objective	**Goal**	**Deliverables**	**Dates**	**Lead Staff**	**Review Date**
19. Serving Culturally and Linguistically Diverse Members Cross functional goal	➢ The Quality Department will work with other SWMBH Departments to address the Cultural and Linguistic needs of its membership. ➢ Review the annual Network Adequacy Plan and provide feedback for improvement projects/interventions.	➢ 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 Provider Network to improve network adequacy to meet the needs of underserved groups. ➢ Work with Provider Network to perform analysis on the network adequacy report and support identification of culturally diverse provider resources. ➢ Review Annual Cultural Competency Policies and Plan. ➢ Annually review and update Cultural Competency Goals and work plan. ➢ Annually review CMHSP partner Cultural Competency Plans.	October 2019 - September 2020	QAPI Specialist QAPI Director Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant All Senior Leadership Director of Provider Network SWMBH Cultural Committee Chair Person	Annually

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
20. Serving Members with Complex Health Needs **Cross functional goal**	➢ The Quality Management Department will work with the Utilization Management and Clinical Departments 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 ➢ Evaluate and monitor efforts to identify eligible CCM members.	October 2019 – September 2020	Integrated Care Nurse QAPI Director Medical Director or Consultant Director of Clinical Quality Director of Utilization Management	Quarterly

XV. QAPI – UM 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.

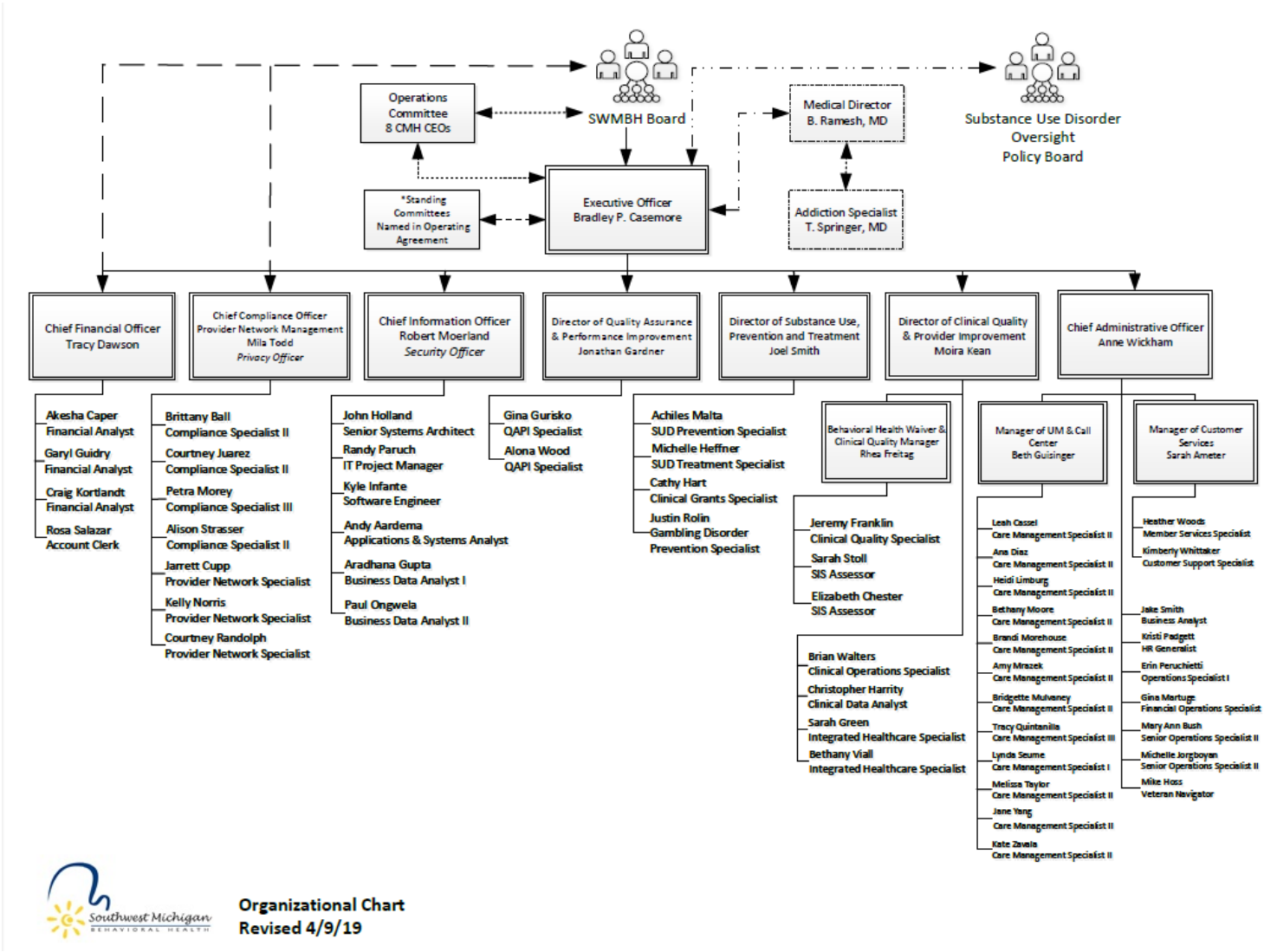
A Performance Improvement/Corrective Action Plan may be required for any area where performance gaps are identified. This describes a project improvement plan of action (including methods, timelines, and interventions) to correct the performance deficiency. A corrective action/performance improvement 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.

XVI. References:

BBA Regulations, 42 CFR 438.240
MDHHS –PIHP Contract Attachment P 6.7.1.1 et al SWMBH Quality Management Policies 3.1 and 3.2 NCQA – 2019 MBHO Accreditation Standards – QI 11B Quality Management Committee Charter

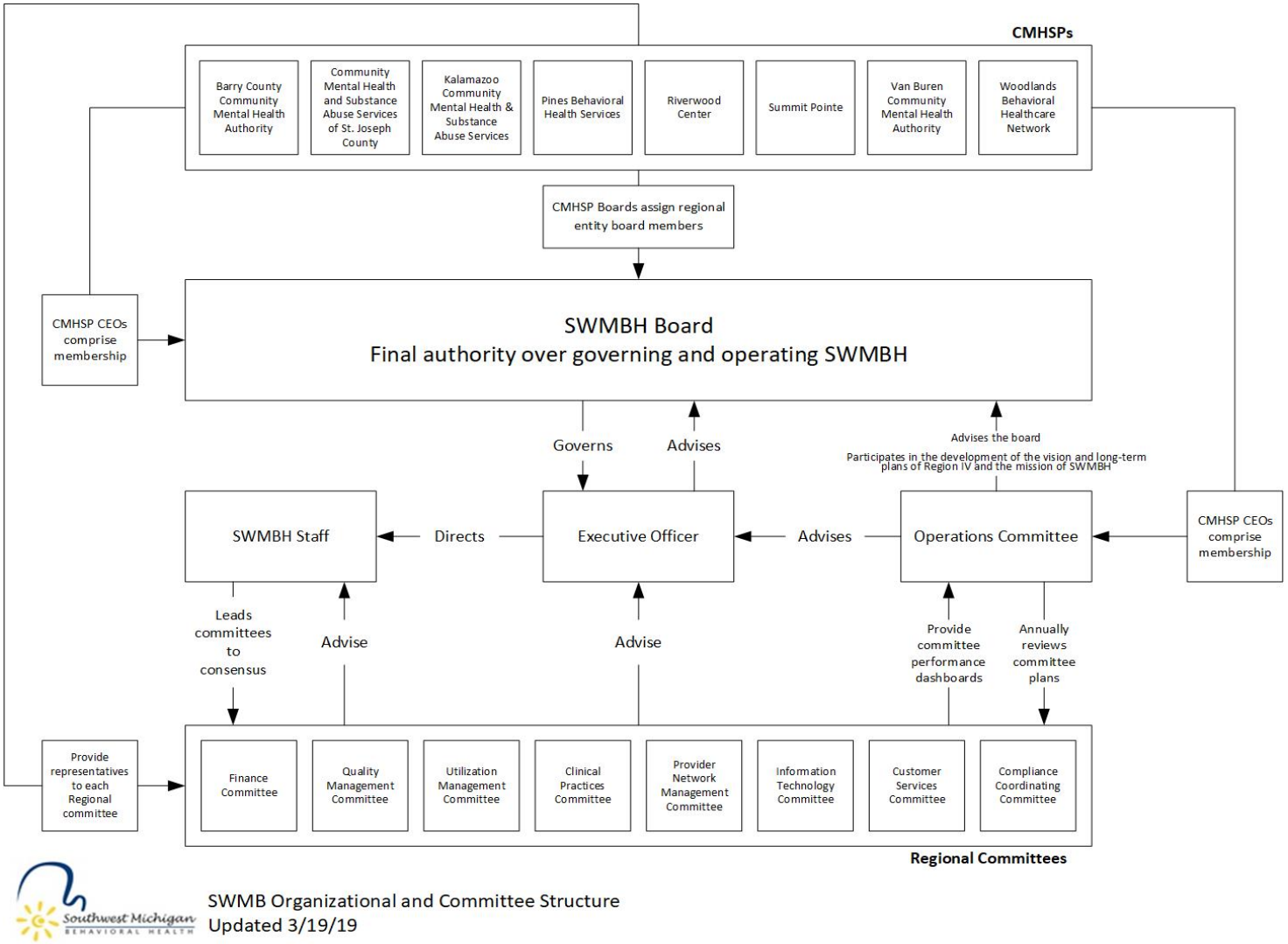
XVII. Attachments

Attachment A: Southwest Michigan Behavioral Health Organizational Chart



Attachment B: SWMBH Regional Committee Structure

SWMBH Organizational and Committee Structure



SWMB Organizational and Committee Structure
Updated 3/19/19

Attachment C: MI Health Link Quality Management Committee Charter

☒ **MI Health Link**
☒ **SWMBH Committees: Quality Management (QMC);** ☒ **Provider Network Credentialing (PNCC);** ☒ **Clinical and Utilization Management (CUMC);** ☒ **Cultural Competency Management**
Duration: ☒ **On-Going** ☐ **Deliverable Specific**

Charter Effective Date: 6/1/15
Charter last Review Date: 12/17/19

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, and contractual obligations and tasks. MI Health Link Committees ensure a care management quality control program is maintained at all times and that the 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. The committee 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. 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.
Accountability:	The committee is one method of participant communication, alignment, and advice to SWMBH. The committee tasks are determined by the committee chair and members, member needs, MI Health Link demonstration guidelines including the Three-Way Contract, the ICO-PIHP Contract and NCQA requirements. Each committee is accountable to the SWMBH Executive Officer and is responsible for assisting SWMBH Leadership to meet the Managed Care Benefit requirements within the MI Health Link demonstration, the ICO-PIHP contract, and across 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; QI 2: Program Operations: QI Committee Responsibilities, Element A.* • 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 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).* • 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 1: Program Structure; 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 6: Member Experience; 9: Complex Case Management, Member Experience with Case Management, Element I (Factor 1); UM 10 Experience with the UM Process.* • Review of current status and upcoming MHL audits • Review of demonstration year quality withhold measures **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). Aetna Contract-Attach C4; Meridian Contract.* • 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). Aetna Contract; 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). Aetna Contract; Meridian Contract.* • 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; Meridian Contract

- 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). Aetna Contract & Meridian Contract
- Ensures reporting of practitioner suspension or termination to the appropriate authorities.
  NCQA, MBHO, CR 6: Notification to Authorities and Practitioner Appeal Rights, Actions Against Practitioners, Element A (Factor 2); NCQA, MBHO, CR 6: 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 6: Notification to Authorities and Practitioner Appeal Rights, Element A (Factor 4); CR 6: 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:
  - 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) Aetna Contract & Meridian Contract
  - 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). Aetna Contract& Meridian Contract
- Ensures annual audits of practitioner complaints to determine if there are complaints alleging discrimination.
  NCQA, MBHO, CR 5: Ongoing Monitoring, Ongoing Monitoring and Intervention: Element A (Factor 3). Aetna Contract; Meridian Contract.

Utilization Management Committee:

- Reviews and authorizes policies and procedures.
  NCQA, MBHO, UM 1: Utilization Management Structure, UM Program Description Element A.
- 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; Meridian Contract.

- 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.; Meridian Contract.
- 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. Aetna Contract; Meridian Contract-Attach C.
- 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); Meridian Contract
- Ensures the organization:
  - 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). Aetna Contract; Meridian Contract-Attachment C.
  - 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). Aetna Contract; Meridian Contract.
  - 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). Aetna Contract; Meridian Contract.
  - Involves appropriate practitioners in developing, adopting and reviewing criteria.

    NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 4). Aetna Contract; Meridian Contract-Attachment C.
  - 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; Meridian Contract

Cultural Competency Management Committee:

- Has written policies, procedures and plan for promoting and ensuring a culturally competent, sensitive and inclusive environment.
- Conducts an annual review of the Network Adequacy Report to ensure that the data covers all members' language, race and ethic needs as well as ensure that there is data available for practitioner race, ethnic background and language skills. There will be a comparison of the two data sets to determine if the provider network is enough to meet its members' needs, identify areas of improvement and set interventions if needed. Will review internal and provider organizational systems to determine level of compliance with the Culturally & Linguistic Appropriate Services (CLAS) standards and other pertinent requirements for MI Health Link.

  NCQA, MBHO, QI 4: Availability of Practitioners and Providers.

	Integrated Care/Clinical Quality Committee: • Ensures the organization approves and adopts clinical practice guidelines and promotes them to practitioners. *NCQA, MBHO, QI 10: Clinical Practice Guidelines-Element A; 2: Program Responsibilities, QI Committee Responsibilities, Element A.* • Monitors the continuity and coordination of care that members receive across the behavioral healthcare network and takes action, as necessary, to improve and measure the effectiveness of these actions. • The organization collaborates with relevant medical delivery systems to monitor, improve and measure the effectiveness of actions related to coordination between behavioral and medical care. *NCQA, MBHO, CC 1 & 2: Collaboration between Behavioral Healthcare and Medical Care Aetna Contract-Attachment C.2; Meridian Contract* • Ensures assessment of population health needs, including social determinants and other characteristics of member population, is completed annually, and the CCM program is adjusted accordingly. *NCQA, MBHA, QI 9A: Complex Case Management, Population Assessment* • Ensures member survey results feedback is reviewed and follow-up occurs as appropriate. *NCQA, MBHO, QI 9J: Complex Case Management, Experience with Case Management* • The organization demonstrates improvements in the clinical care and service it renders to members. *QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program* • Monitors performance for all HEDIS/NQF measurements minimally annually. *NCQA, MBHO, QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program* • Selects 3 or more clinical issues for clinical quality improvements annually. Ensures that appropriate follow up interventions are implemented to improve performance in selected areas. *NCQA, MBHO, QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program* • Approves developed logic for calculating HEDIS measure and ensure it follows HEDIS specifications. *NCQA, MBHO, QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program*
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 Executive Officers 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 D: Quality Management Committee Charter

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: **12/19/19**

Next Scheduled Review Date: **12/20/20**

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.

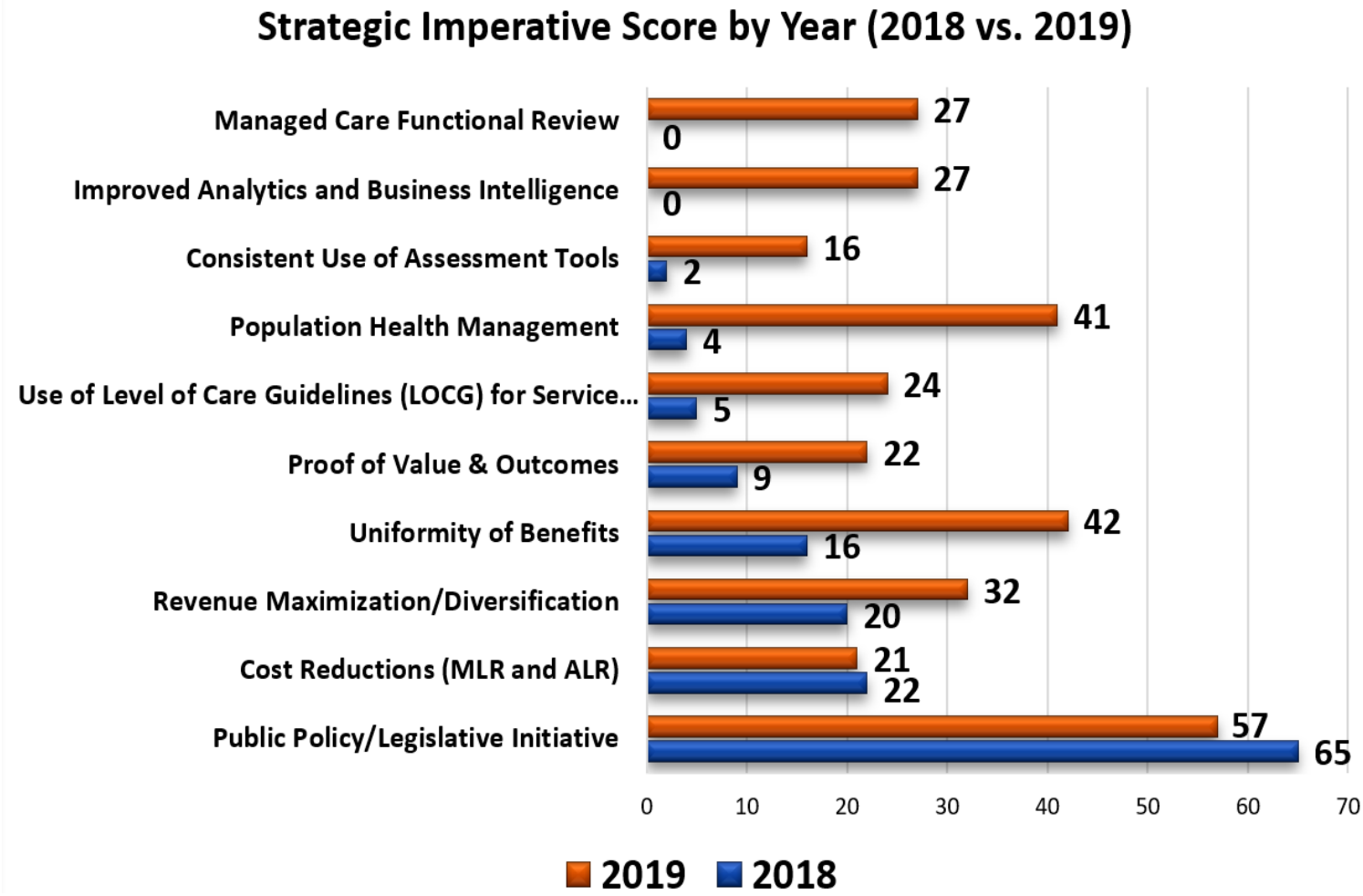
Committee Purpose:	• *The QMC will meet at a minimum on a quarterly basis to inform quality activities and to demonstrate follow-up on all findings and to approve required actions, such as the QAPI Program, QAPI Effectiveness Review/Evaluation, and Performance Improvement Projects. Oversight is defined 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 primary task of the QM Committee is to review, monitor and make recommendations related to the listed review activities with the QAPI Program/Plan* • *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.* • *Assist the RITC Committee with management and oversight of the Data Exchange sub-workgroup related to regional strategic imperatives and CMH data submission quality and completeness.* • *Work with the RITC Committee to create sub-workgroups, as needed, to facilitate regional initiatives or address issues/problems as they occur.*

Relationship to Other Committees:	At least annually there will be planning and coordination with the other Operating Committees including: • Finance Committee • Utilization Management Committee • 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 and discussions. Members should also bring relevant quality related challenges from their site to the attention of the SWMBH committee for possible project creation and/or assistance. Membership shall include: 1. Appointed participant CMH representation 2. Member of the SWMBH Customer Advisory Committee with lived experience 3. SWMBH staff as appropriate 4. Provider participation and feedback

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 and 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 will lose the right to participate in the voting structure for that meeting.
Deliverables:	The Committee will support SWMBH Staff in the: • Annual Quality Work Plan development and review • QAPI Evaluation development and review • Michigan Mission-Based Performance Indicator System (MMBPIS) regional report • Event Reporting Dash Board • Regional Survey Development and Analysis • Completion of Regional Strategic Imperatives or goals, assigned to the committee • Completion, feedback and analysis on any Performance Improvement Projects assigned to, or relevant to the committee

Attachment E: Strategic Imperative Score by Year



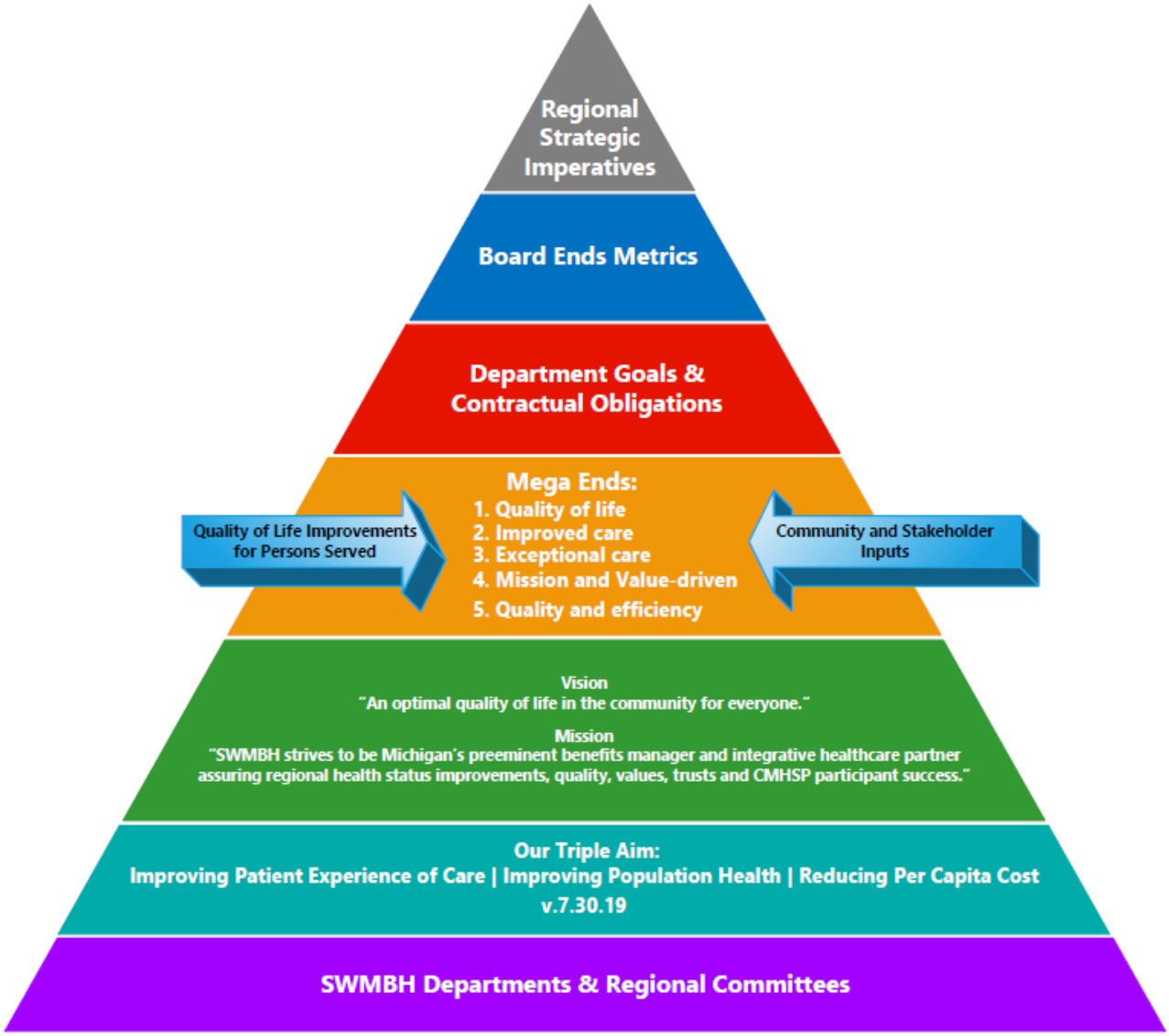
2018 Results:

1. Public Policy/Legislative Initiative	65
2. Cost Reductions (MLR and ALR)	44
3. Revenue Maximization/Diversification	43
4. Uniformity of Benefits	24
5. Proof of Value & Outcomes	18
6. Use of Level of Care Guidelines (LOCG) for Service Authorization Consistency	14
7. Population Health Management	8
8. Consistent Use of Assessment Tools	3
9. Improved Analytics and Business Intelligence	1
10. Managed Care Functional Review	0

2019 Results:

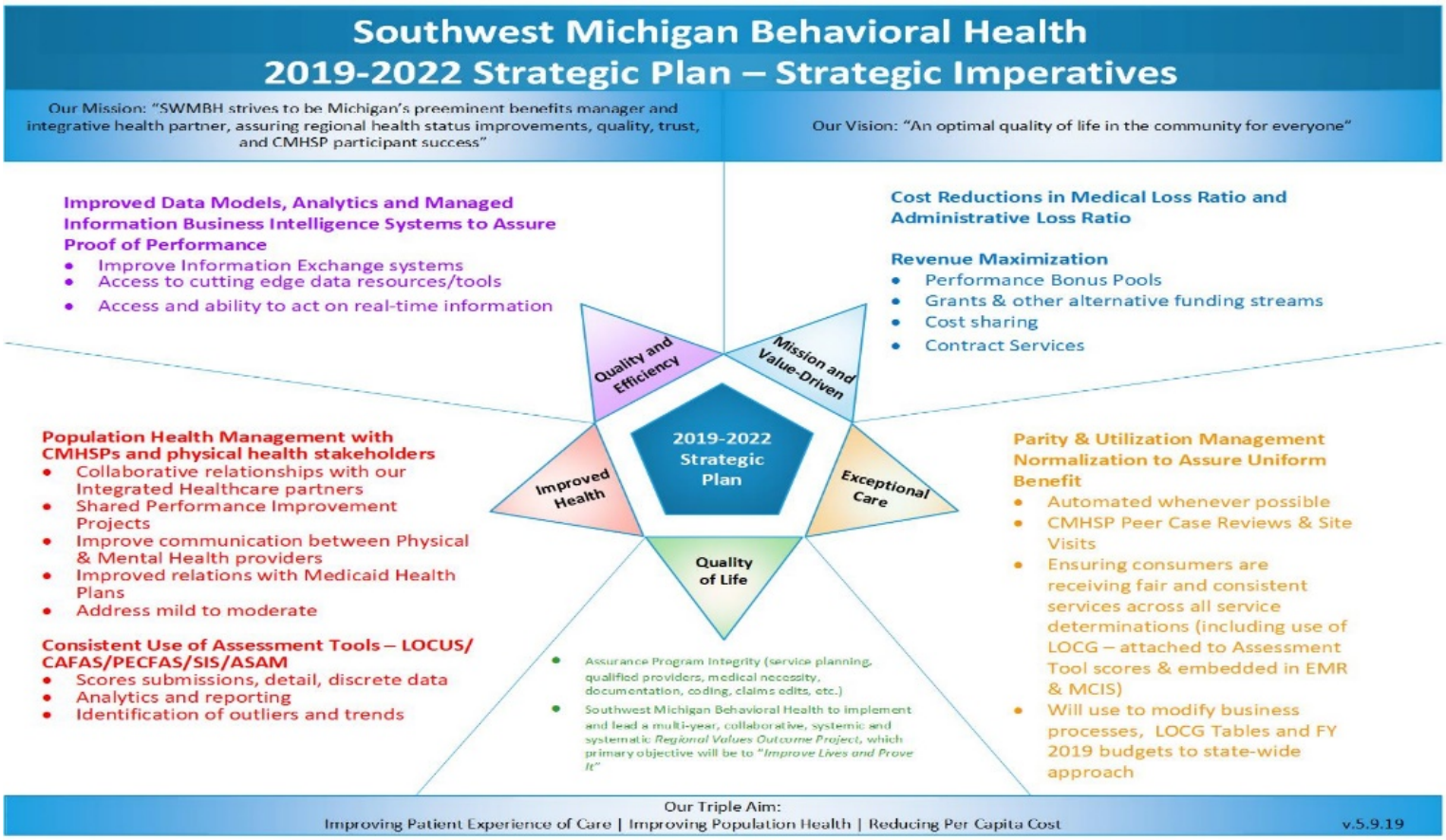
1. Public Policy/Legislative Initiative	57
2. Uniformity of Benefit	42
3. Population Health Management	41
4. Revenue Maximization	32
5. Improved Analytics and Business Intelligence	27
6. Managed Care Functional Review	27
7. Use of Level of Care Guidelines (LOCG) for Service Authorization Consistency	24
8. Cost Reductions (MLR and ALR)	21
9. Proof of Value & Outcomes	22
10. Consistent Use of Assessment Tools	17

Attachment F: Regional Strategic Imperatives



Strategic Alignment – Annual Goal Planning
Revised 7/30/19

Attachment G: 2018-2021 Strategic Plan – Board Ends Metrics



Attachment H: 2019 Board Member Roster

2020 Board Member Roster

Barry County
- Robert Nelson
- Robert Becker (Alternate)

Berrien County
- Edward Meny - Vice-Chair
- Nancy Johnson (Alternate)

Branch County
- Tom Schmelzer - Chair
- Jon Houtz (Alternate)

Calhoun County
- Patrick Garrett
- Kathy-Sue Vette (Alternate)

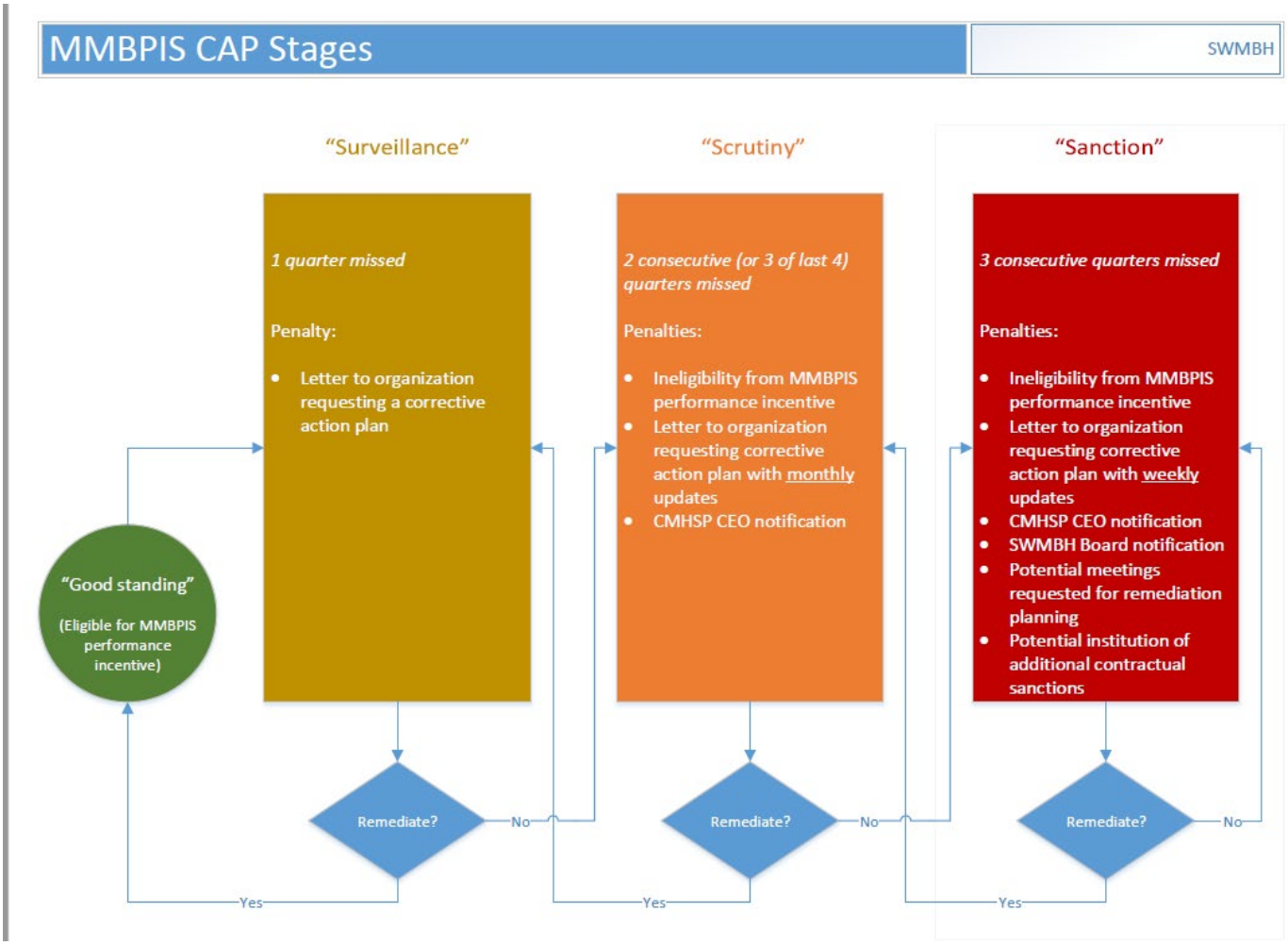
Cass County
- Michael McShane
- Karen Lehman (Alternate)

Kalamazoo County
- Moses Walker
- Patricia Guenther (Alternate)

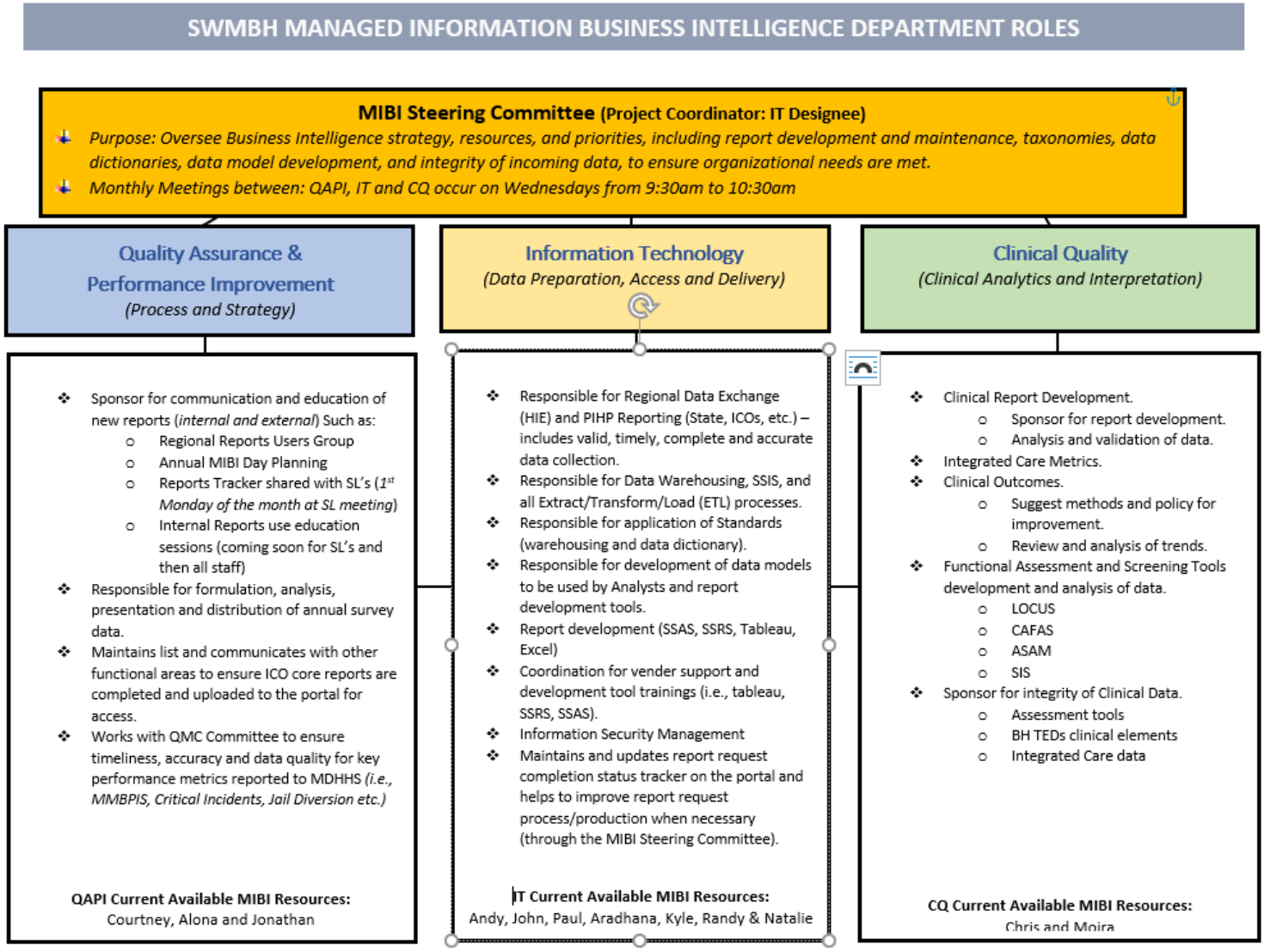
St. Joseph County
- Angie Price
- Cathi Abbs (Alternate)

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

Attachment I: MMBPIS CAP Stages



Attachment J: Managed Information Business Intelligence Department Roles



Attachment K: SWMBH Value Framework

Value Framework

Our Mission

"SWMBH strives to be Michigan's preeminent benefits manager and integrative healthcare partner, assuring regional health status improvements, quality, value, trust, and CMHSP participant success".

Mega Ends

Quality of Life	Improved Health	Exceptional Care	Mission and Value-Driven	Quality and Efficiency
Persons with Intellectual Developmental Disabilities, Serious Mental Illness, Autism Spectrum Disorder, Serious Emotional Disturbances and Substance Use Disorders in the SWMBH region see improvements in their quality of life and maximize self-sufficiency, recovery and family preservation.	Individual mental health, physical health and functionality are measured and improved.	Persons and families served are highly satisfied with the care they receive.	CMHSPs and SWMBH fulfill their agencies' missions and support the values of the public mental health system.	The SWMBH region is a learning region where quality and cost are measured, improved and reported.

Triple Aim

Improving Patient Experience of Care | Improving Population Health | Reducing Per Capita Cost

Our Vision

"An optimal quality of life in the community for everyone".

Attachment L: Board Ends Metrics

2020 – 2021 SWMBH Board Ends
Fiscal and Calendar Year Metrics
Board Approved on November 8, 2019

2020-2021 Board Ends Metrics Review and Approval Schedule:

- *2019-2020 Strategic Imperatives discussion by SWMBH Board on: 5/10/19*
- *Operations Committee Review and Endorsement on: 10/30/19*
- *Utilization Management and Clinical Practices Committee Review and Endorsement on: 10/14/19*
- *Quality Management Committee Review and Endorsement on: 9/26/19*

Mega Ends:

1. **Quality of Life**: Persons with Intellectual Developmental Disabilities (I/DD); Serious Mental Illness (SMI); Serious Emotional Disturbances (SED); Autism Spectrum Disorders (ASD) 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 health, physical health and functionality are measured and improved.
3. **Exceptional Care**: Persons and families 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, improved and reported.

Our Mission:

"SWMBH strives to be Michigan's preeminent benefits manager and integrative healthcare partner, assuring regional health status improvements, quality, value, trust, and CMHSP participant success".

Our Vision:

"An optimal quality of life in the community for everyone."

Our Triple Aim:

Improving Patient Experience of Care | Improving Population Health | Reducing Per Capita Cost

Quality of Life

Persons with Intellectual Developmental Disabilities (I/DD); Serious Mental Illness (SMI); Serious Emotional Disturbances (SED); Autism Spectrum Disorders (ASD) 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 health, physical health and functionality are measured and improved.

PROOFS	STATUS	PROOFS	STATUS
1. Achieve 95% of Performance Based Incentive Program monetary award based on MDHHS specifications. Metric Measurement Period: (10/1/19 - 11/15/20) Metric Report Date: March 12, 2021 (or when DHHS replies) A. **Identification of Veteran's eligible for services**: Timely submission of the Veteran Services Navigator (VSN) Data Collection form through DCH File transfer. Improve and maintain data quality on BH-TEDS military and veteran fields. Measurement period: 10/1/19 – 3/31/20 B. **Increased Data sharing**: Send ADT messages for purposes of care coordination through health information exchange. Submit report addressing IT systems barriers and remediation efforts by: 7/31/20 C. **Initiation and Engagement**: The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: Initiation of AOD Treatment: The percentage of enrollees who initiate treatment within 14 calendar days of the diagnosis. D. SWMBH will submit a qualitative narrative Summary report to MDHHS, related to efforts, activities and achievements with the following metrics: (By: November 15, 2020) 1. Comprehensive Care 2. Patient – Centered Medical Homes 3. Coordination of Care 4. Accessibility to Services 5. Quality and Safety	This metric has been modified to align with 2020 MDHHS approved PBIP Narrative Language	**2. Achieve the following Joint expectations for the MHP's and SWMBH. There are 100 points possible for this bonus metric in FY2019:** Metric Measurement Period: (1/1/20 - 12/30/20) Metric Report Date: October 9, 2020 (or when DHHS replies) 1. ***Joint Care Management***: 90% of care plans evaluated must achieve full compliance. 2. ***Follow-up after Hospitalization for Mental Illness (30 days):*** The adult minimum standard is 58% and the child minimum standard is 70%. 3. **Plan All-Cause Readmission (30 days):** Review and validate data, noting discrepancies found that impact the measure results, as well as actions taken to address data issues. Submit report (By: June 30, 2020) 4. **Follow-up after Emergency Department Visit for Alcohol and Drug Dependence:** Members 13 years and older with an (ED) visit for alcohol and other drug dependence, that had a 30-day follow-up visit. Submit a narrative report (4 pages) on findings of efforts to review data. Analysis should include disparities among racial and ethnic minorities. Submit report. Informational only in 2020. (By: June 30, 2020). *Possible bonus credit for #2 Follow-up after Hospitalization: +1 point – Youth over 90% +1point – Adults over 85%	This metric has been modified to align with 2020 MDHHS approved Metrics Language

Exceptional Care:		Mission and Value Driven:	
Persons and families served are highly satisfied with services they receive.		CMHSPs and SWMBH fulfill their agencies' missions and support the values of the public mental health system.	
PROOFS	**STATUS**	**PROOFS**	**STATUS**
3. 2020 Customer Satisfaction Surveys collected by SWMBH are at or above the SWMBH 2019 results for the following categories: Metric Measurement Period: (1/1/20 - 9/30/20) Board Report Date: January 10, 2021 A. Mental Health Statistic Improvement Project Survey (MHSIP) tool. *(Improved Functioning – baseline: 85.1%)* B. Youth Satisfaction Survey (YSS) tools. *(Improved Outcomes – baseline 81.3%)* C. Initiate Performance Improvement Project (PIP), targeting consumer feedback category with the highest volume of responses and potential improvement. (By: July 31, 2020)	Modified Metric	**4. 48/56 or 85% of State Measured MMBPIS Indicators will be at or above the State benchmark for 4 quarters for FY 20.** Metric Measurement Period: (1/1/20 - 12/31/20) Board Report Date: March 12, 2021 **Measurement:** Total number of indicators that met State Benchmark Total number of indicators measured	New Indicators may be informational only for 2020, until a new benchmark is established (2a, 2b and 3) No exceptions or exclusions for indicators: (2a, 2b and 3)
5. Implementation of the GAIN Assessment Tool for FY20 by 10/1/20 Per MDHHS Contract. Metric Measurement Period: (10/1/19 - 10/1/20) Board Report Date: December 11, 2020 a. Full system Implementation and integration by CMHSP's and Provider sites (By: 10/1/20) b. Training and certifying all relevant clinicians to administer the GAIN (By: 8/1/20) c. Establish baseline in FY20 for FY21.	New	**6. Regional Habilitation Supports Waiver slots are full at 98% throughout FY20.** Metric Measurement Period: (10/1/19 - 9/30/20) Board Report Date: October 9, 2020 **Measurement:** (%) of waiver slot (months) filled x 12 (#) of waiver slot (months) available *+1-point bonus credit will be awarded for (5) or more new HSW Slots SWMBH receives from MDHHS during FY20.	Existing Metric 2019 Slots: 690 2020 Slots: 710

7. Each quarter, at least 53% of parents and/or caregivers of youth and young adults who are receiving Applied Behavior Analysis (ABA) for Autism will receive Family Behavior Treatment Guidance. This service supports families in implementing procedures to teach new skills and reduce challenging behaviors. Metric Measurement Period: (10/1/19 - 9/30/20) Board Report Date: December 11, 2020 **Measurement:** # of youth/young adults whose parents and/or caregivers received behavior treatment guidance at least once per quarter # of youth/young adults receiving ABA services	Measure is in alignment with DHHS language and logic.
8. Achieve a (4 percentage point) improvement in the rate of Diabetes screenings for consumers with schizophrenia or Bipolar Disorder who are using Antipsychotic Medications. Metric Measurement Period: (1/1/20 - 12/31/20) Board Report Date: June 11, 2021 **Measurement:** Percent of members 18-64 years old with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening testing during the measurement year. **Target Goal:** 80% Current Status: 76%	+4% points improvement would be considered a statistically significant improvement This measure is reviewed and validated by HSAG

The following Board End Metrics fall into multiple Mega End categories.

Quality and Efficiency:	Mission and Value Driven:
The SWMBH region is a learning region, where quality and cost are measured, improved and reported.	CMHSPs and SWMBH fulfill their agencies' missions and support the values of the public mental health system.

9. 2020 Health Service Advisory Group (HSAG) External Quality Compliance Review. All standards and corrective action plans evaluated, will receive a minimum compliance score of 90% or designation that the standard has been "Met". Metric Measurement Period: (1/1/20 - 12/30/20) Board Report Date: February 12, 2021 **Measurement:** Number of Standards Identified "Met" at 90% Total Elements Evaluated (8)	**Scheduled for September 2020** 2018 Results: 167/187 or 89% of Total Elements Evaluated achieved compliance. Standards evaluated at (Below 90%): 1. Customer Service (2018 score – 86%) 2. Grievance Process (2018 score – 81%) 3. Appeals (2018 score – 87%) SWMBH ranked 2nd highest among 10 PIHP's. The Board Metric of 90% was "Not Met".
10. 2020 HSAG Performance Measure Validation Audit Passed with (95% of Measures evaluated receiving a score of "Met") Metric Measurement Period: (1/1/20 - 6/30/20) Board Report Date: September 11, 2020 **Measurement:** Number of Critical Measures that achieved "Met" Total number of Critical Measures Evaluated	**Scheduled for July 2020** **2019 Results** 37/37 or 100% of Total Elements Evaluated received a designation score of "Met", "Reportable" or "Accepted". The Board Ends Metric was successfully "Met".
11. A. 97% of applicable MH served clients (with an accepted encounter) **will have a matching and accepted BH TEDS record as confirmed by the MDHHS quarterly status report.** B. **97% of applicable SUD** served clients (with an accepted encounter) **will have a matching and accepted BH TEDS record as confirmed by the MDHHS quarterly status report.** Metric Measurement Period: (1/1/20 - 7/1/20) Board Report Date: September 11, 2020 **Measurement:** (#) of reportable MH/SUD encounters (#) of MH/SUD encounters with BH TEDS matching record	Data Source: MDHHS Monthly Status Reports Current Baseline: 2/16/19 • MH = 87.12% • SUD = 85.63% Current Status: 8/5/19 • MH = 94.11% • SUD = 94.43% 95% puts SWMBH in the green (compliance) on the MDHHS report. Matching rules as defined by MDHHS. Must have a matching and accepted BH TEDS record completed within one year of the encounter. For MH, this means that SWMBH minimally need an annual update record completed by the provider/CMHSP.

12. Completion of LOC guidelines to ensure consistent Medicaid benefit across the Region. (By: 4/15/20)

Metric Measurement Period: (10/1/19 - 4/1/20)
Board Report Date: April 10, 2020

A. Significant Improvement of Functional Assessment tool detailed sub- element scores (LOCUS, ASAM, CAFAS, SIS) are received electronically by SWMBH from CMHSPs. (By: 4/1/20)
B. Complete detailed specification sheets for each Assessment tool, including; what elements are required in transactions and validity and quality of data standards. (By: 3/6/20)

Tool	Current Status	Goal
LOCUS:	98.6%	99.6%
ASAM:	85.1%	88.3%
CAFAS:	95.6%	97.2%
SIS:	88.8%	91.8%

Replacement
Metric

Goal for each Assessment was based on a significant variation (%) improvement calculation.

(subtract benchmark number from target result and divide the result by the benchmark number, equals final (%) improvement variance result)

(ex. 85.1 – 89.3/89.3x = 88.3)

Each completed Goal is ¼ point. (1/4 x 4 = 1 point)
If all Goals are completed successfully +1 bonus point awarded.

13. SWMBH will achieve 90% of available monetary bonus award for achievement of quality withhold performance measures identified in the (2019-2020) MHL Integrated Care Organization (ICO) contracts including:

Metric Measurement Period: (1/1/20 - 12/30/20)
Board Report Date: March 10, 2021

a. 90% of paid claim encounters are submitted by the 15th of the month following payment.
b. 95% CMS initial acceptance rate of PIHP encounters are received monthly.
c. 95% of enrollees have a level II assessment completed within 15 days of their level I assessment.
d. 80% of enrollees with an inpatient psychiatric admission discharged to home or any other site of care for whom a transition record was transmitted within (24 hours) of discharge to the facility or BH professional designated for follow-up care.
e. 95% of enrollees have documented discussions regarding care goals.

Modified
Contingent on Demonstration
Year 4-5 approved Quality
Withhold Metrics

f. The PIHP will designate (2) members to serve on the MHL advisory board. *SWMBH achieves 1-point credit for achievement of (*90% of total possible points - each contract*) +1pt. Aetna Quality Withhold Measures +1pt. Meridian Quality Withhold Measures	

Each Board End Metric proof's current status will be placed into one of (3) categories.

LEGEND: COMPLETED GOAL/ON TARGET: GREEN GOAL NOT MET/BEHIND SCHEDULE: RED PENDING: BLUE

Pending: proof could mean that;

- More Information is needed.
- The event/program/intervention has been scheduled, but not taken place (i.e., audits or final data submissions).
- Data has not been completed yet (i.e., due on a quarterly basis or different time table/schedule).
- Metric is on hold, until further information is received.

Goal Not Met: proof could mean that;

- The proof is behind its established timeline in being completed.
- Reports or evidence for that proof have not been identified.
- The identified metric proof has passed its established timeline target.

Completed Goal:

- Evidence/proof exists that the metric has been successfully completed.

All Board Ends Metrics will be in alignment with 2020-2021 Board Approved Strategic Imperatives

1. Public Policy and Legislative Initiatives.

2. Parity and Utilization Management Normalization to Assure Uniformity of Benefit.
3. Cost Reductions in Medical Loss and Administrative Loss Ratio.
4. Improved Data Models, Analytics and Managed Information Business Intelligence Systems.
5. Development of Performance Based Care and Outcomes Metrics.
6. Integrated Care Management with CMHSP and Physical Health Stakeholders.
7. Revenue Maximization - Capture all possible and available revenue opportunities.