



Southwest Michigan Behavioral Health

Quality Assurance and Performance Improvement Program

All SWMBH Business Lines

Year 2018 (October 1, 2017 - September 30, 2018)

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Approved by:

A handwritten signature in black ink, appearing to read "Jennifer G. Gaudin".

Date:

1/13/2018

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I. Introduction

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

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

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

II. Purpose

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

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

Additional purposes of the QAPIP are to:

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

III. Guiding Principles

During the December 8, 2017 Board Meeting, the SWMBH Board approved the 2018-2019 Board Ends Metrics and revised Mega Ends. The Mega Ends serve as the guiding principles for 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. Core Values

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

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

V. Authority and Structure

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

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

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

Internal Staffing and Resources of the QAPI Department

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

The QAPI Department is staffed with a Director of Quality Assurance and Performance Improvement which oversees the QAPI Department including the 4 Full-Time staff and one external contract position. The QAPI Director collaborates on many of the QAPI goals and objectives with the SWMBH Senior Leadership team and SWMBH Regional Committees, such as the; Quality Management Committee (QMC), Regional Information Technology Committee (RITC), Regional Utilization Management Clinical Protocol Committee (RUMCP) and the Consumer Advisory Committee (CAC).

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

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

Adequacy of Quality Management Resources

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

Title	Department	Percent of time per week devoted to QM
Director of Quality Assurance and Performance Improvement	QAPI	100%
(2) QAPI Specialist	QAPI	100%
Business Data Analyst I	QAPI	100%
Business Data Analyst II	QAPI	80%
Consulting Statistician	QAPI and PNM	25%

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

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

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

The QAPI Department is responsible for collecting measurements reported to the state and to improve and meet SWMBH's mission. In continuing the development of a systematic improvement system and culture, the goal of this program and plan is to identify any needs the organization may have in the future so that performance improvement is effective, efficient and meaningful. The QAPI Department monitors and evaluates the overall effectiveness of the QAPI, 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/vendors 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

VI. Committees

Quality Management (QM) Committee

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

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

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

Quality Management Committee (QMC) Membership

The QMC shall consist of an appointed representative from each participating CMHSP, representative(s) from the SWMBH Customer Advisory Committee (CAC) and SWMBH QAPI Departmental staff. All other ad hoc members shall be identified as needed, 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, to 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 same responsibilities of members when participating in committee work.

QMC Committee Commitments include:

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

Decision Making Process

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

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

QMC Roles and Responsibilities

- QMC will meet on a regular basis (at a minimum quarterly) to inform quality activities and to demonstrate follow-up on all findings and to approve required actions, such as the QAPIP, QAPI & UM Effectiveness Review/Evaluation, and Performance Improvement Projects (PIPs). Oversight is defined as reviewing data and approving projects.
- Members of the committee will act as conduits and liaisons to share information decided on in the committee. Members are representing the regional needs related to quality. It is expected that QMC members will share information and concerns with SWMBH QAPI staff. As conduits, it is expected that committee members attend all meetings by phone or in person. If members are not able to attend meetings, they should notify the QMC Chair Person as soon as possible. QMC members should be engaged in performance improvement issues, as well as bringing challenges from their site to the attention of the SWMBH committee for deliberation and discussion.
- Maintaining connectivity to other internal and external structures including the Board, the Management team, other SWMBH committees and MDHHS.
- Provide guidance in defining the scope, objectives, activities, and structure of the PIHP's QAPIP.
- Provide data review and recommendations related to efficiency, improvement and effectiveness.
- Review and provide feedback related to policy and tool development.
- The primary task of the QMC is to review, monitor and make recommendations related to the listed review activities with the QAPIP.
- The secondary task of the QMC is to assist the PIHP in its overall management of the regional QAPI functions by providing network input guidance and make suggestions for process improvement opportunities, with the ultimate goal of improving consumer outcomes.

2018 Quality Management Committee Goals

1. Implementation of a Regional Report Users and Analysis Group (By: 10/30/2018)
 - i. Determine who the members of the report users and analysis group will be
 - ii. Send out calendar invites to selected report user group members
 - iii. Formulate a charter, which defines the purpose and roles of the report users and analysis group
 - iv. Determine schedule reports will be build and reviewed on, based on Regional priorities and needs
 - v. Users Group to perform analysis, identify trends, improve function of reports
 - vi. Users Group to present reports to relevant Regional Committees for feedback and use
2. Formulate a series of instructional videos/tutorials, which live on the SWMBH SharePoint Portal for SWMBH and CMHSP access (By: 10/30/2018)
 - 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. Identify the list of Regional Trainings to be developed and prioritize them for development
 - iv. Form sub-groups within QMC to put together materials/trainings and present trainings
 - 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
 - vii. Review Priority-Training Development List and make adjustment for ongoing development as necessary
 - viii. Review Process and formulate ongoing report improvement and access strategies

MI Health Link Committee

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

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

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

MI Health Link Committee Membership

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

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

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

Decision Making Process

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

---See Attachment A, “Southwest Michigan Behavioral Health Committee Structure.”

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

Functional Area	Objectives	Lead Staff	Review Date
	Complex Case Management	Director of Utilization Management or Integrated Care Specialist	Monthly
	NCQA Measures	Director of Provider Network or Director of Utilization Management	Monthly
	Policy and Procedure Review and Updates.	Director of Utilization Management or Manager of Utilization Management	As needed

MI Health Link Committee Roles and Responsibilities:

- Maintaining connectivity to other internal and external structures including the Board, the Management team, other SWMBH committees and MDHHS.
- Provide guidance in defining the scope, objectives, activities, and structure of the QAPIP.
- Provide data review and recommendations related to efficiency, improvement, and effectiveness.
- Review and provide feedback related to policy and tool development.
- The secondary task of the Committee is to assist the PIHP in its overall management of the regional QAPI functions by providing network input and guidance.
- The primary task of the Committee is to review, monitor and make recommendations related to the listed review activities with the QAPI Program.
- Ensures follow-up as appropriate. Ensures practitioner participation in the QAPI program through planning, design, implementation or review. Ensures discussion (and minutes) reflects:
 - Appropriate reporting of activities, as described in the QM program description.
 - Reports by the QM director and discussion of progress on the QM work plan and, where there are issues in meeting work plan milestones and what is being done to respond to the issues.
- Ensures the organization describes the role, function and reporting relationships of the QM Committee and subcommittees.
- Ensures all MHL required reporting is conducted and reviewed, corrective actions coordinated where necessary, and opportunities for improvement are identified and followed-up.
- Ensures member and provider experience surveys are conducted and reviewed, and opportunities for improvement are identified and followed-up.
- Ensures the organization approves and adopts clinical practice guidelines and promotes them to practitioners. The appropriate body to approve the clinical practice guidelines may be the organization's QM Committee or another clinical committee.
- Ensures the organization approves and adopts preventive health guidelines and promotes them to practitioners in an effort to improve health care quality and reduce unnecessary variation in care. The appropriate body to approve the preventive health guidelines may be the organization's QM Committee or another clinical committee.
- The organization annually:
 - Documents and collects data about opportunities for collaboration.
 - Documents and conducts activities to improve coordination between medical care and behavioral healthcare.
- Ensures the ICO and PIHP identify shared quality improvement measurement requirements and develop and implement related processes sharing results and undertaking correction and quality improvement activities.
- Ensures a care management quality control program is maintained at all times.

- Ensures Call Center quality control program is maintained and reviewed, which should include elements of internal random call monitoring.
- The PIHP will have a minimum of (2) members participate in MI Health Link Advisory Group meetings.

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 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.

These quality performance measures include:

- 95% of claims per final reconciliation were received timely as monthly encounters.
- 95% of enrollees have a level II assessment completed within 15 days of their level I assessment.
- 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.
- 95% of enrollees have documented discussions regarding care goals.

VII. Standards and Philosophy

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

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

- ✓ Strategies to improve performance

Other methodologies are used to control process include:

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

VIII. Review Activities

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

Review Activity	Activity Description
1. Annual QAPI Plan	<p>The QAPI plan is a document that reflects the ongoing progress on QAPI activities throughout the year. The QAPI plan is developed by the QAPI Department with guidance from the QMC and RUMCP. The Plan is reported annually to the EO, Operations Committee the SWMBH Board, and to customers and other stakeholders. The plan consists of the quality improvement, performance and outcome goals to be achieved throughout the year and addresses:</p> <ul style="list-style-type: none"> • Yearly planned QI objectives/goals for improving: <ul style="list-style-type: none"> – 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. <p><i>--See Section XI, "2018 Quality Assurance Improvement Plan"</i></p>
2. Annual QAPI & UM Effectiveness Review & Evaluation	<p>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:</p> <ul style="list-style-type: none"> • 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, Outcome monitoring	<ul style="list-style-type: none"> 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 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. <p>see attachment (G) – “2018-2019 Board Ends Metrics”</p>
4. Access Standards	<ul style="list-style-type: none"> 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. <ul style="list-style-type: none"> Behavioral Health will meet the following standards: <ol style="list-style-type: none"> Routine Non-Life Threatening Emergency within 6 hours Urgent Care within 48 hours Routine Office Visits within 10 business days Call Center calls will be answered by a live voice within 30 seconds Telephone call abandonment rate is within 5%
5. Key Administrative Functions	<p>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):</p> <ul style="list-style-type: none"> <i>Provider Network</i> <i>Compliance</i> <i>Customer Services</i> <i>Utilization Management</i> <i>Administrative Support</i> <p>Performance measures for respective functional areas are further described in functional documents, which provides description of associated plans, performance measures, and tracking processes</p>
6. Credentialing	SWMBH will ensure that services and supports are consistently provided by staff (contracted or direct operated) who are properly and currently credentialed, licensed, and qualified. The SWMBH Credentialing and Re-Credentialing policy outlines the guidelines and responsibilities for credentialing and re-credentialing for SWMBH. Credentialing activities will be completed and monitored through the Provider Network functional area in conjunction with QAPI and Provider Network departmental staff, QMC, MHL Committee and the Provider Network Committee.

7. Provider Monitoring Reviews	SWMBH Provider Network department in conjunction with QAPI Department will monitor its provider network to ensure systematic and comprehensive approaches to monitoring, benchmarking, and implementing improvements.																		
8. 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.																		
9. Performance Improvement Projects (PIPs)	<p>Every year at least two projects are identified as PIPs. This is done by the QMC as directed by MDHHS and is based on identified gaps in service quality, penetration, or other performance improvement functions. The PIPs are aimed at impacting error reduction, improving safety and quality. Reported to EO, the Operations Committee, customers, relevant other committees, and to other stakeholders according to MDHHS reporting requirements, and/or according to project plan.</p> <p>Every year at least three projects are defined as PIPs for MHL.</p> <p>The following are a list of current PIPs that have been selected for each business line:</p> <table border="1" data-bbox="521 810 1448 1797"> <thead> <tr> <th data-bbox="521 810 984 856">MDHHS – Medicaid PIPs:</th><th data-bbox="984 810 1448 856">MI Health Link PIPs:</th></tr> </thead> <tbody> <tr> <td data-bbox="521 856 984 989"><i>Improvement Project #1: (EQR evaluated): “Improving Diabetes Treatment for Consumers with a Co-morbid Mental Health Conditions”.</i></td><td data-bbox="984 856 1448 1020">1. (NQF 1879): “Adherence to Antipsychotic Medications For Individuals with Schizophrenia” – National Quality Strategy Domain: Patient Safety</td></tr> <tr> <td data-bbox="521 989 984 1150"><i>Improvement Project #2: “Improving Medication Management for persons with Intellectual and Developmental Disabilities”.</i></td><td data-bbox="984 1020 1448 1150">2. (NQF 1932) : “Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications”</td></tr> <tr> <td></td><td data-bbox="984 1150 1448 1247">3. (NQF 0576) “Follow-Up after Hospitalization for Mental Illness (FUH-7 days)”.</td></tr> <tr> <td></td><td data-bbox="984 1247 1448 1314">4. “Follow-Up after Hospitalization for Mental Illness (FUH-30 days)”.</td></tr> <tr> <td></td><td data-bbox="984 1314 1448 1446">5. “Initiation and Engagement of Alcohol and Other Drug Dependence Treatment” – Initiation Phase</td></tr> <tr> <td></td><td data-bbox="984 1446 1448 1579">6. “Initiation and Engagement of Alcohol and Other Drug Dependence Treatment” – Engagement Phase</td></tr> <tr> <td></td><td data-bbox="984 1579 1448 1711">7. “Thirty-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF)”.</td></tr> <tr> <td></td><td data-bbox="984 1711 1448 1797">8. “Antidepressant Medication Management: Effective Acute Phase Treatment”</td></tr> </tbody> </table>	MDHHS – Medicaid PIPs:	MI Health Link PIPs:	<i>Improvement Project #1: (EQR evaluated): “Improving Diabetes Treatment for Consumers with a Co-morbid Mental Health Conditions”.</i>	1. (NQF 1879): “Adherence to Antipsychotic Medications For Individuals with Schizophrenia” – National Quality Strategy Domain: Patient Safety	<i>Improvement Project #2: “Improving Medication Management for persons with Intellectual and Developmental Disabilities”.</i>	2. (NQF 1932) : “Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications”		3. (NQF 0576) “Follow-Up after Hospitalization for Mental Illness (FUH-7 days)”.		4. “Follow-Up after Hospitalization for Mental Illness (FUH-30 days)”.		5. “Initiation and Engagement of Alcohol and Other Drug Dependence Treatment” – Initiation Phase		6. “Initiation and Engagement of Alcohol and Other Drug Dependence Treatment” – Engagement Phase		7. “Thirty-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF)”.		8. “Antidepressant Medication Management: Effective Acute Phase Treatment”
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	8. “Antidepressant Medication Management: Effective Acute Phase Treatment”																		
10. Customer and 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																		

	<p>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.</p>
11. Customer and Provider Assessments (MIHL)	<p>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.</p>
12. Michigan Mission Based Performance Indicators (MMBPIS)	<p>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.</p>
13. Critical Incidents/Sentinel Events/Risk Events	<p>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.</p>
14. Customer Grievances and Appeals	<p>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.</p>
15. Behavior Treatment Review Data	<p>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.</p>

16. Utilization Management	<p>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.</p> <p>The Utilization Management (UM) Plan Evaluation Components include:</p> <ul style="list-style-type: none"> a. 2018 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 <ul style="list-style-type: none"> i. Telephone Access to Services and Staff. e. Timeliness of UM Decisions <ul style="list-style-type: none"> i. Services ii. Appeals f. UM Decision-Making <ul style="list-style-type: none"> i. Clinical Criteria ii. Availability of Criteria iii. Consistency of Applying Criteria iv. Inter-rater reliability (IRR audit) g. Coordination of Care h. Quality of Care i. Outlier Management j. Over or under utilization k. Hospital Follow-Up l. Behavioral Healthcare Practitioner Involvement
17. Jail Diversion Data	<p>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).</p>
18. Emergent and Non-Emergent Access to care	<p>Emergent and non-emergent cases are periodically monitored to ensure compliance with standards. Standards:</p> <ul style="list-style-type: none"> i. All crisis/emergent calls are immediately transferred to a qualified practitioner without requiring an individual to call back. ii. For non-emergent calls, a person's time on-hold awaiting a screening must not exceed three minutes without being offered an option for callback or talking with a non-professional in the interim. iii. All non-emergent callbacks must occur within one business day of initial contact. iv. For individuals who walk in with urgent or emergent needs, an

	<p>intervention shall be immediately initiated.</p> <p>v. Those individuals with routine needs must be screened or other arrangements made within thirty minutes.</p>
19. Medicaid Verification	Managed by compliance department with report to the QM department for analysis and process evaluation.
20. Business Line Management	Manage quality improvement activities as required by different business lines of the SWMBH including Medicaid, Healthy Michigan, Coordinating Agency, and MME as required in the appropriate contract.
21. Call Center Monitoring Plan	<p>The QM Department in collaboration with UM Department is responsible for ensuring a call center monitoring plan is in place. The monitoring plan includes elements such as: providing routine quality assurance audits through random call monitoring and tracking call center service lines (crisis, emergent, immediate and routine) calls for timely responses. Call center performance measures may include:</p> <ul style="list-style-type: none"> a. A 96.25% performance criteria scoring rate. b. A call abandonment rate of 5% or less. c. Average call center answer time of 30 seconds or less. d. Service level standard of 75% or above.
22. Serving members with Complex Health Needs	The SWMBH is committed to serving all customers including those with complex health needs. The QM Department will work with The UM Department to use process and outcome measurement, evaluation and management tools to improve quality performance. Program effectiveness, processes, member satisfaction data and quality improvement measures will be reviewed and revised each year based on the population assessment and all quantitative and qualitative measures available regarding the program.
23. Activities for serving a culturally and linguistically diverse membership	The SWMBH is committed to serving all customers including those with complex health needs. The QM Department will work with The UM Department to use process and outcome measurement, evaluation and management tools to improve quality performance. Program effectiveness, processes, member satisfaction data and quality improvement measures will be reviewed and revised each year based on the population assessment and all quantitative and qualitative measures available regarding the program.
24. Patient Safety	To improve the safety of clinical care and services provided to customers, safety initiatives are provided to providers and customers to help reduce, avoid and prevent adverse events or injury. To develop and evaluate the effectiveness of regional safety initiatives, the QM department and Committee analyzes data from various sources including customer surveys, audits, reported incidents and member or provider complaints. Collaborate and discuss findings with Provider Network, Regional Utilization Management, MHL and Clinical Committee meetings.
25. Collaborative Activities	In an effort to improve outcomes, the QM Department collaborates with multiple functional areas on a quarterly basis to provide quality updates and data reviews. Many of the QM Department functions overlap with Technology, Utilization Management and Clinical objectives/goals. The QM Department has an active presence 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 vendors to share information, to improve overall member outcomes.
26. Active Participation of providers and consumers in the QAPI process	<p>SWMBH QI Policy 3.2- III.D: Indicates that: "<i>Member feedback on QAPI activities will be sought and incorporated into the QAPI plan</i>".</p> <p>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.</p> <p>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.</p>

IX. 2018 Quality Assurance/Utilization Management Departmental Goals

2018 QAPI Departmental Goals:

1. Design and formulate MMBPIS dashboards on the Tableau Visual Analysis platform, for internal and external access and review. (by: 9/30/18)
 - i. Ensure all CMHSPs are equipped to utilize reporting template
 - ii. Monthly submissions of template by all CMHSPs to FTP
 - iii. Create dashboards in Tableau and populate indicator status on monthly basis
 - iv. Establish automated alerts/targets for each indicator
 - v. Review and evaluate indicator statuses during relevant regional committee meetings using Tableau
 - vi. Research alternative/automated options for indicator data submissions
2. Formulate a series of instructional videos/tutorials, which live on the SWMBH Share Point/Portal site for SWMBH and CMHSP access/use. (by: 9/30/17)
 - 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. Identify the list of Regional Trainings to be developed and prioritize them for development
 - iv. Form sub-groups within QMC to put together materials/trainings and present trainings
 - 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
 - vii. Review Priority-Training Development List and make adjustment for ongoing development as necessary

- viii. Review Process and formulate ongoing report improvement and access strategies
3. Improve categorization and organization of Tableau Report Dashboards (by: 9/30/17)
 - i. Review current category strategy and organization process
 - ii. Identify and consolidate all reports into 6-8 categories
 - iii. Research best practice and use cases with Tableau report organization
 - iv. Discuss methods during Regional Committee meetings on making reports more accessible and easier to find
 - v. Identify and use Tableau menu features to enhance report organization and accessibility
 - vi. Present and test a few mock menus to RITC and QMC to gain feedback
 - vii. Rollout and advertise new report menu in Tableau to SWMBH and CMH users

2018 Utilization Management Departmental Goals:

1. Demonstrate knowledge and understanding of clinical decision criteria and a welcoming attitude
 - i. Complete inter-rater reliability testing with staff for determinations or recommendations 6x per year with 90% accuracy
 - ii. Perform call monitoring on a sample of 100 calls annually with audit achieving 90%
2. Develop a comprehensive plan to streamline OP service determination processes across MHL MH/SUD and MA/HMP/BG/SUD business lines
 - i. Compare business lines service determination policies and processes to make recommendations to align where possible
 - ii. Compare business lines service determination policies and processes with Medicaid Health Plan's policies and processes to make recommendations to align where possible
 - iii. Evaluate cross functional impact of aligning processes across business lines and make recommendations for modifications
 - iv. Develop an implementation plan to address recommendations
3. Develop and implement plan to improve the MHL psychiatric IP follow up to hospitalization process (requires confluence with Integrated Care)
 - i. Establish a baseline of current follow up care and assess barriers
 - ii. Identify best practice(s) for follow up care
 - iii. Evaluate current practices and modify/develop practices based on recommendations for improvement

X. 2018 QMC Regional Commitments & Goals

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

2018 Quality Management Committee (QMC) Goals

1. Implementation of a Regional Report Users and Analysis Group (By: 10/30/2018)
 - vii. Determine who the members of the report users and analysis group will be
 - viii. Send out calendar invites to selected report user group members
 - ix. Formulate a charter, which defines the purpose and roles of the report users and analysis group
 - x. Determine schedule reports will be build and reviewed on, based on Regional priorities and needs
 - xi. Users Group to perform analysis, identify trends, improve function of reports

- xii. Users Group to present reports to relevant Regional Committees for feedback and use
2. Formulate a series of instructional videos/tutorials, which live on the SWMBH SharePoint Portal for SWMBH and CMHSP access (By: 10/30/2018)
- ix. Perform a gap analysis to identify Regional Education needs, based on current contractual/oversight obligations
 - x. Identify Training resources and software/tools we will use to create educational resources.
 - xi. Identify the list of Regional Trainings to be developed and prioritize them for development
 - xii. Form sub-groups within QMC to put together materials/trainings and present trainings
 - xiii. Test Access to the trainings/tutorials and ensure all CMHSP/SWMBH users have access to them
 - xiv. Present trainings to relevant Regional Committees or Internal SWMBH/CMHSP departments
 - xv. Review Priority-Training Development List and make adjustment for ongoing development as necessary
 - xvi. Review Process and formulate ongoing report improvement and access strategies

XI. Data Management

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

- 1. System Reviews- the QM Department along with IT is responsible for ensuring that there are:
 - Data Reviews before information is submitted to the state
 - Random checks of data for completeness, accuracy and that it meets the related standards.
 - Source information reviews to make sure data is valid and reliable.
- 2. The QMC and QM Department will address any issues identified in the system review.
- 3. Processes should be clearly defined and replicable with consistently applied methods of tracking to assure measurability in data collection. Re-measurements should happen as often as determined necessary for the identified project(s).
- 4. 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.

XII. Communication

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

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

- Stakeholders (Including providers inside the provider network), Customers and family

- members of customers (when appropriate)
- SWMBH Board
- CMH staff and SWMBH staff
- Others - State representatives

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

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

XIII. 2017 Quality Assurance and Performance Improvement Plan

(October 2017- September 2018)

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.	<ul style="list-style-type: none"> ✓ Maintain a dashboard tracking system to monitor progress on each indicator throughout the year (located on SWMBH Portal). ✓ Report indicator results to MDHHS on a Quarterly basis. ✓ Status updates to relevant Committees such as: QMC; RUMCP; CAC and Operations Committee. ✓ Ensure CMHSPs are using newly (MCIS/QMC workgroup) approved template to submit Indicators on a monthly schedule to SWMBH. 	October 2017 – September 2018	Aradhana Gupta, Jonathan Gardner, Chase Grounds Moira Kean Joel Smith	Quarterly Submissions to MDHHS CMHSPs submit monthly reports To SWMBH via the FTP site

2. Event Reporting (Critical Incidents, Sentinel Events and Risk Events)	<ul style="list-style-type: none"> ➤ 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. 	<ul style="list-style-type: none"> ✓ Event Reporting Quarterly reports to QMC; RUMCP, CAC and MHL committees as part of process. ✓ Quarterly Reports of any qualified events to MDDHS including: <ul style="list-style-type: none"> ▪ 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 2017 – September 2018	Chase Grounds Jonathan Gardner	Monthly
3. Uniformity of Benefits	<ul style="list-style-type: none"> ➤ Implement and perform analysis on the consistency of functional assessment tools. ➤ Ensure reliable use of selected tools. 	<ul style="list-style-type: none"> ✓ Perform analysis on tool scores relative to medically necessary level of care. ✓ Identify and schedule reports on functional assessment tool scores. 	October 2017 – September 2018	Kim Rychener Cathy Hart Andy Aardema Jonathan Gardner Paula Ongwela	Quarterly
4. Behavioral Treatment Review Committee Data	<ul style="list-style-type: none"> ➤ 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. 	<ul style="list-style-type: none"> ✓ The QMC Committee will review the data collected from CMHs on a quarterly basis. ✓ The QMC Committee will formulate methods for improving care of “vulnerable” people. 	October 2017 – September 2018	Chase Grounds Jonathan Gardner Moir Kean Kim Rychener	Quarterly

5. Jail Diversion Data Collection	➤ Information is collected by SWMBH from CMHSPs and available for review.	✓ The QMC will evaluate data trends and specific CMHSP results. ✓ Jail Diversion data is shared at QMC/RUMCP regional committees.	October 2017 – September 2018	Chase Grounds Jonathan Gardner Moiria Kean Kim Rychener	Annually or as needed
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6. External Monitoring Reviews	<ul style="list-style-type: none"> ➤ Ensure that the participant has achieved each Quality element, as identified in the 2018 site review tool with satisfactory results. ➤ Help to formulate Corrective Action Plans for any Quality Review Elements scored out of compliance. 	<ul style="list-style-type: none"> ✓ 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 2017 – September 2018	Chase Grounds Jonathan Gardner Moiria Kean Kim Rychener Rhea Freitag Sarah Hirsch	Annually or as needed
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7. Review of Provider Network Audits, Clinical Guidelines, and Medicaid Verification	<p>➤ Review audits and reports from other SWMBH departments for continuous improvement opportunities.</p>	<ul style="list-style-type: none"> ✓ 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. 	<p>October 2017 – September 2018</p>	<p>Jonathan Gardner</p> <p>Chase Grounds</p> <p>Paul Ongwela</p> <p>Moiria Kean</p> <p>Kim Rychener</p> <p>Nancy Wallace</p> <p>Rhea Freitag</p> <p>Mila Todd Sackett</p>	<p>Annually</p>
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8. Monitor the Complaint tracking system for Providers and Customers	<ul style="list-style-type: none"> ➤ Monitor Grievance, Appeals and Fair Hearing Data ➤ Monitor denials and UM decisions for trends related to provider complaints 	<ul style="list-style-type: none"> ✓ At a minimum quarterly reports on customer complaints to the QMC Committee; MHL Committee; RUMCP Committee and CAC Committee are reviewed. ✓ Ensure proper reporting, monitoring and follow-up resolution of Grievance and Appeals data including: <ul style="list-style-type: none"> ➤ Billing or Financial Issues ➤ Access to Care ➤ Quality of Practitioner Site ➤ Quality of Care ➤ Attitude & Service 	October 2017 – September 2018	Chase Grounds Moira Kean Kim Rychener Jonathan Gardner Sarah Hirsch	Quarterly
9. External Monitoring, Audits and Reviews	<ul style="list-style-type: none"> ➤ The Quality Management Department will coordinate the reviews by external entities, including MDHHS, HSAG, NCQA and other organizations as identified by the SWMBH board. ➤ The Quality Department will make sure that SWMBH achieves the goal/score established by the Board Ends Metrics, or meets the reviewing organizations expectations. 	<ul style="list-style-type: none"> ✓ 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 2017 – September 2018	Jonathan Gardner Chase Grounds Moira Kean Kim Rychener Mila Todd Sackett Paul Ongwela Robert Moerland	Annually or audits as scheduled

10. Utilization Management	<ul style="list-style-type: none"> ➤ 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. 	<ul style="list-style-type: none"> ➤ 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: <ul style="list-style-type: none"> ○ Department Compliance with Established UM standards ○ Adequate Access/Telephone Access to Services & Staff ○ Timeliness of UM Decisions: Service & Appeal ○ UM Decision-Making: Clinical Criteria; Availability of Criteria; Consistency of Applying Criteria; Inter-rater reliability (IRR audit) ○ Coordination of Care ○ Quality of Care ○ Outlier Management ○ Over or under utilization ○ Hospital Follow-Up 	October 2017 – September 2018	Kim Rychener Jonathan Gardner Heather Sneden Natalie Tenney Sarah Hirsch	Some components are monitored Monthly. All results are included in the QAPI annual Evaluation.
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11. Emergent and Non-Emergent Access	<ul style="list-style-type: none"> ➤ Emergent and non-emergent cases are periodically monitored to ensure compliance with standards. 	<ul style="list-style-type: none"> ✓ 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 2017 – September 2018	Jonathan Gardner Kim Rychener Natalie Tenney Moiria Kean Sarah Hirsch	Monthly
12. Call Center Monitoring (SWMBH reporting) for MI Health Link Business Line	<ul style="list-style-type: none"> ➤ Ensure that a call center monitoring plan is in place ➤ Provide routine quality assurance audits. ➤ Random (live) Monitoring of calls for quality assurance. ✓ Tracking and monitoring of all service lines (crisis, emergent, immediate and routine) 	<ul style="list-style-type: none"> ✓ A review of calls and agent performance to meet a scoring criteria of 96.25% performance rate is completed and evaluated. ✓ 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 calls will be evaluated per month (<i>calls selected randomly across all available agents</i>) 	October 2017 – September 2018	Jonathan Gardner Chase Grounds Robert Moerland Sarah Hirsch Kim Rychener Natalie Tenney	Monthly

13. Management of Information Systems and Data Reporting	<ul style="list-style-type: none"> ✓ Quality Department; QMC and MHL Committee to review quality and timeliness of data reporting. ✓ Ensure Reports are timely and accurate for internal/external stakeholders. 	<ul style="list-style-type: none"> ✓ 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: <ul style="list-style-type: none"> ➤ 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: 90% of encounters adjudicated through submission cycle within 30 days or less. ➤ Assessments: 90% of consumers received the appropriate assessment 	October 2017 – September 2018	Jonathan Gardner Chase Grounds John Holland Robert Moerland Paul Ongwela	Monthly

14. Coordination of Care	<ul style="list-style-type: none"> ✓ Monitors for continuity and coordination of care members receive across the network and actions improve. ✓ Demonstrate re-measurement for selected interventions. ✓ Quantitative and causal analysis of data to identify improvement opportunities. ✓ Collaboration with health plans to coordinate BH treatment for members. 	<ul style="list-style-type: none"> ✓ 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 an 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 prescreening process and reduce IP admissions. ✓ Increase outreach to Veteran and Military Families that are not currently receiving services. 	<p>October 2017 – September 2018</p>	<p>Jonathan Gardner</p> <p>Rhea Freitag</p> <p>Moira Kean</p> <p>Kim Rychener</p> <p>Nancy Wallace</p> <p>Sarah Hirsch</p>	<p>Quarterly</p>
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15. Quality of Clinical Care	<ul style="list-style-type: none"> ➤ Provide Qualitative analysis for the identified opportunities. ➤ Re-measure identified opportunities and determine if interventions were effective. 	<ul style="list-style-type: none"> ✓ Create a procedure describing how the organization assists pediatric members with transition to adult practitioner. ✓ Implementation and analysis of electronic based technologies, such as: <ul style="list-style-type: none"> ○ E-visits ○ E-Appointment scheduling ○ E-prescribing ○ E-referrals ○ E-enrollment in case management or wellness programs ○ Online record access ○ Healthwise Patient Education System ○ My Strength Program ✓ Assist with Clinical Quality Site Reviews with monitoring the following categories: <ul style="list-style-type: none"> ○ Physician Coordination ○ Assessment Case files and Scoring ○ Progress Notes/Goals/Objectives ○ Periodic Review ○ TEDS and Customer Discharge/Transfer 	October 2017 – September 2018	Jonathan Gardner Nancy Wallace Sarah Hirsch Kim Rychener Moira Kean Cathy Hart	Quarterly
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16. Safety of Clinical Care	<ul style="list-style-type: none"> ➤ Track patient safety activities and make recommendation for regional improvement. ➤ Provide a comparative report using current year and previous year's data to identify safety concerns and trends. 	<ul style="list-style-type: none"> ✓ Complete an annual analysis of patient safety activities. ✓ Track and provide analysis on patient safety concerns, risk incidents including Adverse incidents, Critical Incidents or Sentinel Event that are reported by CMHSPs on a monthly basis. ✓ Monitoring/Discussions and collect minutes during the BRTC meetings. ✓ Cover and identified network-wide safety issues during Regional Clinical and Quality meetings. ✓ ICO Case Management ✓ Review of I & A's ✓ Background checks for Providers during Credentialing/Recredentialing process ✓ Case Management Review Sessions 	October 2017 - September 2018	Sarah Hirsch Moira Kean Rhea Freitag Scott VanKirk	Quarterly or as needed
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17. Member Experience	<p>➤ To develop and evaluate the effectiveness of programs and initiatives, the QM department and QMC and MHL Committee analyzes data and customer input from various sources including customer surveys, audits, reported incidents and member or provider complaints.</p> <p>➤ Data is used to identify trends and make improvements for the customer experience and improved outcomes.</p>	<p>✓ Distribution and analysis of an annual customer satisfaction survey for members who have received multiple services during the survey time period.</p> <p>✓ Medicaid Member Service Satisfaction Surveys.</p> <p>✓ Medicare Member Service Satisfaction Surveys.</p> <p>✓ MI Health Link – Dual Eligible Member Satisfaction Surveys.</p> <p>✓ Complex Case Management Member Experience Survey.</p> <p>✓ Distribution and analysis of MH and Physical Health provider communication satisfaction surveys.</p> <p>✓ 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.</p> <p>✓ Member Grievance and Appeals data Complex Case Management.</p> <p>✓ Grievance and Appeals data Results are presented to the EO, Customer Advisory Committee, Operations Committee, QMC, MHL Committee, RUMCP, SWMBH Board and other stakeholders annually.</p>	<p>October 2017 – September 2018</p>	<p>Jonathan Gardner</p> <p>Chase Grounds</p> <p>Moira Kean</p> <p>Mike Vincent</p> <p>Sarah Hirsch</p> <p>Rob Moerland</p> <p>Kim Rychener</p>	<p>Annually</p>
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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.	<ul style="list-style-type: none"> ✓ Ensure availability of information about QI program and results through newsletter, mailings, web-site, and member handbook and practitioner agreements. ✓ Provide newsletter articles communicating QI performance results and satisfaction results for members and practitioners. ✓ Provide access to QMC and MHL meeting minutes and materials to internal customers. ✓ Access to the SWMBH website for various publications and Provider Directory. ✓ Access to the SWMBH SharePoint Portal for internal and external stakeholders, as a collaborative information sharing resource and report delivery system. 	October 2017 - September 2018	Jonathan Gardner Chase Grounds Aradhana Gupta Nancy Wallace Moiria Kean Kim Rychener Kimberly Whittaker	Quarterly
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19. Serving Culturally and Linguistically Diverse Members	➤ The Quality Department will work with other SWMBH Departments to address the Cultural and Linguistic needs of its membership.	<ul style="list-style-type: none"> ✓ Ensure that Cultural Competency policies are being followed. ✓ Review Cultural Competency Plan on an annual basis to address any identified barriers to care. ✓ Work with Clinical Team and RUMCP Committee to reduce health care disparities in clinical areas. ✓ Work with Provider Network to improve network adequacy to meet the needs of underserved groups. ✓ Work with Provider Network to perform analysis on the network adequacy report and support identification of culturally diverse provider resources. ✓ Improve Cultural Competency materials and communication. ✓ 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 2017	Jonathan Gardner	Annually
			September 2018	Achilles Malta Kim Rychener Joel Smith Moira Kean Sarah Hirsch	

20. Serving Members with Complex Health Needs	➤ The Quality Management Department will work with the Utilization Management Department to use process and outcome measures to improve quality and performance.	<ul style="list-style-type: none"> ✓ 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 2017 – September 2018	Moira Kean Kim Rychener Nancy Wallace Natalie Tenney Ashley Esterline Sarah Hirsch	Quarterly
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21. State Mandated Performance Improvement Projects (PIP)	<p>➤ Identify (2) PIP projects that meet MDHHS and NCQA standards:</p> <p><i>Improvement Project #1: (EQR evaluated): “Improving Diabetes Treatment for Consumers with a Co-morbid Mental Health Conditions”.</i></p> <p><i>Improvement Project #2: “Improving Medication Management for persons with Intellectual and Developmental Disabilities”.</i></p>	<ol style="list-style-type: none"> 1. HSAG report on PIP interventions and baseline 2. PIP Status updates to relevant SWMBH Committees such as: QMC; RUMCP; CAC, Operations and MHL Committees 3. QMC to consider selection of PIP projects aimed at impacting error reduction, improving safety and quality. <p>NCQA PIPs to be considered:</p> <ol style="list-style-type: none"> 1. (NQF 1879): “<i>Adherence to Antipsychotic Medications For Individuals with Schizophrenia</i>” – National Quality Strategy Domain: Patient Safety <p>➤ Using HEDIS specifications, the measure assesses MI Health Link members 18–64 years of age in 2016 and in 2017 who have schizophrenia and were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.</p> <ol style="list-style-type: none"> 2. (NQF 1932) : “<i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i>” <p>➤ Using HEDIS specifications, the measure assesses MI Health Link members 18–64 years of age in 2016 and in 2017 with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.</p> <ol style="list-style-type: none"> 3. (NQF 0576) “<i>Follow-Up after Hospitalization for Mental Illness (FUH-7 days)</i>”. <p>➤ Using HEDIS specifications, the measure identifies the percentage of MI Health Link members in 2016 and in 2017 who received follow-up within 7 days of discharge.</p> <ol style="list-style-type: none"> 4. (NQF 0576) “<i>Follow-Up after Hospitalization for Mental Illness (FUH-30 days)</i>”. <p>➤ Using HEDIS specifications, the measure identifies the percentage of MI Health Link members in 2016 and in 2017 who received follow-up within 30 days of <i>discharge</i>.</p>	<p>October 2017 – September 2018</p>	<p>Mike Vincent Moiria Kean Jonathan Gardner Paul Ongwela Nancy Wallace Sarah Hirsch</p>	<p>Quarterly</p>
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XII. Evaluation

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

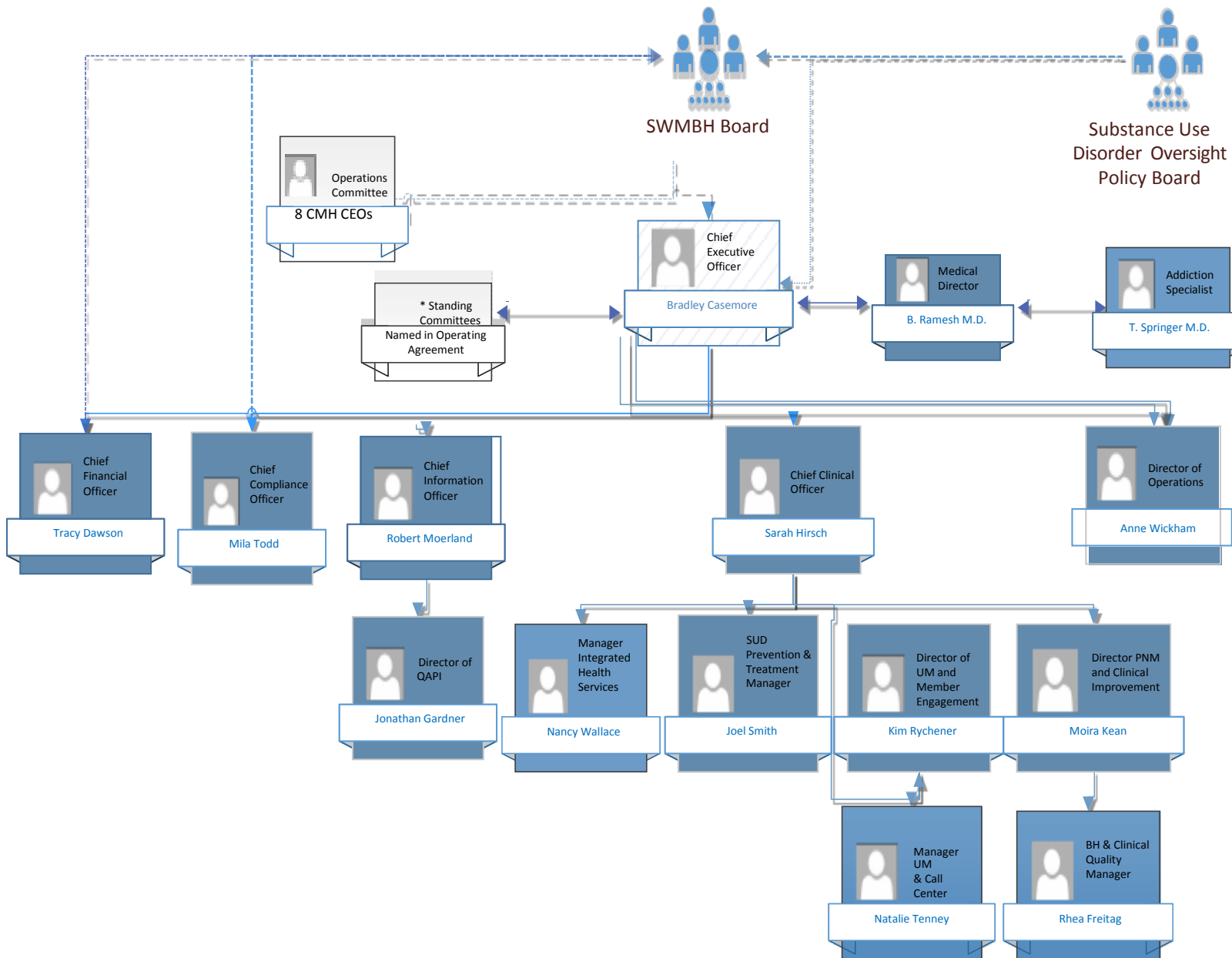
A Performance Improvement/Corrective Action Plan may be required for any area where performance gaps are identified. This describes a project improvement plan of action (including methods, timelines, and interventions) to correct the performance deficiency. A corrective action/performance improvement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

References:

- BBA Regulations, 42 CFR 438.240
- MDHHS –PIHP Contract Attachment P 6.7.1.1 et al
- SWMBH Quality Management Policies 3.1 and 3.2
- NCQA – 2017 MBHO Accreditation Standards – QI 11B
- Quality Management Committee Charter

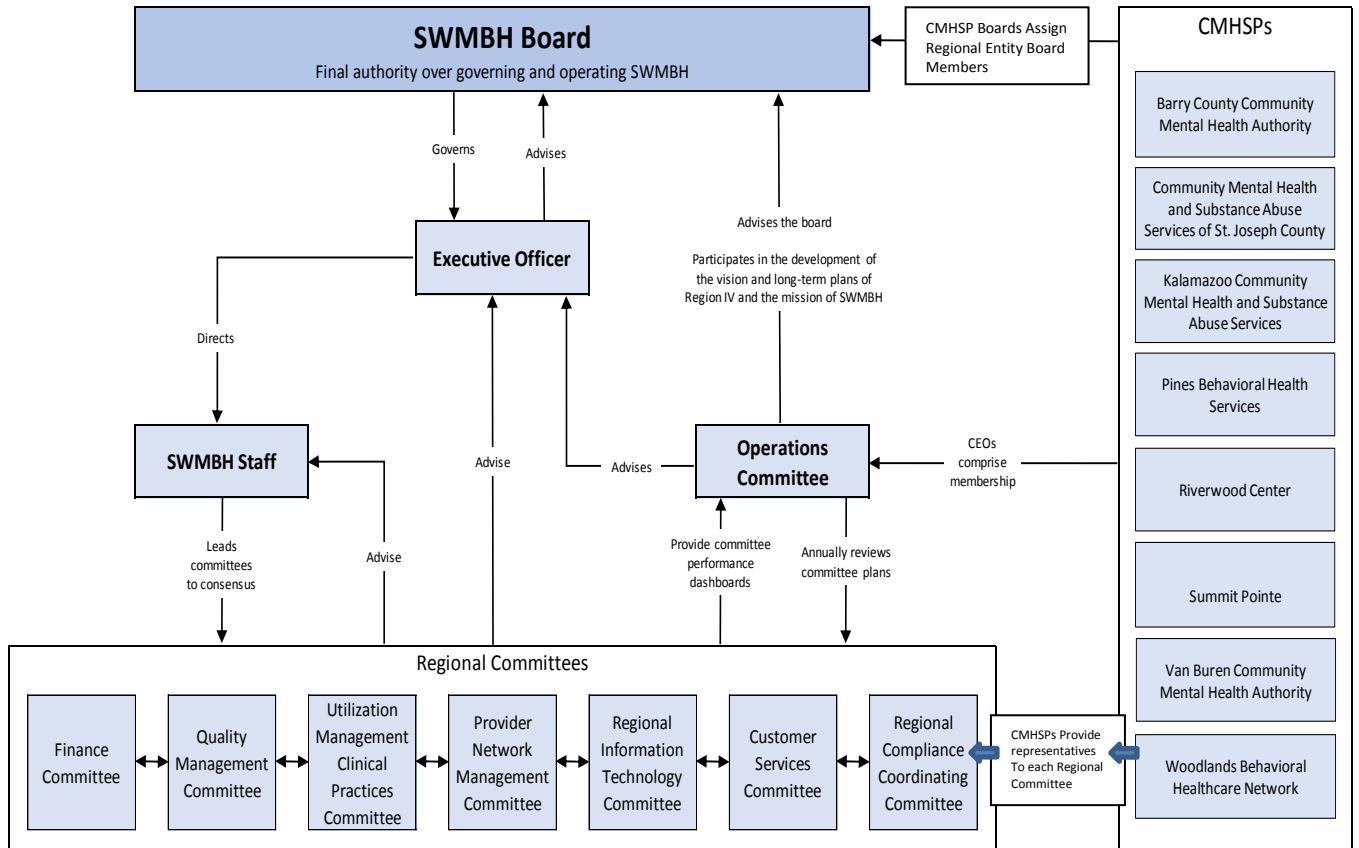
Attachment A

Southwest Michigan Behavioral Health Organizational Chart



Attachment B

SWMBH Regional Committee Structure



Attachment C

Quality Management Committee Charter



☒ SWMBH Committee Quality Management Committee (QMC) ☐ SWMBH Workgroup: _____

Duration: ☒ On-Going ☐ Deliverable Specific

Date Approved: 5/1/14

Last Date Reviewed: 4/28/17

Next Scheduled Review Date: 4/28/18

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:	<p>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.</p> <p>The committee is to provide their expertise as subject matter experts.</p>
Committee Purpose:	<ul style="list-style-type: none">• <i>The QMC will meet on a regular basis to inform quality activities and to demonstrate follow-up on all findings and to approve required actions, such as the QAPI Program, QAPI Effectiveness Review/Evaluation, and Performance Improvement Projects. Oversight is defined as reviewing data and approving projects.</i>• <i>The QMC will implement the QAPI Program developed for the fiscal year.</i>• <i>The QMC will provide guidance in defining the scope, objectives, activities, and structure of the PIHP's QAPIP.</i>• <i>The QMC will provide data review and recommendations related to efficiency, improvement, and effectiveness.</i>• <i>The QMC will review and provide feedback related to policy and tool development.</i>

	<ul style="list-style-type: none"> • <i>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.</i> • <i>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</i>
Relationship to Other Committees:	<p>At least annually there will be planning and coordination with the other Operating Committees.</p> <ul style="list-style-type: none"> • Finance Committee • Utilization Management Clinical Practices Committee • Provider Network Management Committee • Health Information Services Committee • Customer Services Committee • Regional Compliance Coordinating Committee
Membership:	<p>The Operating Committee appoints their CMH participant membership to each Operating Committee. The SWMBH EO appoints the committee Chair.</p> <ul style="list-style-type: none"> • Members of the committee will act as conduits and liaisons to share information decided on in the committee. This includes keeping relevant staff and local committees informed and abreast of regional information, activities, and recommendations. • Members are representing the regional needs related to Quality. It is expected that members will share information and concerns with SWMBH staff. As conduits it is expected that committee members attend and are engaged in issues, as well as bringing challenges from their site to the attention of the SWMBH committee for possible project creation and/or assistance. <p>Membership shall include appointed participant CMH representation, a member of the SWMBH Customer Advisory Committee with lived experience, SWMBH staff as appropriate, and the CA Director.</p>
Decision Making Process:	<p>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.</p> <p>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</p>

	Representative either by phone or in person they also lose the right to participate in the voting structure on that day.
Deliverables:	<ul style="list-style-type: none"> • Annual Committee Work Plan <p>The Committee will support SWMBH Staff in the:</p> <ul style="list-style-type: none"> • <i>QAPIP</i> • <i>QAPI Evaluation</i> • <i>Michigan Mission-Based Performance Indicator System (MMBPIS) regional report</i> • <i>Event Reporting Dash Board</i>

Attachment D

MI Health Link Quality Management Committee Charter



☒ MI Health Link

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

Duration: ☒ On-Going ☐ Deliverable Specific

Charter Effective Date: 6/1/15

Last Review Date: 1/30/2017

Approved By:

Signature:

Date:

Purpose:	SWMBH MI Health Link Committees are formed to assist SWMBH in executing the MI Health Link demonstration goals and requirements, NCQA requirements, as well as its contractual obligations and tasks.
Accountability:	<p>The committee is one method of participant communication, alignment, and advice to SWMBH. The committee tasks are determined by the SWMBH EO, committee chair and members, member needs, MI Health Link demonstration guidelines including the Three-Way Contract, ICO-PIHP Contract and NCQA requirements. Each committee is accountable to the SWMBH EO, and is responsible for assisting the SWMBH Leadership to meet the Managed Care Benefit requirements within the MI Health Link demonstration, the ICO-PIHP contract, and across all business lines of SWMBH.</p> <p>The committee is to provide their expertise as subject matter experts.</p>
Committees Purposes:	<p>Quality Management Committee:</p> <ul style="list-style-type: none"> 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. <i>NCQA, MBHO, QI 1: Program Structure; Quality Improvement Program Structure, Element A</i>

	<p><i>(Factor 4) & QI 2: Program Operations; QI Committee Responsibilities, Element A (Factor 1-4).</i></p> <ul style="list-style-type: none"> • 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. <i>NCQA, MBHO, QI 2: Program Operations, QI Committee Responsibilities Element A (Factor 1, 2 & 5)</i> • Ensures practitioner participation in the QI program through planning, design, implementation or review. <i>NCQA, MBHO, QI 2: Program Operations, Element A QI Committee Responsibilities, Element A (Factor 3).</i> • Ensures discussion (and minutes) reflects: <ul style="list-style-type: none"> ○ Appropriate reporting of activities, as described in the QI program description. <i>NCQA, MBHO, QI 1: Program Structure, Quality Improvement Program Structure, Element A (Factor 1).</i> ○ 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. <i>NCQA, MBHO, QI 1: Program Structure, Quality Improvement Program Structure, Element A (Factor 7). QI 1: Annual Evaluation, Element B (Factor 3).</i> • Ensures the organization describes the role, function and reporting relationships of the QI Committee and subcommittees. <i>NCQA, MBHO, QI 1: Program Structure, Quality Improvement Program Structure, Element A (Factor 1 & 4).</i> • 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. <i>NCQA, MBHO, QI 2: Program Operations, QI Committee Responsibilities, Element A.</i> • Ensures member and provider experience surveys are conducted and reviewed, and opportunities for improvement are identified and followed-up. <i>NCQA, MBHO, QI 9: Complex Case Management, Member Experience with Case Management, Element I (Factor 1).</i> • Ensures the organization approves and adopts clinical practice guidelines and promotes them to practitioners. The appropriate body to approve the clinical practice guidelines may be the organization's QI Committee or another clinical committee. <i>NCQA, MBHO, QI 2: Program Responsibilities, QI Committee Responsibilities, Element A.</i> • Ensures the organization approves and adopts preventive health guidelines and promotes them to practitioners in an effort to improve health care quality and reduce unnecessary variation in care. The appropriate body to approve the preventive health guidelines may be the organization's QI Committee or another clinical committee. <i>NCQA, MBHO, QI 10: Clinical Practice Guidelines, Adopting Relevant Guidelines, Element A.</i> • The organization annually: <ul style="list-style-type: none"> ○ Documents and collects data about opportunities for collaboration. <i>NCQA, MBHO, CC 2: Collaboration between Behavioral Healthcare and Medical Care, Data Collection, Element A.</i> ○ Documents and conducts activities to improve coordination between medical care and behavioral healthcare. <i>NCQA, MBHO, CC</i>
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	<p style="text-align: center;"><i>2: Collaboration between Behavioral Healthcare and Medical Care, Data Collection, Element A. Aetna Contract-Attachment C.2</i></p> <ul style="list-style-type: none"> • 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. <i>Aetna Contract p. 33 (9.22)</i> • Ensures a care management quality control program is maintained at all times. <i>Aetna Contract Attachment C.2</i> • Ensures Call Center quality control program is maintained and reviewed, which should include elements of internal random call monitoring. <i>NCQA, MBHO, QI 5: Accessibility of Services, Assessment against Telephone Standards, Element B. Aetna Contract</i> <p>Credentialing Committee:</p> <ul style="list-style-type: none"> • Uses a peer review process to make credentialing and recredentialing decisions and which includes representation from a range of participating practitioners. <i>NCQA, MBHO, CR 2: Credentialing Committee, Element A (Factor 1). Meridian Contract. Aetna Contract-Attach C4.</i> • Reviews the credentials of all practitioners who do not meet established criteria and offer advice which the organization considers. <i>NCQA, MBHO, CR 2: Credentialing Committee, Element A (Factor 2). Meridian Contract.</i> • Implements and conducts a process for the Medical Director review and approval of clean files. <i>NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A (Factor 10); CR 2: Credentialing Committee, Element A (Factor 3). Meridian Contract.</i> • Maintains meeting minutes. <i>NCQA, MBHO, CR 2: Credentialing Committee, Element A (Factor 2).</i> • Reviews and authorizes policies and procedures. <i>NCQA, MBHO, CR 1: Credentialing Policies; CR 2: Credentialing Committee. QI 2: Program Responsibilities, QI Committee Responsibilities, Element A. Aetna Contract-Attach C4.</i> • Ensures that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the committee's decision. <i>NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A: (Factor 9). Meridian Contract</i> • Ensures reporting of practitioner suspension or termination to the appropriate authorities. <i>NCQA, MBHO, CR 7: Notification to Authorities and Practitioner Appeal Rights, Actions Against Practitioners, Element A (Factor 2); NCQA, MBHO, CR 7: Notification to Authorities and Practitioner Appeal Rights, Reporting to the Appropriate Authorities, Element B. Aetna & Meridian Contracts.</i> • Ensures practitioners are informed of the appeal process when the organization alters the conditions of practitioner participation based on issues of quality or service. <i>NCQA, MBHO, CR 7: Notification to Authorities and Practitioner Appeal Rights, Element A (Factor 4); CR 7: Notification to Authorities and Practitioner Appeal Rights, Practitioner Appeal Process: Element C (Factor 1). Meridian Contract.</i>
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	<ul style="list-style-type: none"> Ensures the organization’s procedures for monitoring and preventing discriminatory credentialing decisions may include, but are not limited to, the following: <ul style="list-style-type: none"> 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. <i>NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A: (Factor 7)</i> Periodic audits of credentialing files (in-process, denied and approved files) that suggest potential discriminatory practice in selections of practitioners. <i>NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A: (Factor 7).</i> Ensures annual audits of practitioner complaints to determine if there are complaints alleging discrimination. <i>NCQA, MBHO, CR 6: Ongoing Monitoring, Ongoing Monitoring and Intervention: Element A (Factor 3). Aetna Contract.</i> <p>Clinical/Utilization Management Committee:</p> <ul style="list-style-type: none"> Reviews and authorizes policies and procedures. <i>NCQA, MBHO, UM 1: Utilization Management Structure, UM Program Description Element A.</i> 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. <i>NCQA, MBHO, CC 2: Collaboration Between Behavioral Healthcare and Medical Care, Opportunities for Collaboration, Element B. Aetna Contract, p. 22 (9.22)</i> Is involved in implementation, supervision, oversight and evaluation of the UM program. <i>NCQA, MBHO, UM 1: Utilization Management Structure, UM Program Description Element A. UM 1: Utilization Management Structure, Behavioral Healthcare Practitioner Involvement, Element B.</i> Ensures Call Center quality control program is maintained and reviewed, which should include elements of internal random call monitoring. <i>NCQA, MBHO, QI 5: Accessibility of Services, Assessment Against Telephone Standards, Element B. Aetna Contract</i> Maintains meeting minutes and ensures review of tools/instruments to monitor quality of care are in meeting minutes. <i>NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria, Element A. Aetna Contract-Attachment C.2</i> Ensures annual written description of the preservice, concurrent urgent and non-urgent and post service review processes and decision turnaround time for each. <i>NCQA, MBHO, UM 5: Timeliness of UM Decisions, Timeliness of UM Decision Making, Element A & Notification of Decisions, Element B. Meridian Contract-Attach C.</i> Ensures a care management quality control program is maintained at all times. <i>Aetna Contract-Attach C.2</i> 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
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	<p>review and approval. <i>NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 5). Aetna Contract, p. 33-34 (9.27).</i></p> <ul style="list-style-type: none"> • Ensures PIHP shall render an authorization and communicate the authorized length of stay to the Enrollee, facility, and attending physician for all behavioral health emergency inpatient admissions in authorized timeframes. <i>Aetna Contract, p. 33 (9.25.3). Meridian Contract-Attachment C.</i> • Ensures the organization: <ul style="list-style-type: none"> ○ Has written UM decision-making criteria that are objective and based on medical evidence. <i>NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 1). Meridian Contract-Attachment C.</i> ○ Has written policies for applying the criteria based on individual needs. <i>NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 2).</i> ○ Has written policies for applying the criteria based on an assessment of the local delivery system. <i>NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 3).</i> ○ Involves appropriate practitioners in developing, adopting and reviewing criteria. <i>NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 4). Meridian Contract-Attachment C.</i>
Relationship to Other Committees:	<p>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.</p>
Membership:	<p>The SWMBH EO and Chief Officers appoint the committee Chair and Members. Members of the committee will act as conduits and liaisons to share information decided on in the committee. This includes keeping relevant staff and local committees informed and abreast of regional information, activities, and recommendations.</p> <p>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.</p>
Decision Making Process:	<p>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.</p> <p>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.</p>

Attachment 1: - Credentialing

<i>Membership Name</i>	<i>Organization/County</i>	<i>Type of member (Ad hoc, standing, voting, alternate)</i>
<i>Nancy Wallace, R.N., B.S, M.A Integrated Healthcare Manager</i>	Western Michigan University	<i>Voting</i>
<i>Dr. Bangalore K. Ramesh D.O., Psychiatrist (Medical Director/ Practitioner/Provider)</i>	Western Michigan University	<i>Voting</i>
<i>Kim Rychener LMSW, MSW Director of UM and Member Engagement</i>	SWMBH	<i>Voting</i>
<i>Jonathan Gardner B.S, CHES, PTA Director of Quality Assurance and Performance Improvement</i>	SWMBH	<i>Voting</i>
<i>Moiria Kean LLP, M.A. Director of Provider Network Management and Clinical Improvement</i>	SWMBH	<i>Voting</i>
<i>Scott VanKirk B.S. Provider Network Specialist</i>	SWMBH	<i>Voting</i>
<i>Bethany Viall, RN (Practitioner) Integrated Healthcare Specialist</i>	SWMBH	<i>Voting</i>
<i>Natalie Tenney LMSW, CAADC Manager of UM and Call Center</i>	SWMBH	<i>Voting</i>
<i>Lori Ryland, PHD, BCBA-D, CAADC (Practitioner and Provider)</i>	Skywood - Foundations Recovery Center (MH/SUD/Autism)	<i>Voting</i>
<i>Daniel Spencer Price, LLP, CAADC (Practitioner and Provider)</i>	St. Joe CMH (SUD)	<i>Voting</i>
<i>Stephanie Lagalo, LMSW, CAADC, CCS (Practitioner and Provider)</i>	Interact of Michigan (MH/SUD)	<i>Voting</i>

Attachment 2: - Quality/UM/Clinical

<i>Membership Name</i>	<i>Organization/County</i>	<i>Type of member (Ad hoc, standing, voting, alternate)</i>
<i>Nancy Wallace, R.N., B.S, M.A Integrated Healthcare Manager</i>	SWMBH	<i>Voting</i>
<i>Dr. Bangalore K. Ramesh D.O., Psychiatrist (Medical Director/ Practitioner/Provider)</i>	Western Michigan University	<i>Voting</i>
<i>Kim Rychener LMSW, MSW Director of UM and Member Engagement</i>	SWMBH	<i>Voting</i>
<i>Tim Dubois MBA, PMP IT Project Manager</i>	SWMBH	<i>Voting</i>
<i>Jonathan Gardner B.S, CHES, PTA Director of Quality Assurance and Performance Improvement</i>	SWMBH	<i>Voting</i>
<i>Moir Kean LLP, M.A. Director of Provider Network Management and Clinical Improvement</i>	SWMBH	<i>Voting</i>
<i>Scott VanKirk B.S. Provider Network Specialist</i>	SWMBH	<i>Voting</i>
<i>Natalie Tenney LMSW, CAADC Manager of UM and Call Center</i>	SWMBH	<i>Voting</i>
<i>Bethany Viall, RN (Practitioner) Integrated Healthcare Specialist</i>	SWMBH	<i>Voting</i>

Attachment E

QMC Regional Committee Goals

2018 Quality Management Committee S.M.A.R.T GOAL #1	
Directions:	Complete goals collaboratively using the S.M.A.R.T. goals process (Specific, measurable, achievable, realistic, time-bound). Goals include applicable departmental or individual objectives. Periodically during the year (i.e., monthly quarterly, or annually) and complete the "Results" section stating the outcomes for each.

Ends Metric:		Quality and Efficiency	
Goal Description:		Implementation of a Regional Report Users Group	
	Specific: What is the desired specific result?	The users group will be formulated to provide guidance and analysis of existing reports and assist with the development and prioritization of new reports.	
	Measurable: How will you measure success?	10 Reports will be developed, evaluated, prioritized and shared with other Regional Committees.	
	Achievable: What are the potential obstacles to success?	Scheduling meetings, so all selected members can attend. Agreeing on report development priorities.	
	Relevant: Is it in alignment with the Charter?	This goal is in alignment with SWMBH and QMC Regional Charter and 2018 goals.	
	Time-Based: What is the timeline?	Target date of completion is: October 31, 2018.	
	Defined Steps and Timeline for Goal Completion:		Result:
	Step 1	Determine who the members of the group should be.	January 30, 2018
	Step 2	Send calendar invites to selected members and establish meeting schedule.	February, 28, 2018
	Step 3	Formulate a charter, which will define the purpose, roles and goals of the group.	March 28, 2018
	Step 4	Determine which and priority of reports to be built/developed and reviewed.	April 28, 2018
	Step 5	Perform analysis on reports with emphasis on identification of regional trends.	May 28, 2018
	Step 6	Develop schedule of report presentations to regional committees.	June 28, 2018
	Step 7	Re-evaluate progress and process and incorporate improvement strategies.	August 30, 2018

2018 Quality Management Committee S.M.A.R.T GOAL #2

Directions:	Complete goals collaboratively using the S.M.A.R.T. goals process (Specific, measurable, achievable, realistic, time-bound). Goals include applicable departmental or individual objectives. Periodically during the year (i.e., monthly quarterly, or annually) and complete the "Results" section stating the outcomes for each.
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Ends Metric:		Quality and Efficiency
Goal Description:		Formulate a series of instructional videos/tutorials, for CMHSP and SWMBH access on the portal.
	Specific: What is the desired specific result?	Develop a series of instructional, educational tutorials (based on regional need) for CMHSP and SWMBH team members to use for guidance.
	Measurable: How will you measure success?	10 videos/tutorials will be developed and be accessible on the portal by CMHSP and SWMBH team members.
	Achievable: What are the potential obstacles to success?	Agreement on priorities for development. Cost of editing software and additional equipment/tools.
	Relevant: Is it in alignment with the Charter?	This goal is in alignment with SWMBH and QMC Regional strategy and framework principles.
	Time-Based: What is the timeline?	Target date for completion is: October 31, 2018
Defined Steps and Timeline for Goal Completion:		Result:
	Step 1	Perform a gap analysis to identify Regional education needs, based on contractual/oversight/monitoring obligations/requirements. February 28, 2018
	Step 2	Identify training resources and software/tools needed to develop videos. March 30, 2018
	Step 3	Identify and prioritize list of Regional Trainings for development. April 28, 2018
	Step 4	Create sub-workgroups within QMC to assemble cast/scripts for trainings. June 28, 2018
	Step 5	Determine location of the trainings on the portal and test access to trainings on the portal through SWMBH and CMHSP permissions. August 30 , 2018
	Step 6	Create user guidance document and distribute to SWMBH Regional Committees. September 30, 2018
	Step 7	Review process and update priority list for development in 2019. October 30, 2018

Attachment F

SWMBH 2018-2019 Board Ends Metrics

Board Approved on: 12/8/17

2018-2019 Board Ends Metrics Review and Approval Dates:

- *Mega Ends; Approved by SWMBH Board on: 3/11/2016*
- *Mega Ends; Endorsed by Operations Committee on: 3/2/2016*
- *Operations Committee Review and Endorsement on: 11/29/2017*
- *Utilization Management and Clinical Committee Review on: 11/13/2017*
- *Quality Management Committee Review on: 10/26/2017 & 11/30/2017*

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:

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
<p>Fully utilize contractually obligated assessment tools for persons with Intellectual Developmental Disabilities (I/DD); Substance Use Disorders (SUD); Serious Mental Illness (SMI); Autism Spectrum Disorders (ASD) and Serious Emotional Disturbances (SED).</p> <p>A. 100% of assessment scores will be received as automated data file transfers to SWMBH at the domain and dimension level (By: 1/30/18)</p> <p>B. 80% of members who have had an encounter during FY18, receive the appropriate assessment within the required timeframe (By: 9/30/18)</p> <ol style="list-style-type: none"> 1. LOCUS- Level of Care Utilization System Tool 2. SIS- Supports Intensity Scale Tool 3. CAFAS- Child/Adolescent Assessment Scale Tool 4. ASAM- American Society of Addiction Medicine Tool <p>C. SWMBH will develop and make available; Regional assessment reports in Tableau, with appropriate filters/analysis for each assessment tool (By: 5/31/2018)</p>	New Metric	<p>SWMBH shall complete and submit a qualitative narrative to MDHHS for FY 2018 (October 1, 2017 – September 30, 2018) no later than 11/15/2018. The report shall encompass four (4) areas:</p> <p>A. Collaboration between MHPs and PIHP will demonstrate that joint care plans exist for members with appropriate severity/risk that have been identified as receiving services from both entities</p> <ol style="list-style-type: none"> 1. Provide MDHHS a list of joint served members for whom care coordination plans have been developed 2. Submit a narrative description to MDHHS including dates, attendees, and examples of the diagnosis of members discussed at monthly care management meetings <p>B. Follow-up after Hospitalization for Mental Illness within 30 days</p> <ol style="list-style-type: none"> 1. 70% ages (6-20) 2. 58% ages (21 and older) <p>C. Completion of narrative and demonstration of SWMBH’s participation in Patient Centered Medical Home initiatives</p> <ol style="list-style-type: none"> 1. Comprehensive Care 2. Patient – Centered 3. Coordinated Care 4. Accessible Services 5. Quality and Safety <p>D. Completion of narrative , Veterans’ Needs and Services</p>	New Metric MDHHS PBIP Metrics

		<ol style="list-style-type: none">1. Provide quantitative data/narrative2. Provide show proofs on collaborative efforts	
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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
<p>Customer Satisfaction Surveys collected by SWMBH are at or above the SWMBH 2017 results; for the <i>Improved Functioning</i> (MHSIP survey) and <i>Improved Outcomes</i> (YSS survey) measurement categories, utilizing the following survey tools:</p> <ul style="list-style-type: none"> a. Mental Health Statistic Improvement Project Survey (MHSIP) tool. (<i>Improved Functioning</i>) b. Youth Satisfaction Survey (YSS) tools. (<i>Improved Outcomes</i>) <p>(By: December 31, 2018)</p> <p>Measurement: (MHSIP) <u>2018 MSHIP Improved Functioning Score</u> 2017 MSHIP Improved Functioning Score</p> <p>Measurement: (YSS) <u>2018 YSS Improved Outcomes Score</u> 2017 YSS Improved Outcomes Score</p>	Rollover Metric	<p>92% of MMBPIS Indicators will be at or above the State benchmark for 3 quarters for FY 18. (October 17 – September 18)</p> <ul style="list-style-type: none"> A. SWMBH will improve MMBPIS data collection process by designing and implementing a new data collection tool (By: 12/30/17) B. MMBPIS Indicator reports will be submitted to SWMBH on a monthly schedule via an automated method (By: 3/30/18) C. Reports/dashboards and performance indicator analysis will be developed and available on the portal (By: 6/30/18) <p>Measurement: <u>Total number of indicators that met State Benchmark</u> Total number of indicators measured (51)</p>	Rollover Metric With Additions
<p>SWMBH will complete the indicated MDHHS Home and Community Based Service (HCBS) reporting obligations with 95% success rate.</p> <ul style="list-style-type: none"> A. 95% of required Home and Community-Based Service (HCBS) Provider corrective action plans for the Habilitation Supports Waiver will be requested and approved by SWMBH. (By: June 30, 2018) B. SWMBH will validate and verify that 95% of (Hab Waiver) corrective action plans have been completed and implemented. (By: December 31, 2018) <p>Measurement: <u>Number of corrective action plans completed and submitted to MDHHS</u> Total number of provider corrective action plans issued</p>	Rollover Metric	<p>Regional Habilitation Supports Waiver slots are full at 99% throughout the year. (October 17 - September 18)</p> <p>Measurement: <u>(%) of waiver slot (months) filled x 12</u> (#) of waiver slot (months) available</p> <p>*Special Note: (20) additional slots awarded to SWMBH by MDHHS in October, 2017.</p>	Rollover Metric
<p>In FY18, at least 48% of persons with Autism Spectrum Disorders who have an Individual Plan of Service (IPOS) which includes ABA services, will receive ABA services consistent with their plan ($\geq 75\%$ units approved). DHHS-defined family "inactivity periods" are excluded from the calculation. SWMBH will earn 1 point bonus credit toward the final 2018-2019 Board Ends Metrics calculations if at least 53% of persons with Autism Spectrum Disorders who have an IPOS which includes ABA services receive ABA services consistent with their plan ($\geq 75\%$ units approved). (By: December 31, 2018).</p> <ul style="list-style-type: none"> A. SWMBH will develop measurements and analysis to show improvements in populations served <ol style="list-style-type: none"> 1. Report and visual analysis will be available on portal, to show current status <p>Measurement: (%) of Autism consumers that received services consistent with IPOS / Total number of Autism consumers with an (IPOS)</p>		New Metric	

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

Quality and Efficiency:

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

SWMBH will apply for and achieve no less than (One Year) NCQA MBHO Accreditation for the MI Health Link Duels Business Line.

(By: April 2018)

- A. SWMBH will complete all necessary tools (ISS and IRT) during the accreditation process.
- B. SWMBH will plan and facilitate all necessary on-site and desk review requirements.
- C. SWMBH will achieve no less than (One-Year) accreditation with a score between (70-83)
 - I. The organization's programs for quality improvement and consumer protection are well organized and established to meet the majority of NCQA standards. NCQA gives the organization a list of recommendations and within *15 months* reviews the organization Again to determine if it qualifies for Full Accreditation.
- D. If SWMBH achieves the level of (Full) Accreditation with a score between (84-100); SWMBH will earn 1pt of bonus credit toward the final 2018-2019 Board Ends Metrics calculation.
 - II. The organization's programs for quality improvement and consumer protection exceed NCQA standards. The duration of accreditation status is valid for *36 months* from date of accreditation.

2018 Health Service Advisory Group (HSAG) External Quality Compliance Review (90% of Sections evaluated receiving a score of "Met").

(By: September 30, 2018)

Measurement:

Number of Element Sub-Sections "Met"

Total Elements Evaluated

Mission and Value Driven:

CMHSPs and SWMBH fulfill their agencies' missions and support the values of the public mental health system.

STATUS

Rollover Metric with Additions

New Metric

<p>2018 HSAG Performance Measure Validation Audit Passed with (95% of Measures evaluated receiving a score of “Met”) (By: September 30, 2018)</p> <p>Measurement: <u>Number of Critical Measures that achieved “Met”</u> Total number of Critical Measures Evaluated</p>	<p>STATUS</p> <p>Rollover Metric</p>
<p>FY 2018 Medicaid Administrative Loss Ratio for the region is (< or = to 9.5%) (By: September 30, 2018)</p> <p>Measurement: <u>(Medicaid) Administrative and other Costs</u> Total Medicaid Revenue</p>	<p>Rollover Metric</p>
<p>SWMBH to implement and lead a multi-year, collaborative, systemic and systematic <i>Regional Values Outcome Project</i>, which primary objective will be to “<i>Improve Lives and Prove It</i>”.</p> <p>B. A Steering Committee consisting of CMHSP and SWMBH functional leaders will be assembled to provide guidance on the following key categories of interest: 1) Improving Behavioral Health, 2) Improving Physical Health, 3) Improved Social Functioning, and 4) Reducing Avoidable Behavioral and Physical Health Service Utilization. (By: January 19, 2018)</p> <ol style="list-style-type: none"> Conduct assessment of potential metrics that align with key categories of interest. Conduct assessment of current data availability and integrity of that data. Prioritize metrics for reporting based on value of metric(s) and data availability/integrity. (By: October 31, 2018) Implement regional reporting on prioritized metric(s). Analyze regional performance based on report data and qualitative analyses. Make recommendations for regional best practice models to improve performance where indicated. Implement best practice models. Re-measure performance to assess impact of best practices. 	<p>New Metric</p>

<ul style="list-style-type: none"> i. Rotating process that will continue until all priority categories and metrics are completed (At least two complete improvement cycles complete by December 2019) <p>C. Sharing interdepartmental and inter-organizational efforts through publications such as; newsletters, website, media campaigns and health fairs with our community partners, legislators, customers, team members, providers and other stakeholders. (By: December 31, 2019)</p>	
<p>SWMBH will achieve all quality withhold performance measures identified in the Integrated Care Organization (ICO) contracts including: (By: December 31, 2018)</p> <ul style="list-style-type: none"> a. 95% of claims per final reconciliation were received timely as monthly encounters. b. 95% of enrollees have a level II assessment completed within 15 days of their level I assessment. c. 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. d. 95% of enrollees have documented discussions regarding care goals. e. The PIHP will designate (2) members to serve on the advisory board. 	New Metric
<p>Per Board Directive: "Work with CMHs and contractors to assess and modify as appropriate regional managed care functions and roles to achieve greater efficiency and lower overall expenses." (By: March 30, 2019)</p> <ul style="list-style-type: none"> 1. Revenue Maximization 2. Revenue Diversification <p>Measurement: Financial Statements. Preliminary results December 2018 with final results March 2019.</p>	New Metric

<p>SWMBH to “Establish and implement an inclusive formal Regional public policy, legislative education program.” (By: September 30, 2018)</p> <p>Goal: Michigan and federal legislative branch education and public policy involvement resulting in greater awareness of legislators about the values and results of the Michigan public behavioral health system and the SWMBH region and component CMHSPs.</p> <p>Measurement: Report deliverable detailing; types and numbers of events and contacts with elected officials and staff. Elected official qualitative assessment of Michigan public behavioral health system, SWMBH region, SWMBH Regional Entity, and SWMBH CMHSPs.</p>	<p>New Metric Subject to discussion with Operations Committee</p>
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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.

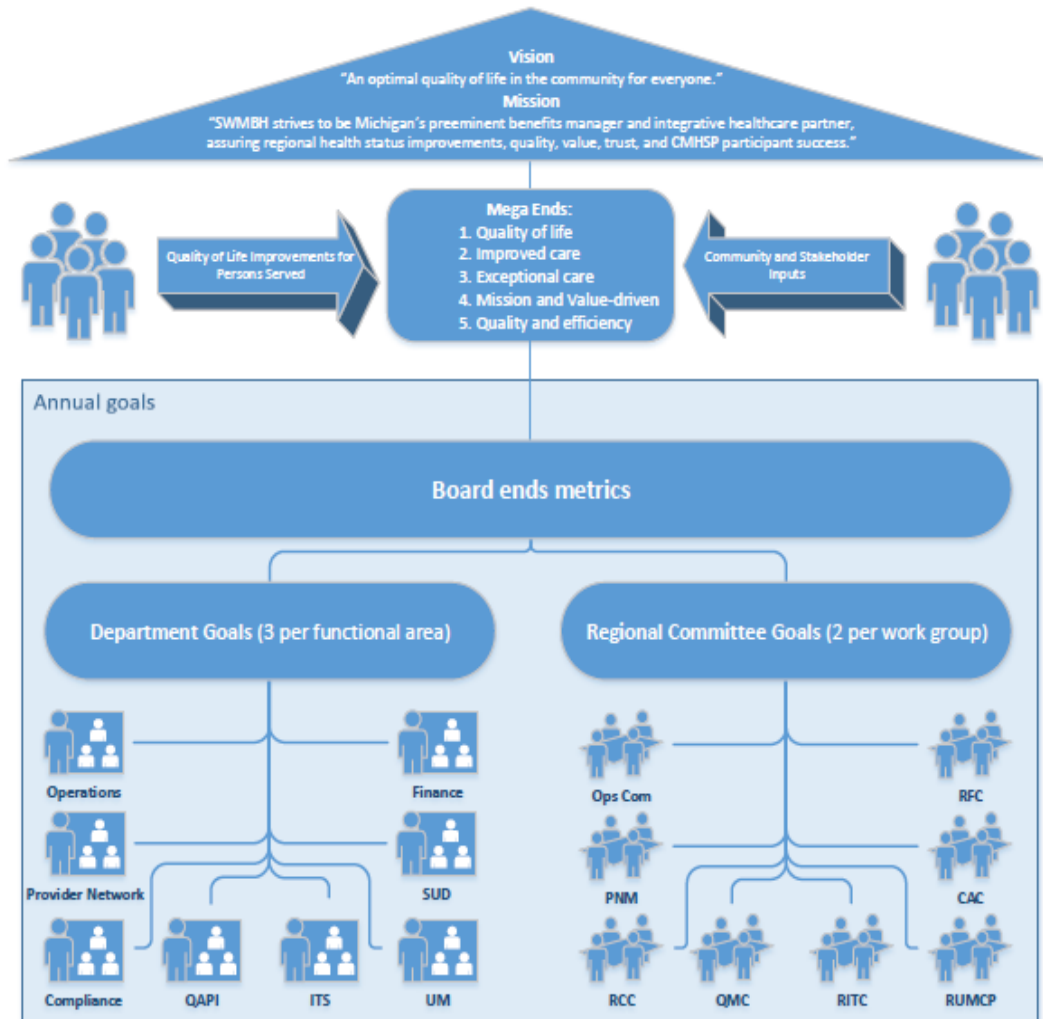
Completed Goal:

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

Attachment G

SWMBH Strategic Alignment Goal Planning Flow Chart

Strategic Alignment – Annual Goal Planning



10.10.2017

Attachment I

2018 Board Member Roster

2018 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

- Jim Blocker
- Kathy-Sue Vette (Alternate)

Cass County

- Robert Wagel
- Mary "May" Myers (Alternate)

Kalamazoo County

- Moses Walker
- Patricia Guenther (Alternate)

St. Joseph County

- Anthony Heiser
- Timothy Carmichael (Alternate)

Van Buren County

- Susan Barnes - Secretary
- Angie Dickerson (Alternate)