Quality Assessment & Performance Improvement

Annual Report

2016 Program Evaluation
2017 Program Plan

Board Approved: 1/24/17

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I. Introduction

The Quality Assessment & Performance Improvement Program (QAPIP) Steering Committee of Montcalm Care Network (MCN) is proud to submit this report as a communication vehicle about the organization's approaches to process design, as supporting documentation of goal achievement for the fiscal year 2015/2016, and the basis for performance improvement for 2017.

The Quality Assessment & Performance Improvement Program at MCN reflects the expectations and standards of:

- The Michigan Department of Health and Human Services (MDHHS);
- The Commission for the Accreditation of Rehabilitation Facilities (CARF);
- Mid-State Health Network (MSHN), the regional Prepaid Inpatient Health Plan
- The Center for Medicare and Medicaid Services (CMS) for a Quality Improvement System for Managed Care (QISMC) as outlined through the quality assurance provisions of the Balanced Budget Act of 1997 as amended.

This past year on the Regional level, data reporting has continued to mature. Data sources, particularly Zenith's ICDP warehouse of Medicaid claims and individual demographic & service information, has been able to provide information on trends of persons served, resulting in the MSHN Quality Improvement and Utilization Management Councils to focus on regional and local data-driven initiatives to improve and manage services.

Locally, significant agency changes affected the QAPI program. MCN had its first full year with its new Electronic Health Record (EHR)—finding it to be a stable and reliable data source—and allowing us to conduct our first Meaningful Use reporting—an incentive-based program and precursor to alternative payment systems. State reporting became more accurate and efficient. MCN also expanded its staffing resources to include a full time Data Analyst. Supervisors are now using a variety of management reports to assess productivity and work efficiencies, and advanced efforts are being made on measuring specific program and consumer level outcomes. MCN also joined the Great Lakes Practice Transformation Network—part of a national effort aimed at transforming clinical and quality practices in preparation of the future of healthcare delivery and compensation.

MCN envisions 2017 to be a year full of continued advancements in the areas of data management and quality improvement—supporting programs and staff in their service decision-making, and preparing MCN to be able to compete in the changing healthcare industry and succeed under value-based payment arrangements.

Respectfully Submitted by the QAPIP Steering Committee:

Tammy Quillan, Executive Director
Julianna Kozara, Clinical Director
Jim Wise, Finance Director
Linda Norkey, Acute Services Manager
Joel Sneed, Transitional Services Manager
Liz Ingraham, Children's Services Manager
Robin Ferguson, Integrated Health Nurse Manager
Marcy Rosen, Community Services Manager
Sally Culey, Quality & Information Services Manager
Bill Mason, Information Technology Coordinator
Jan Krings, Human Resources Coordinator
Crystal Stanton, Fiscal Team Leader
Steve Stanton, Maintenance & Facilities Coordinator
Angela Loiselle, Recipient Rights Officer
Dr. David Lyon, Medical Director - Consultant

II. Overview

Quality assessment and performance improvement is a continuous process. It involves measuring the functioning of important processes and services, and, when indicated, identifying changes that enhance performance. These changes are incorporated into new or existing work processes, products, or services with monitoring of performance to ensure improvements are sustained.

This Quality Assessment and Performance Improvement Program Plan exists to provide a leadership driven plan to set expectations, develop plans, and to manage processes to assess, improve, and maintain the quality of the organization's governance, management, treatment, care, services, and support activities as well as reduce the risk of unanticipated adverse events. The plan shall contain: future goals, studies undertaken, results, subsequent actions, aggregate data on utilization and quality of services rendered, and assessment of continuity, effectiveness, and acceptability.

III. Commitment and Conceptual Framework

Montcalm Care Network shall have a Quality Assessment Performance Improvement Program that achieves, through ongoing measurement and interventions, improvement in aspects of clinical care and non-clinical services that can be expected to affect consumer health status, quality of life, and satisfaction.

MCN has adopted, and is committed to, quality assessment and performance improvement (QAPI) philosophy and principles and to continuously measuring and assessing performance to ensure that the organization's mission, vision, and values are consistently supported over time.

Mission: To provide a comprehensive array of services and supports that promotes the mental health and wellness of individuals in Montcalm County.

Vision: To be a valued partner in building a community that is committed to wellness and embraces the full participation of every citizen.

Values:

Innovative: Our staff is dedicated to learning, leading and utilizing technologies and resources to maximize improvement opportunities for the benefit of our consumers.

Compassionate: Our services are provided in a professional and caring manner with respect for diversity and individuality.

Accessible: Our services are integrated in the community and responsive to its needs.

Recovery Oriented: Our services are aimed at supporting the individual through a person-centered approach that honors choice, emphasizes strengths and desires, promotes personal empowerment, and contributes to overall health, wellness and an inclusive and meaningful life in the community.

Exceptional Service: Our interactions in the community build relationships and result in positive experiences.

Performance is *what* is done and *how well* it is done to provide health care. The level of performance in health care is:

- The degree to which *what* is done is *efficacious* and *appropriate* for the individual.
- The degree to which it is *available* in a *timely* manner to individuals who need it, *effective*, *continuous* with other care and care providers, *safe*, *efficient*, and *caring* and *respectful* of the individual.

The Goals of the QAPIP include:

- Approaching quality as a management strategy
- Building quality into the processes and systems
- Defining quality as meeting the needs of the consumer
- Focusing on processes and systems, not people (staff)
- Eliminating the high cost of undoing mistakes
- Promoting organization-wide emphasis on a the mission, vision and values
- Looking beyond quality care and focusing on the quality of lives
- Capturing perspectives from a wide-range of consumers
- Assuring that consumers' rights are preserved
- Supporting and strengthening the skills of staff members

The program shall promote the six hallmarks of Performance Improvement: Leadership Commitment, Recognition, Employee Involvement, Education and Training, Teamwork, and Communication.

Appendix A: Principles of Performance Improvement

Resources:

- Leadership shall allocate adequate resources for measuring, assessing, and improving the organization's performance and improving consumer safety.
- Sufficient staff shall be assigned to conduct activities for performance improvement and safety improvement.
- Adequate time for all staff will be allotted so participation is insured. Staff involvement in QAPIP activities is considered a high priority.
- Staff shall be trained in performance improvement and safety improvement approaches and methods.
- QAPIP activities are reprioritized in response to significant changes in the internal or external environment.
- Other resources include space, equipment, training and funds to cover expenses associated with QAPI. Support to the QAPIP by providing resources for documentation.
- Adequate information systems and appropriate data management processes to support collection, management, and analysis of data needed to facilitate ongoing performance improvement shall be maintained.

Data Collection:

- Data collection allows informed judgments about the stability of existing processes, opportunities for incrementally improving processes, identifying the need to redesign processes, and/or determining if improvements or redesign of processes meets objectives.
- Data collection focuses on high risk, high volume, problem prone processes, outcomes, targeted areas of study, and comprehensive performance measures.
- The QAPIP uses data from internal and external sources to assess and analyze performance over time.
- In working toward the goals of focusing on process, rather than people, and to protect the confidentiality of consumers and staff, the collection and reporting of data will be aggregated. In instances where aggregated data do not support the QAPI function, numerical codes will be used to guarantee confidentiality. Further protection is provided to consumers by virtue of the Mental Health Code and HIPAA.
- Collected data are aggregated and analyzed (transformed into information) using statistical tools and techniques at frequencies appropriate to the activity or process being studied.
- Data analysis is performed when data comparisons indicate that levels of performance, patterns, or trends vary substantially from those expected, when undesirable variation occurs which changes priorities, and/or as chosen by leaders.

Performance Measures:

Performance measures are quantitative tools that provide an indication of an organization's performance in relation to a specified process. They shall be objective, measurable, and based on current knowledge and clinical experience. The measures shall not be limited to those selected by the MDHHS. Methods and frequency of data collections shall be appropriate and sufficient to detect need for program change.

- The measure can identify the events it was intended to identify and the data intended for collection is available.
- The measure has a documented numerator and denominator statement or description of the population to which the measure is applicable.

- The measure has defined data elements & allowable values and can detect changes in performance over time.
- The measure allows for comparison overtime within the organization or between organizations.
- The results can be reported in a way that is useful to the organization or stakeholders.

Analysis:

Analysis plays a critical role in the process of lending meaning to gathered data. Once analyzed data becomes information and is then available for decision making at the clinical and administrative levels as well as for ongoing research, performance improvement, education (provider or consumer) and policy formulation and planning. Additionally, the information is extremely valuable from a comparison perspective (i.e., benchmarking, best practice development, etc.)

IV. QAPIP Organizational Structure

MCN QAPIP Committee Structure & Membership 2017

Board of Directors

Executive Director
Tammy Quillan

Steering Committee
Sally Culey, Quality & Information Services Manager (Chair)
Robin Ferguson, Integrated Health Nurse Manager
Liz Ingraham, Children's Services Manager
Julianna Kozara, Clinical Director
Angela Loiselle, Recipient Rights Officer
Bill Mason, Information Technology Coordinator
Linda Norkey, Acute Services Manager
Tammy Quillan, Executive Director
Marcy Rosen, Community Srvs Mgr
Jan Krings, Human Resources Coordinator
Joel Sneed, Transitional Services Manager
Crystal Stanton, Fiscal Team Leader
Steve Stanton, Maintenance & Facilities Coordinator
Jim Wise, Finance Director
Dr. David Lyon, Medical Director (Consultant)

Behavioral Treatment Plan Review Committee
Joel Sneed, Transitional Svcs Mgr (Chair)
Linda Norkey, Acute Svcs Mgr
Dr. David Lyon, Medical Director/Psychiatrist
Ken Rapp, Psychologist
Julie Rasmussen, Psychologist (Consultant)
Angela Loiselle, Recipient Rights Officer (Consultant)

Consumer Advisory Committee
Primary & Secondary Consumers (Chair & Vice Chair)
Jonathan Halliwill, Peer Support Specialist (Liaison)
Joel Sneed, Transitional Srvs Mgr
Tammy Quillan, Executive Director (Consultant)

Recipient Rights Committee
Kurt Peasley, Board Member (Chair)
Consumer Representatives & Community Members
Angela Loiselle, Recipient Rights Officer (Consultant)
Sally Culey, Quality & Info Srvs Mgr (Consultant)
Tammy Quillan, Executive Director (Consultant)

Consumer Care Committee
Liz Ingraham, Children's Srvcs Mgr (Chair)
Theresa Patnoude, Care Specialist
Julianna Kozara, Clinical Director
Dr. David Lyon, Medical Director
Kirk Ferris, Access Specialist
Will Overton, Children's Srvcs Rep
Michelle Hudkins, Peer Support Specialist/ACT
Melissa MacLaren, RN
Kate Long, PA
Marcy Rosen, Community Srvs Mgr
Linda Norkey, Acute Svcs Mgr, Ad Hoc
Joel Sneed, Transitional Svcs Mgr, Ad Hoc
Sally Culey, Quality & Info Srvs Mgr (Consultant)

Environment of Care
Steve Stanton, Maint/Facilities Coord (Chair)
Tanya Douglas, Adult Care Specialist
John Couture, Nurse
Carol Doyle, Transcriptionist
Kindra Wilson, Clubhouse Rep
Robin Ferguson, Integrated Health Nurse Manager
Jim Young, Wellness Center Team Leader
Sally Culey, Quality & Info Srvs Mgr (Consultant)

Quality Of Work Life
Amber Lund, Receptionist Nicole Fox, Care Coordinator
CeCe McIntyre, Consumer Registration
Denise Vanderklok, Peer Support Specialist
Jackie Burns, Clubhouse Aide
Leigha Harris, Employment Connections (Co-Chair)
Angela Loiselle, Recipient Rights Officer (Co-Chair)
Carol Dimet, Peer Support Specialist
Melissa Bolanos, Care Specialist

Bill Mason, IT Coordinator
Tammy Quillan, Executive Director (Consultant)

Compliance Committee
same as Steering Committee above

Board of Directors

The Board holds the ultimate fiduciary responsibility for the organization. As such it sets the policies related to Quality Assessment & Performance Improvement Program (QAPIP) and oversees the performance of the organization through progress reports. The Board shall routinely receive written reports from the QAPIP describing actions taken, progress in meeting objectives, and improvements made. In addition to progress reports, the Board shall review and approve the QAPI program**,** evaluation, and plan at least annually.

Executive Director

The Executive Director is responsible for linking Strategic Planning and QAPIP functions. Appropriate policies are recommended to the Board for action. Through performance measures, the progress of the organization is routinely evaluated with reporting to the Board. The Executive Director has a unique role in conveying the importance of QAPIP to staff and recognizing staff contributions and the organization's success. The Executive Director may assign staff to participate in QAPIP activities.

Medical Director

The Medical Director has a unique role in providing clinical oversight related to quality and utilization of services both directly, in the form of case supervision, and indirectly, via consultative committee involvement related to clinical standards/guidelines.

Leadership Team

The organization's leadership will be trained in and understand QAPI methods. The leaders set expectations, develop plans, and manage processes to assess, improve, and maintain the quality of the organization's governance, management, clinical, and support activities. They shall assume an active and visible role in QAPIP activities, develop with staff appropriate performance measures, oversee continuous assessment and improvement of the quality of care and services at the operating unit level, and participate in cross-organizational performance improvement activities such as participating on committees and work teams. Leadership shall utilize QAPI principles and practices, document departmental QAPI activities, identify performance improvement opportunities, implement improvement activities, and maintain achieved improvements. Leadership shall support and encourage staff participation in committees and work groups by identifying and recognizing successful initiatives and staff contributions.

QAPIP Coordinator

The Quality Manager is designated as the QAPIP Coordinator. This Coordinator shall be responsible for the creation and implementation of a QAPI Program that is reflective of expectations and standards set forth by payors and accrediting bodies. The Coordinator oversees the quality structure and provides training and communication of quality efforts to the Board, leadership, staff, and stakeholders. The Coordinator serves as Chairperson of the QAPIP Steering Committee and provides technical assistance to committees and teams. The Coordinator is responsible for maintaining QAPIP records.

Staff

Staff has the opportunity to participate in a wide variety of unit-specific and organization-wide performance improvement initiates. At new hire orientation, staff will be introduced to the organization's QAPIP Plan and the expectation of their participation. In addition to participation on committees and workgroups, staff also participates in data collection related to performance measures at the department/unit level; in the analyses of performance measures from the operating and organizational levels; in identifying department/unit and organization-wide performance improvement opportunities; in identifying and recognizing peers for their contributions; and, in staying informed about performance improvement activities. When part of a QAPIP activity, staff represents their entire department and shall remain process and consumer focused.

Consumers

Consumers of Montcalm Care Network are encouraged to participate in developing new programs and improving existing processes. There are a variety of ways in which consumers can participate in performance improvement.

- Consumers have a voice through satisfaction & treatment surveys. The organization collects data on the perception of care, treatment, and services of consumers including their specific needs and expectations, how well the organization meets those needs and expectations, and how the organization can improve consumer safety.
- Consumers can provide information or file grievances with MCN's Customer Services representative who will assist with resolving issues and providing resource information.

- The Consumer Advisory Council is a permanent standing committee that is designed by consumers, for consumers, and about consumers.
- There is consumer involvement on the Recipient Rights Advisory standing committee and on the Board of Directors.
- At various times, consumer input is solicited through the use of focus groups or in consideration of specific processes.

Appendix B: Consumer Satisfaction Surveys & Findings for 2016

QAPIP Steering Committee

The Quality Assessment & Performance Improvement structure has been developed to carry out the goals and objectives of the system. The QAPIP Steering Committee meets at least quarterly. The Steering Committee performs the following functions in carrying out its goals and objectives:

- Assigns responsibility for actions to standing committees, teams and individuals within the organization, taking into consideration the organization's vision, mission, and values, as well as the goals and strategic direction established by the Board.
- Prioritizes, monitors, and approves the quality improvement activities delegated to standing committees, teams, and individuals within the organization. These include responsibilities as outlined in the committee structure as well as overall standards compliance and program evaluation.
- Establishes standardized quality indicators for objective evidence of high quality care based on the systematic, ongoing collection and analysis of valid and reliable data. The indicators are used to monitor and evaluate the quality of important functions that affect patient care and outcomes. Performance measures established by MDHHS in areas of access, efficiency, and outcomes are utilized with the goal being to meet or exceed all performance levels established by MDHHS.
- Evaluates the system and its components at least annually to ensure effectiveness. These components include, but are not limited to, whether there have been improvements in the quality of health care and services for recipients, the standing committee activities and plans, employee involvement, recognition, communication, leadership, and teamwork.
- Documents and communicates outcomes to the system. Information on initiatives, improvement projects, performance measures, etc., will be communicated through periodic emails postings, and staff meetings.
- Ensures that QAPI systems are being sustained and monitors effectiveness through:
  - Evaluation of Annual Standing Committee reports
  - Annual Employee Survey

Appendix C: Annual Employee Survey Findings for 2016

Appointment and Membership

- Every administrative staff member is a career-long member of the Steering Committee.
- Quality Manager is a member of the Steering Committee.
- Chairpersons of standing committees may be appointed to the Steering Committee.
- Steering Committee members are expected to attend all Steering Committee meetings.
- It is desirable to make decisions by consensus; however, voting will be used to approve agenda items as needed.
- Steering Committee meetings may be cancelled and/or re-scheduled if there is not a quorum or for lack of agenda items.

Reporting

- QAPIP meeting minutes will be shared with entire staff through the Lotus Notes program on the network computer system.
- Quarterly updates will be provided to staff through the General Staff agenda.
- Quarterly reports will be provided to Board Members through the Director's Report.
- An annual report will be provided for review and approval of Board Members.
- The Quality Manager shall be responsible for keeping permanent records of QAPIP activities.

System Improvements

- Staff and consumers can communicate to the Quality Manager and the QAPIP Steering Committee an opportunity for improvement.
- MCN encourages staff to report opportunities for system improvement through their supervisor, the Quality Manager, or any QAPIP Steering Committee member.

- Suggestions for system improvements may also be submitted on the annual agency Employee Survey.

Improvement Opportunity Criteria

- Presents a clear opportunity to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement of clinical and non-clinical services.
- Can be assigned to a team that has the knowledge and skills to complete the task successfully.
- Will result in a beneficial effect on health outcomes and/or consumer satisfaction.
- Not every process improvement requires a work group. Process Improvement can be achieved without a team, as long as "customers" of the process have input into the re-design and the improvement is documented.
- The following areas are not appropriate for QAPIP activities.
  - Personnel policies & issues, including job descriptions.
  - Wages and benefits.
  - Allocation of resources, budget, and personnel.
  - Personality issues and conflicts.
  - Union contract issues.
  - Agency policies and directions *(Note: policies may be developed as a byproduct of QAPIP activities and are subject to Board approval.)*
  - Board of Directors by-laws and practices/procedures.

QAPIP Standing Committees

- Standing committees present annual goals to the QAPIP Steering Committee and report periodically to the QAPIP Steering Committee.
- Standing committees shall select and utilize performance measures. Methods and frequency of data collections shall be appropriate and sufficient to detect need for program change.
- Standing committees are responsible for improving processes and systems that fall under their area of accountability. The committees focus on important aspects of care and service by considering the following:
  - What are the most frequent activities?
  - What are the problem prone processes?
  - Where do we incur high levels of liability/risk?
  - What are the highest cost activities?
  - What is critical to consumer satisfaction?
- Committees make recommendations to the QAPIP Steering Committee for improvements based on work team findings and indicator monitoring in the standing committee's areas of responsibility.
- As issues are identified for improvement, the standing committee must identify (or guide the work team in identifying) the "customers" of that process. These "customers" are to include the internal, external, and ultimate customers. Representatives from the affected customer groups are to have input into the process development and improvement.

Appointment and Membership

- Individuals may volunteer for committee appointment based on interest or may be asked to serve based on job function or expertise.
- Committee members serve minimum one-year terms with no more than one third of the membership turning over in a given year. Membership may extend beyond one year either voluntarily or by need due to job function or expertise.
- Standing Committee members are expected to attend scheduled meetings. Excessive absences will be reported to Supervisors for appropriate follow up action.

Reporting

- Each Standing committee will have an identifiable chairperson and minute taker.
- Chairpersons shall provide the Quality Manager with copies of all meeting and activity documents.
- Minutes must be generated from each standing committee meeting and are shared with the entire staff through the Lotus Notes program on the network computer system.
- Significant action will be communicated to staff by the Quality Manager through a General Staff agenda item.

QAPIP Work Teams

- Work Teams are convened by the QAPIP Steering Committee for specific planning/implementation activities related to new process, services, or programs. They are also convened to address specific performance improvement initiates. In general, the Work Team reports to the QAPIP Steering Committee, but may, depending upon the focus, be assigned to a standing committee. Work Teams are expected to be time limited in nature.
- The QAPIP Steering Committee may request participation of specific staff or teams based on expertise or need for input. Supervisors are responsible for identifying staff for work teams and assuring participation.
- Once the team has been assembled the Quality Manager will attend at least the first meeting to facilitate the establishment of the team, to communicate the expected outcomes of the team, and assist in development of a team structure.
- The work teams will report progress to the Steering Committee and/or assigned standing committee. The Steering Committee approves all changes in systems based upon the work team recommendations. The Quality Manager notifies the team leader of the Steering Committees decision(s) who in turn communicates to the work team.
- The Steering Committee assists in implementation of work team outcomes as necessary. The Quality Manager or designee shall communicate those changes to staff through a general staff agenda item. Work teams will communicate to all staff via Lotus Notes.

V. Requirements Related to Performance Improvement

Commission for the Accreditation of Rehabilitation Facilities (CARF)

As part of its contract with DCH, and to promote quality clinical and administration services, MCN has pursued for several years accreditation from an external entity. In 2014, MCN successfully achieved a 3-year accreditation through CARF. It was determined that CARF's mission—to promote the quality, value, and optimal outcomes of services through a consultative accreditation process and continuous improvement services that center on enhancing the lives of the persons served—fit well with the mission, vision and values of MCN, with a focus on performance and quality service delivery.

MCN accredits the following programs under CARF:

- Assertive Community Treatment (ACT)
- Assessment & Referral (Access Services—new for 2017 accreditation)
- Case Management/Services Coordination (CSM/SC)
- Community Integration (Heartland House Clubhouse)
- Crisis Intervention (Emergency Services)
- Integrated Behavioral Health/Primary Care (new for 2017 accreditation)
- Intensive Family-Based Services (Home Based Services)
- Outpatient Treatment

MCN measures outcomes related to each of the programs in the areas of access, effectiveness, and efficiency of services, and satisfaction of persons served and other stakeholders.

Appendix D: CARF-Accredited Program Outcome Data

Quality Improvement System for Managed Care

As required by federal legislation and the MDHHS contract, Montcalm Care Network, together with the Mid-State Health Network, is responsible for implementation of the QISMC standards for performance improvement projects. Said projects will focus on achieving demonstrable and sustained improvement in services likely to have beneficial effects on health outcomes and consumer satisfaction. Topics identified for potential projects will be prioritized and selected based on stakeholder input and will closely adhere to QISMC standards. Topics for potential QISMC projects may also be assigned by the MDHHS. Selection and prioritization of projects will be based on the following three factors:

- Focus Area: Clinical (prevention or care of acute or chronic conditions; high volume or high risk services; continuity and coordination of care), or Non-Clinical (availability, accessibility, and cultural competency or services; interpersonal aspects of care; appeals, grievances, and other complaints.)

- Impact: Affects a significant portion of consumers served and has a potentially significant effect on quality of care, services, or satisfaction.
- Compliance: Adherence to law, regulatory, or accreditation requirements.

For the required project, PIHPs were to focus on the integration of primary and mental health care, and MDHHS encouraged the ongoing access by PIHPs to Medicaid services claims data to assist with data measurements. MDHHS also continues to require a second project of the PIHPs choice. MSHN's two selected projects as identified and approved in 2014, and continued in 2016/2017, include the following.

- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (this project also meets DCH's request for PIHPs to begin implementation of a selected HEDIS measure, which are performance measures required of Health Plans)
- Recovery Performance Improvement

Appendix E: MSHN Performance Improvement Projects

Medicaid Event Verification

As mandated by MDHHS starting in 2015/2016, the PIHP conducts Event Verification processes of the CMHSPs. MSHN implemented new processes for 2016 and conducted two (2) on-site reviews to review claims and claims reporting processes.

Appendix F: 2016 MSHN Event Verification Reports

MDHHS Mission Based Performance Indicator System

The MDHHS requires reporting on indicators for the Michigan Mission Based Performance Indicator System, which indicators covering the four domains of quality identified as access, adequacy/appropriateness, efficiency, and outcomes. Aggregated performance indicator data is submitted quarterly to the PIHP for submission to MDHHS. Quarterly consultation drafts are provided by MDHHS on most indicators using statistical and graphical methods. The QAPIP Steering Committee and the PIHP PI/Quality Committee monitor achievement of minimum performance levels as established by MDHHS. Outliers and/or anomalies are analyzed with improvements as needed.

Appendix G: Quarterly CMHSP Performance Indicator Reports

Adverse Events

In an effort to assure and maximize safe clinical practices and stress the importance of member safety, Montcalm Care Network has established processes to effectively:

- Identify and report the occurrence of critical health and safety incidents;
- Evaluate the factors involved which caused critical health and safety incidents to occur;
- Identify and implement actions to eliminate or lessen the risk of critical health and safety incidents from future occurrence; and,
- Review aggregate data to identify possible trends.

Individuals involved in the review of adverse events shall have the appropriate credentials to review the scope of care. Events are reviewed and addressed individually by supervisors and staff as appropriate for event-specific follow-up, and identifying improvement and preventative actions. Events are also reviewed as aggregated data reports in MCN committees for the purpose of identifying trends, actions for improvements and results of improvements taken, necessary education and training of personnel, and prevention of recurrence.

Sentinel event reporting procedures, including review, investigation, and follow up, will be in accordance to applicable guidelines issued from regulatory agencies which may include, but are not limited to, the June 1998 HCFA Waiver Document, September 2001 MDCH Guidance on Sentinel Event Reporting, and CARF Sentinel Event Reporting requirements.

Appendix H: Critical Incident & Adverse Event Annual Analysis & Reports

Behavioral Treatment Review

As per the MDHHS Behavioral Treatment Technical requirement, Montcalm Care Network together with the PIHP, collects and aggregates data on events and interventions on a quarterly basis.

Appendix I: Behavioral Treatment Review Reports

Credentialing and Qualifications

Montcalm Care Network has policies and procedures establishing processes for ensuring the credentials and qualifications of its staff (employed or contractual) initially upon employment and on an ongoing basis as appropriate. These processes include, but are not limited to, the following:

- Certification and/or Licensure: Initially and at renewal, staff must submit copies of current certification, registration, and/or licensure to the Human Resources Department. Primary source verification of said documents will be made in writing, by telephone, or via the internet.
- Educational Background: Initially and as degrees are granted, transcripts from educational institutions are submitted to the Human Resources Department. Primary source verification of said documents will be made in writing, by telephone, or via the internet.
- Relevant Work Experience: An initial review of relevant work experience will be conducted by the hiring supervisor/manager.
- Criminal Background: Initially and periodically, criminal backgrounds searches will be performed to assure appropriateness for employment/contract.
- Sanctions/Exclusions: Initially and periodically, state and national data banks will be checked to verify eligibility to participate in Medicaid/Medicare programs.

Appendix J: MCN Credentialing and Privileging Procedure

Privileging

Montcalm Care Network has policies and procedures establishing processes for privileging licensed independent practitioners (employed or contractual). These processes include, but are not limited to, the following:

- Initial Privileging: Through an application process, licensed independent practitioners will be granted, for a period of two years, specific clinical privileges in the major clinical work tasks they perform. The process will include verification of credentials, a review of relevant experience, and peer recommendations.
- Re-Privileging Process: Re-privileging of practitioners will occur every two years through the privileging application process. The process will include re-verification of credentials along with findings from peer reviews, record reviews, performance evaluations, and satisfaction surveys.
- Quality Improvement Program Involvement: Data generated through the quality system is available for review during the privileging and re-privileging processes as relevant.

Appendix J: MCN Credentialing and Privileging Procedure

Provider Network Monitoring

Montcalm Care Network has policies and procedures establishing processes for monitoring its subcontracted provider network to which it has delegated care functions, including service and support provision. To improve provider network monitoring functions, MCN has recently hired a full time staff to conduct all provider network monitoring functions where previously these were split amongst various staff. These processes include, but are not limited to, the following:

- Review of provider quality and compliance with required service standards as part of the biannual privileging practices for individual practitioners, and annual monitoring of quality and compliance.
- Annual quality and compliance review of contracted agency providers. Minimally annual quality and compliance review of contracted Adult Foster Care providers, including monthly onsite visits and reviews by case managers and annual reviews, in conjunction with the MCN Recipient Rights Officer.

Appendix K. MCN Recipient Rights, Corporate Compliance and Contract Monitoring of Contracted Providers Procedure

Corporate Compliance

Montcalm Care Network has developed a Corporate Compliance program, including a plan, policies, and procedures for preventing, detecting, and reporting fraud and abuse.

Appendix L: MCN Compliance Policy

Utilization Management

Montcalm Care Network has policies and procedures to evaluate medical necessity and processes for monitoring under- and over-utilization of services through prospective, concurrent, and retrospective reviews. Reviews are completed by staff with appropriate clinical expertise with decisions to deny or reduce services made by qualified health professionals. Reasoning for decisions is clearly documented and available to the consumer. Appeal mechanisms exist for both providers and consumers and notification of review decisions include a description of how to file an appeal.

Appendix M: MCN Utilization Decisions Procedure
Appendix N: MCN Grievance and Appeal Policy & Reports

VI. MSHN QAPIP Program

Introduction

Mid-State Health Network, is the Prepaid Inpatient Health Plan for the affiliate region of Bay Arenac Behavioral Health, Clinton-Eaton-Ingham Community Mental Health, Community Mental Health for Central Michigan, Gratiot County Community Mental Health, Huron Behavioral Health, The Right Door (Ionia County), Lifeways (Jackson-Hillsdale), Montcalm Care Network, Newaygo County Community Mental Health, Saginaw County Community Mental Health Authority, Shiawassee County Community Mental Health, Tuscola Behavioral Health Systems.

MSHN Vision

To continually improve community well-being/wellness through the provision of premiere behavioral health care and leadership in the coordination of a network of community partnerships essential to address the multiple needs for quality of life and the reduction of per capita costs, with priority focused on the most vulnerable citizens.

MSHN Values

- Consumer-focused alignment with system transformation initiatives.
- Provider-sponsored plan design ensures strong consumer focus.
- Increased regionalization of risk management supports development of local accountable care.
- Recognition of CMHSPs as the foundation for specialty behavioral health homes for persons with severe and persistent mental illness, substance use disorders, and developmental disabilities.
- Preserves the essential role of habilitative services necessary for recovery and self-determination.
- Supports the continued state and county partnership related to public mental health services.

Appendix O: MSHN Draft 2017 QAPIP Plan (Final version not available as of this report.)

VII. Committee Annual Reports and Recommendations

Behavior Treatment Plan Review Committee: Annual Report & Recommendations

Committee Structure:

A. *Mission:* To address treatment of behavioral disorders by the least restrictive means possible and to provide a mechanism by which treatment for behavioral challenges is systematically and thoroughly reviewed.
B. *Responsibilities:* Review behavior plans that include restrictive or intrusive techniques.
C. *Representation:* Clinical Services Manager (Chair), Psychologist, Clinical Services staff, Medical Director and/or Psychiatrist, Recipient Rights Officer (consultant), Quality Manager (consultant), and/or others as appointed by the Executive Director.
D. *Meeting Schedule:* At least monthly or more often as needed

Activities and Accomplishments for 2015/2016:

- Regular meetings were held during the year for the purpose of fulfilling committee responsibilities.
- All behavioral plans were reviewed quarterly, or more often as needed.
- Data reports were submitted to MSHN for aggregation and reporting as required.
- Reduced restrictive and intrusive measures in plans that had been in place for a period of time.

Goals for 2017:

1. Meet on a monthly basis or more often as needed to fulfill responsibilities.
2. Submit behavior treatment review data to MSHN for aggregation and analysis.
3. Review behavioral findings, both through the use of aggregate data reports as available and through individual case/anecdotal reviews as appropriate.
4. Revise and update plans as clinically warranted.

Compliance Committee: Annual Report & Recommendations

Committee Structure:

A. Mission: To assure good faith efforts in complying with applicable health care laws, regulations and third party payor requirements.
B. Responsibilities: Assures implementation of the Corporate Compliance Program, evaluate its effectiveness, and make recommendations for changes to enhance compliance.
C. Representation: Compliance Officer (Chair), Executive Director, Clinical Director, Finance Director, Children's Services Manager, Transitional Services Manager, Community Services Manager, Acute Services Manager, Integrated Health Nurse Manager, HR Coordinator, Recipient Rights Officer, IT Coordinator, Fiscal Team Leader, Maintenance & Facilities Coordinator, Medical Director (consultant).
D. Meeting Schedule: Quarterly or more often as needed.

Activities and Accomplishments for 2015/2016:

- The Committee met in conjunction with the QAPIP Steering Committee quarterly meetings in 2016.
- There were 2 investigations during the year.
- Quarterly Claims Verification audit findings were reviewed in and November 2015. In April 2016, MSHN began their claims verification audits; findings were reviewed in July 2016.
- QI and Demographic Data completeness findings were reviewed quarterly in November 2015. MDHHS switched to collecting BHTEDs data (Behavioral Health Treatment Episode Data Sets), and preliminary data reviews were conducted in April and July 2016.
- Annual Compliance Plan/Program was reviewed and approved by the Board in October 2016 which includes the agency Risk Management Plan.
- Annual staff compliance training was completed through Relias Learning.

Goals for 2017:

1. Review complaints and investigations logs for appropriateness of response. (Goal: As Needed)
2. Monitor compliance in focus areas, specifically review of findings of MSHN Event Verification audits.
3. Assure annual review and Board approval of the Compliance & Risk Management Plan.
4. Review and approve annual IT Plan.
5. Monitor IT Systems Compliance & Security matters.
6. Assure annual staff training in the areas of corporate compliance, and IT compliance & security.

Consumer Advisory Council: Annual Report & Recommendations

Committee Structure:

A. Mission: To play a vital role in designing, reviewing, and improving behavioral health care services provided at Montcalm Care Network by becoming active, involved and informed participants.
B. Responsibilities: Recognize consumer efforts/contributions to the mental health system; review consumer satisfaction reports and performance data; review consumer informational materials; create community awareness through outreach activities; provide input on programs and services; and, participate in the Regional (MSHN) Consumer Advisory Council.
C. Representation:
   - All primary (have ever received public mental health services) and secondary (family member of a primary consumer) consumers of Montcalm Care Network are welcome to attend any meeting.

- A group of 12 consumers, representing all populations served (MI, DD, SED, SU, Geriatric), are appointed by the Executive Director to serve as voting members of the Council. Appointed members serve for four-year terms and are eligible to receive a stipend to offset any financial burden of attending meetings.
- The Council holds annual elections for the position of Chairperson and Vice Chairperson.
- The Executive Director and Transitional Services Manager provide assistance and support to the Council.

D. Meeting Schedule: Bimonthly

Activities and Accomplishments for 2015/2016:

- Bylaws were reviewed & updated in August 2016.
- Customer Satisfaction Surveys were reviewed in December 2015, and February & August 2016.
- Quality Report Cards were reviewed in December 2015.
- MCN suggestion box items were reviewed in April, June & August 2016.
- Annual Performance Improvement Project data reports were reviewed in February & June 2016.
- Reviewed results of Recovery Assessment Scale in November 2015.
- MSHN Regional Consumer Advisory Council meetings were attended in December 2015, and March, June and August 2016.
- Input was provided on: the National Core Indicator (NCI) report from DCH on "A Guide to Person-Centered Planning;" MCN's updated Strategic Plan; and ongoing Peer Support Services WHAM groups.
- Council members were recognized for years of service in October 2015.
- Council members participated in the Walk-A-Mile event through the Clubhouse in May 2016.
- Council members attended forums on Section 298 in February and March 2016.

Goals for 2017:

1. Review Customer Satisfaction Survey findings & Suggestion Box entries and identify areas of concern and/or make recommendations for improvements. (Goal: At least annually)
2. Review performance data as contained in Performance Indicator Reports. (Goal: Quarterly)
3. Review and provide feedback on Regional Performance Improvement Projects. (Goal: Annually)
4. Participate in Regional Advisory Council meetings. (Goal: Quarterly)
5. Provide input on changes to services, development of new services, or changes to policies and procedures related to the provision of services. (Goal: As needed)
6. Provide input on informational materials for consumers and customer services practices. (Goal: As needed)
7. Consider participation in Mystery Shopper activities—either locally and/or statewide initiatives—to help assess quality of access and customer services. (Goal: Annually)
8. Advocate for awareness and mental health promotion by participating in local community events. (Goal: Semi-Annually)
9. Advocate for awareness and mental health promotion by participating in statewide events. (Goal: Semi-Annually)
10. Receive updates on Peer Support efforts/initiatives/educational opportunities. (Goal: As available)
11. Receive training on agency services, specifically on Court Outreach services and services to the Elderly.) (Goal: Two trainings)

Consumer Care Committee: Annual Report & Recommendations

Committee Structure:

A. *Mission:* To ensure quality of care.
B. *Responsibilities:* Assess treatment continuum, review service utilization and clinical records, critical incident reviews and sentinel event reporting.
C. *Representation:* Children's Services Manager (Chair), Clinical Director, Community Services Manager Acute Services Manager, Adult Services Rep, Children's Services Rep, Transitional Services Manager, Medical Director, RN, Quality & Information Services Manager (consultant).
D. *Meeting Schedule:* Monthly

Activities and Accomplishments for 2015/2016:

- Critical Incidents/Sentinel Events were reviewed and reported as required.
- Record Reviews quarterly data reports were reviewed in December 2015, March, April, and June 2016.
- There were no wait lists to review for 2016.
- Reviewed and updated Procedure #8305F on Look-Alike/Sound-Alike Medications in March 2016.
- Reviewed performance indicator reports in November 2015, and January, April, and July 2016.
- Received reports on Consumer Experience/Satisfaction Surveys in December 2015, and February, March, April, June, July and August 2016.
- Received updates on regional best practices initiatives in December 2015.
- Reviewed Critical Incident & Risk Event reports in December 2015 and June 2016.
- Membership was reviewed in December 2015 Children's Service Manager remains chairperson.
- Reviewed reports on Level of Care Reviews in December 2015.
- Reviewed Grievance and Appeals data in March 2016.
- Discussed data and reviewed process improvement related to Abandoned Calls in March 2016.
- Reviewed MSHN Performance Improvement Projects data in January, April, June, July and August 2016.
- Reviewed population service penetration rates data in June 2016.
- In December 2015, reviewed annual staff training requirements and topics and made recommendations for updates/changes for 2016.
- Reviewed National Core Indicator reports from MDHHS on "Importance of Relationships" and "A Guide to Person-Centered Planning" in June 2016.

Goals for 2017:

1. Review and monitor data reports, specifically:
   a. Record Reviews (Goal: Quarterly)
   b. Performance Indicators (Goal: Quarterly)
   c. Critical Incident & Risk Event Reports (Goal: Biannually)
   d. Mortality Data Reports (Goal: Annually)
   e. GF Waiting List (Goal: As list occurs.)
   f. Consumer Experience/Satisfaction Survey Reports (Goal: Annually)
   g. Access Timeliness Data (Goal: Quarterly)
   h. National Core Indicator Reports (Goal: As made available by MDHHS)
   i. Grievance & Appeals Reports (Goal: Quarterly)
   j. Regional Performance Improvement Projects data.
2. Revise Utilization Management practices.
3. Identify agency & program performance outcomes for measurement, including revising processes for evaluating & monitoring Evidence Based Practices.
4. Annual review of agency procedure #8305F on Look-Alike or Sound-Alike Medications.
5. Annual review of staff trainings, and provide recommendations for changes.

Environment of Care Annual Report & Recommendations

Committee Structure:

A. *Mission:* To provide a safe, accessible, and supportive environment for consumers and staff.
B. *Responsibilities:* Planning for Safety Management, Security Management, Hazardous Materials & Waste Management, Emergency Management, Fire Prevention Management, Medical Equipment Management, Utilities Management, and Infection Control.
C. *Representation:* Maintenance & Facilities Coordinator (Chair), Nurse, Clinical Services Representative, Support Services Representative, PSR/Clubhouse Representative, Wellness Works Representative, Health 360 Clinic Representative, Quality & Information Services Manager (consultant).
D. *Meeting Schedule:* Quarterly

Activities and Accomplishments for 2015/2016:

- Discussed updates on new buildings/facilities and the Health 360 Clinic in January, April and July 2016.
- Quarterly data reports related to incidents, injuries and facility maintenance were reviewed in January, April and July 2016.
- Evaluated flu vaccination rates and supported flu-prevention training for staff in January 2016.
- Emergency drills practices were conducted and reviewed to meet CARF standards.

- Staff was trained on Environment of Care and Safety topics throughout the year via monthly emails and General Staff meetings.
- "Do 1 Thing" materials were shared with staff as available.
- The annual Hazard Vulnerability Analysis was completed in July 2016 for all locations: Stanton State Street and Main Street offices, Wellness Works, and the Greenville and Howard City locations.
- Reviewed CARF Health & Safety Standards in April 2016.
- The committee reviewed findings from external audits in January 2016.

Goals for 2017:

1. Review aggregate data to identify trends and/or improvements for the following:
    a. Safety/Security Incidents (Goal: Quarterly)
    b. Staff Injuries (Goal: Quarterly)
    c. Facility Maintenance (Goal: Quarterly)
2. Review findings from annual external facility inspections for all MCN locations. (Goal: Annually)
3. Assure emergency drills are conducted minimally annually at all MCN locations for:
    a. Fire Evacuation
    b. Severe Weather/Sheltering
    c. Utility Failure
    d. Bomb Threat
    e. Medical Emergency
    f. Violent/Threatening Situation
4. Evaluate completed drills for improvement opportunities. (Goal: Per Occurrence)
5. Assure staff is trained on Environment of Care topics. (Goal: Monthly)
6. Participate in the "Do 1 Thing" program. (Goal: Monthly)
7. Review and update the Environment of Care Management Plans. (Goal: Annually)
8. Review and update procedures to assure conformance with CARF accreditation Health & Safety standards. (Goal: Annually)
9. Conduct a Hazard Vulnerability Analysis to identify and address risks in the environment. (Goal: Annually)
10. Evaluate staff influenza vaccination rate, reasons for declining vaccination and identify opportunities for further staff education on flu prevention. (Goal: Annually)
11. Disseminate product recall information to staff. (Goal: Weekly/As information obtained.)
12. Assess and assure appropriate health & safety practices at all MCN buildings and Health 360 Clinic to meet all regulatory requirements, and incorporate committee review of policies, procedures, inspections and data reports as required. (Goal: Quarterly)

Quality of Work Life Annual Report & Recommendations

Committee Structure:

A. *Mission:* To sustain a program to promote, enhance and encourage a positive, productive working environment for all staff of the Montcalm Care Network.
B. *Responsibilities:* Promote a quality work environment.
C. *Representation:* HR/Admin Assistant (Chair), Adult Specialty Services, Children's Services, Support Services, Executive Director (consultant), Quality & Information Services Manager (consultant).
D. *Meeting Schedule:* Monthly

Activities and Accomplishments for 2015/2016:

- During calendar year 2016, MCN staff donated $1,167.16 to various Montcalm County charities via events organized by the QWL.
- Staff were provided anniversary cards for their work anniversary.
- Staff were recognized for years of service (one, five, ten, fifteen, etc.) during the year.
- Staff activities were provided on a monthly basis.
- Jeans Day fundraisers were conducted.
- Annual Staff Survey was completed.
- Collected United Way pledges.

Goals for 2017:

1. Acknowledge staff longevity through years of service gifts in years five, ten, fifteen, twenty, etc. (Goal: Distributed Monthly)
2. Plan one activity per month in appreciation of staff.

3. Survey staff annually for feedback and suggestions.
4. Complete a follow up survey from the annual staff survey that was conducted.
5. All staff will receive an anniversary card recognizing their work anniversary.
6. Conduct a monthly "jean day" fundraiser for charity.
7. Continue annual United Way fundraiser.

Recipient Rights Advisory Committee Annual Report & Recommendations

Committee Structure:

A. *Mission:* To provide a mechanism by which recipient rights issues are systematically and thoroughly reviewed.
B. *Responsibilities:* Oversee rights education and rights protection.
C. *Representation:* Board Member (Chair), Primary Consumers, Secondary Consumers, Community Stakeholder, Recipient Rights Officer (consultant), Quality Manager (consultant), Executive Director (consultant).
D. *Meeting Schedule:* Quarterly

Activities and Accomplishments for 2015/2016:

- Maintained support for the Office of Recipient Rights (ORR) and a full-time officer through the annual review and submission of the ORR budget and recommendations in November 2015.
- Quarterly ORR Formal Compliant Logs were reviewed in November 2015, and February, May and August 2016.
- Quarterly reports on ORR Activities were reviewed in November 2015, and February, May and August 2016.
- Quarterly aggregate data on Incident Reports were reviewed in November 2015, and February, May and 2016.
- Annual and semi-annual State Recipient Rights data submissions were reviewed in November 2015 and May 2016.
- Reviewed agency Recipient Rights policies and procedures in November 2015 and February, May and August 2016.
- Membership was expanded to include more consumer representatives.
- A new Recipient Rights Advisor was added.
- The committee received training in May 2016 on the Report of Investigative Findings.

Goals for 2017:

1. Advocate for continued support from the Board of Directors to ensure the recipient rights system and office are equipped to discharge required duties, including a full-time rights officer. (Goal: Annual Budget and Recommendations)
2. Continue to monitor performance of the ORR through the following reports:
   a. Review of ORR Formal Compliant Log to include status and outcomes of investigations, complaints, and concerns. (Goal: Quarterly)
   b. Review of ORR Activities to include training attendance by the ORR, consultation and training offered to staff, providers, and consumers on rights related topics, and completed site visits. (Goal: Quarterly)
   c. Review of aggregate Incident Report data. (Goal: Quarterly)
   d. Review of data submissions to the MDHHS. (Goal: Annually and Semi-Annually)
3. Continue to collaborate with ORR's within the MSHN and local LPH ORR's in an effort to improve communication and share resources. (Goal: Ongoing).
4. New RRAC members will view the MDHHS-ORR online RRAC training, will seek opportunities to attend MDHHS-led RRAC training when available and as appropriate, and will be encouraged to attend the New Hire training presented by the ORR, (Goal: Ongoing)
5. Review and provide feedback on all MCN RR policies. (Goal: Annually)
6. Conduct one "mock" rights complaint appeal or review of a previously completed appeal. (Goal: Annually)

QAPIP Steering Committee Annual Report & Recommendations

Committee Structure:

A. *Mission & Responsibilities:* The QAPIP Steering Committee ensures the QAPIP is implemented and shall sustain a quality system that encourages and involves the contributions of staff, consumers, and other stakeholders in support of the agency's mission, vision, values.

B. *Representation:* Quality & Information Services Manager (Chair), Executive Director, Clinical Director, Finance Director, Children's Services Manager, Transitional Services Manager, Acute Services Manager, Integrated Health Nurse Manager, Community Services Manager, HR Coordinator, IT Coordinator, Recipient Rights Officer, Fiscal Team Leader, Maintenance & Facilities Coordinator, Medical Director (consultant).

C. *Meeting Schedule:* Quarterly, or more often as needed.

Activities and Accomplishments for 2015/2016:

- Monitored standing committees and prioritized work efforts as needed in all quarterly meetings.
- All General Staff Meetings on a quarterly basis (or more often) included an update on quality efforts.
- Refined annual Employee Survey tool, implemented it in September 2016, and reviewed/responded to findings.
- Sustained involvement of staff and consumers in quality system: In 2016, 39% of staff (39 of 101) participated on a quality committee or special workgroup (Goal: 25%). And 38% of positions on quality committees (22 of 58) were filled by primary and/or secondary consumers (Goal: 25%).
- 2016 QAPIP Assessment & Performance Improvement Annual Report was reviewed, and Board approved in January 2016.
- 2016 Accessibility Plan was revised and approved by the Committee in July 2016.
- 2016 Cultural Diversity Plan was revised and approved by the Committee in April 2016.
- 2015 Critical Event Annual Analysis was completed in January 2016.

Goals for 2017:

1. Monitor standing committees and prioritize work efforts as needed. (Goal: Quarterly)
2. Communicate quality efforts to Board and staff, specifically:
   a. General Staff Meeting Updates (Goal: Quarterly)
   b. Postings in mail room
3. Continue to refine annual Employee Survey tool and review/respond to findings. (Goal: Annual)
4. Sustain involvement of staff and consumers in the quality system, specifically:
   a. 25% of staff will participate on a quality committee/workgroup during the year.
   b. 25% of all participation opportunities (as designated by committee structure or workgroup charter) are held by consumers during the year.
5. Conduct annual review of the QAPIP Assessment & Performance Improvement Annual Report.
6. Conduct annual review of the Accessibility Plan.
7. Conduct annual review of the Cultural Diversity Plan.
8. Conduct annual review of the Critical Event Annual Analysis.