Quality Assessment & Performance Improvement

Annual Report

2018 Program Evaluation
2019 Program Plan

Board Approved: 1/29/19

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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 2017/2018, and the basis for performance improvement for 2019.

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 (BBA) of 1997 as amended.

At the Regional level this past year, one of MSHN's primary quality assessment and improvement activities focused on the region's various identified key performance measures. Activities included ensuring accuracy and reliability of data being collected across all CMHs, as well as identification of best practices amongst high performing CMHs. MSHN was able to provide CMHs with very specific data reports by which we could compare our performance to the performance levels of each CMH in the region, as well as compared to Health Plans statewide and nationally. MSHN also implemented its own managed care electronic health record (EHR) which is working to create efficiencies for the region in specific areas of performance data reporting. MCN responded to these activities by utilizing these data reports to continue to hone in on specific areas for improvement and to further develop internal practices and protocols to improve services and meet performance targets, as well as implementing enhancements to its own EHR.

As described in last year's QAPIP report, many of the region's key performance measures are associated with "pay for performance" arrangements whereby financial incentives, and likewise penalties, are based on performance to targets. These types of alternative payment methods are only expected to continue and grow to be typical, and significant, funding practices. In 2018, the MDHHS-PIHP Medicaid contract included language related to withholding funding dependent on the performance on a measure related to provider follow-up with consumers following hospitalization; the MSHN region, including MCN, met the state's target and avoided funding withholds.

MCN staff have made *considerable* efforts this past year to implement additional clinical quality measures, conduct intensive data analytics, develop new internal protocols, and enhance EHR functions to be prepared for various alternative payment methods and improve quality of care. MCN has excelled in these areas, resulting in the opportunity to present its efforts at a State-wide conference, and being given "exemplary status" within a multi-state practice transformation network with further recognition of such at the national level.

Though much focus is put on "meeting targets," "gaining incentives/avoiding penalties," "comparing with Health Plans" and being prepared for what the future might hold, we do not lose sight of the principal behind all of this work: providing the finest integrated quality of care for persons served within a stable, collaborative and constructive environment.

For 2019, MCN's quality activities will continue to focus on these aims: 1) utilizing data and best practices to enhance quality clinical practices 2) ensuring readiness for involvement in alternative payment methodologies and changes in the structure of the CMH system, and 3) promoting a supportive, collaborative culture at MCN.

Respectfully Submitted by the QAPIP Steering Committee:

Tammy Warner, Executive Director
Julianna Kozara, Clinical Director
Jim Wise, Finance Director
Gwen Alwood, Acute Services Manager
Joel Sneed, Transitional Services Manager
Liz Ingraham, Children's Services Manager
Dawn Herriman, Community Services Manager
Sally Culey, Quality & Information Services Director
Melissa MacLaren, Integrated Health Nurse Manager
Bill Mason, Information Technology Coordinator
Jan Krings, Human Resources Coordinator
Dawn Caruss, Fiscal Manager
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 Evaluation and 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: previous year's achievements, future goals, aggregate data on utilization and quality of services rendered, and assessment and description of processes to ensure effectiveness and efficiency of QAPI-related practice The QAPIP, in alignment with MCN's quadruple aim of Better Care, Better Outcomes, Better Value and a Collaborative, Effective Workforce, supports MCN's mission to be the provider of choice for residents of the county—as well as one that is readied for the future.

Appendix A: MCN Strategic Plan 2017-2020 Quadruple Aim

Many of the specific data points referenced in this plan are included in summary on the MCN 2018 Performance Measures Dashboard. Full data reports and related QAPI activities are managed and maintained by the various committees within the QAPIP organizational structure and are available to all agency staff via committee minutes and reports packets.

Appendix B: MCN 2018 Performance Measures Dashboard

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 be the integrated care provider of choice for the residents of Montcalm County by delivering services and supports that result in better care, better outcomes and better value for those we serve.

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 services are evidence based and maximize the use of technologies in providing individualized care that is efficient and effective.

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, and contributes to overall health and wellness.

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 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.

Linking Process Design and Performance Improvement

The Juran Trilogy[1] provides a framework for linking process design with performance improvement. It provides the following three interrelated processes:

1. ***Quality Planning –*** creating a process that will be able to meet established goals and do so under operating conditions. Careful planning to ensure that consumer needs are met must occur before implementing a new process, program, or service. Often, existing performance measures identify the need for a new service or process, which is then incorporated into formal strategic planning. Environmental observations may also reveal opportunities as well as new initiatives at State or National levels. The more revolutionary the new process, service, or program is, the more time and energy will be required to adequately plan and implement it. Included in the planning phase should be an assessment of the organization's current internal competencies and capabilities, and whether additional inputs (staff, skills, equipment, etc.) need to be acquired. Prospective performance measures are developed and then, after the initial launch period, are reviewed whenever a new process, service, or program is launched. Planning initiatives will often occur in a cross-functional work group.

2. ***Quality Control –*** following the planning, the process is turned over to the operating forces. It is their responsibility to run the process at the optimal effectiveness. The appropriate department or committee will utilize ongoing performance measures to evaluate the new initiative. Included in the scope of data collection are the processes that involve risks or may result in sentinel events. Performance should be compared to similar organizations whenever possible.

3. ***Quality (Performance) Improvement*** **– the process for developing unprecedented levels of** performance. The ongoing performance measures may identify an opportunity to improve the program, process, or service. Examples of improvements that may be identified include: improving clinical outcomes, increasing response times, decreasing waste, or improving stakeholder perception (i.e., consumer satisfaction). Performance improvement should utilize a narrow focus on incremental and evolutionary change and constrain working time to less than six months. Cross-functional work groups are generally convened to address the specific performance improvement initiatives.

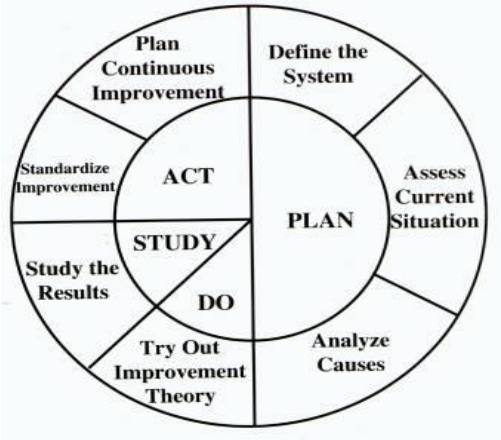
Malcolm Baldridge Health Care Criteria for Performance Excellence Framework provides an integrated systems perspective framework model for performance improvement (see Figure 1).

> "The ***Organizational Profile*** (top of figure) sets the context for the way the organization operates. The environment, key working relationships, and strategic challenges serve as an overarching guide for the organizational performance management system.
>
> ***Leadership*** (Category 1), ***Strategic Planning*** (Category 2) and ***Focus on Patients, Other Customers and Markets*** (Category 3) represent the leadership triad. These categories are placed together to emphasize the importance of a leadership focused strategy and patients/customers. Senior leaders set the organizational direction and seek future opportunities for the organization.
>
> ***Staff Focus*** (Category 5), ***Process Management*** (Category 6) and ***Organizational Performance Results*** (Category 7) represent the results triad. The organization's staff and its key processes accomplish the work of the organization that yields performance results.
>
> All actions point toward ***Organizational Performance Results***—a composite of health care, patient and other customer, financial and internal operational performance results, including staff and work systems results and social responsibility results.
>
> The horizontal arrow in the center of the framework links the leadership triad to the results triad, a linkage critical to organizational success. Furthermore, the arrow indicates the central relationship between ***Leadership*** (Category 1) and ***Organizational Performance Results*** (Category 7). The two-headed arrow indicates the importance of feedback in an effective performance management system.
>
> ***Measurement, Analysis and Knowledge Management*** (Category 4) are critical to the effective management of the organization and to a fact-based system for improving health care and operational performance. Measurement, analysis and knowledge serve as a foundation for the performance management system."[2]

Performance Improvement Plan Development and Implementation Cycle

The Plan-Do-Study-Act (**PDSA**) Cycle[3] provides a precise method for committees, work groups, and performance improvement plan developers to focus their efforts (see Figure 2).

Figure 2.



Three underlying questions should be kept in mind during the use of the PDSA Cycle in order to develop improvement ideas and plans.

A. What are we trying to accomplish?
- This should be time-specific and measurable
- Define the specific population to be affected

B. How will we know that a change is an improvement?
- Determine quantitative measures that will allow demonstrable change leading to improvement
- Use a balanced set of measures for all improvement efforts; measures include:
  1. Outcome Measures: How is the system performing? What is the result?
  2. Process Measures: Are the parts/steps of the system performing as planned?
  3. Balancing Measures: Are changes designed to improve one part of the system causing new problems in other parts of the system?

C. What changes can we make that will result in improvement?
- All improvement requires change; not all change results in improvement
- Identify changes most likely to result in improvement

Plan:
1. Define the current situation or system: understand the processes or systems that will be improved; state the objective of the test; gather baseline data for definition of the system.
2. Assess the current situation: Gather data to describe the processes as they are currently working; make predictions about what will happen and why.
3. Analyze causes: identify causes of the variation or problems and develop theories to address these (Who? What? When? Where?)

Do:
1. Try out theory for improvement of the current situation or system: test on a small (pilot) scale
2. Document problems and unexpected observations
3. Begin analysis of the data

Study:
1. Study the results: determine the impact of the intervention using quantitative data; compare resulting data to predicted results.
2. Summarize and reflect on what was learned.

Act:
1. Standardize the action: if the theory for improvement tested successfully, apply it more widely throughout the system; if not, refine the change—determine what modifications should be made.
2. Plan for ongoing improvement: Continue to gather data and monitor the process for continuous quality improvement or select another process to address.

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.)

REFERENCES:

[1] Juran, J.M. 1986. The Quality Trilogy: A Universal Approach to Managing for Quality p. 3-4 http://pages.stern.nyu.edu/~djuran/trilogy1.doc

[2] Baldridge National Quality Program 2003 Health Care Criteria for Performance Excellence p. 5-6

[3] Scholtes, P.R. 1991. The Team Handbook Madison, WI: Joiner Associates, Inc. p. 5-31

IV. QAPIP Organizational Structure

MCN QAPIP Committee Structure & Membership 2019

Board of Directors

Executive Director
Tammy Warner

Steering Committee
Sally Culey, Quality & Information Services Director (Chair)
Melissa MacLaren, Integrated Health Nurse Manager
Liz Ingraham, Children's Services Manager
Julianna Kozara, Clinical Director
Angela Loiselle, Recipient Rights Officer
Bill Mason, Information Technology Coordinator
Gwen Alwood, Acute Services Manager
Tammy Warner, Executive Director
Dawn Herriman, Community Srvs Mgr
Jan Krings, Human Resources Coordinator
Joel Sneed, Transitional Services Manager
Dawn Caruss, Fiscal Manager
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)

Dawn Herriman, Community Srvs Mgr
Dr. Razvan Adam, Psychiatrist
Terra Bazzi, 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 Warner, 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 Dir (Consultant)
Tammy Warner, Executive Director (Consultant)

Consumer Care Committee
Liz Ingraham, Children's Srvcs Mgr (Chair)
Tracey Clark, Adult Services Rep
Julianna Kozara, Clinical Director
Dr. David Lyon, Medical Director (Consultant)
Jodi Busscher, Access Specialist
Theresa Hedrick, Children's Srvcs Rep
Beth Brundage, Peer Support Specialist
Melissa MacLaren, RN
Dawn Herriman, Community Srvs Mgr
Adam Stevens, Data Analyst
Gwen Alwood, Acute Svcs Mgr, Ad Hoc
Joel Sneed, Transitional Svcs Mgr, Ad Hoc
Sally Culey, Quality & Info Srvs Dir (Consultant)

Environment of Care
Steve Stanton, Maint/Facilities Coord (Chair)
Tanya Douglas, Adult Care Specialist

Carol Doyle, Consumer Registration Specialist
Elizabeth Gillson, Clubhouse Rep
Melissa MacLaren, Integrated Health Nurse Manager
Jim Young, Wellness Center Team Leader
Sally Culey, Quality & Info Srvs Dir (Consultant)

Quality Of Work Life
Leigha Harris, Employment Connections (Co-Chair)
Angela Loiselle, Recipient Rights Officer (Co-Chair)
Jackie Burns, Peer Support Specialist
Carol Dimet, Peer Support Specialist
Melissa Bolanos, Adult Care Specialist, Team Leader
Brittany Kindig, Home Based
Laura Shattuck, Medical Assistant
Bill Mason, IT Coordinator
Raeann Borton, Medical Records Specialist
Tammy Warner, 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.

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 and 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.

Appointment and Membership

- Every administrative staff member is a career-long member of the Steering Committee. Additional members, including representatives from Standing Committees, may be assigned as determined by 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 on the network to be accessible by the entire staff. 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

It is the expectation within the culture and practice of the organization, that all staff, teams, programs, committees and workgroups strive to identify improvement opportunities and work to improve practices and systems through their day to day activities. The QAPIP Steering Committee is responsible for

making available the tools these staff/teams need: providing ongoing information, training and access to needed resources, and empowerment in support for their efforts.

Under the formal QAPIP structure:

- 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 on the network to be accessible by the entire staff.
- 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 appropriate channels, ie., staff meetings, email, etc..

V. Requirements Related to Performance Improvement

Commission for the Accreditation of Rehabilitation Facilities (CARF)

As part of its contract with MDHHS, and to promote quality clinical and administration services, MCN has pursued for several years accreditation from an external entity. In 2014, MCN successfully achieved its first 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.

In 2017, MCN accredited the following programs under CARF. Accreditation is good through April 2020. Two programs have since been discontinued as noted:

- Assertive Community Treatment (ACT) (program was discontinued mid-year 2017)
- Assessment & Referral (Access Services—new for 2017 accreditation)
- Case Management/Services Coordination (CSM/SC)
- Community Integration: Psychosocial Rehabilitation (Heartland House Clubhouse)
- Crisis Intervention (Emergency Services)
- Integrated Behavioral Health/Primary Care (new for 2017 accreditation, and discontinued mid-year of 2018 with the closing of the Health 360 Clinic.)
- 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.

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 through 2016/2017, included the following. These projects have been completed as of 2017/2018:

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

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The same requirements have been established by MDHHS for 2018-2020/2021, and the following are the selected projects:

- Diabetes Monitoring for People with Schizophrenia
- Recovery Performance Improvement: Administrative Review

Medicaid Event Verification

As mandated by MDHHS starting in 2015/2016, the PIHP conducts Event Verification processes of the CMHSPs. MSHN conducted two (2) on-site reviews in 2018 to review claims and claims reporting processes. As additional verification, MCN has implemented its own internal Event Verification processes that duplicate MSHN's review of claims, as well as conducts internal audits during the course of business should a question or issue arise that may warrant such. MCN works closely with MSHN to identify and correct errors, as well as improve claims reporting processes. MCN identifies trends of issues, following up with staff and contracted providers to make improvements to practices where indicated.

MDHHS Mission Based Performance Indicator System

The MDHHS requires reporting on indicators for the Michigan Mission Based Performance Indicator System, with 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 allowing CMHs to compare their performance to other CMHs across the state. The QAPIP Steering Committee and the PIHP Quality Council monitor achievement of minimum performance levels as established by MDHHS. Outliers and/or anomalies are analyzed with improvements as needed.

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.

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. MSHN provides quarterly Behavioral Treatment data reports, whereby MCN is able to compare itself to affiliate and MSHN averages. Improvement actions are identified regionally and locally. The MCN Behavioral Treatment Plan Review Committee reviews this data quarterly and makes recommendations or takes action on improvements as indicated.

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.

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.

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. Conducting all provider network monitoring functions in keeping with State and Regional requirements continues to grow in amount of detail and level of complexity. Processes generally include, but are not limited to, the following. MCN will continue to evaluate and refine its Provider Network Management processes during 2019.

- 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.
- Ensuring proper credentialing of provider staff.
- Ensuring proper training of provider staff.

- 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.
- Management of provider contracts and reviewing for compliance to contract requirements.

Corporate Compliance

Montcalm Care Network has developed a comprehensive Corporate Compliance program, including a plan, policies, and procedures for preventing, detecting, and reporting fraud and abuse. MCN works closely with the MSHN Corporate Compliance Officer, who in turn is closely linked to the Michigan Office of Inspector General, for information and consultation and to ensure proper reporting and follow up on compliance matters.

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. These mechanisms are clearly outlined in agency policies and procedures, which are available to providers in the MCN provider manual posted on MCN's website and are available to consumers in various brochures and notices.

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 Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network, 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 Health & Wellness, Tuscola Behavioral Health Systems.

MSHN Vision

To continually improve the health of our communities through the provision of premiere behavioral healthcare and leadership. MSHN organizes and empowers a network of publicly-funded community partnerships essential to ensure quality of life while efficiently and effectively addressing the complex needs of the most vulnerable citizens in our region.

MSHN QAPIP

MSHN implements and maintains a Quality Management system which includes processes for monitoring and oversight of its provider network. MSHN retains responsibility for developing, maintaining and evaluating its annual QAPIP Plan and Report in collaboration with CMHSPs of the region. Responsibility for implementation of the QAPIP is delegated to the CMHSPs, with oversight by MSHN. MCN implements the requirements of the MSHN QAPIP within its own local QAPIP and incorporates the MSHN Quality Management policy as Technical Requirement TR-5700-01 in MCN's Policy & Procedure manual.
The annual MSHN Quality Assessment and Performance Improvement Plan is available on the MSHN website.

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 2017/2018:

- 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 2019:

1. Meet on a monthly basis or more often as needed to fulfill responsibilities.
2. Implement modifications to the committee and its processes as advised by the State of Michigan and Mid-State Health Network.
3. Submit behavior treatment review data to MSHN for aggregation and analysis.
4. Review behavioral findings, both through the use of aggregate data reports as available and through individual case/anecdotal reviews as appropriate.
5. 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 Manager, Maintenance & Facilities Coordinator, Medical Director (consultant).
D. Meeting Schedule: Quarterly or more often as needed.

Activities and Accomplishments for 2017/2018:

- The Committee met in conjunction with the QAPIP Steering Committee quarterly meetings in 2018.
- There were 13 investigations during the year for alleged HIPAA and Medicaid Compliance concerns.
- Biannual MSHN Medicaid Claims Verification audit findings were reviewed.
- Annual Compliance Plan/Program was reviewed and approved by the Board in October 2018 which includes the agency Risk Management Plan.
- Annual staff compliance training was completed through Relias Learning.
- Annual IT Plan was reviewed and input provided.
- Discussion on IT staff activities related to upgrading of security, and reviewed results of annual Penetration Testing of MCN computer security systems.
- Reviewed & discussed 2019 requirements of the State Office of Inspector General (OIG) and MSHN policy/procedure for fraud & abuse compliance reporting & tracking as well as exclusion of disqualified providers.

Goals for 2019:

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, and implement internal 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.
7. Implement new fraud & abuse compliance reporting & tracking as well as exclusion of disqualified providers in accordance with State OIG and MSHN standards.

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 2017/2018:

- Bylaws were reviewed & updated.
- Customer Satisfaction Surveys were reviewed.
- MCN Performance Measure Dashboards were reviewed.
- MCN suggestion box items were reviewed and input provided.
- Annual Performance Improvement Project data reports were reviewed.
- Review of results of annual Clubhouse Member survey.
- MSHN Regional Consumer Advisory Council meetings were attended by Council representatives.
- Council members were recognized for years of service.
- Council members participated in the Walk-A-Mile event through the Clubhouse in May 2018.

Goals for 2019:

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 and programs. (Goal: As needed/requested)

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 data reports, conduct critical incident reviews and sentinel event reviews.
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, Peer Support Rep, Access Services Rep, Medical Director, RN, Data Analyst, Quality & Information Services Director (consultant).
D. *Meeting Schedule:* Monthly

Activities and Accomplishments for 2017/2018:

- Critical Incidents/Sentinel Events were reviewed and reported as required.
- Record Reviews quarterly data reports were reviewed and recommendations made for process improvements as indicated.
- Reviewed Utilization Management data, comparing service utilization measures to MSHN/affiliate averages; this included penetration rates, dispositions of eligible consumers, and hospital admission/readmission data.
- There were no wait lists to review for the year.
- Reviewed Procedure #8305F on Look-Alike/Sound-Alike Medications for any updates.
- Reviewed Performance Measurement dashboard & Key Performance Indicator reports and made recommendations for process improvements as indicated.
- Reviewed periodic reports on Consumer Experience/Satisfaction Survey results, including Core Program Annual Surveys, Access Experience with Care, Clubhouse Member Annual Survey, Health 360 Clinic surveys, and End of Services surveys.
- ➢ Reviewed local and regional Critical Incident & Risk Event reports.
- Reviewed Mortality Data—causes and trends of deaths for persons in services.
- Reviewed Access Timeliness and Call data.
- Membership was reviewed and representatives rotated for some; Children's Service Manager remains chairperson.
- Reviewed MSHN Grievance and Appeals reports.
- Reviewed MSHN Performance Improvement Projects, including local performance data and made recommendations for process improvements where indicated.
-
- Reviewed 2018 Michigan Customer Services Mystery Shopper results.
- Reviewed results from 2018 DBT MiFAST Review.
- Reviewed various data reports, including CAFAS/PECFAS, development of consumer-level data dashboards, and multiple reports implemented within PowerBI (Microsoft Office platform).
- Discussed ideas for programmatic use of funding.
- Discussed ideas related to consumer transportation needs.

Goals for 2019:

1. Review and monitor data reports, minimally:
   a. Record Reviews (Goal: Quarterly)b. Performance Measures/Key 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 & Call Data (Goal: Quarterly)

   h. Various data analytic reports, through use of PowerBI (Goal: Quarterly)
   i. Grievance & Appeals Reports (Goal: Quarterly)
   j. Regional Performance Improvement Projects data.

k. CAFAS/PECFAS Aggregate Reports (Goal: Annually)
l. Regional & Local Utilization Management reports (Goals: Quarterly)

2. Revise Utilization Management practices based on regional standardization of activities, including such activities as oversight of LOCUS exception reports, changes to service authorization processes, and new processes for review of prescreens and continuing stay reviews..
3. Evaluate findings from MiFAST evidence based practice reviews.
4. Identify agency & program performance outcomes for measurement, including revising processes for evaluating & monitoring Evidence Based Practices.
5. Annual review of agency procedure #8305F on Look-Alike or Sound-Alike Medications.
6. Conduct Critical Incident & Sentinel Event Reviews (As needed)

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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 Director (consultant).
D. *Meeting Schedule:* Quarterly

Activities and Accomplishments for 2017/2018:

- Discussed updates on buildings/facilities.
- Reviewed quarterly data reports related to safety, facility security and vehicle incidents, injuries and facility maintenance.
- Reviewed reports from building/facility inspections conducted by external parties.
- Evaluated annual staff flu vaccination rates and supported flu-prevention training for staff.
- 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 monthly.
- Product recalls are distributed regularly to staff when potentially applicable to agency, staff or consumers.
- The annual Hazard Vulnerability Analysis was completed for all locations: Stanton State Street and Main Street offices, Wellness Works, Clubhouse, and the Greenville and Howard City offices.
- Reviewed CARF Health & Safety Standards to ensure continued agency conformance to standards.
- The committee reviewed findings from external audits facility audits/maintenance inspections as they occurred.
- Reviewed materials and made recommendations on a new agency procedure regarding responding to an "Active Shooter" in the building and staff training on such.
- Discussed and supported Hepatitis A vaccination clinic to be held at MCN for staff and consumers.

Goals for 2019:

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 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 CARF accreditation Health & Safety standards to ensure continued agency conformance. (Goal: Annually)
8. Conduct a Hazard Vulnerability Analysis to identify and address risks in the environment. (Goal: Annually)
9. Evaluate staff influenza vaccination rate, reasons for declining vaccination and identify opportunities for further staff education on flu prevention. (Goal: Annually)
10. Disseminate product recall information to staff. (Goal: Weekly/As information obtained.)
11. Assess and assure appropriate health & safety practices at all MCN facilities 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:* Staff volunteers. Currently: Employment Specialist & Recipient Rights Officer (Co-Chairs), Adult Specialty Services, Children's Services, Peer Support Services, Medical Services, Medical Records and IT representatives; Executive Director (consultant).
D. *Meeting Schedule:* Monthly

Activities and Accomplishments for 2017/2018:

- MCN staff donated to various Montcalm County charities via fund-raising events organized by the QWL.
- Staff were recognized for years of service during the monthly General Staff meeting, and the end of the year Board/Staff meeting.
- Staff activities were provided on a monthly basis.
- Jeans Day fundraisers were conducted.
- Annual Staff Survey was completed.
- Collected United Way pledges.
- Implemented Employee of the Month, and Employee of the Year, awards.
- Implemented monthly Birthday Lunches with the Director.

Goals for 2019:

1. Plan one activity per month in appreciation of staff.
2. Survey staff annually for feedback and suggestions.
3. Conduct a monthly "jean day" fundraiser for charity.
4. Continue annual United Way fundraiser.
5. Continue Employee of the Month, and Employee of the Year, awards.
6. Continue supporting monthly Birthday Lunches with the Director.

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 2017/2018:

- 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.
- Reviewed quarterly ORR Formal Compliant Logs.

- Reviewed quarterly reports on ORR Activities.
- Reviewed quarterly aggregate data on Incident Reports.
- Reviewed annual and semi-annual State Recipient Rights data submissions.
- Reviewed agency Recipient Rights policies and procedures, ensuring compliance with MDHHS ORR standards.
- Membership was expanded to include more consumer and provider representatives.
- Reviewed and discussed potential impact of the 298 Workgroup Initiative.
- For annual appeal training, the committee received & reviewed an information packet containing materials for conducting RR appeals.
- Reviewed MDHHS ORR triennial on-site assessment report, in which MCN was found to be in full compliance.
- Kept apprised of MCN RR Officer coverage of RR duties for Gratiot County CMH while their ORR was on leave.

Goals for 2019:

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, and provide input on outcomes of the MCN ORR, including making recommendations as needed to the MCN Board of Directors. (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).
5. 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)
6. Review and provide feedback on all MCN RR policies. (Goal: Annually)
7. 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 Director (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 Manager, Maintenance & Facilities Coordinator, Medical Director (consultant).
C. *Meeting Schedule:* Quarterly, or more often as needed.

Activities and Accomplishments for 2017/2018:

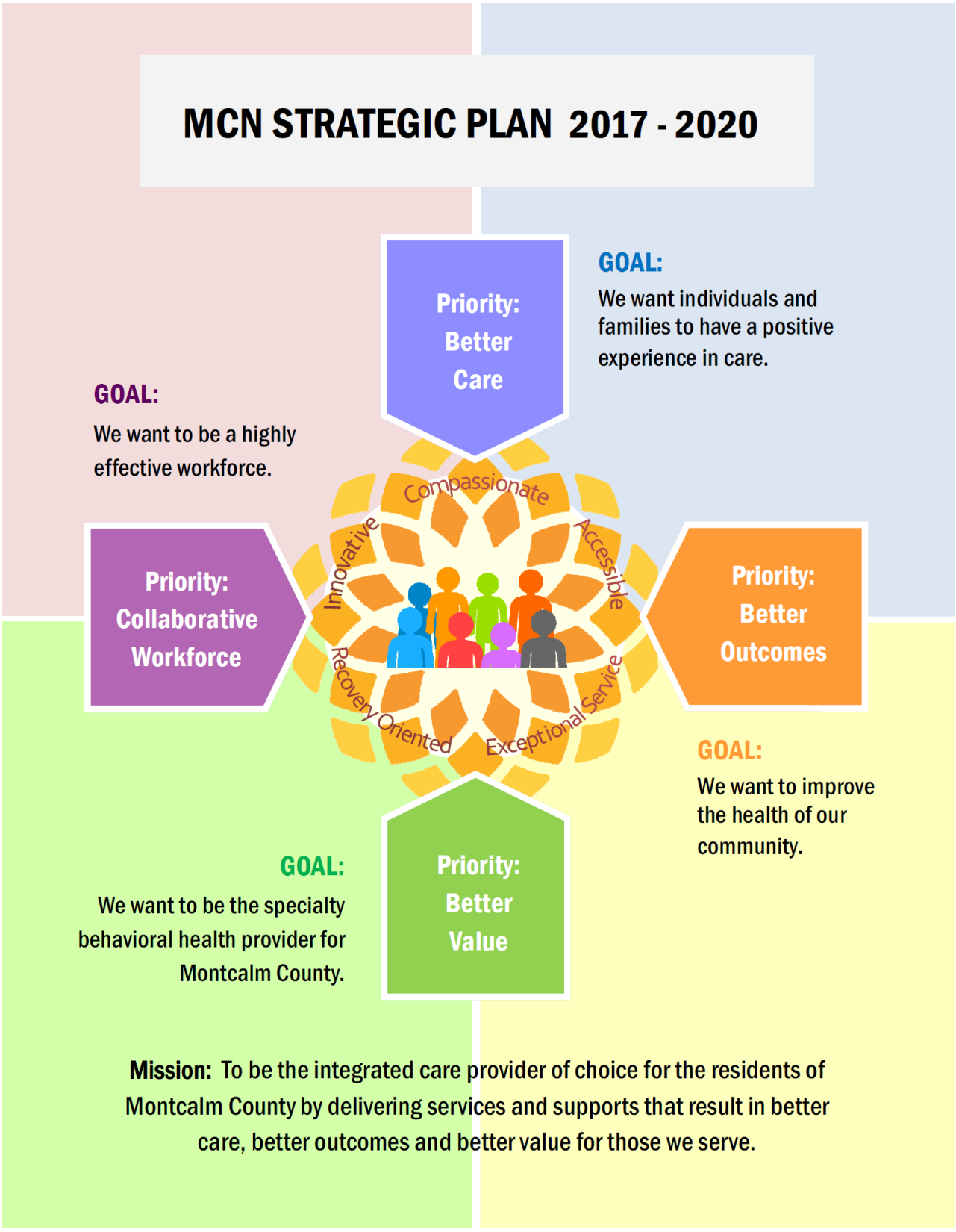
- Monitored standing committees and prioritized work efforts as needed.
- Provided an update on quality efforts at all General Staff Meetings. Continued processes & activities to promote of a culture of quality with the organization and discussed other methods for promoting based on focusing on improved consumer outcomes. Implemented us of Yammer (Microsoft Office feature) as a new means of staff communication & information sharing..
- Revised and implemented the annual Employee Survey; reviewed and responded to findings. Discussed ideas/plans for additional follow up and staff training.

- Sustained involvement of staff and consumers in quality system: In 2018, 35% of staff (37 of 107) participated on a quality committee or special workgroup (Goal: 25%). And 35% of positions on quality committees (21 of 59) were filled by primary and/or secondary consumers (Goal: 25%).
- Quarterly review of Performance Measurement reports.
- Annual QAPIP Assessment & Performance Improvement Annual Report was reviewed and recommended to the Board.
- Annual Accessibility Plan was revised and approved by the Committee.
- Annual Cultural Diversity Plan was revised and approved by the Committee.
- Annual Critical Event Annual Analysis was completed.
- Review of new MSHN Performance Improvement Project: Follow Up After Hospitalization.
- Review and discussion of new federal Merit-based Incentive Payment System (MIPS).

Goals for 2019:

1. Monitor standing committees and prioritize work efforts as needed. (Goal: Quarterly)
2. Communicate quality efforts to Board and staff, further promoting a culture of quality.
3. Continue to refine annual Employee Survey tool and review/respond to findings. (Goal: Annual)
4. Promote staff focus groups, or staff involvement in workgroups, related to agency changes (Goal: As new opportunities arise).
5. 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.
6. Conduct annual review of the QAPIP Assessment & Performance Improvement Annual Report.
7. Conduct annual review of the Accessibility Plan.
8. Conduct annual review of the Cultural Diversity Plan.
9. Conduct annual review of the Critical Event Annual Analysis.
10. Ongoing review of status on Performance Indicators.

Appendix A: MCN Strategic Plan 2017-2020 Quadruple Aim



Appendix B: MCN 2018 Performance Measures Dashboard

Montcalm Care Network - Performance Measures Dashboard

Key Performance Areas	Key Performance Indicators	Actual Value	Target Value (Target Set By)	Performance Level	Covered Period	Last Update
Better Care	Access Timeliness MMBPIS Performance Indicators (Prescreen Disposition, Follow Up to Hospitalization, Access to Services)	99.1%	95% MDHHS		10/1/17-9/30/18	12/11/2018
	Walk In Wait Time--Less than 30 mins	99%	95% MCN/MDHHS		12/1/2017-11/30/2018	12/10/2018
	Call Back Wait Time for Non-Urgent Requests for Service--Within 1 business day	98%	95% MCN/MDHHS		12/1/2017-11/30/2018	12/10/2018
	30 Day Follow-up After Psychiatric Hospitalization for MH - Adults (21+)	77%	58% MDHHS		12/1/2017-11/30/2018	12/10/2018
	30 Day Follow-up After Psychiatric Hospitalization for MH - Children (6-20)	80%	70% MDHHS		12/1/2017-11/30/2018	12/10/2018
	Diabetes Screening for Adults with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications (are at-risk for Metabolic disorders) (Actual Results)	94%	83% MHP		12/1/2017-11/30/2018	12/10/2018
	Diabetes Montioring for Adults with Schizophrenia and Diabetes: annual A1c & LDL testing (NEW) (Actual Results)	82%	56% Current MSHN Ave		12/1/2017-11/30/2018	12/10/2018
	Satisfaction with Level of Participation in Treatment/Treatment Planning (Consumer Surveys)	92%	85% MSHN		FY18 Surveys	6/4/2018
	Overall Satisfaction with Services (Consumer Surveys)	91%	85% MSHN		FY18 Surveys	6/4/2018
Better Outcomes	Improved Health: Percentage of IHLOC 4 Adult Patients with an Initial BMI of 30+ who were Losing Weight (Downward Trending Slope) During the Measurement Year	49.5%	50% MCN		12/1/2017-11/30/2018	12/10/2018
	Improved Health: Percentage of Adult Patients with Hypertension During their Initial Measurement Year BP Recording who are Trending to be Hypertension-Free One Year Out from the Initial Recording	67.8%	50% MCN		12/1/2017-11/30/2018	12/10/2018
	Improved Health: Percentage of IHLOC 4 Children Patients with an Initial BMI of 30+ who were Losing BMI (Downward Trending Slope) During the Measurement Year	50.0%	50% MCN		12/1/2017-11/30/2018	12/10/2018
	Improved Functioning-Children: Percentage of Children with Improved CAFAS Scores (Homebased>=20 points, Outpatient >= 0 points) from Initial Two Assessments to Most Recent Assessment	61.1%	60% MCN		12/1/2017-11/30/2018	12/10/2018
	Improved Functioning-Adults: Percent of Patient's with an Active Depression Diagnosis who were Trending Downwards in PHQ-9 Scores During the Measurement Year	60.2%	60% MCN		12/1/2017-11/30/2018	12/10/2018
	Decreased Emergency Department Use: Decrease in ED Visits from Six Months Prior to MCN Services to Six Months During/Post MCN Services for Newly Opened Consumer in Service at Least 60 Days	42.9%	TBD		7/1/2017-7/30/2018	12/10/2018
Better Value	Cost Per Case: Percent Above or Below (-) MSHN Average Cost Per Case (Medicaid)	-18%	At or Below MSHN Ave		FY17 Rates	6/4/2018
	Cost Per Case: Percent Above or Below (-) MSHN Average Cost Per Case (HMP)	31%	At or Below MSHN Ave		FY17 Rates	6/4/2018
	Cost Per Case: Percent Above or Below (-) MSHN Average Cost Per Case (Autism)	-75%	At or Below MSHN Ave		FY17 Rates	6/4/2018
	Cost per Unit: Percent Above or Below (-) MSHN Average Cost per Unit (for 11 key services/service codes)	22%	At or Below MSHN Ave		FY17 Rates	3/30/2018
	Increased Productivity: Percent Change Year over Year	-2.1%	3% MCN		11/2017 - 11/2018	12/10/2018
	Estimated Medical Cost Savings from Decreased Emergency Department Use (positive is cost savings)	$14,796	TBD		7/1/2017-7/30/2018	12/10/2018
Collaborative-Effective Workforce	Timeliness of Documentation: Documents Signed in Under 24 Hours	83%	95% MCN		9/1/2018 - 11/30/2018	12/10/2018
	Reported Recognition of Efforts (Employee Survey)	71%	80% MCN		FY18 Survey	12/11/2018
	Reported Positive Work Environment (Employee Survey)	79%	85% MCN		FY18 Survey	12/11/2018