Quality Assessment & Performance Improvement

Annual Report

2022 Program Evaluation
2023Program Plan

Board Approved: 1/24/23

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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 2021/2022, and the basis for performance improvement for 2023.

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.

Accomplishments, activities, and highlights from FY2021/2022 were many and varied, much due to "post-pandemic" responses to agency and community needs, including:

-A focus on workplace culture and workforce cohesiveness, communication, and compassion. CE-CERT training was provided for clinical staff on preventing/managing secondary trauma.

-Efforts to recognize and embrace diversity of persons served and staff, and providing Safe Zone & Implicit Bias training for all staff; and identifying ways to improve sensitivity in practices, such as how & when affirmed names and preferred pronouns are used within the electronic health record and in MCN practices.

-Expansion of crisis services with the implementation of Mobile Crisis Services, as well as a grant project providing tablets to the State police department for officer use to connect readily with MCN crisis workers to assist with crisis situations in the field; and MCN involvement in quarterly public safety meetings.

-Conceptualization and initiation of services and supports for persons with Substance Use Disorders, including new programs of Integrated Dual Diagnosis Team (IDD) and Medication-Assisted Treatment (MAT), and making significant increases in the distribution of Narcan kits in the community.

-Expansion of services in the schools; implementation of Integrated Systems Framework (ISF) with Central Montcalm Public Schools; participation in a Behavioral Threat Assessment.

-Establishment of an onsite pharmacy for use by persons served and staff; expanded Customer Services office; and expanded MCN Human Resources.

-Discussions and projects around Social Determinants of Health (SDOH) & Health Equity: identification of "Equity" as the central part of MCN's Strategic Plan Quadruple Aim, and implementation of a focused project within MCN's new Utilization Management Committee to identify further actions MCN may take to better address gaps in services or supports that lead to poor health outcomes and inequity in access to services.

-Utilization of analytics and use of Health Status data of persons served to develop a predictive model identifying factors affecting a person's perception of their mental health.

This coming year is expected to include further development of many of the above initiatives, including full implementation of the IDDT and MAT programs, further roll out of the use of tablets with all police departments in the county, as well as continued attention to workplace culture and staff health and safety. MCN is also in the process of obtaining the status of a Behavioral Health Home (BHH) by April of 2023. This initiative will provide coordinated mental, physical and social services to identified adults with serious mental health and multiple chronic health conditions. New services and supports will include onsite lab services, a Spravato clinic to administer this specialty medication to persons with treatment-resistant depression, new roles for involved staff and result in building and space needs. Additionally for 2023, MCN is seeking its triennial CARF accreditation, and is prepared to respond to the potential effects on services of funding with the Department of Health & Human Services' reinstitution of Medicaid eligibility redetermination. Regardless of what 2023 may bring, MCN will continue to ensure quality supports and services for persons served and the community.

Respectfully Submitted by the QAPIP Steering Committee:

Tammy Warner, Executive Director
Julianna Kozara, Clinical Director
Jim Wise, Finance Director
Gwen Alwood, Acute Services Manager
Tara Allen, Outreach Manager
Joel Sneed, Transitional Services Manager
Liz Ingraham, Children's Services Manager
Dawn Herriman, Community Services Manager
Sally Culey, Quality & Information Services Director
Will Overton, I/DD Community Services Manager
Melissa MacLaren, Integrated Health Nurse Manager
Terry Reihl, Information Technology Manager
Nicole Kipp, Human Resources Manager
Joseph Cappon, Quality Analyst
Dawn Caruss, Fiscal Manager
Matt Stevens, Maintenance & Facilities Coordinator
Angela Loiselle, Recipient Rights Officer
Dr. Razvan Adam, 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 Quadruple Aim

MCN has established performance measures and utilizes data reports across its service programs and business practices. Some measures were identified by MCN itself to assess areas of interest or for improvement, while others are regional, State or accreditation requirements. The information is utilized for different purposes:

- ✓ Informative: such as showing number of persons served, or status of programs (dashboard reports, documentation timeliness, and service cost reports) for information & reference purposes only.
- ✓ Evaluative: showing the level of success or status of an identified area of interest to be used to make decisions on service delivery or business practices; such as whether depression scale scores decrease following services or determining any themes of concern raised by persons served in satisfaction surveys that will be addressed.
- ✓ Predictive: showing possible future trends or improvements based on specific known data elements, to allow for future program and business planning; such as a trend in the increase of individuals served in a specific program may be cause to consider changes needed to increase program capacity in the future.

Many 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. Other data reports are specifically distributed for individual staff, manager or program/department use.

Appendix B: MCN Program & Business Practice Outcomes
Appendix C: MSHN Priority Measures

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 health status, quality of life, and satisfaction of persons served.

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 persons served
- 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 persons served
- Assuring that rights of persons served are preserved
- Supporting and strengthening the skills of staff members
- Promoting a "culture of quality"—that quality is the responsibility of every staff, every day and quality improvement is part of everyday business.

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 the needs of person served 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., satisfaction of persons served). 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.

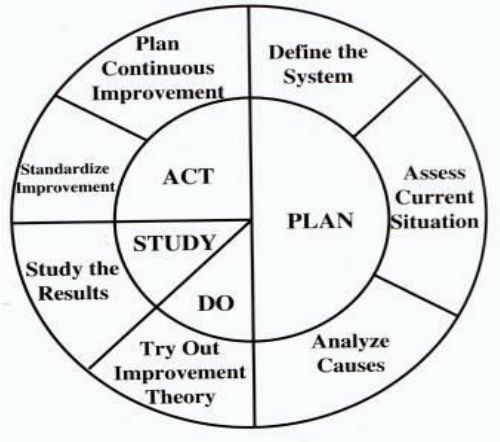
Malcolm Baldridge Health Care Criteria for Performance Excellence Framework provides an integrated systems perspective framework model for performance improvement (see Figure 1).

> "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 safety of persons served.
- 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 persons served 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 persons served 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 person served) and policy formulation and planning. Additionally, the information is extremely valuable from a comparison perspective (i.e., benchmarking, best practice development, etc.)

REFERENCES:

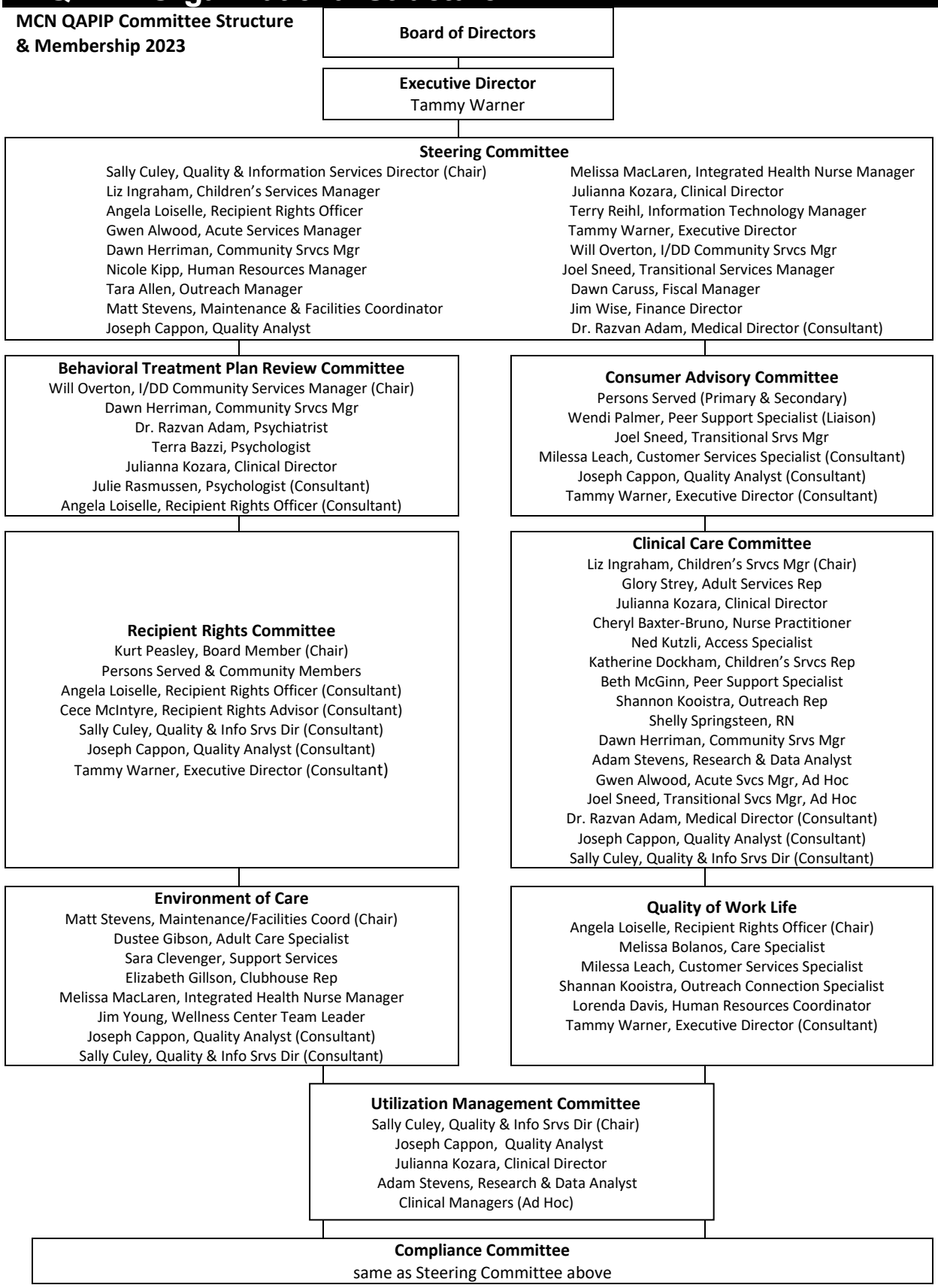
[1] Juran, J.M. 1986. The Quality Trilogy: A Universal Approach to Managing for Quality p. 3-4 http://pages.stern.nyu.edu/~djuran/trilogy1.doc

[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 2023



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, data and program presentations from the QAPIP describing actions taken, progress in meeting objectives, and improvements made. In addition, 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 & information Services Director 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 focused on process and persons served.

Persons Served

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

- Persons served have a voice through satisfaction & treatment surveys. The organization collects data on their perception of care, treatment, and services including their specific needs and expectations, how well the organization meets those needs and expectations, and how the organization can improve their safety.

- Persons served 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 , for, and about persons served.
- There is involvement of persons served on the Recipient Rights Advisory standing committee and on the Board of Directors.
- At various times, input from persons served 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 & Information Services Director 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 may be provided to Board Members through the Director's Report or special data presentations, or through the Board's Program Committee.
- An annual report will be provided for review and approval of Board Members.
- The Quality & Information Services Director shall be responsible for proper management and storage of 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:

- Persons served can communicate directly to the Quality & Information Services Director, the Quality Analyst and the QAPIP Steering Committee an opportunity for improvement, or can submit suggestions via use of suggestion boxes located in the lobbies of MCN offices.
- MCN encourages staff to report opportunities for system improvement through their supervisor, the Quality & Information Services Director, the Quality Analyst or any QAPIP Steering Committee member.
- Suggestions for system improvements may also be submitted on the annual agency Employee Survey, or by use of the "Perspective" link on MCN's intranet—a method for staff to submit comments, ideas, and feedback.

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 satisfaction of persons served.
- 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 satisfaction of persons served?
- 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 or minute takers shall provide the Quality & Information Services Director or Quality Analyst 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 & Information Services Director or designee 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 & Information Services Director or Quality Analyst 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 & Information Services Director or Quality Analyst 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 & Information Services Director or Quality Analyst 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 accreditation for several years 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 and business practices 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 February of 2020, MCN received its third straight 3-year accreditation. CARF will conducting a resurvey with MCN in 2023. The programs currently accredited are:

- Assessment & Referral
- Case Management/Services Coordination (CSM/SC)
- Community Integration: Psychosocial Rehabilitation (Heartland House Clubhouse)
- Crisis Intervention (Emergency Services)
- Intensive Family-Based Services (Home Based Services)
- Outpatient Treatment

MCN also meets CARF standards in all of the following business areas:

- Leadership
- Strategic Planning
- Input from Persons Served and Other Stakeholders
- Legal Requirements
- Financial Planning and Management
- Risk Management

- Workforce Development and Management
- Technology
- Rights of Persons Served
- Accessibility
- Performance Measurement and Management
- Performance Improvement

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

Cultural Diversity, Inclusion & Equity

MCN has an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the MCN service area. Such commitment includes acceptance and respect for the cultural values, beliefs and practices of the community, while competence is demonstrating the ability of our providers, and the organization as a whole, to effectively deliver services to persons with diverse values, beliefs, and behaviors, including tailoring delivery of those services to meet their social, cultural and linguistic needs.

MCN requires trainings for *all* staff and providers in cultural competence minimally annually. Ongoing staff training and conversations help staff to understand, appreciate and respect differences and similarities in beliefs, values and practices within and between cultures, and within the organization and the community.

MCN also has an established Cultural Competency and Diversity Plan that addresses how the organization will respond to the diversity of persons served and other stakeholders. The Plan outlines policies, procedures, knowledge, skills and behavior that will enable and support personnel to identify diversity within the community and their workplace and provide inclusive and equitable services and supports. The plan outlines annual goals of the organization to improve its competence in a number of areas, including: accessibility of services, referral and screening processes, person/family centered planning, in informative materials, staff and provider training, community education and training, and sensitivity to staff values.

Within the Cultural Competency and Diversity Plan, MCN's Utilization Management Committee, and various other avenues, MCN conducts efforts to positively impact Social Determinants of Health and improve Health Equity within the community and those seeking or in need of behavioral health services. MCN identifies "Equity" within the core of its Strategic Plan Quadruple Aim (reference Attachment A.)

Practice Guidelines

MCN utilizes nationally accepted and mutually agreed upon clinical practice guidelines including Evidenced Based Practices (EBP) to ensure the use of research-validated methods for the best possible outcomes for service recipients as well as best value in the purchase of services and supports.

Practice guidelines include clinical standards, evidenced-based practices, practice-based evidence, best practices, and promising practices that are relevant to the individuals served. The process for adoption, development, and implementation is based on key concepts of recovery, and resilience, wellness, person centered planning/individual treatment planning and choice, self-determination, and cultural competency. Practices will appropriately match the presenting clinical and/or community needs as well as demographic and diagnostic characteristics of individuals served. Practice guidelines utilized are an MCN driven process in collaboration with the MSHN Councils and Committees. Practice guidelines are chosen to meet the needs of persons served in the community and to ensure that everyone receives the most efficacious services. MCN ensures the presence of documented practice skills including motivation interviewing, trauma informed care and positive behavioral supports.

Practice guidelines are monitored and evaluated through MSHN's site review process. Information regarding evidenced based practices are reported through the annual assessment of network adequacy. Fidelity reviews are conducted and reviewed as part of MCN's quality improvement program and as required by MDHHS.

Autism Benefit

MSHN oversees provision of the autism benefit within its region. MSHN delegates to MCN the application of the policies, rules and regulations as established. MSHN assures MCN maintains accountability for the performance of the operational, contractual, and local efforts in implementation of the autism program. MCN participates in compliance audits at least annually with MSHN and MDHHS, as well as provides data on the performance of the autism benefit consistent with the Michigan Managed Specialty Supports and Services Early Periodic Screening, Diagnosis and Treatment (EPSDT) State Plan and reviews this data monthly to

quarterly with MSHN and conducts ongoing improvements at the system- and persons served -level. This data is shared with MDHHS as required, for reporting individual-level and systemic-level quality improvement efforts.

Benefit eligibility is managed through MSHN in a review of clinical content and then submitted to MDHHS for Applied Behavior Analysis (ABA) service approval. Re-evaluations address the ongoing eligibility of the aut ism benefit participants and are updated annually. All providers of ABA services are required to meet credentialing standards as identified in the EPSDT benefit and Michigan Medicaid Manual to perform their functions.

Trauma Informed System of Care

In compliance with MDHHS Trauma Policy, MCN has adopted a trauma informed culture including the following: values, principles and the development of a trauma informed system of care ensuring safety and preventing re-traumatization. MCN has developed processes for screening and assessing each population for trauma, adopts approaches to address secondary trauma for staff and utilizes evidenced based practices or evidence informed practice to support a trauma informed culture. An organizational assessment is completed every three years to evaluate the extent to which MCN policies and practices are trauma informed. Organizational strengths and barriers, including assessment of the building and environment to prevent re-traumatization, are identified for improvement efforts.

Health and Welfare

MCN assures the health and welfare of its service recipients through service delivery by establishing standards of care for individuals served. These standards of care are evidenced in individual program standards, performance measures, assessment practices, service protocols, and monitoring and auditing practices. MCN ensures these standards are consistently provided in a manner that considers the health, safety and welfare of not just persons served, but also their family, providers and other stakeholders.

Other practices include:

- Maintaining an established Recipient Rights Office and Customer Services staff;
- Using various types of background checks, credentialing process, approved training curriculums for providers, monitoring and auditing practices of providers and services, including utilizing sanctions or termination for those consistently not meeting standards;
- Reporting and analyzing adverse events and identified risk factors;
- Maintaining an effective infection control plan;
- Maintaining comprehensive policies and procedures related to medication prescribing, consent, monitoring of side effects and documentation;
- Implementing a comprehensive emergency response system, including staff training and drills;
- Collecting information on the health conditions, health status and current health care providers of persons served; providing integrated health services when indicated; and coordinating care with other health care providers.

MCN, as a member of MSHN's Utilization Management Council, monitors population health through data analytics to identify adverse utilization patterns and to reduce health disparities.

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.

Utilization Management

Montcalm Care Network has policies and procedures for evaluating 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. MCN's Utilization Management Committee is responsible for oversight on practices and processes related to these evaluation and monitoring processes; management of reviews; assessing utilization of services according to guidelines; identifying and correcting over/under utilization; and assuring adequate practices in place for evaluating data to ascertain the effects of services and programs. Reasoning for service decisions is clearly documented and available to persons served. Appeal mechanisms exist for both providers and persons served 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 persons served in various brochures and notices.

Behavioral Treatment Review

As per the MDHHS Behavioral Treatment Technical requirement, MCN together with the MSHN, 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. Data collected generally includes:

- Dates and numbers of behaviors that occurred and interventions used, and settings where they occurred.
- Observations about any factors that may have triggered the behavior.
- Documentation of the analysis performed to determine the cause of the behaviors that precipitated the interventions, and description of positive behavioral supports used.
- Behaviors that resulted in termination of the interventions, and length of time of each intervention.
- Staff development and training and supervisory guidance to reduce the use of these interventions.
- Review and modification or development, if needed, of the individual's behavior plan.

MSHN delegates to MCN the collection of feedback from stakeholders on the effectiveness of the Behavior Treatment Committee, which is reviewed annually.

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.

Quality Improvement System for Managed Care-Performance Improvement Projects

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 (PIPs). Said projects focus on achieving demonstrable and sustained improvement in services likely to have beneficial effects on health outcomes and satisfaction with services. Topics identified for potential projects are to be prioritized and selected based on stakeholder input and are to 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 persons served and has a potentially significant effect on quality of care, services, or satisfaction.
- Compliance: Adherence to law, regulatory, or accreditation requirements.

For the 2018-2021 required projects, 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 continued to require a second project of the PIHPs choice. MSHN's two selected projects for this past three years period included:

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

For the 2022-2024 period, MDHHS again requires two projects, both associated with access to services, with one related to racial or ethnic service disparities, and one preferred to be related to current MDHHS's performance indicators. MSHN's two selected projects identified for the period of 2022-2024 are:

- Reduction or elimination of racial or ethnic disparities between the penetration rates of the black/African American population and white population.
- Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population.

Provider Network Monitoring

Montcalm Care Network has policies and procedures establishing processes for monitoring its subcontracted provider network, which is a delegated managed care function from the PIHP. Conducting all provider network monitoring functions in keeping with State and Regional requirements continues to grow in amount of detail and level of complexity. MCN conducts a combination of in-person, virtual and desk auditing of its contracted providers, and utilizes an electronic provider monitoring module, allowing for a more efficient means of monitoring, tracking and reporting.

Provider monitoring processes generally 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..
- 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.
- Inclusion of contracted provider claims in quarterly MCN Event Verification audits to ensure compliance with billing and documentation requirements.

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 an electronic source/application.
- 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 an electronic source/application.
- 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 (e.g., customer satisfaction surveys, customer service complaints, service and documentation data, etc.) is available for review during the privileging and re-privileging processes as relevant.

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.

Medicaid Event Verification

As mandated by MDHHS, the PIHP conducts Event Verification processes of the CMHSPs. MSHN annually conducts two (2) audits to review claims and claims reporting processes. As additional verification, MCN conducts its own internal Event Verification processes twice annually that duplicate MSHN's process of review of claims, as well as conducts internal audits during the course of business to ensure completeness of documentation and billing, as well as at times when a question or issue arises that may warrant such. MCN works closely with MSHN to identify and correct errors, as well as improve claims reporting processes. Where trends are identified, MCN follows up with staff and contracted providers to make improvements to practices where indicated.

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, and 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 (https://midstatehealthnetwork.org).

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, most supportive, 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), Clinical Director, Quality Director or Quality Analyst (consultants), and/or others as appointed by the Executive Director.
D. *Meeting Schedule:* At least monthly or more often as needed

Activities and Accomplishments for 2021/2022:

- 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 2023:

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, I/DD Community Services Manager, Acute Services Manager, Outreach 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 2021/2022:

- The Committee met in conjunction with the QAPIP Steering Committee quarterly meetings in 2022.
- The Compliance Investigation log was reviewed quarterly, which consisted of a total of 18 investigations during the year for alleged HIPAA, Medicaid, or other Compliance concerns.
- Biannual MSHN Medicaid Claims Verification audit findings, and biannual MCN internal claims verification findings were reviewed, and applicable actions taken.
- Annual Compliance Plan/Program was reviewed and approved by the Board in October 2022 which includes the agency Risk Management Plan.
- The Risk Management Plan was periodically reviewed for monitoring status of actions taken.
- Periodic review of Provider Network monitoring activity and reports.
- Annual Board compliance training was completed at the October 2022 Board meeting.
- 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, training efforts, and updates to the MCN disaster recovery plan; and reviewed results of annual Penetration Testing of MCN computer security systems.

- Reviewed & discussed Regional Compliance Committee activities and discussions, including ongoing updates to State Office of Inspector General (OIG) reporting requirements & OIG auditing practices.

Goals for 2023:

1. Review complaints and investigations logs for appropriateness of response. (Goal: Quarterly)
2. Monitor compliance in focus areas, specifically review of findings of MSHN and internal Event Verification audits. (Goal: Quarterly)
3. Review reports from Provider Network monitoring activities of MCN provider network to monitor provider compliance with contractual and regulatory requirements.
4. Assure annual review and Board approval of the Compliance & Risk Management Plan, and implementation of Risk Management Plan.
5. Review and approve annual IT Plan.
6. Monitor IT Systems Compliance & Security matters.
7. Assure annual staff training in the areas of corporate compliance and IT compliance & security.
8. Keep apprised of regional, state and federal compliance activities and requirements, and ensure MCN processes and procedures are updated accordingly.

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 efforts/contributions of persons served to the mental health system; review reports of satisfaction of persons served and program/agency performance data; review informational materials provided to persons served; create community awareness through outreach activities; provide input on programs and services; and, participate in the Regional (MSHN) Consumer Advisory Council.
C. Representation:
   - All persons served(have ever received public mental health services) and secondary users of services (family member or guardian of a person served) by Montcalm Care Network are welcome to attend any meeting.
   - Members, representing all populations served (MI, I/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. The Customer Services Specialist and Quality Analyst act as consultants to the Council.
D. Meeting Schedule: Bimonthly

Activities and Accomplishments for 2021/2022:

- Bylaws were reviewed & updated.
- Customer Satisfaction Surveys were reviewed.
- Meeting with Executive Director, and periodic discussions within committee, on status of COVID-19 and MCN service provision.
- Received a presentation from MCN Access Manager and an Access clinician on MCN Mobile Crisis Services.
- Reviewed various MCN performance reports, including Performance Indicators, MSHN Priority Measures, annual Performance Improvement Projects, Access Call Back & Wait Time data, Critical Incident Reporting data, and Mortality data.
- MCN suggestion box items were reviewed, and input provided.
- Reviewed National Core Indicator Report: national survey data of persons and caregivers of persons diagnosed with I/DD related to key areas concerning employment, rights, service planning, community inclusion, choice and health & safety.
- Reviewed of results of annual Clubhouse Member survey.
- MCN Peer Support Specialist reported on MSHN Regional Consumer Advisory Council meetings; discussed state and local advocacy events, and current system redesign proposals.
- Added new members to the Council.
- Add MCN's Customer Services Representative as a consultant to the Council

Goals for 2023:

1. Work on filling committee seats; several vacancies from this past year.
2. Review Customer Satisfaction Survey findings & Suggestion Box entries and identify areas of concern and/or make recommendations for improvements. (Goal: At least annually)
3. Review performance data as contained in Performance Indicator Reports. (Goal: Quarterly)
4. Review and provide feedback on Regional Performance Improvement Projects. (Goal: Annually)
5. Participate in Regional Advisory Council meetings. (Goal: Quarterly)
6. 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)
7. Advocate for awareness and mental health promotion by participating in local community events. (Goal: Semi-Annually)
8. Advocate for awareness and mental health promotion by participating in statewide events. (Goal: Semi-Annually)
9. Keep apprised of system redesign legislative efforts. (Goal: As new information arises.)
10. Receive updates on Peer Support efforts/initiatives/educational opportunities. (Goal: As available)
11. Receive training on agency services and programs in the area of Health/Integrated Health services, and other identified area of interest. Discuss any questions related to concerns of gaps in services, or service requirements, and make recommendations. (Goal: As needed/requested)
12. Consider name change to the Council, to more clearly define the membership of the council.

Clinical 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 Rep (consultant).
D. *Meeting Schedule:* Monthly

Activities and Accomplishments for 2021/2022:

- Critical Incidents were reviewed and reported as required, including retrospective case reviews and review of MCN and MSHN critical & risk event trends.
- Record Reviews quarterly data reports were reviewed, and recommendations made.
- There were no wait lists to review for the year.
- Advised on results of MCN's triannual Trauma Informed Agency Assessment/Survey and kept apprised of agency's Trauma Informed Workplan and follow up activities.
- Reviewed Performance Measurement dashboard, MSHN Priority Performance Measurement Reports, & MMBPIS Performance Indicator reports and made recommendations for process improvements as indicated.
- Reviewed periodic reports on Experience with Care/Satisfaction Survey results, including Core Program Annual Surveys, Access Experience with Care, Clubhouse Member Annual Survey, and End of Services surveys.
- 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 Services Manager remains chairperson.
- Reviewed MSHN Grievance and Appeals reports.
- Reviewed MSHN Performance Improvement Projects related to Diabetes Monitoring and assessments of a Recovery Oriented Environment, including local performance data and made recommendations for process improvements where indicated.
- Reviewed National Core Indicator Report: national survey data of persons and caregivers of persons diagnosed with I/DD related to key areas concerning employment, rights, service planning, community inclusion, choice and health & safety.
- Reviewed results from MiFAST related to LOCUS use and identified reports for review.

- Reviewed various data reports, including CAFAS/PECFAS, LOCUS timeliness data, retrospective reviews on prescreens and crisis admissions;
- Reviewed results of a survey, conducted by an ad hoc group of MCN staff, of residents of Adult Foster Care (AFC) homes, AFC staff and managers/owners on facets of living and working in AFC homes; created analysis of what constitutes a beneficial, supportive living experience at an AFC, Data was shared with the AFC homes and actions are being followed up with homes by MCN Transitional Services Manager.

Goals for 2023:

1. Review and monitor data reports, minimally:
   a. Record Reviews (Goal: Quarterly)
   b. Performance Measures/MSHN Priority Measures/MMBPIS 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. Experience with Care/Satisfaction Survey Reports (Goal: Annually)
   g. Access Timeliness & Call Data (Goal: Quarterly)
   h. Various data analytic reports (Goal: Quarterly)
   i. Grievance & Appeals Reports (Goal: Quarterly)
   j. Regional Performance Improvement Projects data.
   k. Mobile Crisis data (Goal: Biannually)
2. Evaluate findings from MiFAST evidence-based practice reviews.
3. Identify agency & program performance outcomes for measurement.
4. Conduct retrospective Critical Incident & Sentinel Event Reviews (As needed)
5. Keep apprised of Regional Performance Improvement Projects and provide feedback and/or follow-up, as needed or requested.

Environment of Care Annual Report & Recommendations

Committee Structure:

A. *Mission:* To provide a safe, accessible, and supportive environment for persons served 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, Quality & Information Services Representative (consultant). These members represent all MCN building sites and general program/team types.
D. *Meeting Schedule:* Quarterly

Activities and Accomplishments for 2021/2022:

- Discussed updates on buildings/facilities.
- Discussed and made recommendations related to COVID-19 agency activities, PPE availability, and safety protocols. . Kept apprised of COVID vaccination levels, and addition of availability of on-site COVID testing.
- Kept apprised of status of new on-site pharmacy at Stanton office.
- Discussion on safety questions and comments from staff who work in the community. Followed up with managers; made recommendations related to offering the PERSA system—an emergency/alert system for staff us in the community.
- Reviewed quarterly data reports related to safety, facility security and vehicle incidents, injuries and facility maintenance. Made recommendation to investigate use of a help call button or other device for safety in the office, and possibly in the community.
- Reviewed reports from MCN building/facility inspections, & from maintenance 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. Made recommendations for Relias Learning health & safety training for the year.
- The annual Hazard Vulnerability Analysis was completed for all MCN locations.

- Reviewed CARF Health & Safety Standards to ensure continued agency conformance to standards. Made recommendation for updates to policy/procedure related to emergencies encountered when working in community locations.

Goals for 2023:

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. Review CARF accreditation Health & Safety standards to ensure continued agency conformance. (Goal: Annually)
7. Conduct a Hazard Vulnerability Analysis of each building site to identify and address risks in the environment. (Goal: Annually)
8. Assure plans for accessible flu & COVID vaccinations for staff. (Goal: Annually)
9. 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. Assure safe practice with new activities related to Behavioral Health Home services, such as new onsite lab and Spravato clinic. (Goal: Quarterly)
10. Address safety of staff in the office and in the community, including ongoing pandemic safety issues. (Goal: Quarterly)
11. Support and advocate for health of staff by advocating:
    a. Promoting staff use of Wellness Works.
    b. Promoting use of Employee Assistance Program.

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:* Recipient Rights Officer (Chair), Medical Services, Executive Director (consultant). Additional members are staff volunteers from across agency. Number of members fluctuates.
D. *Meeting Schedule:* Monthly

Activities and Accomplishments for 2021/2022:

- Staff activities were provided around the major holidays.
- Assisted with MCN Summer Carnival in conjunction with Stanton Old-Fashioned Days.
- Organized a summer cook-out for staff.
- Reworked membership of the committee.
- Reworked committee activities and goals, with consideration to current workplace culture.

Goals for 2023:

1.Implement the “Going the Distance” health and wellness monthly program.

2. Conduct/organize monthly activities in recognition/appreciation of staff, and also afford opportunities for staff to gather and create closer connections, including events around major holidays.

- Breakfasts/lunches in appreciation of Clinical staff in March, Administrative Support staff in April, and Integrated Health and Pharmacy in May.
- Food Truck and Summer cookout/potluck with staff activities in June/July.
- Ice Cream Social (Sept)

3. Assist with MCN Summer Carnival in conjunction with Stanton Old-Fashioned Days in August.

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), Persons Served, Parents/Guardians/Family Members, Community Stakeholder, Recipient Rights Officer (consultant), Quality & Information Services Director or Quality Analyst (consultants), Executive Director (consultant).
D. *Meeting Schedule:* Quarterly

Activities and Accomplishments for 2021/2022:

- 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. Notable activities due to pandemic:
    - resumed providing virtual face-to-face rights trainings--both for new hires and refresher classes, for MCN and contracted provider staff--previously provided by Network 180. Conducted unannounced telephone quizzes for provider staff.
    - resumed face-to-face CPI (non-physical intervention) training with safety protocols.
    - provided virtual rights trainings to recipients.
    - kept apprised of site visit activities by the RRO; resumed face-to face visits at sites, yet some periodically still virtually, based on COVID-19/quarantine status of the home;
    - continued discussion and support of providers being issued devices to utilize for the virtual site visits and for interviews with persons served, & for use by persons served to stay in contact with family & friends.
- Reviewed quarterly aggregate data on Incident Reports; continued notable decreases in use of physical intervention due to efforts of provider staff to keep individuals engaged and active during pandemic restrictions, and to MCN for additional support and guidance given to homes with high needs recipients.
- Received training on Hospitalizations, including the process and MCN involvement in involuntary hospitalizations and an overview of Alternative Treatment Orders and forms used. Received training from MDHHS's Office of Recipient Rights, including an overview of the ORR office at the State level, the process of the triennial assessment and review tool.
- Reviewed results of MDHHS triennial assessment of MCN's Office of Recipient Rights: received assessment of Full Compliance and continued 3-year certification.
- Reviewed annual and semi-annual State Recipient Rights data submissions.
- Reviewed agency Recipient Rights policies and procedures, ensuring compliance with MDHHS ORR standards.
- For annual appeal training, the committee received & reviewed an Appeals Training book and participated in an exercise for conducting a RR appeal.

Goals for 2023:

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 persons served 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. Develop a recipient-driven rights training.

7. Create a new Rights booklet, complementary to the MDHHS Rights booklet, but easier to navigate and understand.
8. Review and provide feedback on all MCN RR policies. (Goal: Annually)
9. Conduct one "mock" rights complaint appeal or review of a previously completed appeal. (Goal: Annually)
10. Support ORR to:
    a. Identify mechanisms to reduce abuse & neglect;
    b. Identify persons served with high needs/risks and provide enhanced supervision, training and support to those sites;
    c. Continue to provide ongoing recipient training.
    d. Develop/implement Recipient Rights training for recipients.
    e. Develop/implement Recipient Rights training for families and guardians.

Utilization Management Committee Annual Report & Recommendations

Committee Structure:

A. *Mission:* Assure effective utilization of services in accordance with MCN and regional policies, procedures and requirements, and state and federal laws and regulations.

B. *Responsibilities:* The UM Committee oversees agency service authorization and utilization practices; assists in assessing and driving activities related to Social Determinants of Health and Health Equity.

C. *Representation:* Quality & Information Service Director (Chair), Clinical Director, Quality Analyst, Research & Data Analyst; Clinical Program Managers (Ad Hoc).

D. *Meeting Schedule:* Monthly

Activities and Accomplishments for 2021/2022:

- Established the UM Committee and general monthly agenda items.
- Kept apprised of regional and State UM activities and regulations.
- Conducted review and made recommendations on findings regarding authorization processes and over-/under-utilization of Autism services.
- Reviewed the MSHN report on Penetration Rates and identified causes for potential differences across CMHs.
- Conducted review and made recommendations on findings regarding authorization processes and over-/under-utilization of Home-Based services, and Home Based authorizations compared to CAFAS scores.
- Reviewed reports on LOCUS and CAFAS score changes over time.
- Reviewed and made recommendations on specialized residential use and total costs for personal care & CLS services; as a result, a new rate setting process was established with one of the most utilized/high-cost providers.
- Reviewed MSHN preliminary Core Services Outlier Report and provided input on accuracy of data and investigated outliers.
- Identified current MCN practices that work to impact Social Determinants of Health and areas for possible enhancement.
- Kept apprised of status of State activities regarding Conflict Free Access & Planning.
- Kept apprised of the status of State activities and implementation of the 1915i waiver.

Goals for 2023:

1. Assess for utilization of services according to service guidelines, keeping apprised of changes in regional and State UM initiatives and procedures.
2. Identify and correct for over-/under-utilization of services across a variety of service programs.
3. Assure process for evaluating medical necessity & proper authorization of services.
4. Assure practices for evaluating the effects of services & programs, including use of customer satisfaction, provider satisfaction, fidelity measures and outcome data.
5. Review & utilize regional utilization management practices and data as resources for MCN practices.
6. Utilize county Social Determinant of Health, county and agency demographic data, and other available information to identify potential areas of impact on Health Disparities;

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, persons served, 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, I/DD Community Services Manager, HR Coordinator, IT Coordinator, Recipient Rights Officer, Fiscal Manager, Maintenance & Facilities Coordinator, Quality Analyst, Medical Director (consultant).

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

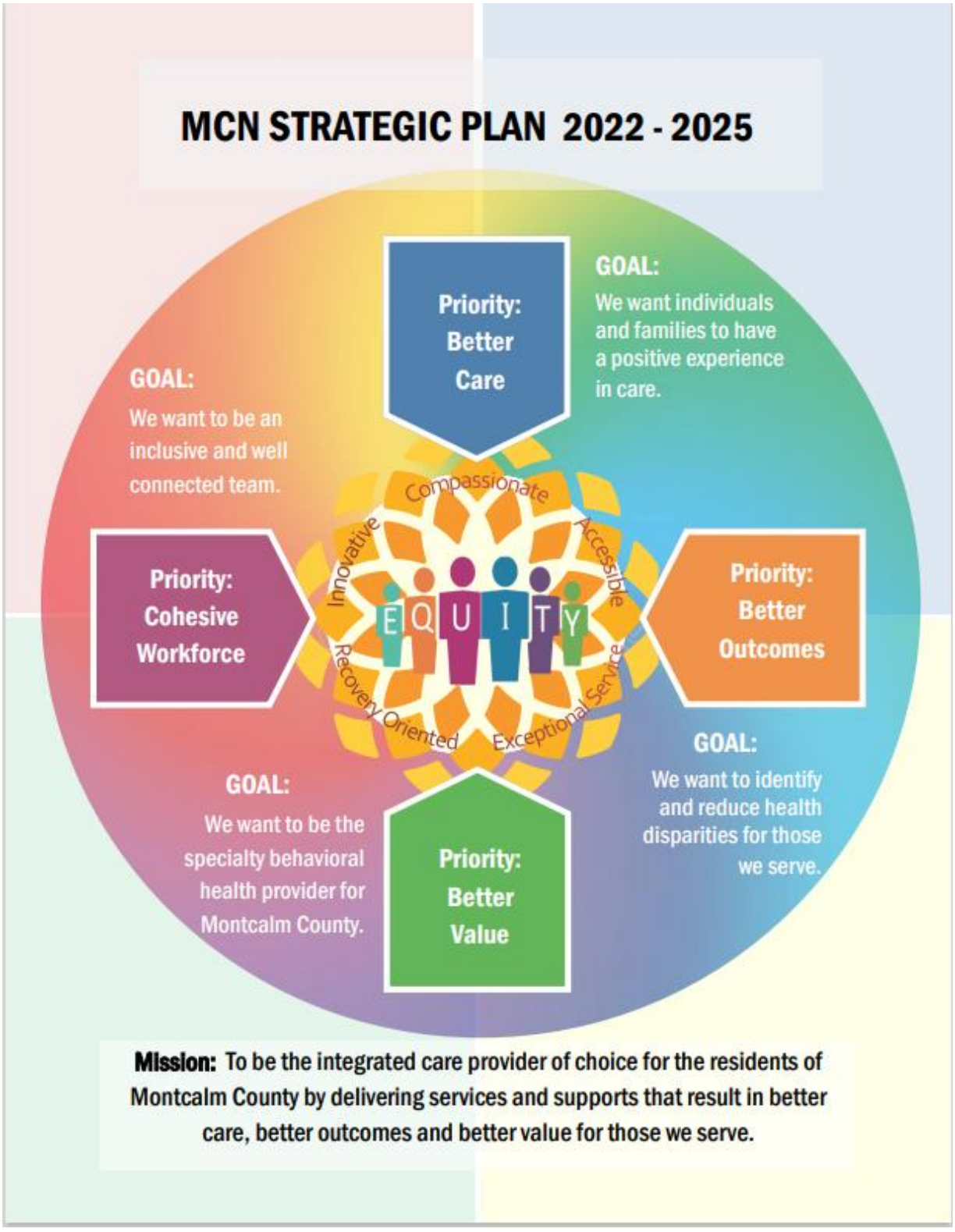
Activities and Accomplishments for 2021/2022:

- Monitored standing committees and prioritized work efforts as needed.
- Reviewed/kept apprised of Regional QAPIP activities, including MDHHS and HSAG audit results; regional performance improvement projects; performance measures and indicator reporting; critical event reporting trends; and satisfaction surveys of persons served.
- Continued processes & activities to promote of a culture of quality with the organization, with a focus on diversity, inclusion and equity. Reviewed and approved 2022 Cultural Diversity & Competency Plan.
- Reviewed and responded to the results of the annual Employee Survey.
- Sustained involvement of staff and persons served in quality system: In 2022, 30% of staff (44 of 146) participated on a quality committee or special workgroup (Goal: 25%). And 30% of positions on quality committees (19 of 64) were filled by persons served and/or parents/guaridians/family members (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 Critical Event Annual Analysis was completed.
- Coordinated annual review of website for updates.

Goals for 2023:

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 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 persons served 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/workgroup structures) are held by persons served 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.
11. Keep apprised of activities and recommendations from regional and State quality councils and ensure implementation or follow-up locally, as indicated.

Appendix A: MCN Strategic Plan Quadruple Aim



Appendix B: MCN Program & Business Practice Outcomes

Program & Business Practice Outcomes: Overview
MCN measures outcomes all of its accredited programs, as well as its general business practices, using the following data sources and standards. Below are some examples of how programs and business practices are measured, but is not all-inclusive of all reports, improvement projects, requirements and general monitoring activities and documentation.

Program	Outcome Type			
	Accessibility	**Efficiency**	**Effectiveness**	**Satisfaction**
Assessment & Referral (Access)	-State Performance Indicator Data: 14 days maximum from Request for Service to Assessment *(State requirement-95%; data collected from Access Specialist service documentation*) -Timeliness Data: Walk-In Wait time in Lobby (State Target <30mins); Request for Service Call Back time *(Target <24 hours); data collected from Access Specialist service documentation & Access Support Staff data entry documentation)* -Access Experience Survey: felt welcomed; waiting room comfortable. *(Target scores: average 4.5-5.0; survey distributed to persons served by Access Support Staff)*	-Access Experience Survey: questions answered in way that was understood *(Target score: average 4.5-5.0; survey distributed to persons served by Access Support)* -State Performance Indicator Data: # Second Opinion Requests on Service Denials resulting in Persons Served Receiving Services *(data collected from Clinical Director second opinion reviews)*	-State Performance Indicator Data: <10% of Assessments resulting in Service Denials (*Target locally set; data collected from Access Specialist service documentation)* -Access Experience Survey: information was helpful & suited to needs *(Target score: average 4.5-5.0; survey distributed to persons served by Access Support)*	Access Experience Survey: overall experience *(Target score: average 4.5-5.0; survey distributed to persons served by Access Support Staff)*

Case Management/Services Coordination (CSM/SC/ Care Management)	-State Performance Indicator Data: 14 days from Assessment to First Ongoing Service *(State requirement-95%; data collected from Access Specialists and Clinicians service documentation)* -MHSIPP & YSS Satisfaction Surveys: 80% satisfaction standard *(Target regionally-set-perception of access domain; data collected from annual surveys of persons served)* -Persons served with a Primary Care Physician or evidence of attempts to connect them with a Primary Care Physician *(Target: 100%; data collected from EHR data as reported by persons served, and supervisor/clinician record reviews)*	-MHSIPP & YSS Satisfaction Surveys: 80% satisfaction standard *(Target regionally-set)-perception of quality & appropriateness; data collected from annual surveys of persons served)* -Record Reviews of Evidence Based Practices standards for Integrated Health Level of Care: 9 standards of evidence of care for Integrated Health LOC 4 *(Data collected from supervisor/clinician record reviews.)*	-End of Services Survey *(Target score: average 1.0-2.0; data collected from surveys of persons served)* -MHSIPP & YSS Satisfaction Surveys: 80% satisfaction standard *(Target regionally-set-perception of outcome of service/functioning; data collected from annual surveys of persons served)*	MHSIPP & YSS Satisfaction Surveys: 80% satisfaction standard *(Target regionally-set; data collected from surveys of persons served: general satisfaction domain-MHSIPP/appropriateness-YSS)*
	Outcome Type			
Program	**Accessibility**	**Efficiency**	**Effectiveness**	**Satisfaction**
Community Integration (Heartland House Clubhouse) ***Heartland House has obtained national clubhouse accreditation.***	Heartland House Member Satisfaction Survey: question about Clubhouse being organized in a way that is easy to get involved *(general target: 70%; data collected from surveys of persons served)*	Heartland House Member Satisfaction Survey: Question about staff working with members & asking for ideas & opinions *(general target: 70%; data collected from surveys of persons served)*	Heartland House Member Satisfaction Survey: Multiple questions on survey *(general target: 70%; data collected from surveys of persons served)*	Heartland House Member Satisfaction Survey: Clubhouse work gives satisfaction *(general target: 70%; data collected from surveys of persons served)*
Crisis Intervention (Emergency Services)	-State Performance Indicator Data: Maximum of 3 hours from Request for Prescreen to Disposition *(State requirement-95%; data collected from emergency services clinicians' service documentation)*	State Performance Indicator Data: 7 day follow up following Psychiatric Inpatient Discharge *(State requirement-95%; data collected from Access Specialists End of Episode documentation and clinicians' service documentation)*	State Performance Indicator Data: Psychiatric Readmissions within 30 days of Psychiatric Discharge (State requirement- <15%; *data collected from Access Specialists hospitalization documentation & emergency services clinician's service documentation)*	MHSIPP & YSS Satisfaction Surveys: 80% satisfaction standard *(Target regionally-set; data collected from surveys of persons served: general satisfaction domain-MHSIPP/appropriateness- YSS)*

	Outcome Type			
Program	**Accessibility**	**Efficiency**	**Effectiveness**	**Satisfaction**
Intensive Family-Based Services (Home Based)	-State Performance Indicator Data: 14 days from Assessment to First Ongoing Service *(State requirement-95%; data collected from Access Specialists and Clinicians service documentation)* -YSS Satisfaction Surveys: 80% satisfaction standard *(Target regionally-set-perception of access domain; data collected from annual surveys of persons served.)* -Persons served with a Primary Care Physician or evidence of attempts to connect them with a Primary Care Physician *(Target: 100%; data collected from EHR data as reported by persons served, and supervisor/clinician record reviews)*	-YSS Satisfaction Surveys: 80% satisfaction standard *(Target regionally-set)-perception of quality & appropriateness of care; data collected from annual surveys of persons served)* -Record Reviews of Evidence Based Practices standards for Integrated Health Level of Care: 9 standards of evidence of care for Integrated Health LOC 4 *(Data collected from supervisor/clinician record reviews.)*	-End of Services Survey *(Target score: average 1.0-2.0; data collected from surveys of persons served)* -YSS Satisfaction Surveys: 80% satisfaction standard *(Target regionally-set-perception of outcome of service/functioning; data collected from annual surveys of persons served)*	YSS Satisfaction Surveys: 80% satisfaction standard *(Target regionally-set; data collected from surveys of persons served: general satisfaction domain/appropriateness-YSS)*
Outpatient Treatment	-State Performance Indicator Data: 14 days from Assessment to First Ongoing Service *(State requirement-95%; data collected from Access Specialists and Clinicians service documentation)* -MHSIPP & YSS Satisfaction Surveys: 80% satisfaction standard (*(Target regionally-set-perception of access domain; data collected from*	-MHSIPP & YSS Satisfaction Surveys: 80% satisfaction standard *(Target regionally-set)-perception of quality & appropriateness of care; data collected from annual surveys of persons served)*	-End of Services Survey *(Target score: average 1.0-2.0; data collected from surveys of persons served)* -MHSIPP & YSS Satisfaction Surveys: 80% satisfaction standard *(Target regionally-set-perception of outcome of service/functioning; data collected from annual surveys of persons served)* -Decrease Emergency Department (ED) Use: High and Trending High Utilizers are reviewed for Level of Care and Intensity of Services	MHSIPP & YSS Satisfaction Surveys: 80% satisfaction standard *(Target regionally-set; data collected from surveys of persons served: general satisfaction domain/appropriateness-YSS)*

	annual surveys of persons served.) -Persons served with a Primary Care Physician or evidence of attempts to connect them with a Primary Care Physician *(Target: 100%; data collected from internal Record Reviews)*		*(Target: 100%; data collected from MDHHS's CareConnect 360 application.)*	
	Outcome Type			
Program	**Accessibility**	**Efficiency**	**Effectiveness**	**Satisfaction**
Business Practices: **-Customer Services** **-Facility Management /Health & Safety** **-Financial** **-Management/ Administration** **-Recipient Rights**	-Recipient Rights Semi-Annual and Annual Reports, Recipient Rights Complaint Logs: Number of Complaints & Results *(Data collected by Recipient Rights Officer & Customer Services Rep; reviewed by Recipient Rights Advisory Committee.)* -Recipient Rights Officer Activities: Training Provided and Sites Visited *(Data collected by Recipient Rights Officer & Customer Services Rep; reviewed by Recipient Rights Advisory Committee.)* -MHSIPP Satisfaction Surveys: P*ersons served* were given rights information. *(Data collected from surveys of persons served)* -Grievance, Appeals & Second Opinion: Timeliness of resolutions. *(Regional target: 100%; data collected by Customer Services Rep. and Clinical Director documentation; reviewed by*	-Recipient Rights Semi-Annual and Annual Reports: timeliness of investigations *(Data collected by Recipient Rights Officer & Customer Services Rep; reviewed by Recipient Rights Advisory Committee.)* -Record Review Data: Evidence of financial being completed within the last 12 months. *(Data collected by medical records specialist review of EHR charts.)* -Persons Served Compared to Costs *(Data collected from EHR—clinician service documentation compared to financial reports)* -Sign Time Details: Timeliness from service to documentation signature *(Data collected from signatures on key documents, collected by Data Analyst)* -Budget Reports: Revenue & Expenditure status compared to budget. *(Data reports pulled from EHR and financial reports)*	-Health & Safety Incident Reporting: ongoing monitoring of incidents *(Target: MSHN averages; data reported by clinicians and provider staff incident reporting; collected by QI Director/Quality Analyst)* -Staff Injury Reports: ongoing monitoring of incidences *(data reported by clinicians and provider staff incident reporting; collected by Facilities Manager, HR Specialist & QI Director/Quality Analyst)* -Management Reports: Staff/Program Caseloads, Unsigned Documents, Alerts/Services Due, Direct Service Hours compared to Hours Worked *(Data collected from EHR—from clinician service documentation)* -Annual Employee Satisfaction Survey: Positively Contribute *(Data collected via annual employee survey by QI Director/Quality Analyst)* -MIPS: Data collection and reporting of standards to meet MIPS; Payment Incentive Programs *(Data collected*	Annual Employee Satisfaction Survey: Work Life Balance; Connection with Co-Workers *(Data collected via annual employee survey by QI Director/Quality Analyst)*

	MSHN Customer Service Council) -Annual Employee Satisfaction Survey: Positive Work Environment *(Data collected via annual employee survey by QI Director/Quality Analyst)*	-Critical Incident rates per persons served *(Target: MSHN averages; data reported by clinicians and provider staff incident reporting; collected by QI Director/Quality Analyst)* - Annual Employee Satisfaction Survey: Inspired to do Best Work *(Data collected via annual employee survey by QI Director/Quality Analyst)*	*from EHR—from clinician service documentation)*	

Appendix C: MSHN Priority Measure

MSHN Performance Measure Portfolio

Portfolio Performance Measure & Description	Rationale	Protocol
1. **Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) -** The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	**Rationale -** As patients with schizophrenia or bipolar disorder are at an increased risk for diabetes, and antipsychotic medications are an expected treatment that increases the risk of metabolic diseases, screening for diabetes will allow for proper diagnosis and treatment, if warranted.	• Ensure CMH psychiatric providers are ordering appropriate health screening or that care manager or designee is coordinating care with PCP to ensure screenings are completed. • When CMH does health screening, ensure appropriate codes are reported. • Ensure care managers are utilizing the CC360 data extract or other health information technology to identify care gaps specific to this measure. • Educate persons served of importance of these health screens and potential side effects of medications.
2. **Diabetes Monitoring for Schizophrenia** - This measure is used to assess the percentage of members 18 to 64 years of age with schizophrenia and diabetes who had both a low-density lipoprotein cholesterol (LDL-C) test and a hemoglobin A1c (HbA1c) test during the measurement year.	**Rationale -** Prevalence rates of metabolic syndrome in people with schizophrenia is 42.6 percent for males and 48.5 percent for females, compared with rates in the general population (24 percent for males, 23 percent for females). Among patients with co-occurring schizophrenia and metabolic disorders, the non-treatment rate for diabetes is approximately 32 percent. In addition to general diabetes risk factors, diabetes is promoted in patients with schizophrenia by initial and current treatment with olanzapine and mid-potency first-generation antipsychotics (FGA), as well as by current treatment with low-potency FGAs and clozapine. Improving blood sugar control has shown to lead to lower use of health care services and better overall satisfaction with diabetes treatment. People who control their diabetes also report improved quality of life and emotional well-being.	• Ensure CMH care managers are coordinating care with primary care providers to track completion of screenings • Ensure care managers are utilizing the CC360 data extract or other health information technology to identify care gaps specific to this measure • When CMH provides the monitoring directly (such as via a primary care clinic run by the CMH), ensure the appropriate codes are reported • Educate persons served of importance of these health tests, the prevalence rates of these comorbid conditions, and benefits of effective management of these chronic conditions

3. Plan All-Cause Readmissions (30 day) - This measure is used to assess the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days, for members 18 years of age and older.	**Rationale -** Discharge from a hospital is a critical transition point in a patient's care. Poor care coordination at discharge can lead to adverse events for patients and avoidable rehospitalization. Hospitalization readmissions may indicate poor care or missed opportunities to coordinate care better. Research shows that specific hospital-based initiatives to improve communication with beneficiaries and their caregivers, coordinate care after discharge and improve the quality of care during the initial admission can avert many readmissions. There is extensive evidence about adverse events in patients, and this measure aims to distinguish readmissions from complications of care and pre-existing comorbidities. Potentially preventable readmissions are defined as readmissions that are directly tied to conditions that could have been avoided in the inpatient setting. While not all preventable readmissions can be avoided, most potentially preventable readmissions can be prevented if the best quality of care is rendered and clinicians are using current standards of care.	• Ensure CMH care managers are coordinating care with primary care providers and specialty health care providers to coordinate aftercare following an inpatient admission • Ensure CMHs are utilizing ADT feeds or other health information tools to notify care managers of the need for discharge planning and follow up care due to an inpatient admission • Educate care managers regarding their role for coordinating with health plans, providers and/or persons served regarding the need for follow up care following ***any*** inpatient admission (for psychiatric or physical health care needs) • Educate persons served regarding the importance of following through with after care appointments
4. **Use of Multiple Concurrent Antipsychotics** – This measure is to assess the percentage of children and adolescents ages 1-17 years of age who are prescribed 2 or more concurrent antipsychotic medications. The measure looks at *persons served* who have received 90 days of continuous antipsychotic medication treatment with 2 or more concurrent antipsychotic medications.	**Rationale –** Safe and judicious use of antipsychotic medications is a critical issue for children and youth, especially vulnerable children in Medicaid and foster care. Antipsychotics are powerful medications that are indicated for treating a limited range of children's mental health problems and come with a potential for serious side effects that have life-long consequences. Much care and monitoring must be used when treating youth with antipsychotic medications to ensure there is a primary indication for their use, and to show that care is consistent with clinical guidelines.	• Ensure CMH psychiatric providers are continually monitoring medication efficacy and prescribing medications with the least risk of harm, yet most effective, for each youth. • Ensure CMH medical staff are monitoring for sometimes serious, common side effects. • Ensure other services (supportive therapies, care management, integrated health services, etc.) are in place to support the youth and their families to monitor, manage and report symptoms, behavior and side effects.

5. **ADHD Follow Up – Children—**There are 2 measures used to assess ADHD medication use and follow up. **Initiation Phase:** the percentage of children (6-12 years of age) newly prescribed ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. **Continuation & Monitoring Phase:** the percentage of children (6-12 years of age) with ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least 2 follow-up visits within 270 days (9 months) after the Initiation Phase.	**Rationale -** Attention deficit/hyperactivity disorder (ADHD) is one of the more common chronic conditions of childhood. Children with ADHD may experience significant functional problems, such as school difficulties; academic underachievement; troublesome relationships with family members and peers; and behavioral problems (American Academy of Pediatrics [AAP], 2000). Given the high prevalence of ADHD among school-aged children (4 to 12 percent), primary care clinicians will regularly encounter children with ADHD and should have a strategy for diagnosing and long-term management of this condition (AAP, 2001). Practitioners can convey the efficacy of pharmacotherapy to their patients. AAP guidelines (2000) recommend that once a child is stable, an office visit every 3 to 6 months allows assessment of learning and behavior. Follow-up appointments should be made at least monthly until the child's symptoms have been stabilized.	• Ensure CMH psychiatric providers have capacity to provide necessary follow-up visits within required time frame • Ensure that CMH psychiatric providers provide follow-up visits within required time frame • Ensure care managers are utilizing the CC360 data extract or other health information technology to identify care gaps specific to this measure (if ADHD medication is prescribed by an external provider)
6. **Follow-Up After Hospitalization—Child & Adult** – These two measures are used to assess the percentage of discharges for patients 6 years to 17 years of age, and 18 years and older, older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient service, or partial hospitalization with a mental health provider within 30 days of discharge.	**Rationale -** It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner after discharge is recommended to make sure that the patient's transition to the home or work environment is supported and that gains made during hospitalization are not lost. It also helps health care providers detect early post-hospitalization reactions or medication problems and provide continuing care. According to a guideline developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Psychiatric Association (APA) (1997), there is a need for regular and timely assessments and documentation of the patient's response to all treatments.	1. Provide appropriate discharge planning services while individual is still receiving inpatient care. 2. Ensure all persons served are provided a follow-up appointment within 7 days of discharge per current PIHP contract requirements.

7. **Cardiovascular Screening**- The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year.	**Rationale -** In 2010, heart disease and diabetes were the leading causes of death in the United States (U.S.) (Murphy, Xu, & Kochanek, 2013). Because persons with serious mental illness who use antipsychotics are at increased risk of cardiovascular diseases and diabetes, screening and monitoring of these conditions is important.	• Ensure CMH Psychiatric providers are ordering appropriate health screening or that care manager or designee is coordinating care with primary care providers to ensure screenings are completed • When CMH provides health screening, ensure the appropriate codes are reported • Ensure care managers are utilizing the CC360 data extract or other health information technology to identify care gaps specific to this measure • Educate persons served of importance of these health screens and potential side effects of medications • Medical director to provide education/training to psychiatric providers regarding measurement requirements
8. **Adult Access to Primary Care** - This measure is used to assess the percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line: Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year, and Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.	**Rationale -** Without a patient visit, members do not receive counseling on diet, exercise, smoking cessation, seat belt use and behaviors that put them at risk. If the organization's services are not being used, are there barriers to access? Maintaining access to care requires more than making providers and services available—it involves analysis and systematic removal of barriers to care	1. Ensure care managers are utilizing the CC 360 data extract and/or other health information technology to identify care gaps specific to this measure 2. Ensure that care manager is coordinating care with primary care providers to ensure the adult is receiving primary care 3. Educate care managers regarding measurement requirements and the role of care manager to support/assist the adult to access primary care 4. Educate persons served about the advantages of engaging in ongoing, preventative primary care 5. Support persons served to maintain insurance coverage

9. **Child Access to Primary Care -** This measure is used to assess the percentage of members 12 months to 19 years of age who had a visit with a primary care practitioner (PCP). The organization reports four separate percentages for each age category: Children 12 to 24 months, 25 months to 6 years, 7 to 11 years, and adolescents 12 to 19 years of age.	**Rationale -** Without a patient visit, members do not receive counseling on diet, exercise, smoking cessation, seat belt use and behaviors that put them at risk. If the organization's services are not being used, are there barriers to access? Maintaining access to care requires more than making providers and services available—it involves analysis and systematic removal of barriers to care.	Ensure care managers are utilizing the CC360 data extract and/or other health information technology to identify care gaps specific to this measure Ensure that care manager is coordinating care with primary care providers to ensure the child/adolescent is receiving primary care Educate care managers regarding measurement requirements and the role of care manager to support/assist the family to access primary care Educate families served about the advantages of engaging in ongoing, preventative primary care Support families served to maintain insurance coverage for youth.