HealthWest
Muskegon's Behavioral Wellness Connection

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN
FY2020

I. PURPOSE

The HealthWest QAPIP is intended, at a high level, to provide an overall structure for and description of the QI activities undertaken at HealthWest. Together with the agency's strategic plan, ongoing needs assessments and policies and procedures, the QAPIP lays out intended priorities and actions to be taken in order to identify and address performance issues at any level within the organization, establish and promote a culture of continuous improvement, address the needs of various stakeholders and further our organizational pursuit of providing high-quality, effective, high-value treatment for individuals in Muskegon County.

This commitment to excellence is found in HealthWest's mission, vision and values statements; the following QAPIP plan summarizes and describes the structures and practices (both formal and informal) that we will utilize to assess, plan, measure and improve our processes and continuum of care. Additionally, this plan describes how the QI activities at HealthWest are organization-wide, involve all levels of stakeholders from the board of directors to individual consumers, and impact all aspects of our agency's operations (governance, management, clinical, financial and administrative).

II. APPLICATION

This plan applies to all HealthWest staff, employees of contracted provider agencies, members of the HealthWest Board of Directors, and community stakeholders including individuals served and their families, partner organization and other community members. Together, these stakeholders will ensure that the QAPIP is implemented and HealthWest fulfills all requirements and meets standards of performance and quality.

III. PERFORMANCE IMPROVEMENT PROGRAM GOALS

The following items reflect the general goals of the HealthWest QAPIP and apply to the HealthWest QAPIP every year. Specific goals for this fiscal year and targeted initiatives are described in other areas of the plan.

A. Target improvement at all levels including the Board, management, administration, and programs. Clinical care and non clinical dimensions of care such as access, efficiency, coordination of services, timeliness, safety, respect and caring, effectiveness, appropriateness, continuity and outcomes are included.
B. Maintain a formal process to identify areas of improvement.
C. Involve consumers and providers in assessing and improving consumer satisfaction with services delivery and outcomes.
D. Involve consumer, family members and providers in quality improvement activities and representation on quality improvement committees.
E. Develop key performance indicators to assure services are effective and efficient.
F. Ensure the proper tools are in place for the collection, storage, analysis and application of data, both clinical and administrative.

G. Implement processes that monitor data quality and completeness, and take actions to resolve any identified issues with data integrity.
H. Use analysis of reliable and valid data for decisions.
I. Track and compare the agency's performance on key indicators to statewide and/or national data to assess the agency's performance over time and in comparison to industry standards.
J. Monitor the QI structure, including activities of standing committees and workgroups.
K. Assure providers of service fulfill contractual or employment obligations in accordance with applicable regulatory and accreditation standards.
L. Assure providers of service are competent and capable of providing services through a system of competency evaluation, credentialing and privileging.
M. Assure that providers of services are culturally competent, and make accommodations to consumers, as needed.
N. Assure that performance indicators and QI activities impact all populations served by the agency, including longer term consumers.
O. Review all sentinel events and take action based on reviews.
P. Assure coordination and integration of QAPIP and Utilization Management activities.
Q. Carry out performance improvement projects as required State and Federal Guidelines.

IV. CONFIDENTIALITY AND CONFLICT OF INTEREST

All Quality Assessment and Performance Improvement Activities take place in a manner consistent with State and Federal confidentiality regulations and agency policy. All member information is kept strictly confidential. No written reports, records or any work product or communication related to Quality Assessment (QA) and Performance Improvement (PI) activities are identifiable except when specific reference to an individual provider, program or clinician is necessary to meet the goals of the PI program.

HealthWest policies and procedures, QI-related committee meeting minutes, documentation of QI activities and initiatives, and records of QI/PI data and analysis, will be open to review by the Michigan Department of Health and Human Services, the Lakeshore Regional Entity (LRE) and its contracted entities (e.g. Beacon), accrediting bodies (including CARF and HSAG), and state and federal regulatory agencies, when applicable.

V. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT MODEL

A. HealthWest QI activities are driven by a Continuous Quality Improvement (CQI) philosophy, which is operationalized according to the principles of the Plan-Do-Study-Act (PDSA) cycle.

B. The Quality Assessment and Performance Improvement program spans across all internal operational areas as well as clinical functions that affect consumers, their families and broader caregiving network, and members of the Muskegon County community.

C. Establishing and successfully carrying out strategies to eliminate statistical performance outliers, incorporate best practices, and optimize consumer outcomes is key to continuous quality improvement. The particular strategy or sets of strategies used vary according to the situation and the kind of improvement that is desired.

D. The CQI cycle at HealthWest may be initiated by an instance of feedback shared by staff, consumers or other stakeholders; it may also begin with an insight uncovered through monitoring data or a recognition for a need for improvement in some process or system.

E. A variety of activities may occur within each step of the PDSA cycle:

1. Planning incorporates response to the development, implementation and review of a variety of internal plans, including HealthWest's Strategic Plan, Risk Management Plan, Utilization Plan, Information Management Plan, Safety Plan, Procurement/Network Plan, Corporate Compliance Plan, Cultural Competency Plan, Accessibility Plan and Training Plan.

   According to the PDSA approach, the planning step defines topics of study or measurement through data collection and analysis and stakeholder and consumer input. The planning step identifies the type of information and data that are necessary for development of the measurement methodology using research of literature to establish benchmarks based on best practices, when possible. The planning step results in the establishment of a team of knowledgeable individuals to lead the PDCA processes. Individuals may include employees, contracted providers, consumer members and/or community members. Planning also includes the identification of the specific data required and the individual(s) responsible for data collection and report development.

2. Doing includes all of the work that goes into implementation of the improvements: collecting and analyzing the available data and putting corrective actions in motion to address the identified need.

3. Studying involves continuing to monitor performance following the implementation of the improvements and analyzing whether the changes that were made resulted in the desired impacts. Ongoing measurement and monitoring must also occur to assess the effectiveness of the improvement strategy to achieve sustained improvement.

4. Acting involves taking any additional corrective action deemed necessary to make further improvements; this typically involves improvements upon the original changes that were made or a refinement of approach following analysis data. As is the case with each step in the PDSA cycle, acting also includes the sharing of information with all stakeholders, so that involved parties are informed of changes, improvements and ongoing needs.

VI. STRUCTURE/ROLES

The most effective QI programs and plans are tailored to the unique needs of the organization, and include both a formal structure and consistent processes through which quality can be defined, pursued, achieved and monitored, as well as an informal component that includes the nature of interpersonal relationships, organizational culture and an integration of agency values.

There are some consistencies across CMHs, however, and many components of the HealthWest QI program are common to other members of the LRE. The following table describes some of the more common standards, assessment activities, measurements, and improvement strategies used by the CMHSPs of the LRE.

QUALITY MANAGEMENT SYSTEM			
Quality Standards	**Assessment Activities**	**Performance Measurements**	**Improvement Strategies**
• Federal & State Rules/Regulations • Stakeholder Expectations • MDHHS/PIHP Contract • Provider Contracts • Practice Guidelines • Accreditation Standards • Policies and • Standards • Evidence Based Practices	• Provider Monitoring Reviews • Accreditation Surveys • Credentialing • Risk Management • Utilization Reviews • External Quality Reviews • Stakeholder Input • Sentinel Events • Critical Event Reports • MDHHS Site Review Report • Behavior Treatment Analysis • Fidelity Monitoring Reviews	• MDHHS MMBPIS • Outcomes Management System • Dashboards • Benchmarking • Status Reports on Strategic Planning • Audit Reports • Grievances & Appeals • Board Ends Report using • Dashboards	• Corrective Action/ Improvement Plans • Improvement Projects • Change Teams • Strategic Planning • Adherence to Practice Guidelines • Organizational Learning • Staff Development and Training • Improvements through Root Cause Analysis

VII. PRACTICE GUIDELINES

Practice Guidelines may be adopted for a variety of reasons: for adherence to State contract requirements, in response to internal data analysis and following research and application of evidence-based best practices. The Medical Director and Executive Leadership Team participate in the review of practice guidelines related to outcomes of care. And together with the Executive Leadership Team, the QI team oversees the adoption, development, implementation and continuous monitoring and evaluation of practice guidelines, which are disseminated to all relevant staff using the methods applied to other HealthWest policies and procedures.

VIII. PERFORMANCE ANALYSIS

The organization utilizes performance indicators and quality improvement measures established by the Department of Health and Human Services in the areas of access, efficiency and outcomes. Monitoring measures in the area of access/penetration, continuity of care, denial/appeals, supported employment and quality of life is collected and analyzed. Data is reported to PIHP (the LRE) and MDHHS. An internal Michigan Mission Based Performance Indicator System (MMBPIS) Report Card is utilized to monitor on-going adherence to established standards and to benchmark the organization compared to the performance of neighboring regions.

Agency Performance Indicators are in the process of being developed, monitored and reported to the HealthWest Executive Team, Board of Directors and supervisors/managers as appropriate. Indicators focus on effectiveness, efficiency, access and satisfaction.

IX. BEHAVIOR TREATMENT REVIEW

The Behavior Support Committee reviews behavior treatment plans on a quarterly basis. The Behavior Support Committee reports quarterly an analysis of data where intrusive or restrictive techniques have been approved. Only techniques that have been approved during person-centered planning by the individuals or his/her guardian, and supported by a current peer reviewed psychological and psychiatric literature may be used. Data shall include numbers of interventions and length of time the interventions were used. The use of physical management is reviewed by Recipient Rights and/or the Behavioral Support Committee through data obtained from critical incidents reports. In responding to and incorporating the philosophy of Gentle Teaching, use of physical management is not allowed in behavior plans. Any use of physical management is considered emergency use and reported with an incident report.

The Behavior Support Committee reviews and reports quarterly additional critical events that put individuals at risk of harm. The analysis is used to determine what actions need to be taken to remediate the problems or situation and to prevent the occurrence of additional events and incidents.

Risk Event Monitoring

Service	Harm to Self	Harm to Others	Police Calls	Physical Management	Hospitalization
Supports Coord	●	●	●	●	●
Case Management	●	●	●	●	●
ACT	●	●	●	●	●
Homebased	●	●	●	●	●

X. SENTINEL EVENTS & UNEXPECTED DEATHS

Adverse incidents and Sentinel Events are defined in the organization's policy number 04-024 Peer Review and Root Cause Analysis. Network providers are responsible to report sentinel events to the Agency's Office of Recipient Rights and are reviewed by the Recipient Rights workgroup. A Peer Review process is utilized to review agency procedures, evaluate actions taken and make recommendations for further training, procedures change, or interventions that will improve care for individuals served. Staff involved in reviewing and analyzing sentinel events must have appropriate credentials to review the scope of care. The Medical Director is consulted as needed. Sentinel events are reported to the Recipient Rights office. Within 48 hours of a sentinel event occurrence, the Quality Manager convenes a Root Cause Analysis workgroup. Within 20 days the Root Cause Analysis workgroup conducts an evaluation and prepares a report containing full documentation of the Root Cause Analysis. The report is forwarded to the Executive Director and PIHP Regulatory Management Supervisor. The Executive Director accepts or revises the recommendations and assigns responsibility to the appropriate supervisor(s) who are responsible to provide quarterly reports to the Risk Management Committee who evaluates the effectiveness of the improvements.

The Agency Office of Recipient Rights is responsible to ensure that the Department of Health and Human Services and CARF International are informed of all reportable events.
The critical incident reporting system captures information on reportable events. HealthWest will report to MDHHS the following events within 60 days after the end of the month in which the event occurred for individuals who, at the time of the event, were actively receiving services:

Reporting of Critical Incidents to MDHHS

Service	Suicide	Death	EMT	Hospital	Arrest
CLS	●	●			
Supports Coord	●	●			
Case Management	●	●			
ACT	●	●			
Homebased	●	●			
Wraparound	●	●			
Hab Waiver	●	●	●	●	●
SED Waiver	●	●	●	●	●
Child Waiver	●	●	●	●	●
Any other Service	●				
Living Situation					
Specialized Resid	●	●	●	●	●
CCI	●	●	●	●	●

All unexpected deaths of individuals who at the time of their death were receiving specialty supports and services are reviewed. The review includes:

- Screens of individual deaths with standard information (e.g. coroner's report, death certificate).
- Involvement of medical personnel in the mortality reviews.
- Documentation of the mortality review process, findings, and recommendations.
- Use of mortality information to address quality of care.
- Aggregation of mortality data over time to identify possible trends.

XI. CUSTOMER SATISFACTION

The assessment of consumer satisfaction with services and outcomes occurs through qualitative and quantitative methods and throughout an individual's involvement with the agency and post discharge. The assessments address issues of quality, availability, accessibility and respect. At the program level, individuals are asked for feedback about their satisfaction with services at the time of the Person Centered Plan development. Every consumer also has the opportunity to complete a satisfaction survey and/or participate in a focus group (as such groups are available). Additionally, "How are We Doing" satisfaction survey cards are placed at each CMH location for completion as often as an individual would like to provide feedback. All survey instruments provide an opportunity for an individual to request a follow-up contact. Customer Services staff conduct and document the outcome of the follow-up. Survey data is captured electronically and may be aggregated and analyzed in a variety of ways. Satisfaction survey results are distributed through CMH/PIHP publications such as newsletters and annual reports to community partners and Family Resource Centers. Results can also be obtained through the CMH/PIHP customer services department.

XII. PROVIDER SATISFACTION

HealthWest will facilitate opportunities for provider agencies provide feedback regarding contractual management, support provided by HealthWest and their ability to provide services that meet the needs of consumers and fulfill contractual obligations. The opportunities include monthly provider meetings, ad hoc provider surveys and provider-specific meetings convened

either at the request of HealthWest or the provider agency. Provider Satisfaction is monitored and addressed by the HealthWest Executive Team and the Network Management/Contracts team.

XIII. PERFORMANCE IMPROVEMENT PROJECTS

HealthWest participates with the Lakeshore Regional Entity PIHP to conduct "performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and (consumer) satisfaction" (Domain One of the Quality Improvement System for Managed Care [QISMC], Part 1.1.2). Stakeholders are encouraged to regularly submit improvement recommendations, and each CMHSP will provide input to the QI ROAT regarding performance improvements.

At least two performance improvement projects meeting Michigan QAPIP standards and BBA standards will be conducted per each two-year CMS Michigan waiver period by the LRE. One of the two projects conducted will be a project that is mandated by MDHHS and will be reviewed and evaluated by HSAG for compliance with requirements. Performance Improvement projects are outcome-oriented, demonstrate meaningful change and result sustained improvements in care and services.

Performance improvement projects may address any aspect of operations, are approved at the regional level and are then the responsibility of each CMHSP to implement. Information regarding the regional PIPs is within the minutes and communication from the LRE's Performance Improvement Plan (PIP) Workgroup.

XIV. CLINICAL CHART REVIEWS

The agency has had a chart review process in place since 1994. Since 1999 a comprehensive effort has been made to integrate program specific chart reviews into a common comprehensive review. In January, 2004 a revised Clinical Chart Review procedure was implemented. This process was updated in 2018 and is currently a monthly review of consumer charts, conducted on a random sample of charts, such that 10% of all active charts are reviewed within a given year. Items included within the clinical chart review are reviewed for relevance on a regular basis and updated as needed.

XV. CREDENTIALING, PRIVILEGING AND COMPETENCY

The agency maintains a complete system for credentialing, privileging and competency assessment for staff and contractual providers. Procedures are in place to ensure criminal background checks and source verification of educational and State licensing status occur at the time of hire/contract. Job descriptions are available for all county employees with a detailed scope of responsibility specifying expectations, and cultural competence, for each position. Annually, all staff receives a performance/competency evaluation by their supervisor. Applicable policy and procedures and additional supporting documentation are noted in the Reference section.

XVI. CULTURAL COMPETENCE

A. The agency evaluates access and treatment trends of ethnic and minority groups through the annual Diversity Plan, which is developed and implemented by the Team for Inclusion, Diversity and Equity (TIDE).
B. All new hires are required to attend a Cultural Competency class and external providers are required to ensure staff receives initial and on-going training in Cultural Competence.
C. Ongoing information and training is made available, as defined in the Diversity Plan.
D. On-line training course(s) are available to staff and external providers through Relias Learning Management System.

XVII. VERIFICATION OF SERVICES PROVIDED TO MEMBERS

HealthWest verifies that services claimed by providers have been provided. A policy titled "Claims Verification" covers all claims for the entire CMH network, whether from CMH service divisions or from contracted providers. The policy ensures that the Agency shall review a sample of claims to determine that payments for services are properly made. This includes determining that the service claimed was provided, is eligible for payment from the claimed funding source, is identified in a person-centered plan and is properly documented. Additionally, HealthWest participates in regular Medicaid Verification audits conducted by the PIHP.

XVIII. COMMUNICATION AND TRAINING

Training and information about Quality Improvement is provided at the time of new hire orientation and on an on-going basis. Information and activities are communicated in a number of ways:

A. A systematic means for staff to make suggestions related to any quality issues is provided through the use of agency suggestion form and procedure.
B. Minutes of standing committees are available via the Intranet.
C. Information and activities about quality improvement efforts are included in the Director report to the Board each month.
D. Quality Improvement reports including satisfaction and service outcomes are posted to the CMH website.
E. Quality Improvement communications are included in the external Provider meetings.

XIX. LINKAGE TO UTILIZATION MANAGEMENT

Quality Assessment and Performance Improvement philosophy and methodology is central to Utilization Management's procedures for identifying, analyzing and correcting under utilization as well as over utilization. To achieve the Utilization Management goals, a number of UM functions are used:

- Eligibility Screening, including Psychiatric Hospitalization pre-evaluation;
- Service Authorization
- Utilization Review
- UM Committee: Prospective (eligibility determinations, medical necessity and level of care determinations), concurrent and/or retrospective procedures are established based on the principles of quality improvement.
- Development and Maintenance of Standards and Guidelines

These utilization management activities and operating processes are detailed in the UM Plan.

XX. EVALUATION OF THE QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN

The Quality Assessment and Performance Improvement policy is reviewed annually and revised as needed to keep pace with the changing needs and input of the CMH/PIHP stakeholders. The Quality Assessment and Performance Improvement Plan is evaluated annually and ongoing methods of evaluation include:

- Periodic review of specific goals of QAPIP related to organizational performance improvement.
- Ad Hoc studies, surveys and informally gather data related to the above.
- Review of quality, outcomes and other data on an ongoing basis, to identify trends and new issues requiring attention.
- Feedback from CMH/PIHP Network providers and Consumer Councils.
- Review of Satisfaction surveys related to the quality of care review process, and other qualitative/quantitative measure of satisfaction and input.
- Auditing for continuous improvement in the provider network.

The annual evaluation of Quality Assessment and Performance Improvement effectiveness includes a workgroup/committee self-assessment, which cover such aspects as:

- Do the performance indicators cover the key dimensions relevant to best practice performance standards?
- Does problem resolution result in long term improvement?
- Is the mission and composition of workgroups conducive to meeting the agency Strategic Plan objectives?
- What are the Process Improvement Accomplishments?
- Are reports effective and timely?
- Has the QA&PI program improved the efficacy, appropriateness and cost-effectiveness of managing consumer benefits, outcomes and satisfaction?
- Have stakeholders participated in the design, delivery and evaluation of the CMH/PIHP through quality improvement processes.

The Director and the Quality Manager are responsible to present findings and recommendations to the Board of Directors.

XXI. PERFORMANCE IMPROVEMENT PROGRAM OBJECTIVES:

During FY19, the focus for many of our improvement activities was on building and strengthening the QI infrastructure, to allow for more meaningful and consistent QI activities. These improvements included the following:

- Development and deployment of Cx360, the new electronic health record (EHR) provided by Core Solutions
- Transitioning all of our SUD data, claims and billing from Ottawa County CMH's Provider Connect system to our own internal system (Cx360)
- Preparing for the implementation of new MMBPIS performance indicators regarding timeliness and accessibility of care
- Completion of the FY19 annual report, which highlights the accomplishments of the past year and provides detailed data regarding the clinical and financial operations of HealthWest
- Continued use of critical incident data, BH-TEDS records, utilization data,

- Collaboration with Beacon, the LRE and partner CMHSPs as part of the EDI/BIA workgroup regarding the development of provider and authorization file exchanges
- Expansion of the resources within the IT and QI departments

During FY20, many of these initiatives will continue, with the priorities for the upcoming year including the following:

- Launch of Cx360 for internal HealthWest staff
- Ongoing training for Cx360 users
- Implementation of reports and dashboards to monitor and improve data integrity
- Deployment of Tableau, a data analytics tool that will allow for the development of interactive dashboards and reports
- Emphasis on completion of BH-TEDS and encounter records
- Implementation of new MMBPIS performance indicators
- Modifications to customer satisfaction survey process and application and an increase in opportunities for consumer engagement
- Preparation for CCBHC operations
- Evaluation of the impact of COVID-19
- Increased emphasis on monitoring productivity data and its impact on agency finances

A review of progress on these goals will be provided to the Board following the completion of FY20.

XXII. REFERENCES:

- CARF International Standards
- Policy Quality Assessment and Performance Improvement
- Policy Peer Review and the Root Cause Analysis of Sentinel Events
- Implementation and Monitoring of CMH Satisfaction Surveys
- Policy Claims Verification
- Procedure- Billing Audit
- Policy Clinical Chart Review
- Person- Centered Planning Best Practice Guideline
- Provider Orientation & Implementation of Person Centered Planning
- Procedure New Hire process
- Policy Verification of Registration and/or Licensure of CMH Professional Employees and Contracted Professional Providers.
- Contract Boiler Plate
- Strategic Plan
- Risk Management Plan
- Utilization Plan
- Information Management Plan
- Corporate Compliance Plan
- QISMC Guidelines
- MDHHS Contract Attachment
- Lakeshore Regional Partners QAPIP and Utilization Plan
- Balanced Budget Act, 1997