HealthWest
Muskegon's Behavioral Wellness Connection

PROGRAM AND PERSONNEL COMMITTEE

Friday, April 16, 2021
8:00 a.m.

Zoom: https://healthwest.zoom.us/j/92718779426
Join by Phone: (312) 626-6799, 92718779426#

Program and Personnel Committee Chair: Cheryl Natte
Program and Personnel Committee Vice-Chair: John Schrier

AGENDA

		Disposition
1)	Call to Order	Quorum
2)	Approval of Minutes of February 12, 2021 meeting as written. (Previously Forwarded)	Action
3)	Items for Consideration	
	A. Authorization to approve the position changes as outlined on the attached Position Changes for FY 2021 County Budget (Attachment #1)	Action
	B. Authorization to approve the FY21 Quality Assessment and Performance Improvement Program (Attachment #2)	Action
4)	Old Business	
5)	New Business	
6)	Communication	
7)	Director's Comments	Information
8)	Audience Participation	
9)	Adjournment	Action

REQUEST FOR HEALTHWEST BOARD CONSIDERATION AND AUTHORIZATION

COMMITTEE Personnel Committee	BUDGETED NON-BUDGETED PARTIALLY BUDGETED X	
REQUESTING DIVISION Administration	REQUEST DATE April 16, 2021	REQUESTOR SIGNATURE Julia Rupp, Executive Director

SUMMARY OF REQUEST (GENERAL DESCRIPTION, FINANCING, OTHER OPERATIONAL IMPACT, POSSIBLE ALTERNATIVES)

HealthWest Board authorization is requested to

1. Reclass Board Certified Assistant Behavior Analyst (BCABA), Position X09901 (Wage Grade HX 00210, $22.063 – $27.771/Cost Center 7319), to a Board Certified Behavior Analyst (BCBA) (Wage Grade HX 00360, $31.963 – $40.447/Cost Center 7319). We have the caseload to support another full-time BCBA and we have applicants available. This will increase our capacity to serve more children and decrease the wait time for an opening with a BCBA.

2. Reclass Building Maintenance Mechanic I, Position G12201 (Wage Grade GU-00150, $13.20-$18.59/Cost Center 7706) to a Building Maintenance Mechanic II (Wage Grade GU-00240, $15.59-22.09/Cost Center 7706). The employee in this position is already completing Building Maintenance Mechanic II job duties for HealthWest and possess the knowledge, skills and abilities required for the position. Additional duties include repairing heating and air conditioning systems, repairing and maintaining plumbing fixtures, making recommendations for contracted services when necessary, and maintaining facilities records.

3. Reclass Supports Coordinator, Position X85204 (Wage Grade HX-00160, $20.024-$25.222/Cost Center 7144) to an EHR and Client Information Specialist (Wage Grade HX-00210, $22.063-$27.772/Cost Center 7551). The employee in this position was re-deployed several months ago and is already performing the functions of the EHR and Client Information Specialist. Job duties include assisting with the management and support of the help-desk activities specific to the electronic health record, providing technical assistance to individuals and teams, setting up user profiles, changing passwords, and maintaining user roles in the system.

4. Add one Supports Coordinator position (Wage Grade HX-00160, $20.024-$25.222/Cost center 7144) to replace the position that is being reclassed in #3 above. This position is for our IDD team and is needed to support the caseloads in that department.

The remainder of the changes are funding org changes to ensure costs are allocated to the proper cost centers.

SUGGESTED MOTION (STATE EXACTLY AS IT SHOULD APPEAR IN THE MINUTES)

I move to authorize the position changes as outlined on the attached Position Changes for FY 2021 County Budget, effective May 9, 2021.

COMMITTEE DATE	COMMITTEE APPROVAL _____ Yes _____ No _____ Other
BOARD DATE	BOARD APPROVAL _____ Yes _____ No _____ Other

Position Changes for FY 2021 County Budget

Personnel Committee Date:
Board Meeting Date:

New Positions

New Position Title	Budget Org	%	Wage Grade
Supports Coordinator	7144	100	HX 00160

Reclassifications

Current position Title	Current Position #	Current Wage Grade	Incumbent Employee	Current Budget Org	%	New Position Title	New Budget Org	%	New Wage Grade
Board Certified Assistant Behavior Analyst (BCABA)	X09901	HX 00210	Vacant	2319	100	Board Certified Behavior Analyst (BCBA)	7319	100	HX 00360
Building Maintenance Mechanic I FT	G12201	GU 00150	Leon Puterbaugh	7705	100	Building Maintenance Mechanic II	no change	no change	GU-00240 (17.70 - 25.53)
Supports Coordinator FT	X85204	HX 00160	James Robinson	7144	100	EHR and Client Information Specialist	7551	100	HX 00210

Funding Org changes

Position Title	Position #		Incumbent employee	Budget Org	%		Budget Org	%
Case Manager	X11107		Norman Kittleson	7066	100		7337	100

REQUEST FOR HEALTHWEST BOARD CONSIDERATION AND AUTHORIZATION

COMMITTEE Program/Personnel Committee	BUDGETED NON-BUDGETED PARTIALLY BUDGETED	
REQUESTING DIVISION Quality Improvement	REQUEST DATE April 17, 2021	REQUESTOR SIGNATURE Julia Rupp, Executive Director

SUMMARY OF REQUEST (GENERAL DESCRIPTION, FINANCING, OTHER OPERATIONAL IMPACT, POSSIBLE ALTERNATIVES)

As part of its commitment to excellence, HealthWest undertakes a variety of Quality Improvement (QI) and Performance Improvement (PI) activities each year, which aim to improve the access, effectiveness, efficiency, value and satisfaction of the services we provide. These QI activities, which are a fundamental component of HealthWest's responsibility as a CMHSP, are described and documented within the HealthWest Quality Assurance and Performance Improvement Plan (QAPIP). The HealthWest Performance Improvement (PI) Committee, which provides oversight of the implementation of the QAPIP and the agency's QI activities, is required to provide the Board of Directors with an annual review of the Quality Improvement (QI) activities from the past year as well as the proposed QAPIP developed for the upcoming year.

Board approval is requested to accept the FY2021 QAPIP as written, which includes the review of FY2020 performance measures and FY2021 workplan and performance goals.

SUGGESTED MOTION (STATE EXACTLY AS IT SHOULD APPEAR IN THE MINUTES)

I move to accept the FY2021 QAPIP as written and submitted to the HealthWest Board of Directors.

COMMITTEE DATE	COMMITTEE APPROVAL _____ Yes _____ No _____ Other
BOARD DATE	BOARD APPROVAL _____ Yes _____ No _____ Other

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

ANNUAL PLAN FY2021

PREPARED BY: MATT PLASKA
REVIEWED AND APPROVED BY: JULIA RUPP
REVIEWED AND APPROVED BY: HEALTHWEST BOARD

Definitions

Beneficiary: A person served by the publicly funded behavioral health and substance use disorder system or his/her representative.

Credentialing: The process of establishing the qualifications of licensed professionals and assessing their background and legitimacy.

Clinical Privileging Committee: The committee of professional peers/staff appointed to evaluate and recommend an individual practitioner to be allowed to provide specific services for HealthWest within well-defined training criteria.

CMHSP: Community Mental Health Services Program. For the purposes of this document refers to HealthWest.

Network Provider: Any provider that receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the state's contract with the Lakeshore Regional Entity (LRE), its member CMHSPs, and the Substance Use Disorder provider panel.

HealthWest Leadership Committee: A committee comprised of key, senior HW staff who are responsible for strategic planning, agency operations, and decision-making.

HealthWest Executive Committee: A committee comprised of executive-level HealthWest staff who are responsible for approval of policies and procedures.

HealthWest Performance Improvement Committee: The CMHSP performance improvement (PI) committee comprised of HealthWest staff and persons served; responsible for oversight of QAPIP.

Prepaid Inpatient Health Plan (PIHP): One of ten organizations in Michigan responsible for managing Medicaid services related to behavioral health, intellectual/development disabilities, and substance use.

Adverse Events: Adverse Events include any event that is inconsistent with or contrary to the expected outcomes of the organization's functions that warrants a review. Subsets of these adverse events will qualify as "reportable events" according to the MDHHS Critical Event Reporting System. These include MDHHS defined sentinel events, critical incidents, and risk events.

Purpose

As the CMHSP for Muskegon County, HealthWest has developed this Quality Assessment and Performance Improvement Program (QAPIP) to guide the quality improvement activities of the agency. The QAPIP is intended to serve several functions, including but not limited to:

1. Serve as the quality improvement structure for the managed care activities of HealthWest.

2. Link, monitor, and coordinate activities around organizational performance improvement priorities;

3. Provide support to organizational efforts to integrate a performance improvement philosophy into the everyday work of the organization;

4. Make recommendations to Leadership and/or Executive Team for specific improvement actions and changes;

5. Communicate improvements and challenges within and outside the organization;

6. Weigh risks and opportunities associated with identified organizational performance improvement opportunities; and

7. Describes how these functions are accomplished in the written plan, including the organizational structure and responsibilities relative to these functions.

Policy

HealthWest will have a fully operational QAPIP that meets the conditions specified in the PIHP-CMH Contract.

The QAPIP will be reviewed and approved on an annual basis by HealthWest Governing Board. Through this process, the governing board gives authority for implementation of the plan and all its components. This authority is essential to the effective execution of the plan.

Consistent with the structure of HW, and the structure of its Governing Board, this authority is discharged through the HealthWest's Executive Director. In turn, the CEO discharges this authority through the Director of Quality/Performance Improvement.

Authority

A strong quality assurance and performance improvement process requires consistent accountability across the organization. This means that the Performance Improvement (PI) Committee has the ability to recommend to the HealthWest Leadership Committee that opportunities for improvement are prioritized and specific actions to address these improvement opportunities are taken. Ultimate authority for Quality Assurance/Performance Improvement at HealthWest rests with the HealthWest Board of Directors, who vests responsibility for all operations of the organization with the HealthWest Executive Director. The HealthWest Executive Director places responsibility for the leadership, implementation, and overall organizational coordination of Performance Improvement/Quality Assurance Activities with the Director of Quality Improvement.

Structure

1. Provider/Consumer Involvement

   The involvement of provider and person served representatives is essential to comprehensiveness of the QAPIP. As such, this involvement is sought, encouraged, and supported at several levels, including:

   a. The HealthWest Governing Board will have persons served as members.
   b. HealthWest will have a consumer advisory panel that provides input to various managed care activities.
   c. The Performance Improvement Committee will be comprised of staff from HealthWest, and representation of primary and secondary persons served.

2. CMHSP Leadership Committee

   HealthWest Leadership Committee will have the central responsibility for the implementation of the QAPIP. The membership consists of key staff from HW, including:

   a. Julia Rupp, Executive Director (Chair)
   b. Brandy Carlson, Chief Financial Officer
   c. Cyndi Blair, Chief Clinical Officer
   d. Randi Bennett, Director Information Systems
   e. Matt Plaska, Director of Quality Improvement
   f. Kelly France, Clinical Quality Assurance Manager
   g. Jennifer Stewart, Clinical Quality Assurance Manager for SUD
   h. Mickey Wallace, Director of Diversity, Equity and Inclusion
   i. Lauren Meldrum, Director of Community Relations
   j. Cece Riley, Communications and Training Manager
   k. Gregory Green, M.D., Medical Director
   l. Amie Bakos, Clinical Services Manager of IDD

3. CMHSP Performance Improvement Committee

   The Performance Improvement (PI) Committee will be responsible for ensuring that Network Providers have appropriate performance improvement structures and activities necessary to monitor the provision of quality services and to meet federal and state requirements. This group provides the primary link between the performance improvement structures of Network Providers and HW.

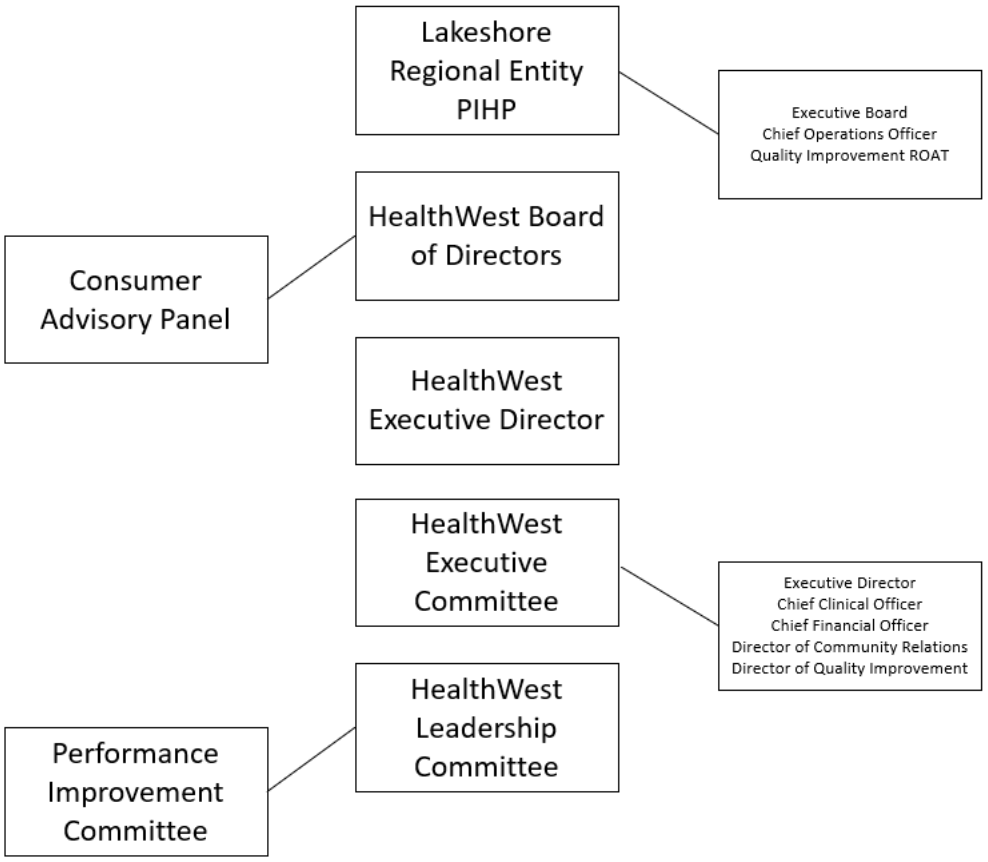
   PI Committee is chaired by the Director of Quality Improvement with the Quality Improvement Administrative Assistant acting as the Recorder. The committee is comprised of:

   a. Cyndi Blair, Chief Clinical Officer
   b. Matt Plaska, Director of Quality/Performance Improvement (chair)
   c. Natalie Walther, Data Architect and Analytics Manager
   d. Mickey Wallace, Director of Diversity, Equity and Inclusion
   e. Pam Kimble, Director of Autism and Co-chair of Behavior Supports Committee
   f. Amie Bakos, Clinical Services Manager of I/DD and Co-chair of Behavior Supports Committee
   g. Kelly France, Clinical Quality Assurance Manager
   h. Jennifer Stewart, SUD Quality Assurance Manager
   i. Gary Ridley, Communications and Social Marketing Coordinator
   j. Additional members of Leadership Committee as designated by the Executive Director
   k. Primary or secondary persons served from appropriate service populations, including persons with developmental disabilities, adults with mental illness, children with severe emotional disturbances, and persons with substance use disorders.
   l. Ad hoc members include all members of the Leadership/Executive Team, the Medical Director, Recipient Rights Officer, Privacy Officer, Corporate Compliance Officer, Human Resources Coordinator, Director of Information Systems, contract providers and/or other stakeholders, and any member of the HealthWest staff.

4. Accountability

   One of the basic tenets of performance improvement, and a key element of all successful teams, is accountability. Consequently, the success of this plan is dependent on each component understanding, and meeting, its accountabilities. This begins with the basic premise that each employee and/or agent of each organization, whether HealthWest, its Network Providers, contract agency, or subcontract agency, will be accountable for the quality and integrity of his/her work: accountable to beneficiaries, coworkers, various committees to which he/she belongs, and to his/her employer. The following table displays the reporting accountability of the various formal components of the quality improvement and assessment program.

HealthWest Performance Improvement Structure



Responsibilities

Each of the components of the QAPIP structure will have specific responsibilities. These various tasks, when taken in whole, will ensure that HealthWest and its Network Providers are administering quality services, effectively managing and protecting available resources, protecting the rights of service beneficiaries, and identifying opportunities to improve.

1. The Lakeshore Regional Entity (LRE) Board of Directors is accountable for the regional quality assessment and performance improvement activities across the 7-county affiliation of the PIHP. The LRE Board will annually review and evaluate the written regional Quality Assessment and Performance Improvement Plan. The Board will regularly receive specific reports of affiliation-wide performance indicators, quality oversight activities, and corrective actions as requested. They vest authority for management of Quality Oversight to the Chief Operating Officer (COO) for the LRE. The LRE COO is responsible for implementation of Quality Oversight at the PIHP Level and is responsible for facilitation of the affiliation-wide Quality Oversight Committee.

   Members of HealthWest PI Committee sit as members of the LRE QI Regional Operations and Advisory Team and support affiliation-wide Quality Oversight Functions.

   As part of the contractual arrangement between the LRE and HealthWest, Quality Assurance/Performance Improvement is a delegated function, whereby the affiliation ensures compliance with federal and state requirements for a functioning quality improvement system but HealthWest is responsible for its implementation. All Community Mental Health Service Programs, as part of this arrangement, will develop, implement and maintain quality improvement programs and will report results of monitoring and improvement activities to the LRE's Quality Improvement Regional Advisory and Operations Team (QI ROAT) as requested.

2. HealthWest Leadership Committee

   HW Leadership Committee, will have the lead role in implementing the QAPIP. This begins with responsibility for the performance, quality, effectiveness, and efficiency of the managed care activities. In addition to managing the "PI" function for the managed care organization, HW Leadership Committee also has responsibility for the following:

   a. Claims Verification

      The verification of Medicaid claims is required both by federal regulation and the MDHHS PIHP contract. Primary responsibility for this activity is with the PIHP. The LRE policy on Medicaid Verification defines the specific processes used for ongoing record review, including the verification of documentation for services provided, timeliness of documentation and quality of service provided and documented. The Lakeshore Regional Entity PIHP performs regular record reviews and results are provided to PI, Executive Team, and HW Corporate Compliance Officer. If HealthWest's performance is below accepted PIHP thresholds, the HW Corporate Compliance officer will share findings with the Leadership Committee. The Leadership Committee will determine actions necessary to improve performance. HW Corporate Compliance Officer also shares individual level data/findings with appropriate HW staff.

   b. Practice Guidelines

      HW recognizes the state of the art in clinical practice is rapidly changing as our knowledge base on disability and treatment evolve. National research provides a foundation for direction for treatments specific to diagnostic categories, however, this research usually does not provide for clear guidance for persons with multiple disabilities or severe and persistent mental illness. The HealthWest Clinical Leadership Committee is responsible for reviewing the literature for guidelines with research supporting evidence or expert

consensus, assessing the validity of the method, based on the strength of the evidence and expert judgment, assessing the reliability and reproducibility of the practice, and examining clinical applicability including attention to multidisciplinary strengths that benefit the people we serve.

HW is also responsible for implementing all contractually mandated Practice Guidelines. These include but are not limited to Person Centered Planning/Family-Centered Planning, Self-Determination Policy and Practice Guideline, Inclusion, Housing, Consumerism, Co-occurring Treatment, Jail Diversion, and School to Community Transition.

The process for developing, reviewing, adopting, and disseminating practice guidelines as specified in HW "Practice Guidelines" policy and procedure will be assigned to the Clinical Oversight Committee. These guidelines will be approved by the Executive Committee. Dissemination to contract providers is the responsibility of the Contract Manager. HealthWest Leadership Committee will have the responsibility for ensuring the policy and procedure are implemented.

c. Adverse Events

Adverse Events include any event that is inconsistent with or contrary to the expected outcomes of the organization's functions that warrants a review. Subsets of these events, adverse events, will qualify as "reportable events" according to the MDHHS Critical Event Reporting System. These include MDHHS defined sentinel events, critical incidents, and risk events. HW has a system in place to monitor these events, utilizing staff with appropriate credentials for the scope of care, and within the required timeframes. HealthWest submits and/or reports required events to the PIHP. The PIHP then reports adverse events to MDHHS including events requiring immediate notification as specified in the Medicaid Managed Specialty Supports Services contract within the timelines required by MDHHS. HealthWest is responsible for the process of review and follow-up of sentinel events, critical incidents, and other events that put people at risk of harm to its CMHSP Participants. HealthWest will take appropriate action to ensure that any immediate safety issues have been addressed, including the identification of a sentinel event within three business days in which the critical incident occurred and the commencement of a root cause analysis within two business days of the identification of the sentinel event. HW will ensure that those involved in the root cause analysis process have appropriate credentials to address the scope of the issues involved. Following completion of a root cause analysis, or investigation, HealthWest will develop and implement either a plan of action or an intervention to prevent further occurrence or recurrence of the adverse event, or documentation of the rationale for not pursuing an intervention. The plan shall address the staff and/or program/committee responsible for implementation and oversight, timelines, and strategies for measuring the effectiveness of the action. Sentinel Events are tracked at HealthWest via a Critical Incident database. Notification of the occurrence of a Sentinel Event is reported to the LRE. For additional information see the HW Policy on Sentinel Events.

i. Sentinel Events

Primary responsibility for review of sentinel events will be vested in HealthWest and its Network Providers. The Director of Quality will be responsible for

ensuring that this occurs, with proper reporting, as specified in HW "Critical Incident, Risk Event, Sentinel Event, and Death Reporting" policy and procedure. HealthWest Leadership Committee will have the responsibility for assuring the policy and procedure is implemented appropriately.

ii. Critical Incidents and Risk Events

At least quarterly, HealthWest Leadership Committee will analyze critical incident and risk event data. Based upon this analysis, HealthWest Leadership Committee will, as appropriate, review additional information needed to determine when and what actions are needed to remediate a situation or to reduce the potential for similar events.

d. Credentialing

In compliance with MDHHS's Credentialing and Re-Credentialing Processes (FY20 Attachment P7.1.1, FY20 Attachment PII.B.A), HealthWest has established written policy and procedures for ensuring appropriate credentialing and re-credentialing of the provider network. HW shall ensure that credentialing activities occur upon employment/contract initiation, and minimally every two (2) years thereafter. HW written policies and procedures also ensure that non-licensed providers of care or support are qualified to perform their jobs. Credentialing, privileging, primary source verification and qualification of staff who are employees of HW or under contract to the CMH, are the responsibility of HW. Credentialing, privileging, primary source verification and qualification of CMHSP Participant/SUD Provider staff is delegated to the HealthWest from the PIHP. HW is responsible for ensuring that each provider, employed and contracted, meets all applicable licensing, scope of practice, contractual, and Medicaid Provider Manual requirements, including relevant work experience and education, and cultural competence. HealthWest is responsible for the selection, orientation, training and evaluation of the performance and competency of their own staff and subcontractors. Credentialing is the responsibility of the Human Resources Manager at hire and annually thereafter. Clinical Privileges are the responsibility of the privileging committee chaired by Clinical Quality Assurance Managers.

e. Utilization Management

HealthWest will have a Utilization Management Plan that will identify the following:

i. Strategies for evaluating medical necessity, criteria used, information sources, and the processes used to review and approve the provision of medical, clinical and support services;
ii. Mechanisms for regular and ongoing review of individual needs of the persons served, circumstances and services being delivered:
iii. Mechanisms to identify and correct under-utilization as well as over-utilization;
iv. Procedures for conduction prospective, concurrent, and retrospective reviews of authorizations.

Data and recommendations for system-related Performance Improvement opportunities are directed to the PI Committee for their review and action and/or recommendation.

f. Provider Monitoring

HealthWest will monitor its Network Providers and ensure their adherence to contract requirements. This includes contracted providers, and certain out-of-network providers, as needed. Monitoring will include a review service and support provision, and compliance with administrative requirements. As appropriate, targeted monitoring activities for people identified as "vulnerable" are also conducted. When a provider is found to be out of compliance with a contractual requirement, appropriate corrective actions are required, as specified in HealthWest policy and procedure. However, at this time, the formal quality site reviews will be conducted by the PIHP on behalf of the CMHSP.

3. Performance Improvement Committee

The PI Committee will be HealthWest's primary connection to the quality improvement activities and structures of Network Providers. This committee will also be a vehicle for beneficiary input. The primary responsibilities of the PI Committee include.

a. Coordination with Network Provider Structures

An inherent principle of quality improvement is that improvement is best addressed by the individuals involved in the systems to be improved. Consequently, those best equipped to improve the various functions of the Network Providers are those within the organizations. For this reason, HealthWest has taken a position of supporting the existing QI structures within the various provider organizations. It will be the responsibility of the HealthWest, however, to ensure that each of these structures meets the requirements of federal and state regulations and the MDHHS-PIHP contract.

b. Performance Indicators

The MDHHS has established performance indicators for PIHPs. HealthWest will report performance indicators for all services populations to the MDHHS. Additionally, HealthWest reports performance indicators for Medicaid beneficiaries. This information includes beneficiaries served, whether for mental health, intellectual/developmental disability or substance abuse disorders. The PI Committee will monitor HealthWest performance in this area. When standards are not met, the PI Committee will do an analysis of the indicator and determine what is the cause of the non-compliance and develop a plan to bring the indicator into compliance.

c. Consumer Satisfaction and Outcome Measures

The PI Committee will be responsible for conducting surveys of beneficiaries to assess their degree of satisfaction with services. The PI Committee Annual Work Plan will address specifics for implementation of satisfaction surveys. Additionally, the PI Committee will advance the implementation of outcome measurement as appropriate.

d. Performance Improvement Projects

Federal regulations and the MDHHS-PIHP contract require that each PIHP conduct at least two Performance Improvement Projects each year. Currently, MDHHS mandates the topic

of one of the two projects. The PI Committee will be responsible for selecting the second topic. The Director of Performance Improvement will be responsible for reporting the Performance Improvement Projects.

Performance Improvement Projects are designed such that they achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and satisfaction of the individuals served. Performance improvement projects must address clinical and non-clinical aspects of care. Clinical areas include, but are not limited to, high-volume services, high-risk service, and continuity and coordination of care. Non-clinical areas include, but are not limited to, appeals, grievances and complaints, and access to, and availability of services. Project topics will be selected in a manner which considers the potential impact on the individuals the organization serves, and the particular demographic characteristics and health risks of individuals served.

In addition, HealthWest also participates in an ongoing basis in the Quality Assurance Performance Improvement Projects identified by MDHHS at the PIHP Level and in other Performance Improvement Projects identified and approved at that level.

e. Analysis of Behavior Treatment Data

The PI Committee will review, at least quarterly, an analysis of data from HealthWest's behavior treatment review committee. This review will include any intrusive or restrictive techniques that have been approved or used with beneficiaries where physical management was necessary in an emergency. At a minimum, this review will include number of incidents and duration of intervention, trend analysis as possible, as well as evidence that HealthWest is examining possible changes in treatment. As appropriate, the Chair of HealthWest's Behavior Treatment Review Committee (known as the "Behavior Supports Committee" at HealthWest) will attend the PI Committee meeting to present and discuss data and the analysis of trends. This is intended to maximize the value of this process by providing expert analysis and insight.

4. Director of Quality Improvement

This HealthWest staff position will be the individual with primary responsibility for implementation of the QAPIP, including providing appropriate staff support to the various committees and structures.

On an annual basis, the Director of Quality Improvement will work with various committees to conduct a review of the quality assessment and performance improvement activities of HealthWest. This will include a review of annual work plans, developing a work plan for the coming year, reviewing the written QAPIP, and recommending changes as needed. Information on the effectiveness of the HealthWest's QAPIP will be provided annually to persons served and stakeholders.

The Director of Quality Improvement will also ensure that HealthWest maintains an appropriate quality improvement program to meet the requirement of federal regulations and national accreditation. Summary reports of the quality improvement activities, minutes of quality

improvement meetings, revised quality improvement plans, as well as annual evaluations of the quality improvement plan/program will be submitted to the LRE. All quality improvement programs and activities will be consistent with the standards and requirements for managed care, as specified in federal regulation and the MDHHS-PIHP contract. Reporting to the PI Committee will, in most cases, be sufficient to ensure compliance with these requirements.

Confidentiality

HealthWest is completely committed to maintaining the confidentiality of individuals served in our organization. The following statements below reflect specific tenets of this commitment. Specific details regarding confidentiality and the protection of consumer records are reflected in HealthWest Policy and Procedure. For purposes of the QAPIP, the following expectations are highlighted:

1. The contents of clinical records and provider credentialing files are confidential.
2. Although usually accomplished via aggregate non-individual-identifying reports, at times QI may review specific individually identifiable and confidential information.
3. Access to confidential performance improvement or quality oversight information (i.e., clinical information, medical history, credentialing information) shall be restricted to those individuals and/or committees charged with the responsibility and accountability for the various aspects of the program.
4. Individual provider information may be utilized and/or evaluated at the time of re-credentialing or contracting.
5. All information about individuals served and/or provider-specific information will be kept in a confidential manner in accordance with applicable federal and state laws and will be used solely for the purposes of quality oversight and/or directly related activities. Disclosing confidential information about individuals served and/or provider information internally or externally may be grounds for immediate dismissal from the committee.

Corrective Action Initiatives

Corrective Action or Plan of Correction (POC) may be requested by the PI Committee at any point in time regarding an identified performance challenge where the organization, a provider, a department, or a team does not meet the established thresholds or standards (as set by the organization, via contract, or accrediting body). Problems requiring corrective action may be identified through routine performance indicator monitoring, results of a monitoring study, results of a special study, results of a site visit, results of a Utilization Management/Utilization Review study, and/or results of a root cause analysis. Minimum elements of an acceptable plan of correction (POC) or corrective action include summary of the assessment of the nature of the problem, plan to address the problem with timeframes, identified leads, action steps, proofs, timeline for next monitoring, and a statement regarding how to know a plan of correction is completed (for all required elements see Attachment 1). POCs may be accepted or rejected by PI Committee and consultative recommendations may be added at the discretion of the committee. Problems with implementing a POC should be shared with the PI and primary supervisor in advance of the deadline for completion. Repeated failure to submit timely plans of correction or corrective action plans will be addressed first through the behavioral contract and then through the attention of the primary supervisor.

Priorities for Performance Improvement

Performance Improvement opportunities occur at various times throughout the life of a system. On occasion, the improvement opportunity identified conflicts with other existing organizational priorities. The PI Committee thus engages in an ongoing process of identifying and prioritizing Performance Improvement Opportunities that it identifies over the course of the year. Recommendations regarding prioritization of these issues are sent to the Leadership Committee for prioritization within the context of other organizational Strategic Plan Goals and Improvement Projects. The prioritization schema utilized at HealthWest at both the PI Committee and Leadership Committee level asks individuals to prioritize activities based upon the impact of the issue on:

- Mission, Vision, Values (M, V, V critical)
- Level of Risk (contractual, person served, accreditation, other)
- Number of individuals served by the organization who would be affected.
- Process complexity
- Impact on other well-functioning processes
- Drain on organizational resources.

Standing Performance Measures

The following list of performance measures will be analyzed and reported to the PI Committee at least annually. Where appropriate, analysis will include performance compared to established benchmarks or targets, tracking of performance over time, actions to improve performance, outcomes of the actions to improve performance, and ongoing plans for each measure. Detailed reports are made to PI Committee at appropriate intervals, and performance on all the listed measures will be summarized annually as part of the PI Committee's annual program evaluation.

Measure	Category	Source	Frequency
Michigan Mission-Based Performance Indicator System (MMBPIS): 1. Timeliness of Pre-Admission Screenings, Determinations for Inpatient Admission 2. Timeliness of Assessments 3. Timeliness of Start of Services 4. Follow-up to discharge from inpatient hospitalization and SUD detox admissions 5. Inpatient recidivism within 30 days of discharge 6. Proportion of requests that resulted in denial of eligibility, second opinions and starting of services	Access, Efficiency, Outcomes	MMBPIS	Quarterly
BH-TEDS completeness	Effectiveness	MDHHS	Quarterly
Medicaid Verification Results	Compliance	LRE	Quarterly
Critical Incidents and Risk Events	Health & Safety	PI Committee	Quarterly
Physical Management and Behavior Treatment Review Committee Data	Health & Safety	BSC report	Quarterly
Mobile Crisis Utilization	Access, Efficiency	Clinical QA	Quarterly

Jail Diversion Data	Access	LRE	Semi-annual
SUD Sentinel Events	Health & Safety	PI Committee	Semi-Annual
Annual Submission: Requests for Services and Disposition of Requests, Waiting Lists, Priority Needs and Action Plans and Provider Network Capacity	Access, Efficiency, Satisfaction	MDHHS	Annual
DHIP Outcomes Measures 1. Improvement on CAFAS 2. Improvement on PECFAS	Effectiveness	CAFAS and PECFAS outcome reports	Annual
Post-Discharge Monitoring (MH and SUD)	Satisfaction	PI Committee	Annual
Grievance and Appeal Monitoring	Business Function	Customer Services	Annual
Customer Service Activity	Business Function	Customer Services	Annual
Prescriber Peer Review	Effectiveness, Health & Safety	Prescriber Peer Review	Semi-Annual
Monitoring effects of psychotropic medications: metabolic labs, AIMS, and side effects	Health & Safety	Prescriber Peer Review	Semi-Annual
Suicide deaths and suicide attempts	Health & Safety	Sentinel Events, CIRE	Ongoing
UM Summaries	Effectiveness, efficiency	UM dept.	Monthly
Accessibility assessment	Access	Customer Services	Annual
Performance Measurement and Improvement: Results achieved for persons served (per program)	Effectiveness, Outcomes	CARF	Annual
Performance Measurement and Improvement: Experience of services received and other feedback from the person served (per program)	Satisfaction	CARF	Annual
Performance Measurement and Improvement: Experiences of services and other feedback from other stakeholders (per program)	Satisfaction	CARF	Annual
Performance Measurement and Improvement: Resources used to achieve results	Efficiency	CARF	Annual
Performance Measurement and Improvement: Service Access	Access	CARF	Annual
Provider Network Quality Oversight – Site Reviews	Compliance	LRE	Annual, per provider
CMHSP Site Review	Compliance	LRE	Annual
CMHSP Waiver Audit	Compliance	LRE	Annual
PIHP Waiver & SUD Services Audit	Compliance	MDHHS	Biennial
CARF Accreditation Summary	Compliance	CARF	Triennial
PI Committee Self-Evaluation	Effectiveness	PI Committee	Annual

Reporting

Reports and corrective action plans developed at the request of the committee are submitted to the Director of Performance Improvement for distribution to the committee as part of the monthly/quarterly meeting packet. The findings of monitoring and evaluation activities and/or Plans of Corrections are presented to the PI Committee by the individual responsible for the study and/or POC.

Minutes of all PI committee meetings will be kept in a standard format sufficient to document the topics discussed, analysis and resulting action items. The minutes will be approved by the PI committee and will include original attachments. Meeting packets and accompanying minutes from the previous meetings will be maintained by the Director of Quality Improvement and are available for audit and/or review as requested. All records, audit materials and communications/correspondence will be retained according to regulatory record keeping requirements. Such records are not available as part of "Discovery" or other proceedings associated with litigation and may not be copied or distributed in any manner. Such records are not part of the medical record.

Communicating Performance Data to Staff and Stakeholders

On a monthly basis, the PI Committee will select reports that are important and of interest to staff and the general public. These reports will be shared with staff, persons served and other stakeholders via appropriate communication channels.

Annual Self-Assessment

In order to ensure the ongoing effectiveness of the committee and to support a strong QA/PI process within the organization, the PI Committee will conduct an annual self-assessment of the workings of the committee. Annually, all members will be advanced a series of questions designed to assess the workings of the committee (see Attachment #2). The group allocates time on the agenda for a thoughtful discussion of the strengths and challenges of the committee. Recommendations regarding improving performance are then drafted and reviewed by the committee to determine if they will achieve the desired impact. Results of the Annual Self-Assessment are incorporated into the Annual Program Evaluation described below.

Annual Program Evaluation

The PI Committee completes an annual QAPIP evaluation that includes:

1. A review of QAPIP Goals of the previous year;
2. A review of the Committee annual Self-Evaluation results;
3. A review of all quality oversight activities;
4. A review of the appropriateness and relevance of current measures (contained throughout this report).
5. Identify QAPIP Goals for the coming year.
6. An overall performance summary including Improvements to Quality-of-Service Delivery, Trends in Service Delivery and Health Outcomes over Time, and Progress on Goals and Objectives
7. Recommendations and next steps.

Documentation of the QAPIP annual review, its findings and recommendations are forwarded to the Leadership/Executive Team, the Board, the provider network, the Consumer Advisory Panel, and any person served upon request.

The annual review may lead to:

1. Identification of educational/training needs.
2. Establishment and revision of policies and procedures related to performance initiatives.
3. Recommendations regarding credentialing of practitioners.
4. Changes in operations to minimize risks in the delivery of quality services, and;
5. Development of objectives for the coming year.

Attachment 1

Plan of Correction (POC) Monitoring Template

Instructions: Each POCs monitoring plan submitted should include all of the following elements. See below for an example of a POC that contains all the necessary elements.

Standard Number: Usually an acronym (DHHS, CWP, etc.) and letters and number to identify the standard.

Citation: Brief description of the standard that was not met; should explain the reason a POC was required.

Plan of Correction: A description of the tasks to be completed to correct the identified opportunity for improvement and achieve the desired outcome.

Proofs: What evidence will you bring forward to show evidence that the outcome has been achieved.

Responsible Person(s): Name of the person(s) responsible for completing the tasks identified in POC. These are also the individuals who will be contacted for monitoring updates and proofs.

How will we know when POC is completed? This is a brief statement of when the POC will be considered "done" and taken off the POC monitoring list.

Status or Monitoring: Is this a status update or a full monitoring proof? A status proof requires a discreet change that needs to be made and reported while a monitoring proof requires a change that requires ongoing monitoring or measurement to substantiate that the change has been made.

Completion Time Frame: When will the tasks identified in the POC be completely implemented?

- Plans of correction written will remedy the situation within 30 – 60 days of receiving the citation.
- Monitoring will take place at a minimum of every 30 days.
- If after 60 days, there is no incremental improvement, appropriate staff and leadership will work together to write a new POC.
- The new POC will be monitored at a minimum of every 30 days.
- If after an additional 60 days, there is no incremental improvement, appropriate deputy directors will be notified and will assist in the POC process.

Monitoring Frequency: How frequently will the status of this POC be reviewed and where? All POCs will be reviewed at PI Committee for completion at least quarterly, but you may identify more frequent intervals at additional locations if it is helpful to you for getting the POC completed, and the outcome achieved.

- Monitoring will take place at a minimum of every 30 days.

Standard: MMBPIS #2	Mark when Complete: ☐
CITATION (OK to summarize; also include reason for POC) Timeliness—95% of assessments have not occurred within 14 calendar days of the person's first request for services.	

<table>
<tr><td colspan="3">PLAN OF CORRECTION

The Assessment and Stabilization Team supervisors will re-train staff on the 14-day standard and proper documentation when the person being served chooses to have their assessment appointment more than 14 days after the date when services were first requested. Clinician must document on the Call Log at least one assessment appointment date that was offered to the person within 14 calendar days of their request for services and complete a Chart Memo as needed.</td></tr>
<tr><td>PROOFS

At least two consecutive quarters of performance within the 95% standard.</td><td colspan="2">RESPONSIBLE PERSON(S):

Assessment and Stabilization Supervisors</td></tr>
<tr><td>HOW DO WE KNOW WHEN IT'S DONE?

HealthWest meets the 95% standard for this indicator for 2 consecutive quarters</td><td>Check one:

☐Status

☒Monitoring</td><td>COMPLETION TIMEFRAME:

September 30, 2021</td></tr>
<tr><td colspan="3">Monitoring Frequency: Monthly at PI Committee</td></tr>
</table>

Attachment 2

Performance Improvement Committee
Committee and Self-Evaluation

There are three basic reasons for committees in healthcare organizations to perform periodic self-evaluations. The first is that today's unforgiving health care environment demands nothing less than excellence in healthcare. The second is that a well-constructed self-evaluation process can help a committee improve its performance and achieve and maintain excellence in quality oversight. The third is that regulatory groups (BBA, DHHS, CARF, etc.) specifically require that committees evaluate their own performance.

Self-evaluation provides a committee with a structured opportunity to look at its past performance and to plan ahead. The process allows the committee to ask itself such questions as: What are we doing well? What could we be doing better? What are our objectives? How well did we achieve our objectives, or why did we not achieve our objectives? The committee may then use the answers to develop an action plan to improve its performance and establish new goals.

The aggregated responses from the Performance Improvement Oversight Committee self-evaluation questionnaires will be used to facilitate discussion at the next committee meeting. It is this discussion that provides the real value of the self-evaluation process.

Instructions: Please read each item in the left column and indicate in 1 of the 4 right columns your rating for our committee's performance in this area (Note: in the last section, please rate only your own personal performance).

	Very Good	Good	Fair	Poor
Section 1: Mission and Planning Oversight				
A. Each committee member has received a copy of our committee charge.				
B. Proposals brought before our committee are evaluated to ensure that they are consistent with our committee's charge.				
C. The committee periodically reviews, discusses, and if necessary recommends changes to the committee's charge to ensure that it remains current and relevant.				
D. The committee periodically reviews, discusses, and if necessary recommends changes to the Quality Assurance Performance Improvement Plan (QAPIP) and supportive policy statements.				
E. The committee provides support to organizational efforts to integrate a performance improvement philosophy into the everyday work of the organization.				
F. Committee members are active and effective in representing HW's quality oversight interests.				
G. Our committee supports and assists the HW Executive Director in achieving the HW mission.				
Section 2: Quality Oversight				
A. The committee reviews and discusses performance reports that provide comparative statistical data about HW services.				
B. The committee reviews feedback from community partners including residential homes, the LRE, DHS, referral sources, community agencies, and others, regarding HW's overall performance as a service provider.				

	Very Good	Good	Fair	Poor
C. The committee effectively communicates performance data to HW staff and other stakeholders (communicates improvements and challenges within and outside the organization).				
Section 3: Committee Effectiveness				
A. The committee evaluates its own performance and the individual performance of each committee member.				
B. Committee members work for the overall good of the organization and those we serve.				
C. The frequency and duration of committee meetings are appropriate.				
D. The committee chair ensures that members have equal opportunity to participate, meeting time is used appropriately, and agenda items are addressed with adequate discussion.				
E. Committee members receive the agenda and back-up materials well in advance of meetings.				
F. Committee members come to meetings well prepared.				
Section 4: Individual Self-Assessment				
A. I prepare for meetings, attend meetings, participate in committee discussions and assume a fair workload when applicable.				
B. I deal fairly and appropriately with other committee members.				
C. I support the committee chair in fulfilling the committee charge.				
D. I maintain privacy regarding information discussed in committee meetings.				
E. I am satisfied that no conflict of interest exists in my service as a committee member.				
F. As a committee member, I act as a liaison between HW and the community, representing the interests of both.				

Attachment 3

During FY20, HealthWest's performance improvement initiatives focused on standard performance measures, in order to monitor, understand and mitigate any negative effectives of the Cx360 EHR implementation and the COVID-19 pandemic. The following measures reflect HealthWest performance in access, effectiveness, efficiency and business functions, as reflected in the selected indicators.

Access

Performance Measure: Michigan Mission-Based Performance Indicator System (MMBPIS) indicators, as defined in the MDHHS and PIHP contract. Note: performance data only reflects FY20 Q3 and Q4 because of the changes to the performance indicator definitions that occurred at that time.

FY20Q3

Indicator	Population	In Compliance	Out of Compliance	HW Performance	Standard	Met Standard?
1: Timeliness of Pre-Admission Screening Decision	Child	33	1	97.06%	95%	Yes
	Adult	272	2	99.27%	95%	Yes
	Total	305	3	99.03%	95%	Yes
2a: Timeliness of Assessment Following Request for Services	MI Child	72	5	93.51%	N/A	N/A
	MI Adult	155	22	87.57%	N/A	N/A
	DD Child	19	2	90.48%	N/A	N/A
	DD Adult	10	0	100.00%	N/A	N/A
	Total	256	29	89.82%	N/A	N/A
3: Timeliness of Start of Services Following Assessment	MI Child	46	14	76.67%	N/A	N/A
	MI Adult	67	7	90.54%	N/A	N/A
	DD Child	7	7	50.00%	N/A	N/A
	DD Adult	5	2	71.43%	N/A	N/A
	Total	125	30	80.65%	N/A	N/A
4a: Follow-Up After Discharge from Inpatient	Child	8	0	100.00%	95%	Yes
	Adult	82	0	100.00%	95%	Yes
	Total	90	0	100.00%	95%	Yes
4b: Follow-Up After Discharge from SUD Detox	SUD	16	0	100.00%	95%	Yes
	Total	16	0	100.00%	95%	Yes
10: Inpatient Recidivism	Child	11	1	8.33%	15%	Yes
	Adult	99	13	11.61%	15%	Yes
	Total	110	14	11.29%	15%	Yes

FY20Q4

Indicator	Population	In Compliance	Out of Compliance	HW Performance	Standard	Met Standard?
1: Timeliness of Pre-Admission Screening Decision	Child	48	0	100.00%	95%	Yes
	Adult	279	3	98.94%	95%	Yes
	Total	327	3	99.09%	95%	Yes

2a: Timeliness of Assessment Following Request for Services	MI Child	122	17	87.77%	N/A	N/A
	MI Adult	211	15	93.36%	N/A	N/A
	DD Child	27	3	90.00%	N/A	N/A
	DD Adult	7	1	87.50%	N/A	N/A
	Total	367	36	91.07%	N/A	N/A
3: Timeliness of Start of Services Following Assessment	MI Child	54	18	75.00%	N/A	N/A
	MI Adult	74	2	97.37%	N/A	N/A
	DD Child	10	14	41.67%	N/A	N/A
	DD Adult	2	4	33.33%	N/A	N/A
	Total	140	38	78.65%	N/A	N/A
4a: Follow-Up After Discharge, Inpatient	Child	2	0	100.00%	95%	Yes
	Adult	82	0	100.00%	95%	Yes
	Total	84	0	100.00%	95%	Yes
4b: Follow-Up After Discharge, SUD Detox	SUD	24	1	96.00%	95%	Yes
	Total	24	1	96.00%	95%	Yes
10: Inpatient Recidivism	Child	7	0	0.00%	15%	Yes
	Adult	110	18	14.06%	15%	Yes
	Total	117	18	13.33%	15%	Yes

Effectiveness

Performance Measure: DHIP Outcomes Report for CAFAS and PECFAS Improvements. Each year, reports are submitted to MDHHS for the selected children for whom DHIP incentive payments were received by the CMHSP. The following results were observed during FY20:

CAFAS		
Average Initial Total Score	Average Last Total Score	Average Improvement
112	74.00	36.09

PECFAS		
Average Initial Total Score	Average Last Total Score	Average Improvement
97	68.10	28.95

Efficiency

Performance Measures: Program Caseloads (as reflected in Cx360) and BHTEDS completeness (as measured by submissions to the LRE)

BHTEDS completeness

- Mental Health (non-crisis): 4,288/4,394 = 97.59 % complete
- Mental Health (crisis only): 1,085/1,134 = 95.70 % complete
- SUD: 1,530/1,574 = 97.20 % complete

FY20 Caseloads

Program	9/30/2020	12/31/2020	4/12/2021
ACT	43	33	33
Adult Assessment and Stabilization	677	759	887
Adult Brief Services Program	53	61	82
Adult Groups	55	91	110
Adult Mental Health Court			18
Autism Contractual Services	21	18	15
Autism Services	122	15	101
Behavior Supports Management	64	103	71
Brinks Crisis Residential	8	65	
Clinical Services Contracted	29	29	28
CLS Support Services Contracted	244	240	243
Clubhouse Services	259	236	212
Community Health Coordination	119	120	123
Correctional Services	402	315	274
DD Community Based	468	462	449
DD Intensive Case Management	31	28	29
DD Medically Complex Services	67	72	73
DD Outpatient Services	49	45	46
DD Respite Services Contracted	145	140	140
DD Specialized Residential Contracted	197	199	199
DD Transitions Team	73	67	64
DD Vocational Services Contracted	155	146	138
HealthWest Crisis Residential			7
HealthWest Integrated SUD Team	46	5	49
HealthWest MAT	19	41	26
HealthWest Outpatient Clinic	145	25	211
In Jail Treatment Team	1	171	202
Individual Placement and Support	173	128	159
Jail Diversion Team			20
Juvenile Justice Team	25	160	18
Methadone Services Program	1	15	3
MI Adult Community Based	635	638	629
MI Adult Inpatient Contracted	50	46	58
MI Adult Intensive DBT	58	55	68
MI Adult Low Intensity	4	3	2
MI Adult Partial Hospitalization Contracted	5	6	5
MI Adult Specialized Residential	53	54	54
MI Adult Vocational Services Contract	5	3	3
MI Child Crisis Residential Contracted	1	1	1
MI Child Inpatient Contracted	1	6	13

MI Respite Services	2	4	4
Mobile Crisis Intervention Program	35	111	236
OT-PT-ST Services	120	128	135
Psychiatric Health Services	1706	1684	1793
Psychological Testing Services	124	132	199
SUD Contractual Services	1166	1289	1433
Veterans Navigator Program	5	15	22
Youth Assessment and Stabilization	167	200	252
Youth Behavioral Support Team	19	29	46
Youth Brief Services Program	16	16	20
Youth DD	156	154	176
Youth Empowerment Specialist Contracted	13	16	17
Youth Groups	14	26	26
Youth Home Based Services	63	64	87
Youth Infant and Early Childhood Mental Health	74	59	59
Youth Office Based Services	235	251	235
Youth School Based Brief	1	2	2
Youth School Based Outreach Supports			123
Youth Transition Age Team	56	44	56
Youth Wrap Around	36	29	30

Business Functions

Performance Measures: final scores for Medicaid Claims Verification reports and CMHSP Site Review final report score (both as calculated by the LRE).

- FY 2020 Medicaid Verification
    - Review #1
        - HealthWest Overall % of "Yes – Claim Verified" = 98.57%
        - HealthWest SUD Overall % of "Yes – Claim Verified" = 87.03%
    - Review #2
        - HealthWest Overall % of "Yes – Claim Verified" = 95.83%
        - HealthWest SUD Overall % of "Yes – Claim Verified" = n/a (no claims selected)

- FY 2020 CMHSP Site Review final report score: 91.18%

Attachment 4

FY21 Performance Improvement (PI) Committee Workplan

For the FY21 QAPIP, HealthWest has set organizational goals in a variety of areas. Some of the goals are related to the HealthWest strategic plan, while others reflect goals for standing performance measures. Additionally, HealthWest is also working to achieve goals established as part of the LRE's regional QAPIP and annual Performance Improvement Project (PIP) initiatives set by the PIHP and MDHHS. The PI Committee will facilitate and oversee initiatives to achieve these goals, as well as taking action in a number of areas related to HealthWest Performance Improvement.

- Access
    - HealthWest will maintain timely completion of timely determinations (within 3 hours of request) for pre-admission screenings for inpatient hospitalization admissions for 95% of all screenings conducted, for both children and adults.
    - HealthWest will provide a comprehensive mental health assessment within 14 days of request for services. Due to implementation of new indicators, this year will be used to focus on reporting accuracy, monitoring trends, and establish baseline standards.
    - HealthWest consumers will start services within 14 days of their initial assessment and determination of eligibility. Due to implementation of new indicators, this year will be used to focus on reporting accuracy, monitoring trends, and establish baseline standards.
    - HealthWest SUD consumers will begin services within 14 days of the request for service. Due to implementation of new indicators, this year will be used to focus on reporting accuracy, monitoring trends, and establish baseline standards.
    - Consumers discharged from inpatient hospitalization admissions and SUD residential detox admissions will receive follow-up care within 7 days of discharge.
- Effectiveness
    - HealthWest consumers qualifying for DHIP incentive payments will demonstrate positive improvements daily functioning, as measured by the composite score on the CAFAS or PECFAS, as appropriate by age.
    - BH-TEDS Outcomes
    - Improvement in cardiovascular screening for persons with schizophrenia or bi-polar diagnosis (see LRE QAPIP goals for details).
    - Improvement in medication maintenance for persons with major depression or schizophrenia (see LRE QAPIP goals for details).
- Efficiency
    - HealthWest will establish caseload dashboards and self-service reports for teams and supervisors to use in managing caseloads, with both available by 6/1/2021.
    - BHTEDS completeness will remain above 95% for FY21.
- Satisfaction
    - Consumers (and guardians) will report average scores of 5.0 or higher (out of 6.0) regarding overall satisfaction with services for all surveys administered during FY21.
    - HealthWest will fulfill 100% of its assigned target for NCI survey participation, as determined by MDHHS sample selections.

    - Consumers (and guardians) will report average satisfaction scores of 4.0 or higher (out of 5.0) on responses to each item on the annual Behavior Treatment Plan survey administered during FY21.
- Business Functions
    - Medicaid Verification will be conducted according to CMHSP policy, PIHP/CMHSP contract requirements, MDHHS/PIHP contract requirements, and Medicaid standards, with recoupment not required on any claims reviewed within the sample.
    - HealthWest will achieve an overall score of 95% or above on the FY21 CMHSP Site Review final report
    - HealthWest will provide sentinel event notification to the LRE within the established timeframes (within 24 hours of notification of the event) for 100% of sentinel events.
    - The PI Committee will be re-established and will meet at least 10 times prior to the end of FY21.

In order to achieve the above goals, the PI Committee has identified the following actions, which will occur in FY21:

- Staff training and development
    - Continuation of bi-weekly Clinical Documentation TA sessions
    - MIFAST review of the ACT/IDDT Team
- System improvements
    - Resolution of outstanding tickets within Cx360 EHR
    - Implementation of Power BI for reporting, data analytics, self-service data requests and performance measurement
    - Implementation of the updated customer satisfaction survey
- Data Integrity
    - Data integrity/data quality monitoring and clean-up, with an emphasis on user profiles, client profiles and proper documentation of direct services and cancellations/no-shows)
    - Resolution of issues identified within SIU reports and BHTEDS/Data Integrity reports provided by Beacon
    - Resolution of issues within the EHR Encounter Error Log
    - Reconciliation of discrepancies identified by MDHHS and the LRE during submission of the annual Encounter Quality Initiative (EQI) report
- Performance and Compliance Activities
    - Completion of quarterly Program Integrity activities including monitoring reports, auditing of records, investigation of complaints, and ensuring the resolution of issues identified through SIU reports

FY 2021 Standard Performance Measures

Measure	Category	Source	Frequency
Michigan Mission-Based Performance Indicator System (MMBPIS): 1. Timeliness of Pre-Admission Screenings, Determinations for Inpatient Admission 2. Timeliness of Assessments 3. Timeliness of Start of Services 4. Follow-up to discharge from inpatient hospitalization and SUD detox admissions 5. Inpatient recidivism within 30 days of discharge 6. Proportion of requests that resulted in denial of eligibility, second opinions and starting of services	Access, Efficiency, Outcomes	MMBPIS	Quarterly
BH-TEDS Completeness	Effectiveness	MDHHS	Quarterly
Medicaid Verification Results	Compliance	LRE	Quarterly
Critical Incidents and Risk Events	Health & Safety	PI Committee	Quarterly
Physical Management and Behavior Treatment Review Committee Data	Health & Safety	BSC report	Quarterly
Mobile Crisis Utilization	Access, Efficiency, Business Function	Clinical QA	Quarterly
Jail Diversion Data	Access	LRE	Semi-annual
SUD Sentinel Events	Health & Safety	PI Committee	Semi-Annual
Annual Submission: Requests for Services and Disposition of Requests, Waiting Lists, Priority Needs and Action Plans and Provider Network Capacity	Access, Efficiency, Satisfaction	MDHHS	Annual
DHIP Outcomes Measures 3. Improvement on CAFAS 4. Improvement on PECFAS	Effectiveness	CAFAS and PECFAS outcome reports	Annual
Post-Discharge Monitoring (MH and SUD)	Satisfaction	PI Committee	Annual
Grievance and Appeal Monitoring	Business Function	Customer Services	Annual
Customer Service Activity	Business Function	Customer Services	Annual
Prescriber Peer Review	Effectiveness, Health & Safety	Prescriber Peer Review	Semi-Annual
Monitoring effects of psychotropic medications: metabolic labs, AIMS, and side effects	Health & Safety	Prescriber Peer Review	Semi-Annual
Suicide deaths and suicide attempts	Health & Safety	Sentinel Events, CIRE	Ongoing

UM Summaries	Effectiveness, efficiency	UM dept.	Monthly
Accessibility assessment	Access	Customer Services	Annual
Performance Measurement and Improvement: Results achieved for persons served (per program)	Effectiveness, Outcomes	CARF	Annual
Performance Measurement and Improvement: Experience of services received and other feedback from the person served (per program)	Satisfaction	CARF	Annual
Performance Measurement and Improvement: Experiences of services and other feedback from other stakeholders (per program)	Satisfaction	CARF	Annual
Performance Measurement and Improvement: Resources used to achieve results	Efficiency	CARF	Annual
Performance Measurement and Improvement: Service Access	Access	CARF	Annual
Provider Network Quality Oversight – Site Reviews	Compliance	LRE	Annual, per provider
CMHSP Site Review	Compliance	LRE	Annual
CMHSP Waiver Audit	Compliance	LRE	Annual
PIHP Waiver & SUD Services Audit	Compliance	MDHHS	Biennial
CARF Accreditation Summary	Compliance	CARF	Triennial
PI Committee Self-Evaluation	Effectiveness	PI Committee	Annual