QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PLAN (QAPIP)

FY 2022 REVIEW

PREPARED BY: MATT PLASKA AND KELLY FRANCE

Accountability and Responsibility for the QAPIP

A strong quality assurance and performance improvement process requires consistent accountability across the organization. This means that the Performance Improvement (PI) Committee is responsible for recommending to the HealthWest Leadership Team opportunities for improvement that can be prioritized and addressed through specific actions. Ultimate authority for Quality Assurance and 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 organization of the QAPIP with the Manager of Accreditation and Performance Improvement.

Review of Quality Assurance and Performance Improvement Structure

1. **Reorganization of business functions with focus HealthWest's Core Values: Diversity, Excellence, Integrity, and Development**

    - **HealthWest focused efforts towards strategic planning and implementation**. The FY 2022 strategic plan developed by the Leadership Team and implemented by the agency included reorganization of several teams and demonstrated a commitment to core values (Attachment A).
    - **Reorganization of Quality Improvement, Data Analytics and Clinical Quality Assurance departments:** HealthWest reorganized from one Quality Improvement (QI) team into two teams: Clinical Quality Assurance and Data Analytics. Efforts continue to establish and clearly define these two teams, and to ensure adequate staff capacity to fulfill the full scope of responsibilities of both.

2. **Provider/Consumer Involvement**

    - The HealthWest Board of Directors continues to have persons served as members.
    - As part of the strategic plan, a current HealthWest staff member moved into a new leadership role in 2022 focused on development and facilitation of a Consumer Advisory Panel. This new position at our agency is focused on recruiting, building, and developing meaningful membership for the Consumer Advisory Panel and supporting efforts to increase and enhance consumer satisfaction and engagement.
    - The Performance Improvement Committee was reorganized during 2022, ensuring adequate membership and orientation to the role of the committee. Although no consumer involvement has been initiated yet on this team, the team has started planning action steps to ensure involvement in FY 2023.
    - The PI Committee has also developed a plan to ensure representation of the provider network within the committee. Provider Relations staff will begin attending PI Committee meetings in FY 2023.

3. **CMHSP Leadership Team**

    HealthWest Leadership Team will have the central responsibility for the implementation of the QAPIP. In 2022, this team used the process of strategic planning and the formation of action-oriented committees to address priorities, including the QAPIP and Quality Assurance at the organizational level. The membership of the Leadership Team consists of

key staff from teams across HealthWest and is updated as appropriate to reflect the strategic leadership and decision-making needs of the agency.

4. **Development of CMHSP Performance Improvement Committee**

- **The Performance Improvement Committee was established** as a key strategy in the HealthWest Strategic Plan, a requirement of HealthWest as a CMHSP, and as a part of the reorganization of the Clinical Quality/Quality Improvement and Data Analytics departments.
- Significant accomplishments and action steps from 2022 include:
    - In early 2022, a charter statement for the HealthWest Performance Improvement Committee was drafted (Attachment B).
    - The Performance Improvement Committee completed a self-evaluation in early 2022 to ensure all members were aligned with the strategy and competencies needed for the team.
    - In April 2022, Priority Key Data Sets were established by Leadership Team and provided to Performance Improvement Committee. A request to Data Analytics Team was completed for creation of Power BI Dashboards to use for data analysis.
    - In August 2022, Program-Specific Performance Measures, which will be used across clinical teams, were defined by the PI Committee. Requests have been submitted to the Data Analytics Team for development dashboards for these indicators as well.
- **In FY 2022, Matt Plaska, Manager of Accreditation and Performance Improvement, was appointed as the staff member responsible for chairing the PI Committee and overseeing implementation of the QAPIP.**
    - Committee membership was determined by the HealthWest Leadership Team. Participants were selected based on their responsibilities within the agency, involvement in strategic initiatives, capacity for performing analysis and monitoring of performance indicators, and ability to develop and influence improvement activities. Membership is reviewed annually and adjusted as necessary.
    - In FY 2023, membership will be expanded to include consumers, Provider Relations staff, and staff from under-represented departments such as Utilization Management and Access.

5. **Report on Accountability**

- The HW Performance Improvement Committee has been focused on establishing accountability in FY 2022 by:
    - Ensuring strong leadership structure in the Committee.
    - Using formal communication structures for communication
        - Implementing structures within Microsoft Teams for documentation and collaboration
        - Use of formal Memorandum of Understanding for members
        - Completion of formal self-evaluation tool for all members
        - Implementation of agenda setting and minute taking to ensure accountability to the structure and commitments made
        - Implementation of a PI Committee Action Plan

- Establishing an annual schedule that documents the responsibilities of the PI Committee and defines when each topic and/or data set is reviewed.

Review of Core 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 provide quality services, effectively manage and protect available resources, protect the rights of service beneficiaries, and identify opportunities to improve.

1. **Regional PIHP: Review of HealthWest Participation in Quality Assurance and Performance Improvement Activities Led by the Lakeshore Regional Entity (LRE)**

    - HealthWest reorganized from one Quality Improvement (QI) team into two teams: Clinical Quality Assurance and Data Analytics. The Director of Clinical Quality is assigned as primary HealthWest representative at the Quality Improvement Regional Operations and Advisory Team (QI ROAT). HealthWest is an active member of the QI ROAT. The QI ROAT Charter was developed and is attached (Attachment C).
    - HealthWest Clinical Quality Assurance staff attended 100% of QI ROAT meetings in FY 2022. Information from ROAT was used across the agency in Continuous Quality Improvement efforts as will be recognized throughout the rest of this report.
    - In 2023, HealthWest will be participating in the regional Performance Improvement Project (PIP) along with the other affiliate CMHSPs of the LRE. The LRE continues to work with MDHHS to obtain final approval of the details of the PIP. However, the HealthWest Leadership Team identified the PIP measure as a priority data set for the agency and the Data Analytics Team is currently developing a Power BI dashboard that will be used to proactively monitor HealthWest performance in the area of follow-up to discharges from psychiatric inpatient episodes.

2. **HealthWest Leadership Team: Review of Roles and Responsibilities**

    HealthWest's Leadership Team will have the lead role in overseeing implementation of the HealthWest QAPIP. This begins with responsibility for ensuring the accessibility, effectiveness, efficiency, and satisfaction of services provided by HealthWest, as well as the performance and quality of contractually required managed care activities. In addition to managing the performance improvement functions of HealthWest as a managed care organization, the HealthWest Leadership Team also has responsibility for the following:

    - **Claims Verification**
      Kelly France, Director of Clinical Quality, was primarily responsible for coordination of Claims Verification audits during FY 2022. Within FY 2022, HealthWest participated in 100% of quarterly claims verification with LRE. HealthWest's overall scores from the four quarterly reviews were 100%, 98.99%, 100%, and 99.97%, respectively. A summary report of the results from HealthWest's Medicaid Claims Verification reviews is contained in Attachment E.
    - **Practice Guidelines**
      Cyndi Blair, Chief Clinical Officer, ensured a review of Practice Guidelines occurred this fiscal year (as part of our prep for the annual LRE site review). A link to the

Lakeshore Regional Entity's Best Practice Guidelines was placed on The Compass (HealthWest's new intranet) for staff use.

- **Adverse Events**
  Kelly France, Director of Clinical Quality, along with Clinical Services Manager, Jennifer Stewart, have taken direct leadership of ensuring adequate review of adverse events and compliance with reporting to region and state:
    - Sentinel Events: Recipient Rights and Clinical Quality Assurance departments worked together to develop a process for timely and thorough review of all sentinel events. This is managed and tracked through Microsoft Teams, which ensures the following are completed:
      - Death Certificate requesting, review and processing
      - Root Cause Analysis completion, review, and processing
      - Timely and Accurate reporting to LRE
    - Critical Incidents and Risk Events: Recipient Rights enters all Critical Incidents and Risk Events into an Access Database. The Data Analytics Team at HealthWest runs a report from the database and sends data to the LRE per requirements monthly. HealthWest will begin using the Critical Incident module within Lat43 at the start of FY 2023 for recording and reporting of critical incidents.
- **Credentialing**
  HealthWest prioritized the development of a credentialling process and procedure aligned with state and CCBHC requirements during FY 2022. Amber Berndt, Administrative Assistant, was transferred to the Clinical Quality Assurance department with primary responsibility of developing formal process and procedures for adequate credentialing. Amber worked closely with the LRE and our regional partners while HealthWest developed the job description and staffing pattern needed to ensure ongoing compliance:
    - Credentialing processes and procedures were developed ensuring Credentialing starts with Human Resources Manager at hire and moves to Credentialing and Privileging Committee for oversight thereafter.
    - Clinical Privileges are the responsibility of the Credentialing and Privileging Committee chaired by Clinical Quality Assurance staff.
    - Laserfiche forms were developed and are being used to capture data and documentation throughout the credentialing process.
    - A Power BI dashboard is in development by the Data Analytics Team to enable monitoring of credentials and due dates.
    - Quarterly Reports are sent to LRE for National Credential Database.
- **Utilization Management**
  Carrie Crummett, Clinical Services Manager of Utilization Management, has provided leadership under Cyndi Blair, Chief Clinical Officer, to ensure utilization review is a priority of HealthWest.
    - Level of Care Determination and Benefit Plan in new Electronic Health Record Latitude 43 was developed, tested and implemented.
    - Carrie attends Clinical Manager meetings each week for UM data review, participates in the regional UM ROAT, and is the point person for retrospective reviews of inpatient pre-admission screenings and continued stay reviews conducted by the LRE.
- **Provider Monitoring**
  Jennifer Stewart, Clinical Manager in Clinical Quality Assurance, has partnered with Provider Network Managers for ongoing compliance and administrative oversight.

- Provider Network Managers started attending Clinical Quality Assurance staff meetings and learning about audit requirements.
- Clinical Quality Assurance leadership has started attending Provider Network Meetings.
- Provider Network Managers are engaging in more site-based oversight by increasing site visits with providers.
- Provider Network Managers will begin attending PI Committee meetings in FY 2023.

3. Performance Improvement Committee: Review of prioritized activities.

- **Performance Indicators**
  The PI Committee is responsible for monitoring performance across all federal, state, and local quality measures and performance indicators within required reports. Although PI Committee has not yet acquired its own Power BI dashboards during FY 2022, the PI committee has been working with the Data Analytics Team to develop a variety of dashboards for monitoring, including for Priority Data Sets selected by HealthWest Leadership, Health Disparities indicators, and Program-Specific Performance Indicators/Quality Measures identified by the PI Committee. Until then, raw data has been used to make decisions and indicate progress. A summary of HealthWest performance on MDHHS-defined performance indicators is included in Attachment E.
- **Consumer Satisfaction and Outcome Measures:**
  With the implementation of Latitude43 in February 2022, HealthWest included Customer Satisfaction data collection in the clinical progress note and Individual Plan of Service (IPOS) documentation. Director of Clinical Quality, Kelly France, has worked with the LRE and regional partners in a workgroup to redesign the Regional Customer Satisfaction Survey which will be implemented in FY 2023.
- **Performance Improvement Projects**
  As an affiliate of the Lakeshore Regional Entity (LRE), HealthWest will participate in the Performance Improvement Project identified by MDHHS as well as the Performance Improvement Project identified and approved at the PIHP level. The regional PIP selected by the LRE, which focuses on health disparities among adults during follow-up to discharges from psychiatric inpatient episodes, is also incorporated into HealthWest's strategic plan and will be a focus of the PI Committee in FY 2023.
- **Coordination with Network Provider Structures**
  HealthWest has taken a position of supporting the existing Quality Assurance 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. In FY 2022, Clinical Quality Assurance staff have worked closely with Provider Network Managers to start supporting providers in the QA process. Action steps in FY 2022:
    - Providers have increased access to LAT43 for integrated documentation and care.
    - Providers have been intimately involved in the LRE and MDHHS audit efforts in coordination with Clinical QA.

4. Corrective Action Initiatives

HealthWest's primary corrective action for FY 2022 was the implementation of Latitude43. HealthWest partnered with PCE to launch Latitude43 as the quickest implementation PCE has ever done. This was an exceptional challenge for both PCE and HealthWest staff, but it was necessary to meet the demand for a sophisticated electronic health record that could fulfill the agency's data and reporting needs. HealthWest is happy to report the launch of LAT43 was remarkably successful; the new system has significantly enhanced the ability to capture data and will be the primary source for PowerBI dashboards used for monitoring the measures below. Our Data Analytics Team is now tasked with learning the backend of LAT43 and pulling the available data for dashboard creation.

Performance Indicators and Quality Measures

The Performance Indicators and Quality Measures utilized by HealthWest (listed below) are drawn from a variety of sources: reporting requirements in the MDHHS contract, quality measures and reporting responsibilities in the CCBHC handbook, standards for best practice found in the CARF standards manual, Performance Improvement Projects adopted by the LRE, and strategic objectives within the strategic plan. The PI Committee is responsible for monitoring and analyzing these performance indicators, which reflect the accessibility, effectiveness, efficiency, and satisfaction of services. During their analysis, committee members will be expected to analyze all available data. Committee members' analysis will also include evaluating HealthWest's performance compared to established benchmarks or targets, tracking of performance over time, identification of trends, and impact of actions to improve performance. Following each analysis, the PI Committee will identify potential areas for improvement, make recommendations to the Leadership Team or Clinical Leadership when appropriate, and facilitate corrective action whenever necessary.

Measure	Definition	Performance Target	Population Applied To	Measure Source	Reporting Frequency
ACCESS *– individuals must be able to access services with ease and in a timely, barrier-free manner*					
On-hold times for non-emergent callers	On-hold wait times for non-emergent requests for screening must not exceed 3 minutes without being offered options for callback or talking with a non-professional in the interim	100%	All	MDHHS	Ongoing
Wait times for routine requests	Individuals with routine needs, must be screened or other arrangements made within 30 minutes	100%	All	MDHHS	Ongoing
Timeliness of determination for inpatient admission	Determinations must occur within 3 hours of request	> 95%	Children, Adults	MDHHS	Quarterly
Timeliness of initial evaluation (I-EVAL)	Initial assessments must occur within 14 days of request for service	> 95%	All	MDHHS, CCBHC	Quarterly
Timeliness of first service	First face-to-face service must occur within 14 days of initial assessment	> 95%	All	MDHHS	Quarterly

Timeliness of start of SUD treatment	First face-to-face service (any type) must occur within 14 days of request for services	> 95%	SUD	MDHHS	Quarterly
EFFECTIVENESS *– outcomes and changes experienced by persons served as a result of services*					
Inpatient recidivism	Individuals discharged from an inpatient psychiatric unit will not be readmitted within 30 days of discharge	< 15%	Children, Adults	MDHHS	Quarterly
Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)	Percentage of consumers 18+ with BMI documented during current encounter or previous 6 months AND BMI outside normal parameters, with a follow-up plan documented during encounter or the 6 months prior to the encounter	TBD	Adults	CCBHC	Annual
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)	Percentage of children age 3-17 with PCP or OB/GYN outpatient visit and evidence of BMI documentation, counseling for nutrition and physical activity during measurement year	TBD	Children	CCBHC	Annual
Tobacco Use: Screening & Cessation Intervention (TSC)	Percentage of consumers 18+ who were screened for tobacco use 1+ times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	TBD	Adults	CCBHC	Annual
Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	Percentage of consumers 18+ screened at least once in the last 24 months for unhealthy alcohol use using a systematic screening method AND received brief counseling if identified as an unhealthy alcohol user	TBD	Adults	CCBHC	Annual
Child/adolescent major depressive disorder (MDD): Suicide Risk Assessment (SRA-BH-C)	Percentage of visits for consumers aged 6-17 with a diagnosis of major depressive disorder with an assessment for suicide risk	23.9%	Children	CCBHC	Annual
Major depressive disorder (MDD): Suicide risk assessment (SRA-A)	Percentage of consumers 18+ with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during a visit in which a new diagnosis or recurrent episode is identified	12.5%	Adults	CCBHC	Annual
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	Percentage of consumers 18+ screened for depression during an encounter or 14 days prior to the encounter using an age-appropriate standardized screening tool, and a follow-up	TBD	Adults	CCBHC	Annual

	plan documented on the date of the eligible encounter if positive.				
Depression Remission at 12 months (DEP-REM-12)	Consumers 18+ with diagnosis of Major Depression or Dysthymia who reached remission 12 months (± 30 days) after an index visit.	TBD	Adults	CCBHC	Annual
Adherence to Antipsychotic Meds for Individuals with Schizophrenia (SAAAD)	Percentage of adults 18+ with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic med for at least 80% of their treatment episode.	58.5%	Adults	CCBHC	Annual
Follow-Up After Hospitalization for Mental Illness, ages 18+ (FUH-AD)	Percentage of discharges (age 18+) hospitalized for mental illness who had a follow-up visit with a mental health provider, reported for follow-up within 7 and 30 days after discharge.	58%	Adult	CCBHC	Annual
Follow-Up After Hospitalization for Mental Illness, ages 6-17 (FUH-CH)	Percentage of discharges (age 6-17) hospitalized for mental illness who had a follow-up visit with a mental health provider, reported for follow-up within 7 and 30 days after discharge.	70%	Children	CCBHC	Annual
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)	Percentage of consumers age 13+ with a new episode of AOD dependence who initiated treatment through inpatient AOD admission, outpatient visit, IOP encounter, or partial hospitalization within 14 days of diagnosis OR initiated treatment and had 2+ services with a diagnosis of AOD within 30 days of the initiation visit	Initiate 42.5% Engage 18.5%	SUD (Age13+)	CCBHC	Annual
Follow-Up After Hospitalization for Mental Illness (FUH)	Increase the number of individuals identifying as African American who received follow-up services within 30 days of discharge from inpatient hospitalization	TBD	All	LRE	Annual
EFFICIENCY *– the resources required to achieve desired outcomes for persons served*					
Follow-up to discharge from SUD detox	At least 95% of consumers discharged from SUD detox episodes will receive follow-up SUD treatment within 7 days of discharge.	< 95%	SUD	MDHHS	Quarterly
Follow-up to discharge from inpatient hospitalization	Consumers discharged from inpatient hospitalization episodes will receive follow-up care with a mental health professional within 7 days of discharge.	< 95%	All	MDHHS	Quarterly

Consumers receive regular services throughout their treatment episode	Consumers receive at least one face-to-face service every 30 days	100%	All	HW	Ongoing
SATISFACTION *– persons served and other stakeholders are satisfied with their experience of care*					
Experience of Care	Consumers will report overall satisfaction with services based on responses to satisfaction surveys	> 95%	All	MDHHS, CARF, CCBHC, HW	Ongoing
BUSINESS FUNCTIONS					
CMHSP Site Review	HealthWest will achieve an overall score above 95% on the final site review report for FY 2022.	> 95%	n/a	LRE	Annual
Medicaid Verification Results	100% of Medicaid claims selected for verification will be supported by source documentation, resulting in zero recoupments.	100%	All	MDHHS, LRE	Quarterly
BHTEDS completeness	At least 95% of required BHTEDS records will be submitted and accepted, for all record types.	> 95%	All	MDHHS	Ongoing
Timeliness of report submissions	100% of required report submissions will be submitted on time.	100%	n/a	HW	Ongoing

Fiscal Year 2022

STRATEGIC PLAN

HealthWest

OUR VISION

Building a healthier, more informed, and inclusive community through innovation and collaboration.

OUR MISSION

To be a leader in integrated health care, inspiring hope and wellness in partnership with individuals, families, and the community.

DIVERSITY

Implement a comprehensive approach to increasing inclusion, diversity and equity at HealthWest

Reduce health disparities

Promote accessible vaccination for individuals in services

Improve staff recruitment to fill open positions

Implement a plan to enhance diversity, equity and inclusion, including:
- Diverse representation on committees and leadership
- CQ Cultural Intelligence Training
- Diversity Walks

Improve employee morale and reduce staff turnover
- Staff recognition
- Community connectedness and wellness
- Measuring staff morale
- Social and charitable events
- Formal complaint resolution processes
- Psychological First Aid supports

EXCELLENCE

Position HealthWest for excellence by fully transitioning to a Certified Community Behavioral Health Clinic Model

Maintain certification as a Certified Community Behavioral Health Clinic

Maintain a comprehensive data collection and analysis plan for quality improvement of care

Improve outcomes for children via MYalliance System of Care

Enhance and strengthen community-based partnerships

Implement programs and services to fill gaps
Independent living/residential and community support alternatives · Detox · Children's services · Crisis stabilization units

Increase community outreach and engagement efforts

Implement evidence-based practices, with a focus on:
Dialectical Behavior Therapy · Motivational Interviewing · Zero Suicide

Focus on integration and coordination of care

DEVELOPMENT

Develop sustainable and responsive systems for ongoing development, learning and growth

Increase staff competencies and create additional opportunities for development, including:
- Up-to-date staff performance evaluations
- Increased development plans
- Succession planning
- Training and support plans for staff and agency leaders

Increase number of people trained on community-based behavioral health topics

Offer new opportunities for consumer input and engagement

INTEGRITY

Demonstrate high integrity in all business operations

Implement a business plan to adapt to the changing public health environment, which includes:
- Standard cost allocation
- Fixed asset system
- Allocation system to track staff time

Realign the Quality Assurance Department to meet the needs of HealthWest, including implementation of a comprehensive credentialing and privileging process

Streamline internal communications

Complete necessary obligations to obtain and sustain authority status

Create a plan for building space/ locations for HealthWest services

Vision: Building a healthier, more informed, and inclusive community through innovation and collaboration.

Mission: To be a leader in integrated health care, inspiring hope and wellness in partnership with individuals, families, and the community.

Performance Improvement Committee
Committee Charter

Adopted: March 30, 2022

Mission: to create an organization-wide framework for continuous quality improvement and to ensure that staff and teams across the agency have the necessary performance measures and indicator data to improve quality of care, make strategic data-driven decisions, and identify and address areas for improvement.

Vision: HealthWest operates as a high-performing organization with a universal and integrated commitment to continuous quality improvement. Across HealthWest, performance is measured, performance and quality indicator data is analyzed and actively applied, and all staff participate in continuous improvement in pursuit of excellent accessibility, efficiency, effectiveness, and satisfaction in our services.

Assigned Strategic Plan Objective(s) with purpose statement: *By December 2022, the Performance Improvement Committee will implement a health disparities reduction plan to reduce targeted health disparities as identified by HealthWest and the LRE contract by 15%*

Primary Strategies:

1. Develop an agency-wide framework for continuous quality improvement
2. Development of program-specific performance indicators that measure access, efficiency, effectiveness, and satisfaction of services
3. Compile a performance and quality measures index that integrates all of HealthWest's performance and quality measures
4. Integrate CCBHC quality measures into HealthWest's collection of performance and quality measures, and applying our CQI processes and framework for monitoring, analyzing, and improving performance.
5. Assemble and lead a diverse team to collect and review data, develop a targeted action plan, establish monitoring tools, and implement the established plan to reduce disparities and ensure service delivery and outcomes are equitable across populations.
6. Development of a Key Performance Indicators (KPI) report to be used by agency leadership, including the Leadership Team and Board of Directors.

I. Purpose

The PI Committee is an important component of the continuous quality improvement program at HealthWest, a function required of managed care organizations, and a contractual obligation reflected in the PIHP-CMHSP contract and operating agreement. The Performance Improvement (PI) Committee is responsible for monitoring performance data regarding the accessibility, effectiveness, efficiency, and satisfaction of internal HealthWest programs, services, and business operations. Additionally, the PI Committee is responsible for identifying areas for improvement, overseeing the development and implementation of improvement projects, and participating in the analysis and development of the annual QAPIP. Finally, the PI Committee serves as a liaison and communications link, sharing regular updates regarding performance data, improvement priorities and progress toward goals with HealthWest leadership, the HealthWest Board of Directors, and other stakeholders including staff and persons served.

II. Strategic Direction

Priorities and action plans for the PI Committee developed to align with and support the following:

a. HealthWest Strategic Plan
    i. Objective: "By December 2022, the Performance Improvement Committee will implement a health disparities reduction plan to reduce targeted health disparities as identified by HealthWest and the LRE contract by 15%."
        1. Strategy and Purpose: "Assign a diverse team to collect and review data, and develop a targeted plan and monitoring dashboard to reduce disparities, ensuring service delivery and outcomes are equitable across populations."
b. HealthWest Quality Assurance and Performance Improvement Plan (QAPIP)
    i. The PI Committee is responsible for the implementation of the HealthWest QAPIP, including an annual review of the previous year's plan and development of upcoming year's workplan
    ii. PI Committee members are also tasked with recommending annual performance improvement goals, which are a required component of the HealthWest QAPIP. In addition to the strategic plan objective, proposed performance improvement goals for FY22 include:
        1. Adoption of CCBHC quality measures
        2. Development of program-specific performance indicators that measure access, efficiency, effectiveness, and satisfaction of services
        3. Development of a Key Performance Indicators (KPI) report to be used by agency leadership, including the Leadership Team and Board of Directors
c. MDHHS/PIHP Contract, Attachments, and Reporting Requirements Calendar
    i. The PI Committee monitors all performance indicator data points contained within required report submissions, identifies areas of improvement, and oversees corrective action as needed
d. HealthWest Program Descriptions
    i. The PI Committee monitors all performance measures regarding the accessibility, effectiveness, efficiency, and satisfaction of programs and services, as reflected in program descriptions
e. CCBHC Demonstration Handbook
    i. The PI Committee will ensure the adoption and integration of all CCBHC quality measures and quality-bonus payment measures into the agency's CQI framework and processes
f. CARF Standards Manual
    i. The PI Committee will also incorporate performance measure data into the overall QAPIP and performance measurement/management efforts, in keeping with best practices outlined in the CARF standards manual.
g. LRE QAPIP and Performance Improvement Projects
    i. The PI Committee will also monitor HW progress on the identify PIP goals established by the LRE and its affiliate members' leadership
h. Evidence-Based Practices Fidelity Standards

III. Structure and Roles

a. Chair
    i. The PI Committee chair is appointed by the HealthWest Executive Director
    ii. The chair is responsible for planning agendas and facilitating each meeting, ensuring minutes are taken and posted, and ensuring committee members uphold their responsibilities
    iii. The chair is also responsible for ensuring that committee members have the necessary performance data available to monitoring and improvement organizational performance
    iv. Additional leadership roles will be appointed as needed, to fulfill the responsibilities of recorder and subcommittee leadership (as needed).
b. Committee Members
    i. Members of the PI Committee are invited to join the committee due to their responsibilities, their interest and ability to engage with performance data, their understanding of and alignment with the strategic direction of the agency, and a capacity in their role to effect meaningful change and performance improvement.

ii. Committee membership is evaluated annually.
iii. Committee members are asked to commit to serving at least one year on the committee. However, members may request to step down at any time if they are unable to continue their participation and/or fulfill their obligations as committee members.
iv. The most important responsibilities of committee members are attendance and engagement. Committee members are expected to attend all meetings and to notify the chair in advance when they cannot attend scheduled meetings. Committee members are expected to participate fully and maintain a safe space where honest, objective, and solution-focused discussion occurs.
v. Members commit to preparing for each meeting by reviewing all assigned materials and completing assigned follow-up tasks.
vi. Members who join subcommittees may be required to complete additional work on behalf of the subcommittee.
vii. PI Committee members take on the responsibilities of the committee with the full support of the agency and their supervisor.

c. Meeting Schedule
   i. Committee meetings occur from 3-4pm on the second Wednesday of each month
   ii. Sub-committee meetings may occur at other times, as determined by subcommittee members
d. Meeting Agendas and Minutes
   i. Agendas will be distributed to PI Committee members at the week before each meeting
   ii. Minutes will be posted following each meeting and reviewed by committee members for accuracy and completeness
   iii. All agendas, minutes, data sets and reports, and other committee materials will be saved under the PI Committee's team in Microsoft Teams for all members to access
e. Communication
   i. Quarterly updates will be provided to the HealthWest Leadership Team and Board of Directors according to the schedule established for all committees
   ii. The PI Committee charter, workplan, meeting minutes, and quarterly reports will be posted in the All-Staff Informational Hub in Microsoft Teams

IV. Membership

Current members of the PI Committee for fiscal year 2022 are listed below:

Name	Title
Amie Bakos	Director of I/DD Services, Behavior Supports Committee Co-chair
Calvin Davis	Quality Improvement Specialist
Cyndi Blair	Chief Clinical Officer
Gary Ridley	Communications and Social Marketing Coordinator
Jennifer Stewart	SUD Quality Assurance Manager
Julia Rupp	Chief Executive Officer
Kelly France	Director of Clinical Quality
Lisa VanderLee	Data Analytics Administrative Assistant
Matt Plaska (chair)	Manager of Accreditation and Performance Improvement (chair)
Mickey Wallace	Director of Diversity, Equity, and Inclusion
Natalie Walther	Director of Data Architecture and Data Analytics
Pam Kimble	Director of Autism, Behavior Supports Committee Co-chair
Rachael Hindman	Data Analyst

* *Additional members of Leadership Committee may be designated by the Executive Director*
* *Primary or secondary persons served from various populations may be invited to attend, as appropriate, including persons with developmental disabilities, adults with mental illness, children with severe emotional disturbances, and persons with substance use disorders*

* *Ad hoc members will be also invited as necessary and may include the Recipient Rights Officer, Privacy Officer, Corporate Compliance Officer, Human Resources Manager, any HealthWest staff member, representatives of contracted provider agencies, and other stakeholders*

LAKESHORE REGIONAL ENTITY

REGIONAL OPERATION ADVISORY TEAM CHARTER

NAME: QUALITY IMPROVEMENT ROAT
LRE DESIGNEE: LRE QUALITY MANAGER
ADOPTED: 12/14/2021
REVIEWED:

This charter shall constitute the structure, operation, membership and responsibilities of Lakeshore Regional Entity (LRE) Quality Improvement Regional Operations Advisory Team (QI ROAT).

Purpose of the Quality Improvement Regional Operations Advisory Team: The LRE QI ROAT will advise the Operations Council and the Chief Executive Officer concerning quality improvement matters.

Responsibilities and Duties: The responsibilities and duties of the QI ROAT shall include the following:

- Advise and assist the LRE Quality Manager with the development, implementation, operation, and distribution of the Quality Assessment and Performance Improvement Plan (QAPIP) and supporting LRE policies and procedures
- Recommending and monitoring development of internal systems and controls to carry out the Quality Assessment and Performance Improvement Program and supporting policies as part of daily operations
- Development of valid and reliable data collection related to performance measures/indicators at the organizational/provider level.
- Evaluating the effectiveness of the QAPIP
- Identify organizational and regional opportunities for improvement, including but not limited to the safety of consumers
- Determining the appropriate strategy/approach to promote compliance and detect potential violations and areas of risk as well as areas of focus
- Reviewing audit results and corrective action plans, making recommendations when appropriate

Decision-Making Context and Scope:
General Decision-Making Process: Consensus shall be the primary mode of decision making and efforts shall be made to extend dialogue and gather information toward consensus to the extent possible.

Should consensus not be achieved, any member of the QI ROAT may call for a vote of the members. A vote of the body is not binding on the Lakeshore Regional Entity; rather it is used to further inform as to the strength of the member's position on the subject. Any decision made subsequent to a vote of the QI ROAT, including any items referred to the LRE Quality Manager, shall reflect both the majority and minority opinions on that matter. The LRE Quality Manager shall inform the LRE CEO and/or Operations Council members of the final decision/recommendation before further action is taken.

Defined Goals, Monitoring, Reporting and Accountability
The QI ROAT shall establish metrics and monitor criteria to evaluate progress on the following primary goals:

- Implementation of the Quality Assessment and Performance Improvement Plan (QAPIP),

- Performance Measures included within the QAPIP as required by MDHHS and identified through Operations Council.
- Improvement efforts as it relates to external reviews including but not limited to the External Quality Reviews and MDHHS reviews.
- Compliance and oversight of the above identified areas.

Additionally, the QI ROAT seeks to assess and achieve the following secondary goals:

- Retained function contracts achieved defined results
- Collaborative relationships are retained
- Reporting progress through Operations Council
- Regional collaboration regarding expectations and outcomes
- Efficiencies are realized through standardization and performance improvement; and
- Improved performance is realized through collective strength

Membership

The LRE QI ROAT will be comprised of the LRE Quality Manager, one subject matter expert from each member CMHSP's Quality Improvement staff who is appointed by the respective CMHSP Chief Executive Officer/Executive Director, and one CMHSP Chief Executive Officer/Executive Director. All Member CMHSPs will be equally represented. The LRE QI ROAT will be chaired by the LRE Quality Manager.

a. There will be equal CMHSP representation and voting on all ROATs, workgroups and committees unless otherwise required by law.
b. Membership shall be representative of the LRE Region with each CMHSP having one vote.
c. CMHSP representatives become members of the committee through appointment by their respective CEO/Executive Director (ED) and approval by the LRE Operations Council.
d. Primary and/or secondary consumer(s) representing adults with mental illness, adults with developmental challenges, adults with a substance use disorder, parents/guardians of a child/children with mental illness, and/or parents/guardians of a child/children with developmental challenges, to be appointed through an application process.
e. Alternates may attend and speak with the power granted by their appointed CMHSP Executive Director. Alternates do not have a vote when it comes to decision making.
f. Others in attendance are by invitation only (not regularly attending), should have a clearly defined purpose for attendance, are not intended to offer commentary on other agenda topics, and shall be excused when they have completed their purpose for meeting attendance. Subject matter expert (SME) may be invited by the QI ROAT for a specific agenda topic and shall only participate during the related topic.

Roles and Responsibilities

a. LRE Chairperson/Facilitator – Prepares the agenda, facilitates the meeting and maintains order; provides guidance and direction, serves as the point of contact for the ROAT; serves as a conduit for other planning/action occurring at LRE, is accountable for representing the ROAT and making reports on behalf of the ROAT. Serves as the point of contact with the Operations Council. The chairperson/facilitator is a voting member of the ROAT.

b. LRE Recorder – Serves as the staff support to the ROAT. Captures discussions, problem solving and planning of the committee in an unbiased manner and prepares minutes following each meeting.
c. Member – A participant appointed to the committee by the LRE or CMHSP Director who is selected based on content/process expertise/interest or customer/supplier representation.
d. Subject Matter Experts (SME's) –may participate in a ROAT meeting for the purpose of providing information, consultation, etc. Participation as a Subject Matter Expert does not constitute authority to participate in decision making. Subject matter experts should typically leave once their expressed purpose is complete.
e. CMHSP CEO/Executive Director – appointed by the Operations Committee to attend the ROAT meeting and serve as a liaison between the ROAT and the Operations Committee. Responsible for providing regular reports to the Operations Committee from the ROAT and communicating directives for work product to the ROAT from the Operations Committee. CEO/Executive Director is not a voting member of the ROAT.

Member Conduct/Ground Rules: Members of the LRE QI ROAT seek a meeting culture that is professional, productive, and comfortable. To that end, the following ground rules have been adopted:

1. Respect of others
   - Only one person speaks at a time; no one will interrupt while someone is speaking.
   - Each person expresses their own views, rather than speaking for others at the table or attributing motives to them.
   - No sidebars or end-runs.
   - Members will avoid grandstanding (i.e., extended comments/speaking), so that everyone has a fair chance to speak.
   - No personal attacks. "Challenge ideas, not people."
   - Everybody will seek to focus on the merits of what is being said, making a good faith effort to understand the concerns of others. Questions of clarification are encouraged. Disparaging comments are prohibited.
   - Each person will seek to identify options or proposals that represent shared interests, without minimizing legitimate disagreements. Each person agrees to do their best to take account of the interests of the group as a whole.
2. Meeting Efficiency
   - The agenda and related materials will be distributed to QI ROAT members one week in advance of the meeting.
   - Members are prepared for the agenda content and have completed related assignments on time.
   - Everybody agrees to make a strong effort to stay on track with the agenda and to move the deliberations forward.
   - Members share equally in the work of the body.
   - It is recommended and members are required, if possible, to utilize video during virtual meetings.
3. Decision Making
   - Members are respectful of the defined decision-making protocol and support decisions made of the body even when presenting a minority view.

- Each person reserves the right to disagree with any proposal and accepts responsibility for offering alternatives that accommodates their interests and the interests of others.
- Everybody will follow the "no surprises" rule. Concerns should be voiced when they arise, not later in the deliberations.

Meetings

a. Regular Meetings – Will normally occur monthly.
b. Special Meetings – Special meetings shall occur as determined by the consensus of the group and as business of the body necessitates.
c. Attendance at Meetings - Members shall regularly attend or send a designee (rarely) who is prepared to act on behalf of the appointed member.
d. Agenda - The Agenda shall be prepared by the LRE Quality Manager and shall be distributed in advance of the meeting with related attachments. To the extent possible the agenda shall clarify the context and timing of a discussion to support the need for SMEs or in determining an alternate for meeting attendance.
e. Minutes of Proceedings - The recorder shall prepare a meeting summary that reflects key decisions and required actions to occur subsequent to the meeting. The required actions shall specify what, who, and by when.

Sources:

LRE QAPIP

LRE Compliance Plan

LRE Policies

LAKESHORE REGIONAL ENTITY

LRE Medicaid Verification FY22 Quarter 1 (Sept-Dec2021)

						Does the service informationin				Does the documentation include the			
	Is the provided service eligible for payment under Medicaid?	The Benficiary was eligble for Medicaid on the date of service?	Was the service delivered by a staff person qualified to provide the	Was the IPOS in effect for the date of service, available for review?	Was the provided service identified in the Plan of Service?	Identified Amount	Identified Scope	Identified Duration	Is there documentation indicating the service was provided on the date billed?	Signatures and Credentials of Service Provider	Unit based services have start and stop times	Documentation supports the services as reported	The billed services amount / units match provided documentation
HealthWest													
Yes	78	78	78	78	78	78	78	78	78	77	46	78	78
No	0	0	0	0	0	0	0	0	0	0	0	0	0
N/A				0	0	0	0	0		1	32	0	
% of Yes	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
HealthWest Overall % of Yes			**100.00%**										

Printed Date: 8/1/2022 Report Version: 20201016

LAKESHORE REGIONAL ENTITY

LRE Medicaid Verification FY22 Quarter 2 (Jan-March2022)

						Does the service informationin				Does the documentation include the			
	Is the provided service eligible for payment under Medicaid?	The Benficiary was eligble for Medicaid on the date of service?	Was the service delivered by a staff person qualified to provide the	Was the IPOS in effect for the date of service, available for review?	Was the provided service identified in the Plan of Service?	Identified Amount	Identified Scope	Identified Duration	Is there documentation indicating the service was provided on the date billed?	Signatures and Credentials of Service Provider	Unit based services have start and stop times	Documentation supports the services as reported	The billed services amount / units match provided documentation
HealthWest													
Yes	220	220	220	205	199	199	199	199	202	207	102	202	202
No	0	0	0	0	1	0	0	0	18	0	0	18	18
N/A				15	20	21	21	21		13	118	0	
% of Yes	100.00%	100.00%	100.00%	100.00%	99.50%	100.00%	100.00%	100.00%	91.82%	100.00%	100.00%	91.82%	91.82%
HealthWest Overall % of Yes			**98.99%**										

Printed Date: 2/6/2023 Report Version: 20201016

LAKESHORE REGIONAL ENTITY

LRE Medicaid Verification FY22 Quarter 3 (April-June2022)

						Does the service informationin				Does the documentation include the			
	Is the provided service eligible for payment under Medicaid?	The Benficiary was eligble for Medicaid on the date of service?	Was the service delivered by a staff person qualified to provide the	Was the IPOS in effect for the date of service, available for review?	Was the provided service identified in the Plan of Service?	Identified Amount	Identified Scope	Identified Duration	Is there documentation indicating the service was provided on the date billed?	Signatures and Credentials of Service Provider	Unit based services have start and stop times	Documentation supports the services as reported	The billed services amount / units match provided documentation
HealthWest													
Yes	194	194	194	170	153	153	153	153	194	166	84	194	194
No	0	0	0	0	0	0	0	0	0	0	0	0	0
N/A				24	41	41	41	41		28	110	0	
% of Yes	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
HealthWest Overall % of Yes			**100.00%**										

Printed Date: 11/22/2022 Report Version: 20201016

LAKESHORE REGIONAL ENTITY

LRE Medicaid Verification FY22 Quarter 4 (July-Sept 2022)

						Does the service informationin				Does the documentation include the			
	Is the provided service eligible for payment under Medicaid?	The Benficiary was eligble for Medicaid on the date of service?	Was the service delivered by a staff person qualified to provide the	Was the IPOS in effect for the date of service, available for review?	Was the provided service identified in the Plan of Service?	Identified Amount	Identified Scope	Identified Duration	Is there documentation indicating the service was provided on the date billed?	Signatures and Credentials of Service Provider	Unit based services have start and stop times	Documentation supports the services as reported	The billed services amount / units match provided documentation
HealthWest													
Yes	376	376	376	351	294	294	294	294	375	337	194	375	375
No	0	0	0	0	0	0	0	0	1	0	1	1	1
N/A				25	82	82	82	82		39	181	0	
% of Yes	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.73%	100.00%	99.49%	99.73%	99.73%
HealthWest Overall % of Yes			**99.97%**										

Printed Date: 12/27/2022 Report Version: 20201016

Attachment E

FY22 MDHHS Performance Indicator Summary Report

Performance Measure	Indicator	Population	FY22Q1	FY22Q2	FY22Q3	FY22Q4	FY22 Trends
Timeliness of Pre-Admission Screening Decision	1	Child	100.0%	98.7%	98.15%	100%	
	1	Adult	99.1%	99.4%	99.72%	99%	
	1	Total	99.3%	99.3%	99.35%	99%	
Timeliness of Assessment Following Request for Services*	2a	MI Child	94.6%	79.8%	68.95%	66.7%	
	2a	MI Adult	97.1%	73.4%	48.76%	56.0%	
	2a	DD Child	96.3%	79.3%	95.24%	70.4%	
	2a	DD Adult	93.8%	71.4%	68.42%	77.8%	
	2a	Total	96.0%	75.9%	58.15%	60.7%	
Timeliness of Start of Services Following Assessment*	3	MI Child	79.2%	73.0%	67.48%	74.6%	
	3	MI Adult	72.9%	37.9%	67.58%	62.7%	
	3	DD Child	92.6%	53.8%	83.33%	66.7%	
	3	DD Adult	94.1%	60.0%	85.00%	53.8%	
	3	Total	78.0%	58.4%	69.05%	66.5%	
Follow-Up After Discharge from Inpatient	4a	Child	100.0%	100.0%	100.00%	81.3%	
	4a	Adult	95.5%	95.1%	95.65%	94.7%	
	4a	Total	96.1%	95.6%	96.30%	92.4%	
Follow-Up After Discharge from SUD Detox	4b	SUD	100.0%	95.2%	100.00%	100%	
	4b	Total	100.0%	95.2%	100.00%	100%	
Inpatient Recidivism	10	Child	4.2%	28.6%	4.00%	15%	
	10	Adult	8.3%	7.0%	12.20%	3%	
	10	Total	7.6%	10.4%	10.81%	5%	

* MDHHS has not established performance thresholds for these measures yet, following implementation of new indicator definitions in April 2020.