QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PLAN (QAPIP)

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HealthWest Leadership Team
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Definitions

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.

Beneficiary: A person served by the publicly funded behavioral health and substance use disorder system, or the person's representative.

CARF: Commission on Accreditation of Rehabilitation Facilities. An international non-profit organization that accredits health and human service programs.

CCBHC: Certified Community Behavioral Health Clinic. Designated provider organizations that have adopted a model focused on increasing access to high-quality care, integrating behavioral health with physical health care, promoting the use of evidence-based practices, and establishing standardization and consistency with a set criterion for all certified clinics to follow.

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.

Credentialing: The process of reviewing the education, experience, and background of all staff to establish their qualifications for providing services. This includes all licensed professional staff as well as non-licensed staff who provide services.

HealthWest Leadership Team: A committee comprised of staff designated by the HealthWest executive director who are responsible for strategic planning and decision-making.

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.

Performance Improvement Committee: The CMHSP committee comprised of HealthWest staff and persons served; responsible for oversight and implementation of the agency's QAPIP.

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

Purpose

As the CMHSP for Muskegon County, HealthWest has developed this Quality Assessment and Performance Improvement Program (QAPIP) to guide the agency-wide quality improvement activities of HealthWest. 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 the Leadership 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 upholds industry standards for best practices in performance measurement, performance management, and performance improvement, as described in MDHHS contracts, CARF standards for behavior healthcare providers, and the CCBHC Handbook.

The QAPIP will be reviewed and approved on an annual basis by HealthWest Board of Directors. Through this process, the 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 HealthWest and its Board of Directors, this authority is discharged through the HealthWest's Executive Director. In turn, the CEO discharges this authority through the Manager of Accreditation and 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 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.

Structure

1. Provider/Consumer Involvement

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

a. The HealthWest Board of Directors will have persons served as members.
b. HealthWest will have a Consumer Advisory Panel that provides input to the Board and various managed care activities.
c. The Performance Improvement Committee will be comprised of staff from HealthWest and include representation of primary and secondary persons served.
d. Provider Relations staff will participate in the Performance Improvement Committee and integration of providers into quality oversight activities.

While HealthWest services and organizational operations must meet the highest standards for all consumers, HealthWest acknowledges that certain individuals and groups may be especially vulnerable for a variety of reasons. Examples of vulnerable populations may include those most likely to experience health disparities, individuals of a particular age or diagnosis, groups of people with identified risk factors, or individuals with a greater number of or higher intensity of needs. As appropriate, the PI Committee will conduct targeted monitoring activities for people identified as vulnerable and make recommendations for improvement whenever necessary.

2. CMHSP Leadership Team

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

a. Brandy Carlson, Chief Financial Officer
b. Cyndi Blair, Chief Clinical Officer
c. Dave McElfish, Chief Information Officer
d. Kelly France, Director of Clinical Quality
e. Jennifer Stewart, Clinical Quality Assurance Manager for SUD
f. Mickey Wallace, Director of Diversity, Equity, and Inclusion
g. Cece Riley, Communications and Training Manager
h. Gregory Green, M.D., Medical Director
i. Amie Bakos, Clinical Services Director – IDD
j. Christy LaDronka, Clinical Services Manager – Intake and Crisis Intervention
k. Ann Judson, Clinical Services Director – Children and Youth
l. Phil McPherson, Human Resources Manager
m. Holly Brink, Executive Assistant
n. Lauren Meldrum, Contracted Services
o. Catherine Kloska, Contracted Services

3. CMHSP Performance Improvement Committee

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, as well as services delivered by contracted provider agencies. 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. The PI Committee also collaborates with the HealthWest Leadership Team, Provider Relations, Clinical Quality Assurance, and other departments at HealthWest to ensure that Network Providers have appropriate performance improvement structures and carry out the necessary activities to monitor the provision of quality services and to meet federal and state requirements.

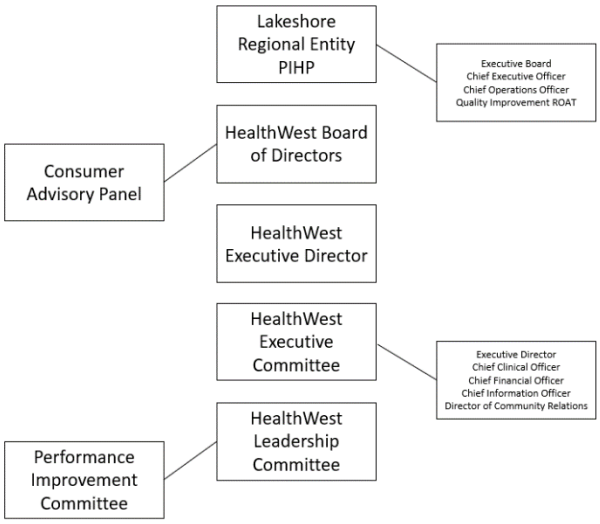
PI Committee is chaired by the Manager of Accreditation and Performance Improvement. The committee is comprised of:

a. Matt Plaska, Accreditation and Performance Improvement Manager (chair)
b. Cyndi Blair, Chief Clinical Officer
c. Natalie Walther, Director of Data Architecture and Analytics
d. Mickey Wallace, Director of Diversity, Equity, and Inclusion
e. Pam Kimble, Director of Autism Services, Behavior Supports Committee Co-chair
f. Amie Bakos, Director of I/DD Services, Behavior Supports Committee Co-chair
g. Kelly France, Director of Clinical Quality Assurance
h. Jennifer Stewart, Clinical Quality Assurance/SUD Manager
i. Gary Ridley, Communications and Advocacy Coordinator
j. Calvin Davis, Data Analyst/Quality Improvement Specialist
k. Carrie Crummett, Clinical Services Manager – Utilization Management
l. Jackie Farrar, Provider Relations/Network Manager
m. Brian Speer, Provider Relations/Network Manager
n. Lacressa Farmer, Trained Family Consultant
o. Kwame James, Trained Family Consultant
p. Shawnda Jackson, Trained Family Consultant
q. Primary or secondary consumers from appropriate service populations, including persons with developmental disabilities, adults with mental illness, children with severe emotional disturbances, and persons with substance use disorders.
r. Additional staff, contracted provider representatives, and community stakeholders will be included in meetings as required and appropriate. While not an exhaustive list, such ad hoc membership may include members of the Leadership Team, HealthWest's Recipient Rights, Privacy, and Corporate Compliance Officers, and members of clinical leadership.

4. Accountability

One of the basic tenets of performance improvement and a key element in the success of this plan, is accountability. This begins with the basic premise that each employee and/or agent of each organization, whether HealthWest or any of the contracted agencies within its Provider Network, will be accountable for the quality and integrity of their work; accountable to beneficiaries, coworkers, and the various committees to which they belong; and to their employer. It is critical that each component of HealthWest's quality assurance and performance improvement program, displayed in the following figure, understands and fulfills its responsibilities within the QAPIP.

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 deliver quality services, effectively manage available resources, fulfill all expectations and requirements, protect the rights of service beneficiaries, and identify and confront 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 Quality Officer (CQO) for the LRE. The LRE CQO is responsible for implementation of Quality Oversight at the PIHP Level and is responsible for facilitation of the affiliation-wide Quality Oversight Committee.

   HealthWest is represented within the membership of the LRE QI Regional Operations and Advisory Team and supports affiliation-wide Quality Oversight and Quality Improvement 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 Operations and Advisory Team (QI ROAT) as requested.

2. HealthWest Leadership Team

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:

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 provides the results of those reviews to HealthWest. If HealthWest's performance is below established thresholds, the Leadership Team will determine actions necessary to improve performance. HealthWest Corporate Compliance Officer and Director of Clinical Quality also share individual-level data and specific findings with appropriate HealthWest staff.

b. Practice Guidelines

HealthWest recognizes that research and experience continue to expand our knowledge base regarding effective care and treatment, and that the agency's practice guidelines must also evolve to reflect these developments. Within HealthWest, the Leadership Team has assigned the Clinical Operations Group the responsibility of ensuring HealthWest's practice guidelines are aligned with the latest research and clinical expertise, as supported by strong, valid evidence. The Clinical Operations Group is also responsible for ensuring HealthWest practice guidelines are clinically applicable and appropriate for the individuals served by HealthWest with co-occurring mental illness, substance use disorders, and/or intellectual and development disabilities; reflect the current needs, strengths, and resources of our local community; align with HealthWest treatment models and values; meet all federal, state, and local requirements; and are suitable for delivery within HealthWest's multidisciplinary teams. Maintaining such awareness may involve periodic literature reviews, consultation with subject matter experts, participation in ongoing educational and professional development, and coordination with fellow clinical professionals.

HealthWest is also responsible for implementing all contractually mandated Practice Guidelines and Technical Requirements published by MDHHS. These include, but are not limited to, Behavior Treatment Plans, Consumerism Practices, Family-Driven and Youth-Guided Practices, Housing Practices, Inclusion Practices, Person-Centered Planning, Self-Determination, Co-occurring Treatment, Jail Diversion, Trauma-Informed Care, and School to Community Transition Practices.

The process for developing, reviewing, adopting, and disseminating practice guidelines will follow the established HealthWest policy (01-001) regarding the Preparation, Distribution, and Revision of Policies and Procedures. The HealthWest Leadership Team

will have the responsibility for ensuring practice guidelines are communicated and implemented, that staff have the training and knowledge necessary to provide treatment according to the practice guidelines, and that all agency policies and procedures are upheld.

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 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. HealthWest has a system in place to document and monitor such events, report to the PIHP and MDHHS as required within the appropriate timeframes, ensure root cause analyses are performed as required by staff with the appropriate credentials, and improvements and preventative measures are put in place to address safety issues and avoid future adverse events. HealthWest's policies, procedures, and reporting system for adverse events were developed to fulfill all requirements specified in the MDHHS/PIHP Medicaid Managed Care Specialty Supports Services Contract as well as the requirements established by the Lakeshore Regional Entity for its affiliate CMHSPs. For additional information see the HealthWest Policy on Adverse Events (04-019), MDHHS QAPIP Practice Guidelines, and the MDHHS/PIHP

i. Sentinel Events

Primary responsibility for review of sentinel events will be vested in HealthWest and its Network Providers. The Director of Clinical Quality will be responsible for ensuring that this occurs, with proper reporting, as specified in HealthWest policies and procedures for adverse events, including Critical Incidents, Risk Events, Sentinel Event, and Death Reporting. HealthWest Leadership Team will have the responsibility for assuring the policy and procedure is implemented appropriately.

ii. Critical Incidents and Risk Events

At least quarterly, HealthWest Leadership Team will analyze critical incident and risk event data. Based upon this analysis, HealthWest Leadership Team 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

As the regional PIHP, the Lakeshore Regional Entity has retained responsibility for conducting provider site reviews, as well as the credentialing and re-credentialing of provider agencies within the region. However, credentialing and re-credentialing, privileging, primary source verification, and qualification of CMHSP Participants (staff who are employees of HealthWest or under contract to the CMHSP) are delegated by the LRE to the HealthWest. HealthWest is also responsible for the selection, orientation, training and evaluation of the performance and competency of their own staff and subcontractors. Accordingly, HealthWest has established written policies and

procedures for the credentialing and re-credentialing of providers in compliance with MDHHS's Credentialing and Re-Credentialing Processes Guidelines. These policies and procedures ensure 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's Credentialing and Privileging Committee applies the established agency policies and procedures to conduct credentialing and privileging of all HealthWest staff who provide services, as well as licensed individual practitioners upon hire/contract initiation, and annually thereafter. HealthWest written policies and procedures also ensure that non-licensed providers of care or support are qualified to perform their jobs. Credentialing is the responsibility of the designated Clinical Quality Assurance staff, and Clinical Privileges are the responsibility of the Credentialing and Privileging Committee chaired by Clinical Quality Assurance Managers.

Staff employed by external provider agencies contracted by HealthWest must also be appropriately credentialed and qualified to provide services. Credentialing, privileging, primary source verification, and qualification of staff employed by contracted external provider agencies is conducted by the provider agency. Oversight is provided by Provider Relations/Network Manager, integrated into contractual requirements, and verified during CMHSP and provider site reviews.

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 to be directed to the PI Committee for their review, action, and 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 of service and support provision, and compliance with administrative requirements. 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 primary responsibilities of the PI Committee include.

a. Performance Indicators

The PI Committee is responsible for monitoring performance across all federal, state, and local quality measures and performance indicators within required reports.

i. MDHHS has established performance indicators for PIHPs and CMHSPs, as detailed in the MDHHS-PIHP and MDHHS-CMHSP contracts. These performance indicators measure access, effectiveness, efficiency, and satisfaction with services. HealthWest will report performance indicators for all service populations to MDHHS as well as reporting performance indicators regarding Medicaid beneficiaries in particular. Performance indicators will be reported based on age and population served (mental health, intellectual/developmental disability or substance use disorders), though the PI Committee will also monitor performance indicators for variance based on a variety of factors in order to identify and address any health disparities in services provided or outcomes achieved. When standards are not met, the PI Committee will do an analysis of the indicator, determine the cause of the non-compliance and collaborate with relevant staff to develop and recommend a plan to bring the indicator into compliance.

ii. As a CCBHC, HealthWest also upholds all standards of care and reporting requirements expected of such organizations. HealthWest will establish mechanisms for capturing and reporting all CCBHC-reported quality measures and will ensure that MDHHS has the necessary data to calculate the remaining MDHHS-reported measures. These quality measures are crucial to increasing accessibility, improving quality of care, protecting client safety, and integrating behavioral health with physical health care in order to achieve improved outcomes. CCBHC quality measures are included in the set of performance indicators within the HealthWest QAPIP, and as a result are monitored by the Performance Improvement Committee on an ongoing basis, in addition to the annual review of the HealthWest QAPIP.

b. Consumer Satisfaction and Outcome Measures

The PI Committee will be responsible for conducting surveys of beneficiaries to assess their level of satisfaction with services and to gather feedback regarding potential changes and improvements. The PI Committee's annual QAPIP Action Plan will address specifics for the implementation of satisfaction surveys, including integration with the work of the Customer Services and the Clinical Quality Assurance departments. Additionally, the PI Committee will advance the implementation of outcome measurement as appropriate, with a strategic emphasis on improved behavioral and physical health outcomes and a reduction in health disparities.

c. 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. 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 services, 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 demographics and health risks of individuals served.

Therefore, 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. Participation will include collaboration with other affiliates to develop interventions, submissions of necessary data to improve performance, and evaluation of the impact of any changes made at HealthWest.

As part of its strategic plan implementation and ongoing performance indicator monitoring, HealthWest will also undertake other improvement projects as needed to increase quality of care, improve consumer safety, reduce health disparities, and address concerns with the accessibility, effectiveness, efficiency, and satisfaction of services.

d. 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. The Chair of HealthWest's Behavior Treatment Plan Review Committee (known as the Behavior Supports Committee at HealthWest) is a member of the PI Committee, in order to ensure inclusion of expert analysis and insight in the discussion of behavior treatment data and trends.

e. 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.

4. Manager of Accreditation and Performance 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.

   The Manager of Accreditation and Performance Improvement will facilitate an annual review and evaluation of the QAPIP and attached QAPIP action plan. And as chair of the Performance Improvement Committee, the Manager of Accreditation and Performance Management will also work with committee members to develop a new QAPIP action plan for the upcoming year. The updated QAPIP with any recommendations or changes, annual review and evaluation, and new QAPIP action plan will be presented and approved by the Board of Directors. Information on the effectiveness of the HealthWest's QAPIP will be provided annually to persons served and stakeholders.

   The Manager of Accreditation and Performance Improvement and the Director of Clinical Quality Assurance 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.

Priorities for Performance Improvement

Performance improvement opportunities can occur at any point during an organization's operations. Regardless of when an opportunity presents itself, and whether it arises following a specific event or as the result of ongoing monitoring, corrective action must be taken to address all performance concerns. However, there may be times when improvement opportunities appear to conflict with other existing organizational priorities due to the limitations in time, resources, and staff capacity. Nevertheless, it is important that improvement projects and priorities align with the overall strategic direction and priorities of the agency. The PI Committee thus engages in an ongoing process of identifying performance improvement opportunities and working with the Leadership Team to prioritize improvement projects within the context of the agency's overall strategic plan goals and existing improvement projects already underway. The prioritization framework utilized by the PI Committee in collaboration with the Leadership Team seeks to balance consistency with context; as a result, improvement opportunities are assessed based on their impact on the following:

- Safety of persons served and staff (at HealthWest as well as provider agencies)
- Quality of care and services provided
- Potential to improve performance
- Relevance to HealthWest Mission, Vision, and Values

- Level of risk (contractual, person served, accreditation, other)
- Number of individuals served that would be affected
- Complexity of the processes involved
- Scope of the proposed change
- Impact on other processes and systems
- Availability of organizational resources (funding, staff time, expertise, etc.)

Performance Indicators and Quality Measures

The Performance Indicators and Quality Measures utilized by HealthWest (see Appendix A) 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. An annual schedule for the topics and data sets reviewed by the PI Committee is included in Appendix B.

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. Performance on the listed performance indicators and quality measures will be summarized annually as part of the PI Committee's annual QAPIP review and evaluation.

Corrective Action Initiatives

HealthWest's commitment to continuous quality improvement compels the agency to undertake corrective action any time performance does not meet established expectations for quality, safe care. All HealthWest and provider staff are expected to remain vigilant for the need for improvement in their daily work and to take corrective action within their role in HealthWest's clinical workflows and agency operations whenever necessary.

In addition to this shared ownership of continuous quality improvement, the PI Committee continuously monitors performance indicators to recognize potential areas for improvement and recommend corrective action. Whenever the PI Committee observes that the organization, a provider, a department, a team, or an individual does not meet established standards (as set by the organization, a contract, an oversight entity, or an accrediting body), it will recommend a Plan of Correction (POC). Such plans of correction may follow a specific occurrence or adverse event, or may result from routine performance indicator monitoring, monitoring or other special studies, a site visit or audit, results of a Utilization Management/Utilization Review study, or a root cause analysis.

A formal POC provides the agency an opportunity to document the original findings, analyze available data, describe the improvement plan, facilitate the implementation of changes, and monitor the impact of any changes on the identified issue. Minimum elements of an acceptable plan of correction include a summary of the assessment of the nature of the problem; a plan to address the problem that includes responsible parties, specific action steps, measurable objectives, and

defined timelines; expected impact of improvements; and evidence that will be used to assess the successfulness of the improvement plan. (see Appendix C for a sample template that staff may use while developing a plan of correction). Plans of correction will be reviewed by the PI Committee, which will accept the plan as written or provide consultation and recommendations on changes to be made before approval. Staff responsible for plans of correction are then expected to provide regular updates to the PI Committee, consult with the PI Committee as needed, ensure stated timeframes and deadlines are upheld, and proactively work with their supervisor and the PI Committee to resolve any challenges that arise throughout implementation of the plan.

Communication and Reporting

Reports and corrective action plans developed at the request of the committee are submitted to the Manager of Accreditation and Performance Improvement for distribution to the committee. Responsible individuals may be invited, as appropriate and necessary, to present updates and outcomes of plans of correction to the PI Committee. Updates on all active and recently concluded plans of correction will be shared with the HealthWest Leadership Team within required quarterly committee reports.

Minutes of all PI committee meetings will be documented using a standard format and will include sufficient detail regarding attendees, topics discussed, outcomes of analyses, and required action items. Meeting minutes will be reviewed and approved by the PI committee and will be posted (including attachments) according to HealthWest committee procedures for all staff to access. Meeting minutes and accompanying materials from all meetings will be maintained by the Manager of Accreditation and Performance Improvement and are available for audit and/or review as requested. All records, data, reports, audit materials, communication, and correspondence will be retained according to regulatory requirements for document retention. However, 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 any consumer's medical record.

On a quarterly basis, the PI Committee will ensure the HealthWest Board of Directors and Leadership Team receives the key performance indicators report. During each monthly meeting, the PI Committee will identify any data or reports that are important and of interest to staff and stakeholders. These reports will be shared with staff, persons served and other stakeholders via appropriate communication channels.

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.

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 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 and/or disciplinary action.

Annual Self-Assessment

In order to ensure the ongoing effectiveness of the committee and to support a strong quality assurance and performance improvement 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 Appendix D). 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 QAPIP review and evaluation described below.

Annual QAPIP Review and Evaluation

The PI Committee completes an annual QAPIP review and evaluation that includes:

1. A review of QAPIP goals from the previous year;
2. A review of the PI Committee's objectives and actions from the previous year;
3. A review of the annual PI Committee self-evaluation results;
4. A review of all quality oversight activities;
5. A review of the appropriateness and relevance of current performance indicator and quality measures (contained throughout this report);
6. An overall performance summary including progress on improvement projects and trends within the accessibility, effectiveness, efficiency, and satisfaction of HealthWest services;
7. Identification of QAPIP goals and priorities for the coming year;
8. Recommendations and next steps.

Upon its completion, the annual QAPIP review and evaluation is provided to the HealthWest Leadership Team and Board of Directors, as well as the provider network and Consumer Advisory Panel. Additionally, the annual QAPIP review and evaluation is available to staff, consumers, and members of the community and can provided at any time 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.

Annual QAPIP Action Plan

In addition to the annual review and evaluation, the PI Committee also develops an annual action plan. The annual action plan will contain the strategic plan objective(s) assigned to the PI Committee and describe the specific action steps that will be taken to achieve the identified objective(s). The annual action plan, which is always aligned with the HealthWest strategic plan and guidance from the Leadership Team and Board of Directors, is also meant to guide the PI Committee in its efforts to implement the QAPIP by identifying components of the QAPIP to be prioritized in the upcoming year. The annual action plan will be based upon the requirements of the agency's QAPIP, MDHHS QAPIP practice guidelines, MDHHS/PIHP contract requirements, and PIHP/CMHSP contract agreements; the current HealthWest strategic plan; findings and recommendations from the preceding annual QAPIP review and evaluation; and any areas for performance improvement that require corrective action.

Appendix A

Performance Indicators and Quality Measures

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 (MMBPIS)	Quarterly
Timeliness of initial evaluation (I-EVAL)	Initial assessments must occur within 14 days of request for service	> 95%	All	MDHHS (MMBPIS) CCBHC	Quarterly
Timeliness of first service	First face-to-face service must occur within 14 days of initial assessment	> 95%	All	MDHHS (MMBPIS)	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 (MMBPIS)	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 (MMBPIS)	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	TBD	Adults	CCBHC	Annual

	counseling intervention if identified as a tobacco user				
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 plan documented on the date of the eligible encounter if positive.	TBD	Adults	CCBHC	Annual
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	Percentage of consumers age 13+ with a new episode of AOD	Initiate 42.5%	SUD (Age13+)	CCBHC	Annual

Dependence Treatment (IET-BH)	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	Engage 18.5%			
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 (MMBPIS)	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 (MMBPIS)	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 FY22.	> 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	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

Appendix B

Quarterly PI Committee Data Review Schedule

Over the course of the year, the PI Committee monitors a variety of performance and quality measures. The calendar below summarizes when and how often the committee reviews the data for each measure. Three data sets, which are each reviewed and reported quarterly, anchor this annual calendar: Key Performance Indicators (reported to the Board of Directors), Priority Data Sets (selected by the Leadership Team), and Program-Specific Performance Measures (shared with clinical leadership). Additional performance data the PI Committee must monitor, as described in the QAPIP, have been added to each month as well. This schedule will be maintained by the PI Committee and modified as necessary to reflect changes to data sets or the review schedule.

	Q2			Q3			Q4			Q1		
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Strategic Plan Objective *Reduce Health Disparities (MMBPIS indicators, FUH-A, FUH-C)*	x	x	x	x	x	x	x	x	x	x	x	x
Improvement Projects *Ongoing monitoring of performance and quality improvement projects, as needed*	x	x	x	x	x	x	x	x	x	x	x	x
Priority Data Sets *Leadership Team: Encounters, BHTEDS, CCBHC QBP, LRE and HW PIP (FUH)*	x			x			x			x		
Utilization Management *Authorizations, Claims, Utilization, Service Authorization Denials, Retro Reviews*	x			x			x			x		
Medication Management *Psychiatric Prescriber Peer Reviews*	x			x			x			x		
Practice Guidelines	x			x			x			x		
QAPIP Evaluation and Review *Annual Review of QAPIP Outcomes, PI Committee Self-Evaluation*										x		
Key Performance Indicators *HW Board Report*		x			x			x			x	
Medicaid Claims Verification *Medicaid Verification Results*		x			x			x			x	
Customer Services *Grievances, Appeals, Satisfaction Surveys*		x			x			x			x	
Provider Monitoring *Quality of Care, Network Adequacy, Access and Availability, Site Reviews*		x			x			x			x	
Program Performance Measures *Access, Effectiveness, Efficiency, Satisfaction*			x			x			x			x
Adverse Events *Critical Incidents, Risk Events, Sentinel Events*			x			x			x			x
Behavior Treatment Data *Behavior Treatment Plans, Physical Management Interventions, BTP Survey*			x			x			x			x

Appendix C

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 leadership 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.

Sample Template and Plan of Correction

<table>
<tr><td colspan="2">Standard:

MMBPIS #2</td><td>Mark when Complete: ☐</td></tr>
<tr><td colspan="3">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.</td></tr>
<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>

Appendix D

Performance Improvement Committee
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 HealthWest's quality oversight interests.				
G. Our committee supports and assists the HealthWest Executive Director in achieving the HealthWest mission.				
Section 2: Quality Oversight				
A. The committee reviews and discusses performance reports that provide comparative statistical data about HealthWest services.				

	Very Good	Good	Fair	Poor
B. The committee reviews feedback from community partners including residential homes, the LRE, MDHHS, referral sources, community agencies, and others regarding HealthWest's overall performance as a service provider.				
C. The committee effectively communicates performance data to HealthWest 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 HealthWest and the community, representing the interests of both.				