QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN (QAPIP)

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HealthWest Leadership Team June 3, 2025

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Mission Statement

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

Vision Statement

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

Quality Assessment

The systematic process used to evaluate if services meet quality standards. This includes assessment of our performance in meeting contractual requirements and other agreed upon quality standards.

Quality Improvement

A systematic approach guided by data to improve the quality, safety, and effectiveness of integrated healthcare services.

Performance Improvement

An efficient approach for improving employee and organizational performance to achieve results. It is a process that describes preferred performance, identifies causes of performance concerns, and then selects, designs, and implements interventions to fix the cause and measure change in performance.

The Goal of Quality and Performance Improvement

To improve healthcare delivery for enhanced access to care, improved consumer outcomes, and increased satisfaction with services. To recognize opportunities for enhancement in performance at the organizational, system, process, and employee levels to achieve desired organizational results of high-quality, sustainable behavioral health services that increase positive outcomes for consumers.

I. PURPOSE

The HealthWest Quality Assessment and Performance Improvement Plan (QAPIP) aims to follow a process of assessment, strategy development, stakeholder input, plan implementation, results review, and change using the cycle of continuous quality improvement (CQI). HealthWest will seek to improve outcomes for those receiving services.

The function of the QAPIP is to guide the agency-wide quality improvement activities of HealthWest and support the integration of a continuous quality improvement philosophy into the organization's everyday work.

Continuous quality improvement is based on the following assumptions:

1. Persons working on behalf of the organization seek to provide high-quality services.
2. In nearly all situations, improvement can be made by analyzing processes and systems for completing work.
3. Persons served will be involved in defining the quality of services.
4. Decisions are based on reliable data.

The QAPIP addresses the contractual requirements of the Michigan Department of Health and Human Services (MDHHS) and the Pre-Paid Inpatient Health Plans (PIHP), as well as CARF accreditation requirements. In addition, it also fulfills the requirement that each Certified Community Behavioral Health Clinic (CCBCH) have a Continuous Quality Improvement (CQI) Plan for clinical services and clinical management.

II. 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 Certified Community Behavioral Health Clinic (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 the 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 HealthWest's Executive Director. In turn, the Executive Director discharges this authority through the Director of Quality Assurance.

III. GOALS

1. Target improvements at all levels, including management, administration, and programs. Dimensions of care such as access, effectiveness, efficiency, and satisfaction will be addressed.
2. Involve people served and those who care for them in assessing and improving satisfaction with outcomes and services.
3. Develop performance indicators to ensure that services are effective, safe, respectful, and appropriate.
4. Track key performance indicators, comparing performance to statewide and/or nationwide data when available.
5. Ensure that service providers fulfill their contractual or employment obligations per applicable regulatory and accreditation standards.
6. Ensure that service providers are competent and capable of providing services through a system of competency evaluation and credentialing.
7. Ensure that HealthWest provides effective, equitable, understandable, and respectful quality care and services responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
8. Ensure that performance indicators and improvement activities impact all populations served by the agency, including but not limited to populations such as persons served over a long period of time, older adults, children, non-English speakers, and those with developmental disabilities.

IV. PLAN REQUIREMENTS

The Quality Assessment and Performance Improvement Plan will meet the following requirements:

1. Meet the Michigan Mission-Bases Performance Indicator System (MMBPIS) standards. Failure to meet the standards for one quarter will result in initiating a performance improvement project and in-depth analysis.
2. Certified Community Behavioral Health Clinic (CCBHC) Continuous Quality Improvement Plan for clinical services and clinical management.
3. Develop internal standards for performance when these standards are not set by MDHHS, CARF, the LRE, federal standards, and/or awarded grant requirements.
4. Quality improvement projects will sustain improvement in significant aspects of clinical and non-clinical services.
5. Monitor and review activities to ensure systematic problems are identified and corrected.
6. Meet all MDHHS and awarded grant requirements for grievances and appeals and maintain an active member services function.
7. Maintain a record of all performance improvement projects and provide follow-up data to ensure improvements are demonstrated and maintained.
8. Quality and performance improvement activities in the clinical area will strive to improve prevention, acute, chronic, high-volume, and high-risk services, providing a whole-person

approach to health care services as well as any process that may be relevant to service improvement.

9. Quality and performance improvement activities in non-clinical processes may include availability, accessibility, cultural competency, quality of providers, processes regarding billing and authorizations, appeals, grievances, and complaints.
10. Identify quality improvement initiatives through a regular process of data gathering, analysis, and prioritization, which considers prevalence, need, risks, and the interest of persons served in pursuing the project.
11. Ensure that whole-person wellness promotion occurs for persons served who are eligible for services.
12. Review all sentinel events and implement action items based on these reviews.
13. Implement a utilization management function that clearly identifies criteria for services with the agency, publicizes these to those individuals currently and potentially receiving services, and reviews trends in access and service utilization.
14. Carry out quality projects as required by the State, Federal and awarded grant guidelines.

The Quality Assessment and Performance Improvement Plan (QAPIP) will be reviewed on an annual basis. Review and evaluation will include:

1. A review of QAPIP goals from the previous year;
2. A review of the Quality Improvement Committee's objectives and actions from the previous year;
3. A review of the annual Quality Improvement Committee self-evaluation results;
4. A review of all quality oversight activities;
5. A review of the appropriateness and relevance of current performance indicators 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 Committee. Additionally, the annual QAPIP review and evaluation is available to Staff, consumers, and members of the community. The QAPIP can be provided at any time upon request.

V. RESPONSIBILITIES

A. The HealthWest Board will annually approve the Quality Assessment and Performance Improvement Plan. The Board will also periodically review performance improvement data and information.

B. The Executive Director will ensure that a quality improvement (QI) system is in place. The director will review recommendations from the Leadership Team and authorize any subsequent action plans.

C. The Medical Director or designee shall provide consultation to any committee that requires medical consultation. The Medical Director or designee will serve as an ad hoc member of the Leadership Team and will ensure that psychiatric representation is available for the Pharmacology & Therapeutics/Medication Committee, Utilization Management Committee, Sentinel Event Review, Quality Improvement Committee, and the Behavior Treatment Review Committee, as needed.

D. The Director of Quality Assurance will be responsible for the implementation and ongoing functions of the QI system. The Director of Quality Assurance will serve as a member of the Leadership Team and will provide facilitation and data analysis within the QI system. This includes the ongoing development of the QAPIP and evaluation of the QI system.

E. The HealthWest Leadership Team will be responsible for reviewing performance indicators on a regular basis, developing action plans to improve performance where required, and ensuring compliance with clinical care standards. The Leadership Team has central responsibility for the implementation of the QAPIP.

F. HealthWest Staff will ensure consistent, high-quality care and services. Whether providing clinical or administrative services, staff work to support the mission, vision, and guiding values of HealthWest. Staff are responsible for identifying areas which need improvement and suggesting process and system changes by bringing quality issues to their direct supervisor or a member of the Quality Assurance team. Quality and performance initiatives may also start based on findings in process and data quality monitoring such as Medicaid Verification. Staff will serve on committees, performance improvement workgroups, and participate in the Kata process if approved by their direct supervisor.

G. Contractual agencies will be evaluated based on the performance standards stated in their contracts. They will be provided a regular means of communicating issues to HealthWest, such as the Provider Network Meeting, which meets monthly or by submitting issues to the contracts department.

VI. STRUCTURE

The structure of the quality assurance system is graphically depicted in Appendix B: Quality Assurance and Performance Improvement Structure:

The Quality Improvement Committee will regularly report to the Leadership Team with findings and recommendations. See *Appendix C: Quality Improvement Committee Members* and *Appendix E: QAPIP Data Review Schedule* for a detailed review of committee responsibility for plan development, policy, CARF standards, and performance indicators. The duties and responsibilities of Quality Improvement Committee include:

1. Receive regular outcome reports from committees and departments.
2. Review and evaluate various survey results and identify priorities for improvement.
3. Review and evaluate all employee-generated suggestions for improvement.
4. Annually review and approve the QAPIP.
5. Annually review the committee structure to ensure comprehensive improvement process.
6. Assure that plans for improving systems are in place and effectively implemented, monitored, and communicated.
7. Identify the organization's training needs related to quality assurance and performance improvement.
8. Recommend priorities for action based on data and recommendations.
9. Maintain a log that tracks the status of all actions taken.
10. Ensure that any work group assigned by the Quality Improvement Committee understands its role and function clearly.

The Quality Assurance Team is responsible for the following:

1. Presents the Quality Assessment and Performance Improvement Plan to the Leadership Team and the CMH Board on an annual basis.
2. Provides consultation and support to departments and the Leadership Team in their role of quality assurance.
3. Reviews internal Peer Chart Review and Medicaid Event Verification audits to ensure quality standards are met and to identify areas for improvement.
4. Ensures that quality and performance improvement data is regularly presented to the Leadership Team.
5. Prepares reports for the MDHHS and PIHP performance indicators and other required quality-related reporting.
6. Coordinates the PIHP Medicaid Event Verification process.
7. Completes state-required consumer satisfaction surveys and reports data.
8. Facilitates completion of root cause analysis for sentinel events warranting such analysis.
9. Leads preparation for Commission on Accreditation of Rehabilitation Facilities (CARF) surveys, Michigan Department of Health and Human Services (MDHHS) audits, and Lakeshore Regional Entity (LRE) site reviews.
10. Leads preparation for Michigan Fidelity Assistance Support Team (MIFAST) Reviews, including reviews for Assertive Community Treatment (ACT), Dialectical Behavior Therapy (DBT), Level of Care Utilization System (LOCUS), and Supported Employment/Individual Placement and Supports (IPS).

VII. STANDING COMMITTEES

Standing committees serve functions that are directly related to contract or accreditation requirements. They are long-standing and are responsible for monitoring and reporting specific findings identified in the Quality Assessment and Performance Improvement Plan. They may or may not be required by MDHHS, CARF, etc. Committees include HealthWest staff and may include persons served by the organization or persons who care about them, such as family members, guardians, and advocates. *See Appendix B: Quality Assurance and Performance Improvement Structure*

Behavior Treatment Review Committee: This committee, mandated by MDHHS contract, reviews restrictive, intrusive, or aversive behavior plans, whether developed by HealthWest clinical staff or contracted programs, and psychotropic medications prescribed for behavioral control purposes. The committee also educates Staff regarding behavior issues. Refer to *Policy and Procedure No. 06-001 Behavior Treatment Plan Review Committee* for full details. The committee provides recommendations for Staff seeking interventions for challenging cases. The committee meets monthly and reports quarterly to the Quality Improvement Committee and to the Lakeshore Regional Entity's regional committee.

CARF Committee: This committee reviews the CARF accreditation standards, periodically audits for compliance with CARF standards, and educates program staff in the standards. In addition, they participate in the QAPIP by monitoring the performance measures for Access, Effectiveness, Efficiency, Satisfaction, and Business Functions as they relate to CARF accredited programs and for any program which we may seek to become accredited for in the future. Over the three-year accreditation cycle, the committee meets as follows: year one the committee meets quarterly to review recommendations and implement performance improvement projects, year two the committee meets bi-monthly to step up efforts in performance improvement, year three the committee meets monthly to increase efforts in education, communication, and preparation regarding upcoming CARF survey. This committee reports quarterly to the Quality Improvement Committee.

Certified Community Behavioral Health Clinic (CCBHC) Committee: This committee works to maintain CCBHC Certification, meeting 100% of requirements. It aligns with CCBHC certification criteria to secure additional funding and position our organization for the future model of behavioral healthcare. Sub-committees include Designated Collaborative Organizations (DCOs) and Care Coordination. The committee meets bi-weekly and reports to the Quality Improvement Committee quarterly.

Clinical Operations Committee: This committee provides oversight, guidance, and direction regarding clinical operations across the organization to improve workflow and clinical communications, discover and implement efficiencies, ensure adherence to all standards and requirements, support evidence-based and best practices, and improve the overall staff and consumer experience in the delivery of clinical care. The committee collaborates with the Quality Assurance Department to ensure clinical decisions align with the standards of governing bodies, addresses systemic level issues identified through audits and corrective action plans, reviews and supports initiatives related to implementation

and sustainability of evidence-based and best practice models (*Policy and Procedure No. 06-017*), oversees clinical practices and policies, and reviews credentialing when there is ambiguity as to if the credentials are appropriate/qualify for a position. This committee regularly reviews, monitors use of, evaluates, and, at least annually, formally adopts Clinical Practice Guidelines (https://www.lsre.org/clinical-practice-guidelines) for the provision of long-term care services that are relevant to the target populations served. The committee meets monthly and reports to the Quality Improvement Committee quarterly.

Compliance Committee: This committee provides oversight of the compliance functions of the organization, reviews compliance incidents and data, and oversees policy and procedure development in privacy, security, and compliance. The committee develops a *Corporate Compliance Plan* and an annual *Risk Management Plan,* which covers a variety of risk factors such as programmatic, financial, or health and safety. This committee is responsible for the agency's Risk Management and Corporate Compliance Plans. The committee meets monthly and reports to Leadership Team quarterly.

Consumer Advisory Committee: This committee comprises HealthWest staff and current HealthWest consumers or guardians. The committee reviews satisfaction surveys, consumer experiences, and other information to make recommendations to the agency. The committee meets monthly and reports to the HealthWest Board bi-monthly.

Doctors' and Pharmacy Workgroup: This committee is chaired by the HealthWest Medical Director. The committee addresses areas related to the safety and quality of healthcare provided to individuals in services. The committee also provides an organized mechanism for evaluation and assessment of medical Staff through the Peer Review process. Refer to *Policy and Procedure No. 12-003 Medical Staff Peer Review Protocol*. It monitors the utilization of medications in HealthWest-operated and contractual programs. The workgroup reviews significant medication errors, assures compliance with internal and external standards and policies, provides assistance to programs for the purpose of developing procedures, and revises HealthWest policies and procedures regarding medication. Refer to *Policy and Procedure No. 06-010 Medication Management*. Record reviews are completed monthly by prescribers, pharmacists, and nurses, independent of the monthly committee meeting. The committee meets monthly and reports to the Quality Improvement Committee quarterly. The quarterly summary report from these findings is used to identify opportunities for performance improvement and areas for additional education. The committee meets monthly and reports to the Quality Improvement Committee quarterly.

Environment of Care Committee: This committee oversees efforts across the organization to ensure that effective safety, emergency preparedness, and security issues are addressed. The committee meets quarterly and reports to the Compliance Committee quarterly. Please refer to *Policy and Procedure No. 10-009 Environment of Care*.

Integrated Health and Care Coordination Committee: This committee recognizes integrated and holistic care is the best practice for supporting recovery of individuals with behavioral health concerns,

developmental delay, and concerns with substance use. Members work to ensure HealthWest staff are accurately integrating and coordinating care, including documentation of care. The committee also focuses on external referrals, model payments, spend-downs, insurance benefit planning, housing, and other various ancillary services. The committee meets bi-weekly and reports to the Quality Improvement Committee quarterly.

Provider Contract Meeting: This is not a committee but a standing meeting that works to address any HealthWest provider network issues that may be related to contractual changes, HealthWest Latitude 43 issues, Provider Performance and Compliance issues, as well as any other HealthWest provider concerns such as billing changes. This group includes HealthWest staff and provider staff and meets monthly. Information from this meeting is used to update the Network Adequacy Plan. The plan and data related to it is presented to the Quality Improvement Committee semi-annually.

Recipient Rights Advisory Committee: This committee, mandated by MDHHS contract, helps to ensure that every individual receiving HealthWest services has certain protected rights. The committee membership is appointed by the Board and includes board members. The committee meets every other month. Refer to *Policy and Procedure No. 04-006 Safeguarding the Rights of Recipients*. It is the responsibility of the Recipient Rights Office to collect and report data to the Quality Improvement Committee quarterly.

Utilization Management Steering Committee: This committee monitors the utilization of resources to ensure that services are clinically necessary, effective, and provided in the most cost-effective manner. Regular data reports will be reviewed, and adjustments will be made in the organization based on the data. It is responsible for the agency's Utilization Plan. The committee meets monthly and reports to the Quality Improvement Committee quarterly.

VIII. 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 that 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 and Procedure No. 04-019 Reporting Unusual Incidents*, *MDHHS QAPIP Practice Guidelines*, and the MDHHS/PIHP Contract. See also *Appendix F: Critical and Risk Event Incident Reporting Grids*.

1. Critical Incidents: Events or incidents that meet MDHHS reporting requirements, including Suicide, Non-Suicide Death, Emergency Medical Treatment due to Injury or Medication Error, Hospitalization due to Injury of Medication Error, Arrest of a consumer living in a residential setting or receiving waiver services, or injury as a result of physical management.
    a. Critical incidents will be reported consistent with MDHHS contract requirements.
    b. The Quality Assurance Team will analyze critical incident and risk event data. This information will be reported regularly to the Leadership Team, who will, as appropriate, review additional information needed to determine when and what actions to remediate a situation or to reduce the potential for similar events to be implemented.
    c. Critical incident reporting will be submitted to Lakeshore Regional Entity by the 15th of each month. *See Appendix F* for a grid of critical incidents.
2. Risk Events: Events that put an individual at risk of harm. Such an event is reported internally and analyzed to determine what action needs to be taken to remediate the problem or situation and prevent additional events and incidents. Risk events minimally include:
    a. Harm to Self: Actions taken by consumers that cause physical harm requiring emergency medical treatment or hospitalization due to an injury that is self-inflicted (e.g. pica, head banging, self-mutilation, biting, suicide attempts.)
    b. Harm to Others: Actions taken by consumers that cause physical harm to others (family, friends, Staff, peers, public, etc.) that result in injuries requiring emergency medical treatment or hospitalization of the other person(s).
    c. Police Calls: Police calls by Staff of specialized residential settings, general (AFC) residential homes or other provider agency staff for assistance with a consumer during a behavioral crisis situation.
    d. Emergency Use of Physical Management: Techniques used as an emergency intervention to restrict the movement of an individual by continued direct physical contact despite the individual's resistance to prevent them from physically harming themselves or others. The term "physical management" does not include briefly holding an individual to comfort him or her or to demonstrate affection or holding their hand.
    e. Two or more unscheduled admissions to a hospital w/in a 12-month period.
    f. Risk Event reporting will be submitted to Lakeshore Regional Entity by the 15th of each month. *See Appendix F* for a grid of Risk Event incidents.
3. Sentinel Events:
    a. Critical incidents that meet the criteria as sentinel events will result in a full review and analysis, referred to as a Root Cause Analysis (RCA). This is reported semiannually by HealthWest to MDHHS and the Lakeshore Regional Entity compliance point-person. The review will meet requirements as defined by MDHHS and specified in HealthWest *Policy No. 04-021, Reporting a Review of Recipient Death*. Following completion of the RCA, any recommendations for change or corrective action plans, will be presented to the Compliance Committee and to Leadership.
    b. The Quality Assurance Team determines the necessity of an RCA and provides support during the review.

c. The Quality Assurance Team will maintain a log of all recommendations, assuring that actions steps are completed as required.
d. Staff involved in the review will have the proper training, expertise, and credentials for the specific event being reviewed. The Medical Director or other assigned medical professional will participate in the process and review all results when appropriate.
e. HealthWest will report all applicable deaths to the State per *attachment C 6.5.1.1 in the State contract* and will ensure that all deaths subsequent to leaving a state facility within a 6-month period will be properly reported.

4. Immediately Reportable Events:
   a. Any death that occurs because of a suspected staff member action or inaction or any death that is the subject of a recipient rights, licensing, or police investigation is reported to LRE within 24 hours of either the death, receipt of notification of death, or receipt of notification that a rights, licensing, and/or police investigation has commenced. The LRE has 48 hours to report to MDHHS. The report must include:
      i. Name of person served
      ii. Case Number
      iii. Date, Time, and Place of Death (if a licensed foster care facility, include the license number),
      iv. Preliminary cause of death
      v. Contact person's name and email address
   b. Relocation of a consumer's placement due to licensing suspension or revocation within five (5) business days of relocation.
   c. An occurrence that requires the relocation of any CMHSP or provider panel service site, governance, or administrative operation for more than 24 hours within five (5) business days of relocation.
   d. The conviction of a CMHSP or provider panel staff member for any offense related to the performance of their job duties or responsibilities which result in exclusion from participation in federal reimbursement within five (5) business days of knowledge.
   e. Any changes to the composition of the provider network organizations that negatively affect access to care within seven (7) days of any change.
   f. Critical incidents which may be newsworthy or represent a community crisis must be reported to LRE immediately, for reporting to MDHHS.

IX. INVOLVEMENT OF PERSONS SERVED

HealthWest will ensure that persons served will be offered input and involvement in the performance improvement system through the following mechanisms:

1. Primary consumers of mental health services serve on the CMH Board.
2. HealthWest consumers serve as full members of the Consumer Advisory Committee.
3. HealthWest consumer(s) will serve on the Quality Improvement Committee.
4. Satisfaction surveys are completed according to the following frequency:

a. Behavior treatment - annually
b. Persons served with mental illness or emotional disturbance – annually.
c. Persons served with developmental disabilities (includes parents and guardians) – annually.
d. Post-discharge satisfaction surveys – monthly.
e. Satisfaction with contractual provider services – completed during contract review and pre-planning and treatment planning process.
f. ACT and Home-Based satisfaction as mandated by MDHHS.
g. Progress note completion or quarterly outcome measures in the electronic medical record as required.

5. Persons served will always be given the opportunity to contact a representative of HealthWest directly as part of the satisfaction process.
6. When specific issues are discovered, special efforts may be utilized, such as targeted consumer interviews or focus groups.
7. Involvement of persons served will be solicited to address issues relating to the quality, availability, and accessibility of services.
8. HealthWest will seek to improve the representation of people served in quality improvement participation, policy setting, employment, and volunteer opportunities.
9. HealthWest will communicate information on satisfaction, performance indicators, and needs assessment to consumers and stakeholders.
    a. The Consumer Advisory Committee will receive this information for discussion and be given the opportunity to make recommendations to the HealthWest Executive Director and HealthWest Leadership Team.
    b. Data will be provided to the CMH Board on a regular basis. Performance Indicator data will be presented at least quarterly.
    c. Findings and analysis will be made available on the HealthWest website. Periodically, information will be made available in agency lobbies and offices.

X. QUALITY IMPROVEMENT/REMEDIAL ACTIONS/TRAINING

The Leadership Team will identify issues that require additional effort to resolve and improve. In addition to standing committees, workgroups may be developed. A workgroup is not mandated by MDHHS, CARF, or any other compliance standard. It is established by the HealthWest Leadership Team to address a specific project or identified focus area within the agency. Workgroups are comprised of HealthWest staff across multiple departments and assigned on a voluntary basis. Group/project outcomes will be used by HealthWest Leadership and Board to measure growth in the identified focus area. The duration of the group is dictated by the assigned scope. A "Committee/Workgroup Charter" will be completed that specifies the scope of expectation for any group sanctioned by the Leadership Team.

The Quality Assurance Team provides support to the QI system by serving as consultants to the committees and performance improvement groups. This includes using QI tools and methods to assist in problem identification and plan development. Below are some of the most common tools that will be used in improvement efforts at HealthWest.

KATA. HealthWest will use a process improvement tool called Improvement KATA. Improvement KATA accomplishes improvements through a scientific process with a goal-oriented method to meet objectives. KATA allows practitioners to evaluate existing conditions, define a work goal or objective, and work towards these goals using a Plan, Do, Check, Act (PDCA) process. KATA also works on the foundations of LEAN thinking, which aims to remove waste in processes and increase value to the consumer through an efficient and timely process. (https://www.lean.org/lexicon/kata)

Flowcharting. A process used at HealthWest to visualize a workflow or process. It gives a picture of each step within a process in the order it occurs. It is useful when analyzing how a process is done, where there may be gaps or departmental overlaps in a process that can be improved, and when planning a new workflow or process.

Root Cause Analysis (RCA). Tools and methodologies used to identify causal factors in a specific event or, more broadly, in situations where performance has dropped below standards. Common tools used to complete an RCA include but are not limited to, "The Five Whys", Fishbone diagram, Pareto Chart, and scatter plot diagrams. Events or situations that may require an RCA can come from many sources, such as incident reports, appeals/grievances, or corrective action plans. The highest priority is given to events that result in significant harm or death, followed by those that may be "near miss" events or those events that could have resulted in harm but did not.

Performance improvement opportunities can occur at any point during HealthWest'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. The Quality Improvement Committee and Leadership Team will prioritize improvement projects within the context of the regulatory requirements and the agency's overall strategic plan goals, as well as existing improvement projects already underway. To assist in the prioritization of Performance Improvement projects a Prioritization Matrix will be used, *Appendix H: PI Project Prioritization Matrix.* Ratings will be completed as a committee/team, as opposed to one individual, to reduce the risk of bias in the process.

XI. CARF ACCREDITATION

HealthWest maintains accreditation with CARF International. The most recent CARF survey was conducted in May 2024. The agency is currently accredited in the follow programs: Assertive Community Treatment, Behavioral Consultation Services-Autism Spectrum Disorder, Case

Management/Services Coordination, Community Employment Services, Community Integration, Crisis Programs, Governance, Health Home, Intensive Family-Based Services, and Outpatient Treatment *See Appendix D: CARF-HealthWest Program Crosswalk*. CARF standards 1.M.4 - 1.M.9 state that each program/service seeking accreditation will have measures for Effectiveness, Satisfaction, Efficiency, Service Access, and Business Functions.

CARF standard 1.M.10 requires that staff are provided with training and education related to their roles and responsibilities in performance measurement and management. This is an area that will require continued development, including the incorporation of performance measurement and management training during staff orientation and onboarding. A CARF Committee has been established and will be responsible for tracking adherence to CARF standards between survey windows. This committee will report to the Quality Improvement Committee.

XII. CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC (CCBHC)

HealthWest is responsible for developing, implementing, and maintaining an effective, data-driven continuous quality improvement plan for clinical services and clinical management related to the CCBHC population. Projects should be clearly defined, implemented, and evaluated annually. The number and scope of projects are based on the needs of the CCBHC population and reflect the scope, complexity, and past performance of the services and operations. The plan addresses priorities for improved quality of care and client safety and requires all improvement activities be evaluated for effectiveness. The plan focuses on indicators related to improved behavioral and physical health outcomes and takes actions to demonstrate improvement in CCBHC performance. The CCBHC documents each project implemented, the reasons for each project, and the measurable progress achieved by each project. The CCBHC Project Coordinator is responsible for operating the plan, with assistance from the QA Department.

It is noted that there are specific events which are expected to be addressed as part of the plan for CCBHC, these include:

1. Explicit focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities) and address how disaggregated data from the quality measures and, as available, other data to track and improve outcomes for these populations will be used.
2. CCBHC persons served suicide deaths or suicide attempts;
3. Fatal and non-fatal overdoses;
4. All causes of mortality among people receiving CCBHC services;
5. CCBHC persons served 30-day hospital readmissions for psychiatric or substance use reasons;
6. Such other events the state or applicable accreditation bodies may deem appropriate.

XIII. CREDENTIALING, PRIVILEGING, AND COMPETENCY OF STAFF

Credentialing/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 HealthWest. 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. Practices relating to these functions are explained in detail in HealthWest *Policy and Procedure No. 02-026 Credentialing and Re-Credentialing Requirements of HealthWest Employees and Licensed Independent Practitioners* and *No. 10-004 Credentialing and Re-Credentialing of Contracted Agency Provider*. The 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 maintains a complete system for credentialing and competency that includes HealthWest staff and contractual Staff. HealthWest is also responsible for the selection, orientation, training, and evaluation of the performance and competency of their own Staff and subcontractors. HealthWest conducts 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.

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 the Provider Relations/Network Manager, integrated into contractual requirements, and verified during CMHSP and provider site reviews.

XIV. HEALTH DISPARITIES

HealthWest will continue to evaluate access and treatment trends of ethnic/minority groups. Evaluation analyzes all current activities designed to assure equitable access and effective treatment to persons with cultural barriers to receiving services. In addition, the Quality Improvement Committee will specifically track health disparities between those who identify as Black/African American and those who identify as White. The primary focus of intervention will be to increase the percentage of individuals who receive follow-up to hospitalization within 7 and 30 days after an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm while also reducing the racial disparity measure between Black/African American and White individuals.

Additional efforts to reduce disparities in other areas of the agency are being implemented by the Diversity, Equity, and Inclusion Team and the Human Resources Team. These efforts will also be

reported to and tracked by the Quality Improvement Committee. Efforts include increasing diversity in hiring at all levels and in increasing cultural intelligence capabilities and values throughout the agency.

XV. UTILIZATION MANAGEMENT SYSTEM

HealthWest will have a Utilization Management Committee that will be responsible for the following:

1. 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.
2. Mechanisms to review trends in service utilization, outcomes, and costs on a regular basis.
3. Procedures for conducting prospective, concurrent, and retrospective reviews of authorizations.
4. Development and maintenance of a Utilization Management Plan.

XVI. CLAIMS VERIFICATION OF MEDICAID SERVICES

HealthWest and the PIHP will conduct an audit of internal and external programs to ensure that claims billed under Medicaid have met standards as identified by the Lakeshore Regional Entity, MDHHS, and federal standards. Data will be provided to the Lakeshore Regional Entity as requested. Findings will be presented to HealthWest's Compliance Committee. Immediate recommendations may be made to the agency's Leadership Team. Claims found to be deficient will result in a required plan of correction. Restitution will be sought for those claims when necessary.

XVII. APPENDICES

Appendix A: Acronyms and Definitions
Appendix B: Quality Assurance and Performance Improvement Structure
Appendix C: Quality Improvement Committee Members
Appendix D: CARF-HealthWest Program Crosswalk
Appendix E: QAPIP Data Review Schedule
Appendix F: Critical and Risk Event Incident Reporting Grids
Appendix G: PI Project Prioritization Matrix

Appendix A: Acronyms and 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.

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

Committee: Committees serve functions that are directly related to contract or accreditation requirements. They are long-standing and are responsible for monitoring and reporting specific findings identified in the Quality Assessment and Performance Improvement Plan. They may or may not be required by MDHHS, CARF, etc. Committee members may be assigned by the Executive Director or be voluntarily assigned as appropriate. All committees report to and are monitored by the Quality Improvement Committee/Quality Team.

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.

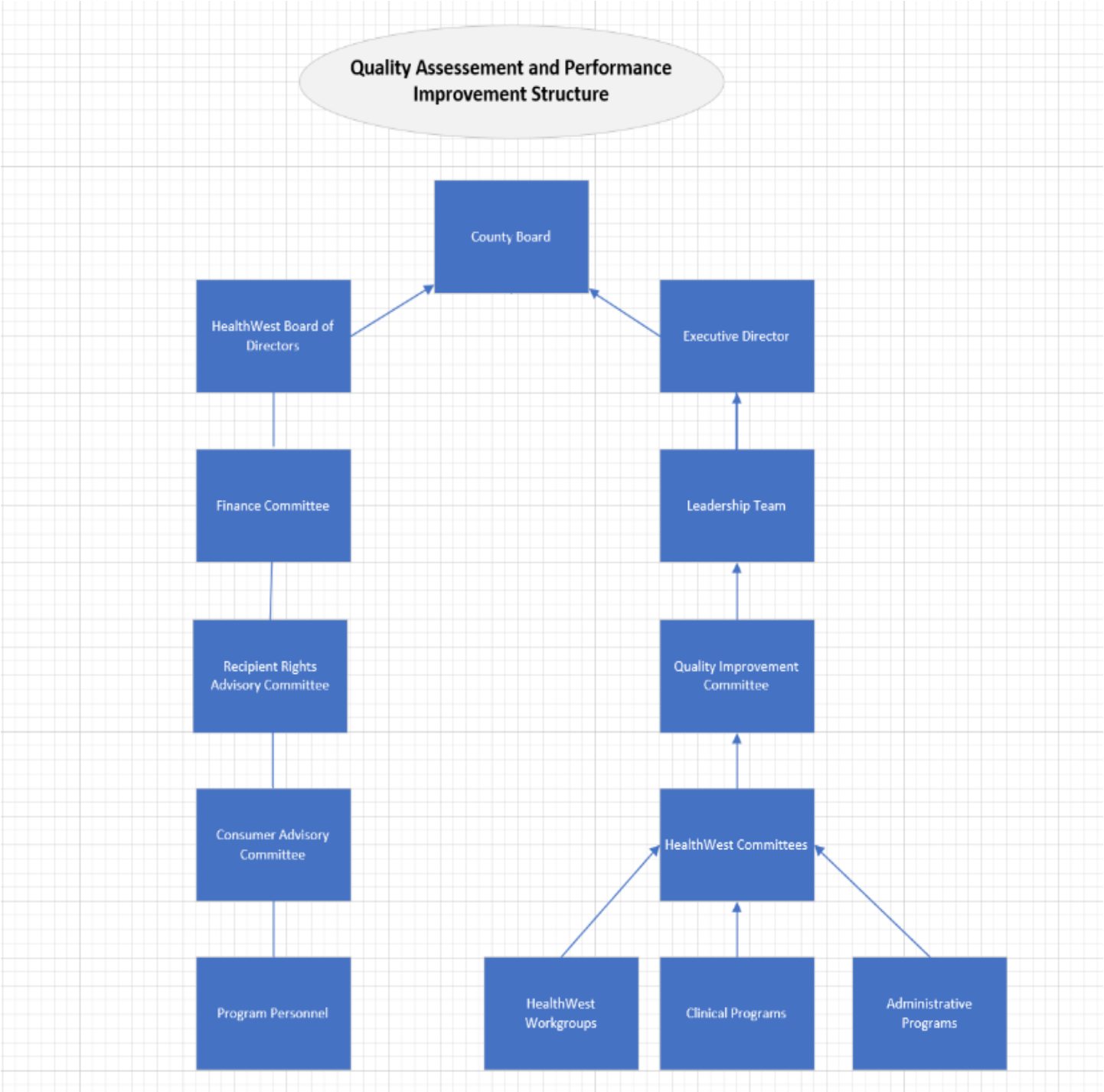
Network Provider: Any provider that receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the state's contract with the Lakeshore Regional Entity (LRE), its member CMHSPs, and the Substance Use Disorder provider panel.

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.

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

Workgroup: Workgroups are established by the HealthWest leadership team to address a specific project or identified focus area within the agency. They are not mandated by MDHHS, CARF, or any other compliance standard. They are comprised of HealthWest staff across multiple departments and assigned on a voluntary basis. Group/project outcomes will be used by HealthWest leadership and Board to measure growth in the identified focus area. The duration of the group is dictated by the assigned scope.

Appendix B: Quality Assurance and Performance Improvement Structure



Appendix C: Quality Improvement Committee Members

Voting Members *Voting members make decisions and direct actions*	
Chief Clinical Officer	Christy LaDronka
Clinical Services Manager	Carrie Crummett
Communications and Training Manager	Gary Ridley
Consumer Advisory Committee Representative	David Scholtens
Compliance Manager	Helen Dobb
Director of Adult Clinical Services	Amie Bakos
Director of Children's Clinical Services	Ann Gatt
Director of Data Architecture and Analytics	Natalie Walther
Director of Engagement	Mickey Wallace
Director of Finance	Carly Hysell
Director of Information Systems	Randi Bennett
Director of Quality Assurance	Pamela Kimble
Human Resources Manager	Susan Plotts
Manager of Procurement and Provider Network	Jackie Farrar
Recipient Rights Officer – Recipient Rights Advisory Committee	Linda Wagner
Non-Voting Members *Non-voting members report data, offer information, and participate in discussions*	
Behavior Treatment Plan Committee Chairperson	Aimee Howard
Customer Services Specialist	Kelly Betts
Evaluation and Innovation Specialist – Peer Chart Review/CIRE	Shawna Curran
Manager of Performance Improvement and Accreditation	Bennie Chambers
Quality Improvement Specialist	Calvin Davis
Director of SUD Prevention and Treatment	Jennifer Stewart
Waiver Coordinator – CWP/HSW, Self-Direction Lead	Melissa Vanas Pfenning
Waiver Coordinator – iSPA/SEDW, HCBS Lead	Lauren Davis

Appendix D: CARF-HealthWest Program Crosswalk

	CARF Program Standard	HW Program/Team
BEHAVIORAL HEALTH	Assertive Community Treatment: Integrated: SUD/MH (Adults)	- Assertive Community Treatment (ACT)
	Case Management: Integrated IDD/MH (Adults)	- Adult DD Community Based - Medically Complex
	Case Management: Integrated IDD/MH (Children & Adolescents)	- Youth DD - Youth Behavioral Support
	Case Management: Integrated SUD/MH (Adults)	- HW Integrated SUD Team
	Case Management: MH (Adults)	- MI Adult Community-Based
	Case Management: MH (Children and Adolescents)	- Youth SED Outpatient 1 & 2 - Youth Juvenile Justice - Transition-Age Team
	Community Integration: MH (Adults)	- Clubhouse
	Crisis Intervention: MH (Adults)	- Access - Intensive Crisis Stabilization
	Crisis Intervention: MH (Children & Adolescents)	- Access - Intensive Crisis Stabilization
	Crisis Stabilization: MH (Adults)	- Crisis Residential Unit
	Health Home: Comprehensive Care (Adults)	- Integrated Health Clinic (IHC) - All HealthWest Treatment Teams
	Intensive Family-Based Services: MH (Children & Adolescents)	- Home-Based Services - Wraparound - Infant Mental Health (IMH)
	Outpatient Treatment: MH Adults	- Outpatient Clinic
COMMUNITY & EMPLOYMENT	**CARF Program Standard**	**HW Program/Team**
	Community Employment Services: Employment Supports	- Supported Employment/IPS
	Community Employment Services: Job Development	- Supported Employment/IPS
	Behavioral Consultation Services (ASD – Children and Adolescents)	- Autism - Behavior Treatment Plan Review Committee

Appendix E: QAPIP Data Review Schedule

HealthWest

Quality Assessment and Performance Improvement Plan

		Q1			Q2			Q3			Q4		
Committee/Department	**Reporting Topic/Description**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
QAPIP Evaluation and Review	*Performance Data, QAPIP Updates, Kata Updates*		x		x		x		x		x		x
Recipient Rights	*Semi-Annual Report on Rights Complaints*				X						X		
Audits/MIFAST Fidelity	*Audit CAP updates, MIFAST Program bi-annual report outs on program outcomes*	x		x		x		x		x		x	
Clinical Operations Committee	*Integrated Health Committee, Doctor/Pharmacy Workgroup, Clinical Quality Improvement Efforts, QI Projects*	x			x			x			x		
Behavior Treatment Plan Review Committee	*#Restrictive BPs, Types of Restrictions, Progress, HCBS Final Rule Compliance, BTPRC Survey Results, PI Use/911 Calls, QI Projects*	x			x			x			x		
Quality Measures	*MMBPIS Data and CAP updates, QI Projects, CCBHC Quality Data, QBP Measures*	x			x			x			x		
Motivational Interviewing	*MI training status, QI Projects, Data related to use of MI.*	x			x			x			x		
TIDE	*Staff Resource Groups, Engagement Efforts, QI Projects*	x			x			x			x		
Trauma Informed Care Committee	*MI, PFA, Suicide Safter Care, Survey results including recommendations, actions, and updates to related QI projects.*	x			x			x			x		
Adverse Events/Root Cause Analysis	*Critical Incidents, Risk Events, Sentinel Events, RCA data/recommendations, QI Projects*		x			x			x			x	
Utilization Management Steering Committee	*Committee Update – GF Use, Rates, Utilization Review, Retro Reviews, QI Projects*		x			x			x			x	
Human Resources	*Credentialling, Staff Support, QI Projects*		x			x			x			x	
Finance	*Financial reports update, Areas of improvement needed, QI Projects*		x			x			x			x	
Peer Chart Review/Medicaid Claims Verification	*Results, QI Data, Areas of need, Areas of improvement, QI Projects*		x			x			x			x	
Provider Network	*Provider audit results, provider adequacy, QI Projects*		x			x			x			x	
CARF Committee	*QIP updates, CARF Outcomes Data, Status on next survey*			x			x			x			x
Compliance Committee	*Provider network, Recipient Rights, Provider Network, Environment of Care*			x			x			x			x
IT Committee	*IT Tech Plan, systems testing results, QI projects*			x			x			x			x
SUD Quality Measures/Grant Reporting	*SUD data, service/provider updates, Audit and CAP updates, QI Projects*			x			x			x			x
Customer Services/Consumer Advisory Committee	*Grievance and Appeal Data, Consumer Survey Results, Training Needs and Data, Outreach, CAC Updates, QI Projects*			x			x			x			x
Waiver/HCBS	*#waiver slots, review of utilization, compliance concerns/improvements, policy updates, QI Projects*			x			x			x			x

Appendix F: Critical and Risk Event Incident Reporting Grids

Critical Incidents are submitted to the LRE by the 15th of each month. They must be reported by LRE to MDHHS within sixty (60) days after the end of the month, except for suicides which are reported within thirty (30) days in which the incident occurred for individuals who, at the time of the incident, were actively receiving services:

Service	Suicide (01)	Death (02)	EMT (03)	Hospital (04)	Arrest (05)	Death of Unknown Cause (06)	PM w/out Injury	Emergency Response	Use of Restraint
ACT	●	●				●			
CLS	●	●				●			
Case Management	●	●				●			
Homebased	●	●				●			
Wraparound	●	●				●			
Any Other Service	●	●				●			
1915 iSPA	●	●	●	●		●			
HAB Waiver	●	●	●	●	●	●			
SED Waiver	●	●	●	●	●	●			
Child Waiver	●	●	●	●	●	●			
Living Situation									
Specialized Residential	●	●	●	●	●	●			
Child Caring Institution	●	●				●			
Crisis Stabilization Unit	●	●				●	●	●	●

In additional to the reporting of critical incidents, as cited above, all SUD critical and sentinel events are also reported to LRE:

Service	Suicide (01)	Death (02)	EMT-Injury/Med Error (03)	Hospital – Injury/Med Error (04)	Arrest (05)	Death of Unknown Cause (06)	MAT Med Error (07)	SUD Med Error (08)	Serious Challenging Behaviors (09)
SUD Services	●	●				●	●		

Service	MAT Med Error (07)	SUD Med Error (08)	Serious Challenging Behaviors (09)	Conviction	Serious Illness Requiring Hospitalization	Accident EMT or Hospital	Alleged Cause of Abuse or Neglect
SUD 24-Hr Specialized Residential	●	●	●	●	●	●	●

Risk Events are submitted to the LRE by the 15th of each month, and must be reported by LRE to MDHHS within sixty (60) days after the end of the month in which the event occurred for individuals who, at the time of the event, were actively receiving services:

Service	Harm to Self	Harm to Others	Police Calls	Physical Management	Hospitalization 2+ w/in 12 Months
Case Management	●	●	●	●	●
ACT	●	●	●	●	●
Home-Based	●	●	●	●	●
CLS	●	●	●	●	●
Wraparound	●	●	●	●	●
HAB Waiver	●	●	●	●	●
SED Waiver	●	●	●	●	●
Child Waiver	●	●	●	●	●
1915 iSPA	●	●	●	●	●
Living Situation					
Specialized Residential	●	●	●	●	●
Child Caring Institution	●	●	●	●	●
Crisis Stabilization Unit	●	●	●	●	●
SUD 24-Hr Specialized Residential			●	●	

Appendix G: PI Project Prioritization Matrix

			Performance Improvement Requests							
Criteria	Weight	Scoring Values		Enter Scoring Value		Enter Scoring Value		Enter Scoring Value		Enter Scoring Value
- Regulatory Requirement (MDHHS, LRE, CARF, CCBHC, etc.) - Strategic Plan Requirement - Other services/departments depend on it	5	0: None are true 3: One is true 6: Two are true 9: All are true	0		0		0		0	
Risk Mitigation - Are consumers at risk if improvement is not made? - Is the agency at risk if improvement is not made?	4	0: Little risk if not made 3: Some risk if not made 6: Much risk if not made 9: High risk if not	0		0		0		0	
Value to Stakeholders - How much value does the PI project provide to consumers, staff, community?	3	0: Little value to stakeholders 3: Some value to stakeholders 6: A lot of value to stakeholders 9: Essential/Critical to stakeholders	0		0		0		0	
Cost - Includes implementation and maintenance costs - Includes financial costs, staff time/capacity, and other resources.	2	0: Lots of unknow or hidden costs 3: Some costs are known 6: Many costs are known 9: All costs, direct & indirect, are known, tabulated and approved.	0		0		0		0	
Total Score			0		0		0		0	