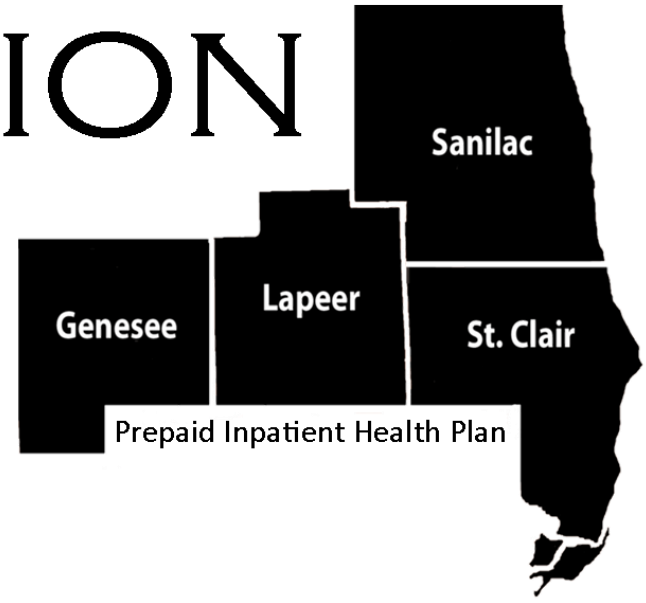
REGION 10



QUALITY IMPROVEMENT PROGRAM & WORKPLAN

FY 2021

Region 10 PIHP

Quality Assessment & Performance Improvement Program Description

(October 1, 2020 – September 30, 2021)

Region 10 PIHP has a catchment area of Genesee, Lapeer, Sanilac, and St. Clair counties. Prior to the reconfiguration of 18 PIHPs to 10 PIHPs, Genesee Health System (GHS) served as the PIHP and SUD Coordinating Agency of Genesee county and St. Clair CMH (d/b/a Thumb Alliance PIHP) was the PIHP and SUD Coordinating Agency of Lapeer, Sanilac, and St. Clair counties. With the new boundaries drawn as part of the reconfiguration, two PIHPs were eliminated and the region created a new PIHP entity. Region 10 PIHP's mission is "Promoting Opportunities for Recovery, Discovery, Health and Independence for individuals receiving services through ease of access, high quality of care and best value."

I. Written Description of the PIHP Quality Improvement Program (QAPIP)

A. Organizational Structure:

The Region 10 PIHP has responsibility for oversight and management of the regional PIHP. This responsibility includes approving and monitoring the region's Quality Assessment and Performance Improvement Program (QAPIP).

The Quality Assessment and Performance Improvement Program policy delineates the features of the Quality Improvement (QI) Program for both the PIHP and its provider network. The PIHP manages its provider network of SUD Providers and four Community Mental Health agencies. Each CMH has accountability to how it implements the PIHP's QI Program within its designated catchment area.

To implement the QI Program, the PIHP Board has established a Quality Improvement (QI) Committee. The QI Committee assures that its sub-structure is aligned with the mandates and improvement priorities of the PIHP Board. The PIHP Medical Director provides clinical input, feedback, direction and oversight to the QI Program. The Chief Clinical Officer (CCO) provides operational direction and oversight leadership to the QI Program and the QI Committee. The QI Committee is composed of core members including PIHP Chief Executive Officer, PIHP Medical Director, PIHP Chief Finance Officer, PIHP Chief Operations Officer, PIHP Chief Information Officer, PIHP Chief Clinical Officer (Clinical PhD), PIHP Administrative Director, PIHP Compliance Officer, PIHP Quality Manager and Standing Committee Chairs. The Standing Committees consist of the following designated areas: Compliance Committee, Finance Committee, Improving Practices Leadership Team, Privileging and Credentialing Committee, Information Systems Committee, Provider Network Committee, Quality Management Committee, Sentinel Events Review Committee, and Utilization Management Committee.

Functional areas of the QI Program are detailed through assigned QI Program Standing Committees. The Compliance Committee focuses on regulatory compliance as well as corporate compliance issues to ensure service provision in network as required. The Finance Committee focuses on budget and funding issues to provide good management of the PIHP network. The Improving Practices Leadership Team develops and monitors clinical service areas such as clinical practice guidelines, evidence-based practices, care integration processes, home and community-based services transition planning to ensure quality of clinical care, safety of clinical care, quality of service, and enhance members' experience. The Privileging and Credentialing Committee focuses on ensuring network practitioners and providers have the appropriate qualifications to provide services to ensure safety and quality of clinical care. The Provider Network Committee focuses on contract compliance to ensure services are provided as required and that the network is adequate to ensure provision of services. The Quality Management Committee focuses on performance indicator data, conducting and analyzing

satisfaction survey data, oversight of performance improvement projects, and monitoring QI plans to ensure quality of services, and evaluate members' experience. Sentinel Events Review Committee focuses on reviewing and monitoring critical and sentinel events to ensure safety of clinical care, and quality of service. Utilization Management Committee focuses on service utilization within the network to ensure quality and safety of clinical care and quality of service.

Committees include representatives from the PIHP and each CMH Affiliate (see QI Program organizational structure chart for member list). These health care practitioners provide direct input on the QI Program through their assigned committee. The Committees meet on a designated frequency, with most meeting monthly. Each committee member participates fully in their committee(s), including developing goals to address in the annual work plan, working on assigned tasks to meet goal performance objectives, reporting to committee monthly on improvement activities, evaluating progress towards goals, determining actions to be taken to meet objectives, identifying potential barriers to achieving targets, providing feedback, and identifying additional opportunities for improvement efforts.

The QI Standing Committee members report directly to their specific Standing Committee. The Standing Committee Chair completes a monthly status update which is discussed at the monthly Quality Improvement Committee (QIC). Any recommendations from Standing Committees are reviewed and appropriate action is taken by the QIC. Written reports of the status of each goal within the QI Annual Workplan are presented to the Governing Body (PIHP Board of Directors) quarterly. The PIHP Board approves any modification to the QI Workplan. The quarterly and annual QI Program Plan performance reports are prepared by the Quality Manager and QI Department technician.

Resources and analytical support are provided to the QI Program from several sources. The Electronic Medical Record software (MIX) contains service data, encounter claims data, demographic data and standardized reports. CareConnect 360 is a web-based system containing service data (both Behavioral Health and Physical Health) for persons with Medicaid. The Michigan Department of Health and Human Services (MDHHS) provides downloads of encounter and demographic data regularly and upon request. The PIHP has contractual relationships with TBD Solutions to provide analytic support and training to the PIHP.

The organization delegates administration of the Consumer Satisfaction Survey to the CMHs/SUD Providers. The CMHs/SUD Providers report the data up to the PIHP for compilation into the annual report.

Many of the goals in the annual QI Workplan are collaborative in nature as the CMH practitioner standing committee members work to achieve goal objectives within their CMH systems. For example, the QMC provides oversight to the Performance Improvement Projects (PIPs), but the CMH systems develop and work on the goal areas to implement the PIPs. The practitioner CMH representatives on the QM Committee develop action plan goals, identify barriers to implementation, work to bring compliance to the set target within their individual CMHs, and report back to the Committee on the progress made towards achieving the target within their organizations. Communication and feedback mechanisms are both formal (Committee reporting) as well as informal (i.e., discussing the project via conference calls or email). Then the results and actions taken are compiled into a region-wide report on the PIP.

To ensure direct customer involvement and participation in the PIHP's Quality Improvement Program, the PIHP Board has identified Consumer Advisory Councils within its county/catchment area. QI Plan and status reports are regularly communicated and discussed.

The QI Program includes objectives to serve a diverse membership by reducing health care disparities in clinical areas and by improving the network adequacy to meet the needs of underserved groups. The organization strives to improve quality and safety of clinical care, quality of services, and members' experiences for members

with complex health needs including physical and developmental disabilities, severe mental illness, and chronic conditions.

The PIHP evaluates the overall effectiveness of the QI program annually. The evaluation reviews all aspects of the QI program with emphasis on determining whether the program has demonstrated improvement in the quality of care and services provided to customers. The QI Department develops an annual written report on quality, including a report of completed QI activities, trending of clinical and service indicators and other performance data, and demonstrated improvements in quality. This report is presented to the QI Committee and the PIHP Board for review and approval.

An Organizational Chart of the organizational model for the PIHP and its QI Program structure is included in this plan.

B. Components and Activities:

Annually, the PIHP Board reviews and approves the Quality Improvement (QI) Program Plan for the network. The QI Program Plan includes the following two components: (1) a detailed narrative description of the overall Quality Improvement Program; and (2) an annual Quality Improvement Workplan (referred to as the QI Plan) that addresses ongoing QI activities and contains the PIHP Board's prioritized goals, improvement strategies and anticipated outcomes designed to improve the PIHP's overall systemic processes. The QI Workplan details the Standing Committees' goals which are designed to improve quality of clinical care, safety of clinical care, quality of service, and members' experience. The goals describe the timeframe for completion, responsible staff for each activity, monitoring of previously identified issues, and evaluation of the QI Program. The QI Workplan is a dynamic document and is updated annually or more frequently as needed. The PIHP Quality Management staff is responsible for overall evaluation of the QI Program's success and for providing mid-year status updates.

The PIHP's QI Program includes the following items:

- Design and planning, performance measurement, intervention strategies, and outcome evaluation are the primary components of the PIHP quality improvement process. Quality improvement activities are determined by the PIHP's mission, vision, contractual requirements, strategic plan, and historical data for the region. Along with standards of care and markers developed from external data sources (e.g., reports, accreditation standards, state and federal reports), improvement activities occur in response to customer needs, safety of clinical care issues, ethical guidelines, cultural considerations, clinical standards, and good business practices.

- Indicators: the activities, events, occurrences, or outcomes for which data are collected which allows for the tracking of performance and improvement over time. The quality indicators employed are objective, measurable, and based on current knowledge and clinical experience to monitor and evaluate key aspects of care and service.

- Performance goals: the desired level of achievement of the standard of care and benchmarks for measuring the best performance for an indicator.

C. Roles for Recipients of Service:

Customer participation and involvement in the development and ongoing monitoring of the PIHP's QAPIP is critical and occurs through a three-tiered model.

First, at the Policy-level, of the fifteen PIHP Board members, no less than one-third of the membership are recipients of service and/or their family member representatives. This framework provides for direct customer involvement in QI Program policy setting and goal prioritization. Second, the PIHP has designated Consumer

Advisory Councils within all counties that provide direct input and feedback on critical program plan and development areas. Third, individuals directly participate on the PIHP's committees and monitoring activities.

In addition to the above direct involvement, input is also obtained through a variety of satisfaction surveys used to make system and service changes to respond to identified needs.

D. Mechanisms for Adopting and Communicating Process and Outcome Improvements:

Communication processes occur through four (4) primary mechanisms within the PIHP's organizational structure.

First, the PIHP Board ultimately establishes the PIHP's Quality Improvement (QI) Program and its annual program description and plan, which includes prioritization of each fiscal year's improvement activities. Semi-annual and annual reports are provided to the PIHP Board on the QI program status and outcomes. These reports are also communicated with the QI Committee, Consumer Advisory Councils, and key stakeholder and community advocacy groups.

Second, the QI Committee through its committees is an integral part of the QI Program communication process. Opportunities for quality improvement activities and outcome status reports are discussed at the monthly QI Committee meetings. Improvement activities can arise from the discussion of problem areas, or from the identification of new processes that need to be improved. Each committee has assigned annual performance goals/indicators that are a part of the overall QI plan, as approved by the PIHP Board. These goals become the primary committee goals for the upcoming fiscal year.

Third, customer input into the QI Plan, and on-going review of status reports (semi/annually), are an important communication mechanism within the PIHP's quality improvement program. This occurs through the PIHP's designated Consumer Advisory Councils, SUD Advisory Boards and the PIHP Board of Directors.

Fourth, MDHHS, as the principal payer, has direct input into the PIHP's QI Program. Annually, two State-mandated Performance Improvement Projects are prioritized and implemented through the PIHP provider network. These improvement projects are led by PIHP staff and assigned to the Quality Management Committee for design and implementation methodology. Progress reports on these projects are submitted to the PIHP Board and MDHHS on a semi-annual basis. Information on these project results is then communicated to the various CMH Boards, Consumer Advisory Councils, and community advocacy groups that work with the PIHP and its provider network.

II. Governing Body Responsibilities

A. Oversight of QI Program:

As stated earlier, the Region 10 PIHP Board has ultimate oversight for the PIHP's QI Plan. Annually, the PIHP Board is charged with the responsibility for the approval and monitoring of the PIHP's Quality Improvement Plan.

Management of the region's QI Program implementation is done by QI Committee. In this manner, it is the QI Committee that develops the committees, and then provides direct oversight of the network's staff to achieve the plan. The QI Committee also evaluates periodic status reports on plan progress. Status reports are provided to the PIHP Board on a semi-annual and annual basis.

B. QI Plan Progress Reports:

A plan is created annually that directs the activities that are the focus of Quality Improvement efforts for the coming year. Region 10 PIHP QI Committee monitors progress on planned quality improvement activities, through each committee's meeting minutes/report.

Quarterly, the PIHP's Quality Management staff prepares a QI Plan Status Report. This report is shared with the PIHP Board, QI Committee, PIHP / CMH Provider Network, and various customer/interested party and community stakeholders. The report is also posted on the PIHP website for public viewing.

C. Annual QAPIP Review Report:

At year-end, the PIHP's Quality Management staff prepares an annual report that summarizes the PIHP's QI Program efforts for the year, including QI Plan results. This report is shared with the PIHP Board, Consumer Advisory Councils, QI Committee, PIHP / CMH Provider Network, MDHHS, and various customer / interested party and community stakeholders. The report will be posted on the PIHP website for public viewing.

D. Submission to MDHHS:

Once reviewed / approved by the PIHP Board, the Annual QI Program Report is sent to MDHHS along with a list of the PIHP Board Members.

III. Designated Senior Officials:

The Region 10 PIHP Chief Executive Officer has the overall responsibility to the Region 10 PIHP Board for the QI Program. Additionally, the PIHP Medical Director provides direct clinical oversight and medical supervision of the QI Program Plan. The Chief Clinical Officer (CCO) provides day-to-day guidance on clinical initiative, clinical issues, and interventions implemented by the PIHP, accepting questions and reviewing progress of the clinical initiatives for direction in consultation with the Medical Director.

IV. Active Participation of Providers and Customers

Both providers and customers are encouraged to contribute suggestions relating to potential areas for investigation and/or improvement. Individuals receiving services have membership on Consumer Advisory Groups which provide formal opportunities for participation.

The PIHP utilizes a variety of mechanisms to identify important areas for improvement and to set meaningful priorities. The voices of its customers are legitimate sources of information in formulating quality improvement efforts, and customer satisfaction is indicative of quality services. The monitoring and evaluation of important aspects of care includes services provided to high-volume and high-risk customers.

In addition to seeking input from its customers, the PIHP solicits input from providers and stakeholders. Information gathering is used to determine satisfaction among these groups and identify methods of addressing concerns and fostering increased satisfaction.

V. Performance Measurement

A. State Performance Measures

The PIHP measures its performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data. A crucial part of the member satisfaction / data collection piece involves striving to surpass the benchmarks set for Performance Indicators established by the MDHHS in the areas of access, efficiency, and outcome. Performance Indicator data is submitted to MDHHS on a quarterly basis.

B. Other Performance Indicators

Other key performance indicators are evaluated and monitored through the QI Program, including items such as utilization management and Evidenced Based Practices. Each CMHSP has tools for promoting compliance with performance indicators which is monitored by the PIHP.

C. Clinical and Safety Initiatives

Region 10 PIHP focuses on clinical initiative to improve the safety of clinical care and service provided to the member. Region 10 PIHP conducts robust Coordination of Care initiatives, and annually conducts needs assessment studies for SPMI individuals who have multiple medical issues, identifying participants, enrolling them in the Complex Case Management program, and assessing for specific care the member needs.

VI. QI Program Utilization to Assure Achievement of Performance Levels

The system for assuring QI Program implementation is two-fold: (1) Utilization of the PIHP's QI Committee and its designated committees charged with QI Program implementation; and (2) The PIHP's sub-contract compliance monitoring process of the PIHP's provider network to ensure quality improvement efforts have been implemented.

The QI Committee ensures that the QI Program remains in the forefront of the PIHP's improvement efforts, by meeting monthly and receiving reports from each Committee on goal status. Key issues and action items are addressed at each QI Committee meeting.

Secondly, each PIHP contract with providers includes specific performance and outcome requirements that are reviewed in the contract monitoring process. The monitoring is a collaborative effort between PIHP staff and the provider staff to monitor and assure quality of care on a regular basis. Policies and audit tools have been developed by staff to guide the monitoring and evaluation process.

The PIHP reports on performance via the Performance Indicators Report, which is required by MDHHS. This series of tables provides performance data on several indicators related to access, efficiency and outcome measures. The QI Committee assures that quality measurements are in place to continuously monitor performance and to identify problems as they arise. This information is shared with management at the PIHP and the provider agencies on a regular basis. Also, specific problem analysis is conducted as requested or as problems are identified in the monitoring process.

Lastly, quarterly and annual reports are made available to the PIHP Board, QI Committee, Consumer Advisory Councils and key community interest groups, as well as posting of the reports on the PIHP web site for public viewing.

VII. Performance Improvement Projects

Performance improvement projects will be included in the QI Program that focus on achieving demonstrable and sustained improvement in both clinical and non-clinical services which are likely to have beneficial effects on health outcomes and customer satisfaction.

A. Clinical and Non-Clinical projects

Clinical areas to be targeted include integration of physical health care information for treatment. Non-clinical areas include administrative data collection methodology related to the integration of physical health care information.

B. Project topics

Selection of project topics will be based on requirements from MDHHS with a focus on the integration of physical health care data. The prevalence of a condition among, or need for a specific service by, the organization's individuals; consumer demographic characteristics and health risks; and the interest of individuals in the aspect of service to be addressed will also be part of the selection criteria. The Quality Management Committee (QMC) provides oversight to the Performance Improvement Projects. Project topic selection includes consultation with QMC members.

C. State- and PIHP-established aspects of care

Aspects of care established by the State and PIHP will be used to identify performance improvement projects.

D Number of projects undertaken during the waiver renewal period

The PIHP will engage in a minimum of two projects during the waiver renewal period.

Improvement Project #1
Tobacco Cessation: the proportion of SMI adult Medicaid consumers identified as tobacco users who had at least one reported encounter during the CY for prescribed medications to assist in reducing or eliminating tobacco use.

Improvement Project #2
The goal of this PIP is to ensure that children and adults within the region who are Medicaid beneficiaries will receive follow-up services within 30 days after discharge from a psychiatric inpatient hospital. This study topic aligns with the Performance Bonus Incentive Pool metric "Follow-up After Hospitalization for Mental illness within 30 Days", which applies performance standards for these two clinical cohorts. PIP performance targets have been set to exceed these performance standards.

VIII. Review and Follow Up of Sentinel Events

A. Ensuring appropriate action

The Region 10 PIHP policy, Sentinel Events and Critical Incidents, establishes the guidelines for reporting and reviewing possible Sentinel Events and/or Critical Incidents. The policy states that the PIHP will conduct Administrative reviews and follow-up of Sentinel Events per the following:

1. The PIHP Chief Executive Officer will provide PIHP oversight to local Provider Network review processes and reporting.
2. Recipient Sentinel Events will be reviewed locally by each CMHSP or SUD Provider, through its Medical Director's Office and / or Sentinel Events Review Committee.
3. The PIHP or its delegate has three (3) business days after a critical incident occurs to determine if it is a sentinel event.
4. Once classified as a sentinel event, the PIHP or its delegate has two (2) subsequent business days to commence a root cause analysis of the event.

The local CMHSP / SUD Provider develops an "appropriate response" to a sentinel event that "includes a thorough and credible root cause analysis, implementation of improvements to reduce risk, and monitoring the effectiveness of those improvements" to ensure safety of clinical care and services. This should be completed by the assigned CMHSP / SUD Provider staff and forwarded to the CMHSP/SUD Sentinel Event Review Committee. Following completion of a root cause analysis or investigation, the CMHSP / SUD Provider develops

and implements either a) a plan of action or intervention to prevent further occurrence of the Sentinel Event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement, and when and how implementation will be monitored or evaluated.

The local Sentinel Events Review Committee will report Sentinel Event findings to the PIHP for review and analysis, and to document follow-up and system improvement efforts, as required by MDHHS practice guidelines.

The PIHP Sentinel Event Review Committee (SERC) will conduct review and analysis of sentinel events report, submitted by CMHSP/SUD Providers. The SERC submits periodic summary and recommendations to the PIHP QI Committee for action response / disposition. The PIHP may require follow-up action on the part of the provider in the form of a Corrective Action Plan / Improvement Plan.

B. Credentials of reviewers

Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. Sentinel event findings and recommendations are reviewed by the CMH Medical Director, the CMH Office of Recipient Rights, CMH Quality Improvement Committee and the PIHP Medical Director. The CMH and PIHP Medical Directors are physicians.

C. Review of Unexpected Deaths

All unexpected deaths of Medicaid beneficiaries who at the time of their death were receiving specialty supports and services will be reviewed by the Provider. Refer to PIHP policy on Sentinel Events and Critical Incidents for specific review procedures.

D. Immediate Event Notification

Following immediate event notification to MDHHS, the PIHP will submit information on relevant events through the Critical Incident Reporting System.

Following immediate event notification to MDHHS the PIHP will submit to MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within one year of the recipient's discharge from a state-operated service.

E. Critical Incidents Reporting System

The critical incident reporting system collects information on critical incidents that can be linked to specific service recipients. The Critical Incident Reporting System captures information on five specific reportable events: suicide, non-suicide, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error and arrest of consumer. The populations on which these events must be reported differ slightly by type of event. All critical incidents are submitted monthly by the Office of Recipient Rights. Quarterly reports generated via the Critical Incident Reporting System provide initial analyses on CI data per CI categorical findings. Further analyses are prepared by the PIHP staff regarding relevant clinical and demographic factors, thus to identify systemic improvement opportunities within the provider programs and provider network. These findings are submitted as systems analysis and improvement recommendations to the CMH Quality Improvement Council (QIC) on a quarterly basis for CMH review, analysis and recommendations. These CMH QIC review dispositions are then submitted to the PIHP QI Committee for quarterly review and final disposition.

F. Risk Events Management

The PIHP has a process for analyzing additional critical events that put individuals at risk of harm. This analysis is used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. This documentation will be available to MDHHS at site visits. These events minimally include: actions taken by individuals who receive services that cause harm to themselves; actions taken by individuals who receive services that cause harm to others; two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period; police calls by staff of specialized residential settings, or general (AFC) residential homes or other provider agency staff for assistance with an individual during a behavioral crisis situation regardless of whether contacting police is addressed in a behavioral treatment plan; and emergency use of physical management by staff in response to a behavioral crisis.

IX. Review of Behavior Treatment Plan Review Committee Data

The PIHP quarterly reviews analyses of data from the Behavior Treatment Plan Review Committee where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management or 911 contact with law enforcement has been used in an emergency. Only techniques that have been approved during person-centered planning by the beneficiary or his/her guardian and are supported by current peer-reviewed psychological and psychiatric literature may be used with beneficiaries. Data shall include numbers of interventions and length of time the interventions were used per person.

X. Periodic Quantitative and Qualitative Assessments of Member Experiences with Services

A. Issues addressed in assessments

The purpose of a QI program is to improve the quality of care and service provided to customers. An effective QI program demonstrates that its activities have resulted in significant improvements in the care or service delivered to customers. Improvements of the QI process is demonstrated by improvements in either the processes through which care and service are delivered or in the outcomes of care.

Issues of quality, availability, and accessibility of care are evaluated through periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of customer (Beneficiaries) experiences with services. The assessments will be representative of the persons served and supports offered.

B. Actions resulting from assessments

The PIHP and Providers will use the assessment results to improve services for customers. Processes found to be effective and positive will be continued, while those with questionable efficacy or low customer satisfaction will be revised using the following:

- Takes specific action on individual cases as appropriate,
- Identifies and investigates sources of dissatisfaction,
- Outlines systemic action steps to follow-up on the finding, and
- Informs practitioners, providers, recipient of service and the governing body of assessment results.

C. Evaluation of the effects of actions

Just as the original processes must be evaluated, so do interventions used to increase quality, availability, and accessibility of care. Therefore, all actions taken because of assessments will be evaluated periodically.

Quality Improvement is never static, and it is an expectation that all evaluation efforts will be examined on an ongoing basis.

D. Incorporation of customers in the evaluation process

Customers, including those receiving long-term supports or services (e.g., customers receiving case management or supports coordination), are included in the Quality Improvement process, as survey participants, as members of Consumer Advisory Councils, and as members of the PIHP Board. In this way customers are incorporated into the review and analysis of information obtained from quantitative and qualitative methods.

XI. Monitoring of Clinical Protocols & Practice Guidelines

The PIHP monitors quality of care on a regular basis. All PIHP contracts with providers require that contractors adhere to accrediting bodies, state and federal agency requirements and all relevant regulatory documents.

Clinical protocols and practice guidelines are utilized as a tool to determine eligibility for services and assist in making determinations regarding continued necessity of care. In other words, the PIHP refers to these protocols and guidelines to determine medically necessary supports, services, or treatment for those that they serve.

Adoption Process:

The Region 10 PIHP, via its QI Committee, is the lead entity to develop and maintain up to date clinical Practice Guidelines for the PIHP provider network. The PIHP Medical Director, with the support of the Chair and membership of the Improving Practices Leadership Team, assumes lead for this process. The following criteria are considered when establishing priorities for adopting Clinical Practice Guidelines relevant to the membership: the incidence or prevalence of the diagnosis or condition, the degree of variability in treatment approaches or outcomes for the diagnosis or condition, the availability of scientific and medical literature related to the effectiveness of various treatment approaches, input from Region 10 staff and Physician Reviewers, requests from Practitioners or Members, and evidence-based Guidelines that have been developed by recognized sources involving exhaustive review of the literature supplemented by expert consensus when the body of available research literature is not conclusive. The Quality Improvement Committee is responsible for adopting Clinical Practice Guidelines and processes for measuring adherence with Clinical Practice Guideline recommendations on behalf of Region 10. The final step occurs when the guidelines are posted on the PIHP website for provider use and access.

Development Process:

With the support of the Improving Practices Leadership Team and the direction of the PIHP Medical Director, the Region 10 PIHP staff develops a comprehensive package of practice guidelines that are well researched and well documented in the literature. Prior to adopting a Clinical Practice Guideline from a recognized source with modification, input is gathered from appropriate board-certified Practitioners by presenting the Clinical Practice Guideline and any proposed modifications to network Practitioners for review and comment. To further develop the most effective behavioral health care services and methodologies for those that are served, the PIHP has developed both clinical service protocols, which focus on the type of service to be delivered, as well as diagnostic treatment protocols, which focus on specific evidenced based treatment delivery methodologies for key diagnostic classifications. Additionally, key stakeholders such as providers and users of services are invited to participate. Public review and comment are also an integral piece of the developmental process.

Implementation:

Following a series of clinical trainings and postings on the PIHP website of the most updated clinical protocols and practice guidelines, implementation takes place via the Utilization Management Process. Those staff completing the utilization management reviews are expected to routinely utilize the practice guidelines to assist in determining eligibility, as well as the most effective clinical standards of care. Additionally, all providers should utilize the practice guidelines to assist in ongoing treatment decisions and methods of behavioral health care.

Continuous Monitoring:

PIHP staff under direction of the PIHP Medical Director assumes responsibility for continuous monitoring and updating of all practice guidelines and clinical protocols, regarding the latest literature, state/federal rules and regulations, and most effective standards of care. Updates are completed at a minimum of every two (2) years.

Evaluation:

Typically, a 30-day public review, comment, and feedback period takes place for any updates and/or changes to the practice guidelines. Evaluation of adherence to guideline recommendations and effective implementation of the practice guidelines are determined by a structured evaluation process, in part informed by Utilization Management and its case record review process.

XII. Assurance of Practitioner Licensure, Credentialing, Staff Qualification, and Staff Training

The qualifications of Physicians and other licensed behavioral healthcare practitioners/professionals employed by or under contract to the PIHP are reviewed by following the various PIHP guidelines on credentialing as in the PIHP Credentialing and Privileging policy (01.06.05).

Within this framework, the PIHP credentials all organizational providers under direct contract to the PIHP and its own PIHP behavioral healthcare practitioners. Conversely, the PIHP has delegated to each CMH the responsibility of credentialing of all organizational providers under direct contract to the CMH; and all behavioral health practitioners employed directly or under contract to the CMH as part of its panel network. The PIHP has delegated to each SUD Treatment Provider the responsibility of credentialing all behavioral health practitioners employed by the provider.

All CMHs and SUD Treatment Providers will have Credentialing policies in place that are approved by the PIHP and that cover all behavioral health care practitioners. Providers are also bound by PIHP contract requirements and MDHHS standards to provide training for all new staff and periodic training and staff development activities for all staff. This requirement includes Recipient Rights training. Other specific trainings are designated for non-licensed staff to ensure competency skills.

The PIHP and its Provider Network's Staff Training program will ensure, regardless of funding mechanism (e.g., voucher), that staff possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following: educational background; relevant work experience; cultural competence; and certification, registration, and licensure as required by law. A program shall train new personnel regarding their responsibilities, program policy, and operating procedures. A program shall identify staff training needs and provide in-service training, continuing education, and staff development activities.

All PIHP CMHs and SUD Treatment Providers (other than peer recovery and recovery support services when these are provided through a prevention license) are required by contract to be accredited by one of the major healthcare or rehabilitation accreditation bodies and are responsible for ensuring that staff are qualified and trained. Under the established accreditation standards, practitioner licensure, credentialing, staff qualification, and staff training are required. The requirement that organizational providers be accredited (or demonstrate

how they meet accreditation standards) as specified in the PIHP Credentialing and Privileging Policy, affords the PIHP with the capacity to provide assurances that all provider staff (including those not specifically privileged via the credentialing process) meet minimum qualifications for providing specific services and have access to adequate training related to services provided within the PIHP network. Assurances that these criteria are met are documented via the Organizational Credentialing and Enrollment process, as well as via the PIHP Contract Monitoring process. Policies, credentials and documentation concerning these requirements are reviewed during PIHP Contract Management Team audits and during the MDHHS annual site review. This provider requirement is also discussed and reviewed through periodic examination of provider QI Plans and policies that are reviewed and maintained by the PIHP.

XIII. Verification of Medicaid Services

All program and clinical case records will comply with existing standards, rules or interpretative guidelines as defined by the PIHP, Department of Community Health and CMS/Medicaid.

A. The PIHP has a policy regarding claims verification. An annual plan is developed that outlines the methodology for verification.

B. Annually the PIHP submits a report to MDHHS which contains its methodology for verification and its findings from the process, as well as providing any follow up actions that were taken because of the findings.

In addition to the PIHP's process to conduct claims verification, the PIHP has a process to provide Explanation of Benefits (EOBs) to consumers receiving services.

XIV. Utilization Management Program

The PIHP's Utilization Management (UM) program is an integral part of the PIHP's quality improvement plan. The PIHP's UM program core goals are as follows:

- Prompt and easy access to services and supports for all service recipients;
- Services and supports provided are appropriate for recipients' needs and are neither insufficient nor excessive;
- Services and supports provided are high quality, clinically appropriate, and are the most cost-effective available; and
- Coordination among all providers of supports and services.

To ensure the above goals are achieved, the PIHP has developed a comprehensive Utilization Management program for its provider network in the management of its plan benefits.

Oversight of the PIHP's Utilization Management program is provided through two components: (i) The PIHP Medical Director provides clinical oversight and direction of the PIHP's overall UM program and staff; and (ii) The PIHP Chief Clinical Officer operates a Utilization Management Committee to ensure both the PIHP staff and its provider network are following the PIHP's clinical policies and practices.

To achieve its Utilization Management goals, the PIHP engages in several specific UM functions with some items being delegated to an affiliate.

- Eligibility Screening, including Psychiatric Hospitalization pre-evaluation;
- Service Authorization
- Utilization Review

- UM Committee: Retrospective Review & Outlier Management
- Development and Maintenance of Standards and Guidelines

These utilization management activities and operating processes are detailed in the PIHP UM Plan which will be approved by the PIHP Board. The UM Plan details the above UM functions performed by the PIHP and any delegated items. In addition, for specific procedures on UM processes please refer to the PIHP Policy Manual.

XV. Provider Network Monitoring

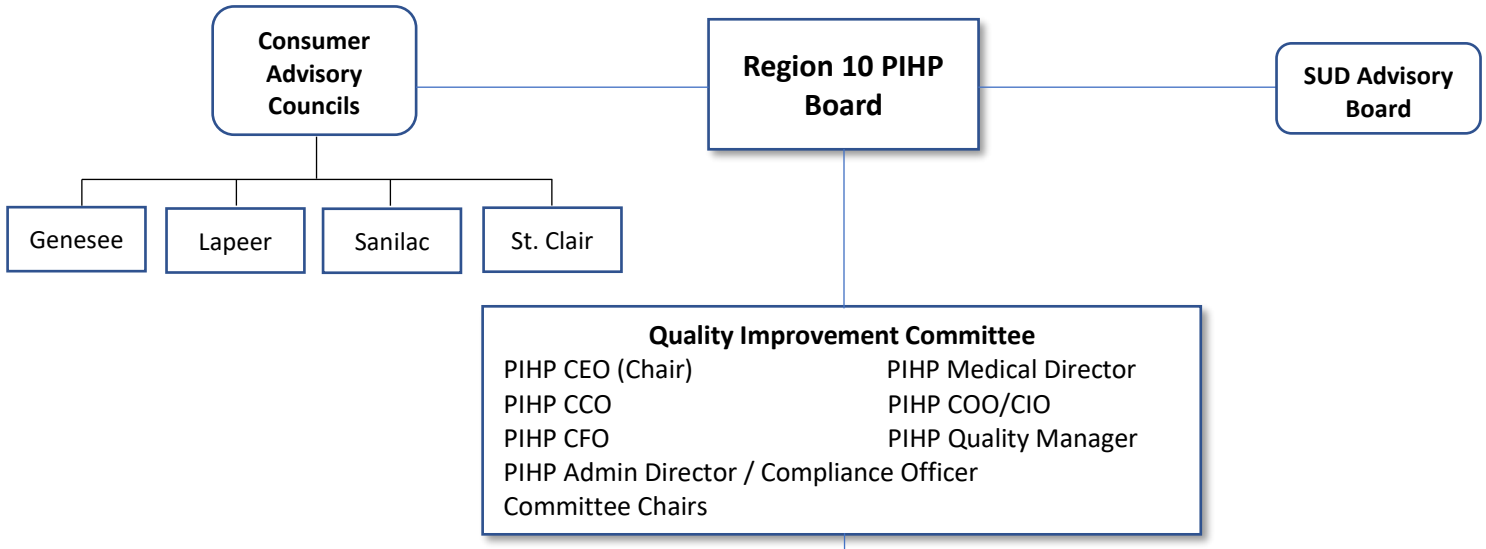
The PIHP annually monitors its provider network, including any affiliates or subcontractors to which it has delegated managed care functions, including service and support provision. The PIHP shall review and follow-up on any action items regarding provider network monitoring of its subcontractors.

XVI. Special Targeted Monitoring Activities

The PIHP continually evaluates its oversight of vulnerable people to determine opportunities for improving oversight of their care and outcomes. MDHHS will continue to work with the PIHP to develop uniform methods for targeted monitoring of vulnerable people and those with complex health needs including physical and developmental disabilities, severe mental illness, and chronic conditions.

The PIHP shall review and approve plans of correction that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate interval. Reports of the annual monitoring and plans of correction shall be subject to MDHHS review.

REGION 10 QAPIP ORGANIZATIONAL STRUCTURE



	Compliance Committee	*Finance Committee*	*Improving Practices Leadership*	*Privileging and Credentialing*	*Provider Network Management*	*Quality Management*	*Sentinel Events Review*	*Utilization Management* **Behavior Mgmt. Treatment Plan Review*
Region 10	√	√	√	√	√	√	√	√
CMH Providers	√	√	√		√	√		√
SUD Providers	√							

Quality Management Fiscal Year (FY) 2021 Work Plan (October 1, 2020 – September 30, 2021)

Component	Goals/Timeframe	Planned Activities	Responsible Staff/Department	Status Update
QI Program Structure - Annual Evaluation	• Submit FY2020 QI Program Evaluation to Quality Improvement Committee and the Region 10 PIHP Board by 12/1/2020.	• Present the Annual Evaluation to the Quality Improvement Committee. The Quality Improvement Committee will be responsible for providing feedback on the qualitative analysis, proposed interventions and implementation plan. • After presentation to the Quality Improvement Committee the Annual Evaluation will be presented to the Region 10 PIHP Board for discussion and approval.	Lauren Bondy QI Department QI Program Standing Committees	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No
QI Program Structure - Program Description	• Submit FY2021 QI Program Description to Quality Improvement Committee and the Region 10 PIHP Board by 12/1/2020.	• Review the previous year's QI Program and make revisions to meet current standards and requirements. • Include changes approved through committee action and analysis. • Include signature pages, Work Plan, Evaluation, Policies and Procedures and attachments.	Lauren Bondy QI Department QI Program Standing Committees	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No

Component	Goals/Timeframe	Planned Activities	Responsible Staff/Department	Status Update
QI Program Structure - Annual Work Plan	• Submit FY2021 QI Program Description to the Quality Improvement Committee and the Region 10 PIHP Board by 12/1/2020. • Develop the FY2021 QI Program Work Plan standard by 12/1/2020. • Present the work plan to committee by 12/1/2020.	• Utilize the annual evaluation in the development of the Annual Work Plan for the upcoming year. • Prepare work plan including measurable goals and objectives. • Include a calendar of main project goal and due dates	Lauren Bondy QI Department QI Program Standing Committees	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
Aligned System of Care	The goals for FY2021 Reporting Year are as follows: • To promote an aligned system of care throughout the PIHP Provider Network to ensure quality and safety of clinical care and quality of service.	• Monitor utilization of the PIHP Clinical Practice Guidelines. • Review Evidence-Based Practices and related fidelity review activities to promote standardized clinic operations across the provider network, e.g. IDDT, LOCUS. • Monitor and advise on ESC activities to encourage CMHSP a) employment targets, b) standardized	Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
		employment services data and report formats, and c) share and learn opportunities. • Assist in aligning network care integration processes for persons with Medicaid Health Plans, including shared case record operations and aligned network practices in utilizing the CC360 system. • Monitor and advise on the CMHSP network's work on the continuation and remediation plans addressing Home and Community-Based Services transition.		
Home & Community Based Services	The goals for FY2021 Reporting are as follows: • Monitor network implementation of the Home and Community Based Services transition to ensure quality of clinical care and service.	• Monitor network completion of the FY2020 HCBS re-survey cycle • Monitor Heightened Scrutiny work • Monitor the provisional approval process	Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:**

<table>
<tr><th>Component</th><th>Goals/Timeframe/Analysis</th><th>Planned Activities</th><th>Responsible Staff/Department</th><th>Status Update</th></tr>
<tr>
<td></td>
<td>
<table>
<tr><th>FY20 Re-Survey Group</th><th># of Out of Compliance Providers</th><th># of CAPs Required</th><th># of CAPs Approved</th><th># of Attestations Sent</th><th># of Attestations Received</th><th># of Compliance Letters Sent</th></tr>
<tr><td>GHS</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Lapeer</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Sanilac</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>St. Clair</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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<td>Next Steps:

Continue Objective(s)?
☐ Yes ☐ No</td>
</tr>
<tr>
<td>Event Reporting (Critical Incidents, Sentinel Events & Risk Events)</td>
<td>The goals for FY2021 Reporting are as follows:
• To review and monitor the safety of clinical care.</td>
<td>• Review critical incidents, to ensure adherence to data and reporting standards and to monitor for trends, to improve systems of care.
• Monitor sentinel event review processes and ensure follow-up as deemed necessary.
• Monitor unexpected deaths review processes and ensure follow-up as deemed necessary.</td>
<td>Tom Seilheimer

Sentinel Event Review Committee</td>
<td>Goal Met:
☐ Yes ☐ No

Quarterly Update:
Q 1: (Oct-Dec):
Q 2 (Jan-Mar):
Q 3 (Apr-June):
Q 4 (July-Sept):

Evaluation:

Barrier Analysis:

Next Steps:
Continue Objective(s)?
☐ Yes ☐ No</td>
</tr>
<tr>
<td>Employment Services</td>
<td>The goals for FY2021 Reporting are as follows:
• To monitor and advise on Employment Services activities as the CMHSPs</td>
<td>• Encourage and support CMHSP progressive employment services practices.
• Support to CMHSP pursuit of local employment</td>
<td>Tom Seilheimer

Employment Services Committee</td>
<td>Goal Met:
☐ Yes ☐ No

Quarterly Update:
Q 1: (Oct-Dec):
Q 2 (Jan-Mar):
Q 3 (Apr-June):
Q 4 (July-Sept):</td>
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</table>

<table>
<tr><th>Component</th><th>Goals/Timeframe/Analysis</th><th>Planned Activities</th><th>Responsible Staff/Department</th><th>Status Update</th></tr>
<tr><td></td><td></td><td>targets pertaining to competitive employment (community-based) and compensation (minimum wage or higher).
• Explore additional opportunities to utilize standardized employment services data and report formats.
• Provide share and learn opportunities as such may pertain to employment targets and collaborative practices, e.g. MRS.</td><td></td><td>Evaluation:

Barrier Analysis:

Next Steps:

Continue Objective(s)?
☐ Yes ☐ No</td></tr>
<tr><td>Michigan Mission Based Performance Indicator System (MMBPIS)</td><td>The goals for FY2021 Reporting are as follows:
• The goal is to attain and maintain performance standards as set by the MDHHS contract.

<table>
<tr><th></th><th>FY19 Q4</th><th>FY20 Q1</th><th>FY20 Q2</th><th>FY20 Q3</th></tr>
<tr><td colspan="5">Ind. 1 - Percentage of persons receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. Standard = 95%</td></tr>
<tr><td>1.1 Children</td><td></td><td></td><td></td><td></td></tr>
<tr><td>1.2 Adults</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Ind. 2a – Percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of non-emergency request for service. No standard</td></tr>
<tr><td>2a PIHP Total</td><td></td><td></td><td></td><td></td></tr>
<tr><td>2a.1 MI-Children</td><td></td><td></td><td></td><td></td></tr>
</table>
</td><td>• Report indicator results to MDHHS quarterly per contract
• Provide status updates to relevant committees such as QMC, PIHP CEO, PIHP Board
• Review quarterly MMBPIS data</td><td>Lauren Bondy

QI Department

Quality Management Committee (QMC)</td><td>Goal Met:
☐ Yes ☐ No

Quarterly Update:
Q 1: (Oct-Dec):
Q 2 (Jan-Mar):
Q 3 (Apr-June):
Q 4 (July-Sept):

Evaluation:

Barrier Analysis:

Next Steps:

Continue Objective(s)?</td></tr>
</table>

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
	2a.2 MI-Adults 2a.3 DD-Children 2a.4 DD-Adults **Ind. 2b - Percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders. No standard** 2b SUD **Ind. 3 – Percentage of new persons during the quarter starting any needed on-going service within 14 days of non-emergent face-to-face assessment with professional. No standard** 3 PIHP Total 3.1 MI-Children 3.2 MI-Adults 3.3 DD-Children 3.4 DD-Adults **Ind. 4 – Percentage of discharges from a psychiatric inpatient unit / SUD Detox unit that were seen for follow-up care within 7 days. Standard = 95%** 4a.1 Children 4a.2 Adults 4b SUD **Ind. 10 – Percentage of readmissions of children and adults to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less** 10.1 Children 10.2 Adults			☐ Yes ☐ No
Members' Experience	The goals for FY2021 Reporting are as follows: • Conduct assessments of members' experience with services o Complete the member satisfaction survey by August 2021. o Conduct the Recovery Self-Assessment survey. o Conduct other assessments of members' experience as needed.	• Conduct annual regional consumer satisfaction survey • Participate in MDHHS annual customer satisfaction survey as specified by MDHHS	Lauren Bondy QI Department Quality Management Committee (QMC)	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
		• Conduct the Recovery Self-Assessment survey • Conduct other assessments of members' experiences as needed • Develop interventions to address areas for improvement based on member satisfaction survey		Continue Objective(s)? ☐ Yes ☐ No
State Mandated Performance Improvement Projects	The goals for FY2021 Reporting are as follows: • Identify and implement two PIP projects that meet MDHHS standards: Improvement Project #1 Tobacco Cessation: the proportion of SMI adult Medicaid consumers identified as tobacco users who had at least one reported encounter during the CY for prescribed medications to assist in reducing or eliminating tobacco use. Improvement Project #2 The goal of this PIP is to ensure that children and adults within the region who are Medicaid beneficiaries will receive follow-up services within 30 days after discharge from a psychiatric inpatient hospital. This study topic aligns with the Performance Bonus Incentive Pool metric "Follow-up After Hospitalization for Mental illness within 30 Days", which applies performance standards for these two clinical cohorts. PIP performance targets have been set to exceed these performance standards.	• Review HSAG report on PIP interventions and baseline • Provide / review PIP status updates to Quality Management Committee • QMC to consider selection of PIP projects aimed at impacting error reduction, improving safety and quality	Tom Seilheimer Quality Management Committee (QMC)	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No
External Monitoring Reviews	The goals for FY2021 Reporting are as follows: • To monitor and address activities pertaining to the PIHP Waiver Programs (HSW, CWP, SEDW): a) Ensure non-licensed, non-verified providers meet required qualification	• QMC members will follow up and report monthly on each CMHSPs follow up activities	Lauren Bondy Quality Management	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
	b) Ensure support and service providers receive required training on IPOS	to ensure compliance with the MDHHS HSW, CWP, and SEDW requirements	Committee (QMC)	**Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No
Monitoring of Quality Areas	The goals for FY2021 Reporting are as follows: • To explore and promote quality and data practices within the region.	• Monitor critical incidents • Monitor emerging quality and data initiative / issues and requirements • Monitor and address Performance Bonus Incentive Pool activities and indicators • Monitor and address changes to service codes • Review / analysis of various regional data reports • Review / analysis of BH TEDS reports	Lauren Bondy Quality Management Committee (QMC)	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No
Financial Management	The goals for FY2021 Reporting are as follows to promote sound fiscal management of the region: • Evaluate funding allocation methodology.	• Determine appropriate risk factors to drive payment methodology.	Richard Carpenter Finance Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
		• Create funding report in MIX based on appropriate risk factors. • Present side-by-side comparison of funding under old and new methodology.		**Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No
Financial Management	The goals for FY2021 Reporting are as follows to promote sound fiscal management of the region: • Implement risk-based payment methodology.	• Identify any barriers to the new risk-based funding model • Modify funding model to eliminate barriers or reduce them to an acceptable level. • Implement new risk-based funding as primary funding mechanism	Richard Carpenter Finance Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No
Financial Management	The goals for FY2021 Reporting are as follows to promote sound fiscal management of the region: • Implementation of MDHHS Standardized Cost Allocation Model.	• Receive further direction from MDHHS regarding new process for standardized cost allocation model • Participate in relevant MDHHS training webinars	Richard Carpenter Finance Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
		• Identify barriers to the new model • Review process and implement strategies		**Next Steps:** Continue Objective(s)? ☐ Yes ☐ No
Utilization Management	The goals for FY2021 Reporting are as follows: • Ensure that monthly regional service utilization reports are generated (10/1/2020 – 9/30/2021).	• Monitor and advise on regional Crisis service utilization reports (monthly PCE-based reports), including new services implementation	Tom Seilheimer Utilization Management (UM) Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No
Utilization Management	The goals for FY2021 Reporting are as follows: • Provide periodic oversight on the use of restrictive and intrusive behavioral techniques, physical management or 911 contact with law enforcement use on an emergency basis.	• Monitor and advise on BTPRC data on use of Restrictive and Intrusive techniques, physical management or contact with law enforcement use on an emergency behavior basis; evaluate reports per committee review / discussion of findings, trends, potential systems improvement	Tom Seilheimer Utilization Management (UM) Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
		opportunities, adherence to standards.		
Utilization Management	The goals for FY2021 Reporting are as follows: • Conduct Utilization Review (UR)	• Conduct UR of SUD Provider Network • Conduct UR of CMHSP Provider Network per CMHSP Delegation • Conduct UR of CMHSP per Centralized UM Operations • Explore feasible opportunities for additional outlier-based UR linked to high-cost, high-risk, or tele-med formats	Tom Seilheimer Utilization Management (UM) Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No
Utilization Management	The goals for FY2021 Reporting are as follows: • Promote aligned care management activities across key areas of network operations.	• Implement Centralized UM System • Promote aligned care management activities across Access Management System Access sites • Monitor and advise on community access care management activities: Quarterly	Tom Seilheimer Utilization Management (UM) Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
		Customer Involvement, Wellness/Healthy Communities reports		
Corporate Compliance	The goals for FY2021 Reporting are as follows: • Compliance with 42 CFR 438.608 Program Integrity requirements.	• Review requirements • Identify and document responsible entities • Identify and document supporting evidence / practice • Policy review • Review PIHP Corporate Compliance Plan updates	Katie Forbes Corporate Compliance Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No
Corporate Compliance	The goals for FY2021 Reporting are as follows: • Support reporting requirements (quarterly and ongoing) as defined by MDHHS, OIG, PIHP, etc.	• Review of reporting process	Katie Forbes Corporate Compliance Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
Corporate Compliance	The goals for FY2021 Reporting are as follows: • Review regional Corporate Compliance monitoring standards, reports, and outcomes.	• Review regional PIHP contract monitoring results • Review current CMH Subcontractor contract monitoring process / content	Katie Forbes Corporate Compliance Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No
Corporate Compliance	The goals for FY2021 Reporting are as follows: • Improve reciprocity and efficiency within the PIHP Provider Network.	• Review MDHHS Network Management Reciprocity & Efficiency Policy • Create Regional Corporate Compliance Complaint Form (for Complainant Use) • Create Regional Corporate Compliance Complaint Summary Form (for Compliance Office Use) • Create Regional HIPAA Breach	Katie Forbes Corporate Compliance Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
		Notification Letter Templates • Review PIHP and Provider Corporate Compliance Webpage Content		
Provider Network	The goals for FY2021 Reporting are as follows: • Address service capacity concerns and ensure resolution of identified gaps in the network based on Gap Analysis Reports.	• Review CMH Gap Analysis Reports • Review SUD Network gaps • Address cultural and linguistic needs of members. • Review capacity concerns identified (e.g. Autism, Mobile Intensive Crisis Stabilization).	Amanda Zabor Provider Network Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No
Provider Network	The goals for FY2021 Reporting are as follows: • Review Network Adequacy requirements and address compliance with standards.	• Review MDHHS standards and current Network Adequacy • Address Network Adequacy concerns	Amanda Zabor Provider Network Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No

<table>
<tr><th>Component</th><th>Goals/Timeframe/Analysis</th><th>Planned Activities</th><th>Responsible Staff/Department</th><th>Status Update</th></tr>
<tr><td>Provider Network</td><td>The goals for FY2021 Reporting are as follows:
• Ensure Provider Directories are updated monthly and provide MDHHS-required information for individuals served.</td><td>• Review MDHHS requirements
• Address opportunities for reporting efficiency and effectiveness
• Identified staff participate in PIHP Provider Directory Workgroup</td><td>Katie Forbes

Provider Network Committee</td><td>Goal Met:
☐ Yes ☐ No

Quarterly Update:
Q 1: (Oct-Dec):
Q 2 (Jan-Mar):
Q 3 (Apr-June):
Q 4 (July-Sept):

Evaluation:

Barrier Analysis:

Next Steps:
Continue Objective(s)?
☐ Yes ☐ No</td></tr>
<tr><td>Provider Network</td><td>The goals for FY2021 Reporting are as follows:
• Review most recent FY PIHP Contract Monitoring Results.</td><td>• Review FY Contract Monitoring Aggregate Report
• Discuss trends and improvement opportunities</td><td>Amanda Zabor

Provider Network Committee</td><td>Goal Met:
☐ Yes ☐ No

Quarterly Update:
Q 1: (Oct-Dec):
Q 2 (Jan-Mar):
Q 3 (Apr-June):
Q 4 (July-Sept):

Evaluation:

Barrier Analysis:

Next Steps:
Continue Objective(s)?
☐ Yes ☐ No</td></tr>
<tr><td>Customer Service Inquiries</td><td>The goals for FY2021 Reporting are as follows:
• To review and analyze baseline customer service inquiry data for the region for FY2021.

<table><tr><th colspan="8">Reporting Period: FY2021</th></tr><tr><th></th><th colspan="3">Q1</th><th rowspan="2">Q2</th><th rowspan="2">Q3</th><th rowspan="2">Q4</th><th rowspan="2">Total</th></tr><tr><th>Oct</th><th>Nov</th><th>Dec</th></tr><tr><td>GHS</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Lapeer</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table></td><td>• To track and trend internally the customer service inquiries on a quarterly basis.
• Identify consistent patterns related to</td><td>Katie Forbes

Quality Improvement Committee</td><td>Goal Met:
☐ Yes ☐ No

Quarterly Update:
Q 1: (Oct-Dec):
Q 2 (Jan-Mar):
Q 3 (Apr-June):
Q 4 (July-Sept):

Evaluation:</td></tr>
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<table>
<tr><td>PIHP</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Sanilac</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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<tr><td>SUD</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>TOTAL</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="7">Inquiry Dispositions:</td><td>Total</td></tr>
<tr><td colspan="7">Appeal</td><td></td></tr>
<tr><td colspan="7">Grievance</td><td></td></tr>
<tr><td colspan="7">Referral to Access</td><td></td></tr>
<tr><td colspan="7">Rights Complaint</td><td></td></tr>
<tr><td colspan="7">Referral to Provider</td><td></td></tr>
<tr><td colspan="7">Other</td><td></td></tr>
<tr><td colspan="7">Pending</td><td></td></tr>
</table>
</td>
<td>member customer service inquiries.
• Develop interventions to address critical issues within the organization.</td>
<td></td>
<td>Barrier Analysis:

Next Steps:

Continue Objective(s)?
☐ Yes ☐ No</td>
</tr>
<tr>
<td>Appeals</td>
<td>The goals for FY2021 Reporting are as follows:
• To review and analyze baseline appeals data for the region for FY2021.

<table>
<tr><td colspan="8">Reporting Period: FY2021</td></tr>
<tr><td></td><td colspan="3">Q1</td><td>Q2</td><td>Q3</td><td>Q4</td><td>Total</td></tr>
<tr><td></td><td>Oct</td><td>Nov</td><td>Dec</td><td></td><td></td><td></td><td></td></tr>
<tr><td>GHS</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Lapeer</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>PIHP</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Sanilac</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>St. Clair</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>SUD</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>TOTAL</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="7">Reason for Appeal:</td><td>Total</td></tr>
<tr><td colspan="7">Grievance not resolved within 90 days</td><td></td></tr>
<tr><td colspan="7">Grievance not resolved within allowed days</td><td></td></tr>
<tr><td colspan="7">Request not acted on within 14 days</td><td></td></tr>
<tr><td colspan="7">Service Denial</td><td></td></tr>
<tr><td colspan="7">Service not started within 14 days</td><td></td></tr>
<tr><td colspan="7">Service Reduction</td><td></td></tr>
<tr><td colspan="7">Service Suspension</td><td></td></tr>
<tr><td colspan="7">Service Termination</td><td></td></tr>
</table>
</td>
<td>• To track and trend internally the appeals on a quarterly basis.
• Identify consistent patterns related to member appeals.
• Develop interventions to address critical issues within the organization.</td>
<td>Katie Forbes

Quality Improvement Committee</td>
<td>Goal Met:
☐ Yes ☐ No

Quarterly Update:
Q 1: (Oct-Dec):
Q 2 (Jan-Mar):
Q 3 (Apr-June):
Q 4 (July-Sept):

Evaluation:

Barrier Analysis:

Next Steps:

Continue Objective(s)?
☐ Yes ☐ No</td>
</tr>
</table>

<table>
<tr><th>Component</th><th>Goals/Timeframe/Analysis</th><th>Planned Activities</th><th>Responsible Staff/Department</th><th>Status Update</th></tr>
<tr>
<td>Grievances</td>
<td>The goals for FY2021 Reporting are as follows:
• To review and analyze baseline grievance data for the region for FY2021.

<table>
<tr><th colspan="8">Reporting Period: FY2021</th></tr>
<tr><th></th><th colspan="3">Q1</th><th rowspan="2">Q2</th><th rowspan="2">Q3</th><th rowspan="2">Q4</th><th rowspan="2">Total</th></tr>
<tr><th>Oct</th><th>Nov</th><th>Dec</th></tr>
<tr><td>GHS</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Lapeer</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>PIHP</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Sanilac</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>St. Clair</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>SUD</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>TOTAL</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><th colspan="7">Reason for Grievance:</th><th>Total</th></tr>
<tr><td colspan="7">Financial Matters</td><td></td></tr>
<tr><td colspan="7">Quality of Care</td><td></td></tr>
<tr><td colspan="7">Service Concerns / Availability</td><td></td></tr>
<tr><td colspan="7">Service Environment</td><td></td></tr>
<tr><td colspan="7">Suggestions / Recommendations</td><td></td></tr>
<tr><td colspan="7">Other</td><td></td></tr>
</table>
</td>
<td>• To track and trend internally the grievances on a quarterly basis.
• Identify consistent patterns related to member grievances.
• Develop interventions to address critical issues within the organization.</td>
<td>Katie Forbes

Quality Improvement Committee</td>
<td>Goal Met:
☐ Yes ☐ No

Quarterly Update:
Q 1: (Oct-Dec):
Q 2 (Jan-Mar):
Q 3 (Apr-June):
Q 4 (July-Sept):

Evaluation:

Barrier Analysis:

Next Steps:

Continue Objective(s)?
☐ Yes ☐ No</td>
</tr>
<tr>
<td>Credentialing / Privileging</td>
<td>The goals for FY2021 Reporting are as follows:
• Complete Privileging and Credentialing reviews and approval process of Organizational Applications for CMH and SUD Providers.</td>
<td>• Review all Organizational Applications:
o Current Providers
o New Providers
o Existing Provider Renewals / Updates
o Provider Terminations / Suspensions / Probationary Status</td>
<td>Amanda Zabor

Privileging and Credentialing Committee</td>
<td>Goal Met:
☐ Yes ☐ No

Quarterly Update:
Q 1: (Oct-Dec):
Q 2 (Jan-Mar):
Q 3 (Apr-June):
Q 4 (July-Sept):

Evaluation:

Barrier Analysis:
Next Steps:

Continue Objective(s)?
☐ Yes ☐ No</td>
</tr>
</table>

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
		○ Provider Adverse Credentialing Determinations		
Credentialing / Privileging	The goals for FY2021 Reporting are as follows: • Complete Privileging and Credentialing reviews and approval process of all applicable Region 10 staff.	• Review all Practitioner Applications (includes PIHP Medical Director, Chief Clinical Officer, Clinical Manager, Access Clinicians [leased staff and direct hires]): ○ Current Practitioners ○ New Practitioners ○ Existing Practitioner Renewals / Updates ○ Practitioner Terminations / Suspensions / Probationary Status ○ Practitioner Adverse Credentialing Determinations	Amanda Zabor Privileging and Credentialing Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No
Credentialing / Privileging	The goals for FY2021 Reporting are as follows: • Maintain a current and comprehensive policy on Privileging and Credentialing inclusive of MDHHS and Medicaid standards.	• Review policy content. ○ Review for alignment between policy	Amanda Zabor Privileging and Credentialing Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
		and applications ○ Revise and clarify language where needed		**Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No
Credentialing / Privileging	The goals for FY2021 Reporting are as follows: • Maintain current and comprehensive Privileging and Credentialing applications for Organizational Providers and Individual Practitioners inclusive of MDHHS and Medicaid standards.	• Review application content: ○ Clarify and streamline Organizational Provider Applications ○ Clarify and streamline Individual Practitioner Applications ○ Enhance Application Review Process	Amanda Zabor Privileging and Credentialing Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No

<table>
<tr><th>Component</th><th>Goals/Timeframe/Analysis</th><th>Planned Activities</th><th>Responsible Staff/Department</th><th>Status Update</th></tr>
<tr>
<td>Autism Program</td>
<td>
The goals for FY2021 Reporting are as follows:
• The PIHP will monitor and bring system-wide improvement to the ABA program.

A) Reduce the number of beneficiaries waiting to start ABA services, as measured by the number of persons on the overdue list and length of stay on the overdue list before beginning services.
<table>
<tr><th colspan="2"></th><th>FY20 2Q</th><th>FY20 3Q</th><th>FY20 4Q</th><th colspan="3">FY21 1Q</th></tr>
<tr><th colspan="2"></th><th>Mar</th><th>Jun</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th></tr>
<tr><td>GHS</td><td>Overdue List Total</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>≥90 (Days)</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>60-89</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>30-59</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>0-29</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Lapeer</td><td>Overdue List Total</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>≥90</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>60-89</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>30-59</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>0-29</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Sanilac</td><td>Overdue List Total</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>≥90</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>60-89</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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<tr><td></td><td>0-29</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>St. Clair</td><td>Overdue List Total</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>≥90</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>60-89</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
</td>
<td>
• Monitor persons on autism services overdue list total
• Monitor completion of behavioral plans of care
• Monitor service provision in specified areas
• Monitor documentation submission to Waiver Support Application (WSA)
• Monitor services (encounters) using the funding Source Bucket Report (FSBR)
</td>
<td>Lauren Bondy

Monitored by Quality Improvement Committee (QIC)</td>
<td>
Goal Met:
☐ Yes ☐ No
Quarterly Update:
Q 1: (Oct-Dec):
Q 2 (Jan-Mar):
Q 3 (Apr-June):
Q 4 (July-Sept):

Evaluation:

Barrier Analysis:

Next Steps:

Continue Objective(s)?
☐ Yes ☐ No
</td>
</tr>
</table>

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update

30-59						
0-29						

B) Autism benefit enrollees will receive one or more Family Behavior Treatment Guidance service per quarter.

Percentage of individuals receiving ≥ 1 Family behavior Treatment Guidance service per quarter.
Data source: Waiver Support Application (WSA) and Funding Source Bucket Report (FSBR)

	FY20 2Q	FY20 3Q	FY20 4Q	FY21 1Q
Genesee				
Lapeer				
Sanilac				
St. Clair				

Standard: 100% of individuals will receive ≥ 1 Family Behavior Treatment Guidance Service per quarter, as measured using the FSBR report.

C) Autism Benefit enrollees with an active plan of service will receive one or more ABA service per quarter.

Percentage of individuals receiving ≥ 1 ABA service per quarter.
Data source: Waiver Support Application (WSA) and Funding Source Bucket Report (FSBR)

	FY20 2Q	FY20 3Q	FY20 4Q	FY21 1Q
Genesee				
Lapeer				
Sanilac				
St. Clair				

Standard: 100% of individuals will receive ≥ 1 ABA service per quarter, as measured using FSBR report.

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
External Quality Review Corrective Actions	During the 2019-2020 External Quality Review of Region 10 PIHP, corrective action plans (CAPs) from the 2017-2018 and 2018-2019 Compliance Monitoring were reviewed. CAPs for the following areas were reviewed: Standard II. Quality Measurement and Improvement Standard V. Utilization Management Standard VI. Customer Service Standard VII. Enrollee Grievance Process Standard IX. Subcontracts and Delegation Standard XI. Credentialing Standard XIV. Appeals Standard XVI. Confidentiality of Health Information Standard XVII. Management Information Systems Per the 2020 External Quality Review Performance Measurement Validation Report for Region 10 PIHP, it was recommended Region 10 PIHP support future efforts MDHHS initiates to further improve upon performance indicator data accuracy and MDHHS Codebook clarity.	• The Subject Matter Expert Lead staff for each area will provide updates regarding the status of corrective action plan activities	**Compliance Monitoring:** II. Quality Measurement and Improvement – Lauren Bondy V. Utilization Management – Kristen Potthoff VI. Customer Service – Kristen Potthoff VII. Enrollee Grievance Process – Kristen Potthoff IX. Subcontracts and Delegation – Kristen Potthoff XI. Credentialing – Kristen Potthoff XIV. Appeals – Kristen Potthoff XVI. Confidentiality of Health Information – Kristen Potthoff	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** **Continue Objective(s)?** ☐ Yes ☐ No

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
			XVII. Management Information Systems – Lauren Bondy **Performance Measurement Validation:** Lauren Bondy	

Region 10 PIHP Board Officers

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Lori Curtiss

VICE CHAIRMAN
Robert Kozfkay

SECRETARY
Wanda Cole

TREASURER
Edwin Priemer

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Terry Bankert

Ronald Barnard

Dr. Niketa Dani

DeElla Johnson

Joyce Johnson

Gary Jones

Elva Mills

Wayne Strandberg

Nancy Thomson

Bobbie Umbreit

As of 10.08.2020