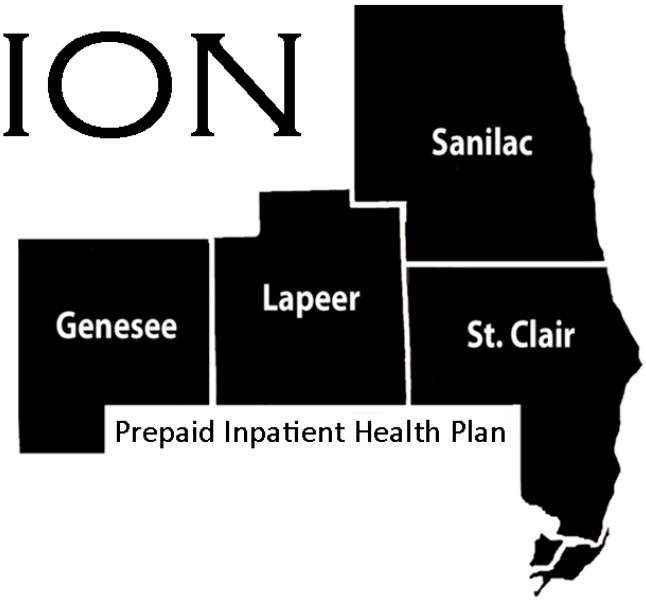
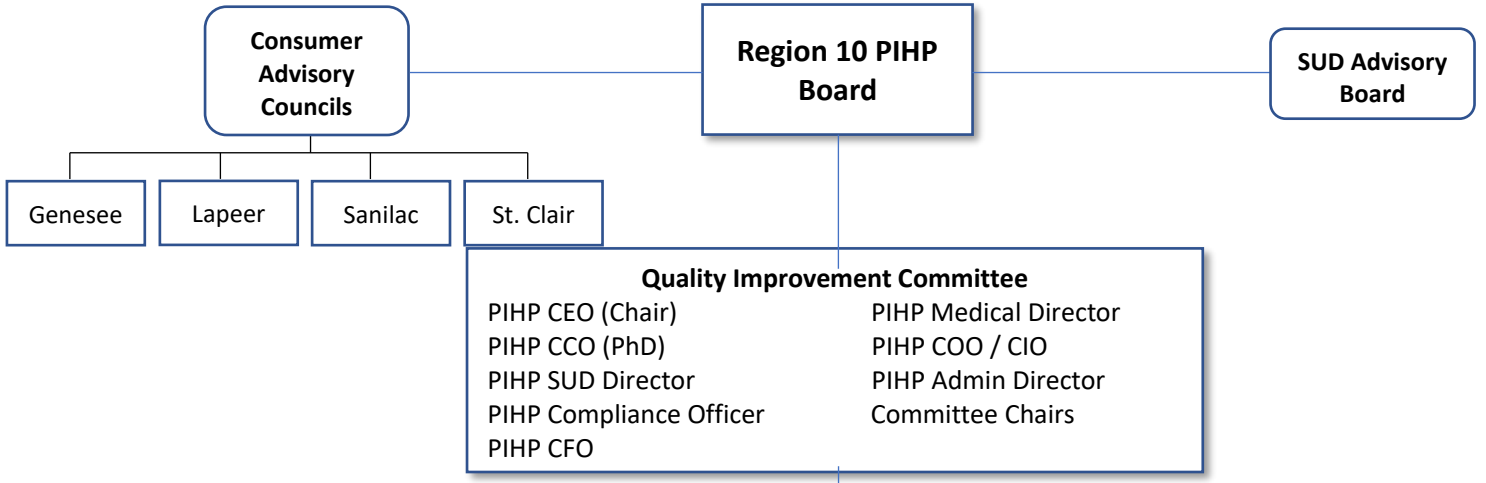
REGION 10



QUALITY IMPROVEMENT WORKPLAN

FY 2018 FINAL REPORT

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	√							√

Component	Goals/Timeframe	Planned Activities	Responsible Staff/Department	Status Update
QI Program Structure - Annual Evaluation	• Submit 2017 QI Program Evaluation to "Quality Improvement Committee" and the Region 10 PIHP Board by December 1, 2017.	• 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.	Pattie Hayes QI Department QI Program Standing Committees	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1 (Oct-Dec):** **The Quality Improvement Annual Report was finalized and presented to the QI Committee on 10/16/17 for review and approval. The QI Annual Report was presented to the PIHP Board on 10/20/17 for discussion and approval. Goal completed.** **Q 2 (Jan-Mar):** **No change. Goal completed.** **Q 3 (Apr-June):** **No change. Goal completed.** **Q 4 (July-Sept):** **No change. Goal completed.** **Evaluation: Goal completed** **Barrier Analysis: No barriers noted** **Next Steps: Continue per plan** Continue Objective(s)? ☒ Yes ☐ No **Goal will be continued in FY2019 workplan for FY2018 QI Annual Report.**

Component	Goals/Timeframe	Planned Activities	Responsible Staff/Department	Status Update
QI Program Structure - Program Description	• Submit 2018 QI Program Description to "Quality Improvement Committee" and the Region 10 PIHP Board by December 1, 2017.	• Review the previous year's QI Program and revise 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.	Pattie Hayes QI Department QI Program Standing Committees	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **The QI Program Description was presented to the QI Committee on 10/16/17 for review and approval. It was then presented to the PIHP Board on 10/20/17 for review and approval. A revised version of the QI Program Description was presented to the QIC (11/6/17) and PIHP Board on 11/17/17. The revised QI Program Description was approved on 11/17/17.** **Q 2:** (**Jan-Mar):** N**o change. Goal completed.** **Q 3: (Apr-June):** **No change. Goal completed.** **Q 4:** (**July-Sept): No change. Goal completed.** **Evaluation: Goal completed** **Barrier Analysis: No barriers noted** **Next Steps: Continue per plan** Continue Objective(s)? ☒ Yes ☐ No **Goal to be continued for FY19. FY2019 QI Program Description will be presented to QIC on 10/8/18 for review and approval.**

Component	Goals/Timeframe	Planned Activities	Responsible Staff/Department	Status Update
QI Program Structure - Annual Work Plan	• Submit 2018 QI Program Description to the "Quality Improvement Committee" and the Region 10 PIHP Board by December 1, 2017. • Develop the 2018 QI Program Work Plan standard by December 1, 2017. • Present the work plan to committee by December 1, 2017.	• 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	Pattie Hayes QI Department QI Program Standing Committees	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **The QI Annual Work Plan was completed and presented to the QI Committee (10/16/17) and PIHP Board (10/20/17) for review and approval. A revised QI Annual Workplan was presented and approved by the QIC (11/6/17) and the PIHP Board (11/17/17).** **Q 2: (Jan-Mar):** **Autism goals were added to QI Workplan and approved by QIC at March meeting. Will request Board approval of Autism goal addition at April Board meeting.** **Q 3: (Apr-June):** **Autism goals were approved by Board to add to QI Plan in April.** **Q 4: (July-Sept): No change. Goal completed.** **Evaluation: Progress.** **Barrier Analysis: No barriers noted.** **Next Steps: Continue per plan.** Continue Objective(s)? ☒ Yes ☐ No **Goal to be continued throughout FY18. The annual QI Workplan summary will inform the development of FY2019 QI Workplan.**
QI Program Structure - Policies and Procedures	• Submit policies and procedures to the "Quality Improvement Committee" and the Region 10 PIHP Board for approval by December 1, 2017.	• Review all standing policies and procedures and make revisions as needed to meet all regulatory and contract requirements. • Develop new policies and procedures for any areas not currently covered or to meet new/current regulatory and contract requirements.	Pattie Hayes QI Department	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **The QAPIP (QI Program) policy was presented and approved at the QI Committee on 10/16/17 and by the PIHP Board on 10/20/17. Goal complete.** **Q 2: (Jan-Mar):** **No change. Goal completed.** **Q 3: (Apr-June):** **No changes. Goal complete.** **Q 4: (July-Sept): No change. Goal completed.** **Evaluation: Goal Completed**

Component	Goals/Timeframe	Planned Activities	Responsible Staff/Department	Status Update
				Barrier Analysis: No barriers noted **Next Steps: N/A; Goal is complete.** Continue Objective(s)? ☐ Yes ☒ No

Component	Goals/Timeframe	Planned Activities	Responsible Staff/Department	Status Update
Autism Program	The goals for 2018 Reporting are as follows: Meet the following standards as set by the MDHHS contract and Region 10 PIHP. A) Reduce the number of beneficiaries waiting to start ABA services, as measured by the number of persons on the waitlist and length of stay on the waitlist before beginning services.	• Monitor persons on autism services waitlist • Monitor completion of behavioral plans of care • Monitor service provision in specified areas • Review quarterly MDHHS Q.I. Reports • Monitor documentation submission to Waiver Support Application (WSA)	Lauren Bondy Monitored by Quality Improvement Committee (QIC)	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2: (Jan-Mar):** **Requesting approval of this new Autism goal.** **A.) The MDHHS Performance Indicator Standard in this category is 0 cases waiting ≥90 days:** • **GHS increased enrollment by 20, and decreased beneficiaries waiting ≥90 days.** • **Lapeer maintains 1 case waiting 30-59 days, meeting the MDHHS Performance Indicator Standard.** • **Sanilac increased enrollment by 1, maintaining 1 case waiting 30-59 days, meeting the MDHHS Performance Indicator Standard.** • **St. Clair increased enrollment by 2, and decreased beneficiaries waiting >90 days.** **B.) Data selection methodology was corrected by MDHHS in 2Q, supporting a significant increase in compliance for GHS. During the identified data period (4Q FY17), Plan of Correction activities noted**

		1Q	2Q	3Q	4Q
GHS	**Waitlist Total**	**53**	**71**	**56**	**55**
	≥90 (Days)	49	34	36	45
	60-89	1	2	4	1
	30-59	2	15	9	0
	0-29	1	20	7	9
Lapeer	**Waitlist Total**	**4**	**1**	**2**	**3**
	≥90	0	0	0	1
	60-89	0	0	0	2
	30-59	1	1	0	0
	0-29	3	0	2	0
Sanilac	**Waitlist Total**	**1**	**2**	**0**	**1**
	≥90	0	0	0	0
	60-89	0	0	0	0
	30-59	1	1	0	0
	0-29	0	1	0	1
St. Clair	**Waitlist Total**	**6**	**5**	**10**	**8**
	≥90	3	2	4	5

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

60-89	2	0	1	0
30-59	1	1	3	0
0-29	0	2	2	3

Standard:
1Q: Baseline
2Q: By March 31, 2018, 0 beneficiaries will wait > 90 days from eligibility determination date to begin ABA services.
3Q: By June 30, 2018, 0 beneficiaries will wait > 60 days from eligibility determination date to begin ABA services.
4Q: By September 30, 2018, 0 beneficiaries will wait > 30 days from eligibility determination date to begin ABA services.

B) For persons receiving ABA services, increase the number of beneficiaries with ABA services being provided as specified in their Individual Plan of Service (IPOS).

Percentage of individuals receiving services as indicated in IPOS.
Data source: MDHHS Quarterly Q.I. report

	1Q *04/01/17 - 06/30/17 data*	**2Q** *07/01/17 - 09/30/17 data*	**3Q** *10/01/17 - 12/31/17 data*	**4Q** *01/01/18 - 03/31/18 data*
Genesee	12.2	45.3	34.8	N/A
Lapeer	75.0	65.3	62.1	N/A
Sanilac	63.7	65.0	35.0	N/A
St. Clair	61.6	51.4	26.3	N/A

Standard: 100% of individuals will have services provided as indicated in IPOS, as measured by MDHHS Quarterly Q.I. report.

providers began to amend policies and procedures in beneficiary attendance-monitoring to improve compliance in this indicator.

Q3: (Apr-June):

A.) The MDHHS Performance Indicator Standard in this category is 0 cases waiting ≥90 days:

- **GHS increased total enrollment by 2; beneficiaries waiting ≥90 days increased by 2. However, during 3Q, 24 of the 34 individuals identified in 2Q who had been waiting ≥90 days were transitioned into services.**
- **Lapeer decreased total enrollment by 4 and has zero cases waiting 30+ or ≥90 days, meeting the PIHP and MDHHS Performance Indicator Standard.**
- **Sanilac increased total enrollment by 3 and maintains 0 cases waiting ≥90 days.**
- **St. Clair increased total enrollment by 1; beneficiaries waiting ≥90 days increased by 2 due to terminating a contract provider with repeated non-compliance and concerns for appropriately credentialed staff.**

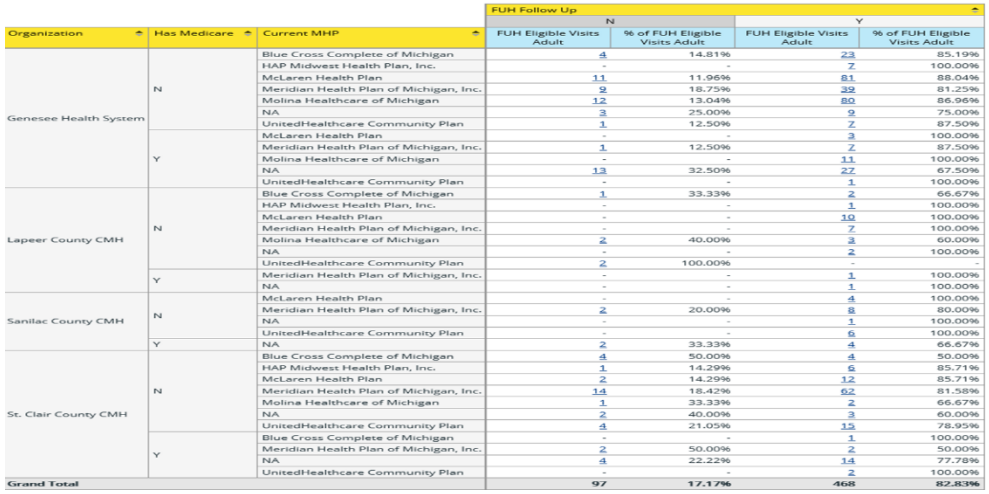
B.) The data source for this goal, MDHHS Quarterly Q.I. report, has not been received for Q3. Anticipate fully completing this table by 07/30/18.Q 4: (July-Sept): A.) The MDHHS Performance Indicator Standard in

Component	Goals/Timeframe	Planned Activities	Responsible Staff/Department	Status Update
				this category is 0 cases waiting >90 days: • **GHS decreased total enrollment by 3; beneficiaries waiting ≥90 days increased by 9. GHS currently has an RFP to expand their ABA provider network. Current GHS contracted ABA providers are making efforts to increase staffing.** • **Lapeer decreased total enrollment by 5; beneficiaries waiting ≥90 days increased by 1.** • **Sanilac decreased total enrollment by 3 and maintains 0 cases waiting ≥90 days.** • **St. Clair increased total enrollment by 1: beneficiaries waiting ≥90 days increased by 1. St. Clair CMH began contracting with an ABA provider which has contributed to a reduced number of total cases waiting to begin services. St. Clair CMH continues to explore adding new contract ABA providers.** **B.) MDHHS will not be providing a FY18 Q4 QI Report. Currently, Region 10 does not have a report to generate the compliance rate or to identify cases noncompliant with this standard. This will be discontinued until a report is available.** **Evaluation: Progress**

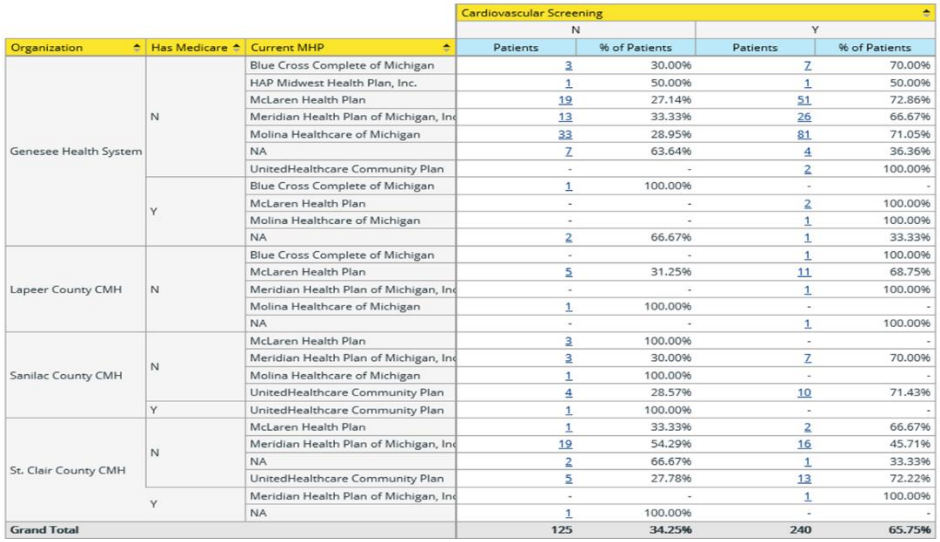
Component	Goals/Timeframe	Planned Activities	Responsible Staff/Department	Status Update
				Barrier Analysis: Lack of provider network capacity. **Next Steps:** **A.) Continue monitoring overdue list and provider capacity.** **B.) Discontinue measuring regional totals and compliance rates on the QI Workplan, until a report is available.** **Continue Objective(s)?** ☒ Yes ☐ No

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
Clinical Program - HEDIS Performance: Follow up after Hospitalization for Mental Illness- Child	Measure description: The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. The goals for 2018 Reporting Year are as follows: To attain and maintain compliance rate set by MDHHS contract by September 2018. Timeframe: March 1, 2017 to February 1, 2018	• Track HEDIS measures proactively • Improvement activities may include but are not limited to the following: • Set follow-up appointment at the time of discharge • Make reminder calls 2 days prior to the appointment date • Make post-visit calls to ensure member's parent complied with the follow-up appointment, if not inquire further for the reasons for not keeping the appointment • Inform parents of the necessity of a follow-up appointment	TBD Monitored by IPLT Committee, UM Committee, QM Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec): Continue to monitor, State target for FUH measure on performance bonus is 70% for children** **Q 2: (Jan-Mar): Continue to monitor, State target for FUH measure on performance bonus is 70% for children. MHP field has been implemented for review.** **Q 3: (Apr-June): NO UPDATE due to discontinuation of ZTS contract. Working on alternate reporting options for this measure.** **Q 4: (July-Sept): No update. Continue to work on alternate reporting options for this measure.** **Evaluation: on hold** **Barrier Analysis: discontinuation of ZTS contract is barrier to this report; working on other reporting options for this measure.** **Next Steps: continue activities when reporting capabilities expanded** Continue Objective(s)? ☐ Yes ☒ No

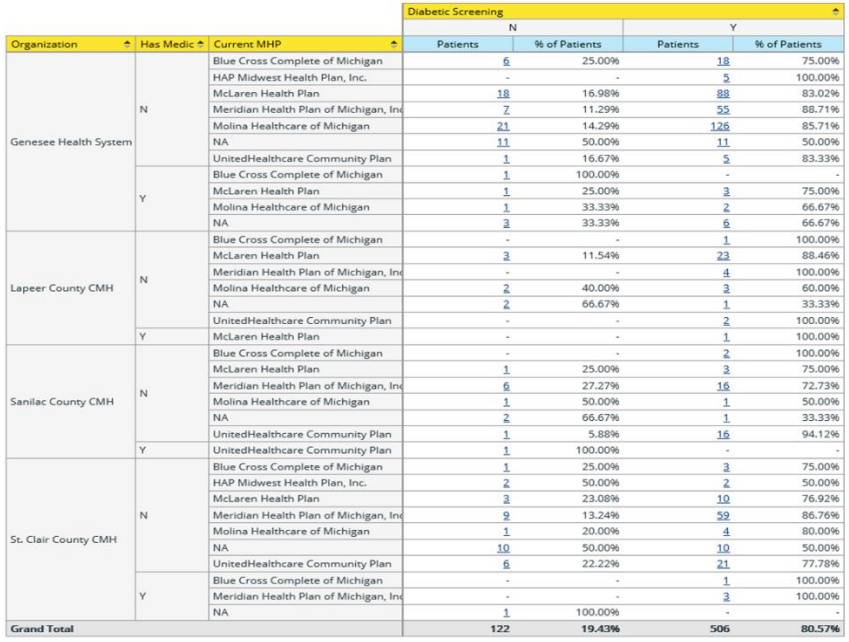
			FUH Follow Up			
			N		Y	
Organization	Has Medicare	Current MHP	FUH Eligible Visits Child	% of FUH Eligible Visits Child	FUH Eligible Visits Child	% of FUH Eligible Visits Child
Genesee Health System	N	Blue Cross Complete of Michigan	5	45.45%	6	54.55%
		HAP Midwest Health Plan, Inc.	-	-	2	100.00%
		McLaren Health Plan	-	-	21	100.00%
		Meridian Health Plan of Michigan, Inc	5	19.23%	21	80.77%
		Molina Healthcare of Michigan	6	14.29%	36	85.71%
		NA	8	47.06%	9	52.94%
		UnitedHealthcare Community Plan	-	-	1	100.00%
Lapeer County CMH	N	McLaren Health Plan	-	-	9	100.00%
		Meridian Health Plan of Michigan, Inc	-	-	5	100.00%
		Molina Healthcare of Michigan	-	-	2	100.00%
		NA	-	-	1	100.00%
Sanilac County CMH	N	Meridian Health Plan of Michigan, Inc	-	-	5	100.00%
		Molina Healthcare of Michigan	-	-	1	100.00%
		NA	-	-	4	100.00%
		UnitedHealthcare Community Plan	-	-	5	100.00%
St. Clair County CMH	N	Blue Cross Complete of Michigan	-	-	2	100.00%
		McLaren Health Plan	2	15.38%	11	84.62%
		Meridian Health Plan of Michigan, Inc	-	-	20	100.00%
		Molina Healthcare of Michigan	-	-	1	100.00%
		NA	-	-	2	100.00%
		UnitedHealthcare Community Plan	1	5.88%	16	94.12%
Grand Total			**27**	**13.04%**	**180**	**86.96%**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
Clinical Program - HEDIS Performance: Follow up after Hospitalization for Mental Illness- Adult	Measure description: The percentage of discharges for members with 21 years or older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. The goals for 2018 Reporting Year are as follows: To attain and maintain compliance rate set by MDHHS contract by September 2018  Timeframe: March 1, 2017 to February 1, 2018	• Track HEDIS measures proactively • Improvement activities include but are not limited to the following: • Set follow-up appointment at the time of discharge • Make reminder calls 2 days prior to the appointment date • Make post-visit calls to ensure member complied with the follow-up appointment, if not inquire further for the reasons for not keeping the appointment • Inform member of the importance of a follow-up meeting	TBD Monitored by IPLT Committee, UM Committee, QM Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Continue to monitor, State target for FUH measure on performance bonus is 58% for adults** **Q 2: (Jan-Mar):** **Continue to monitor, State target for FUH measure on performance bonus is 58% for adults. MHP field has been implemented to be reviewed.** **Q 3: (Apr-June):** **NO UPDATE due to discontinuation of ZTS contract. Working on alternate reporting options for this measure.** **Q 4: (July-Sept):** **No update. Continue to work on alternate reporting options for this measure.** **Evaluation: on hold** **Barrier Analysis: discontinuation of ZTS contract is barrier to this report; working on other reporting options for this measure.** **Next Steps: continue activities when reporting capabilities expanded**

			FUH Follow Up			
			N		Y	
Organization	Has Medicare	Current MHP	FUH Eligible Visits Adult	% of FUH Eligible Visits Adult	FUH Eligible Visits Adult	% of FUH Eligible Visits Adult
Genesee Health System	N	Blue Cross Complete of Michigan	4	14.81%	23	85.19%
		HAP Midwest Health Plan, Inc.	-	-	7	100.00%
		McLaren Health Plan	11	11.96%	81	88.04%
		Meridian Health Plan of Michigan, Inc.	9	18.75%	39	81.25%
		Molina Healthcare of Michigan	12	13.04%	80	86.96%
		NA	3	25.00%	9	75.00%
		UnitedHealthcare Community Plan	1	12.50%	7	87.50%
	Y	McLaren Health Plan	-	-	3	100.00%
		Meridian Health Plan of Michigan, Inc.	1	12.50%	7	87.50%
		Molina Healthcare of Michigan	-	-	11	100.00%
		NA	13	32.50%	27	67.50%
		UnitedHealthcare Community Plan	-	-	1	100.00%
Lapeer County CMH	N	Blue Cross Complete of Michigan	1	33.33%	2	66.67%
		HAP Midwest Health Plan, Inc.	-	-	1	100.00%
		McLaren Health Plan	-	-	10	100.00%
		Meridian Health Plan of Michigan, Inc.	-	-	7	100.00%
		Molina Healthcare of Michigan	2	40.00%	3	60.00%
		NA	-	-	2	100.00%
		UnitedHealthcare Community Plan	2	100.00%	-	-
	Y	Meridian Health Plan of Michigan, Inc.	-	-	1	100.00%
		NA	-	-	1	100.00%
Sanilac County CMH	N	McLaren Health Plan	-	-	4	100.00%
		Meridian Health Plan of Michigan, Inc.	2	20.00%	8	80.00%
		NA	-	-	1	100.00%
		UnitedHealthcare Community Plan	-	-	6	100.00%
	Y	NA	2	33.33%	4	66.67%
St. Clair County CMH	N	Blue Cross Complete of Michigan	4	50.00%	4	50.00%
		HAP Midwest Health Plan, Inc.	1	14.29%	6	85.71%
		McLaren Health Plan	2	14.29%	12	85.71%
		Meridian Health Plan of Michigan, Inc.	14	18.42%	62	81.58%
		Molina Healthcare of Michigan	1	33.33%	2	66.67%
		NA	2	40.00%	3	60.00%
		UnitedHealthcare Community Plan	4	21.05%	15	78.95%
	Y	Blue Cross Complete of Michigan	-	-	1	100.00%
		Meridian Health Plan of Michigan, Inc.	2	50.00%	2	50.00%
		NA	4	22.22%	14	77.78%
		UnitedHealthcare Community Plan	-	-	2	100.00%
Grand Total			97	17.17%	468	82.83%

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Continue Objective(s)? ☐ Yes ☒ No
Clinical Program - HEDIS Performance: Cardiovascular Screening	Measure Description: The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year. The goals for 2018 Reporting Year are as follows: Provide and analyze baseline data for this indicator.  Timeframe: March 1, 2017 to February 1, 2018	• Track HEDIS measures proactively • Improvement activities include but are not limited to the following: • Make reminder phone calls when it is time for a member's screening • Make follow-up call to ensure member attended appointment, if not, inquire at the reason • Educate members on nearby providers with available appointments • Work with local providers to preemptively call members in need of appointments • Develop materials to educate members on importance of screening	TBD Monitored by IPLT Committee, UM Committee, QM Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Continue to monitor. Unusual pattern in Cardiovascular KPI trend lines noted at December QMC, resolved via tech support request to Zenith.** **Q 2: (Jan-Mar):** **Continue to monitor. KPI Trend line shows no unusual pattern. The screening shows a 58.92%, would like to see the rate increase for Patients to receive screening. There's a decrease in % of Patient receiving the service of 1.03%.** **Q 3: (Apr-June):** **NO UPDATE due to discontinuation of ZTS contract. Working on alternate reporting options for this measure.** **Q 4: (July-Sept):** **No update. Continue to work on alternate reporting options for this measure.** **Evaluation: on hold**

			Cardiovascular Screening			
			N		Y	
Organization	Has Medicare	Current MHP	Patients	% of Patients	Patients	% of Patients
Genesee Health System	N	Blue Cross Complete of Michigan	3	30.00%	7	70.00%
		HAP Midwest Health Plan, Inc.	1	50.00%	1	50.00%
		McLaren Health Plan	19	27.14%	51	72.86%
		Meridian Health Plan of Michigan, Inc	13	33.33%	26	66.67%
		Molina Healthcare of Michigan	33	28.95%	81	71.05%
		NA	7	63.64%	4	36.36%
		UnitedHealthcare Community Plan	-	-	2	100.00%
	Y	Blue Cross Complete of Michigan	1	100.00%	-	-
		McLaren Health Plan	-	-	2	100.00%
		Molina Healthcare of Michigan	-	-	1	100.00%
		NA	2	66.67%	1	33.33%
Lapeer County CMH	N	Blue Cross Complete of Michigan	-	-	1	100.00%
		McLaren Health Plan	5	31.25%	11	68.75%
		Meridian Health Plan of Michigan, Inc	-	-	1	100.00%
		Molina Healthcare of Michigan	1	100.00%	-	-
		NA	-	-	1	100.00%
Sanilac County CMH	N	McLaren Health Plan	3	100.00%	-	-
		Meridian Health Plan of Michigan, Inc	3	30.00%	7	70.00%
		Molina Healthcare of Michigan	1	100.00%	-	-
		UnitedHealthcare Community Plan	4	28.57%	10	71.43%
	Y	UnitedHealthcare Community Plan	1	100.00%	-	-
St. Clair County CMH	N	McLaren Health Plan	1	33.33%	2	66.67%
		Meridian Health Plan of Michigan, Inc	19	54.29%	16	45.71%
		NA	2	66.67%	1	33.33%
		UnitedHealthcare Community Plan	5	27.78%	13	72.22%
	Y	Meridian Health Plan of Michigan, Inc	-	-	1	100.00%
		NA	1	100.00%	-	-
Grand Total			125	34.25%	240	65.75%

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Barrier Analysis: discontinuation of ZTS contract is barrier to this report; working on other reporting options for this measure. **Next Steps: Continue activities when reporting capabilities expanded** Continue Objective(s)? ☐ Yes ☒ No
Clinical Program - HEDIS Performance: Diabetes Screening	Measure Description: The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. The goals for 2018 Reporting Year are as follows: Provide and analyze baseline data for this indicator. 	• Track HEDIS measures proactively • Improvement activities include but are not limited to the following: • Make reminder phone calls when it is time for a member's screening • Make follow-up call to ensure member attended appointment, if not, inquire at the reason • Educate members on nearby providers with available appointments • Work with local providers to preemptively call	Monitored by IPLT Committee, UM Committee, QM Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Continue to monitor. IPLT, UM, and QM Committees have been made aware of recent downward trend in performance on this KPI.** **Q 2: (Jan-Mar):** **Continue to monitor. KPI trend line shows no unusual pattern. Overall, we show a 79% of Patient receiving Diabetes service.** **Q 3: (Apr-June):** **NO UPDATE due to discontinuation of ZTS contract. Working on alternate reporting options for this measure.** **Q 4: (July-Sept):** **No update. Continue to work on alternate reporting options for this measure.**

			Diabetic Screening			
			N		Y	
Organization	Has Medic	Current MHP	Patients	% of Patients	Patients	% of Patients
Genesee Health System	N	Blue Cross Complete of Michigan	6	25.00%	18	75.00%
		HAP Midwest Health Plan, Inc.	-	-	5	100.00%
		McLaren Health Plan	18	16.98%	88	83.02%
		Meridian Health Plan of Michigan, Inc	7	11.29%	55	88.71%
		Molina Healthcare of Michigan	21	14.29%	126	85.71%
		NA	11	50.00%	11	50.00%
		UnitedHealthcare Community Plan	1	16.67%	5	83.33%
	Y	Blue Cross Complete of Michigan	1	100.00%	-	-
		McLaren Health Plan	1	25.00%	3	75.00%
		Molina Healthcare of Michigan	1	33.33%	2	66.67%
		NA	3	33.33%	6	66.67%
Lapeer County CMH	N	Blue Cross Complete of Michigan	-	-	1	100.00%
		McLaren Health Plan	3	11.54%	23	88.46%
		Meridian Health Plan of Michigan, Inc	-	-	4	100.00%
		Molina Healthcare of Michigan	2	40.00%	3	60.00%
		NA	2	66.67%	1	33.33%
		UnitedHealthcare Community Plan	-	-	2	100.00%
	Y	McLaren Health Plan	-	-	1	100.00%
Sanilac County CMH	N	Blue Cross Complete of Michigan	-	-	2	100.00%
		McLaren Health Plan	1	25.00%	3	75.00%
		Meridian Health Plan of Michigan, Inc	6	27.27%	16	72.73%
		Molina Healthcare of Michigan	1	50.00%	1	50.00%
		NA	2	66.67%	1	33.33%
		UnitedHealthcare Community Plan	1	5.88%	16	94.12%
	Y	UnitedHealthcare Community Plan	1	100.00%	-	-
St. Clair County CMH	N	Blue Cross Complete of Michigan	1	25.00%	3	75.00%
		HAP Midwest Health Plan, Inc.	2	50.00%	2	50.00%
		McLaren Health Plan	3	23.08%	10	76.92%
		Meridian Health Plan of Michigan, Inc	9	13.24%	59	86.76%
		Molina Healthcare of Michigan	1	20.00%	4	80.00%
		NA	10	50.00%	10	50.00%
		UnitedHealthcare Community Plan	6	22.22%	21	77.78%
	Y	Blue Cross Complete of Michigan	-	-	1	100.00%
		Meridian Health Plan of Michigan, Inc	-	-	3	100.00%
		NA	1	100.00%	-	-
Grand Total			**122**	**19.43%**	**506**	**80.57%**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
	Timeframe: March 1, 2017 to February 1, 2018	members in need of appointments • Develop materials to educate members on importance of screening		**Evaluation: on hold** **Barrier Analysis: Discontinuation of ZTS contract is barrier to this report; working on other reporting options for this measure.** **Next Steps: Continue activities when reporting capabilities expanded** Continue Objective(s)? ☐ Yes ☒ No
Aligned System of Care	The goals for 2018 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 the implementation of the PIHP Clinical Practice Guidelines. • Review Evidence-Based Practices to promote standardized clinical operations across the provider network. • Monitor Employment Services Committee (ESC) activities as all CMHSPs a) develop and address employment targets, b) utilize standardized employment services data and report formats, and c) coordinate share	Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Team members completed their consultation and support activities toward final policy draft, and the policy was sent to the Board for review and approval. CMH Evidence-Based Practices (EBP) fidelity review activities/dates have been identified and placed on the committee schedule for monitoring and share-and-learn. In addition, Team members reviewed the current EBP list and drafted an attachment document for the Clinical Practice Guidelines policy. Behavioral Health**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
		and learn opportunities as they work toward their respective employment targets. • Identify and promote aligned network practices in utilizing the Care Connect 360 system.		**Treatment Encounter Data Set (BH-TEDS) pilot reports have been generated to help inform the Employment Services Committee (ESC) launch scheduled for 2Q.** **Discussions are ongoing with CMH utilization of Care Connect 360, in addition to monitoring Medicaid Health Plans/PIHP care integration work group's use of Care Connect 360 for joint care planning and intervention.** **Q2: (Jan-Mar):** **Clinical Practices Guidelines discussed in terms of EBP fidelity review updates; also discussed the addition of Adolescent Peer Supports (St. Clair) and Parent-Child Interaction Therapy (GHS) and their potential utility across all CMH affiliates.** **Developed EBP tickler to track fidelity review activities; LOCUS MiFAST review opportunity was discussed; also reviewed recent MiPractices EBP article published in CMHJ in connection to transdisciplinary clinical skills.** **Developed plan to reactivate ESC per February launch meeting.**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Sanilac conducted a share-and-learn on its use of CC360 as a systems improvement tool; discussion also advocated for each CMH affiliate to train all case holders in using CC360. **Q 3: (Apr-June):** **Three practice areas have been identified for annual assessment** **Reviews pending receipt as per their respective fidelity review schedule** **ESC meeting scheduled for July Quarterly contract monitoring implementation reports have been reviewed to help facilitated member discussion. Access to CPGs have been monitored and EBP fidelity activities have been taking place; CMHs vary in their CC360 implementation priorities and activities but all are utilizing CC360; ESC is active per its annual plan** **Q 4: (July-Sept):** **Annual CPG monitoring study was completed (ACT, DBT, IMH); no substantive practice updates identified, and current practices are demonstrating effectiveness and fidelity; recommendations to continue.**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Lapeer and St. Clair MIFAST reports on DBT were presented for share-and-learn regarding fidelity and implementation improvement. Lapeer and Sanilac are developing employment targets, scheduled for FY 19 implementation; St. Clair has identified its employment targets; GHS has elected not to identify employment targets, citing that this is not a part of its subcontracted services. Lapeer and St. Clair are utilizing the IPS EBP format, and Sanilac plans to adopt this report format for FY 19; GHS has elected not to adopt the IPS format, citing that this is not a part of its subcontracted services. Share -and-learn discussion took place regarding the September BHDDA Competitive Employment Meeting; field successes with MRS collaborations were noted along with a new I/DD employment planning tool. **The CC360 service plan and contact note functions used by the MHP/PIHP/CMH integrated care project were discussed, noting**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				successes and challenges using these functions; feedback was given to the PIHP project representative. **Evaluation: progress toward all goals; IPLT annual planning discussion also took place.** **Barrier Analysis: no barriers identified.** **Next Steps: continue per annual plan.** Continue Objective(s)? ☒ Yes ☐ No
Healthcare Integration / Care Coordination	The goals for 2018 Reporting Year are as follows: Align network healthcare integration / care coordination processes for persons served to ensure quality and safety of clinical care and quality of service.	• Implement Joint Care Management Processes. Continue collaboration between entities (PIHP / Medicaid Health Plans) for the ongoing coordination and integration of services. • Follow Up Hospitalization (FUH) reports for Mental Illness within 30 days. The percentage of discharges for members 6 years of age and older who	Tom Seilheimer Staff TBD Improving Practices Leadership Team (IPLT)	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Recent Improving Practices Leadership Team (IPLT) feedback informed an inaugural set of shared service protocols.** **Joint care management activities and reports have been presented and discussed at Improving Practices Leadership Team (IPLT).** **Improvement feedback given thus far has focused on the fact that CMHs are meeting their performance targets.** **Q2: (Jan-Mar):**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
		were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, and intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 days.		**The first of the two work group protocols (diabetes screening) was discussed in detail and members reported back to their management teams for discussion.** **Reports were reviewed, and favorable trends were noted; no other input was given.** **Q 3: (Apr-June): Monitoring reports have been shared and discussed; reminders have been conveyed regarding project tasks and completion dates; CMH reps have expressed no questions or concerns.** **Q 4: (July-Sept): Collaborative activities were discussed, with per-case and case management systems improvement suggestions offered for consideration; the standardized goals/objectives reference document was discussed and sent to CMH representatives to help them more clearly understand the treatment role of their MHP colleagues. The FUH reports are deactivated.** **Evaluation: progress achieved toward the first goals and the second goal was deactivated.**

<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></td><td></td><td>Barrier Analysis: none identified.

Next Steps: continue per annual plan.

Continue Objective(s)?
☒ Yes ☐ No</td></tr>
<tr><td>Home & Community Based Services</td><td>The goals for 2018 Reporting are as follows:
Monitor network implementation of the Home and Community Based Services transition to ensure quality of clinical care and service.

<table>
<tr><th></th><th>Second CAP Request</th><th>Second CAP Received</th><th>Second CAP N/A</th><th>Final CAP Approved</th><th>CMH Site Visits/Desk Audits</th><th>Final Approval</th></tr>
<tr><td>HSW Non-Residential</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Genesee</td><td>234</td><td>218</td><td>16</td><td>218</td><td>218</td><td>89</td></tr>
<tr><td>Lapeer</td><td>23</td><td>13</td><td>10</td><td>13</td><td>13</td><td>12</td></tr>
<tr><td>Sanilac</td><td>46</td><td>37</td><td>9</td><td>37</td><td>37</td><td>37</td></tr>
<tr><td>St. Clair</td><td>23</td><td>18</td><td>5</td><td>18</td><td>18</td><td>6</td></tr>
<tr><td>PIHP Total</td><td>326</td><td>286</td><td>40</td><td>286</td><td>286</td><td>144</td></tr>
<tr><td>HSW Residential</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Genesee</td><td>128</td><td>97</td><td>31</td><td>97</td><td>97</td><td>0</td></tr>
<tr><td>Lapeer</td><td>5</td><td>4</td><td>1</td><td>4</td><td>4</td><td>4</td></tr>
<tr><td>Sanilac</td><td>12</td><td>9</td><td>3</td><td>9</td><td>9</td><td>6</td></tr>
<tr><td>St. Clair</td><td>66</td><td>59</td><td>7</td><td>59</td><td>59</td><td>0</td></tr>
<tr><td>PIHP Total</td><td>211</td><td>169</td><td>42</td><td>169</td><td>169</td><td>10</td></tr>
</table>

<table>
<tr><th colspan="3">Heightened Scrutiny Cases</th></tr>
<tr><th></th><th>HSW Non-Residential</th><th>HSW Residential</th></tr>
<tr><td>Genesee</td><td>32</td><td>140</td></tr>
<tr><td>Lapeer</td><td>5</td><td>17</td></tr>
<tr><td>Sanilac</td><td>0</td><td>22</td></tr>
<tr><td>St. Clair</td><td>1</td><td>11</td></tr>
<tr><td>PIHP Total</td><td>38</td><td>190</td></tr>
</table>
</td><td>Monitor the following elements to ensure Home and Community Based Services (HCBS) compliance by providers:
• Number of Providers required to submit a revised/Second CAP per individual
• Number of providers who submitted a second (revised) CAP per individual
• Number of individuals N/A due to death, moved from facility, or initial CAP was approved.
• Number of providers who have an approved revised CAP per individual
• Number of Individuals needing site visit or desk audit conducted by their CMH</td><td>Tom Seilheimer
Christy Koons

Improving Practices Leadership Team (IPLT)</td><td>Goal Met:
☒ Yes ☐ No

Quarterly Update:
Q 1: (Oct-Dec):
Habilitation Support Waiver (HSW) corrective action plans from residential providers have been reviewed.
Notifications to residential providers on approval or disapproval of their corrective action plans will begin in late December.
Revised HSW corrective action plans from non-residential providers are still being received.
Review of revised non-residential corrective action plans has been completed for those received. Notification to providers on approval or disapproval of their revised corrective action plans will begin in late December.
The B3 survey closed on December 15, 2017. Data analytics to determine</td></tr>
</table>

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
	<table><tr><th></th><th>Out of Compliance</th><th>Heightened Scrutiny Cases</th></tr><tr><td>B3 Survey</td><td></td><td></td></tr><tr><td>PIHP Total</td><td>377</td><td>100</td></tr></table>	• Number of providers who are determined Heightened Scrutiny cases by Michigan Department of Health and Human Services (MDHHS)		**HCBS compliance for the B survey will begin in January.** **Numbers are pending.** **Q2: (Jan-Mar):** **An HCBS Update was given regarding the Heightened Scrutiny Resurvey Process, the Provisional Survey Process for New Providers, and the Corrective Action Plans. Members will take this information, including applicable start and due dates, and the upcoming MDHHS site review.** **Q 3: (Apr-June):** **No change to the numbers from previous months. State transition plan has not been approved waiting on approval from CMS. B3 survey completion results: 92% Participant Surveys completed for R10, 91% Provider Surveys completed for R10, 6 out of 10 regions were in the 90's. MDHHS is pursuing a "good faith effort" towards the March 2019 HCBS deadline.** **Q 4: (July-Sept):** **Numbers were updated to reflect the current CAPs, Site visits/Desk Audits conducted by the CMHs and the Final CAP**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Approval. All four CMHs are working on their Site visits and/or desk audits and will return an attestation to Region 10 when they are complete. B Survey will be coming soon per the State leads meeting, numbers were updated reflecting what the state report has. **Evaluation: progress toward all goals.** **Barrier Analysis: none identified.** **Next Steps: continue per implementation plan.** Continue Objective(s)? ☒ Yes ☐ No
Event Reporting (Critical Incidents, Sentinel Events & Risk Events)	The goals for FY2018 Reporting are as follows: To review and monitor the safety of clinical care.	• Review critical incidents to ensure adherence to data and reporting standards and to monitor for trends to improve system of care. • To provide sentinel event monitoring and analysis and ensure follow-up as necessary.	Tom Seilheimer Sentinel Event Review Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Sentinel events submitted have been reviewed and brought to disposition.** **Monthly CI aggregate reports have been reviewed, and a quarterly report format has been developed to enhance tracking and analysis of trends.** **Monitoring, analysis and follow up activities have been completed as-necessary.**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Q2: (Jan-Mar): Reviewed monthly CI aggregate and detail reports; reviewed 1Q longitudinal report. Follow-up inquiry to CMH Affiliate completed to R/O service system issues. Sentinel Events reported and reviewed as per policy procedure; discussions have contributed to draft clinical advisories pertaining to aspiration events and Rescue Breathing/CPR, to be disseminated by the Medical Director during 3Q. **Q 3: (Apr-June): Reviewed monthly CI aggregate and detail reports, no need for follow up; reviewed second quarter CI report, with no systems issues or actions identified Monitoring of current cases are proceeding according to policy; no final findings and systems improvement activities yet to report; follow up final-drafts of two clinical advisories have been completed by the medical director, and they will be formatted for distribution, pending the medical director**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				generated the list of appropriate addresses **Continuing activities per annual plan, including current SEs monitoring / follow up activities** **Q 4: (July-Sept):** **EMT follow-up monitoring task was completed and ruled-out any systems issues; 4Q monitoring identifies adherence to data and reporting standards as well as no issues with systems of care.** **No sentinel events were received for September or for the prior two months; SE follow-up on two St. Clair SEs were completed in July.** **Evaluation: progress achieved toward all goals.** **Barrier Analysis: none identified.** **Next Steps: continue per annual plan.** Continue Objective(s)? ☒ Yes ☐ No
Employment Services	The goals for FY2018 Reporting are as follows: To monitor and advise on Employment Services activities as the CMHSPs	• Develop and address employment targets, • Utilize standardized employment	Tom Seilheimer Employment Services Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Developmental work continues to fully relaunch committee plan.**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
		services data and report formats, • Coordinate share and learn opportunities as they work toward their respective employment targets.		**CMH members have been identified.** **Pilot reports have been generated.** **Employment targets will be discussed as a primary task of the new membership. In the interim, team members have been providing as needed oversight and leadership to employment issues and topics.** **Q 2: (Jan-Mar):** **CMH employment targets discussed in connection to the most recent BH-TEDS reports.** **ESC members endorsed the FY quarterly and Rolling CY report formats; also agreed to focus on FT and PT employment and wage categories.** **ESC will meet bi-monthly; also completed a share-and-learn on DB101.org and the BHDDS/MRS MOU work group activities; also identified shared interests in responding to Veterans employment issues.** **Q 3: (Apr-June):** **June meeting had to be rescheduled to 7/06/18** **Committee activities are proceeding according to annual plan** **Q 4: (July-Sept):**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Lapeer and Sanilac are developing employment targets, scheduled for FY 19 implementation; St. Clair has identified its employment targets; GHS has elected not to identify employment targets, citing that this is not a part of its subcontracted services **Lapeer and St. Clair are utilizing the IPS EBP format, and Sanilac plans to adopt this report format for FY 19; GHS has elected not to adopt the IPS format, citing that this is not a part of its subcontracted services.** **Share -and-learn discussion took place regarding the September BHDDA Competitive Employment Meeting; field successes with MRS collaborations were noted along with a new I/DD employment planning tool.** **Evaluation: progress achieved toward all goals.** **Barrier Analysis: none identified.** **Next Steps: continue per annual plan.** 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>Michigan Mission Based Performance Indicator System (MMBPIS)</td>
<td>The goals for FY2018 Reporting are as follows:
The goal is to attain and maintain performance standards as set by the MDHHS contract.
<table>
<tr><th></th><th>FY17 Q4</th><th>FY18 Q1</th><th>FY18 Q2</th><th>FY18 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>100%</td><td>99.51%</td><td>100%</td><td>99.69%</td></tr>
<tr><td>1.2 Adults</td><td>99.92%</td><td>99.83%</td><td>99.75%</td><td>100%</td></tr>
<tr><td colspan="5">Ind. 2 – Percentage of new persons receiving a face-to-face assessment with a professional within 14 calendar days of non-emergency request for service. Standard = 95%</td></tr>
<tr><td>2 PIHP Total</td><td>97.87%</td><td>98.47%</td><td>98.99%</td><td>99.23%</td></tr>
<tr><td>2.1 MI-Children</td><td>100%</td><td>100%</td><td>99.29%</td><td>98.92%</td></tr>
<tr><td>2.2 MI-Adults</td><td>100%</td><td>100%</td><td>99.55%</td><td>100%</td></tr>
<tr><td>2.3 DD-Children</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>2.4 DD-Adults</td><td>100%</td><td>100%</td><td>100%</td><td>98.39%</td></tr>
<tr><td>2.5 SUD</td><td>95.70%</td><td>96.64%</td><td>98.41%</td><td>98.79%</td></tr>
<tr><td colspan="5">Ind. 3 – Percentage of new persons starting any needed on-going service within 14 days of non-emergent face-to-face assessment with professional. Standard = 95%</td></tr>
<tr><td>3 PIHP Total</td><td>98.83%</td><td>98.94%</td><td>99.05%</td><td>99.30%</td></tr>
<tr><td>3.1 MI-Children</td><td>99.60%</td><td>98.05%</td><td>96.49%</td><td>98.80%</td></tr>
<tr><td>3.2 MI-Adults</td><td>98.68%</td><td>99.37%</td><td>99.53%</td><td>98.81%</td></tr>
<tr><td>3.3 DD- Children</td><td>100%</td><td>98.81%</td><td>100%</td><td>100%</td></tr>
<tr><td>3.4 DD-Adults</td><td>97.96%</td><td>96.61%</td><td>97.83%</td><td>100%</td></tr>
<tr><td>3.5 SUD</td><td>98.48%</td><td>99.38%</td><td>99.65%</td><td>99.80%</td></tr>
<tr><td colspan="5">Ind. 4 – Percentage of discharges from psychiatric inpatient unit / SUD Detox unit that were seen for follow-up care within 7 days. Standard = 95%</td></tr>
<tr><td>4a.1 Children</td><td>98.90%</td><td>97.35%</td><td>100%</td><td>100%</td></tr>
<tr><td>4a.2 Adults</td><td>97.53%</td><td>97.63%</td><td>97.47%</td><td>98.09%</td></tr>
<tr><td>4b SUD</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td colspan="5">Ind. 10 – Percentage of readmissions of children and adults to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less</td></tr>
<tr><td>10.1 Children</td><td>15.45%</td><td>12.00%</td><td>12.50%</td><td>15.15%</td></tr>
<tr><td>10.2 Adults</td><td>12.26%</td><td>15.22%</td><td>12.54%</td><td>15.51%</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>Pattie Hayes

QI Department

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

Quarterly Update:
Q 1: (Oct-Dec): Performance Indicators for FY17 Q4 were submitted to MDHHS on 12/26/17. The PIHP met the set performance standards for every PI except Ind. 10 Children (15.45%). Lapeer CMH did not meet the performance standard for PI 3 – DDA, PI 10 – Children or Adults. Sanilac CMH did not meet the performance standard for PI 10 – Children. Corrective Action Plans have been received.
Q 2: (Jan-Mar): Performance Indicators for FY18 Q1 were submitted to MDHHS on 3/29/18. The PIHP met the set performance standards for every PI except Ind. 10 - Adults (15.22%). GHS did not meet the set performance standard for Ind. 10 – Adults. Lapeer CMH did not meet the set performance standard for Ind. 3 DD – A. Sanilac CMH did not meet the set performance standard for Ind. 3 MI-C and Ind. 10 – Adults. St. Clair CMH did not meet the set</td>
</tr>
</table>

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				performance standard for Ind. 3 MI-C and DD-A, and for Ind. 10 - Adults. Corrective Action Plans and Root Cause Analyses have been received. **In January, the PI report for Q4 was reviewed by the QMC, Region 10 CEOs Meeting, and PIHP Board during the month.** **The PI workgroup resumed meeting in March to discuss any PI issues with 2nd Q data. The next meeting is 4/10.** **Q 3: (Apr-June):** **PI workgroup met on 4/10. 2nd quarter Performance indicators were submitted to the state on 6/28/18. The PIHP met the set performance standard for all indicators. Ind. 3 – Lapeer CMH did not meet standard for MIC population breakout; St. Clair CMH did not meet set standard for both MIC and DDA population breakouts. Ind. 4a – Sanilac CMH did not meet set standard for adult population. Ind. 10 – Lapeer CMH did not meet set standard for children population. Corrective Action Plans / Root Cause Analyses have been received for any**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				indicators not meeting set standard. **Q 4: (July-Sept):** **3rd quarter PIs were submitted to MDHHS on 9/25. The PIHP met set performance standards for all indicators except #10 for both populations – adult and children. Ind. 2 – Lapeer CMH did not meet the set standard for the DD-A population. Ind. 3 – St. Clair did not meet the set standard for the MI-A population. Ind.10 – GHS did not meet the set standard for either adult or child population; Sanilac CMH did not meet the set standard for children. Corrective Action Plans / Root Cause Analyses have been received for any indicators not meeting the set standard.** **Evaluation: Focus is needed on implementing provider corrective actions, so all set performance standards are met.** **Barrier Analysis: none identified** **Next Steps: continue per plan** Continue Objective(s)? ☒ Yes ☐ No

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
Members' Experience	The goals for FY2018 Reporting are as follows: Complete the member satisfaction survey by August 2018.	• Conduct regional consumer satisfaction survey • Conduct MDHHS annual consumer satisfaction survey • Develop interventions to address areas for improvement based on FY2018 member satisfaction survey	QI Department Quality Management Committee (QMC)	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1 (Oct-Dec):** **The QMC worked on the RSA survey administration which took place in early December. Data was submitted to PIHP SUD Coordinator who completed region's report. The regional Customer Satisfaction survey is completed annually with survey administration usually occurring during the summer months.** **Q 2: (Jan-Mar):** **The Regional Satisfaction survey will be conducted in the summer. Kathy Haines reported at the Outcomes conference that the MDHHS consumer satisfaction survey is not scheduled at this time.** **Q 3: (Apr-June):** **The Customer Satisfaction survey process has begun using the same methodology as previous year; survey will be administered during July with all data due to PIHP by end of Aug. This year SUD surveys will be completed in same manner as CMH surveys. Kathy Haines reported**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				(June Outcomes Conference) that the state consumer satisfaction survey is still under consideration. **Q 4: (July-Sept): Customer Satisfaction surveys were administered during the month of July; the annual Customer Satisfaction report was reviewed at September's QMC meeting. No areas for improvement were noted. The MDHHS consumer survey continues to be on hold per MDHHS.** **Evaluation: Progress** **Barrier Analysis: None identified** **Next Steps: Continue per plan** Continue Objective(s)? ☒ Yes ☐ No
State Mandated Performance Improvement Projects (PIP)	The goals for FY2018 Reporting are as follows: Identify 2 PIP projects that meet MDHHS standards: Improvement Project #1 Behavioral and Physical Health Care Integration - The proportion of SMI adult Medicaid consumers identified with select cardiovascular risk conditions that had at least one reported encounter to the State's data warehouse for a medical service to treat a cardiovascular condition. Replaced with new PIP #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.	• Health Services Advisory Group (HSAG) report on Performance Improvement Project (PIP) interventions and baseline • Performance Improvement Project (PIP) status updates to Quality	Tom Seilheimer Quality Management Committee (QMC)	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec): Re-measurement 3 data set is in development as per project's time frame for both Performance Improvement Projects (PIPs).** **Analyses were scheduled for completion by end of**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
	Improvement Project #2 The goal of this PIP is to ensure that adult consumers with schizophrenia or bipolar disorder who are taking an antipsychotic medication are receiving necessary and relevant diabetes screenings (specifically glucose or HbA1c screenings) related to mental health medicines prescribed. This study topic aligns with the HEDIS measure "Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications."	Management Committee • QMC Quality Management Committee to consider selection of Performance Improvement Project (PIP) projects aimed at impacting error reduction, improving safety and quality.		**1Q. Some issues with the Zenith reports so data analyses not yet completed. Discussions are pending receipt further communiques from Michigan Department of Health and Human Services (MDHHS)** **Q 2: (Jan-Mar): Re-measurement 3 data findings/progress were discussed in connection to updated local QI plans. CMHs completed and shared their local QI plan evaluation and updates for FY 2018 regarding both performance improvement projects. The list of required performance improvement projects (PIPs) has been received from MDHHS; discussions have begun regarding selection/process.** **Q 3: (Apr-June): PIP activities have been completed as-planned to-date; continue new PIP** **Q 4: (July-Sept): A new PIP #1 (Tobacco Cessation) was selected and approved; PIP writeup was sent to HSAG in July and resubmitted per HSAG request at the end of August with additional information.**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Baseline tasks are pended to the current Calendar Year, and interventions are pended to the Root Cause Analysis, in part linked to the baseline findings. **Evaluation: Progress** **Barrier Analysis: none identified** **Next Steps: Continue per plan** Continue Objective(s)? ☒ Yes ☐ No
External Monitoring Reviews	The goals for FY2018 Reporting are as follows: To monitor and address activities pertaining to the PIHP HSW Program Corrective Action Plan: a) Q.2.3. (ensure non-licensed, non-verified providers meet required qualification) b) Q.2.4. (ensure support and service providers receive required training)	• QMC members will follow up and report monthly on each CMHSPs follow up activities to ensure compliance with the MDHHS HSW requirements	Quality Management Committee (QMC)	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **At the November QMC, CMHs reported on actions taken in each system to ensure compliance with the HSW QIPs. R10 continues to request new enrollment packets for HSW; the PIHP is required to keep our HSW slots filled to at least 95% per state. Conference call with MDHHS was held in December to discuss a few questions regarding the HSW QIP submission; result was additional information submitted. Awaiting final report from MDHHS.** **Q 2: (Jan-Mar):**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Received final QIP report from MDHHS; follow-up questions to be posed regarding results. Each CMH has reported on follow-up activities implemented at each affiliate. MDHHS notified Region 10 of the upcoming site review in June; the focus is on the waiver programs and SUD review. **Q 3: (Apr-June):** **For the QIP reviewed in October 2017, MDHHS issued a revised report which indicates that the PIHP is compliance for Q.2.4 however not in full compliance for Q.2.3; this has been forwarded to MDHHS Contract Department. The MDHHS FY18 full Site Review took place from June 11 – June 28. Findings discussed at the Exit Conference indicate that the region was in full compliance for both Q.2.3 and Q.2.4 for the FY18 site review. MDHHS commended the region for the tremendous amount of work to come into full compliance in this area.** **Q 4: (July-Sept):** **MDHHS final HSW Site Review report indicated full compliance in this area for the region.**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Evaluation: Progress **Barrier Analysis: None identified.** **Next Steps: Continue per plan** Continue Objective(s)? ☒ Yes ☐ No
Monitoring of Quality Areas	The goals for FY2018 Reporting are as follows: To explore and promote quality and data practices within the region.	• Monitor critical incidents • Review ICDP reports / KPIs and explore opportunities for regional application • Monitor emerging quality and data initiative / issues and requirements • Monitor and address implementation of the Bonus System Performance Indicators	Quality Management Committee (QMC)	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Critical incident reports are monitored monthly. The QMC has reviewed KPI reports; questions on report results have been forwarded to ZTS for resolution. MDHHS sent an 11/2/17status update on BH TEDS; Region 10 had 98.12% complete for combined MH & SUD (the highest in the state), with 99.07% for MH and 95.66% for SUD. Region 10 received the state report on FY17 FUH performance and requested additional detail from MDHHS: reviewed the FY18 performance bonus information with the committee.** **Q 2: (Jan-Mar):** **Critical Incident reports are monitored monthly. ICDP reports have been**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				reviewed and discussed with follow-up questions posed to ZTS. Service code information has been disseminated to the region. Monthly reports have been shared with the CMHs regarding encounter timeliness. The MHP/PIHP Workgroup determined that the first of two state performance metrics is the Diabetes screening protocol. Care Coordination Plan meetings have been ongoing; enhanced FUH weekly reports have been developed to bring efficiencies to process. Q 3: (Apr-June): Discussed UNC reports to review process. Critical incident reports are reviewed monthly; ZTS contract was terminated so ICDP reports no longer exist; discussed ongoing data issues including FUH weekly reports and how to improve the data. Discussed BH-TEDS updates and the excellent completeness percentage for Region 10, the 6-month UNC reports, Hospital HRA changes, and requested reports for Parity Project. Q 4: (July-Sept):

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Critical Incident reports are monitored monthly. ICDP reports are no longer available; working with PCE to have CC360 data in MIX for report development. BH-TEDS reports from the state continue to be excellent and are shared with QMC as received. Also discussed were interim MUNC report; Hospital HRA follow-up and process to ensure NPI submitted correctly in encounters; Parity report requests. FUH report discussions regarding improvements in timeliness of reporting were ongoing throughout quarter. **Evaluation: Progress** **Barrier Analysis: none identified** **Next Steps: Continue per plan** Continue Objective(s)? ☒ Yes ☐ No
Financial Management	The goals for FY2018 Reporting are as follows: To promote sound fiscal management of the region.	• Finalize new funding allocation and run parallel payment reports • Transition to a risk-based payment	Richard Carpenter Finance Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Funding allocation is in the review stage. We produced month by**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
		methodology effective 10/1/18 • Develop target percent ranges for service administration and managed care administration by 10/1/18 • Develop target service code rates for 5 service codes in each of the four PIHP funding streams (SPB3, HSW, HMP, and Autism by 10/1/18		**month comparisons of PEPM method to new allocation method for review by the CFO group. Recommendation for a managed care administration rate range for the CMHSPs around 2% but not to exceed 2.4%** **Service admin rates will be discussed further now that managed care admin rate has a recommendation.** **Service rates by code is waiting for state-wide data to become available from MDHHS.** **Q 2: (Jan-Mar):** **Payment Methodology – shared the payment comparison with the CMHSP CFOs. Data has been gathered and transmitted to Milliman for the funding allocation analysis.** **Admin Cost – Managed care % target set at 2-2.4%. Discussion about CMHSPs using a consistent methodology for split of administration between service and managed care. Discussion of service cost admin will be back on the agenda for April Meeting.** **Service rates by code analysis is pending the availability of that data**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				from MDHHS. This will be back on the agenda for April Meeting. **Q3: (Apr-June):** **Received the data from Milliman. The report output will be reviewed at the July Finance meeting. Updated FY17 Service cost percentages by funding source were reviewed by CMHSP, including rates with/without GHS to analyze weighting effect on the overall Region 10 percent. Discussed a potential goal / target percent. Further discussions will be held in July meetings.** **FY17 service code rates were reviewed. Cost per code rates for Traditional Medicaid and HMP were reviewed comparing Region 10 to Statewide, and Statewide less Detroit Wayne. Cost/code were also presented for each PIHP Region. Additional review / discussion will be help in the July meeting.** **Q 4: (July-Sept):** **Work continues on finalizing new allocation and running the parallel payment reports. The report output derived from the data received by Milliman will be reviewed**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				at the October Finance meeting, as September Meeting is joint CEO/CFO Meeting to discuss FY2019 Budget. **- The transition to a risk-based payment methodology will occur after running the above parallel payment reports for several months to assure the methodology will give desired result. This will delay implementation until after 10/1/18.** **- The Service Cost Administration target was approved by the QAPIP Finance Committee at an administration target not to exceed 11%. The Managed Care Administration target percentage range of 2% and no higher than 2.4% was approved by the QAPIP Finance Committee in the December 2017 meeting.** **- Autism was selected as one the service code rate to review in detail of the 5 service codes. The Autism rates were received from MDHHS and sent to the Finance Directors on August 18. Further service code rate discussion will be tabled until the**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				October QAPIP Finance Meeting for reason noted above. **Evaluation: Progress Continues toward all goals.** **Barrier Analysis: None at this time.** **Next Steps: Per annual plan. Will Carryover the first, second and fourth goals to the FY19 annual plan. The third goal was completed FY18.** Continue Objective(s)? ☒ Yes ☐ No

Utilization Management	Ensure that monthly regional service utilization reports are generated (10/1/17 – 9/30/18).	• Call for UM reports to be generated by the PIHP affiliates for presentation at committee
		  • Crisis Services, including psychiatric inpatient
		  • Other community-based services (Home-Based Services, Assertive Community Treatment, Targeted Case Management / Supports Coordination,
			Tom Seilheimer
			
			Utilization Management (UM) Committee
				Goal Met:
				☒ Yes ☐ No
				
				Quarterly Update:
				Q 1: (Oct-Dec):
				Scheduled UM reports are being generated and reviewed. These activities are taking place alongside the activities of the Utilization Management Redesign Work Group.
				No new services have been identified during 1Q.
				The number of applicable clinical populations and DM capacity for case-finding varies across CMH affiliates, and this is being studied and discussed by the committee. These

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
		Behavioral Health Treatment) • As-selected new services implementation (e.g. children's prevention services, complex case management) • Evaluate reports per committee review / discussion of findings, trends, potential systems improvement opportunities		**activities are taking place alongside the activities of the Utilization Management Redesign Work Group.** **Q2 (Jan-Mar): Monthly UM (crisis) reports have been generated and reviewed.** **Quarterly (community-based services UR) reports have been generated and reviewed.** **No new services have been identified; focus continues ensuring current UR activities are taking place and being reported.** **Favorable trends are identified in crisis services. Delegated UR activities identify adherence to service standards as well as evidence of identifying and correcting for overutilization and underutilization.** **Q 3: (Apr-June): Reviewed, with no concerning trends noted.** **A new service has been identified: intensive crisis stabilization services for children; GHS and SCCCMH are taking lead in report development** **No systems issues were revealed to warrant systems improvement opportunities**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Q 4: (July-Sept): Monthly crisis services utilization reports have been reviewed, noting favorable quarterly trends, e.g. steady rates or marginally decreased rates in IPU utilization. Quarterly community-based reports have been reviewed, noting relatively low rates of outlier issues. Children's crisis services reports have been developed at GHS and St. Clair; St. Clair is still working on report format issues options, and it has been considering adapting the GHS report format; GHS and St. Clair service utilization has been gradually increasing through the quarter as per their respective implementation plans; Lapeer and Sanilac are still working on staffing capacity and therefore have no activities yet to report; there was committee discussion about the priority of developing service capacity as well as the advantage of adapting what final version report format that St. Clair will be using, given the shared EHR platform.

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Monthly and quarterly reports were reviewed, especially noting the above discussion about children's intensive crisis stabilization services implementation. **Evaluation: Progress Continues toward all goals.** **Barrier Analysis: None at this time.** **Next Steps: Per annual plan.** Continue Objective(s)? ☒ Yes ☐ No
Utilization Management	Provide periodic oversight on the use of restrictive and intrusive behavioral techniques, physical management or contact with enforcement use on an emergency basis	• Call for Behavioral Treatment Plan Review Committee (BTPRC) reports to be generated by the PIHP affiliates for presentation at committee • Evaluate reports per committee review / discussion of findings, trends, potential systems improvement opportunities, adherence to standards	Tom Seilheimer Utilization Management (UM) Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Behavioral Treatment Plan Review Committee (BTPRC) reports are being generated by the CMHs and reviewed by the committee.** **The committee identifies (favorably) extensive use of positive behavior supports, appropriate use of behavioral techniques, and monitoring medication for behavior.** **Q2: (Jan-Mar):** **Reports have been generated and reviewed; members have also been**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				informed about the new BTPRC fidelity program from BHDDA/MiPractices. No affiliate or regional systems issues have been identified. **Q 3: (Apr-June):** **Reports submitted with no service delivery issues identified. That said, one advisory was offered to Sanilac regarding staff documentation of duration of PM; and another advisory was offered to St. Clair regarding the erratic documentation of PM duration by one of its out-of-region ASD providers.** **Q 4: (July-Sept):** **Quarterly reports were submitted in August** **No service delivery issues were identified; ongoing discussions have taken place regarding the BHDDA/MiPractices initiative on BHT training and fidelity reviews, thus far planned for FY 19.** **Evaluation: progress achieved toward all goals.** **Barrier Analysis: none identified.** **Next Steps: continue per annual plan.** Continue Objective(s)? ☒ Yes ☐ No

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
Utilization Management	Conduct Utilization Review (per revisions contingent upon the completion of the UM Redesign Work Group)	• Substance Use Disorder site review audits per Substance Use Disorder Utilization Review Schedule • Targeted case record review of outliers (Home-Based Services, Assertive Community Treatment, Targeted Case Management / Supports Coordination, Behavioral Health Treatment). Explore feasible opportunities for additional outlier-based Utilization Review (linked to high-cost and / or high-risk)	Tom Seilheimer Utilization Management (UM) Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Utilization Review schedule was developed for 2Q implementation, but this was deactivated per a recent administrative decision to implement an outlier-based case-finding method. This method is in development.** **Outlier discussion noted above. No activities or discussions noted regarding other UR pursuits.** **Q2: (Jan-Mar):** **A subcommittee work group is near completion of the outlier UR system to replace the current SUD UR system and schedule; implementation is planned for April.** **Addressed at the March meeting per the quarterly reporting cycle; favorable trends were identified regarding adherence to service standards as well as evidence of identifying and correcting for overutilization and underutilization.** **Q 3: (Apr-June):** **Update was given on the development of the SUD structure and**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				implemented throughout Quarter. Quarterly reports received and reviewed; St. Clair issues with higher levels of HBS utilization and current efforts to remedy were noted; GHS and Sanilac issues with a few instances of lower levels of HBS utilization were noted and UR disposition recommendations for case transfer were supported. Quarterly reports have been received and identify few instances of outliers and those identified have presented per-case issues, only **Q 4: (July-Sept):** **SUD Utilization Review has been completed; broad compliance was identified regarding COD diagnostics and treatment, along with effective practices with regard to service engagement and attention to relapse prevention; corrective actions pertained only on a per-case basis; also, two systems improvement observations were made: 1) increase active outreach to primary care to inform and coordinate treatment, especially for those cases involving**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				opiate use issues, and 2) additional attention needs to be directed to MAT cases to ensure active treatment and effective service transition planning. **Evaluation: Progress achieved toward all goals.** **Barrier Analysis: None identified.** **Next Steps: Continue per annual plan.** Continue Objective(s)? ☒ Yes ☐ No
Utilization Management	Promote aligned care management activities across key areas of network operations	• Provide oversight of the semi-annual report process for the two Access sites, ensuring aligned data reporting and evaluation of access site operations (e.g. screening requests, dispositions, referrals, second opinions, customer service standards) • Review and advise on the PIHP denial and appeal processes • Provide oversight of Utilization	Tom Seilheimer Utilization Management (UM) Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Access end of year report reviewed and approved. Progress toward dual site alignment noted. National Council for Quality Assurance application was discontinued, but access sites' second opinion process is being discussed in ad hoc by the Chief Clinical Officer and supervisors to align access second opinion process.** **Q2: (Jan-Mar):**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
		Management activities delegated to the CMH affiliates to ensure consistency of operations and reporting • Behavioral Treatment Plan Review Committee (BTPRC) activities noted in goal 2 • Targeted Utilization Review noted in goal 3		**Scheduled for third quarter, given the report's semi-annual report cycle. This will be addressed in the AMS Semi-Annual Report, thus this item is deferred to third quarter, given that report's semi-annual report cycle. Standardized BTPRC reports regarding committee review activities (e.g. use of emergency PM, medication for behavior, incidents, behavioral plans) have been reviewed and discussed, identifying no committee or service systems issues. Addressed per the quarterly reporting cycle; favorable trends are identified regarding adherence to service standards as well as evidence of identifying and correcting for overutilization and underutilization.** **Q 3: (Apr-June):** **Mid-Year AMS report was reviewed and approved in May; EOY report pending Oversight provided and noted above.** **Favorably low levels of Access second opinion requests noted (report attached)**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Improvement opportunities also identified (attached report recommendations) **Q 4: (July-Sept):** **EOY report is pending per EOY data.** **No activity this quarter on appeals and denial.** **BTPRC reports submitted with no service delivery issues identified.** **Quarterly outlier UR was completed at the September meeting.** **Evaluation: progress achieved toward all goals** **Barrier Analysis: none identified.** **Next Steps: continue per annual plan.** Continue Objective(s)? ☒ Yes ☐ No
Corporate Compliance	Review of 42 CFR 438.608 Program Integrity requirements. 9/30/18	1. Review requirements. 2. Identify and document responsible entities. 3. Identify and document supporting evidence / practice for following requirements. 4. Make recommendations on potential follow up activities.	Corporate Compliance Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Discussion regarding Program Integrity Requirements and upcoming MDHHS contract revisions.** **Documentation regarding compliance with standards initiated and pending further CMH review.**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Q 2: (Jan-Mar): Discussion regarding continuation of Program Integrity Requirements review. Modifications made to shared document to add efficiency and clarify entity roles / responsibilities. MDHHS recently shared MDHHS / PIHP Contract Requirement "draft" changes which will significantly affect this area (not yet finalized) which are under review by the PIHP Compliance Officers Workgroup and MDHHS / PIHP Contract Negotiations Workgroup. **Q 3: (Apr-June): Received MDHHS Contract Amendment – will significantly impact reporting in this area. Discussion regarding Program Integrity updates and MDHHS / PIHP Contract Amendment. CMH / SUD Contract Amendments complete.** **Q 4: (July-Sept): Reviewed draft FY19 Corporate Compliance Plan. Developed Committee Goals for FY19.** **Evaluation: Progress.** **Barrier Analysis: Staff resources for this area.**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Next Steps: Continue activities. Continue Objective(s)? ☒ Yes ☐ No
Corporate Compliance	Enhancement of available training materials across the region. 9/30/18	1. Share resources. 2. Obtain additional resources.	Corporate Compliance Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Discussion regarding Statewide Training Reciprocity. Draft Training Content currently under review by PIHP Corporate Compliance Officers Workgroup (next meeting scheduled for 1/8/18).** **Q 2: (Jan-Mar):** **PIHP Corporate Compliance Officers Workgroup continues to update Training Content (OIG feedback received and will be included). Expectation to have implemented in April of 2018.** **Q 3: (Apr-June):** **Statewide Training Template has been finalized and customized for our PIHP. New training content will be available in new PIHP training system (Relias) for employee training. CMH and SUD Amendments complete for requirement to utilize.** **Q 4: (July-Sept):**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				July: New training content uploaded to PIHP employee training system (Relias) and sent out to employees for completion. **Evaluation: Progress.** **Barrier Analysis: None.** **Next Steps: Continue activities.** Continue Objective(s)? ☐ Yes ☒ No
Corporate Compliance	Maintain policies and procedures which promote compliance with the PIHP Corporate Compliance Plan. 9/30/18	1. Ongoing policy review. 2. Review contract monitoring results. 3. Review PIHP Plan updates. 4. Review MDHHS / OIG recommendations.	Corporate Compliance Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Annual Corporate Compliance Report presented to Regulatory Compliance Committee on 11/17/17 and to PIHP Board on 12/15/17.** **Reviewed FY2017 Contract Monitoring Review Results for Corporate Compliance areas needing improvement.** **Q 2: (Jan-Mar):** **Notified Committee members of "draft" MDHHS / PIHP Contract changes which may significantly affect existing policy / process.** **PIHP / Provider Contract Amendments finalized**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				regarding Provider notification to the PIHP of all OIG inquiries made directly to Providers. 1Q Contract Monitoring Summary Report will be shared at the 5/14/18 meeting. **Q 3: (Apr-June):** **Received MDHHS Contract Amendment – will significantly impact reporting in this area. PIHP process updates pending. CMH / SUD Contract Amendments complete. At this time, there have been no concerns in this area in our Network via contract monitoring – recommendations on program enhancements have been recorded and discussions with Providers occurred. Claims verification activities (e.g. overpayments) review in process.** **Q 4: (July-Sept):** **Provider policy review completed during PIHP annual contract monitoring – plans of correction / recommendations (as applicable) noted.** **Evaluation: Progress.** **Barrier Analysis: Staff resources for this area.**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Next Steps: Continue activities. Continue Objective(s)? ☒ Yes ☐ No
Corporate Compliance	Support complaint reporting requirements (maintain a cohesive strategy for addressing and reporting Corporate Compliance issues). 9/30/18	1. Ongoing review of reporting process.	Corporate Compliance Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec): Clarification provided on monthly reporting requirements.** **Q 2: (Jan-Mar): Complaints have been reported monthly according to requirements. Data has been aggregated into Report format for presentation to the PIHP Board Regulatory Compliance Committee – next meeting scheduled for 5/18/18.** **Q 3: (Apr-June): Received MDHHS Contract Amendment – will significantly impact reporting in this area. PIHP process updates pending. CMH / SUD Contract Amendments complete. Complaint reporting has enhanced in recent months. Ongoing and improved communication with Provider Network in complaint reporting.** **Q 4: (July-Sept):**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Preliminary review of new (draft) OIG annual and quarterly reporting template requirements. **Evaluation: PIHP form use has streamlined process.** **Barrier Analysis: Staff resources for this area.** **Next Steps: Continue activities.** Continue Objective(s)? ☒ Yes ☐ No
Provider Network	Review Gap Analysis Report results by 9/30/18.	1. Review definition of network gap. 2. Review CMH Gap Analysis Reports. 3. Review SUD Network gaps. 4. Review contract monitoring results. 5. Address cultural and linguistic needs of members. 6. Address service capacity concerns (e.g., Autism, Detoxification / Residential).	Provider Network Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Addressed autism service capacity concerns. PIHP Autism Coordinator reviewed regional performance concerns regarding individuals waiting to receive services following an eligibility determination. Draft recommendations to address service gap in place. Preliminary meetings have taken place regarding PIHP issuance of SUD Detoxification / Residential RFP.** **Q 2: (Jan-Mar):** **CMH Gap Analysis Reports and current services gaps identified**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				and reported. Autism service concerns addressed ongoing through the Contract Monitoring process. Follow up on Autism service gap recommendations – Monthly reports shared with Committee regarding standing performance measures and Contract Monitoring Summary. PIHP SUD RFP posted 2/14/18. Bid submissions (9) received 3/29/18. Bid proposals submitted to all Review Committee Members. Preliminary discussions in place regarding potential service gaps / issues as identified by potential under/over utilization of service codes by the UM Re-Design Workgroup. Q 3: (Apr-June): Monthly reports shared with Committee regarding standing autism performance measures. Contract Manager attendance at CMH autism meetings. PIHP SUD RFP bid submissions reviewed by formal Review Committee / PIHP and recommendations presented to PIHP Board in May. Contract Amendments (2) and new

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Contract (1) in place for Residential and Withdrawal Management services. Services expected to begin following Provider follow up on ASAM designations, accreditation and licensing. **Q 4: (July-Sept):** **Monthly reports shared with Committee regarding standing autism performance measures. Ongoing meetings with CMH providers regarding identified autism service gaps and modifications to PIHP performance measures. Providers awarded bids via the February SUD RFP have contracts / amendments in place and referrals / services started. Performance Objectives added to FY19 CMH contracts to specifically address service gaps. Approval of Committee Goals for FY19.** **Evaluation: Progress** **Barrier Analysis: None.** **Next Steps: Continue activities.** Continue Objective(s)? ☒ Yes ☐ No

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
Grievances	Goal: To review and analyze baseline grievance data for this measure.	• 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.	Rebekah Kleinedler Bob Esselink Quality Improvement Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **A small workgroup has been working to update G & A processes for the PIHP, including proposed changes to the EMRs to categorize grievances according to these categories. Once this work is completed, tech requests will be submitted to align grievance categories within the region's three EMRs.** **Q 2: (Jan-Mar):** **Meetings to develop finalized process have been ongoing throughout the quarter. Workgroup is working to finalize policy and notice language. Once all items finalized, tech requests will be submitted for changes to the EMRs.** **Q 3: (Apr-June):** **Group met in May and June to discuss moving forward with this project and the changes needed, both procedural and within the MIX system. Work is ongoing on this project.** **Q 4: (July-Sept):** **A formalized grievance process/procedure was**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				prepared in September to clarify language and definitions across the providers in the region. This will assist in collecting data and more clearly defining trends. Additional tech requests for changes to MIX also completed. **Evaluation: Progress** **Barrier Analysis: moving beyond previous barriers** **Next Steps: Continue activities** Continue Objective(s)? ☒ Yes ☐ No
Appeals	Goal: To review and analyze baseline appeals data for this measure.	• 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.	Rebekah Kleinedler Bob Esselink Quality Improvement Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **A small workgroup has been working to update G & A processes for the PIHP, including proposed changes to the EMRs to categorize appeals. Once this work is completed, tech requests will be submitted to align appeals categories within the region's three EMRs.** **Q 2: (Jan-Mar):** **Meetings to develop finalized process have been ongoing throughout the quarter. Workgroup**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				is working to finalize policy and notice language. Once all items finalized, tech requests will be submitted for changes to the EMRs. **Q 3: (Apr-June):** **Group met in May and June to discuss moving forward with this project and the changes needed, both procedural and within the MIX system. Work is ongoing on this project.** **Q 4: (July-Sept):** **A formalized appeal process/procedure was prepared in September to clarify language and definitions across the providers in the region. This will assist in collecting data and more clearly defining trends. Additional tech requests for changes to MIX also completed to improve data managment.** **Evaluation: Progress Barrier Analysis: moving beyond previous barriers** **Next Steps: Continue activities** Continue Objective(s)? ☒ Yes ☐ No
Credentialing and Privileging	The goal for FY2018 Credentialing and Privileging is as follows: • Provide oversight of the credentialing process and policy to ensure quality of care and service.	• Complete privileging and credentialing reviews and approval process of	Kim Prowse Privileging and Credentialing Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
		Organizational Applications for CMH and SUD Providers. • Maintain policies and procedures on privileging and credentialing inclusive of MDHHS and Medicaid standards.		**The revised P&C policy was disseminated for public comment during Q1. The Policy was taken to the December 2017 QI Committee, CEO Meeting and the Region 10 Board for approval. Additional organizational application was received, reviewed and approved for either provisional or full credentials. Provisional credentials reflect policy update of 150 days while full privileges will be maintained for up to 2-years.** **Q 2: (Jan-Mar):** **Meetings were held in both February and March of 2nd quarter. During that time, all CMHSPs as well as all SUD providers were noted as having full-privileges for their organization. Region 10 has no provisional or probationary providers on the panel. Additionally, all Port Huron Access staff providing clinical screenings were granted full-privileges. There are no provisional or probationary staff within Port Huron Access Department. Flint Access staff are on a cycle to correspond with the GHS credentialing cycle therefor no applications**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				were reviewed during 2nd quarter. There are currently no provisional or probationary staff within the Flint Access Department. **Q3: (Apr-June):** **There was no meeting held in April or June as there were no applications to be reviewed/approved. During the May 17th meeting, one new credentialing application was reviewed for a new Access Staff. Application was approved. One re-credentialing application was reviewed and approved for the PIHP Chief Clinical Officer.** **Q4 (July-Sept): Meetings were held in both July and September. One Access Clinician was approved. The Region 10 Medical Director was approved and the newly contracted SUD provider, Salvation Army was approved and has begun to provide services.** **Discussion regarding process for direct hire Region 10 clinical (Access) staff took place at the September meeting. An activity was added to the P&C overall goal to review and approve**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				applicable Region 10 practitioner applications. FY19 Goal and added activity recommendation was approved by the committee in September. Goal is ongoing for FY19 **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: Continue Activities** Continue Objective(s)? ☒ Yes ☐ No