

REGION

10



QUALITY IMPROVEMENT PROGRAM & WORKPLAN

FY 2018

Region 10 PIHP

Quality Assessment & Performance Improvement Program Description

(October 1, 2017 – September 30, 2018)

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

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

A. Organizational Structure:

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

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

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

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

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

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

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

Resources and analytical support are provided to the QI Program from a number of sources. The Electronic Medical Record software (MIX) contains service data, encounter claims data, and demographic data. CareConnect 360 is a web-based system containing service data (both Behavioral Health and Physical Health) for persons with Medicaid. Integrated Care Delivery Platform (ICDP) is a web-based system for data analytics. The Michigan Department of Health and Human Services (MDHHS) provides downloads of encounter and demographic data regularly and upon request. The PIHP has contractual relationships with Zenith Technology Solutions (ZTS) and TBD Solutions to provide analytic support and training to the PIHP. The PIHP also has internal data analysts providing analytic support to the organization.

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

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

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

The QI Program includes objectives to serve a diverse membership by reducing health care disparities in clinical areas and by improving the network adequacy to meet the needs of underserved groups. The organization strives to improve quality and safety of clinical care, quality of services, and members' experiences for members with complex health needs including physical and developmental disabilities, severe mental illness, and chronic conditions. Region 10 PIHP conducts a robust cultural and linguistic study annually to identify and develop opportunities for improvement based on findings of the study.

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

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

B. Components and Activities:

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

The PIHP's QI Program includes the following items:

- Design and planning, performance measurement, intervention strategies, and outcome evaluation are the primary components of the PIHP quality improvement process. Quality improvement activities are determined by the PIHP's mission, vision, contractual requirements, strategic plan, and historical data for the region. Along with standards of care and markers developed from external data sources (e.g., reports, accreditation standards, state and federal reports), improvement activities occur in response to customer needs, safety of clinical care issues, ethical guidelines, cultural considerations, clinical standards, and good business practices.
- Indicators: the activities, events, occurrences, or outcomes for which data are collected which allows for the tracking of performance and improvement over time. The quality indicators employed are objective, measurable, and based on current knowledge and clinical experience in order to monitor and evaluate key aspects of care and service.
- Performance goals: the desired level of achievement of the standard of care and benchmarks for measuring the best performance for a particular indicator.

C. Roles for Recipients of Service:

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

First, at the Policy-level, of the fifteen PIHP Board members, no less than 1/3 of the membership are recipients of service and/or their family member representatives. This framework provides for direct customer involvement in QI Program policy setting and goal prioritization. Second, the PIHP has designated Consumer Advisory Councils within all counties that provide direct input and feedback on critical program plan and development areas. Third, individuals directly participate on the PIHP's committees and monitoring activities.

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

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

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

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

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

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

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

II. Governing Body Responsibilities

A. Oversight of QI Program:

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

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

B. QI Plan Progress Reports:

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

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

C. Annual QAPIP Review Report:

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

D. Submission to MDHHS:

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

III. Designated Senior Officials:

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

IV. Active Participation of Providers and Customers

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

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

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

V. Performance Measurement

A. State Performance Measures

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

B. Other Performance Indicators

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

C. Clinical and Safety Initiatives

Region 10 PIHP focuses on clinical initiative to improve the safety of clinical care and service provided to the member. HEDIS measures focus on a number of clinical programs to monitor for potential quality of care issues including, All-Cause Readmissions, sentinel events, medication adherence, and care coordination. Region 10 PIHP conducts robust Coordination of Care initiatives, and annually conducts needs assessment studies for SPMI individuals who have multiple medical issues, identifying participants, enrolling them in the Complex Case Management program, and assessing for specific care the member needs.

VI. QI Program Utilization to Assure Achievement of Performance Levels

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

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

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

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

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

VII. Performance Improvement Projects

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

A. Clinical and Non-Clinical projects

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

B. Project topics

Selection of project topics will be based on requirements from MDHHS with a focus on the integration of physical health care data. The need for a specific service, demographic characteristics and health risks and the interest of individuals in the aspect of service to be addressed will also be part of the selection criteria.

C. State- and PIHP-established aspects of care

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

D. Number of projects undertaken during the waiver renewal period

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

Improvement Project #1

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.

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."

VIII. Review and Follow Up of Sentinel Events

A. Ensuring appropriate action

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

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

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

Sentinel Event Review Committee. Following completion of a root cause analysis or investigation, the CMHSP / SUD organizational provider develops and implements either a) a plan of action or intervention to prevent further occurrence of the Sentinel Event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement, and when and how implementation will be monitored or evaluated.

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

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

B. Credentials of reviewers

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

C. Review of Unexpected Deaths

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

D. Immediate Event Notification

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

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

E. Critical Incidents Reporting System

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

F. Risk Events Management

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

IX. Review of Behavior Treatment Plan Review Committee Data

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

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

A. Issues addressed in assessments

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

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

B. Actions resulting from assessments

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

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

C. Evaluation of the effects of actions

Just as the original processes must be evaluated, so do interventions used to increase quality, availability, and accessibility of care. Therefore, all actions taken as a result of assessments will be evaluated periodically. Quality Improvement is never static, and it is an expectation that all evaluation efforts will be examined on an ongoing basis.

D. Incorporation of customers in the evaluation process

Customers are included in the Quality Improvement process, as survey participants, as members of Consumer Advisory Councils, and as members of the PIHP Board. In this way customers are incorporated into the review and analysis of information obtained from quantitative and qualitative methods.

XI. Monitoring of Clinical Protocols & Practice Guidelines

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

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

Adoption Process:

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

Development Process:

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

Implementation:

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

Continuous Monitoring:

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

Evaluation:

Typically, a 30 day public review, comment, and feedback period takes place for any updates and/or changes to the practice guidelines. Evaluation of effective implementation of the practice guidelines is determined via Utilization Management and its case record review process.

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

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

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

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

All PIHP CMHs are required by contract to be accredited by one of the major healthcare or rehabilitation accreditation bodies. Under the established accreditation standards, practitioner licensure, credentialing, staff qualification, and staff training are required. The combination of the requirement that organizational providers be accredited (or demonstrate how they meet accreditation standards) as specified in the PIHP Credentialing and Privileging Policy, along with the staff level specific requirements contained in the PIHP Training Policy affords the PIHP with the capacity to provide assurances that all provider staff (including those not specifically privileged via the credentialing process) meet minimum qualifications for providing specific services and have access to adequate training related to services provided within the PIHP network. Assurances that these criteria are met are documented via the Organizational Credentialing and Enrollment process, as well as via the PIHP Contract Monitoring process. Policies, credentials and documentation concerning these requirements are reviewed during PIHP Contract Management Team audits and during the MDHHS annual site review. This provider requirement is also discussed and reviewed through periodic examination of provider QI Plans and policies that are reviewed and maintained by the PIHP.

XIII. Verification of Medicaid Services

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

- A.** The PIHP has a policy regarding claims verification. An annual plan is developed that outlines the methodology for verification.
- B.** Annually the PIHP submits a report to MDHHS which contains its methodology for verification and its findings from the process, as well as providing any follow up actions that were taken as a result of the findings.

XIV. Utilization Management Program

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

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

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

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

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

- Eligibility Screening, including Psychiatric Hospitalization pre-evaluation;
- Service Authorization
- Utilization Review
- UM Committee: Retrospective Review & Outlier Management
- Development and Maintenance of Standards and Guidelines

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

XV. Provider Network Monitoring

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

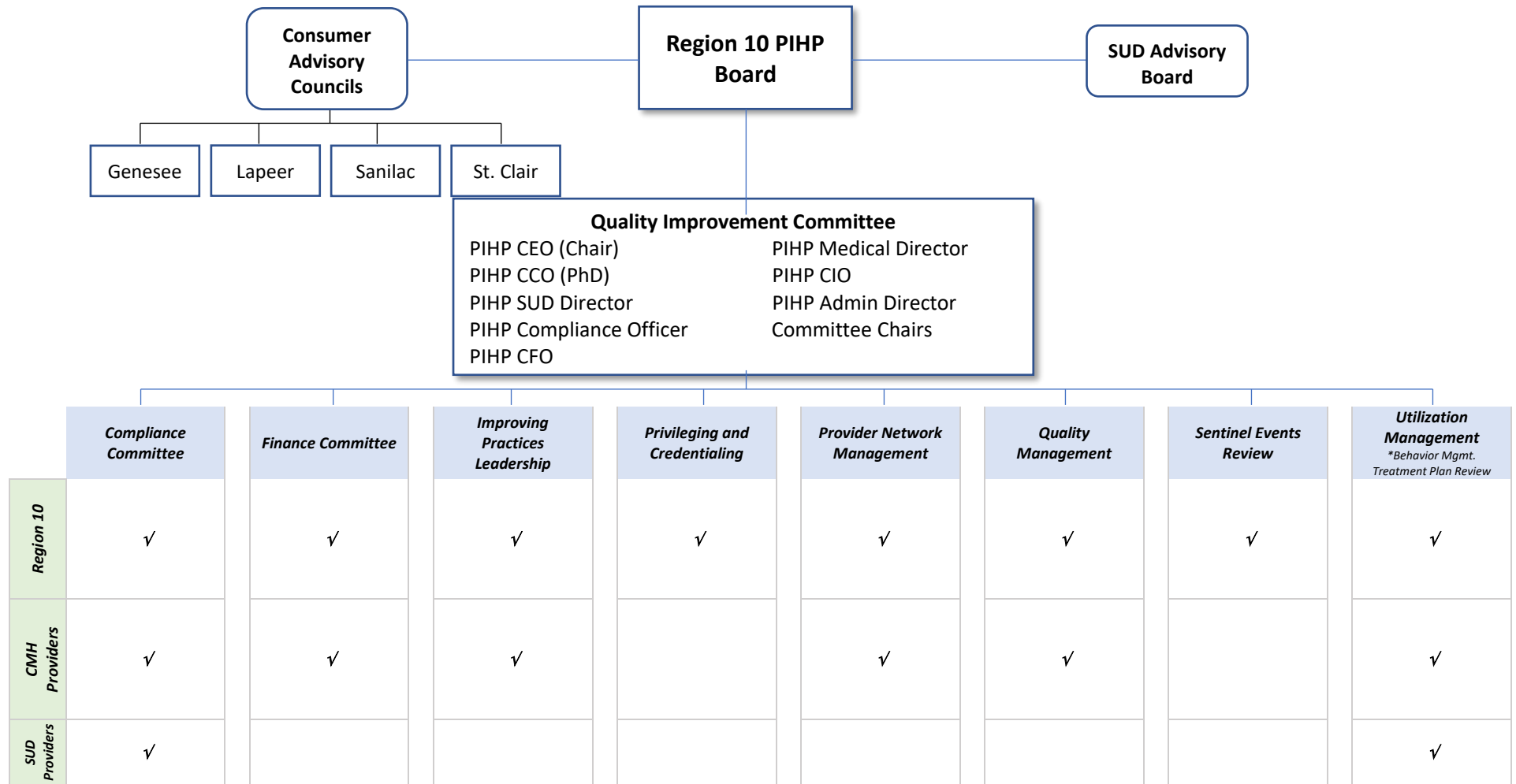
XVI. Special Targeted Monitoring Activities

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

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

S:\Region 10\QAPIP\FY18 Plan and Reports\FY18 QAPIP Program Plans\QAPIP Program Description FY18 10.18.17 FINAL.docx

REGION 10 QAPIP ORGANIZATIONAL STRUCTURE



Quality Management Fiscal Year (FY) 2018 Work Plan (October 1, 2017 – September 30, 2018)

Component	Goals/Timeframe	Planned Activities	Responsible Staff/Department	Status Update
QI Program Structure - Annual Evaluation	<ul style="list-style-type: none"> Submit 2017 QI Program Evaluation to “Quality Improvement Committee” and the Region 10 PIHP Board by December 1, 2017. 	<ul style="list-style-type: none"> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No Quarterly Update: Q 1 (Oct-Dec): Q 2 (Jan-Mar): Q 3 (Apr-June): Q 4 (July-Sept): Evaluation: Barrier Analysis: Next Steps: Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No

Component	Goals/Timeframe	Planned Activities	Responsible Staff/Department	Status Update
QI Program Structure - Program Description	<ul style="list-style-type: none"> Submit 2018 QI Program Description to “Quality Improvement Committee” and the Region 10 PIHP Board by December 1, 2017. 	<ul style="list-style-type: none"> Review the previous year’s QI Program and make revisions to meet current standards and requirements. Include changes approved through committee action and analysis. Include signature pages, Work Plan, Evaluation, Policies and Procedures and attachments. 	Pattie Hayes QI Department QI Program Standing Committees	Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No Quarterly Update: Q 1: Q 2: Q 3: Q 4: Evaluation: Barrier Analysis: Next Steps: Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No

Component	Goals/Timeframe	Planned Activities	Responsible Staff/Department	Status Update
QI Program Structure - Annual Work Plan	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No Quarterly Update: Q 1: Q 2: Q 3: Q 4: Evaluation: Barrier Analysis: Next Steps: Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
QI Program Structure - Policies and Procedures	<ul style="list-style-type: none"> Submit policies and procedures to the “Quality Improvement Committee” and the Region 10 PIHP Board for approval by December 1, 2017. 	<ul style="list-style-type: none"> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No Quarterly Update: Q 1: Q 2: Q 3: Q 4: Evaluation: Barrier Analysis: Next Steps: Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update																																							
Clinical Program - HEDIS Performance: Follow up after Hospitalization for Mental Illness- Child	<p><u>Measure description:</u> 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.</p> <p>The goals for 2018 Reporting Year are as follows: To attain and maintain compliance rate set by MDHHS contract by September 2018.</p> <table border="1"> <thead> <tr> <th colspan="5">FUH Follow Up</th></tr> <tr> <th rowspan="2">Organization</th><th colspan="2">N</th><th colspan="2">Y</th></tr> <tr> <th>FUH Eligible Visits Child</th><th>% of FUH Eligible Visits Child</th><th>FUH Eligible Visits Child</th><th>% of FUH Eligible Visits Child</th></tr> </thead> <tbody> <tr> <td>Genesee Health System</td><td>9</td><td>9.38%</td><td>87</td><td>90.63%</td></tr> <tr> <td>Lapeer County CMH</td><td>-</td><td>-</td><td>11</td><td>100.00%</td></tr> <tr> <td>Sanilac County CMH</td><td>-</td><td>-</td><td>13</td><td>100.00%</td></tr> <tr> <td>St. Clair County CMH</td><td>11</td><td>19.30%</td><td>46</td><td>80.70%</td></tr> <tr> <td>Grand Total</td><td>20</td><td>11.30%</td><td>157</td><td>88.70%</td></tr> </tbody> </table>	FUH Follow Up					Organization	N		Y		FUH Eligible Visits Child	% of FUH Eligible Visits Child	FUH Eligible Visits Child	% of FUH Eligible Visits Child	Genesee Health System	9	9.38%	87	90.63%	Lapeer County CMH	-	-	11	100.00%	Sanilac County CMH	-	-	13	100.00%	St. Clair County CMH	11	19.30%	46	80.70%	Grand Total	20	11.30%	157	88.70%	<ul style="list-style-type: none"> 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 	<p>Andy Graves</p> <p>Monitored by IPLT Committee, UM Committee, QM Committee</p>	<p>Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Quarterly Update: Q 1: Q 2: Q 3: Q 4:</p> <p>Evaluation:</p> <p>Barrier Analysis:</p> <p>Next Steps:</p> <p>Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Clinical Program - HEDIS Performance: Cardiovascular Screening	<p><u>Measure Description:</u> 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.</p> <p>The goals for 2018 Reporting Year are as follows: Provide and analyze baseline data for this indicator.</p> <table border="1"> <thead> <tr> <th colspan="5">Cardiovascular Screening</th></tr> <tr> <th rowspan="2">Organization</th><th colspan="2">N</th><th colspan="2">Y</th></tr> <tr> <th>Patients</th><th>% of Patients</th><th>Patients</th><th>% of Patients</th></tr> </thead> <tbody> <tr> <td>Genesee Health System</td><td>214</td><td>38.28%</td><td>345</td><td>61.72%</td></tr> <tr> <td>Lapeer County CMH</td><td>19</td><td>35.85%</td><td>34</td><td>64.15%</td></tr> <tr> <td>Sanilac County CMH</td><td>16</td><td>32.65%</td><td>33</td><td>67.35%</td></tr> <tr> <td>St. Clair County CMH</td><td>80</td><td>43.96%</td><td>102</td><td>56.04%</td></tr> <tr> <td>Grand Total</td><td>329</td><td>39.03%</td><td>514</td><td>60.97%</td></tr> </tbody> </table>	Cardiovascular Screening					Organization	N		Y		Patients	% of Patients	Patients	% of Patients	Genesee Health System	214	38.28%	345	61.72%	Lapeer County CMH	19	35.85%	34	64.15%	Sanilac County CMH	16	32.65%	33	67.35%	St. Clair County CMH	80	43.96%	102	56.04%	Grand Total	329	39.03%	514	60.97%	<ul style="list-style-type: none"> 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 	<p>Andy Graves</p> <p>Monitored by IPLT Committee, UM Committee, QM Committee</p>	<p>Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Quarterly Update:</p> <p>Q 1:</p> <p>Q 2:</p> <p>Q 3:</p> <p>Q 4:</p> <p>Evaluation:</p> <p>Barrier Analysis:</p> <p>Next Steps:</p> <p>Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Clinical Program - HEDIS Performance: Diabetes Screening	<p><u>Measure Description:</u> 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.</p> <p>The goals for 2018 Reporting Year are as follows: Provide and analyze baseline data for this indicator.</p> <table border="1"> <thead> <tr> <th colspan="5">Diabetic Screening</th></tr> <tr> <th rowspan="2">Organization</th><th colspan="2">N</th><th colspan="2">Y</th></tr> <tr> <th>Patients</th><th>% of Patients</th><th>Patients</th><th>% of Patients</th></tr> </thead> <tbody> <tr> <td>Genesee Health System</td><td>118</td><td>20.31%</td><td>463</td><td>79.69%</td></tr> <tr> <td>Lapeer County CMH</td><td>10</td><td>17.86%</td><td>46</td><td>82.14%</td></tr> <tr> <td>Sanilac County CMH</td><td>10</td><td>20.00%</td><td>40</td><td>80.00%</td></tr> <tr> <td>St. Clair County CMH</td><td>36</td><td>18.46%</td><td>159</td><td>81.54%</td></tr> <tr> <td>Grand Total</td><td>174</td><td>19.73%</td><td>708</td><td>80.27%</td></tr> </tbody> </table>	Diabetic Screening					Organization	N		Y		Patients	% of Patients	Patients	% of Patients	Genesee Health System	118	20.31%	463	79.69%	Lapeer County CMH	10	17.86%	46	82.14%	Sanilac County CMH	10	20.00%	40	80.00%	St. Clair County CMH	36	18.46%	159	81.54%	Grand Total	174	19.73%	708	80.27%	<ul style="list-style-type: none"> 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 	<p>Andy Graves</p> <p>Monitored by IPLT Committee, UM Committee, QM Committee</p>	<p>Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Quarterly Update:</p> <p>Q 1:</p> <p>Q 2:</p> <p>Q 3:</p> <p>Q 4:</p> <p>Evaluation:</p> <p>Barrier Analysis:</p> <p>Next Steps:</p>
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		<ul style="list-style-type: none"> • Work with local providers to preemptively call members in need of appointments • Develop materials to educate members on importance of screening 		Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> 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.	<ul style="list-style-type: none"> • Monitor the implementation of the PIHP Clinical Practice Guidelines. • Review Evidence-Based Practices to promote standardized clinical operations across the provider network. • Monitor ESC activities as all CMHSPs a) develop and address employment targets, b) utilize standardized employment services data and report formats, and c) coordinate share and learn opportunities as they work toward their respective employment targets. • Identify and promote aligned network practices in utilizing the CC360 system. 	Tom Seilheimer Improving Practices Leadership Team (IPLT)	Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> Quarterly Update: Q 1: Q 2: Q 3: Q 4: Evaluation: Barrier Analysis: Next Steps: Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> 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.	<ul style="list-style-type: none"> • Implement Joint Care Management Processes. Continue collaboration between entities (PIHP / MHPs) for the ongoing coordination and integration of services. • Follow-up after hospitalization for Mental Illness within 30 days (FUH). 	Tom Seilheimer Andy Graves Improving Practices Leadership Team (IPLT)	Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> Quarterly Update: Q 1: Q 2: Q 3: Q 4:

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Home & Community Based Services	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><td></td><td>Provider Surveys Received</td><td>Providers Needing CAP</td><td>CAPs Submitted to PIHP</td><td>CAPs Approved by PIHP</td><td>Heightened Scrutiny Cases</td></tr><tr><td>HSW Non-Residential</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Genesee</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Lapeer</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Sanilac</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>St. Clair</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>PIHP Total</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>HSW Residential</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Genesee</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Lapeer</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Sanilac</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>St. Clair</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>PIHP Total</td><td></td><td></td><td></td><td></td><td></td></tr></table>		Provider Surveys Received	Providers Needing CAP	CAPs Submitted to PIHP	CAPs Approved by PIHP	Heightened Scrutiny Cases	HSW Non-Residential						Genesee						Lapeer						Sanilac						St. Clair						PIHP Total						HSW Residential						Genesee						Lapeer						Sanilac						St. Clair						PIHP Total						<ul style="list-style-type: none">• Monitor the following elements to ensure HCBS compliance by providers• Number of providers completing HCBS surveys• Number of providers who are required to complete a corrective action plan based on survey responses• Number of providers who submitted an approved CAP to the PIHP• Number of providers who are determined Heightened Scrutiny cases by MDHHS	Tom Seilheimer Andy Graves Improving Practices Leadership Team (IPLT)	Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No Quarterly Update: Q 1: Q 2: Q 3: Q 4: Evaluation: Barrier Analysis: Next Steps: Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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.						<ul style="list-style-type: none">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: <input type="checkbox"/> Yes <input type="checkbox"/> No Quarterly Update: Q 1: Q 2: Q 3: Q 4: Evaluation: Barrier Analysis: Next Steps: Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No																																										
Employment Services	The goals for FY2018 Reporting are as follows: To monitor and advise on Employment Services activities as the CMHSPs						<ul style="list-style-type: none">Develop and address employment targets,Utilize standardized employment services data and report formats,Coordinate share and learn opportunities as they work	Tom Seilheimer Employment Services Committee	Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No Quarterly Update: Q 1: Q 2:																																										

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Michigan Mission Based Performance Indicator System (MMBPIS)	<p>The goals for FY2018 Reporting are as follows: The goal is to attain and maintain performance standards as set by the MDHHS contract.</p> <table border="1"> <thead> <tr> <th></th><th>FY17 Q4</th><th>FY18 Q1</th><th>FY18 Q2</th><th>FY18 Q3</th></tr> </thead> <tbody> <tr> <td colspan="5">Ind. 1 - Percentage of persons receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. Standard = 95%</td></tr> <tr> <td>1.1 Children</td><td></td><td></td><td></td><td></td></tr> <tr> <td>1.2 Adults</td><td></td><td></td><td></td><td></td></tr> <tr> <td colspan="5">Ind. 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></td><td></td><td></td><td></td></tr> <tr> <td>2.1 MI-Children</td><td></td><td></td><td></td><td></td></tr> <tr> <td>2.2 MI-Adults</td><td></td><td></td><td></td><td></td></tr> <tr> <td>2.3 DD-Children</td><td></td><td></td><td></td><td></td></tr> <tr> <td>2.4 DD-Adults</td><td></td><td></td><td></td><td></td></tr> <tr> <td>2.5 SUD</td><td></td><td></td><td></td><td></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></td><td></td><td></td><td></td></tr> <tr> <td>3.1 MI-Children</td><td></td><td></td><td></td><td></td></tr> <tr> <td>3.2 MI-Adults</td><td></td><td></td><td></td><td></td></tr> </tbody> </table>		FY17 Q4	FY18 Q1	FY18 Q2	FY18 Q3	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%					1.1 Children					1.2 Adults					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%					2 PIHP Total					2.1 MI-Children					2.2 MI-Adults					2.3 DD-Children					2.4 DD-Adults					2.5 SUD					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%					3 PIHP Total					3.1 MI-Children					3.2 MI-Adults					<ul style="list-style-type: none"> 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 	Pattie Hayes QI Department Quality Management Committee (QMC)	Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No Quarterly Update: Q 1: Q 2: Q 3: Q 4: Evaluation: Barrier Analysis: Next Steps: Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
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	3.3 DD- Children							
	3.4 DD-Adults							
	3.5 SUD							
	Ind. 4 – Percentage of discharges from psychiatric inpatient unit / SUD Detox unit that were seen for follow-up care within 7 days. Standard = 95%							
	4a.1 Children							
	4a.2 Adults							
	4b SUD							
	Ind. 10 – Percentage of readmissions of children and adults to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less							
	10.1 Children							
	10.2 Adults							
Members' Experience	<p>The goals for FY2018 Reporting are as follows:</p> <p>Complete the member satisfaction survey by August 2018.</p>					<ul style="list-style-type: none"> 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: <input type="checkbox"/> Yes <input type="checkbox"/> Quarterly Update: Q 1: Q 2: Q 3: Q 4: Evaluation: Barrier Analysis: Next Steps: Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
State Mandated Performance	<p>The goals for FY2018 Reporting are as follows:</p> <p>Identify 2 PIP projects that meet MDHHS standards:</p> <p>Improvement Project #1</p>					<ul style="list-style-type: none"> HSAG report on PIP interventions and baseline PIP Status updates to Quality Management Committee 	Tom Seilheimer Quality Management	Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> Quarterly Update:

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
Improvement Projects	<p>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.</p> <p>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."</p>	<ul style="list-style-type: none"> QMC to consider selection of PIP projects aimed at impacting error reduction, improving safety and quality 	Committee (QMC)	<p>Q 1:</p> <p>Q 2:</p> <p>Q 3:</p> <p>Q 4:</p> <p>Evaluation:</p> <p>Barrier Analysis:</p> <p>Next Steps:</p> <p>Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
External Monitoring Reviews	<p>The goals for FY2018 Reporting are as follows: To monitor and address activities pertaining to the PIHP HSW Program Corrective Action Plan:</p> <p>a) Q.2.3. (ensure non-licensed, non-verified providers meet required qualification)</p> <p>b) Q.2.4. (ensure support and service providers receive required training)</p>	<ul style="list-style-type: none"> 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)	<p>Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Quarterly Update:</p> <p>Q 1:</p> <p>Q 2:</p> <p>Q 3:</p> <p>Q 4:</p> <p>Evaluation:</p> <p>Barrier Analysis:</p> <p>Next Steps:</p> <p>Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
Monitoring of Quality Areas	The goals for FY2018 Reporting are as follows: To explore and promote quality and data practices within the region.	<ul style="list-style-type: none"> • 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: <input type="checkbox"/> Yes <input type="checkbox"/> Quarterly Update: Q 1: Q 2: Q 3: Q 4: Evaluation: Barrier Analysis: Next Steps: Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Financial Management	The goals for FY2018 Reporting are as follows: To promote sound fiscal management of the region.	<ul style="list-style-type: none"> • Finalize new funding allocation and run parallel payment reports • Transition to a risk based payment 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) 	Richard Carpenter Finance Committee	Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> Quarterly Update: Q 1: Q 2: Q 3: Q 4: Evaluation: Barrier Analysis: Next Steps: Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
Utilization Management	Ensure that monthly regional service utilization reports are generated (10/1/17 – 9/30/18).	<ul style="list-style-type: none"> Call for UM reports to be generated by the PIHP affiliates for presentation at committee <ul style="list-style-type: none"> Crisis Services, including psychiatric inpatient Other community based services (HBS, ACT, TCM/SC, BHT) 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 	Tom Seilheimer Utilization Management (UM) Committee	Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> Quarterly Update: Q 1: Q 2: Q 3: Q 4: Evaluation: Barrier Analysis: Next Steps: Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<ul style="list-style-type: none"> Call for 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: <input type="checkbox"/> Yes <input type="checkbox"/> Quarterly Update: Q 1: Q 2: Q 3: Q 4: Evaluation: Barrier Analysis: Next Steps:

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Utilization Management	Conduct Utilization Review (per revisions contingent upon the completion of the UM Redesign Work Group)	<ul style="list-style-type: none"> SUD site review audits per SUD UR Schedule Targeted case record review of outliers (TCM/SC, HBS, ACT, BHT) Explore feasible opportunities for additional outlier-based UR (linked to high-cost and / or high-risk) 	Tom Seilheimer Utilization Management (UM) Committee	Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> Quarterly Update: Q 1: Q 2: Q 3: Q 4: Evaluation: Barrier Analysis: Next Steps: Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Utilization Management	Promote aligned care management activities across key areas of network operations	<ul style="list-style-type: none"> Provide oversight of the semi-annual AMS report process, 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 UM activities delegated to the 	Tom Seilheimer Utilization Management (UM) Committee	Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> Quarterly Update: Q 1: Q 2: Q 3: Q 4: Evaluation: Barrier Analysis: Next Steps:

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
		CMHSPs to ensure consistency of operations and reporting <ul style="list-style-type: none"> • BTPRC activities noted in goal 2 • Targeted UR noted in goal 3 		Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Corporate Compliance	Review of 42 CFR 438.608 Program Integrity requirements. 9/30/18	<ol style="list-style-type: none"> 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: <input type="checkbox"/> Yes <input type="checkbox"/> Quarterly Update: Q 1: Q 2: Q 3: Q 4: Evaluation: Barrier Analysis: Next Steps: Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Corporate Compliance	Enhancement of available training materials across the region. 9/30/18	<ol style="list-style-type: none"> 1. Share resources. 2. Obtain additional resources. 	Corporate Compliance Committee	Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> Quarterly Update: Q 1: Q 2: Q 3: Q 4:

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Evaluation: Barrier Analysis: Next Steps: Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> Quarterly Update: Q 1: Q 2: Q 3: Q 4: Evaluation: Barrier Analysis: Next Steps: Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> Quarterly Update: Q 1: Q 2: Q 3: Q 4:

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				Evaluation: Barrier Analysis: Next Steps: Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No																									
Provider Network	Review Gap Analysis Report results by 9/30/18.	<ol style="list-style-type: none"> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No Quarterly Update: Q 1: Q 2: Q 3: Q 4: Evaluation: Barrier Analysis: Next Steps: Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No																									
Grievances	Goal: To review and analyze baseline data for this measure. <table border="1"> <thead> <tr> <th>Category</th><th>Qtr 1</th><th>Qtr 2</th><th>Qtr 3</th><th>Qtr 4</th></tr> </thead> <tbody> <tr> <td>Total Rate</td><td></td><td></td><td></td><td></td></tr> <tr> <td>Quality of Care</td><td></td><td></td><td></td><td></td></tr> <tr> <td>Access</td><td></td><td></td><td></td><td></td></tr> <tr> <td>Attitude/Service</td><td></td><td></td><td></td><td></td></tr> </tbody> </table>	Category	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total Rate					Quality of Care					Access					Attitude/Service					<ul style="list-style-type: none"> • 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 Quality Improvement Committee	Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No Quarterly Update: Q 1: Q 2: Q 3: Q 4:
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Total Rate																								
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	<p>The goal for FY2018 Credentialing and Privileging is as follows:</p> <ul style="list-style-type: none"> Provide oversight of the credentialing process and policy to ensure quality of care and service. 	<ul style="list-style-type: none"> Complete privileging and credentialing reviews and approval process of Organizational Applications for CMH and SUD Providers. Maintain policies and procedures on privileging and credentialing inclusive of 	Kim Prowse Privileging and Credentialing Committee	Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No Quarterly Update: Q 1: Q 2: Q 3: Q 4:																				

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
		MDHHS and Medicaid standards.		Evaluation: Barrier Analysis: Next Steps: Continue Objective(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No

