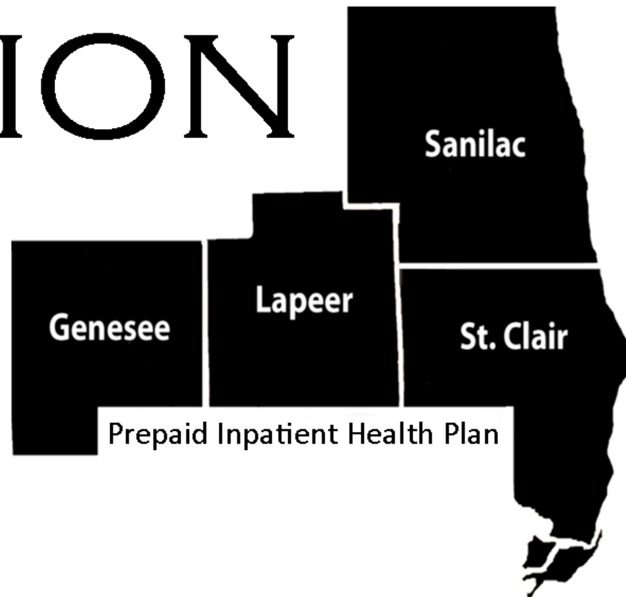
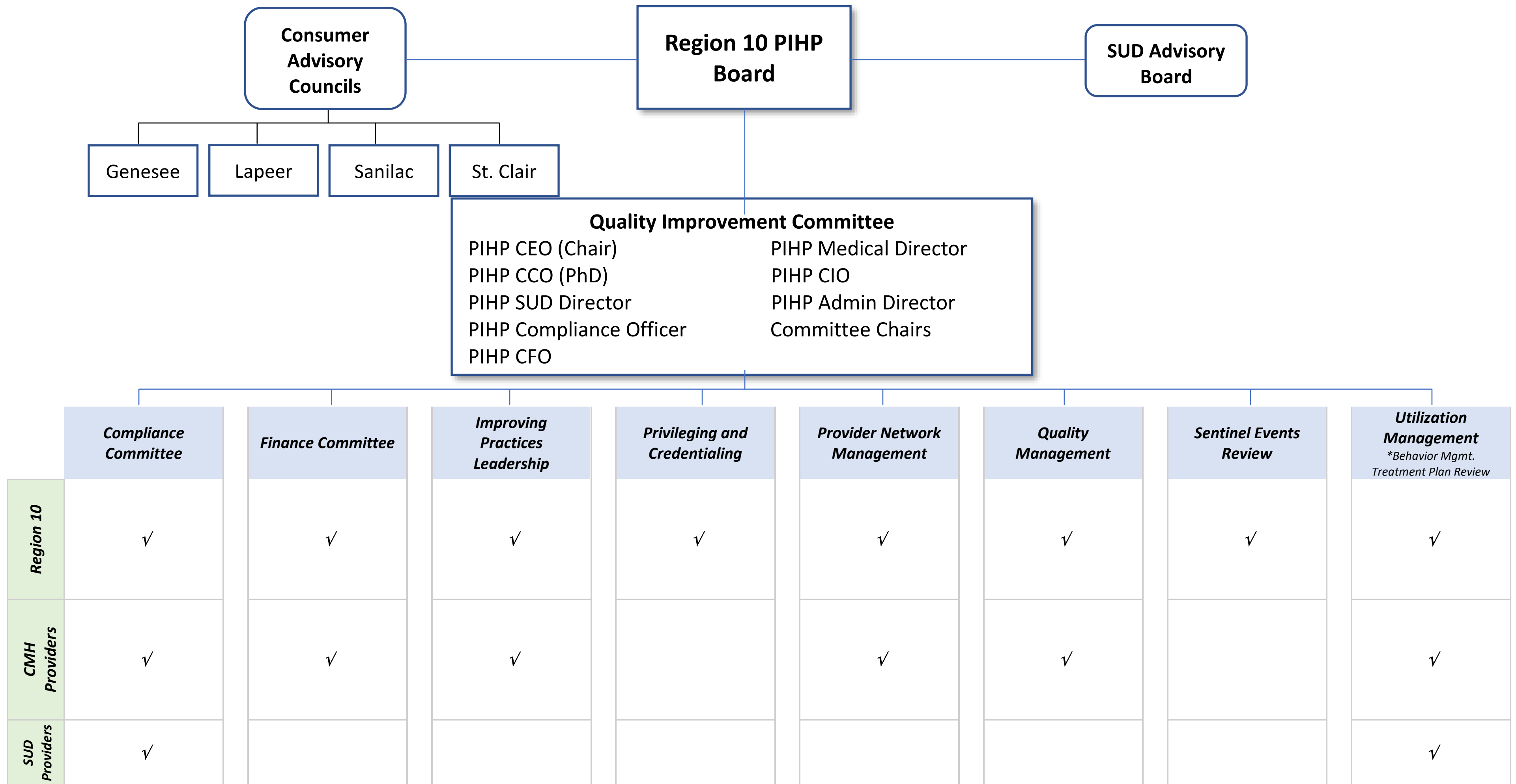


QUALITY IMPROVEMENT WORKPLAN

FY 2018, 1st Quarter

REGION 10 QAPIP ORGANIZATIONAL STRUCTURE



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

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

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):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☒ Yes ☐ No **Goal will be continued in FY2019 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: 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:** **Q 3:** **Q 4:** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☒ Yes ☐ No **Goal to be continued for FY18. If any revisions are needed, they will be brought to QIC and PIHP Board for 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: 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:** **Q 3:** **Q 4:** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☒ Yes ☐ No **Goal to be continued throughout FY18. If any revisions are made to the QI Annual Workplan, they will be presented to the QIC and PIHP Board for review and approval.**
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: 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:** **Q 3:** **Q 4:** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☒ No

<table>
<tr><th>Component</th><th>Goals/Timeframe/Analysis</th><th>Planned Activities</th><th>Responsible Staff/Department</th><th>Status Update</th></tr>
<tr>
<td>Clinical Program - HEDIS Performance: Follow up after Hospitalization for Mental Illness- Child</td>
<td><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.

The goals for 2018 Reporting Year are as follows:
To attain and maintain compliance rate set by MDHHS contract by September 2018.

<table>
<tr><th></th><th>FUH Follow Up</th><th></th><th></th><th></th></tr>
<tr><th></th><th>N</th><th></th><th>Y</th><th></th></tr>
<tr><th>Organization</th><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>
<tr><td>Genesee Health System</td><td>11</td><td>10.58%</td><td>93</td><td>89.42%</td></tr>
<tr><td>Lapeer County CMH</td><td>1</td><td>6.25%</td><td>15</td><td>93.75%</td></tr>
<tr><td>Sanilac County CMH</td><td>1</td><td>7.69%</td><td>12</td><td>92.31%</td></tr>
<tr><td>St. Clair County CMH</td><td>3</td><td>6.00%</td><td>47</td><td>94.00%</td></tr>
<tr><td>Grand Total</td><td>16</td><td>8.74%</td><td>167</td><td>91.26%</td></tr>
</table>

Timeframe: December 1, 2016 to November 1, 2017</td>
<td>• 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</td>
<td>Andy Graves

Monitored by IPLT Committee, UM Committee, QM Committee</td>
<td>Goal Met:
☐ Yes ☐ No

Quarterly Update:
Q 1: Continue to monitor, State target for FUH measure on performance bonus is 70% for children

Q 2:
Q 3:
Q 4:

Evaluation: Progress

Barrier Analysis: ICDP does not reflect MHP data that is used by State in combined MHP-PIHP scoring of FUH measure

Next Steps: Continue per annual plan, explore development of a PCE report as source document for FUH notifications to MHPs

Continue Objective(s)?
☒ Yes ☐ No</td>
</tr>
<tr>
<td>Clinical Program - HEDIS Performance: Follow up after Hospitalization for Mental Illness- Adult</td>
<td><u>Measure description:</u>
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</td>
<td>• 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</td>
<td>Andy Graves

Monitored by IPLT Committee, UM Committee, QM Committee</td>
<td>Goal Met:
☐ Yes ☐ No

Quarterly Update:
Q 1: Continue to monitor, State target for FUH measure on performance bonus is 58% for adults

Q 2:
Q 3:
Q 4:</td>
</tr>
</table>

<table>
<tr><th>Component</th><th>Goals/Timeframe/Analysis</th><th>Planned Activities</th><th>Responsible Staff/Department</th><th>Status Update</th></tr>
<tr>
<td></td>
<td>

Organization	FUH Follow Up			
	N		Y	
	FUH Eligible Visits Adult	% of FUH Eligible Visits Adult	FUH Eligible Visits Adult	% of FUH Eligible Visits Adult
Genesee Health System	52	15.34%	287	84.66%
Lapeer County CMH	2	7.41%	25	92.59%
Sanilac County CMH	1	5.56%	17	94.44%
St. Clair County CMH	26	16.15%	135	83.85%
Grand Total	81	14.86%	464	85.14%

Timeframe: December 1, 2016 to November 1, 2017</td>
<td>

- 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</td>
<td></td>
<td>

Evaluation: Progress

Barrier Analysis: ICDP does not reflect MHP data that is used by State in combined MHP-PIHP scoring of FUH measure

Next Steps: Continue per annual plan, explore development of a PCE report as source document for FUH notifications to MHPs

Continue Objective(s)?
☒ Yes ☐ No</td>
</tr>
<tr>
<td>**Clinical Program - HEDIS Performance: Cardiovascular Screening**</td>
<td>

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.

Organization	Cardiovascular Screening			
	N		Y	
	Patients	% of Patients	Patients	% of Patients
Genesee Health System	344	65.28%	183	34.72%
Lapeer County CMH	44	72.13%	17	27.87%
Sanilac County CMH	42	80.77%	10	19.23%
St. Clair County CMH	107	65.24%	57	34.76%
Grand Total	537	66.79%	267	33.21%

Timeframe: December 1, 2016 to November 1, 2017</td>
<td>

- 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</td>
<td>

Andy Graves

Monitored by IPLT Committee, UM Committee, QM Committee</td>
<td>

Goal Met:
☐ Yes ☐ No

Quarterly Update:
Q 1: Continue to monitor. Unusual pattern in Cardiovascular KPI trend lines noted at December QMC, resolved via tech support request to Zenith.

Q 2:
Q 3:
Q 4:

Evaluation: Progress

Barrier Analysis: None identified

Next Steps: Continue per annual plan

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

<table>
<tr><th>Component</th><th>Goals/Timeframe/Analysis</th><th>Planned Activities</th><th>Responsible Staff/Department</th><th>Status Update</th></tr>
<tr><td></td><td></td><td>members in need of appointments
• Develop materials to educate members on importance of screening</td><td></td><td></td></tr>
<tr><td>Clinical Program - HEDIS Performance: Diabetes Screening</td><td><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.

The goals for 2018 Reporting Year are as follows:
Provide and analyze baseline data for this indicator.

<table>
<tr><th></th><th colspan="4">Diabetic Screening</th></tr>
<tr><th></th><th colspan="2">N</th><th colspan="2">Y</th></tr>
<tr><th>Organization</th><th>Patients</th><th>% of Patients</th><th>Patients</th><th>% of Patients</th></tr>
<tr><td>Genesee Health System</td><td>73</td><td>20.45%</td><td>284</td><td>79.55%</td></tr>
<tr><td>Lapeer County CMH</td><td>5</td><td>11.90%</td><td>37</td><td>88.10%</td></tr>
<tr><td>Sanilac County CMH</td><td>9</td><td>19.57%</td><td>37</td><td>80.43%</td></tr>
<tr><td>St. Clair County CMH</td><td>24</td><td>17.91%</td><td>110</td><td>82.09%</td></tr>
<tr><td>Grand Total</td><td>111</td><td>19.17%</td><td>468</td><td>80.83%</td></tr>
</table>

Timeframe: December 1, 2016 to November 1, 2017</td><td>• 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</td><td>Andy Graves

Monitored by IPLT Committee, UM Committee, QM Committee</td><td>Goal Met:
☐ Yes ☐ No

Quarterly Update:
Q 1: Continue to monitor. IPLT, UM, and QM Committees have been made aware of recent downward trend in performance on this KPI.

Q 2:
Q 3:
Q 4:

Evaluation: Progress

Barrier Analysis: None identified

Next Steps: Continue per annual plan

Continue Objective(s)?
☒ Yes ☐ No</td></tr>
<tr><td>Aligned System of Care</td><td>The goals for 2018 Reporting Year are as follows:</td><td>• Monitor the implementation of</td><td>Tom Seilheimer</td><td>Goal Met:
☐ Yes ☐ No</td></tr>
</table>

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
	To promote an aligned system of care throughout the PIHP Provider Network to ensure quality and safety of clinical care and quality of service.	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 and learn opportunities as they work toward their respective employment targets. • Identify and promote aligned network practices in utilizing the Care Connect 360 system.	Improving Practices Leadership Team (IPLT)	**Quarterly Update:** **Q 1:** • **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 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.** **Q 2:** **Q 3:** **Q 4:** **Evaluation: Progress**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Barrier Analysis: None 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 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.	Tom Seilheimer Andy Graves Improving Practices Leadership Team (IPLT)	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1:** • **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.** **Q 2:** **Q 3:** **Q 4:** **Evaluation: Progress** **Barrier Analysis: None identified** **Next Steps: Continue activities per annual plan** Continue Objective(s)? ☒ Yes ☐ No

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
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.	• Monitor the following elements to ensure Home and Community Based Services (HCBS) compliance by providers • Number of providers completing Home and Community Based Services (HCBS) surveys • Number of providers who are required to complete a Corrective Action Plan (CAP) based on survey responses • Number of providers who submitted an approved Corrective Action Plan (CAP) to the PIHP • Number of providers who are determined Heightened Scrutiny cases by Michigan Department of Health and Human Services (MDHHS)	Tom Seilheimer Andy Graves Improving Practices Leadership Team (IPLT)	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1:** • **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 HCBS compliance for the B survey will begin in January.** • **Numbers are pending.** **Q 2:** **Q 3:** **Q 4:** **Evaluation: Progress** **Barrier Analysis: None identified** **Next Steps: Continue activities per annual plan** Continue Objective(s)? ☒ Yes ☐ No

	Provider Surveys Received	Providers Needing CAP	CAPs Submitted to PIHP	CAPs Approved by PIHP	Heightened Scrutiny Cases
HSW Non-Residential					
Genesee	224	223	61	61	33
Lapeer	24	24	1	1	6
Sanilac	46	42	38	38	0
St. Clair	21	20	20	18	2
PIHP Total	315	308	120	118	41
HSW Residential					
Genesee	128	118	112	0	155
Lapeer	7	4	4	0	23
Sanilac	18	9	9	0	36
St. Clair	66	65	65	0	18
PIHP Total	219	196	190	0	232

	Provider Surveys Sent / Received	Providers Needing CAPs	CAPs Submitted to PIHP	CAPs Approved by PIHP	Heightened Scrutiny Cases
B3 Survey					
Genesee	271 / 267				
Lapeer	215 / 204				
Sanilac	121 / 121				
St. Clair	251 / 214				
PIHP Total	858 / 806				

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
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:** • **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.** **Q 2:** **Q 3:** **Q 4:** **Evaluation: Progress** **Barrier Analysis: None identified** **Next Steps: Continue activities 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 services data and report formats, • Coordinate share and learn opportunities as	Tom Seilheimer Employment Services Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1:** • **Developmental work continues to fully relaunch committee plan. CMH members have been identified.**

<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>they work toward their respective employment targets.</td><td></td><td>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:
Q 3:
Q 4:

Evaluation: Progress

Barrier Analysis: None identified

Next Steps: Continue activities per annual plan

Continue Objective(s)?
☒ Yes ☐ No</td></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></td><td></td><td></td></tr>
<tr><td>1.2 Adults</td><td>99.92%</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>97.87%</td><td></td><td></td><td></td></tr>
<tr><td>2.1 MI-Children</td><td>100%</td><td></td><td></td><td></td></tr>
<tr><td>2.2 MI-Adults</td><td>100%</td><td></td><td></td><td></td></tr>
<tr><td>2.3 DD-Children</td><td>100%</td><td></td><td></td><td></td></tr>
</table></td><td>Report indicator results to MDHHS quarterly per contract
Provide status updates to relevant committees such as QMC, PIHP CEO, PIHP Board
Review quarterly MMBPIS data</td><td>Pattie Hayes

QI Department

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

Quarterly Update:
Q 1: 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.</td></tr>
</table>

<table>
<tr><th>Component</th><th>Goals/Timeframe/Analysis</th><th>Planned Activities</th><th>Responsible Staff/Department</th><th>Status Update</th></tr>
<tr><td></td><td>
<table>
<tr><td>2.4 DD-Adults</td><td>100%</td><td></td><td></td><td></td></tr>
<tr><td>2.5 SUD</td><td>95.70%</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>98.83%</td><td></td><td></td><td></td></tr>
<tr><td>3.1 MI-Children</td><td>99.60%</td><td></td><td></td><td></td></tr>
<tr><td>3.2 MI-Adults</td><td>98.68%</td><td></td><td></td><td></td></tr>
<tr><td>3.3 DD- Children</td><td>100%</td><td></td><td></td><td></td></tr>
<tr><td>3.4 DD-Adults</td><td>97.96%</td><td></td><td></td><td></td></tr>
<tr><td>3.5 SUD</td><td>98.48%</td><td></td><td></td><td></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></td><td></td><td></td></tr>
<tr><td>4a.2 Adults</td><td>97.53%</td><td></td><td></td><td></td></tr>
<tr><td>4b SUD</td><td>100%</td><td></td><td></td><td></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></td><td></td><td></td></tr>
<tr><td>10.2 Adults</td><td>12.26%</td><td></td><td></td><td></td></tr>
</table>
</td><td></td><td></td><td>Q 2:
Q 3:
Q 4:

Evaluation: Progress

Barrier Analysis: None identified

Next Steps: Continue activities per annual plan.

Continue Objective(s)?
☒ Yes ☐ No</td></tr>
<tr><td>Members' Experience</td><td>The goals for FY2018 Reporting are as follows:

Complete the member satisfaction survey by August 2018.</td><td>• Conduct regional consumer satisfaction survey
• Conduct MDHHS annual consumer satisfaction survey
• Develop interventions to address areas for improvement based on FY2018 member satisfaction survey</td><td>QI Department

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

Quarterly Update:
Q 1: 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:
Q 3:
Q 4:</td></tr>
</table>

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Evaluation: Progress **Barrier Analysis: None identified** **Next Steps: Continue activities as planned** Continue Objective(s)? ☒ Yes ☐ No
State Mandated Performance Improvement Projects	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. 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."	• Health Services Advisory Group (HSAG) report on Performance Improvement Project (PIP) interventions and baseline • Performance Improvement Project (PIP) status updates to Quality Management Committee • QMC Quality Management Committee to consider selection of Performance Improvement Project (PIP) projects aimed at impacting error reduction, improving safety and quality	Tom Seilheimer Quality Management Committee (QMC)	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1:** • **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 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:** **Q 3:** **Q 4:** **Evaluation: Analyses are pending receipt of a reliable and valid data set from ZTS**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Barrier Analysis: ZTS has not yet generated a reliable and valid data; feedback given and ZTS is working on it **Next Steps: Do analytics once data set is received** 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: 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:** **Q 3:** **Q 4:** **Evaluation: Progress** **Barrier Analysis: None identified** **Next Steps: Continue activities per plan** Continue Objective(s)? ☒ Yes ☐ No

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.	• 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: 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:** **Q 3:** **Q 4:** **Evaluation: Progress** **Barrier Analysis: None identified** **Next Steps: continue activities 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:**

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		• **Funding allocation is in the review stage. We produced month by 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:** **Q 3:** **Q 4:** **Evaluation: Progress** **Barrier Analysis: The only barrier is on the service rate item. The barrier is that information from the state is not readily available.** **Next Steps: Continue planned activities** 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	Tom Seilheimer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1:**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
		• Crisis Services, including psychiatric inpatient • Other community based services (Home-Based Services, Assertive Community Treatment, Targeted Case Management / Supports Coordination, 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	Utilization Management (UM) Committee	• **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 activities are taking place alongside the activities of the Utilization Management Redesign Work Group.** **Q 2:** **Q 3:** **Q 4:** **Evaluation:** • **By and large, outlier issues are being effectively addressed during the Utilization Review process, as per this delegation activity, program supervision is also facilitated. These activities are taking place alongside the activities of the Utilization Management Redesign Work Group.** **Barrier Analysis:** • **Case-finding activities draw fewer cases across the smaller affiliates and more cases across the larger**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				affiliates, thus raising discussion regarding modification of tasks, noting the utility of a quarterly reporting schedule. **Next Steps:** • **Update the Utilization Review case finding schedule to standardize quarterly reporting for all Utilization Review case finding reports.** 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:** • **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.** **Q 2:** **Q 3:** **Q 4:** **Evaluation: Progress** **Barrier Analysis: None identified**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Next Steps: Continue activities per annual plan Continue Objective(s)? ☒ Yes ☐ No
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:** • **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.** **Q 2:** **Q 3:** **Q 4:** **Evaluation: Progress pending** **Barrier Analysis: None identified but Management Team has placed priority onto Substance Use Disorder outlier-based case-finding method to help further align all Utilization Review activities.** **Next Steps: Complete Substance Use Disorder case-finding method** Continue Objective(s)? ☒ Yes ☐ No

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
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 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	Tom Seilheimer Utilization Management (UM) Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1:** • **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.** **Q 2:** **Q 3:** **Q 4:** **Evaluation: Progress** **Barrier Analysis: None identified** **Next Steps: Continue per semi-annual report cycle** Continue Objective(s)? ☒ Yes ☐ No

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
		• Targeted Utilization Review noted in goal 3		
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: Discussion regarding Program Integrity Requirements and upcoming MDHHS contract revisions. Documentation regarding compliance with standards initiated and pending further CMH review.** **Q 2:** **Q 3:** **Q 4:** **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: Continue planned 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: Discussion regarding Statewide Training Reciprocity. Draft Training Content currently under review by PIHP Corporate Compliance Officers Workgroup (next meeting scheduled for 1/8/18).**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Q 2: **Q 3:** **Q 4:** **Evaluation: Progress pending finalization of training** **Barrier Analysis: None** **Next Steps: Continue planned 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: 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:** **Q 3:** **Q 4:** **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: Continue planned activities** Continue Objective(s)? ☒ Yes ☐ No

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
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: Clarification provided on monthly reporting requirements.** **Q 2:** **Q 3:** **Q 4:** **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: Continue planned 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: 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:** **Q 3:**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				Q 4: **Evaluation: Progress** **Barrier Analysis: Member engagement** **Next Steps: Continue planned activities** Continue Objective(s)? ☒ Yes ☐ No
Grievances	Goal: To review and analyze baseline 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 Quality Improvement Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: 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:** **Q 3:** **Q 4:** **Evaluation:** **Barrier Analysis:** **Next Steps:** Continue Objective(s)? ☐ Yes ☐ No

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
Appeals	Goal: To review and analyze baseline 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 Quality Improvement Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: 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:** **Q 3:** **Q 4:** **Evaluation:** **Barrier Analysis:** **Next Steps:** 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 Organizational Applications for CMH and SUD Providers. • Maintain policies and procedures on privileging and credentialing inclusive of MDHHS and Medicaid standards.	Kim Prowse Privileging and Credentialing Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q 1: 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**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/Department	Status Update
				full privileges will be maintained for up to 2-years. **Q 2:** **Q 3:** **Q 4:** **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: Ongoing Activities** Continue Objective(s)? ☒ Yes ☐ No

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