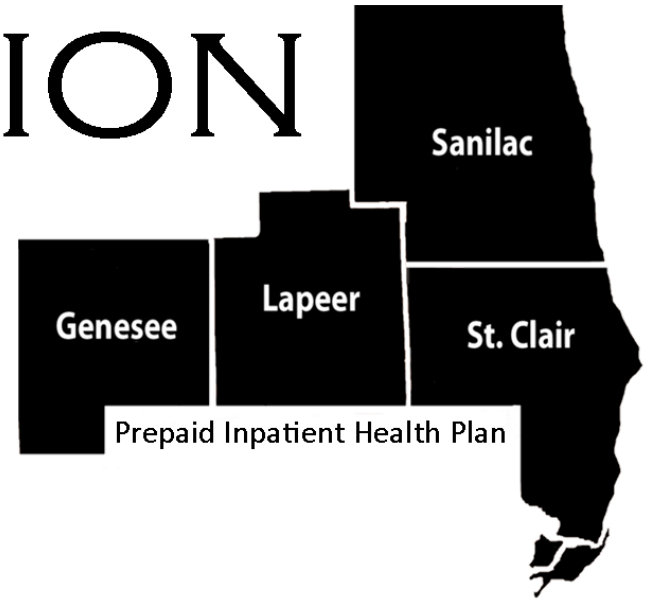
REGION 10



QUALITY IMPROVEMENT PROGRAM

FY 2017 – ANNUAL REPORT

Region 10 PIHP
Quality Improvement Program FY2017 Annual Report

OVERVIEW

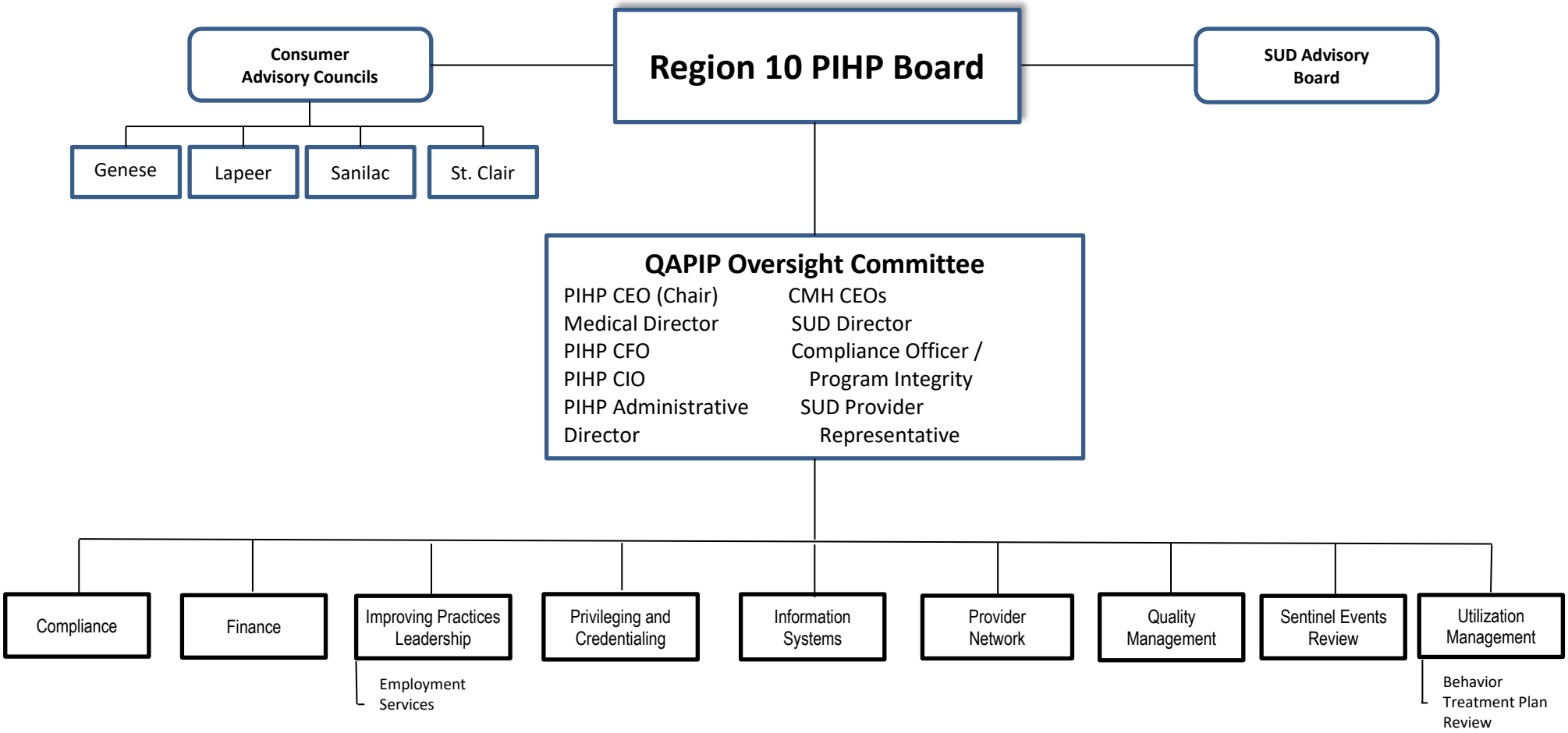
The Region 10 PIHP has responsibility for oversight and management of the regional managed care functions. This responsibility includes approving and monitoring the region's Quality Assessment and Performance Improvement Program (QAPIP). Annually, the PIHP Board approves the Quality Improvement Program Plan which includes the following two components: a narrative description of the overall quality improvement program and an annual workplan detailing the prioritized goals, improvement strategies, and anticipated outcomes designed to improve the PIHP's overall systems processes.

The purpose of this report is to provide an annual review of the Quality Improvement Program Plan for the Region 10 PIHP. The data contained in this report pertains to the reporting period of October 1, 2016 – September 30, 2017. The report contains performance status summaries on the regional goals and performance improvement projects.

QUALITY IMPROVEMENT PLAN

The QI Plan addresses the specific planned efforts of the Quality Improvement Committee and its Standing Committees, as contained in the Quality Improvement Program. The PIHP, via its Standing Committees, develops specific goals to address program development and improvement efforts annually. The goals and activities listed below reflect the prioritized efforts to be undertaken and accomplished by the Quality Improvement Committee via each Standing Committee in the upcoming fiscal year.

REGION 10 QAPIP ORGANIZATIONAL STRUCTURE



Goal Reference / Area for Improvement	PRIORITY GOALS / KEY TASKS	STATUS UPDATE & RECOMMENDATIONS
COMPLIANCE COMMITTEE		
AFP Quality of Service	Review of 42 CFR 438.608 Program Integrity requirements. (Goal Modified 6/30/17)	2017 requirement changes under ongoing review. Grid created to compare previous and updated requirements. PIHP Board appointment of Regulatory Compliance Committee as a standing Committee of the Board established in January to oversee the PIHP Compliance Program. • Written Policies / Procedures: Policy review / revision ongoing (as needed). • Enforcement of Standards / Response to Offenses: Ongoing reporting and review of complaint data. Continued work with OIG regarding complaint reporting (Fraud Referral Form requirement sent from OIG during 2nd Quarter). • Monitoring: PIHP Quarterly and Annual Contract Monitoring reviews complete. Areas of concern noted on Provider Action Plans and monitored ongoing. • Communication: Statewide PIHP Compliance Officers Workgroup established. PIHP Compliance Officer also assigned to Statewide Workgroup Training Subgroup. Annual Report and Plan presented to PIHP Board in December. • Training: PIHP Board Training completed in December. PIHP staff annual training completed and implemented. Ongoing training requirements enhanced in PIHP Policy. *Goal achieved and ongoing.*
Quality of Service	Enhancement of available training materials across the region.	Ongoing sharing of training content resources between members. PIHP Compliance Officer became a member of national Health Care Compliance Association in November as well as Certified in Healthcare Compliance in July. *Goal achieved and ongoing.*
MDHHS	Monitor claims verification activities. (Goal discontinued 6/30/17)	Monitored through Finance Department. *Goal discontinued.*
Quality of Service	Maintain policies and procedures which promote compliance with the PIHP Corporate Compliance Plan. (Goal added 6/30/17)	During Annual PIHP Contract Monitoring Reviews, it was noted there lacked oversight in compliance in the CMH subnetwork of Providers. CMH policies and procedures (subnetwork monitoring) currently under ongoing enhancement and review. *Goal achieved and ongoing.*

Goal Reference / Area for Improvement	PRIORITY GOALS / KEY TASKS	STATUS UPDATE & RECOMMENDATIONS
	Support complaint reporting requirements (Develop/maintain a cohesive strategy for addressing and reporting Corporate Compliance issues.) (Goal Modified 6/30/17)	The PIHP established format for reporting compliance complaints reviewed ongoing. Two separate reporting mechanisms established: (1) Complaints made directly to MDHHS shall also be shared with the PIHP and (2) Complaints regarding Corporate Compliance concerns are reported to the PIHP monthly in established format. All Providers have utilized the monthly reporting form consistently across the network. Use of the reporting form has resulted in a decrease of compliance related complaints due to the specificity identified. Any concerns or questions are addressed with the PIHP Compliance Officer directly. *Goal achieved and ongoing.*
FINANCE COMMITTEE		
	Finalize new funding allocation and run parallel payment reports.	Funding model has been developed and incorporated into the Region 10 encounter submission software (MIX). Reports are available and testing is expected to begin in fiscal 2018. *Goal ongoing.*
	Begin evaluation of the admin cost report and commit to common allocation methodology for the region.	Review of the admin cost report is complete for both St. Clair CMH and Genesee Health System. Based on high level review the methodology appears consistent. *Goal achieved.*
	Track Monthly Spending by CMHSP and Regionally against Budget Workgroup approved plan.	Tracking of monthly spending has been incorporated into the monthly reports presented to the CEOs and Region 10 Board. *Goal achieved.*
	Address final round of funding decreases and produce a balanced FY18 budget	Funding decreases were not as significant as anticipated and additional workgroup support was not needed. *Goal achieved.*
IMPROVING PRACTICES LEADERSHIP TEAM		
Quality & Safety of Clinical Care; Quality of Service	Monitor the development of PIHP Clinical Practice Guidelines.	• A final draft set of PIHP Clinical Practice Guidelines has been developed. *Goal achieved and ongoing.*
Quality of Clinical Care; Quality of Service	Review Evidence-Based Practices fidelity measurement review results.	• EBP activities and fidelity review findings have been reviewed in autism services, IPS supported employment, and in dual-diagnosis capability in mental health treatment. Also, the PIHP evidence-based practices list has been updated and it has also been utilized to help develop the PIHP Clinical Practices Guidelines. *Goal achieved and ongoing.*
Quality & Safety of Clinical Care;	Provide oversight to the Employment Services Committee (ESC)	• Oversight was provided, including ongoing discussion and direction to support ESC participation across all affiliates. Notwithstanding these efforts, the ESC was deactivated in June, and IPLT has discussed methods and

Goal Reference / Area for Improvement	PRIORITY GOALS / KEY TASKS	STATUS UPDATE & RECOMMENDATIONS
Quality of Service		rationale to reactivate the committee for next FY. *Goal achieved and ongoing.*
Quality of Clinical Care; Quality of Service	Develop care integration processes for persons with Medicaid Health Plans.	• Monthly reports were reviewed regarding the MHP/PIHP complex care management meetings. Preferred clinic practices were identified in connection to per-case discussions on care integration (e.g. how to effectively address ED overutilization), thus to promote share and learn activities within affiliate programs. • Pilot data analytics on the All Reason IP Readmissions within 90 Days report have taken place in response to the Medical Director's request to explore this clinical concern and potential practitioner use of these kinds of KPI reports. *Goal achieved and ongoing.*
Quality & Safety of Clinical Care; Quality of Service	Provide a user-group forum to support CMH utilization of the Care Connect 360 system and user Guidelines.	• Best-practices discussions were held, essentially showcasing CC360 implementation successes at Sanilac CMHSP and Lapeer CMHSP. Improvement opportunities remain in aligning network practices in utilizing this data and report system. *Goal achieved and ongoing.*
Quality & Safety of Clinical Care; Quality of Service	Provide clinical monitoring and support to the Home and Community-Based Services transition.	• A FY 2018 implementation was announced during fourth quarter and a Joint Guidance document was disseminated. *Goal achieved and ongoing.*
EMPLOYMENT SERVICES COMMITTEE		
Quality & Safety of Clinical are; Quality of Service	Obtain consistent representation from each agency in Region 10.	• The committee was deactivated 6/30/17 due to affiliate nonparticipation. This result occurred despite ongoing efforts internally as well as through IPLT to promote consistent participation from all affiliates. In its oversight capacity, IPLT continued employment services discussions during the remainder of the FY, in part to help provide recommendation to the QAPIP to reactivate ESC for FY 2018. *Goal discontinued.*
Quality & Safety of Clinical are; Quality of Service	Work mutually to increase respective community awareness of various Supported Employment programs to promote inclusion in the work place.	• Lapeer CMHSP and St. Clair CMHSP met regularly to participate in employment-related share and learn discussions and to support implementation of their evidence-based practices. *Goal discontinued.*
Quality & Safety of Clinical are; Quality of Service	Provide ongoing supports to Region 10 agencies to assist counties in achieving their respective employment goals.	• Fidelity reviews and improvement activities took place in connection to the above goal, but the committee was not able to establish a forum for all affiliates in identifying affiliate employment goals and objectives. *Goal ongoing.*

Goal Reference / Area for Improvement	PRIORITY GOALS / KEY TASKS	STATUS UPDATE & RECOMMENDATIONS
PRIVILEGING AND CREDENTIALING COMMITTEE		
Quality of Service	Complete privileging and credentialing reviews.	The P&C Committee reviewed all SUD practitioner applications and reviewed and approved all SUD and CMH organizations in which they are contracted with as applicable to credentialing terms. In FY18, the PIHP will no longer review submitted SUD practitioner applications, but rather assess compliance through its contract monitoring process. An "Update" form was created to allow for practitioners to fill out a simplified form vs. a complete application for minor updates like licensing expiration date updates or additional MCBAP certifications. Additional practices have been put into place for ongoing notification to the applicants/organizations as privileges are reaching or have exceeded expiration. This information is also reviewed at meetings. *Goal ongoing.*
Quality of Service	Review policies and procedures on privileging and credentialing.	Review of policy and procedure is ongoing. Updates to the application are also ongoing to identify any gaps in the collection of needed information. Multiple NCQA standards around primary source verification were added to the application in FY17. *Goal ongoing.*
INFORMATION SYSTEMS COMMITTEE		
AFP; MDHHS	Monitor timeliness, volume and completeness of 837 encounter submissions to MDHHS.	Region 10 PIHP followed the schedule for 837 submissions. Reports related to submission timeliness are distributed to CMHs monthly. We are meeting MDHHS timeliness standards per contract requirement. PIHP identified and corrected the logic for the QI Completeness report. SUD provider claims were reviewed in detail for completeness and accuracy; provider education occurred regarding accuracy of procedure codes, as determined necessary. Region 10 PIHP monitors timeliness based on time of service. Diagnosis code R99 is no longer accepted; providers need to resolve any encounters or claims with this diagnosis, as any encounters with this code will be rejected by Region 10 PIHP. Discussion was held regarding the variance between encounters reported on the MUNC versus through the encounter reporting process. *Goal Achieved*.
MDHHS - Quality of Service	Monitor and encourage use of CareConnect 360 software	Region 10 continues to use the CC360 Use Policy that was implemented via the IPLT. Region 10 staff and providers continue to work with MDHHS regarding review and approval of CMH user requests for CC360 access. Region 10

Goal Reference / Area for Improvement	PRIORITY GOALS / KEY TASKS	STATUS UPDATE & RECOMMENDATIONS
		continues to discuss the utilization at the monthly MHP-PIHP care coordination updates to the CMH CEOs. CMHs report their CC360 usage and users in the quarterly contract monitoring process. New functionality was added in June related to monitoring of staff utilization of the software. Region 10 encourages the utilization by CMH staff, particularly in relation to the MHP-PIHP care coordination meetings. There will be upcoming CC360 trainings as sponsored by MDHHS. *Goal Achieved*.
MDHHS – Quality of Service	Participate in MiHIN use care scenarios (e.g. ADT).	ADT (Admission – Discharge – Transfer) files from inpatient hospitals are available in CMH electronic health care records. GHS utilizes ADTs received from local and extended hospitals. If an ADT is received that is not assigned a primary case manager it is reviewed by a member of the intake department and Data Management staff review files for ACRS submission. Sanilac, Lapeer, and St. Clair have deployed the ADTs within their system and are receiving from several hospitals. St. Clair CMHA, Lapeer CMH and Sanilac CMHA continue to educate staff on the availability of ADT files. Communication with supervisors and staff regarding these files is ongoing. St. Clair CMHA, Lapeer CMH and Sanilac CMHA submit monthly ACRS files. *Goal achieved.*
MDHHS - Quality of Service	Increase use of ICDP data analytics software.	ICDP reports and KPI reports continue to be prepared for the QMC, UMC, IPLT, and CEO Board and are distributed monthly for review. There were new KPI's added in December. The UMC also receives ICDP Same Reason and All Reason Readmission reports and a report on FGA/SGA adherence. A new procedure for closing ICDP Care Alerts was added to the system in March. CMHSP ICDP users continue to participate in bi-weekly ICDP Working Committee meetings. Zenith offers periodic webinars on ICDP usage that are available to ICDP users. Zenith is currently working to match the ICDP Follow Up After Hospitalization for Mental Illness (FUH) KPI to the State's definitions for the FUH performance bonus. CMHs report their ICDP usage in the quarterly contract monitoring process. *Goal achieved.*
MDHHS	Monitor timeliness and completion of BH-TEDS submission to MDHSS.	Region 10 PIHP followed the published schedule for BH-TEDS submissions. FY17 data set will be used for all BH-TEDS submissions effective 12/19/2016. FY16 BH-TEDS data set is scheduled to be completed 03/31/2017. BH-TEDS submission is discussed at monthly committee meetings. The CMHSPs review monthly reports to monitor completion of BH-TEDS. Mental Health BH-TEDS completeness was scored at 92.74%; Substance use disorder BH-TEDS completeness was scored at 84.64%. Improvement needed. BH-TEDS

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<tr><th>Goal Reference / Area for Improvement</th><th>PRIORITY GOALS / KEY TASKS</th><th>STATUS UPDATE & RECOMMENDATIONS</th></tr>
<tr><td></td><td></td><td>submission timeliness continues to be addressed with providers regarding FY17 files. Goal achieved.</td></tr>
<tr><td colspan="3">PROVIDER NETWORK COMMITTEE</td></tr>
<tr><td rowspan="2">Quality of Service</td><td>Review managed care functions which are delegated to CMH and SUD providers, ensuring standardization.</td><td rowspan="2">Delegation requirements incorporated into FY17 Provider Agreements and areas of concern identified. Draft changes sent to members for review. Significant revisions made to format – including addition of functions in current practice, delineation of PIHP and Provider responsibilities as well as references to related materials. Draft Agreement presented to August CEO Meeting and incorporated into FY18 Provider Agreements. Goal achieved.</td></tr>
<tr><td>Ensure PIHP delegation requirements are communicated to CMH and SUD Providers and reviewed prior to contract recommendations (new or renewal).</td></tr>
<tr><td>Quality of Service / Member Experience</td><td>Review CMH and SUD Gap Analysis Report results.</td><td>CMH Gap Analysis reports completed and shared. Gap Analysis Reports additionally reviewed through formal PIHP Contract Monitoring – areas of improvement identified and incorporated into appropriate recommendations or action plans. Goal achieved and ongoing.</td></tr>
<tr><td colspan="3">QUALITY MANAGEMENT COMMITTEE</td></tr>
<tr><td>Quality of Clinical Care; Quality of Service</td><td>Review quarterly PIHP performance indicator data, including CMH/SUD results.</td><td>The group reviewed PI reports as available and discussed issues as necessary. PI data for the year is below.
<table>
<tr><th></th><th>FY16 Q4</th><th>FY17 Q1</th><th>FY17 Q2</th><th>FY17 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>99.56</td><td>100</td><td>100</td><td>100</td></tr>
<tr><td>1.2 Adults</td><td>99.42</td><td>100</td><td>100</td><td>100</td></tr>
<tr><td colspan="5">Ind. 2 – Percentage of new persons receiving a face-to-face assessment with a professional within 14 calendar days of non-emergency request for service. Standard = 95%</td></tr>
<tr><td>2 PIHP Total</td><td>95.84</td><td>96.78</td><td>96.16</td><td>96.48</td></tr>
<tr><td>2.1 MI-Children</td><td>98.42</td><td>97.73</td><td>* 91.72</td><td>98.34</td></tr>
<tr><td>2.2 MI-Adults</td><td>95.01</td><td>95.45</td><td>97.09</td><td>99.17</td></tr>
<tr><td>2.3 DD-Children</td><td>100</td><td>100</td><td>95.35</td><td>100</td></tr>
<tr><td>2.4 DD-Adults</td><td>98.03</td><td>100</td><td>96.08</td><td>100</td></tr>
<tr><td>2.5 SUD</td><td>95.16</td><td>96.44</td><td>97.25</td><td>*93.93</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>98.70</td><td>98.68</td><td>99.00</td><td>98.80</td></tr>
<tr><td>3.1 MI-Children</td><td>98.78</td><td>95.73</td><td>99.63</td><td>99.30</td></tr>
<tr><td>3.2 MI-Adults</td><td>97.79</td><td>99.14</td><td>97.94</td><td>97.85</td></tr>
<tr><td>3.3 DD- Children</td><td>98.00</td><td>97.14</td><td>98.57</td><td>95.65</td></tr>
<tr><td>3.4 DD-Adults</td><td>97.91</td><td>97.62</td><td>96.36</td><td>100</td></tr>
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<tr><th>Goal Reference / Area for Improvement</th><th>PRIORITY GOALS / KEY TASKS</th><th>STATUS UPDATE & RECOMMENDATIONS</th></tr>
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<tr><td>3.5 SUD</td><td>99.15</td><td>99.77</td><td>99.82</td><td>99.67</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>98.70</td><td>100</td><td>100</td><td>100</td></tr>
<tr><td>4a.2 Adults</td><td>96.57</td><td>96.73</td><td>98.75</td><td>98.07</td></tr>
<tr><td>4b SUD</td><td>95.24</td><td>100</td><td>95.00</td><td>100</td></tr>
<tr><td colspan="5">Ind. 10 – Percentage of readmissions of children and adults to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less</td></tr>
<tr><td>10.1 Children</td><td>14.02</td><td>8.82</td><td>10.34</td><td>7.01</td></tr>
<tr><td>10.2 Adults</td><td>13.21</td><td>12.05</td><td>13.00</td><td>10.84</td></tr>
</table>
* The PIHP did not meet the set performance standard for the population breakout MI Children for Indicator 2 during the second quarter. A Root Cause Analysis and Corrective Action Plan was received from GHS for this indicator.
*The PIHP-SUD did not meet the set performance standard for the population breakout for Indicator 2 during the third quarter. A Root Cause Analysis and Corrective Plan has been received. Goal achieved and ongoing.
</td></tr>
<tr><td>Members' Experience</td><td>Conduct regional consumer satisfaction survey. Participate in MDHHS annual consumer satisfaction survey.</td><td>The MDHHS annual consumer satisfaction survey was completed and submitted to the state in March 2017.
The regional consumer satisfaction survey was administered during July. CMHs submitted data to the PIHP in August to aggregate into the PIHP report. Final report was presented to the QMC committee on September 27, 2017. Areas of improvement were noted. Goal achieved and ongoing.</td></tr>
<tr><td>Safety of Clinical Care</td><td>Monitor critical incidents</td><td>Critical Incident reports have been monitored at monthly meetings to review number of incidents reported and ensure compliance with the contract. No issues noted with data reporting or data trends. Goal achieved and ongoing.</td></tr>
<tr><td>Quality of Clinical Care; Quality of Service</td><td>Oversight of performance improvement projects</td><td>PIP 1 and PIP 2 activities are monitored on-going. PIP 1 Remeasurement 2 findings were shared and improvement action plan findings discussed. PIP 1 and PIP 2 activities for FY 2017 / Re-Measurement 3 have been completed; HSAG status report was submitted by the July 5th deadline. HSAG preliminary report showed the PIP overall scoring was met, but report was enhanced per HSAG's feedback and resubmitted on 8/18. Pending final report results from HSAG. Both PIPs will be continued into FY18 per committee recommendation. Goal achieved and ongoing.</td></tr>
<tr><td>Quality of Clinical Care; Quality of Service</td><td>Review ICDP Reports / KPIs and explore opportunities for regional application</td><td>Monthly reports are being reviewed and discussed, with improvement opportunities and potential uses identified. Goal achieved and ongoing.</td></tr>
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Goal Reference / Area for Improvement	PRIORITY GOALS / KEY TASKS	STATUS UPDATE & RECOMMENDATIONS
Quality of Clinical Care; Quality of Service	Monitor emerging quality initiatives and requirements	NCQA standards continued to be reviewed in terms of additional quality requirements. No other emergent activities were identified. *Goal achieved and ongoing.*
Quality & Safety of Clinical Care; Quality of Service	Monitor and address activities pertaining to the PIHP HSW Program Corrective Action Plan • Q.2.3 (ensure non-licensed, non-verified providers meet required qualifications) • Q.2.4 (ensure support and service providers receive required training) (Goal added February 2017)	This goal was added per the HSW Corrective Action Plan submitted to MDHHS. Discussion of reasons why took place at the February meeting. CMH CAP activities to-date were discussed at the March meeting. A review of the CMH CAP documents and a facilitated share-and-learn discussion is scheduled for the April meeting. PIHP and CMH CAPs and related activities to-date have been monitored on-going. CAPs are being carried out as planned. Thus far, no implementation barriers have been identified. *Goal ongoing.*
Quality of Clinical Care	Monitor and address implementation of the Bonus System Performance Indicators	The State-wide and R10 PIHP baseline reports, and the shared improvement action plan issued by MDHHS, have been reviewed. A monthly reporting and monitoring process has been developed and has been implemented. The group reviewed the state specifications in detail; ZTS is working on the updated FUH report that aligns with state reporting requirements for performance measure. *Goal ongoing.*
UTILIZATION MANAGEMENT COMMITTEE		
Quality & Safety of Clinical are; Quality of Service	Monitor monthly regional service utilization reports • Crisis Services • Supports Coordination / Targeted Case Management • Home-Based Services • Assertive Community Treatment • ASD Services	• Monthly UM (crisis services) reports have been generated and reviewed. A key accomplishment in this area has been to align reporting practices across affiliates, thus to also help align operational perspectives and priorities across the region. Overall, crisis services utilization has revealed a gradual, favorable downward trend, thus reflecting regional efforts to provide appropriate psychiatric inpatient diversion and responsive follow-up care. • Report developments in SC/TCM, HBS, ACT and ASD have been key in developing an aligned outlier-based utilization review system, noted below. *Goal achieved and ongoing.*
Quality & Safety of Clinical are; Quality of Service	Monitor data on use of Restrictive and Intrusive techniques, physical management or contact with enforcement use on an emergency behavior crisis	• BTPRC affiliate reports have been monitored, noting appropriate use of restrictive/intrusive interventions, emphasis on the use of positive behavior supports, and conservative use of emergency management techniques. *Goal achieved and ongoing.*
Quality & Safety of Clinical are; Quality of Service	Conduct Utilization Review • SUD site review audits per CA UR Schedule • Targeted case record review of outliers (SC/TCM, HBS, ACT, ASD)	• The SUD site review UR calendar has been completed, and overall high levels of compliance to service standards and claims requirements have been recorded across the provider network.

Goal Reference / Area for Improvement	PRIORITY GOALS / KEY TASKS	STATUS UPDATE & RECOMMENDATIONS
	• Explore feasible opportunities for additional outlier-based UR (linked to high-cost and / or high-risk)	• UR structures and systems were developed and implemented as per the delegation agreement with the CMH affiliates regarding SC/TCM, HBS, ACT and ASD services. Activities have helped promote the concept and practice of outlier-based case-finding and follow up utilization review. UR findings reveal high levels of compliance to medical necessity requirements as well as generated committee discussion regarding patterns of over/under-utilization. • No additional outlier-based UR issues have been identified, mainly due to committee consensus on the overriding importance of focusing on the current services selected for UR, and to committee opinion that the development and implementation of the UM Redesign Work Group level of care systems will better inform this area of development during FY 2018. *Goal achieved and ongoing.*
Quality & Safety of Clinical are; Quality of Service	Other areas of focus • Access Management System (AMS) (prospective UR, second opinions) • UM Program Plan Consultant work on continued regional alignment of care management • UM Redesign Workgroup oversight • Oversight of delegated CMH UM activities • Oversight of CA SUD NOMs semi-annual reports • Explore feasible drill-down reports based on CA SUD NOMs (Goal to be deleted 6/30/17) • Monitor PIHP/MHP integrated service plans • Review ZTS PI reports	• The AMS six-month reports have been review and approved. Recommendations were endorsed regarding additional alignment opportunities across the two AMS sites, and identifying and address factors linked to divergent second opinion rates. • A draft UM Program Plan and related policy have been developed in consultation with the UM Redesign Work Group consultants and the NCQA MBHO application consultants. • Monitoring of UM Redesign Work Group activities have taken place, to support current redesign efforts. • As noted in the above UR-delegate discussion, oversight of the delegated UR activities has taken place. • As noted in the above SUD UR discussion, oversight of the centralized UR activities has taken place, also in conjunction with discontinuing the NOMS measurement and reporting system. • Monthly MHP/PIHP activity reports have been monitored. • ZTS reports have been reviewed and recommendations have been generated regarding report graphics and format improvements along with discussion of possible report uses by practitioners and program managers. *Goal achieved and ongoing.*

Goal Reference / Area for Improvement	PRIORITY GOALS / KEY TASKS	STATUS UPDATE & RECOMMENDATIONS
SENTINEL EVENT REVIEW COMMITTEE		
Quality & Safety of Clinical are; Quality of Service	Review critical incidents, to reduce their occurrence and to improve systems of care.	• Monthly critical incidents reports have been reviewed. Additional baseline and quarterly analytics have identified low frequencies in most CI categories, along with higher frequencies in CI categories pertaining to physical health issues. Findings here support current efforts by programs across the region to practice integrative approaches toward behavioral and physical healthcare. *Goal achieved and ongoing.*
Quality & Safety of Clinical are; Quality of Service	Provide sentinel event monitoring and follow-up as deemed necessary.	• Sentinel events monitoring has taken place as per policy and resulting systems improvement activities across affiliates have been implemented. *Goal achieved and ongoing.*

Recommendations

The Committee summaries reported above demonstrate the ongoing efforts and accomplishments of each Standing Committee of the Quality Improvement Program during the Fiscal Year 2017. The Standing Committees provided periodic reports throughout the year regarding the implementation of their goals and the prioritized projects of the PIHP. In preparation for the new fiscal year, each Committee evaluated goal progress and achievement, developing new or ongoing goals and objectives which will comprise the FY 2018 Quality Improvement Program Workplan. In addition, in preparation for the PIHP's NCQA Accreditation review during 2018, all committees, goals and processes were reviewed and updated in accordance with NCQA standards. The revised annual work plan will reflect ongoing progress on QI activities throughout the year, addressing planned QI activities and objectives for improving quality of clinical care, safety of clinical care, quality of service and members' experience.

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