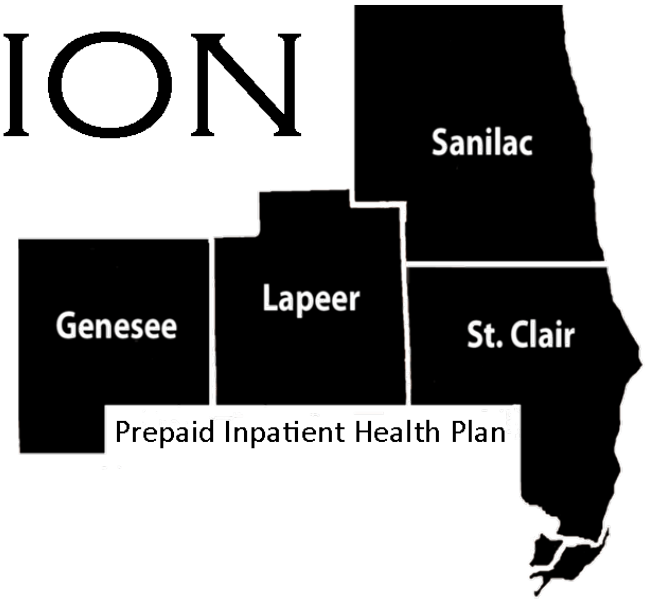
REGION 10



QUALITY IMPROVEMENT PROGRAM & WORKPLAN

FY 2025

Region 10 Prepaid Inpatient Health Plan (PIHP)
Quality Assessment & Performance Improvement Program Description
(October 1, 2024 – September 30, 2025)

Region 10 Prepaid Inpatient Health Plan (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 Substance Use Disorder (SUD) Coordinating Agency of Genesee County and St. Clair Community Mental Health (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

A. Organizational Structure:

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

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

To implement the QI Program, the PIHP Board has established a Quality Improvement (QI) Committee. The QI Committee assures that its sub-structure is aligned with the mandates and improvement priorities of the PIHP Board. The PIHP Medical Director provides clinical input, feedback, direction, and oversight to the QI Program. The Chief Clinical Officer (CCO) provides operational direction and oversight leadership to the QI Program and the QI Committee. The QI Committee is composed of core members including PIHP Chief Executive Officer, PIHP Medical Director, PIHP Chief Financial Officer, PIHP Chief Operations Officer, PIHP Chief Information Officer, PIHP Chief Clinical Officer (Clinical PhD), PIHP Administrative Directors, 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, Provider Network Committee, Quality Management Committee, Sentinel Events Review Committee, and Utilization Management Committee.

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

services, and evaluate members' experience. The Sentinel Events Review Committee focuses on reviewing and monitoring critical and sentinel events to ensure safety of clinical care, and quality of service. The 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. 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) meeting. Any recommendations from Standing Committees are reviewed and appropriate action is taken by the QIC. Written reports of the status of each goal within the QI Annual Workplan are presented to the Governing Body (PIHP Board of Directors) quarterly. The PIHP Board approves any modification to the QI Workplan. The quarterly and annual QI Program Plan performance reports are prepared by the Quality Management Department.

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

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

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

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

The QI Program includes objectives to serve a diverse membership by reducing health care disparities in clinical areas and by improving the network adequacy to meet the needs of underserved groups. The organization strives to improve quality and safety of clinical care, quality of services, and members' experiences for members with complex health needs including physical and developmental disabilities, severe mental illness, and chronic conditions.

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

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

B. Components and Activities:

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

The PIHP's QI Program includes the following items:

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

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

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

C. Roles for Recipients of Service:

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

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

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

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

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

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

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

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

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

II. Governing Body Responsibilities

A. Oversight of QI Program:

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

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

B. QI Plan Progress Reports:

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

Quarterly, the PIHP's Quality Management staff prepares a QI Plan Status Report. This report is shared with the PIHP Board, QI Committee, 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 prepare 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, CMH Provider Network, SUD 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. The annual submission will also include materials to demonstrate the implementation of Performance Improvement Projects.

III. Designated Senior Officials:

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

IV. Active Participation of Providers and Customers

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

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

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

V. Performance Measurement

A. State Performance Measures

The PIHP measures its performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data. As required by MDHHS, the PIHP and Affiliates participate in the Michigan Mission-Based Performance Indicator System (MMBPIS). All four CMHs submit their performance indicator reports independently to the PIHP. For the SUD system, performance indicators are reviewed ongoing and prepared by PIHP staff. The PIHP reviews data and aggregates all data to report to MDHHS as required.

A crucial part of the member satisfaction / data collection piece involves striving to surpass the benchmarks set for Performance Indicators established by the MDHHS in the areas of access, efficiency, and outcome. Performance Indicator data is submitted to MDHHS on a quarterly basis.

B. Other Performance Indicators

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

C. Clinical and Safety Initiatives

Region 10 PIHP focuses on clinical initiative to improve the safety of clinical care and service provided to the member. Region 10 PIHP conducts robust Coordination of Care initiatives, and annually conducts needs assessment studies for individuals with Serious and Persistent Mental Illness (SPMI) 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. Monitoring is a collaborative effort between PIHP staff and the provider staff to monitor and assure quality of care on a regular basis. Policies and audit tools have been developed by staff to guide the monitoring and evaluation process.

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

Specific problem analysis is conducted as requested or as problems are identified in the monitoring process. Also, if a set performance benchmark is not achieved for the region, the indicator is investigated further by various committees within the QAPIP structure such as Quality Improvement Committee, Quality Management Committee, and Improving Practices Leadership Team to increase input from CMH partners, identify contributing factors and systemic issues for the outliers, and review opportunities for improvement across the region. These processes allow the PIHP to assure minimum performance levels on performance indicators are met and that causes of negative statistical outliers are analyzed when they occur.

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

VII. Performance Improvement Projects

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

A. Clinical and Non-Clinical Projects

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

B. Project Topics

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

C. State- and PIHP-Established Aspects of Care

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

D. Number of Projects Undertaken During the Waiver Renewal Period

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

Improvement Project #1
This PIP topic is on racial/ethnic disparities in access-to-service-engagement with Substance Use Disorder (SUD) services. Improvement activities are aimed at reducing the rate of disrupted access-to-service-engagement for persons (Medicaid members and non-Medicaid persons) served within Region 10.

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

E. Methodology

Improvement Project #1
The root cause analysis process included the completion of the Five Whys method, a Fishbone Diagram, and a flowchart/process map of the current referral and intake process. In conjunction, a barrier analysis was completed (Kittle, Bonnie. 2017. A Practical Guide to Conducting a Barrier Analysis (2nd ed.). New York, NY: Helen Keller International). The barrier analysis was initiated by a representative group of SUD program leaders and PIHP Access staff via brainstorming and round robin techniques, followed by cluster analysis. Cluster analysis findings were further discussed by PIHP staff, and an SUD program network survey was developed to further explore potential key service access barriers.

The SUD program network survey was distributed to a representative group of SUD subject matter experts (persons-served and SUD program service staff). Survey analyses generated a comprehensive range of barriers, both in terms of identified Individual (persons-served) Factors and Program (staff/program service delivery) Factors. A follow up barrier analysis survey was developed, and, per point-in-time methodology, this survey was administered to all available subject matter experts. Quantitative data obtained from the barrier analysis survey were analyzed across both barrier analysis Factors and racial/ethnic groups. The barrier analysis identified four significant barriers. Findings from the root cause analysis / barrier analysis activities described above informed the development of service systems improvement action plans.

Objectives of the developed interventions include create/strengthen caller engagement and commitment during the Access screening, expand transportation resources, improve SUD program appointments scheduling capacity and processes, and support SUD program intake and service provision innovations.

Improvement Project #2
Barrier analysis and root cause analysis processes and activities were completed by each of the four CMHs. These activities were completed using quality improvement tools (e.g., force field analysis, fishbone diagram) and in consultation with local consumer oversight or input. CMHs also conducted surveys, focus groups, and reviews of literature. Findings from the root cause analysis / barrier analysis activities described above informed the development of service systems improvement action plans.

Priorities and objectives for the developed interventions include increase awareness of appointments for staff and persons served, improve scheduling flexibility, assess and address transportation needs, outreach to individuals after discharge and after missed appointments, increase hospital liaison contacts for discharge planning at the hospital, notify staff of hospital admissions, provide education to the hospital, conduct anti-stigma campaigns and develop branding, and increase coordination between hospital and CMH staff.

VIII. Review and Follow Up of Sentinel Events

A. <u>Ensuring Appropriate Action</u>

The Region 10 PIHP Sentinel Events, Critical Incidents, and Risk Events Policy 07.01.03 establishes the guidelines for reporting and reviewing possible Sentinel Events, Critical Incidents, and/or Risk Events. The policy states that the PIHP will conduct administrative reviews and follow-up of Sentinel Events per the following:

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

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

presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement, and when and how implementation will be monitored or evaluated.

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

The PIHP Sentinel Event Review Committee will conduct review and analysis of sentinel events report, submitted by CMHSP/SUD Providers. The Sentinel Event Review Committee submits periodic summaries 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. CMHs and SUD Providers have processes for reviewing and analyzing all unexpected deaths. Unexpected deaths are included in mortality reports. Reports are monitored by the PIHP, and the PIHP ensures regional tracking and trending of aggregate mortality data over time. Refer to the PIHP Sentinel Events, Critical Incidents, and Risk Events Policy (07.01.03) 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. Critical incidents are submitted to the PIHP by CMHs and SUD Treatment Providers. Critical incidents from residential treatment providers are included. 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 critical incident data per critical incident categorical findings. Further analyses are prepared by the PIHP staff regarding relevant clinical and demographic factors, thus, to identify systemic improvement opportunities within the provider programs and provider network. These findings are submitted as systems analysis and improvement recommendations to the CMH Quality Improvement Council (QIC) on a quarterly basis for CMH review, analysis and recommendations. These CMH

QIC review dispositions are then submitted to the PIHP QI Committee for quarterly review and final disposition.

F. Risk Events Management

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

IX. Review of Behavior Treatment Plan Review Committee Data

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

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 (beneficiary) experiences with services. The assessments are representative of persons served and supports offered. The PIHP coordinates one quantitative assessment throughout the fiscal year, the Customer Satisfaction Survey. The PIHP delegates qualitative assessments to CMHs/SUD Providers.

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 the interventions used to increase quality, availability, and accessibility of care. Therefore, all actions taken because of assessments will be evaluated periodically. Quality Improvement is never static, and it is an expectation that all evaluation efforts will be examined on an ongoing basis.

D. Incorporation of Customers in the Evaluation Process

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

XI. Monitoring of Clinical Protocols & Practice Guidelines

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

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

Adoption Process:

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

Development Process:

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

key diagnostic classifications. Additionally, key stakeholders such as providers and users of services are invited to participate. Public review and comment are also an integral piece of the developmental process.

Implementation:

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

Continuous Monitoring:

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

Evaluation:

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

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

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

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

Regarding recredentialing of practitioners, the procedures detailed in the PIHP Credentialing and Privileging Policy (01.06.05) include the review of monitoring and intervention of provider sanctions, complaints, and quality issues pertaining to the provider. The review should include Medicare/Medicaid sanctions, State sanctions or limitations on licensure, registration, or certification, member concerns which include appeals and grievance (complaints) information, and PIHP quality issues. The PIHP Credentialing and Privileging Policy (01.06.05) also includes expectations for recredentialing of organizational providers. During recredentialing of organizational providers, quality of care and contract compliance will be considered. This includes contract monitoring findings, grievance and appeal and recipient rights complaints. Additionally, for organization providers, MMBPIS and other performance indicators, if applicable, shall meet standards or have an accepted Root Cause Analysis and/or Plan of Correction approved by the Provider Network Management Department on file.

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

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

All PIHP CMHs and SUD Treatment Providers (other than peer recovery and recovery support services when these are provided through a prevention license) are required by contract to be accredited by one of the major healthcare or rehabilitation accreditation bodies and are responsible for ensuring that staff are qualified and trained. Under the established accreditation standards, practitioner licensure, credentialing, staff qualification, and staff training are required. The requirement that organizational providers be accredited (or demonstrate how they meet accreditation standards) as specified in the PIHP Credentialing and Privileging Policy, affords the PIHP with the capacity to provide assurances that all provider staff (including those not specifically privileged via the credentialing process) meet minimum qualifications for providing specific services and have access to adequate training related to services provided within the PIHP network. Assurances that these criteria are met are documented via the Organizational Credentialing and Enrollment process, as well as via the PIHP Contract Monitoring process. Policies, credentials, and documentation concerning these requirements are reviewed during PIHP contract monitoring 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, MDHHS, and CMS/Medicaid. The PIHP verifies whether services reimbursed by Medicaid were furnished to enrollees by affiliates, providers, and subcontractors. To conduct these reviews, the PIHP first identifies a sample of individuals (and their services) during the specified quarter. PIHP staff then notify the Providers of the review and include the sample selection along with instructions for document collection and submission. Following the PIHP's review of the submitted supporting documentation, results of the verification process are communicated to the provider in writing.

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

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

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

XIV. Utilization Management Program

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

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

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

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

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

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

These utilization management activities and operating processes are detailed in the PIHP UM Plan which will be approved by the PIHP Board. The UM Plan details the above UM functions performed by the PIHP and any delegated items. The UM Plan includes mechanisms to detect under-utilization and over-utilization. For detected under-utilization and over-utilization, utilization reviews are completed on a sample of cases for specific CMH and SUD Treatment services. Findings and reports are reviewed with the UM Committee.

In addition, for specific procedures on UM processes, please refer to the PIHP Policy Manual.

XV. Provider Network Monitoring

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

XVI. Special Targeted Monitoring Activities

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

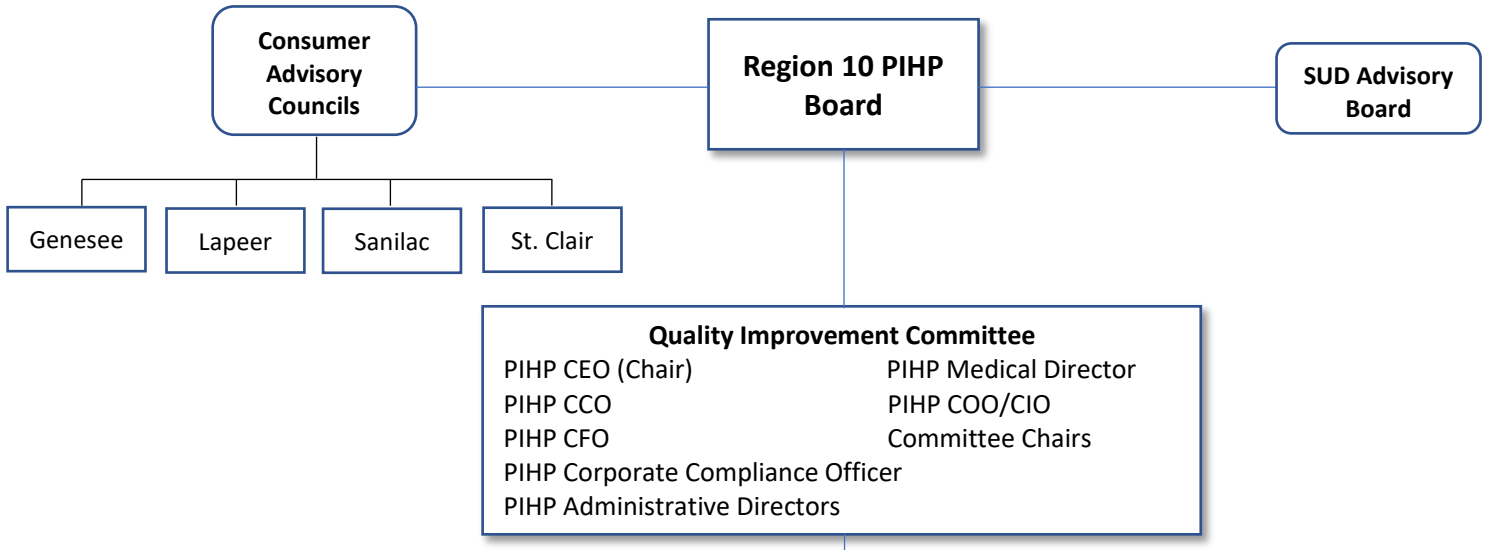
The PIHP shall review and approve plans of correction that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate interval. Reports of the annual monitoring and plans of correction shall be subject to MDHHS review.

XVII. Long-Term Services and Supports

The PIHP has mechanisms to assess the quality and appropriateness of care furnished to beneficiaries receiving long-term services and supports (LTSS), including assessments of care between care settings and a comparison of services and supports received with those set forth in the beneficiary's treatment/service plan. These mechanisms include periodic reviews of plans of service, utilization reviews, claims verification reviews, clinical case record reviews, and customer satisfaction surveys. These mechanisms are represented within the QI Workplan in the areas of Members' Experience, External Monitoring Reviews, Utilization Management, Autism Program, and Verification of Services.

Additionally, the PIHP has mechanisms to comprehensively assess each beneficiary identified as needing LTSS to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring. These mechanisms include biopsychosocial assessments and ancillary assessments.

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 Improvement Fiscal Year (FY) 2025 Work Plan (October 1, 2024 – September 30, 2025)

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
QI Program Structure - Annual Evaluation	The goals for FY2025 Reporting Year are as follows: • Submit FY2024 QI Program Evaluation to Quality Improvement Committee and the Region 10 PIHP Board by 10/1/2024. o 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. o After presentation to the Quality Improvement Committee, the Annual Evaluation will be presented to the Region 10 PIHP Board for discussion and approval.	Shelley Wilcoxon Quality Management Department QI Program Standing Committees	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
QI Program Structure - Program Description	The goals for FY2025 Reporting Year are as follows: • Submit FY2025 QI Program Description and QI Workplan to Quality Improvement Committee and the Region 10 PIHP Board by 11/1/2024. o Review the previous year's QI Program and make revisions to meet current standards and requirements. o Include changes approved through committee action and analysis. • Develop the FY2025 QI Program Work Plan standard by 11/1/2024. o Present the work plan to the committee by 11/1/2024. o Utilize the annual evaluation in the development of the Annual Work Plan for the upcoming year. o Prepare work plan including measurable goals and objectives.	Shelley Wilcoxon Quality Management Department QI Program Standing Committees	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Aligned System of Care	The goals for FY2025 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. o Monitor utilization of the PIHP Clinical Practice Guidelines.	Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Complete annual and biennial evaluation reports as per policy. ○ Review Evidence-Based Practices (EBPs) and related fidelity review activities to promote standardized clinic operations across the provider network, e.g., Integrated Dual Disorders Treatment (IDDT), Level of Care Utilization System (LOCUS), Opioid Health Home (OHH). ○ Facilitate the annual Behavioral Health and Aging Services Administration (BHASA) LOCUS implementation plan. ○ Support CMHSP implementation of the nine core Certified Community Behavioral Health Clinic (CCBHC) EBPs.		**Evaluation:** **Barrier Analysis:** **Next Steps:**
Employment Services	The goals for FY2025 Reporting Year are as follows: • Support progressive and safe community based CMHSP employment service practices throughout the regional Employment Services Committee (ESC). Monitor quarterly ESC meetings designed to facilitate share and learn discussions on: ○ CMHSP employment targets for competitive employment (community-based) and appropriate compensation (minimum wage or higher) ○ Standardized employment services data and report formats ○ In-service / informational materials ○ Community-based employment opportunities and collaborative practices (e.g., Michigan Rehabilitation Services [MRS]) ○ Discuss/support consideration of Individual Placement and Support (IPS) service model.	Tom Seilheimer Improving Practices Leadership Team (IPLT) & Employment Services Committee (ESC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Home & Community Based Services	The goals for FY2025 Reporting are as follows: • Monitor CMHSP network implementation of the Home and Community Based Services (HCBS) Transition Plan to ensure quality of clinical care and service. o Monitor network completion of the HCBS assessment process, Heightened Scrutiny Out of Compliance, and Validation of Compliant Settings process. o Monitor the provisional approval process.	Deidre Slingerland / Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Integrated Health Care	The goals for FY2025 Reporting are as follows: • Monitor CMHSP network implementation of the CMHSP/PIHP/MHP Integrated Health Care (IHC) Care Coordination Plan. o Assist in aligning network care integration processes for persons with Medicaid Health Plans, including shared case record operations and aligned network practices in utilizing the CareConnect360 (CC360) system. o Participate in PIHP/MHP Workgroup initiatives. o Develop a plan to identify members of the youth population appropriate for care coordination.	Deidre Slingerland / Tom Seilheimer Improving Practices Leadership Team (IPLT)	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Event Reporting (Critical Incidents, Sentinel Events & Risk Events)	The goals for FY2025 Reporting are as follows: • To review and monitor the safety of clinical care. o Review CMHSP and SUD critical incidents, to ensure adherence to timeliness of data and reporting standards and to monitor for trends, to improve systems of care. o Monitor CMHSP and SUD sentinel event review processes and ensure follow-up as deemed necessary. o Monitor CMHSP and SUD unexpected deaths / mortality review processes and ensure follow-up as deemed necessary. o Monitor CMHSP and SUD risk events review processes and ensure follow up as deemed necessary.	Tom Seilheimer Sentinel Event Review Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr>
<td>Michigan Mission Based Performance Indicator System (MMBPIS)</td>
<td>The goals for FY2025 Reporting are as follows:
• The goal is to attain and maintain performance standards as set by the MDHHS contract.
o Report indicator results to MDHHS quarterly per contract.
o Review quarterly MMBPIS data.
o Achieve and exceed performance indicator standards and benchmarks.
o Ensure follow up on recommendations and guidance provided during External Quality Reviews
o Provide status updates to relevant committees, such as the PIHP QIC, PIHP CEO, PIHP Board.
o Discuss and prepare for the transition from MMBPIS to standardized measures.

<table>
<tr><th></th><th>FY24 Q3</th><th>FY24 Q4</th><th>FY25 Q1</th><th>FY25 Q2</th></tr>
<tr><td colspan="5">Ind. 1 – Percentage of persons receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. Standard = 95%</td></tr>
<tr><td>1.1 Children</td><td></td><td></td><td></td><td></td></tr>
<tr><td>1.2 Adults</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Ind. 2a – Percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of non-emergency request for service. Standards = 57% and 62%</td></tr>
<tr><td>2a PIHP Total</td><td></td><td></td><td></td><td></td></tr>
<tr><td>2a.1 MI-Children</td><td></td><td></td><td></td><td></td></tr>
<tr><td>2a.2 MI-Adults</td><td></td><td></td><td></td><td></td></tr>
<tr><td>2a.3 DD-Children</td><td></td><td></td><td></td><td></td></tr>
<tr><td>2a.4 DD-Adults</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Ind. 2b – Percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders. Standards = 68.2% and 75.3%</td></tr>
<tr><td>2b SUD</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Ind. 3 – Percentage of new persons during the quarter starting any needed on-going service within 14 days of non-emergent face-to-face assessment with professional. Standards = 72.9% and 83.8%</td></tr>
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</td>
<td>Lauren Campbell

Quality Management Committee (QMC)</td>
<td>Quarterly Update:

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

Evaluation:
Barrier Analysis:
Next Steps:</td>
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<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>
<tr><td>3.3 DD-Children</td><td></td><td></td><td></td><td></td></tr>
<tr><td>3.4 DD-Adults</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Ind. 4 – Percentage of discharges from a psychiatric inpatient unit / SUD Detox unit that were seen for follow-up care within 7 days. Standard = 95%</td></tr>
<tr><td>4a.1 Children</td><td></td><td></td><td></td><td></td></tr>
<tr><td>4a.2 Adults</td><td></td><td></td><td></td><td></td></tr>
<tr><td>4b SUD</td><td></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></td><td></td><td></td><td></td></tr>
<tr><td>10.2 Adults</td><td></td><td></td><td></td><td></td></tr>
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</td><td></td><td></td></tr>
<tr><td>Members' Experience</td><td>The goals for FY2025 Reporting are as follows:
• Conduct assessments of members' experience with services.
o Conduct annual regional customer satisfaction survey.
o Conduct qualitative assessments (e.g., focus groups).
o Conduct other assessments of members' experience as needed.
o Develop action steps to implement interventions to address areas for improvement based on member satisfaction survey.
o Facilitate a workgroup consisting of members of the SUD Provider Network to inform future survey planning.
o Develop and implement action steps to address response rates / totals.</td><td>Deidre Slingerland

Quality Management Committee (QMC)</td><td>Quarterly Update:

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

Evaluation:
Barrier Analysis:
Next Steps:</td></tr>
</table>

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
State Mandated Performance Improvement Projects (PIPs)	The goals for FY2025 Reporting are as follows: • Identify and implement two PIP projects that meet MDHHS standards: Improvement Project #1 This PIP topic is on racial/ethnic disparities in access-to-service-engagement with Substance Use Disorder (SUD) services. Improvement activities are aimed at reducing the rate of disrupted access-to-service-engagement for persons (Medicaid members and non-Medicaid persons) served within Region 10. Improvement Project #2 The goal of this PIP is to ensure that children and adults within the region who are Medicaid beneficiaries will receive follow-up services within 30 days after discharge from a psychiatric inpatient hospital. This study topic aligns with the Performance Bonus Incentive Pool metric "Follow-up After Hospitalization for Mental illness within 30 Days", which applies performance standards for these two clinical cohorts. PIP performance targets have been set to exceed these performance standards. • Review Health Services Advisory Group (HSAG) report on PIP interventions and baseline. • Provide / review PIP status updates to Quality Management Committee. • QMC to consider selection of PIP projects aimed at impacting error reduction, improving safety and quality.	Tom Seilheimer Quality Management Committee (QMC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
External Monitoring Reviews	The goals for FY2025 Reporting are as follows: • To monitor and address activities related to PIHP Waiver Programs (Habilitation Supports Waiver [HSW], Children's Waiver Program [CWP], Children with Serious Emotional Disturbances Waiver [SEDW]: o Follow up and report on activities to ensure compliance with the MDHHS HSW, CWP, and SEDW requirements, including timely submissions for case actions. o Ensure both Professional and Aide staff meet required qualifications.	Shannon Jackson Quality Management Committee (QMC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Ensure compliance with person-centered planning and individual plan of service requirements, with additional focus on areas identified as repeat citations. ○ Discuss CMH, PIHP, and MDHHS Review findings and follow up on remediation activities. ○ Discuss and follow up on HSW slot utilization and slot maintenance.		
Monitoring of Quality Areas	The goals for FY2025 Reporting are as follows: • To explore and promote quality and data practices within the region. ○ Monitor critical incident data and reporting. ○ Monitor risk event data and reporting. ○ Monitor emerging quality and data initiative / issues and requirements. ○ Monitor and address Performance Bonus Incentive Pool activities and indicators. ○ Monitor and address changes to service codes. ○ Review / analysis of various regional data reports. ○ Review / analysis of Behavioral Health Treatment Episode Data Set (BH TEDS) reports.	Lauren Campbell & Laurie Story-Walker Quality Management Committee (QMC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Financial Management	The goals for FY2025Reporting are as follows: • Establish consistent Region-wide finance reporting and provide training as needed. ○ Region 10 Chief Financial Officer (CFO) will provide quarterly training on finance reporting and finance topics, including the Certified Community Behavioral Health Clinic (CCBHC) Demonstration and Encounter Quality Initiative (EQI) reporting.	Richard Carpenter Finance Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Utilization Management	The goals for FY2025 Reporting are as follows: • Provide oversight on CMHSP affiliate crisis services utilization. ○ Monitor and advise on Peter Chang Enterprises (PCE)-based crisis service utilization reports (monthly).	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Evaluation: **Barrier Analysis:** **Next Steps:**
Utilization Management	The goals for FY2025 Reporting are as follows: • Provide oversight on CMHSP affiliate Behavior Treatment Plan Review Committee (BTPRC) management activities over the use of restricted and intrusive behavioral techniques, emergency use of physical management, and 911 contact with law enforcement. o Monitor and advise on BTPRC data spreadsheet reports: Evaluate reports per committee discussion of findings, trends, potential system improvement opportunities, and adherence to standards (quarterly).	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Utilization Management	The goals for FY2025 Reporting are as follows: • Ensure regional Utilization Review (UR). o PIHP UM Department to conduct UR on: ▪ UR on SUD network provider programs (annually) ▪ UR on CMHSP Optimal Alliance Software Information System (OASIS)-user affiliates (quarterly) o Monitor and advise on delegated CMHSP (GHS) UR activity reports (quarterly).	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Utilization Management	The goals for FY2025 Reporting are as follows: • Promote aligned care management activities across key areas of network operations. o Achieve full Implementation of the Centralized Utilization Management (UM) System (UM Redesign Project) ▪ Oversight of the OASIS Users Workgroup and Sub-Workgroup ▪ Complete the development of UM Redesign Project implementation monitoring reports. ▪ Complete the development of scheduled UM monitoring/management reports.	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	▪ Continue to inform and engage GHS in regional implementation of the Centralized UM System. o Monitor and advise on the MDHHS/Region 10 Parity Compliance Plan ▪ Oversight of the Milliman Care Guidelines Indicia System and Indicia Inter-Rater Reliability System. ▪ Oversight of Region 10 participation on the UM Directors Group.		
Utilization Management	The goals for FY2025 Reporting are as follows: • Promote centralized care management operations across the regional Access Management System (AMS). o Monitor and advise on AMS reports (Mid-Year, End-of-Year)	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Utilization Management	The goals for FY2025 Reporting are as follows: • Provide oversight on CMHSP affiliate community access / care management activities. o Monitor and advise on Customer Involvement, Wellness / Healthy Communities reports (quarterly)	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Utilization Management	The goals for FY2025 Reporting are as follows: • Provide oversight on regional Adverse Benefit Determination (ABD) operations and reporting processes. o Monitor and advise on ABD reports: Access Management System, CMHSP affiliates, SUD network provider programs (quarterly).	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Corporate Compliance	The goals for FY2025Reporting are as follows: • Compliance with 42 CFR 438.608 Program Integrity requirements. o Review requirements o Identify and document responsible entities o Identify and document supporting evidence / practice o Policy review o Review PIHP Corporate Compliance Plan updates • Support reporting requirements as defined by MDHHS, Office of Inspector General (OIG), Medicaid Fraud Control Unit (MFCU), PIHP, etc. o Review of reporting process. o Review of contractual language changes in reporting. o Ongoing discussion on OIG feedback (e.g., Program Integrity Report feedback).	Jim Johnson Corporate Compliance Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Corporate Compliance	The goals for FY2025 Reporting are as follows: • Compliance with 45 CFR 164.520 Notice of Privacy Practices o Review requirements. o Identify and document responsible entities. o Identify and document supporting evidence / practice. o Policy review.	Jim Johnson Corporate Compliance Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Corporate Compliance	The goals for FY2025 Reporting are as follows: • Review regional Corporate Compliance monitoring standards, reports, and outcomes. o Review regional PIHP contract monitoring results. o Review current CMH Subcontractor contract monitoring process / content.	Jim Johnson Corporate Compliance Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Provider Network	The goals for FY2025Reporting are as follows:	Jim Johnson	**Quarterly Update:**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	• Address service capacity concerns and support resolution of identified gaps in the network. o Review and address CMH Network gaps and capacity concerns. o Review and address SUD Network gaps and capacity concerns.	Provider Network Committee	**Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Provider Network	The goals for FY2025Reporting are as follows: • Review Network Adequacy requirements and address compliance with standards. o Review requirements. o Identify and document responsible entities. o Identify and document supporting evidence / practice. o Policy review.	Jim Johnson Provider Network Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Provider Network	The goals for FY2025 Reporting are as follows: • Review most recent FY PIHP Contract Monitoring Results. o Review FY Contract Monitoring Aggregate Report. o Discuss trends and improvement opportunities.	Jim Johnson Provider Network Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Customer Service Inquiries	The goals for FY2025 Reporting are as follows: • To review and analyze baseline customer service inquiry data for the region for FY2025. o To track and trend internally the customer service inquiries on a monthly basis. o Identify consistent patterns related to customer service inquiries. o Develop interventions to address critical issues within the Network. **Reporting Period: FY2025**	Katie Forbes PIHP Customer Service Department	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
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<tr><th></th><th colspan="3">Q1</th><th>Q2</th><th>Q3</th><th>Q4</th><th>Total</th></tr>
<tr><th></th><th>Oct</th><th>Nov</th><th>Dec</th><th></th><th></th><th></th><th></th></tr>
<tr><td>GHS</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Lapeer</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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<tr><td>St. Clair</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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<tr><td>TOTAL</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><th colspan="7">Inquiry Dispositions:</th><th>Total</th></tr>
<tr><td colspan="7">Appeal</td><td></td></tr>
<tr><td colspan="7">Grievance</td><td></td></tr>
<tr><td colspan="7">Referral to Access</td><td></td></tr>
<tr><td colspan="7">Rights Complaint</td><td></td></tr>
<tr><td colspan="7">Referral to Provider</td><td></td></tr>
<tr><td colspan="7">Other</td><td></td></tr>
<tr><td colspan="7">Pending</td><td></td></tr>
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</td><td></td><td></td></tr>
<tr><td>Appeals</td><td>The goals for FY2025 Reporting are as follows:
• To review and analyze baseline appeals data for the region for FY2025.
o To track and trend internally the appeals on a monthly basis.
o Identify consistent patterns related to appeals.
o Develop interventions to address critical issues within the Network.

<table>
<tr><th colspan="8">Reporting Period: FY2025</th></tr>
<tr><th></th><th colspan="3">Q1</th><th>Q2</th><th>Q3</th><th>Q4</th><th>Total</th></tr>
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</td><td>Katie Forbes

PIHP Customer Service Department</td><td>Quarterly Update:

Q 1 (Oct-Dec):
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Q 4 (July-Sept):

Evaluation:
Barrier Analysis:
Next Steps:</td></tr>
</table>

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	SUD | TOTAL **Reason for Appeal:** / **Total** Grievance not resolved within 90 days Grievance not resolved within allowed days Request not acted on within 14 days Service Denial Service not started within 14 days Service Reduction Service Suspension Service Termination		
Grievances	The goals for FY2025 Reporting are as follows: • To review and analyze baseline grievance data for the region for FY2025. o To track and trend internally the grievances on a monthly basis. o Identify consistent patterns related to grievances. o Develop interventions to address critical issues within the Network. o Meet with CMHSPs quarterly to discuss procedures for the receipt and completion of grievances. o Conduct a first quarter record review to audit grievance records for alignment with federal and contractual requirements. Interventions will be developed based on findings. Additional record reviews may be developed based on findings. **Reporting Period: FY2025** **Q1** (Oct / Nov / Dec) | **Q2** | **Q3** | **Q4** | **Total** GHS Lapeer PIHP Sanilac	Katie Forbes PIHP Customer Service Department	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

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<tr><td>TOTAL</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="7">Reason for Grievance:</td><td>Total</td></tr>
<tr><td colspan="7">Financial Matters</td><td></td></tr>
<tr><td colspan="7">Quality of Care</td><td></td></tr>
<tr><td colspan="7">Service Concerns / Availability</td><td></td></tr>
<tr><td colspan="7">Service Environment</td><td></td></tr>
<tr><td colspan="7">Suggestions / Recommendations</td><td></td></tr>
<tr><td colspan="7">Other</td><td></td></tr>
</table>
</td><td></td><td></td></tr>
<tr><td>Credentialing / Privileging</td><td>The goals for FY2025 Reporting are as follows:
• Complete Privileging and Credentialing reviews of Organizational Applications for CMH and SUD Providers.
o Review and approve or deny all Organizational Applications:
▪ Current Providers
▪ New Providers
▪ Existing Provider Renewals / Updates
▪ Provider Terminations / Suspensions / Probationary Status
▪ Provider Adverse Credentialing Determinations</td><td>Lauren Campbell

Privileging and Credentialing Committee</td><td>Quarterly Update:

Q 1 (Oct-Dec):
Q 2 (Jan-Mar):
Q 3 (Apr-June):
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Evaluation:
Barrier Analysis:
Next Steps:</td></tr>
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Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Credentialing / Privileging	The goals for FY2025 Reporting are as follows: • Complete Privileging and Credentialing reviews of all applicable Region 10 staff. o Review and approve or deny all PIHP Individual Practitioner Applications (includes PIHP Medical Director, Chief Clinical Officer, Clinical Manager, direct hire Access Clinicians: ▪ Current Practitioners ▪ New Practitioners ▪ Existing Practitioner Renewals / Updates ▪ Practitioner Terminations / Suspensions / Probationary Status ▪ Practitioner Adverse Credentialing Determinations	Lauren Campbell Privileging and Credentialing Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Credentialing / Privileging	The goals for FY2025 Reporting are as follows: • Maintain a current and comprehensive policy on Privileging and Credentialing inclusive of MDHHS and Medicaid standards. o Review and update the current PIHP Privileging and Credentialing policy content. ▪ Review for alignment between policy and applications. ▪ Revise and clarify language where needed.	Lauren Campbell Privileging and Credentialing Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Credentialing / Privileging	The goals for FY2025 Reporting are as follows: • Participate in MDHHS' Universal Credentialing initiative. o Participate in MDHHS-hosted meetings regarding Universal Credentialing. o Develop necessary processes to support Universal Credentialing efforts.	Lauren Campbell Privileging and Credentialing Committee	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis

Autism Program	The goals for FY2025 Reporting are as follows:
	• Reduce and monitor the number of beneficiaries waiting to start Applied Behavioral Analysis (ABA) services. as reported monthly on the Autism Monthly Reporting Form.
	  o Monitor number of individuals eligible and not receiving services through provider numbers presented monthly on the Autism Monthly Reporting Form.
	  o Monitor timely submission of the Autism Monthly Reporting Form and timely communication from the CMHSP Autism Leads.
		Shannon Jackson
		
		Monitored by Quality Improvement Committee (QIC)
			Quarterly Update:
			
			Q 1 (Oct-Dec):
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			Q 3 (Apr-June):
			Q 4 (July-Sept):
			
			Evaluation:
			Barrier Analysis:
			Next Steps:

Customer Relationship Management (CRM) System	The goals for FY2025 Reporting are as follows:
	• Monitor the implementation and integration of the Customer Relationship Management (CRM) System and those business processes that are housed within the platform.
	  o Provide technical assistance to users as needed.
	  o Evaluate implementation throughout Region 10.
	  o Maintain oversight of business processes within the CRM, including:
	  ▪ American Society of Addiction Medicine (ASAM) Level of Care
	  ▪ Certified Community Behavioral Health Clinic (CCBHC) Certification
	  ▪ CMHSP Certification
	  ▪ CMHSP Programs & Services Certification
	  ▪ Contract Management
	  ▪ Critical Incident Reporting
	  ▪ Customer Service Inquiry
	  ▪ First Responder Line
	  ▪ Michigan Crisis and Access Line (MiCAL)
	  ▪ Universal Credentialing
	  ▪ Warmline
		Laurie Story-Walker
		
		Monitored by Quality Improvement Committee (QIC)
			Quarterly Update:
			
			Q 1 (Oct-Dec):
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			Q 4 (July-Sept):
			
			Evaluation:
			Barrier Analysis:
			Next Steps:

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Substance Use Disorder (SUD) Health Home	The goals for FY2025 Reporting are as follows: • Development of the Substance Use Disorder Health Home (SUDHH) model within Region 10. o Identify, enroll, and onboard potential Health Home Partner(s) (HHP). o Increase and manage enrollment of SUDHH beneficiaries. o Development of continuous utilization and quality improvement program.	Jacqueline Gallant Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
State Opioid Response (SOR) Grant	The goals for FY2025 Reporting are as follows: • Ensure the Government Performance and Results Act (GPRA) survey is completed for all applicable SOR-funded treatment services. o Define specific criteria for GPRA survey requirements based on factors such as the demographics of populations served (including diagnosis and funding source eligibility), types of services delivered, and involvement of providers. o Provide comprehensive training for relevant providers to proficiently administer and report GPRA surveys at the necessary intervals for relevant cases. o Establish a streamlined process to communicate the mandatory completion of GPRA surveys for relevant intake referrals. o Develop a protocol to guarantee ongoing communication of the necessity for GPRA survey as individuals served transition to alternate providers.	Heather Haley/SOR Coordinator Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
State Opioid Response (SOR) Grant	The goals for FY2025 Reporting are as follows: • Ensure that Government Performance and Results Act (GPRA) completion is tracked and matched to PIHP ID numbers. o Establish a streamlined procedure to align GPRA surveys reported to Wayne State University with individual cases served by Region 10.	Heather Haley/SOR Coordinator Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Monitor and analyze GPRA completion data from Qualtrics (Wayne State University) in conjunction with referrals initiated by Region 10 Access, ensuring alignment where GPRA surveys are necessary. ○ Institute clear benchmarks for evaluating provider performance and adherence to Region 10's SOR/GPRA criteria. ○ Implement a structured approach for identifying and addressing data disparities, particularly focusing on referrals necessitating GPRA surveys with no corresponding data in Qualtrics.		**Barrier Analysis:** **Next Steps:**
Certified Community Behavioral Health Clinic (CCBHC) Demonstration	The goals for FY2025 Reporting are as follows: • Continue development of the Certified Community Behavioral Health Clinic (CCBHC) demonstration within Region 10. ○ Follow up on and monitor MDHHS Site Visit deficiencies. ○ Review CCBHC Reported Measures and State Reported Measures to maintain oversight of CCBHC Demonstration performance measures and to ensure Quality Bonus Payment benchmarks are met. ○ Oversee enrollment of CCBHC Beneficiaries in the WSA and maintaining accurate enrollee reporting: ▪ Continue updating WSA processes per the most current version of the Demonstration Handbook changes or implementations. ▪ Complete assignment into the program, transfer cases, and disenroll consumers, as needed. ▪ Continuing WSA Subcommittee meetings with CCBHC staff. ○ Educate PIHP and CCBHC staff on Demonstration requirements and operations as changes are made. ○ Enhance oversight of CCBHC encounters submitted to PIHP with qualifying diagnoses.	Dena Smiley Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
1915(i) State Plan Amendment (SPA)	The goals for FY2025 Reporting are as follows: • Continue development of the 1915(i)SPA model within Region 10. o Enroll and manage eligible 1915(i) Home and Community-Based Services State Plan Amendment Benefit beneficiaries in the Waiver Support Application (WSA) and maintain accurate enrollee reporting. o Monitor beneficiary enrollment to meet MDHHS guidelines regarding assessments, evaluator credentials, and overlap with other programs. o Monitor the number of beneficiaries with untimely re-evaluations and document efforts to reduce untimeliness. o Review and share reports and barriers to maintain timely submission and processing of Re-evaluations and disenrollments. o Educate PIHP and CMHSP staff on 1915(i) requirements as changes are made.	Shelley Wilcoxon Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**
Verification of Services	The goals for FY2025 Reporting are as follows: • The PIHP will verify whether services reimbursed by Medicaid were furnished to members by affiliates (as applicable), providers, and subcontractors. o Conduct quarterly claims verification reviews for each provider contracted during the quarter being reviewed. o Prepare and submit an annual report including the claims verification methodology, findings, and actions taken in response to findings. o Update the PIHP Claims Verification Policy 04.03.02 to better reflect current processes. o Send Explanation of Benefits (EOB) letters biannually during the fiscal year. o Send EOB letters to more than 5% of consumers receiving services.	Deidre Slingerland Quality Management & Data Management Departments	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Long-Term Services and Supports	The goals for FY2025 reporting are as follows: • The PIHP will assess the quality and appropriateness of care furnished to beneficiaries receiving long-term services and supports (LTSS), including assessments of care between care settings and a comparison of services and supports received with those set forth in the beneficiary's treatment/service plan. Mechanisms to assess include: o Periodic reviews of plans of service o Utilization reviews o Claims verification reviews o Clinical case record reviews o Customer satisfaction surveys • The PIHP will assess each beneficiary identified as needing LTSS to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring. Mechanisms to assess include: o Biopsychosocial assessments o Ancillary assessments • At least 95% of cases selected for utilization reviews will be in compliance with person-centered planning guidelines.	Tom Seilheimer / Lauren Campbell Monitored by Quality Improvement Committee (QIC)	**Quarterly Update:** **Q 1 (Oct-Dec):** **Q 2 (Jan-Mar):** **Q 3 (Apr-June):** **Q 4 (July-Sept):** **Evaluation:** **Barrier Analysis:** **Next Steps:**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis

External Quality Review Corrective Actions	The goals for FY2025 Reporting are as follows:
	• Implement corrective action plans (CAPs) and address recommendations from External Quality Reviews.
	  o Standard Leads will report Compliance Review CAP updates monthly to the External Quality Review Team.
	  o Recommendations resulting from the Performance Measure Validation (PMV) and Network Adequacy Validation (NAV) Review will be addressed by the Provider Network Management Department, Quality Management Department, and Data Management Department.
	  o Any recommendations resulting from the Encounter Data Validation (EDV) activity will be addressed by the Quality Management Department and Data Management Department.
	
	Following the SFY2024 Compliance Review of Region 10 PIHP, designated Standard Leads will address any recommendations and deficiencies for the following areas:
	
	• Standard I. Member Rights and Member Information
	• Standard III. Availability of Services
	• Standard IV. Assurances of Adequate Capacity of Services
	• Standard V. Coordination and Continuity of Care
	• Standard VI. Coverage and Authorization of Services
		Compliance Monitoring: Standard Leads & External Quality Review Team / Lauren Campbell
		
		Performance Measure Validation and Network Adequacy Validation Review: Lauren Campbell
		
		Encounter Data Validation Activity: Lauren Campbell and Laurie Story-Walker
			Quarterly Update:
			
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			Q 3 (Apr-June):
			Q 4 (July-Sept):
			
			Evaluation:
			Barrier Analysis:
			Next Steps:

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As of 10.03.2024