Quality Assessment and 
Performance Improvement Program

REGIONAL QUALITY IMPROVEMENT PLAN

Fiscal Year 2017
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### SECTION ONE: OVERVIEW

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<tbody>
<tr>
<td>BBA</td>
<td>Balanced Budget Act</td>
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<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
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<tr>
<td>CFR</td>
<td>Code of Federal Regulations</td>
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<tr>
<td>CMHSP</td>
<td>Community Mental Health Service Program</td>
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<td>CMS</td>
<td>Center for Medicare and Medicaid Services</td>
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<td>COO</td>
<td>Chief Operating Officer</td>
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<tr>
<td>CSSN</td>
<td>Comprehensive Specialty Services Network</td>
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<td>EQR</td>
<td>External Quality Review</td>
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<td>EORO</td>
<td>External Quality Review Organization</td>
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<td>HSAG</td>
<td>Health Services Advisory Group</td>
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<td>KPIs</td>
<td>Key Performance Indicators</td>
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<td>LRE</td>
<td>Lakeshore Regional Entity</td>
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<td>LREOC</td>
<td>Lakeshore Regional Entity Operations Committee</td>
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<td>MDHHS</td>
<td>Michigan Department of Health and Human Services</td>
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<td>MMBPIS</td>
<td>Michigan Mission-Based Performance Indicator System</td>
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<td>PDCA</td>
<td>Plan-Do-Check-Act</td>
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<td>PIHP</td>
<td>Prepaid Inpatient Health Plan</td>
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<td>PIP</td>
<td>Performance Improvement Project</td>
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<td>POC</td>
<td>Plan of Correction</td>
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<td>QAPIP</td>
<td>Quality Assessment and Performance Improvement Program</td>
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<td>QI</td>
<td>Quality Improvement</td>
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<tr>
<td>QIP</td>
<td>Quality Improvement Program</td>
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<td>QI-ROAT</td>
<td>Quality Improvement - Regional Operations Advisory Team</td>
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<td>QISMC</td>
<td>Quality Improvement System for Managed Care</td>
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<td>QM</td>
<td>Quality Management</td>
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<td>QMR</td>
<td>Quality Monitoring Reviews</td>
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<tr>
<td>RSA</td>
<td>Recovery Self-Assessment</td>
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<tr>
<td>SED</td>
<td>Children with Serious Emotional Disturbances</td>
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<td>UM</td>
<td>Utilization Management</td>
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<tr>
<td>VDMS</td>
<td>Verification of the Delivery of Medicaid Services</td>
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INTRODUCTION

The Michigan Department of Health and Human Services (MDHHS) requires that each specialty Prepaid Inpatient Health Plan (PIHP) have a documented Quality Assessment and Performance Improvement Program (QAPIP) which meets the specified standards in the contract with MDHHS. This document, referred to as the “Regional Quality Improvement Plan”, updates the QAPIP on an annual basis for the Lakeshore Regional Entity (LRE or “the Region”), which includes Allegan County Community Mental Health (ACCMH), HealthWest (Muskegon County CMH), network180 (Kent County Community Mental Health Authority), Community Mental Health of Ottawa County (CMHOC), and West Michigan Community Mental Health System. Each Community Mental Health Services Program (agency) is referred to as a CMHSP.

In addition to meeting the MDHHS QAPIP requirements, this plan is also designed to meet other requirements:

A. The Center for Medicare and Medicaid Services (CMS) for a Quality Improvement System for Managed Care (QISMC) as outlined through the quality assurance provisions of the Balanced Budget Act of 1997 as amended.
C. Accreditation standards in the areas of quality and organizational improvement.
D. Many of the MDHHS requirements for a CMHSP to have a Quality Improvement Program (QIP) have been standardized across the LRE and are included in this document. Areas where CMHSP distinctions are necessary have been outlined through attachments to this plan. The distinct areas include:
   1. Additional elements of the CMHSP QI structure
   2. Specific CMHSP QI objectives

PURPOSE

Additional purposes for the QAPIP (also known as the Regional QI Plan) are as follows:

A. Continually evaluate and enhance the LRE’s QI Processes and Outcomes.
B. Monitor and evaluate the systems and processes related to the quality of clinical care and non-clinical services that can be expected to affect the health status, quality of life, and satisfaction of persons served by each CMHSP member.
C. Identify, and assign priority to, opportunities for performance improvement.
D. Create a culture that encourages stakeholder input and participation in problem solving.

PERFORMANCE IMPROVEMENT GOALS/OBJECTIVES

The FY2016 LRE quality improvement goals and objectives are outlined at the end of this document (beginning on page 30).
SECTION TWO: QUALITY IMPROVEMENT PROCESS, SYSTEM, STANDARDS AND STRATEGIES

QUALITY IMPROVEMENT AUTHORITY AND STRUCTURE

I. Governance

The LRE Board of Directors retains the ultimate responsibility for the quality of the Medicaid funded services provided by the LRE member agencies. The LRE Board approves the overall Regional Quality Improvement Plan. Each CMHSP Board approves the specific CMHSP’s QIP structure, goals and objectives.

To assist the LRE Board in its oversight of regional services, the LRE Board has created the LRE Operations Committee (LREOC), consisting of CEO representation from all member organizations. As it pertains to the PIHP’s QAPIP, the LREOC reviews the annual Regional QI Plan. The LRE CEO is responsible for submitting a regional QAPIP to the LRE Board of Directors for final approval. In this way, regional governance input occurs via the Plan’s approval process.

II. Management Structure

As noted in the above section, the LRE has overall responsibility for the Regional QI Plan (QAPIP). To facilitate the development and management of the QAPIP, the PIHP has created the LRE Quality Improvement Regional Operations Advisory Team (QI ROAT), which consists of managers from the Regional CMHSPs.

Overall, the Chief Operating Officer (COO) for the PIHP has day-to-day administrative management and oversight of the QAPIP and QIP. The COO keeps the LREOC and LRE Board informed of region-wide quality improvement activities and performance improvement projects, and provides periodic updates to the LRE Board. The LRE organization quality model can be depicted on the following page:
III. Quality Improvement Regional Operations Advisory Team (QI-ROAT)

Membership
The Quality Improvement Regional Operations Advisory Team shall consist of the COO, Quality Coordinator and Quality Specialists of the LRE. Each Member CMHSP will have at least one representative. There will be representation on the ROAT from Consumers and the Provider Network. Other ad hoc members may include functions such as information systems, clinical, contract management, claims management, and finance.

Purpose and Function
Quality Management (QM) is one of the core functional elements of the PIHP. Within the PIHP construct, the LRE Quality Management Division is charged with providing network-wide oversight and management of all the PIHP’s quality management functions, whether administered directly by the PIHP, or delegated to a sub-network provider. Overall, the PIHP is required to manage the quality management system for the entire Lakeshore Region’s specialty benefit provider network.

To ensure network input into its QM program, the PIHP created the Quality Improvement Regional Operations Advisory Team (QI-ROAT). The QI-ROAT is a standing group of the PIHP’s organizational structure. The QI-ROAT is comprised of PIHP, CMHSP, Consumer and Provider Network representatives, and is designed as an avenue for all regional network partners to provide input to the PIHP regarding its development and management of regional network programs, plans, policies, protocols, forms, and processes related to quality management. The QI-ROAT is responsible for providing input in the development and management of the annual PIHP “Quality Assessment Performance Improvement Plan” (QAPIP). The QI-ROAT provides network review, input and program improvement recommendations to minimize the risks of the PIHP, while enhancing service delivery quality across the entire provider network.

The primary task of QI-ROAT is to assist the PIHP in its overall management of the network’s QM function, by providing advisory input on the following:

- The annual review of the PIHP’s QAPIP.
- The annual review/status of the PIHP’s annual QI Plan.
- Provide assistance and support to each member as needed regarding local QM functions.
- Determine, establish and monitor the outcomes of the required PIHP Performance Improvement Projects.
- Establish, as needed, other performance improvement projects that have network-wide impact.
- Assure quality improvement principles and techniques are used to improve critical processes and outcomes.
- Identify and coordinate LRE member/staff educational needs in continuous quality improvement.
- Promote and expand outcome information on persons served and ensure that it is collected, analyzed, used for improvement and shared with relevant stakeholders.
- Promote the use of stakeholder input in decision making across the region.
- Assess PIHP processes and systems, and identify process and teams that can be standardized, reduced in variation, simplified, streamlined and/or improved.
- Provide guidance to the PIHP on community needs and beneficiary feedback survey assessment activities and promote system change based on data/information collected.
• Assist in the preparation and coordination of external reviews of the member agencies (i.e., MDHHS Site Review, External Quality Review) and facilitate corrective action and follow-up where indicated.

• Work closely with other PIHP Teams such as the Customer Services and Utilization Management Teams as well as the Provider Network and Corporate Compliance Committees to analyze aggregate performance data.

• Developing polices, standards and related legal, regulatory and accreditation requirements pertaining to quality management.

• Identifying trends and key indicators related to persons-served and specialty benefit behavioral health care services.

• Reviewing ongoing reports from the LRE’s quality improvement activities, advising on standards and requirements, as defined in the PIHP’s QAPIP.

• Monitoring organizational progress in meeting the quality management program goals and objectives, and evaluates the overall effectiveness of the PIHP’s QAPIP on an annual basis.

• Revising processes and tools for monitoring the provider network system on an annual basis.

• Recommending quality initiative when performance does not meet established quality standards or other requirements.

In addition to the above, each member can refer systemic processes or performance issues to the QI-ROAT. In those instances, where desired process/outcome gain can only be achieved through collaboration of more than one LRE member, the QI ROAT may establish a regional Performance Improvement Project (PIP). Members of the QI ROAT shall help coordinate ad hoc teams and PIPs that may be assembled to resolve specific quality and performance related problems and issues.

The QI-ROAT serves as a central point for the disbursement of quality improvement related reports (i.e., QAPIP, Outlier Reports, Performance Improvement Project reports) and establishes and maintains standardized quality management process (i.e., surveys, data collection provider monitoring review tools) and policies (i.e., Quality Management, Performance Improvement, and Critical Incidents/Event Reporting).

IV. Summary of Additional ROATS/Workgroups

Autism Workgroup
The Autism Workgroup is composed of partner autism leads from each CMHSP member. They meet on a regular basis to address training needs, capacity, timeliness of services and regional issues surrounding autism services.

Clinical ROAT
The purpose of this ROAT is to act as an advisory capacity for the LRE in Clinical related issues. Clinical standards, best practices or evidence-based practices are reviewed for Region-wide application. This ROAT will advise the LRE when specific input on program models and effectiveness is required.

Corporate Compliance Workgroup
The Corporate Compliance Workgroup meets on an ad hoc basis to address any issues pertaining to the compliance plan, policies and procedures, training and education efforts and
processes for reporting compliance to the LRE Compliance Officer. This may include the discussion around regional compliance issues and state and national priorities.

Customer Services Workgroup
The Customer Services Workgroup meets on a monthly basis to review customer services data, update the Guide to services and address regional issues surrounding customer services.

Consumer Advisory Panel
The LRE Consumer Advisory Panel is an advisory group of primary and secondary consumers served by the CMHSPs within the Region. This council assists and advises LRE staff in identifying issues and areas of concern related to regional service delivery and managed care operations. It is a primary source of consumer input into the development of policies, procedures and operations where recipients of service may make recommendations for quality improvement. The LRE Consumer Advisory Panel will focus on region-wide political and advocacy issues and inform the efforts of the LRE Legislation and Advocacy Committee along with region-wide opportunities for stigma reduction related to mental health and substance use disorders. “Mental health” includes children with severe emotional disturbances, adults with mental illness, and persons with intellectual and/or developmental disabilities. In FY 2016 this group became a subgroup of the LRE Board of Directors.

Finance ROAT
This ROAT keeps members up on current Finance related topics at MDHHS and within the Region, and advises regarding financial impact of rates and processes within the region.

HAB Waiver Workgroup
The HSW Workgroup is composed of partner HSW leads from each CMHSP member. They meet on a regular basis to address slot maintenance, recoupments and regional issues surrounding home and community based waiver services. During 2016 the LRE also began meeting with a regional group related to meeting the requirements of the CMS rule changes related to the waiver.

Integrated Healthcare ROAT
This ROAT is still under development. The purpose of this ROAT is to act in an advisory capacity for the development of integrated healthcare with the Health Plans assigned to our Region. The group may also advise on potential service models, needed healthcare data, and desired outcomes for integrated care.

Information Technology ROAT
IT ROAT provides advisory input into strategy and direction for information system needs for the Region. Projects include Regional IT efficiencies, implementation of the Zenith system.

MMBPIS Workgroup
The MMBPIS Workgroup meets quarterly to review, discuss and monitor MMBPIS Report submissions and processes. Membership includes individuals from each of the CMHSP Partners who has the responsibility for reporting the quarterly MMBPIS data to Lakeshore Regional Entity and chaired by LRE Quality Improvement Staff. MMBPIS Workgroup members analyze quarterly MMBPIS data looking for trends and issues. Cases not meeting the MDDHS Standards are reviewed and Workgroup members and issues addressed.
MMBPIS Workgroup members also review MMBPIS data definitions and MMBPIS data collection processes to provide consistency in data collection and interpretation across the Region.

Provider Network ROAT
The Provider Network ROAT provides advisory input to the LRE around the development of a strong and viable provider network. This includes contract development, determination of network adequacy and making recommendations to the LRE for changes in services.

Provider Network Advisory Council
The Provider Network Advisory Council is an open meeting for all providers of Medicaid billable services throughout the Region. The Council meets monthly.

SUD Implementation Workgroup
This workgroup brings together lead people throughout the Region who are responsible for implementing delegated SUD services – Access and Provider Panel management. It is a time to provide updates on regional and statewide developments and priorities as the LRE executes the three-year strategic plan submitted to the State. Project rosters are developed that identify key program development needs for SUD services in the region. The themes are around standardization of services, extension of best practices, development of new recovery support services, budget management, collaborative problem-solving, etc.

Utilization Management ROAT
The Utilization Management ROAT provides oversight to the UM activities occurring in the Region. This oversight includes the development of utilization management policies and procedures and review of service utilization data to evaluate for over/under utilization of services.

V. Incorporation of ROAT Activities
LRE ROAT and workgroup leads are responsible for bringing key advisory input to the LRE Executive and Leadership Groups. An objective for 2017 is to have all meeting minutes from all ROATs and Workgroups available on the LRE Intranet.

VI. QI Team
The QI Team consists of the COO, the QI/Provider Network Coordinator, Quality and Operations Specialist, the HSW/Autism Coordinator and members of the QI/Contract Specialist Team. The Team meets monthly with the purpose of ensuring completion of all day-to-day activities related to quality improvement, implementation of the QAPIP, review of analysis before distribution to other areas of the LRE. Work completed by the QI Team is incorporated into the QI-ROAT for feedback.
The Quality Management System of the Lakeshore Regional Entity combines the traditional aspects of quality assurance and adds the elements of continuous quality improvement by utilizing the Plan-Do-Check-Act process (described below). The Quality Management System helps the LRE achieve its mission, realize its vision, and live its values. It protects against adverse events and it provides mechanisms to bring about positive change. Continuous quality improvement efforts assure a proactive and systematic approach that promotes innovation, adaptability across the region, and a passion for achieving best practices.

The Plan-Do-Check-Act (PDCA) process is a problem-solving approach commonly used in quality control efforts. It is oftentimes referred to as the Deming Cycle. There are four steps to the process and the process can be repeated indefinitely until the desired outcome is achieved:

1. Plan: design (or revise) a process to improve results
2. Do: implement the plan and measure its performance
3. Check: measure and evaluate the results and determine if the results meet the desired goals
4. Act: decide if changes are needed to improve the process. If so, then start the process over.

A graphical representation of the PDCA process is described below:
The Quality Management System includes:

- Predefined quality standards
- Formal assessment activities
- Measurement of outcomes and performance
- Strategies to improve performance that is below standards

The various aspects of the system are not mutually exclusive to just one category, as an aspect can overlap into more than one category. The next table identifies some of the more common standards, assessment activities, measurements, and improvement strategies used by the LRE’s Quality Management System.

<table>
<thead>
<tr>
<th>Quality Standards</th>
<th>Assessment Activities</th>
<th>Performance Measurements</th>
<th>Improvement Strategies</th>
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<tr>
<td>Federal &amp; State Rules/Regulations</td>
<td>Provider Monitoring Reviews</td>
<td>MDHHS MMBPIS</td>
<td>Corrective Action/ Improvement Plans</td>
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<td>Accreditation Surveys</td>
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<td>Risk Management</td>
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<td>Stakeholder Input</td>
<td>Grievances &amp; Appeals</td>
<td>Staff Development and Training</td>
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<td>Evidence Based Practices</td>
<td>Critical Event Reports</td>
<td>Board Ends Report using LRE Dashboards</td>
<td>Improvements through Root Cause Analysis</td>
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<td>Promising Practices</td>
<td>MDHHS Site Review Report</td>
<td>Behavior Treatment Analysis</td>
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| Fidelity Monitoring Reviews | |

1. Quality Standards

Quality Standards provide the specifications, practices, and principles by which a process may be judged or rated. The LRE identifies and sets standards by reviewing, analyzing, and integrating such areas as:

- Performance expectations of stakeholders for both clinical services and administrative functions
- Accreditation standards
- Practice Guidelines
- Clinical pathway protocols and other authorization criteria
- Government requirements, regulations and rules
The LRE’s quality standards are documented in policy and procedure, contracts, and the quality review process. These standards are evaluated, at least annually, to assure continued appropriate and relevant application.

**Confidentiality** – the Lakeshore Regional Entity is absolutely committed to maintaining the confidentiality of persons served in our organization. The following statements below reflect specific tenet of this commitment. Specific details are reflected in the Lakeshore Regional Entity’s Policy and Procedure.

1. The contents of clinical records and provider credentialing files are confidential.
2. Although usually accomplished via aggregate non-individual-identifying reports, at times the Regional Entity’s staff may review specific individually-identifiable information. In those situations, the confidentiality of the information will be protected.
3. Access to confidential quality improvement or quality oversight information (i.e. clinical information, customer history, credentialing information) shall be restricted to those individuals and/or committees charged with the responsibility/accountability for the various aspects of the program.
4. Individual provider information may be utilized and/or evaluated at the time of re-credentialing or contracting.
5. All customers and/or individual provider-specific information will be kept in a confidential manner in accordance with applicable federal and state laws and will be used solely for the purposes of quality oversight and/or directly related activities. Disclosing confidential customers and/or provider information internally or externally may be grounds for immediate dismissal from the committee.

**II. Quality Assessment Activities**

Quality assessment consists of various strategically planned activities that help to identify the actual practices, attitudes, performance, and conformance to standards that are enhancing or inhibiting the achievement of quality. Obtaining stakeholder input is critical to quality assessment activities.

**Stakeholder Input**

All members of the Lakeshore Regional Entity recognize that a vital aspect of any system for the continuous improvement of quality is a means to obtain stakeholder satisfaction and stakeholder input information. Typical stakeholders identified to provide input to the LRE members are service consumers, staff, contract service providers, families/advocates, and the local communities. Stakeholder input is gathered from a variety of methods. These methods include:

1. Satisfaction Surveys
2. Consumer Advisory Panel
3. LRE Customer Services.
4. Scheduled and ad-hoc interviews (such as interviews as part of site review process).
5. Needs Assessments
6. Case Reviews
7. Provider Surveys
8. Public Comment at Board Meetings
Input is collected to better understand how the LRE is performing from the perspective of its stakeholders. Quantitative and qualitative assessments are conducted which address issues of quality, availability and accessibility of care. The input is continually analyzed, and the analysis is integrated into the practices of the LRE. As a result of input from stakeholders, the LRE:

1. Takes specific action on individual cases as appropriate.
2. Identifies and investigates sources of dissatisfaction.
3. Outlines systemic action steps to follow-up on findings.
4. Utilizes stakeholder input in decision-making.
5. Informs practitioners, providers, persons served, and the Board of the results of assessment activities.

The Plan-Do-Check-Act process for Stakeholder input is designed so that when any input is received from the community (in the very broad sense), that input is assigned to the appropriate ROAT, Workgroup or Committee for discussion and resolution. Depending on the subject matter, the input may simply be responded to or the input could be elevated to a committee or project management plan. Once the input has been received, addressed and a resolution created, the results will be communicated within appropriate avenues.

**Quality Monitoring Site Reviews**

The Quality Monitoring Site Review (QMR) process is a systematic and comprehensive approach to monitor, benchmark, identify and implement improvements in the provision of mental health and substance abuse services to funded consumers. The LRE annually monitors its provider network including service and support provisions. Through the QMR process the LRE:

- Establishes clinical and non-clinical priority areas for improvement
- Uses a variety of measures to analyze the delivery of services and quality of care
- Analyzes both the processes and outcomes of care using currently accepted standards.
- Establishes performance goals and compares findings and ratings with past performance
- Conduct additional special targeted monitoring activities of people who are identified as vulnerable (as defined by MDHHS)
- Provides performance feedback to providers through both an exit conference and written report
- Requires an improvement plan (plan of correction) from providers for areas under goal and in non-compliance with accepted standards
- Review and approve improvement plans
- Ensures implementation of each submitted improvement plan.

The Plan-Do-Check-Act process for Quality Monitoring Reviews is designed so each CMHSP is reviewed on an annual basis. If a plan of correction is required, then CMHSP has 30 days to respond. The LRE either accepts the plan of correction as written or requests more information and/or recommends additional changes. Once the plan of correction is approved by the LRE, the CMHSP is required to submit an update 6-months detailing progress on planned changes. The plan of correction is reviewed at the following year’s CMHSP Quality Monitoring Site Review.
**MDHHS Site Reviews**
The LRE will monitor LRE member performance on site reviews conducted by MDHHS. To best address local concerns, each LRE member will draft remedial action for all citations for which the LRE member has been identified as being out of compliance. The QI ROAT will be informed of all findings and provide input into the LRE response.

<table>
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<tr>
<th>NAME OF REVIEW</th>
<th>APPLICATION</th>
<th>FREQUENCY OF REVIEW</th>
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<tr>
<td>MDHHS Site Review</td>
<td>Habilitation Supports Waiver</td>
<td>Full review every other year; follow-up review on off year</td>
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<tr>
<td>Bureau of Substance Abuse and Addiction Services Review</td>
<td>Substance Abuse – Treatment &amp; Prevention</td>
<td>Full review every other year; follow-up review on off year</td>
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<tr>
<td>Children’s &amp; SED Waiver Program Review</td>
<td>Children’s &amp; SED Waiver</td>
<td>Full review every other year; follow-up review on off year</td>
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<td>Children’s Diagnostic &amp; Treatment Services Program</td>
<td>Children’s Services</td>
<td>Every 3 years</td>
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<tr>
<td>Certification Review</td>
<td>Non-accredited CMHSP’s &amp; Providers</td>
<td>Every 3 years</td>
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The Plan-Do-Check-Act process for MDHHS Site Reviews is for LRE lead staff to assume responsibility for ensuring all aspects of each Site Review is properly handled. When a plan of correction is received, the LRE lead staff will distribute to all applicable PIHP/CMHSP staff for plan of correction development. The LRE Executive Team and QI-ROAT will review the plan of correction prior to it being sent to MDHHS for approval. LRE lead staff are responsible for plan of correction implementation and monitoring, with oversight by the QI-ROAT and the LRE Executive Team.

**External Quality Reviews**
The Balanced Budget Act (BBA) of 1997 requires that states contract with an External Quality Review Organization (EQRO) for an annual independent review of each Prepaid Inpatient Health Plan (LRE) to evaluate the quality and timeliness of, and access to, health care services provided to Medicaid enrollees. MDHHS contracts with the Health Services Advisory Group (HSAG) to conduct the reviews within the state of Michigan.

The stated objective of the annual evaluation is to provide meaningful information that MDHHS and the LRE can use for:

- Evaluating the quality, timeliness, and access to mental health and substance abuse care furnished by the LRE
- Identifying, implementing, and monitoring system interventions to improve quality
- Evaluating one of the two performance improvement projects of the LRE
- Planning and initiating activities to sustain and enhance current performance processes.
**Critical Incident Reporting and Risk Events Management**

The Critical Incident Reporting System captures information on specific reportable events: suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and arrest of consumer. The population on which these events must be reported differs slightly by type of event. The Lakeshore Regional Entity will analyze at least quarterly the critical incidents, sentinel events, and risk events to determine what action needs to be taken to remediate the problem or situation and prevent the occurrence of additional events and incidents.

The critical incident reporting system captures information on reportable events. The LRE will report to MDHHS the following events within sixty (60) days after the end of the month in which the event occurred for individuals who, at the time of the event, were actively receiving services:

<table>
<thead>
<tr>
<th>Service</th>
<th>Suicide</th>
<th>Death</th>
<th>EMT</th>
<th>Hospital</th>
<th>Arrest</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLS</td>
<td>•</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supports Coordination</td>
<td>•</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td>•</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td>•</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Home-Based</td>
<td>•</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wraparound</td>
<td>•</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hab. Waiver</td>
<td>•</td>
<td>•</td>
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<td>•</td>
</tr>
<tr>
<td>SED Waiver</td>
<td>•</td>
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<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Child Waiver</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Any Other Service</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td><strong>Living Situation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Specialized Residential</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>CCI</td>
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</tbody>
</table>

The LRE Behavior Treatment Plan Review Team will also be responsible to monitor the additional five (5) critical events identified by MDHHS which put individuals at risk of harm. The analysis is used to determine what actions need to be taken to remediate the problems or situation and to prevent the occurrence of additional events and incidents.

**Risk Event Monitoring**

<table>
<thead>
<tr>
<th>Service</th>
<th>Harm to Self</th>
<th>Harm to Others</th>
<th>Police Calls</th>
<th>Physical Management</th>
<th>Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supports Coordination</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Case Management</td>
<td>•</td>
<td>•</td>
<td>•</td>
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<td>•</td>
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<tr>
<td>ACT</td>
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</tr>
<tr>
<td>Home-Based</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
</tbody>
</table>
Other events requiring notification to MDHHS include:

1. Relocation of a consumer’s placement due to licensing issues.
2. An occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours.
3. The conviction of a PIHP or provider panel staff members for any offense related to the performance of their job duties or responsibilities.

Except for deaths, notification of the above events shall be made telephonically or other forms of communication within five (5) business days to contract management staff members in MDHHS’s Mental Health and Substance Abuse Administration.

**Reporting of Sentinel Events and Unexpected Deaths**

This function is performed across the LRE with materials and processes that are developed to be uniformly compliant with regulations but using procedures developed by the LRE members. The LRE or its delegate has three (3) business days after a Critical Incident occurred to determine if it is a Sentinel Event. If the Critical Incident is classified as a Sentinel Event, the LRE or its delegate has two (2) subsequent business days to commence a Root Cause Analysis of the event. LRE Policy 7.3 Critical Incidents and Sentinel Events:

- Identifies when a Sentinel Event must be reported to the LRE and the time frame for such a report;
- Defines the timeframes for the implementation of a corrective action plan that results from a root cause analysis to the LRE; and
- Stipulates that persons involved in the review of Sentinel Events must have the appropriate credentials to review the scope of care.

All “unexpected deaths” of persons receiving specialty supports and services at the time of their death must be reviewed and must include:

1. Screens of individual deaths with standard information (e.g., Medical Examiner’s report, death certificate).
2. Involvement of medical personnel in the mortality reviews.
3. Documentation of the mortality review process, findings, and recommendations.
4. Use of mortality information to address quality of care.
5. Aggregation of mortality data over time to identify possible trends.

*“Unexpected deaths” include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.*

Following immediate event notification to MDHHS, LRE will submit to MDHHS, within sixty (60) days after the month in which the death occurred, a written report of its review/analysis of the unexpected death of every Medicaid Beneficiary. The written report will include:

1. Beneficiary’s name
2. Beneficiary id number (Medicaid, ABW, or MIChild)
3. Consumer ID number if he/she does not have a beneficiary ID
4. Date, time, and place of death (if in a foster care setting, the foster care license number)
5. Final determination of cause of death (from coroner’s report or autopsy). In the event the Medical Examiner’s report is not available prior to this 60 day after the month time
frame, the CMHSP will report attempts to gather the information and responses back from the Medical Examiner’s office.
6. Summary of conditions (physical, emotional) and treatment or interventions preceding death.
7. Any quality improvement actions taken as a result of an unexpected or preventable death.
8. LRE’s plan for monitoring to assure any quality improvement actions are implemented.

**Behavior Treatment Review Analysis of Data**
The QI ROAT will conduct a quarterly analysis of data from the Behavior Treatment Review Committees of the CMHSP’s when intrusive or restrictive techniques have been approved for use and/or where physical management has been used in an emergency situation. The review of data will include the number of interventions and length of time the interventions were used per individual.

**Credentialing**
The members of the LRE will ensure that services and supports are consistently provided by staff (contracted or directly operated) who are properly and currently credentialed, licensed, and qualified. The LRE Credentialing and Re-Credentialing policy outlines the guidelines and responsibilities for credentialing and re-credentialing for the LRE, and as delegated to the CSSNs and contract service providers.

**Staff Training, Development and Qualifications:**
This function is performed across the region with materials and processes that are developed to be uniformly compliant with regulations but using procedures developed by the LRE members. The LRE Quality and Compliance staff review on an annual basis each member’s adherence to LRE policies and procedures related to staff possessing the appropriate qualifications as outlined in their job descriptions, including the qualifications for all of the following:

a) Educational background;
b) Relevant work experience;
c) Cultural competence;
d) Certification, registration and licensure as required by law; and
e) Training of new personnel with regard to their responsibilities, program policy and staff development activities.

Further, each LRE member is required to identify staff training needs and provide in-service training, continuing education and staff development activities. There is an LRE Work Group that is responsible as well as for the development of staff training and education.

In addition, the LRE Regulatory Compliance unit reviews each LRE member’s Provider’s audits and corrective action plans to ensure that the members are maintaining oversight of the training of provider and Agency staff.

**Quality Assessment of Contract Providers**
In addition to the mechanisms outlined above, the LRE policy on Provider Network Monitoring describes other mechanism for monitoring and assessing compliance with contract, state and federal requirements of service providers.
III. Performance Measurement

Through monitoring and evaluating expected performance on operational activities, the efforts and resources of the LRE can be redirected to obtain the desired outcomes.

By using performance indicators, the variation between the desired target and the current status of the item(s) being measured can be identified. Indicators are used to alert the LRE and CMHSPs of issues that need to be addressed immediately, to monitor trends and contractual compliance, and to provide information to consumers and the public. Performance indicators are the foundation to control and improve processes.

Performance indicator results are used to guide management decision-making related to:

- Strategic planning
- Resource allocation
- Modification of service delivery
- Process improvements
- Staff training
- Marketing and Outreach activities
- Other activities identified by consumers and/or other stakeholders

There are four significant sets of performance indicators for the LRE. These are the Michigan Mission-Based Performance Indicator System, Dashboard and Outcomes Report, Utilization Management, and the Verification of the Delivery of Medicaid Services.

A. Michigan Mission-Based Performance Indicator System

The Michigan Mission-Based Performance Indicator System (MMBPIS) was fully implemented by MDHHS on October 1, 1998 and is in its 6th revision. There are both the PIHP and CMHSP level indicators within the system. The LRE and each of the member partners submit data to MDHHS on a quarterly basis. MDHHS collects, aggregates, trends and publishes the MMBPIS information on the indicators that MDHHS has determined would best monitor the implementation of managed care throughout the state. The QI ROAT reviews MMBPIS results. LRE Member Boards who are out of compliance with MDHHS standards work with the LRE Quality Improvement Coordinator and QI ROAT to ensure the implementation of effective improvement plans.

B. Dashboard and Outcomes Reports

In FY2015, the Lakeshore Regional Entity will complete the implementation of a Region-wide dashboard that will report on Key Performance Indicators (KPIs). One of the goals of the dashboard is to assist in growing a culture of data-based decision making, which in turn will help ensure excellence in the provision and management of the network’s behavioral health services. The LRE KPIs will be developed with stakeholder input and endorsed by LRE leadership. The LRE QI-ROAT will seek to include measures of outcome in the dashboard reports. These indicators were initially developed in 2014 and are in continuing process for further development. LRE
Dashboard and Outcomes will be reported at the PIHP and CMHSP levels. The QI-ROAT will provide advisory input regarding methodology for calculating KPIs and outcome indicators, maintaining a historical record of network-wide performance, and distribute reports to relevant stakeholder groups. Findings will be used to develop recommendations for practice improvements based on KPIs and outcome indicator results.

C. Utilization Management
Utilization Management is guided by LRE policy and procedure and an annual Utilization Management Plan. Utilization Management activities are conducted across the region to assure the appropriate delivery of services. Utilization mechanisms identify and correct under-utilization as well as over-utilization. Utilization Reviews include the review/monitoring of individual consumer records, specific provider practices and system trends. Utilization Management data will be aggregated and reviewed by the LRE Utilization Management ROAT as well as QI-ROAT for trends and service improvement recommendations.

D. Verification of the Delivery of Medicaid Services
MDHHS requires each PIHP to establish a process for the Verification of the Delivery of Medicaid Services (as defined in Attachment P.6.4.1 of the MDHHS/PIHP contract). The purpose of the process is to verify that adjudicated claims are for services identified by MDHHS as Specialty Mental Health and/or Substance Abuse services, and that the services are sufficiently supported by case record documentation. The Verification of the Delivery of Medicaid Services will be completed by qualified PIHP staff. Verification procedures will not be delegated to providers, Core Providers, CMHSPs or MCPNs. The PIHP will perform this function for ALL Providers. Since this is a new contractual requirement beginning FY2016, the LRE is developing a common methodology for verification that will meet all contractual standards including verification procedures, corrective action and recoupment procedures, reporting procedures and documentation standards.

E. Annual Plan
On an annual basis LRE QI Staff will create an Annual Plan Summary Report. This report will provide summary information on performance, trending, timeliness and issues of all quality improvement responsibilities which would include but not limited to; MMBPIS Indicators, Critical Events, Sentinel Events, Medicaid Verification Review, Site Review, Satisfaction and Grievance / Appeals. This summary report will be completed and reviewed by the LRE QI Team and presented to the QI ROAT, LRE Leadership, LRE Board and the Consumer Advisory Council for information and feedback. This report will also be posted on the LRE Website.
IV. Improvement Strategies

Establishing and successfully carrying out strategies to eliminate statistical performance outliers, incorporate best practices, and optimize consumer outcomes is key to continuous quality improvement. The particular strategy or sets of strategies used vary according to the situation and the kind of improvement that is desired. The following provides a brief description of two of the improvement strategies utilized.

A. Regional Performance Improvement Projects

The LRE conducts “performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and (consumer) satisfaction.” (Domain One of the Quality Improvement System for Managed Care [QISMC], Part 1.1.2)

Stakeholders will be encouraged to regularly submit improvement recommendations through local QI processes. Each member partner will provide input to the QI ROAT on LRE process or system improvements where needed.

At least two performance improvement projects meeting Michigan QAPIP standards and BBA standards will be conducted per each two-year CMS Michigan waiver period by the LRE. One of the two projects conducted will be a project that is mandated by MDHHS and will be reviewed and evaluated by HSAG for compliance with requirements.

B. Practice Guidelines

The LRE supports the use of clinical practice guidelines in service provision. Within the LRE, the Regional Utilization Management Committee was established to be the oversight body for the implementation and monitoring of practice guidelines in use by the member partners. The guidelines recommended for implementation are based upon State and National guidelines, when available, and are modified to fit LRE practice patterns. The current practice guidelines for the LRE are referenced in the LRE Clinical Practice Guidelines policy. Guidelines are reviewed annually or more often as indicated by UM/CPC. Monitoring of established LRE guidelines is included as part of the QMR and UM tools.

C. Annual Self-Assessment

In order to determine the committee’s own effectiveness, continuously improve the QAPIP and include committee member input into the ongoing development of the process, the QI ROAT uses an annual QAPIP Self-Assessment (Appendix C). The QAPIP was presented to the QI-ROAT during the fall of 2016 and input was included especially in the objectives for 2017.

D. Annual Program Evaluation

The QI ROATQI ROAT completes an annual QAPIP evaluation that includes:

1. A review of FY2015’s QAPIP Goals (beginning on page 27 this report);
2. A review of the Committee Self-Evaluation (see attachment E beginning on page 41 for this report);
3. A review of all quality oversight activities (see attachment F beginning on page 44 for this report);
4. A review of the appropriateness and relevance of current measures (contained throughout this report).
5. Identify FY2016 QAPIP Goals (see attachment A beginning on page 31 for this report)

Documentation of the QAPIP annual review, its findings and recommendations are forwarded to the LRE COO and the LRE Board of Directors. The annual review may lead to:

1. Identification of educational/training needs;
2. Establishment and revision of policies and procedures related to quality initiatives;
3. Recommendations regarding credentialing of practitioners;
4. Changes in operations to minimize risks in the delivery of quality services, and;
5. Development of objectives for the coming year.

COMMUNICATING QUALITY IMPROVEMENT ACTIVITIES

The LRE acknowledges the importance of disseminating quality-related information and outcome improvements. Communicating Quality Improvement (QI) activities reinforces the concept of quality as an organizational value. System changes that result from QI activities must also be communicated and implemented. Information is communicated in a variety of ways within the Region through:

1. Various reports at LRE Board Meetings
2. Annual CMHSP Performance Reports
3. Policy/Procedure changes
4. The LRE website
5. ROAT meetings
6. Consumer Advisory Council meetings
7. Provider Network Advisory Council meetings
SECTION THREE: EVALUATION AND ACCOUNTABILITY

A. The Quality Improvement Regional Operations Advisory Team (QI ROAT):
1. Reviews progress toward Regional performance improvement goals/objectives and drafts and recommends appropriate goals/objectives for the next year
2. Incorporates MDHHS and accreditation requirement changes as necessary to meet the needs of the LRE
3. Obtains and utilizes stakeholder input in all the various aspects of the Regional QI Plan activities and processes.
4. Proposes revisions/updates to the Regional QI Plan where indicated, at least, on an annual basis.

B. Accountability and Reporting
The QI ROAT is supported by the LRE’s Chief Operating Officer (COO) and Quality Improvement/Provider Network Coordinator. The committee reports findings and provides recommendations to the LREOC and to the LRE Board of Directors.

To ensure effective Committee communication and accountability, the LRE CEO will assure that a chairperson is appointed to the Team, and that the QI ROAT provides status, routine and special reports to the LREOC and Board. The CEO will also assure that minutes with assigned actions and decisions are taken for each meeting, and available for review by all stakeholders.

C. Key Reports and Deliverables
The Team shall develop and submit the following information:
- Committee Goals and Work Plan
- Quarterly Status Reports
- Assigned Routine/Special Reports for Committee area.
- Performance Reports

D. Attachments to the QAPIP
Each Partner CMHSP shall have a unique QIP that specifies their local system for quality assurance and performance improvement.
**Evaluation of FY2016 Goals**

In FY2016, the QAPIP had identified thirteen goals to focus on. The following is the summary of these goals, the progress on the goals and the final evaluation of the goal (as defined as either completed or partially completed. Some goals will continue into 2017.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Develop a regional Consumer Satisfaction Survey</td>
<td>Complete. There may be ongoing discussion related to methodology distribution of the survey.</td>
</tr>
<tr>
<td>2</td>
<td>Implement plan for LRE completion of provider network site reviews.</td>
<td>Complete. The process is in place. Ongoing efficiencies in the process are being identified.</td>
</tr>
<tr>
<td>3</td>
<td>Revise LRE CMHSP site review tool to align with regulatory requirements.</td>
<td>Partial. Some modifications have been made, but this is an ongoing objective.</td>
</tr>
<tr>
<td>4</td>
<td>Develop process to identify Practice Guidelines and to assure region is meeting those guidelines.</td>
<td>Complete. LRE developed a policy in this area regarding the use of practice guidelines and is providing monitoring and oversight.</td>
</tr>
<tr>
<td>5</td>
<td>Develop annual performance reports for CMHSPs.</td>
<td>Complete. Reports were developed. There is a need for updates, so this will be a continuing objective.</td>
</tr>
<tr>
<td>6</td>
<td>Develop plan for receiving input from advocacy groups.</td>
<td>Partial. LRE provided opportunity for input particularly related to the response to the Beacon report. This will be completed again in 2017 related to the Corrective Action Plan.</td>
</tr>
<tr>
<td>7</td>
<td>Implement process to add providers and consumers to the participate in ROATs.</td>
<td>Partial. Providers have been added. There have been more barriers for consumers related primarily to transportation. This will be a continuing objective, and dependent to a degree on the LRE having technology in place for remote access to meetings.</td>
</tr>
<tr>
<td>8</td>
<td>Formal annual review of policies is completed and includes advisory input from ROATs</td>
<td>Partial. A more detailed process in under development to assure consistence across ROATs.</td>
</tr>
<tr>
<td>9</td>
<td>Assure ROATs have a group charge which is reviewed annually.</td>
<td>Partial. Although charges are in place for most ROATs, the annual review needs to be clearer. Continue as objective.</td>
</tr>
<tr>
<td>10</td>
<td>Develop and implement a Clinical ROAT and Integrated Care ROAT.</td>
<td>Partial. Clinical ROAT has been developed. Decision on the Integrated ROAT is pending.</td>
</tr>
<tr>
<td>Goal</td>
<td>Description</td>
<td>Status</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>11</td>
<td>Assure consistency in risk event reporting across the region.</td>
<td>Complete. A group convened to review standards. Will need to assure ongoing consistency over time.</td>
</tr>
<tr>
<td>12</td>
<td>Assure consistency in behavioral treatment review reporting.</td>
<td>Partial. Efforts were made to standardize reporting. Further objective to evaluate current status.</td>
</tr>
<tr>
<td>13</td>
<td>Develop standards for timeliness of data reporting.</td>
<td>Partial. Continue objective as LRE continues to work with CMHSPs on encounter reporting.</td>
</tr>
</tbody>
</table>
## FY2017 GOALS/OBJECTIVES

<table>
<thead>
<tr>
<th>Committee Goals &amp; Goal Driver*</th>
<th>Rationale/Background</th>
<th>Key Deliverables (or Anticipated Outcomes)</th>
<th>Lead Staff (Champion)/Other Lead Staff</th>
<th>Timeframe</th>
</tr>
</thead>
</table>
| **Goal #1: Develop Updated Report Cards for CMHSPs and Report Card for Provider Network reviews. (Continuation from 2016)** | CMHSP report cards were developed last year, but reports with updated data need to be produced. Reports summarizing data by network provider agencies will be added in 2017. | Updated CMHSP Report. Initial network provider report. | ▪ Quality / Operations Specialist  
▪ Provider Network Coord | ▪ 3/31/2017 CMHSP  
▪ 1/31/2017 Network |
| **Goal #2: Continue to enhance involvement of consumers. (Continuation from 2016)** | Use enhanced technology to allow consumers to increase participation in ROATs and the Consumer Advisory Committee through high quality remote connections. | LRE Offices are technology capable and plans for consumer involvement designed with CMHSPs and network providers. | IT Staff Director of Policy, Planning and Communication | ▪ 4/30/2017 |
| **Goal #3: Revise ROAT descriptions and charges, and assure advisory input on policy is being obtained from ROATs. (Continuation from 2016)** | ROATs remain an important means for input into LRE policy and plans. Efforts to further define and develop this role will assist the LRE in its planning. | Review of Committee charges complete. Policy grid developed with ROAT assignment. | Chief Operations Officer | ▪ 5/31/2016  
▪ Policy Grid completed 1/31/2017 |
<table>
<thead>
<tr>
<th>Committee Goals &amp; Goal Driver*</th>
<th>Rationale/Background</th>
<th>Key Deliverables (or Anticipated Outcomes)</th>
<th>Lead Staff (Champion)/Other Lead Staff</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal #4:</strong> Finalize standards for encounter reporting (Continuation from 2016)</td>
<td>Timeliness of data has been identified as a key metric for PIHP success as a managed care organization. LRE will work with CMHSPs to identify process and timeliness improvement.</td>
<td>Metric for % of encounter claims submitted within a specified time frame is developed.</td>
<td>Chief Information Officer</td>
<td>4/30/2017</td>
</tr>
<tr>
<td><strong>Goal #5:</strong> Research the feasibility of developing a common regional plan of service and preplan document.</td>
<td>In order to assure fair and equal practices to consumers in the region, a standard treatment plan and process assists in assuring equity and consistency with standards.</td>
<td>QI ROAT provides a recommendation and assists with plan development for this project.</td>
<td>COO and other QI staff.</td>
<td>6/30/2017</td>
</tr>
<tr>
<td><strong>Goal #6:</strong> Develop SUD related measures and outcomes for the system.</td>
<td>The QI ROAT expressed a desire to have more measures and QI initiatives related to SUD. QI ROAT to work with the SUD ROAT to identify SUD related measures and outcomes.</td>
<td>QI and SUD ROATs provide recommendation to the LRE on possible measures and outcomes.</td>
<td>SUD Coordinator</td>
<td>9/30/2017</td>
</tr>
<tr>
<td><strong>Goal #7:</strong> QI ROAT will review process for ICDP data and provide recommendation to the IT ROAT and the LRE.</td>
<td>The LRE is dedicated to the use of data analytics to assist the region in managing consumer outcomes. The group will provide advisory input to the LRE on the most effective way for CMHSP and Network Providers to access data.</td>
<td>QI ROAT provides written recommendation to the LRE.</td>
<td>COO</td>
<td>6/30/2017</td>
</tr>
<tr>
<td><strong>Goal #8:</strong> Develop a Behavior Treatment Consumer Survey and implement.</td>
<td>There is a need to assure a standard process for surveying consumers is in place for the region.</td>
<td>Survey and Process developed.</td>
<td>Quality Operations Specialist</td>
<td>4/30/2017</td>
</tr>
<tr>
<td>Committee Goals &amp; Goal Driver*</td>
<td>Rationale/Background</td>
<td>Key Deliverables (or Anticipated Outcomes)</td>
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<tr>
<td><strong>Goal #9:</strong> Complete analysis of LRE capacity for NCQA accreditation.</td>
<td>As a managed care entity, it is important for the LRE to be compared to national standards.</td>
<td>Consultant Analysis of LRE completed and work plan developed.</td>
<td>COO</td>
<td>6/30/2017</td>
</tr>
<tr>
<td><strong>Goal #10:</strong> LRE will identify key trends and findings from the site reviews initiated in 2016. Data to include area such as overall quality, health/safety, and training requirements.</td>
<td>LRE QI Team has assumed the function of completing site review of providers. There is a wealth of information that needs further analysis to identify priority areas for quality improvement.</td>
<td>Trend report on one full year of findings.</td>
<td>Provider Network Coordinator</td>
<td>July 30, 2017</td>
</tr>
</tbody>
</table>
Priorities for Performance Oversight and Improvement Activities

In the event that the LRE needs to prioritize projects, we will use this model:

Committee members have a key role in setting priorities regarding quality oversight and improvement activities. This questionnaire provides an organized approach to differentiating between the impacts of potential performance quality activities and should be used to facilitate discussions regarding prioritization between opportunities. Priorities are not static. In situations where unusual or urgent events occur, these criteria can also be used to re-prioritize the LRE’s process oversight and improvement activities.

Does the opportunity for improvement . . .

reflect the region’s mission, vision, goals, and policies?  Yes  No
reflect one of the CARF standards?  Yes  No
address a high-volume, high-risk, or problem-prone process?  Yes  No
pertain to a high-impact clinical service?  Yes  No
pertain to utilization management, risk management, and /or quality control concerns.  Yes  No
address a high-cost function or process?  Yes  No
promise significant cost savings?  Yes  No
represent a cross-discipline, cross functional aspect of performance?  Yes  No

Rate (1-10) the degree to which the improvement opportunity:

reflects priorities of person’s served with respect to their needs, preferences, and expectations.  _______

reflects external stakeholders’ priorities with respect to their needs, preferences, and expectations.  _______

reflects internal staff’s priorities with respect to their needs, preferences, and expectations.  _______

Are the resources required to pursue the improvement opportunity available?  Yes  No
There are three basic reasons for committees in healthcare organizations to perform periodic self-evaluations. The first is that today’s health-care environment demands nothing less than excellence in healthcare. The second is that a well-constructed, self-evaluation process can help a committee improve its performance and achieve and maintain excellence in quality oversight. The third is that regulatory organizations specifically require that committees evaluate their own performance.

Self-evaluation provides a committee with a structured opportunity to look at its past performance and to plan ahead. The process allows the committee to ask itself such questions as: What are we doing well? What could we be doing better? What are our objectives? How well did we achieve our objectives, or, why did we not achieve our objectives? The committee may then use the answers to develop an action plan to improve its performance and establish new goals.

The aggregate responses of the Quality Oversight Committee self-assessment questionnaires and the analysis report will be used to facilitate discussion among committee members. It is this discussion that provides the real value of the self-evaluation process.

The action plan is the key to both improving the performance of the committee, and to satisfying regulatory requirements.

The development of the action plan and strategies for its implementation mark the end of the committee self-assessment discussion. It is then up to the committee and Quality Improvement/Provider Network Coordinator to implement the action plan.

**Instructions:** Please read each item in the left column and indicate in 1 of the 4 right columns your rating for our committee’s performance in this area (Note: in the last section, please rate only your own personal performance).
### APPENDIX C

**LAKESHORE REGIONAL ENTITY - QUALITY IMPROVEMENT PLAN**

**QI ROAT Self-Assessment**

<table>
<thead>
<tr>
<th>Section 1: Mission and Planning Oversight</th>
<th>Very Good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
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<tbody>
<tr>
<td>A. Each committee member has received a copy of our committee charge.</td>
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<td>B. Proposals brought before our committee are evaluated to ensure that they are consistent with our committee’s charge.</td>
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<td>C. Our committee monitors the programs and activities of our partners and coordinating agency to ensure they are consistent with our committee’s charge.</td>
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<td>D. We periodically review, discuss, and if necessary recommend amendment of our committee’s charge to ensure that it remains current and relevant.</td>
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<td>E. Our committee has approved a comprehensive, system-wide QAPIP and supportive policy statements.</td>
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<td>F. Our committee monitors the programs and initiatives of our organization to ensure they are consistent with the committee’s plan.</td>
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<td>G. Our committee assesses the extent to which we’ve met our goals and objectives.</td>
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<td>H. We periodically review, discuss, and if necessary amend our QAPIP to ensure it remains current and relevant.</td>
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<tr>
<td>I. Our committee’s members are active and effective in representing the LRE’s behavioral healthcare quality oversight interests.</td>
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<th>Section 2: Quality Oversight</th>
<th>Very Good</th>
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<tr>
<td>A. Our committee approves an LRE-wide QAPIP plan</td>
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<td>B. We review and carefully discuss quality reports that are part of an LRE-wide QAPIP plan which provides comparative statistical data about our member partner’s services</td>
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<td>C. We periodically review feedback from persons our members serve and organizations or community partners that we coordinate services with (satisfaction surveys, community meetings, stakeholder groups)</td>
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<td>D. We fully understand our responsibilities and relationships with the member partners and CAs, and have effective mechanisms for communicating with them.</td>
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<th>Section 3: Management Oversight</th>
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<tr>
<td>A. Our committee approves management performance policies for the LRE that are consistent with system policies and directives.</td>
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<td>B. Our committee supports and assists the LRE Chief Executive Officer to achieve the Lakeshore Regional Entity’s mission.</td>
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<th>Section 4: Committee Effectiveness</th>
<th>Very Good</th>
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<tr>
<td>A. Our committee evaluates its’ own performance and the individual performance of each committee member.</td>
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<td>B. QOC members understand their roles as committee members and contribute their unique expertise for the overall good of the organization and the individuals we serve.</td>
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<td>C. All members of the committee understand and fulfill their responsibilities and each committee member has received written descriptions of the committee’s duties.</td>
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</table>
D. All members of the committee participate in an orientation program and receive ongoing education about the work of the committee.

E. The frequency and duration of committee meetings are adequate to conduct the committee’s oversight responsibilities.

F. Our committee facilitator exercises a firm and fair hand with individual members to ensure that all have equal opportunity to participate, time is not monopolized by a few, and agenda items are dispatched after reasonable discussion.

G. The committee members receive the agenda and back-up materials well in advance of meetings.

H. Our committee members come to meetings well prepared to discuss agenda items.

I. The LRE maintains an up-to-date policy manual which includes specific policies covering our oversight role in quality and performance management.

Section 5: Individual Self-Assessment

<table>
<thead>
<tr>
<th>A. Continuing Education</th>
<th>B. Demonstrated Interest</th>
<th>C. Interpersonal Relations</th>
<th>D. Relations with Management</th>
<th>E. Confidentiality</th>
<th>F. Conflict of Interest</th>
<th>G. Community Representation</th>
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<tr>
<td>I participate in education opportunities outside the organization to remain current on changing trends and issues affecting our charge and responsibilities and/or I receive regular updates from individuals who attend such opportunities in order to keep myself current.</td>
<td>I prepare for, attend, participate and assume a fair workload at committee and committee meetings.</td>
<td>I deal fairly and appropriately with other committee members.</td>
<td>I support the Quality Improvement Coordinator in achieving the mission of the Committee.</td>
<td>I understand the confidential nature of committee deliberations and maintain privacy regarding issues and information discussed in committee and committee meetings.</td>
<td>I am satisfied that no conflict-of-interest exists in my service as committee member.</td>
<td>As an LRE committee member, I strive to represent the behavioral healthcare needs of the region and share the organization’s needs and concerns with external constituencies.</td>
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# Lakeshore Regional Entity - Quality Improvement Plan

**FY 2017 QI-ROAT Agenda Content Schedule**

(subject to change due to availability of data and scheduling)

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<th>Key Content Area</th>
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## LRE Board & Consumer Advisory Council: QI Reporting Schedule

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Site Review

In FY2016, the LRE conducted Site Reviews at each of the five CMHSPs. Eight specific indicators were evaluated (Admin/Managed Care Functions, Program Specific Reviews, Information Technology, All Staff Training and Credentialing and Autism Specific Training and Credentialing, Grievance and Appeal Audit, Chart Review and Autism Specific Chart Review, MMBPIS Source Document Review, and Medication Verification Spot Check Review). Going forward into FY2017, the indicators Grievance and Appeal Audit and Medication Verification Spot Check Review will not be part of the site review process as they will be managed by LRE instead of the CMHSPs.

Using 95% as a performance benchmark, a review of the summary of each of the CMHSPs yields the following:

- Overall, each of the CMHSPs did well with their individual Site Review. Total scores ranged from 94.29% to 96.87%. This is an improvement in the lowest score, but a decline in the highest from last year’s 93.0% to 97.4% compliance.
- A systemic review of the findings indicates the Person Centered Plan and Documentation Standards indicator showed findings for four out of five CMHSPs. The indicators for Service Delivery Consistent with Plan and Autism Specific Chart Review Questions showed findings for all five CMHSPs, and appear to be systemic issues. The Autism Specific Chart Review Questions indicator was new in FY2016, and not part of the CMHSP site review in FY2015. There were specific indicators which required corrective action. Plans of correction were requested and completed. The LRE will continue to monitor in Annual Site Reviews for additional efficiencies.
- The indicators for verifying the systems for completing Medicaid Verifications remained at 100% across the region from FY2015 to FY2016. This was delegated, but now is a requirement for the PIHP to complete.
- There was significant improvement in 4 out of 5 CMHSPs in the region for the indicator of Staff training and Credentialing in FY2016. These CMHSPs were at or above the performance benchmark for the region.

See the completed LRE CMHSP Site Review FY15 And FY16 Scoreboard Report (dated 09/*28*/2016) for details.

MMBPIS

Performance Measure Overview
Overall, for most quarters the CMHSPs are meeting the performance standards for this indicator over the last four quarters of data reviewed with a couple of exceptions:

- During the last quarter of FY2015, inpatient screenings for children and for adults (disposition within three hours) were not met as a Region (standard is
95% and the Regional score was 91.3% and 91.6% respectively). However, both were met in the first three quarters of FY2016. We will continue to monitor this quarterly.

- During the last quarter of FY2015, and the first quarter for FY2016, the Indicator #3 for Start of Service within 14 days for Developmentally Disabled Child was not met as a Region (standard is 95% and the Regional scores for each quarter were Q4 91.4%, Q1 94.3%). Subsequent quarters reviewed show the standard was met as a Region. We will continue to monitor this quarterly.

- In Quarters 1 and 3 for FY2016, Indicator #3 for Start of Service within 14 days for Developmentally Disabled Adult was not met as a Region (standard is 95% and the Regional scores for each quarter were Q1 94.7%, Q3 80.9%). The standard was met in Quarter 2. We will continue to monitor this quarterly.

Data Validation for MMBPIS Performance Measures
For two of the CMHSPs, there were issues with how the required data was being collected and reported in FY2016. The LRE took corrective action with those CMHSPs, and data collection and reporting improved.

It should be noted that for Indicator #3 for Start of Service within 14 days for Developmentally Disabled Adults, that some CMHSP providers only have one or two consumers in this category per quarter. If the indicator was not met in that quarter for one of those consumers, it can skew the data by creating an extremely low percentage.

See the completed LRE Comparison Of Michigan Mission Based Performance Indicator Reports For Fy 13/14, Fy 14/15, And 15/16 By Affiliate Partner (dated 09/27/2016) for details.

Medicaid Verification
In FY2016, the LRE moved the Medicaid Verification from a delegated function to a function of the LRE. This was due to contractual changes in the LRE’s contract with MDHHS.

A review of FY2016 data was completed in a Medicaid Verification Audit in June/July 2016. It was determined that the overall results of the audit were very positive across all five CMHSPs. Overall scores ranged from 99.28% to 100%. According to the Medicaid Verification Report, there was only one area of concern in the TRIAD SUD section, in regards to one particular contracted provider. The LRE will no longer be contracting with this provider, and this will be followed up on by the LRE for possible recoupment or other corrective action.

See the completed Medicaid Claims Verification Monitoring Report for details.

Critical Incident Report
Critical Incident Events are reported monthly. This includes data on critical incidents, number of deaths, type of deaths (suicide, natural causes, accidental causes, homicide), required emergency medical treatment, emergency room visits due to injury, emergency room visits due to med error, hospitalization due to injury, hospitalization due to med error and arrests. This data will continue to be monitored monthly and with further investigation initiated as needed. This data is reported to MDHHS on a monthly basis.
The data reviewed indicates the overall rates for the region on Critical Incidents were down from last year’s report:

- Total number of Critical Incidents are down to 189 from 201 for the DD Population Group, and 92 from 141 for the MI population group.
- Total deaths reported were down to 100 from 135 for FY2016. All death types were down with the exception of Homicides. Homicide numbers remained the same at 1, however FY2015 this occurred in Kent County, and in FY2016 this occurred in Muskegon County.
- Total Emergency Treatments due to injuries were down to 129 from 132, but Emergency Treatments due to Medication Errors were up to 4 from 0 for FY2016. HealthWest and Network180 each had 1 emergency treatment, and West Michigan had 2, while Allegan and Ottawa remained at 0 for the year.
- Total Hospitalizations were down to 18 from 29 due to injuries, and down to 0 from 4 due to Medication Errors for the year. Ottawa had 1 hospitalization due to injury, up from 0 last year, and West Michigan had 3 hospitalizations up from 1 last year. All other CMHSPs had decreased their numbers.
- Total Arrests reported were down to 29 from 41 for FY2016. HealthWest was the only CMHSP with an increase in arrests (up to 15 from 12) for this year.

Due to reporting timeframes, data for August and September have not yet been compiled for FY2016.


**Risk Events**

Risk Events are gathered on a monthly basis. This included data on risk events reported by population group, number of self-harm risk events reported, number of harm to others risk events reported, number of police calls reported, number of emergency use of physical management and number of individuals with 2 or more hospitalizations per year. This data will continue to be monitored monthly and with further investigation initiated as needed. The standardization of definitions and reporting was identified as a QAPIP goal for FY2016.

The data reviewed indicates the overall rates for the region on Risk Events were down from last year’s report:

- Total number of Risk Events are down to 514 from 520 for the DD Population Group, and 132 from 223 for the MI population group.
- The number of Self-Harm events were down for every CMHSP in the region with the exception of HealthWest which is up to 10 from 2 for the year.
- The number of Harm to Others events were down for every CMHSP.
- The number of Police Calls reported for each CMHSP were down with the exceptions of HealthWest who was up to 18 calls from 2, and Allegan who was up to 19 from 14 calls.

Due to reporting timeframes, data for August and September have not yet been compiled for FY2016.

Satisfaction
Recovery Self Assessment (RSA) - Results from this survey were taken to the Consumer Advisory Committee and the QI-ROAT for review. Both the QI-ROAT and the Consumer Advisory Committee reviewed the RSA Report and requested for the Region to seek methods to improve on Consumer Involvement (this indicator scored 4.01 on a 5.0 Likert-type scale with 5 being “strongly agree”). The Consumer Advisory Committee will continue to work on developing a definition for this indicator and then developing action steps for improvement.

Home-Based Services - This survey is required by MDHHS on an annual basis. The data is collected and reported to the State annually. Baseline results were analyzed by the LRE and the QI-ROAT. We will be conducting a comparison over time (Fy2015 vs. FY2016 data) once the FY2016 data is received. We are awaiting the final report from the State with comparisons across the other Regions before analyzing our results further with FY2015 data.

Assertive Community Treatment (ACT) - This survey is required by MDHHS on an annual basis. The data is collected and reported to the State annually. Baseline results were analyzed by the LRE and the QI-ROAT. We will be conducting a comparison over time (FY2015 vs. FY2016 data) once the FY2016 data is received. We are awaiting the final report from the State with comparisons across the other Regions before analyzing our results further with FY2015 data.

BTRC Data
Behavior Treatment Committee Data is reported to MDHHS on a quarterly basis. Behavior Treatment Data is collected monthly at each of the CMHSP’s Behavior Treatment Plan Review Committees. This data is aggregated quarterly and submitted to the LRE for review and monitoring. LRE has a Behavior Treatment Data Review Workgroup, which has membership from all five of the CMHSPs) reviews and monitors the Behavior Treatment Data prior to submission. One of the main focuses of the workgroup this year has been data definitions to ensure that all five CMHSP’s consistently use agreed upon data definitions in reporting the BTRC data.

In reviewing the BTRC data from FY 15 and FY16 it was found that:
   i. The number of consumers who have a Behavior Treatment Plan has increased from 122 reported in FY15 Quarter 1 to 142 reported for FY16 Quarter 4.
   ii. Incidents of Harm to Self, decreased from 45 reported in FY15 to 12 in FY 16
   iii. Incidents of Harm to Others, decreased from 65 reported in FY15 to 25 reported in FY16.
   iv. Incidents of Physical Management increased from 185 reported in FY15 to 280 reported in FY 16. In reviewing the increase in reported incidents of Physical Management, the Workgroup concluded that better data definitions of physical management resulted in some of the increase. The Behavior Treatment Data Workgroup plans to continue monitoring of this area.

Timeliness
With the exception of a couple of reports, the LRE was successful in submitting all reports in a timely manner. The reports that were initially missed were completed and have been added to
our reporting grid. CMHSPs have overall been timely in reporting, but there will be an effort to track this in a more formal sense as a part of the review of the CMHSPs by the LRE.

**Data Completeness**
CMHSP’s report data files to MDHHS monthly. This file contains data elements including Medicaid Id, Employment Status, Disability Designation, Minimum Wage, and Health Conditions. In October 2015, the Quality Improvement / Demographic data file was replaced with the BH Teds file. The BH Teds file is required to be 100% complete to be accepted by MDHHS so there is no issue or concern for the completeness of this file.

For FY 2017, LRP QI staff will further develop a process to monitor and report the accuracy of data reported in the BH Teds file. MDHHS still requires the submission of a small demographic file which contains a few demographic data elements and the DD Proxy Measures for Individuals with a Developmental Disability. QI Staff will continue to monitor the completeness of the reported DD Proxy Measures. A Plan of Correction will be required from CMHSP’s not meeting the 95% completeness standard for the DD Proxy Measures.

See the completed *LRE Demographic File Monitoring Report* for details.

**HSAG Overview**
- Performance Improvement Project (PIP)
  
  The current Lakeshore Regional Entity PIP for FY 2014 – FY 2016 is titled, “Increasing the Number of Medicaid Eligible Adults Who Filled at Least One Prescription for a Second-Generation Antipsychotic Medication and Received an HbA1c, Lipid Panel or Fasting Panel Glucose.” This PIP, per contract with MDHHS, requires validation from HSAG annually. Lakeshore Regional Entity attained 100% validation for this PIP for FY2014 and FY2015. In FY2016, LRE again attained 100% validation for the third year of this PIP.

  For the FY2016 validation to occur, the LRE had to show a statistically significant increase in the number of Medicaid Eligible adults age 18 – 64 with at least one Medicaid LRP PIHP service who filled at least one prescription for a Second-generation Antipsychotic medication and received lab work for an HbA1c, Lipid Panel or FPG during the measurement period.

  The results analysis from the HSAG report is as follows:

  *The PIHP identified that there were programming errors (i.e., missing code, missing medication, wrong date) in the calculation of the baseline rate that was reported in last year’s PIP Submission Form. The PIHP recalculated and revised the baseline data in this year’s PIP submission. The original baseline rate was 49.7 percent, and the revised baseline rate was 24.9 percentage points higher at 74.6 percent. The Remeasurement 1 rate for the study indicator was 76.8 percent, a statistically significant improvement of 2.2 percentage points above the baseline; however, the rate is 3.2 percentage points below the PIHP’s goal of 80 percent.*

  See the complete *HSAG 2015-2016 PIP Validation Report* for more details.
• **HSAG Performance Measurement Validation (PMV) Report**  
  Lakeshore Regional Entity was reviewed by HSAG Performance Measurement Validation Staff in June 2016. This review involves the validation of LRE encounter data submission and processes, QI data submission and processes, and Michigan Mission Based Performance Indicator System data collection and report completion process. The HSAG PMV report stated that HSAG has no concerns with the LRE data collection, submissions and processes. All areas were found to be in compliance and validated.

A plan of correction was not required, however HSAG did include three recommendations in the report. These recommendations are as follows:

i. Investigate the reasons MMBPIS Indicator #3 did not meet MDHHS standards for the DD population, and explore options for rate improvement.

ii. Consider cross-training additional staff to perform the reporting function at the PIHP level.

iii. Consider adding additional validation steps to the audit tool used for CMHSP oversight to ensure that each CMHSP is in compliance with the requirements.

iv. Thoroughly document all system and process changes and testing procedures as the LRE switches to a new software vendor.

v. Explore opportunities to improve its rates for the next reporting period, based on the new process that was implemented to collect and report demographic information.

LRE QI Staff completed a plan of correction for the three HSAG PMV Report recommendations. This plan of correction will be implemented and completed during FY2017.

See the complete *HSAG 2015-2016 Validation of Performance Measures report* for more details.

• **HSAG Compliance Monitoring Report**  
  Lakeshore Regional Entity was reviewed by HSAG Compliance Staff in July 2015. MDHHS has contracted with HSAG, as required by the Balanced Budget Act, to conduct an external quality review to ensure the PIHP’s compliance with Medicaid managed care standards and the state contract. This quality review focuses on evaluating quality outcomes and the timeliness of, and access to care and services proved to Medicaid beneficiaries. The Compliance review has numerous regulations/requirements within 15 Standards. Lakeshore Regional Entity received an overall score of 98%. Deficiencies were found in each of the following Standards.

i. Utilization Management

ii. Subcontracts and Delegation

iii. Provider Network

iv. Disclosure of Ownership, Control, and Criminal Convictions

Lakeshore Regional Entity Compliance Report indicated there were eight regulations / requirements with deficiencies. Two of the eight standards found to have deficiencies were scored as “substantially met”, and one of the eight was found to be “partially met”. Four standards were found to be “not met”.


Standard 15: Disclosure of Ownership, Control, and Criminal Convictions received the only “not met” scores. Standard 15 was new for FY2015, and per HSAG’s verbal report during the site review most of the PIHP’s across the state did not do well in this area. The LRE improved in this area in FY2015, but four regulations/requirements remained unmet. LRE QI staff have completed a Plan of Correction for all citations and this POC will be implemented and completed during FY2017. LRE has recently finalized a policy acceptable to HSAG and is moving forward with implementation.

See the complete HSAG 2015-2016 External Quality Review Compliance Monitoring Report for more details.