LAKESHORE REGIONAL ENTITY

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM 2020

ANNUAL EFFECTIVENESS REVIEW FY 19

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Reviewed by:

Approved by:

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SECTION ONE: QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

OVERVIEW

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, Network180 (Kent County Community Mental Health Authority), Community Mental Health of Ottawa County (CMHOC), and West Michigan Community Mental Health System (WMCMHS). Effective February 1, 2019, Beacon Health Options, through their contract with Lakeshore Regional Entity is responsible to provide Quality Management Functions on behalf of the PIHP. Included in these responsibilities is development of the LRE Quality Assessment and Performance Improvement Plan (QAPIP)

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

- 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.
- The CMS "Code of Federal Regulations" (CFRs), specifically 42 CFR § 438, and its QAPIP requirements.
- Accreditation standards in the areas of quality and organizational improvement.

MDHHS also requires that the PIHP annually conduct an effectiveness review of its QAPIP as follows:

> *"The PIHP shall annually conduct an effectiveness review of its QAPIP. The Effectiveness review must include analysis of whether there have been improvements in the quality of health care and services for recipients as a result of quality assessment and improvement activities and interventions carried out by the PIHP. The analysis should take into consideration trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives. Information on the effectiveness of the PIHP's QAPIP must be provided annually to network providers and to recipients upon request. Information on the effectiveness of the PIHP's QAPIP must also be provided to the MDHHS upon request"*

Per this requirement, the Lakeshore Regional Entity has conducted an effectiveness review of its Quality Assessment and Performance Improvement Program, detailed in this report. The findings and analysis of this review have informed the development of LRE's 2020 QAPIP structure, processes and performance goals and objectives. This report is posted publicly and is available to MDHHS upon request.

PURPOSE

In addition to meeting contractual requirements, the LRE QAPIP is also intended to:

- Continually evaluate and enhance the LRE's QI Processes and Outcomes.
- 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.
- Identify, and assign priority to, opportunities for performance improvement.

- Create a culture that encourages stakeholder input and participation in problem solving.

The Lakeshore Regional Entity QAPIP is an integrated quality system that combines performance management, quality improvement, and oversight/monitoring of key PIHP functions. In addition to the over-arching regional QAPIP, LRE has delegated the responsibility for development and implementation of a Quality Improvement Program in accordance with its Quality Assessment and Performance Improvement Plan to Beacon Health Options and each of the CMHSP members within the region and provides oversight and monitoring of the implementation of the CMHSP quality programs to ensure consistent regional quality and effectiveness.

PHILOSOPHICAL FRAMEWORK

The LRE QAPIP design is based on a Continuous Quality Improvement (CQI) model whose key principles include:

- Quality services are based on a series of processes in a system leading to outcomes;
- Quality problems can be seen as the result of variation or defects in processes;
- Quality improvement efforts should draw on the knowledge and efforts of individuals involved in these processes, working in teams;
- Quality improvement work is grounded in measurement, statistical analysis and scientific method as well as root cause analysis, collaborative problem-solving, and mutual accountability.
- The focus of improvement efforts should be on the needs of the customer; and improvement should concentrate on the highest priority problems.
- The input of a wide-range of stakeholders – board members, advisory councils, consumers, providers, employees, community agencies and other external entities are critical to success;

This quality framework is intended to help 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.

Data is used for decision making throughout the organization through monitoring service effectiveness, ensuring timeliness of processes, optimizing efficiency and maximizing productivity and utilizing key measures to manage risk, ensure safety, and track achievement of organizational strategies.

QAPIP AUTHORITY AND STRUCTURE

The LRE Board of Directors retains the ultimate responsibility for the quality of the Medicaid funded services provided by the LRE member CMHSPs. The LRE Board approves the overall Regional Quality Improvement Plan. Each CMHSP Board approves the specific CMHSP's QIP structure, goals and objectives. A final copy of the plan is made available to all stakeholders via the agency's website.

The LRE Chief Executive Officer (or designee) is responsible for submitting a regional QAPIP to the LRE Board of Directors for final approval. The LRE Board serves as the Governing Body for the QAPIP. To assist the LRE Board in its oversight of regional services, the LRE Board has created the LRE Operations Committee consisting of CEO representation from all member CMHSPs. In this way, regional governance input occurs via the Plan's approval process. To facilitate the implementation and management of the QAPIP, the PIHP has created the LRE Quality Improvement Regional Operations Advisory Team (QI ROAT), which consists of representation from Beacon Health Options and member CMHSPs. The QI ROAT is responsible for regularly reviewing all activities within the QAPIP and provides regular updates to the Operations Committee, Beacon Health Options and LRE Board. In addition, if

Issues or barriers to operational effectiveness are identified, these are escalated to the Operations Committee and/or the LRE Board for input, resolution and/or awareness.

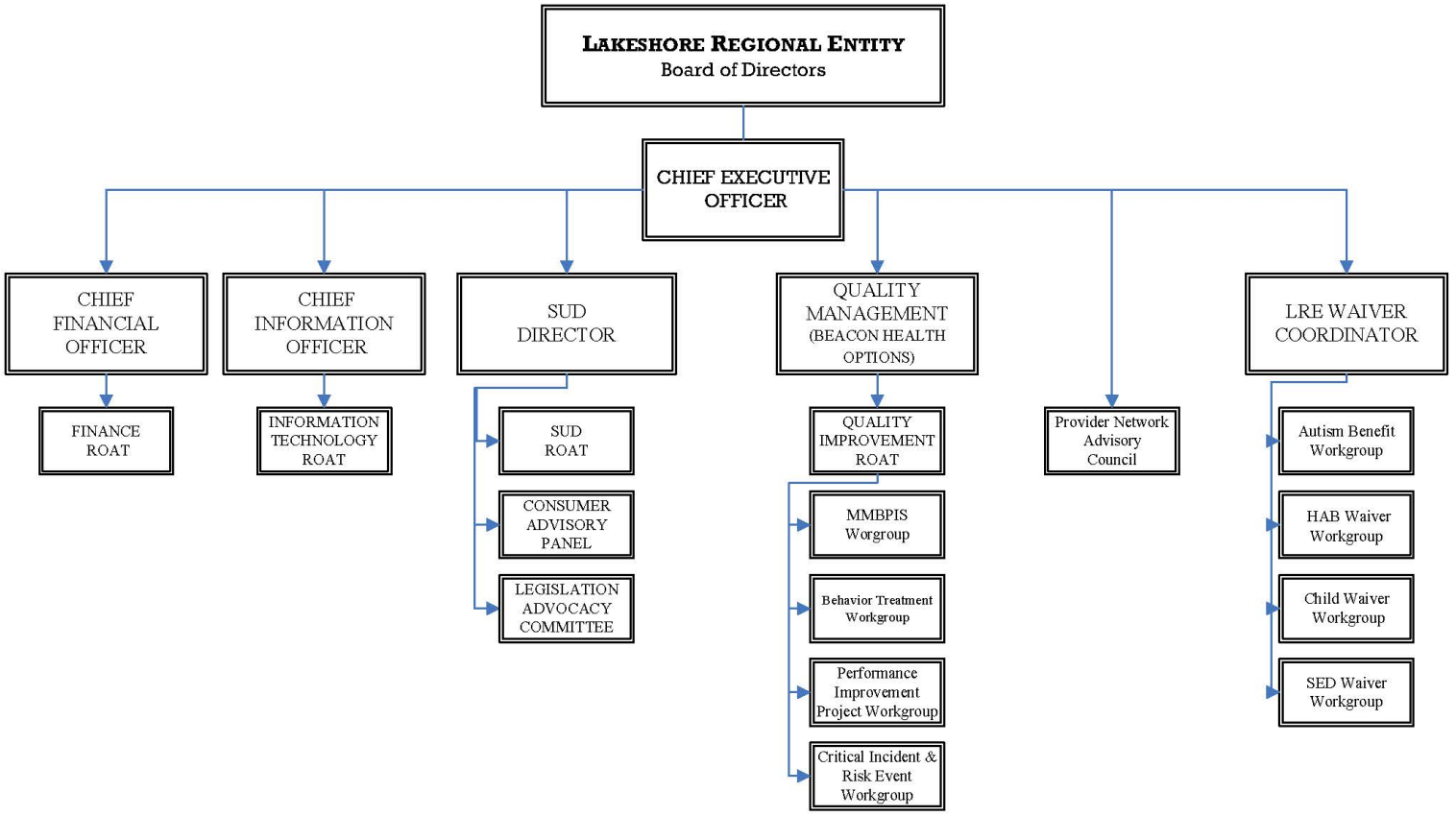
Overall, Beacon Health Options Quality Manager, on behalf of the LRE, has day-to-day administrative management and oversight of the QAPIP and QIP. The Beacon Health Options Quality Manager keeps the LRE Chief Executive Officer informed of region-wide quality improvement activities and performance improvement projects. LRE CEO provides periodic updates to the Operations Committee and LRE Board.

To facilitate an organizational culture of quality improvement across the region, the PIHP has created additional workgroups and Regional Operations Advisory Teams (ROATs) which consists of representatives from member CMHSPs with content knowledge and organizational responsibility for the function or area. Each of these ROATs and Workgroups have an identified charter, scope of responsibility and authority, membership including provider network representatives, and work plans.

ORGANIZATION STRUCTURE

The LRE organization structure to support the QAPIP is depicted as follows:

LAKESHORE REGIONAL ENTITY - QUALITY IMPROVEMENT PLAN
ROAT/WORKGROUP/COMMITTEE FLOW CHART



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QUALITY IMPROVEMENT REGIONAL OPERATIONS ADVISORY TEAM (QI ROAT)

Purpose and Function

The PIHP is required to manage the quality management system for the entire Lakeshore Region's specialty benefit provider network. Through their contract with LRE, Beacon Health Options 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 CMHSP.

To ensure network input into its Quality Management program, the PIHP created the Quality Improvement Regional Operations Advisory Team (QI ROAT), which serves as the Quality Improvement Council of the QAPIP. The QI ROAT is a standing group of the PIHP's organizational structure. The QI ROAT is comprised of PIHP, Beacon Health Options, 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 function of the QI ROAT is to assist the PIHP and Beacon Health Options 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 ROATS and Workgroups to analyze aggregated performance data.
- Develop polices, standards and related legal, regulatory and accreditation requirements pertaining to quality management.
- Identify trends and key indicators related to persons served and specialty benefit behavioral health care services.

- Review ongoing reports from Beacon Health Options quality improvement activities, advising on standards and requirements, as defined in the PIHP's QAPIP.
- Monitor organizational progress in meeting the quality management program goals and objectives, and evaluate the overall effectiveness of the PIHP's QAPIP on an annual basis.
- Review processes and tools for monitoring the provider network system as needed.
- Recommend quality initiative when performance does not meet established quality standards or other requirements (e.g. MMBPIS Workgroup).

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).

The QI ROAT is responsible for the operational implementation of the QAPIP and for reviewing all activities within the QAPIP and provides regular updates to the Operations Committee and LRE Board. The LRE QI ROAT serves the Chief Executive Officer (CEO) and the LRE Operations Committee in an advisory and problem-solving capacity to achieve the goals of the Quality Plan, monitor the performance of the agency and provider network through the performance measurement system, and identify quality improvement activities. The QI ROAT meets monthly to review data and outcomes, reports, and status on all QI-related activities in the organization. All QI ROAT meetings are documented via meeting minutes. In addition, if Issues or barriers to operational effectiveness are identified, these are escalated to the Operations Committee and/or the LRE Board for input, resolution and/or awareness. The PIHP, with input from the QI ROAT, is responsible to provide the leadership necessary to direct and implement appropriate actions to improve performance and comply with standards, requirements or best practices.

Membership of QI ROAT

The Quality Improvement Regional Operations Advisory Team (QI ROAT) consists of the LRE CEO, Beacon Health Options Quality Manager and at least one representative from each CMHSP. There is also representation on the QI ROAT from Consumers and the Provider Network. Other ad hoc members may include functions such as information systems, provider network management, clinical, contract management, claims management, and finance.

Roles and Responsibilities

The LRE Board is responsible for allocating adequate resources for the quality management program and is responsible for linking the strategic plan and operational functions of the organization with the quality management functions. The LRE CEO and LRE Operations Committee are responsible for overall achievement of the goals of the quality improvement plan and to create an environment that is conducive to the success of quality improvement efforts, ensuring stakeholder involvement, removing barriers to positive outcomes, and monitoring results of the quality improvement program across the organization.

The Chief Executive Officer is a participating member of the QI ROAT, the primary liaison between the QI ROAT, the Operations Committee and the Board of Directors, and provides delegated oversight and leadership for the Quality Improvement Program. The Beacon Health Options Quality Manager supports the senior official's role through facilitation of the QI ROAT, dissemination of reports and other duties as needed.

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.

Accountability and Reporting

The QI ROAT is supported by the LRE's Chief Executive Officer (CEO) and Beacon Health Options Quality Manager. The committee reports findings and provides recommendations to the Operations Committee and to the LRE Board of Directors.

To ensure effective Committee communication and accountability, the LRE CEO will assure that the QI ROAT provides status, routine and special reports to the Operations Committee 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. Each of the ROATS periodically solicits feedback from members on the functioning and effectiveness of the ROAT.

The LRE maintains contracts necessary for consultation and decision making from physicians in both the mental health and SUD specialty areas. This includes hospitalization consultation related to second opinions. The organization's Medical Director shall be involved in the review and oversight of the LRE quality management related to system policies and clinical practices. The medical director shall: (a) Advise the organization on mental health policy and treatment issues. (b) Serve as a resource on mental health clinical matters to all divisions within the organization and member CMHSPs, (c) Promote the use of mental health care and treatment best practices that are scientifically validated and recovery oriented, (d) Participate as needed in Dispute Resolution Process for Recertification of Inpatient, Partial Hospitalizations and Crisis Residential.

OTHER WORKGROUPS AND ROATS

The LRE Operations Committee receives regular updates from each of these workgroups and/or ROATs. While each of these workgroups and ROATs are responsible for monitoring performance within their scope of responsibility, providing recommendations for action or improvement and ensuring policy compliance within their scope, the QI ROAT has additional oversight responsibilities to the extent that these workgroups and/or ROATS have roles and responsibilities, goals, and action items identified within the LRE's QAPIP and Annual Plan.

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.

Consumer Advisory Panel (Board sub-Committee)

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 the LRE Board 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.

Finance ROAT

Members of the Finance ROAT include Finance Managers from each of the member CMHSPs. Members are kept informed about 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. A regional group also focuses on meeting the requirements of the CMS rule changes related to the waiver.

Information Technology ROAT

IT ROAT provides advisory input into strategy and direction for information system needs for the Region. The IT ROAT is also responsible for ensuring the accuracy and completeness of all regional data and encounter reporting.

MMBPIS Workgroup

The MMBPIS Workgroup is a subgroup of the QI ROAT which 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 Quality Improvement Staff. MMBPIS Workgroup members analyze quarterly MMBPIS data looking for trends, issues and root causes for unsatisfactory performance. 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 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 ROAT

This ROAT 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 SUD 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, and collaborative problem-solving.

ROLE OF RECIPIENTS AND STAKEHOLDERS

Consumers and families are valued contributors into the regional quality improvement process. In addition to the participation of recipients on several ROATs, LRE supports an active Consumer Advisory Panel. Feedback on policy development or change is requested from stakeholders such as providers, family members, community members, and other service agencies through a public review process. There are multiple opportunities for individuals to respond to satisfaction surveys, and Customer Services staff responds to any request for feedback and assistance. There is a bi-directional feedback and input loop between LRE ROATs and the Consumer Advisory Panel to ensure consumer engagement on quality initiatives. LRE's website includes a link to allow interested parties to provide feedback on any areas of concern at any time.

Provider agency involvement is also important to the LRE Quality Improvement process. ROAT membership includes provider representatives, and there is a regular monthly meeting open to all regional provider organizations which allows an opportunity to share information and consider recommendations for quality improvement.

CORE COMPONENTS OF QUALITY MANAGEMENT SYSTEM

A. Plan-Do-Study-Act:

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-Study-Act process (Attachment *). 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-Study-Act (PDSA) 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. Study: 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 PDSA process is as follows:

The various aspects of the Quality Management System are not mutually exclusive to just one category, as an aspect can overlap into more than one category.

The *Quality Management System* includes:

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

This table identifies some of the more common standards, assessment activities, measurements, and improvement strategies used by the LRE's Quality Management System.

QUALITY MANAGEMENT SYSTEM			
Quality Standards	**Assessment Activities**	**Performance Measurements**	**Improvement Strategies**
• Federal & State Rules/Regulations • Stakeholder Expectations • MDHHS/PIHP Contract • Provider Contracts • Practice Guidelines • Accreditation Standards • LRE Policies and Standards	• Provider Monitoring Reviews • Credentialing • Risk Management • Utilization Reviews • External Quality Reviews • Stakeholder Input • Sentinel Events • Critical Event Reports	• MDHHS MMBPIS • LRE Outcomes Management System • LRE Dashboards • Benchmarking • Status Reports on Strategic Planning • Audit Reports • Grievances & Appeals	• Corrective Action/ Improvement Plans • Improvement Projects • Improvement Teams • Strategic Planning • Adherence to Practice Guidelines • Organizational Learning

• Evidence Based Practices • Promising Practices	• MDHHS Site Review Report • Behavior Treatment Analysis • Fidelity Monitoring Reviews	• Board Ends Report using LRE Dashboards	• Staff Development and Training • Improvements through Root Cause Analysis

B. 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 and Beacon Health Options are 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.

C. 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.

D. 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. Region-wide Satisfaction Surveys for all populations
2. Consumer Advisory Panel
3. LRE/Beacon Health Options Customer Services.
4. Needs Assessments
5. Case Reviews
6. Provider Surveys
7. Public Comment at Board Meetings
8. Review of issues identified in Grievance and Appeals

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.

Stakeholder input when received is assigned to the appropriate ROAT, Workgroup or Committee, Beacon Health Options or LRE staff for discussion and resolution. Depending on the subject matter, the input may be responded to directly or it might 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.

E. Quality Monitoring Site Reviews

The Quality Monitoring Site Review process is a systematic and comprehensive approach to providing oversight and monitoring, identifying and ensuring improvements in the provision of mental health and substance abuse services to funded consumers. Beacon Health Options, through their contract with LRE annually monitors its provider network including service and support provisions. Through the Quality Monitoring Review process, Beacon Health Options:

- 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
- Conducts 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
- Reviews and approves improvement plans
- Ensures implementation of each submitted improvement plan.

The Quality Monitoring Review is designed so each CMHSP and network provider agency is reviewed annually. If a plan of correction is required, the CMHSP has 30 days to respond. Beacon Health Options 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 Beacon Health Options, the CMHSP is required to submit a minimum of a 6-months update detailing progress on planned changes. The plan of correction is reviewed at the following year's CMHSP Quality Monitoring Site Review.

F. MDHHS Site Reviews

Beacon Health Options, in conjunction with LRE monitors CMHSP member performance on site reviews conducted by MDHHS. To best address local concerns, each LRE member CMHSP drafts remedial action for all citations for which the LRE member has been identified as being out of compliance. Workgroups and ROATS may be consulted to address systemic issues that are identified by the MDHHS reviewers.

Beacon Health Options staff assume responsibility for ensuring all aspects of each Site Review is properly handled, including MDHHS Site Reviews. When a plan of correction is received, lead staff distributes to all applicable PIHP/CMHSP staff for plan of correction development. The LRE Executive Team and QI ROAT review the plan of correction prior to it being submitted to MDHHS for approval. In conjunction with LRE staff, Beacon Health Options staff are responsible for plan of correction implementation and monitoring, with oversight by the QI ROAT and the LRE Executive Team.

MDHHS REVIEW ACTIVITIES		
NAME OF REVIEW	**APPLICATION**	**FREQUENCY OF REVIEW**
MDHHS Site Review	Habilitation Supports Waiver	Full review every other year; follow-up review on off year
MDHHS Site Review	Autism Benefit	Full review every other year; follow-up review on off year

MDHHS REVIEW ACTIVITIES		
NAME OF REVIEW	**APPLICATION**	**FREQUENCY OF REVIEW**
Bureau of Substance Abuse and Addiction Services Review	Substance Abuse – Treatment & Prevention	Full review every other year; follow-up review on off year
Children's & SED Waiver Program Review	Children's & SED Waiver	Full review every other year; follow-up review on off year
Children's Diagnostic & Treatment Services Program	Children's Services	Every 3 years
Certification Review	Non-accredited CMHSP's & Providers	Every 3 years

G. 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.

H. Critical Incident Reporting and Risk Event Monitoring

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 LRE/Beacon Quality of Care Committee ensures that all critical incidents, sentinel events, and risk events are analyzed 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. Beacon Health Options, on behalf of the LRE, reports 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:

Service	Suicide	Death	EMT	Hospital	Arrest
CLS	●	●			
Supports Coordination	●	●			
Case Management	●	●			
ACT	●	●			
Home-Based	●	●			
Wraparound	●	●			
Hab. Waiver	●	●	●	●	●
SED Waiver	●	●	●	●	●
Child Waiver	●	●	●	●	●
Any Other Service	●				
Living Situation					
Specialized Residential	●	●	●	●	●
CCI	●	●	●	●	●

The QI ROAT is responsible for monitoring 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

Service	Harm to Self	Harm to Others	Police Calls	Physical Management	Hospitalization
Supports Coordination	●	●	●	●	●
Case Management	●	●	●	●	●
ACT	●	●	●	●	●
Home-Based	●	●	●	●	●

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.

I. Reporting of Sentinel Events and Unexpected Deaths

Beacon Health Options on behalf of the LRE, reports sentinel events and unexpected deaths consistent with MDHHS contract requirements. The CMHSP's per contract are to notify the LRE within 24 hours of learning of the unexpected death / possible Sentinel Event. The CMHSP 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, this CMHSP 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.

The LRE notifies MDHHS of any death that occurs as a result of suspected staff member action or inaction, or any death that is the subject of a recipient rights, licensing, or police investigation. This report shall be submitted electronically within 48 hours of either the death, or the PIHP's receipt of notification of the death, or the PIHP's receipt of notification that a recipient rights, licensing, and/or police investigation has commenced to QMPMeasures@michigan.gov and include the following information

1. Beneficiary's name
2. Beneficiary id number and Medicaid Type
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.

J. Behavior Treatment Review Analysis of Data

LRE delegates the responsibility for the collection and initial evaluation of Behavior Treatment data to each local CMHSP, this includes the evaluation of the effectiveness of the Behavior Treatment Committee by stakeholders. CMHSPs submit Behavior Treatment data to the LRE on a quarterly basis. Behavior Treatment data includes the number of physical management interventions and length of time of the interventions were used for each incident. Beacon Health Options reporting staff aggregate and complete quarterly trending reports from the CMHSP Behavior Treatment data and provide these reports to Beacon QI staff.

The LRE Behavior Treatment Review Committee is part of the LRE QI Structure. Membership on this committee includes representation from all five CMHSP's Behavior Treatment Committees, LRE and Beacon Health Options. The LRE Behavior Treatment Committee conducts a quarterly analysis of Behavior Treatment data, reviewing for trends and/or opportunities for quality improvements. A written summary of the meeting activity and data reviewed will be presented quarterly to the QI ROAT

The Beacon QI Team also provide oversight of the CMHSP's Behavior Treatment Committee, data collection process, and trending reports via the annual site review process at each of the CMHSPs.

Credentialing

The LRE ensures that services and supports are consistently provided by staff (contracted or directly operated) who are properly and currently credentialed, licensed, and qualified. LRE Policy # 4.4: Credentialing Privileging outlines the guidelines and responsibilities for credentialing and re-credentialing for the LRE.

Beacon Health Options is responsible for Organizational Credentialing, which assures that each organization maintains necessary licensure and meets basic expectation for contracting. Credentialing of individual and professional staff is delegated to the CMHSPs. The LRE provides oversight by reviewing a sample of credentialed staff during network reviews and CMHSP site reviews. These findings are reported to CMHSPs, Provider Network ROAT and the Quality Improvement ROAT.

K. Staff Training, Development and Qualifications:

LRE and its members ensure that consumers are served by staff with adequate training, competencies 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. Beacon Health Options Quality 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. A regional Training Work Group is responsible for the development of staff training and education standards to support reciprocity and efficiencies across the region. 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.

L. Quality Assessment of Contract Providers

In addition to the mechanisms outlined above, LRE Policy 4.2 Provider Network and Contract Management describes other mechanism for monitoring and assessing compliance with contract, state and federal requirements of service providers.

M. LRE Medicaid EOB Process

LRE completes an annual EOB Process.

1. LRE will perform a random sampling/selection of approximately 10 % of Medicaid consumers served.
2. Each CMHSP will send out (or hand deliver) EOB letters for the clients selected in the LRE generated random sample list, using a standard letter format
3. Each CMHSP tracks the following information:
    a. Number of clients in the random sample that was drawn by LRE.
    b. Number of EOB's generated.
    c. Number of EOB's mailed, hand delivered, and those that were undeliverable.
    d. The reason mailed EOB's were "returned", such as: 'Not Deliverable as addressed', or 'No forwarding order', etc.
4. Reports of fraud or abuse received via the CMHSP customer service line are forwarded to LRE.
5. Annually in January, each CMHSP will prepare and submit a summary report to LRE showing the statistics for tracked information and including an analysis of "undeliverable" EOB's and whether there were any patterns among those that might be indicative of potential fraud.

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 has been revised multiple times since then. There are 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 and the Information Systems Coordinators ensure the reliability and validity of the data on these indicators across the region, and that these conform to "Validation of the Performance Measures" of the Balanced Budget Act protocols. QI ROAT reviews MMBPIS results and performance across CMHSPs. LRE Member Boards who are out of compliance with MDHHS standards work with LRE / Beacon Health Options Quality Manager and QI ROAT to ensure the implementation of effective improvement plans.

The LRE requires a Plan of Correction for any quarter an indicator is not met. Requests for Plans of Correction are submitted to the CMHSP's Executive Director and QI Director. Data is reported to the QI ROAT, as well as the Board of Directors on a quarterly basis. Due to more consistent failure on certain MMBPIS indicators in FY 2017 , the LRE has identified this as a Performance Improvement Project in FY 2018 that will continue in FY 2020, with focus on Indicator #3 (time from assessment to start of ongoing services). In FY2020, any CMHSP found to be out of compliance five or more quarters (out of the past nine quarters) on a specific indicator by population will be required to report data monthly on the identified indicator.

B. Dashboard and Outcomes Reports

Lakeshore Regional Entity has completed implementation of a region-wide dashboard that reports on Key Performance Indicators (KPIs). The dashboard assists in growing a culture of data-based decision making, which in turn helps ensure excellence in the provision and management of the network's behavioral health services. The LRE KPIs has been presented to the Consumer Advisory Panel and endorsed by LRE leadership. LRE Dashboard and Outcomes are reported at the PIHP and CMHSP levels. The QI ROAT provides advisory input into methodology and content of KPIs. Findings are used to develop recommendations for practice improvements based on KPIs and outcome indicator results. This document is attached to the 2019 QAPIP Document (Appendix C). Results will be provided to a variety of groups such as QI ROAT, Consumer Advisory Panel, and the Operations Committee.

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 Beacon Health Options to identify trends and make service improvement recommendations. Findings will be reported to the LRE CEO and Operations Committee.

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 is completed by qualified Beacon Health Options staff. Verification procedures will not be delegated to providers, Core Providers, CMHSPs or MCPNs. Beacon Health Options, through its contract with LRE, performs this function for ALL Providers. The LRE has developed a common methodology for verification that meets all contractual standards including verification procedures, corrective action and recoupment procedures, reporting procedures and documentation standards.

E. Annual Plan

On an annual basis LRE creates an Annual Plan Summary Report. This report provides summary information on performance, trending, timeliness and issues related to its Quality Improvement Plan and/or reporting requirements. This includes but is not limited to: MMBPIS Indicators, Critical Events, Sentinel Events, Medicaid Verification Review, Site Review results, Satisfaction, and Grievance / Appeals. This summary report is completed by the PIHP 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.

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 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 are 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.

A Performance Improvement Project (PIPs) can be recommended by LRE staff, ROATs, Workgroup, and/or member CMHSPs by submitting the "LRE Plan Do Study Act (PDSA) Worksheet". (see Appendix D). For Performance Improvement Plans required by the state, recommendations would be submitted through the Operations Committee. All identified PIPs will be reported through the QI ROAT, to the Operations Committee and Consumer Advisory Panel.

B. Practice Guidelines

The LRE supports the use of clinical practice guidelines in service provision. 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 Policy #5.9: Practice Guidelines. Monitoring of established LRE guidelines is included as part of the Quality Management CMHSP Site Review.

COMMUNICATING QUALITY IMPROVEMENT ACTIVITIES

Documentation of the QAPIP annual review, its findings and recommendations are forwarded to the LRE CEO 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.

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

PERFORMANCE MEASUREMENT

Performance Management consists of identified performance measures and operational indicators that are monitored and evaluated. The Quality Assessment and Performance Improvement Program encourages the use of objective and systematic forms of measurement. Each measure shall have a baseline measurement when possible, should be re-measured at least annually, and should be actionable and likely to yield credible and reliable data over time.

LRE prioritizes performance measures in the area of access, efficiency, and outcomes and measures consistent with the Triple Aim of Improving the consumer's experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care. Desired performance ranges and/or external benchmarks are included when known.

The Michigan Department of Health and Human Services (MDHHS) has established performance indicators that are contractually required for the CMHSP. At a minimum, these indicators must compose LRE's performance indicator system. However, LRE has also established and monitors other areas of performance. These additional performance indicators are typically identified in one of several ways:

- Indicators established to monitor aspects of consumer care which are critical to customer satisfaction, high risk, high volume
- Functions or entities have a history of substandard performance
- Strategic planning measurements for success
- Key stakeholder recommendations
- Measures developed to monitor areas critical of organizational effectiveness; and
- Ongoing monitoring of performance improvement activities
- Focused on health integration or clinical care improvements
- Organizational or administrative efficiencies

The QI ROAT is responsible for facilitating the development of necessary data collection systems or reports to provide for accurate and reliable data sources. The QI ROAT may make recommendations for changes to the requested indicator or any of its elements to ensure the integrity and reliability of the proposed indicator. Suspicions of integrity issues related to data collected are investigated by the LRE CEO and CIO with QI ROAT and IT ROAT consultation to:

- Evaluate for changes in data definitions;
- Identify limitations of the data;
- Provide an opportunity for correcting the data; and
- Identifying opportunities for improving internal and external systems that lead to data errors.

When minimum performance standards or requirements are not met, the LRE QI ROAT identifies causal factors, interventions, implementation timelines, and any other actions needed to correct undesirable variation.

Information is the critical product of performance measurement that facilitates clinical decision-making, organizational decision-making (e.g., strategic planning and day-to-day operations), performance improvement, and priorities for risk reduction. Data must be systematically aggregated and analyzed to become actionable information.

Beacon Health Options staff prepares an analysis of the data, including recommendations for further investigation, data collection improvements to resolve data validity concerns, and/or system improvements. Undesirable patterns or trends in performance are identified, as well as undesirable variations in performance, and acted on as appropriate. In some instances, further data collection and analysis is necessary to isolate the causes of poor performance or excessive variability. For any performance measure that falls below regulatory standards and/or established targets, plans of correction are required. Final performance and quality reports are made available to stakeholders and the general public as requested and through routine website updates.

DATA DRIVEN DECISION MAKING

A. Data Collection and Analysis

Information is the critical product of performance measurement that facilitates clinical decision-making, organizational decision-making (e.g., strategic planning and day-to-day operations), performance improvement, and priorities for risk reduction. Data must be systematically aggregated and analyzed to become actionable information.

Data is aggregated at a frequency appropriate to the process or activity being studied. LRE data is analyzed over time to identify patterns and trends, and compared to desired performance levels, including externally derived benchmarks when available.

Undesirable patterns or trends in performance are identified, as well as undesirable variations in performance, and acted on as appropriate. In some instances, further data collection and analysis is necessary to isolate the causes of poor performance or excessive variability.

Beacon Health Options staff prepare an analysis of the data, including recommendations for further investigation and identification of data collection or reporting improvements to resolve data validity concerns, and/or system improvements.

B. Taking Action

Process improvements are achieved by taking action based upon data collected and analyzed through performance measurement activities. Actions taken are implemented systematically to insure any improvements achieved are truly associated with the action. Adhering to the following steps promotes process integrity:

- Develop a step by step action plan
- Limit the number of variables impacted
- Implement the action plan, preferably on a small or pilot scale initially
- Collect data to check for expected results
- Continue monitoring to ensure sustained improvement

The process of measurement, data collection, data analysis and action planning is repeated until the desired level of performance/improvement is achieved. Sustained improvement is sought for a reasonable period of time (such as one year) before the measure is discontinued.

PERFORMANCE IMPROVEMENT PROJECTS

Performance Improvement Projects Workgroup and QI ROAT members have a key role in setting priorities regarding quality oversight and improvement activities. The questionnaire found in **Appendix A: Priorities for Performance Oversight and Improvement Activities** 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, the criteria can also be used to re-prioritize the LRE's process oversight and improvement activities.

Formal development of performance improvement plans are completed with consultation from MDHHS, Consumer Advisory Panel and the QI ROAT. Recommendations will be reviewed and approved by the Operations Committee prior to implementation.

Other opportunities for performance improvement can be presented through a variety of avenues including, but not limited to, website feedback, satisfaction surveys, ROAT recommendations, MDHHS review results and Consumer Advisory Panel input. Recommended projects are reviewed by QI ROAT utilizing the PDSA Worksheet to ensure appropriateness and effectiveness.

QUANTITATIVE AND QUALITATIVE ASSESSMENT OF MEMBER EXPERIENCES

The opinions of consumers, their families and other stakeholders are essential to identify ways to improve processes and outcomes. Surveys and focus groups are an effective means to obtain input on both qualitative and quantitative experiences. Consumers receiving services funded by the PIHP are surveyed by CMHSPs at least annually using a region-wide standardized survey tool.

The results of the surveys are collected, analyzed and reported to the QI ROAT and LRE Board in order to identify strengths, areas for improvement and make recommendations for action and follow up as appropriate. The data is used to identify best practices, demonstrate improvements, or identify problem areas. The QI ROAT determines appropriate action for improvements, and the resulting findings are incorporated into program improvement action plans.

MEDICAID VERIFICATION REVIEW

Verification of the Delivery of Medicaid Services is the responsibility of the Beacon Quality Management Team and is achieved via the Medicaid Claims Verification Review Process. The purpose of the Medicaid Verification is to determine if claims submitted meet LRE standards for a complete claim. Medicaid Verification Reviews are conducted for all network providers at least annually and include all programs and populations. The review consists of a desk audit of clinical records and a provider site review to process the findings and obtain any relevant information that was not available in the electronic medical record. At the time of the site visit, the provider is given an itemized list of the Medicaid claims reviewed.

Data collected through the Medicaid Claims Verification process are aggregated, analyzed and reported for review by the QI ROAT where opportunities for improvements or corrective action are identified. Additionally, Beacon QI staff provides a "Medicaid Services Verification Methodology Report", to demonstrate claims data verification, and outcomes. The report includes:

- A summary of the analysis with data
- A description of the deficiencies found, including indication of any repeated deficiencies
- A description of the follow up activities implemented by the CMHSP/PIHP
- A summary of how performance has improved over the CMHSP/PIHP

OVERSIGHT OF "VULNERABLE PEOPLE"

LRE has regional policies, procedures and processes for addressing and monitoring the health, safety and welfare of all individuals served. LRE is responsible to ensure that services are consistently provided in a manner that considers the health, safety, and welfare of consumers, family, providers and other stakeholders. When health and safety, and/or welfare concerns are identified, those concerns will be acknowledged, and actions taken as appropriate.

LRE monitors population health through data analytics software (Integrated Care Delivery Platform – ICDP and MDHHS' Care Connect 360 platforms) to identify adverse utilization patterns and to reduce health disparities.

MONITORING OF ENROLLEE RIGHTS

The QI ROAT receives regular reports related to appeals, grievances, trends and patterns of substantiated Recipient Rights complaints and access to and availability of care. Customer Services, Grievances and Appeals are monitored and will be reported to the QI ROAT quarterly. LRE will annually collect data on substantiated rights complaints and report to the QI ROAT.

SECTION TWO: EVALUATION OF PROGRESS ON FY 2019 QI PLAN GOALS

IN FY 2018/2019, the LRE identified fourteen goals as priorities in the QAPIP. The following is a summary of those goals, progress made in each area, and any identified barriers to completion. Some goals identified in FY2018 /2019 will continue into 2020.

GOALS	STATUS/PROGRESS
Goal 1: Develop a common regional process for conducting root cause analysis	**Incomplete - REMOVE THIS GOAL** Originated for CIRE Committee – when reviewing incidents, many CMHSPs did not want to share their RCA in their entirety. Wanted to ensure consistent regional process. Deb continues to collect reports; LRE/Beacon process is yet to be developed. Does not consider this to be a top priority. From a risk management perspective, the LRE must monitor risk events. Recommendation that this goal be removed from the FY2020 plan – reconsider in future once Beacon processes are established.
Goal 2: Adopt at least two new HEDIS measures	**Complete -**
Goal 3: Train staff on understanding data related to social determinants	**Incomplete – REMOVE THIS GOAL** This was a recommendation from N180.
Goal 4: Complete implementation of ANSA	**In Process – Partialy complete – KEEP THIS GOAL** Currently on hold but still on the table – TBD if this will remain on the plan. Decision to continue not yet made. Regional workgroup continues to meet on SIS/CLS Level of Care activity.
Goal 5: Develop process for ensuring quality and compliance on plans of correction from provider site reviews.	**Incomplete REMOVE THIS GOAL**
Goal 6: Develop Regional Communication Plan	**Incomplete REMOVE THIS GOAL** For further discussion.
Goal 7: Revise ROAT descriptions and charges and assure advisory input on policy is being obtained from ROATs. (Continuation from FY 17)	**In process – KEEP THIS GOAL** ROAT description has been finalized; questions pertaining to structuring with Beacon. (Which ROATs remain, who will represent). Needs more development this year due to changes. There has been discussion that some ROATS find having providers and consumer representation is valuable; others have indicated that having CMHSP/LRE strategic planning is needed.

GOALS	STATUS/PROGRESS
Goal 8: Develop process for tracking IPOS training	**Incomplete - KEEP THIS GOAL** IPOS Training occurred this year. There continues to be inconsistency. MDHHS citation.
Goal 9: Improve Regional Performance on MMBPIS indicators	**In process - KEEP THIS GOAL**
Goal 10: Impact the current Opioid Crisis	**Complete**
Goal 11 Jail Diversion (CAP)	**Incomplete - KEEP THIS GOAL** **Recommendation is to keep this goal for FY2019** CMHSPs are collecting data, report needs to be completed to be presented to the Consumer Advisory Panel.
Goal 12 Exercise Program (CAP)	**Incomplete – REMOVE THIS GOAL** Identified by the Consumer Advisory Panel. Greg will follow up with the group to see if they would like to continue.
Goal 13 Reporting of Credentialing Oversight Findings	**Partially Complete - KEEP THIS GOAL** **Recommendation is to keep this goal for FY2020**
Goal 14 Selection of a Performance Improvement Project (PIP) for region.	**Complete** Deb will schedule a workgroup meeting

SECTION THREE: FY 2020 GOALS

Goal/Opportunity	Objectives (Specific Actions to be taken)	Success Measure How will we know if this was implemented effectively?)	Responsible Party Assigned Workgroup /Person	Estimated Completion Date
Goal 1 Improve Regional Performance on MMBPIS indicators (Continuation from FY 18)	Performance for FY 2018 declined for the region, in particular with Indicator 3 – Face to face services are initiated within 14 days of the assessment. This is an area that required regional attention in order to improve access to care.	Regional work group is formed, issues are identified, plan is developed, and follow up occurs consistent with PDSA process. New process implemented. If CMHSP is out of compliance 5 out of the previous 9 quarters, monthly data reports are required by LRE/Beacon. This stays in effect until the CMHSP is incompliance two quarters in a row.	QI ROAT / Deb Fiedler MMBPIS Workgroup / Deb Fiedler However, this needs to be a focus of other groups as well – Directors & Clinical Leaders.	12/31/2020
Goal 2: Revise ROAT descriptions and charges, and assure advisory input on policy is being obtained from ROATs. (Continuation from FY 18)	Assure that each ROAT has an important role and members understand the role. Assure annual review of assigned policies. Report at least semiannually key findings to Leadership	ROAT charge is developed or reviewed and revised. All policies requiring ROAT review are completed. Summary reports are provided to the Operations Committee.	ROATs / LRE Lead Staff for Each ROAT	12/31/2020

Goal 3: Develop process for tracking IPOS training (Continuation from FY 18)	External reviews have identified inconsistency with CMHSP training of direct care staff on the person-centered plan. Common standard and process for region is required.	Process is developed and approved by Operations Committee.	QI ROAT / LRE Quality Team	12/31/2020
Goal 4: Complete implementation of ANSA	ANSA work plan had been developed for purpose of moving all CMHSPs forward on this project. Purpose is to provide a standard of practice and care for the region.	ANSA work plan is carried out within expected time frames.	Currently on hold. Regional workgroup continues to meet on SIS/CLS Level of Care activity.	12/31/2020
Goal 5: Develop process for tracking IPOS training	External reviews have identified inconsistency with CMHSP training of direct care staff on the person-centered plan. Common standard and process for region is required.	Process is developed and approved by Operations Committee.	QI ROAT / LRE-Beacon Quality Team	12/31/2020
Goal 6: Reporting of Credentialing Oversight Findings	QAPIP Standards require that this data be regularly reviewed as part of the QAPIP.	Credentialing oversight results will be reported to the appropriate ROATs at least 2 times annually.	QI ROAT / LRE-Beacon Quality Team	12/31/2020

SECTION FOUR: REPORTING SCHEDULE AND TRACKER FY 2020

LAKESHORE REGIONAL ENTITY - QUALITY IMPROVEMENT PLAN
FY 2020 QI ROAT AGENDA CONTENT SCHEDULE
(subject to change due to availability of data and scheduling)

Content Area	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Behavior Treatment Report		X			X			X			X	
Behavior Treatment Satisfaction Survey Report												X
Critical Incident Reports		X			X			X			X	
Risk Event Reports		X			X			X			X	
MMBPIS Reports	X			X			X			X		
LRE Satisfaction		X			X			X			X	
Medicaid Verification		X						X				
ICDP- Key Performance Indicators Reports			X			X			X			X
CMHSP Score Card		X										
Provider Site Review Report	X			X			X			X		
CMHSP Data Timeliness Reports			X						X			
QAPIP Goals Monitoring			X			X			X			X
PIP Report*										X		
HSAG PMV										X		
Customer Services Data Report (includes Grievance and Appeals)		X			X			X			X	
RSA								X				
Credentialing/ Re-credentialing						X						X
Jail Diversion											X	
MDHHS POCs*												

*as needed

SECTION FIVE: FY 2019 QAPIP EFFECTIVENESS REVIEW

QAPIP STANDARD	REVIEW FINDINGS	NOTES
1) An adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP	Met	The LRE QAPIP describes the structure and function of the QI system. LRE implemented its QAPIP in FY 2018 according to established protocol.
2) The components and activities of the QAPIP are clearly specified	Met	The LRE QAPIP includes all required components, Where necessary improvements or clarifications to the written plan have been incorporated into the 2020 QAPIP.
3) The role for recipients of services in the QAPIP	Met	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.
4) The mechanisms or procedures to be used for adopting and communicating process and outcome improvement	Partially Met	While the language in the QAPIP meets the standard and intent, this has not necessarily translated into effective practices across the region during FY 2019. Key performance indicators beyond contract requirements were not clearly articulated in the QAPIP or in other public LRE documents. The FY 2018/19 QAPIP included a goal for improved communication, focus on metrics, and process for identifying and implementing performance improvement where needed.
II. QAPIP must be accountable to a Governing Body that is a PIHP; includes	Met	The Operations Committee and LRE Board review the annual Regional QI plan. The FY 2018/19 plan included additional clarification on how the QI ROAT will escalate issues to the Operations Committee or Board as necessary to ensure high performance on all indicators.
A. Oversight of QAPIP- There is documentation that the governing body has approved the QAPIP and an annual QI Plan	Partially met	The LRE Board approves the overall Regional Quality Improvement Plan. On an annual basis. Due to the transition to Beacon, the FY19 QAPIP did not get approved by the Board. The FY 20 QAPIP was completed and reviewed by the LRE Board in December 2019. The completed QAPIP is reviewed by the QI Team and presented to the QI ROAT, LRE Leadership, Beacon Health Options, LRE Board and the Consumer Advisory Council for information and feedback. The QAPIP will also be posted on the LRE Website.

QAPIP STANDARD	REVIEW FINDINGS	NOTES
B. QAPIP progress reports- Routinely receives written reports from the QAPIP describing performance improvement projects undertaken, the actions taken and the results of those actions	Met	The LRE Board has been receiving routine reports on compliance with state standards, including Critical Incident and Risk Event Report, MMBPIS, updates on Provider Site Reviews, Autism, HSAG Plans of Correction, etc.
C. QAPIP Annual Review- Formally reviews on a periodic basis a written report on the operation of the QAPIP	Met	QI Staff create an Annual Plan Summary Report. This summary report is reviewed by the QI Team and presented to the QI ROAT, LRE Leadership, LRE Board, Beacon Health Options Leadership and the Consumer Advisory Council for information and feedback. This report will also be posted on the LRE Website.
III. Designated senior official responsible for the QAPIP implementation	Met	Per the QAPIP, for FY19, and FY20 LRE CEO and Beacon Health Options Quality Manager has administrative management and oversite of the QAPIP.
IV. Active participation of providers and consumers in the QAPIP processes	Met	There is representation on the QI ROAT from Consumers and the Provider Network. 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. Typical stakeholders identified to provide input to the LRE members are service consumers, staff, contract service providers, families/advocates, and local communities. Stakeholder input is gathered from a variety of methods, including satisfaction surveys, Consumer Advisory Panel, public comment at Board meetings, etc. The Consumer Advisory Council does review the Annual Plan Summary Report and provide feedback.
V. Measures performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data	Partially Met	While the QI ROAT and the IT ROAT ensure the reliability and validity of the data on these indicators across the region, and that these conform to “Validation of the Performance Measures” BBA protocols, there were significant data reporting and performance issues identified in FY2018 in the LRE region. These were addressed and majority of identified issues corrected in FY2019 . The process of improving the data quality continues in FY2020.

QAPIP STANDARD	REVIEW FINDINGS	NOTES
A. Must utilize performance measures established by the department in the areas of access, efficiency and outcome and report data to the state as established	Partially met	While the LRE reported and analyzed/ reviewed data per its QAPIP, the process was not adequate to remediate significant data reporting issues in the region during FY 2018. Several CMHSPs still struggle with meeting the MDHHS MMBPIS Standards throughout FY2019 and continues into FY2020. Some of the issues were due to implementation on new EMRs at several CMHSPs
B. May establish and monitor other performance indicators specific to its own program for the purpose of identifying process improvement projects.	Partially Met	The LRE continues to clarify KPI's, which groups or committees are responsible for oversight and performance improvement on these KPI's and the types of reports and/or action taken. The process for identifying issues for process improvement, developing a plan, and tracking improvement over time was a key component of the FY 2018 /2019 QAPIP and this will continue into FY2020.
VI. Utilize QAPIP to assure that it achieves minimum performance levels on performance indicators as established by the department and defined in the contract and analyzes the causes of negative statistical outliers when they occur.	Partially Met	Same as above. LRE must develop improved processes and accountability activities across the region to ensure positive performance
VII. QAPIP includes affiliation-wide performance improvement projects that achieve demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and consumer satisfaction	Partially Met	LRE conducted two performance improvement projects meeting Michigan QAPIP standards and BBA standards. One of the projects conducted was mandated by MDHHS and was reviewed and evaluated by HSAG for compliance with requirements. LRE achieved 100% Compliance with requirements from HSAG in FY2019. The second PIP, has been completed informally and per HSAG should to be written and monitored in a formal matter. This will be completed in FY2020.
A. Performance Improvement Projects must address clinical and non-clinical aspects of care	Met	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."
1. Clinical areas could include high-volume services, high- risk services, and continuity and coordination of care	Met	Current PIP addresses coordination of care and monitoring individuals with Diabetes and Schizophrenia

QAPIP STANDARD	REVIEW FINDINGS	NOTES
2. Non-clinical services may include appeals, grievances and trends and patterns of substantiated RR complaints, and access to, and availability of care	Partially Met	Grievance and Appeal Audit is completed as a part of the LRE annual Site Reviews. LRE Board and Consumer Advisory Council reviewed Grievance and Appeals Data. The FY 2018/19 QAPIP includes a mechanism for the QI ROAT to review data to evaluate trends and determine if performance improvement is needed, this will continue in FY2020. The Appeal process is now delegated to Beacon Health Options.
B. Project topics take into consideration prevalence of consumer conditions, demographics, and consumer interest	Met	The Consumer Advisory Panel provides input on goals, measures and potential project topics.
E. PIHP must engage in at least two projects during waiver renewal period	Partially met	While the LRE did engage performance Improvement projects, these were not clearly identified in the FY2019 QAPIP. The FY 2020 QAPIP will clearly identify the process by which projects are selected and the specific projects chosen. The PIPs identified in FY2018 will continue through FY2021.
VIII. QAPIP describes process of the review and follow-up of sentinel events and other critical incidents	Met	Activities conducted according to QAPIP.
A. Sentinel events must be reviewed and acted upon as appropriate (3 business days)	Met	Activities conducted according to QAPIP.
B. Persons involved in the review must have appropriate credentials relative to the event	Met	Staff involved in reviews have the appropriate credentials.
C. All unexpected deaths of Medicaid beneficiaries must be reviewed and include:	Met	Activities conducted according to QAPIP.
1. Screens of individual deaths with standard information	Met	QAPIP and PIHP policy include all required information.
2. Involvement of medical personnel in the mortality reviews	Met	Clearly stated in QAPIP
3. Documentation of the mortality review process, findings, and recommendations; Use of mortality information to address quality of care; Aggregation of mortality data over time to identify possible trends	Partially Met	The LRE will evaluate the role of the PIHP Medical Director and will ensure that the QAPIP includes review of mortality data trends

QAPIP STANDARD	REVIEW FINDINGS	NOTES
D. Following immediate event notification to MDHHS, PIHP will submit information on relevant events through the Critical Incident Reporting System	Met	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.
E. Critical Incident Reporting System- QAPIP must describe how the PIHP will analyze at least quarterly the critical incidents, sentinel events, and risk events to determine what action needs to be taken.	Met	The Lakeshore Regional Entity /Beacon Health Options analyzes 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. For FY 2020, these events are reviewed by LRE /Beacon Quality of Care Committee and the QI ROAT quarterly.
F. Risk Events Management- • Actions taken by individuals who receive services that cause harm to themselves • Actions taken …that cause harm to others • 2 or more unscheduled admissions to a medical hospital within 12 months. • Written reports within 60 days for each death	Met	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. For FY 2020, these events are reviewed by LRE /Beacon Quality of Care Committee and the QI ROAT quarterly.
IX. QAPIP quarterly reviews analyses of data from the behavior treatment review committee where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis.	Partially met	As of FY 2018, MDHHS no longer required the Behavior Treatment data submission to MDHHS. The Behavior Treatment Data is submitted to the LRE, quarterly from the CMHSP and aggregated into a LRE/Beacon Report. For FY20 this report will be presented to the LRE Behavior Treatment Committee and QI ROAT quarterly to review and discuss data collection, data definitions, and trending of data. Note: For FY19 the Behavior Treatment Committee did not meet, it was re-established in FY20. The CMHSP Behavior Committee Process and Data is reviewed annually by the Beacon Quality Manager during the annual CMHSP Site Review.
X. QAPIP includes periodic quantitative and qualitative assessments of member experiences with its services	Partially Met	The LRE conducted all activities consistent with state requirements and as described in its QAPIP. A consistent region-wide consumer satisfaction survey was administered in FY 2017, FY2018, & FY2019 and continues into FY2020 across all populations. Issue noted in FY 19 –One CMHSP did not submit survey data.
A. Must address issues of the quality, availability, and accessibility of care	Met	LRE Performance Indicators include quality, availability, and accessibility per MDHHS and BBA requirements.

QAPIP STANDARD	REVIEW FINDINGS	NOTES
B. As a result, the organization		
1. Takes specific action on individual cases as appropriate	Met	Activities conducted according to QAPIP for specific examples and individual cases as needed.
2. Identifies and investigates sources of dissatisfaction	Met	This expectation is clearly documented in the QAPIP and LRE/Beacon Health Options conducted specific investigations of consumer and provider dissatisfaction per its policies and procedures.
3. Outlines systemic action steps to follow-up on the findings	Met	Individual corrective action and/or systemic Corrective Action plans were required as needed for the specific findings.
4. Informs practitioners, providers, recipients of service and the governing body of assessment results	Partially Met	This expectation is documented in the QAPIP, however communication of findings, improvement activities and results of those actions was not well documented. LRE identified a goal of improved Communication in its FY 2018/19 QAPIP. This continues to be a priority in FY2020, however the goal itself was not continued into FY2020.
C. Organization evaluates the effects of the above activities	Met	"The Plan-Do-Check-Study process is designed so that when any input or issue is identified, it 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." This expectation is documented in the QAPIP and appears to have been followed during FY 2019.
XI. QAPIP describes the process for the adoption, development, implementation and continuous monitoring and evaluation of practice guidelines when there are nationally accepted or mutually agreed upon (MDHHS and PIHP) clinical standards, evidence-based practices, practice-based evidence, best practices, and promising practices	Partially Met	The Clinical Practice Guidelines recommended for implementation for the LRE 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. For FY 2020, Beacon Health Options has developed a UM Clinical Committee which will be responsible for the adoption, development, implementation and continuous monitoring and evaluation of practice guidelines

QAPIP STANDARD	REVIEW FINDINGS	NOTES
XII. QAPIP contains written procedures to determine whether physicians and other health care professionals are qualified to perform their services. Written procedures exist to ensure non-licensed providers are also qualified to do their job. Evidence of credentialing process. PIP must insure:	Met	The FY 2017 QAPIP referenced the LRE Credentialing and Re-Credentialing policy but did not specify the procedures nor the role of the QI ROAT in providing oversight. The FY 2018/19 QAPIP includes clarifying language related to the role of the QI ROAT in reviewing data and ensuring that standards are met. This clarifying language related to the role of the QI ROAT is also included in the FY2020 QAPIP.
1. Staff possess the appropriate qualifications as outlined in their job descriptions, including a. Educational background b. Relevant work experience c. Cultural Competence d. Certification, registration, and licensure as required by law	Met	LRE/Beacon Health Options staff conducted credentialing reviews throughout the provider network including the annual CMHSP Site Review, to ensure these standards are met.
2. Program shall train new personnel with regard to their responsibilities, program policy, and operating procedures.	Partially Met	The FY 2020 QAPIP references process and procedures and identifies responsible party for ensuring that this function is being performed. Training issues for Autism, HabWaiver staff were noted during FY19
3. Program shall identify staff training needs and provide in- service training, continuing education, and staff development activities.	Partially Met	Each LRE member CMHSP is required to identify staff training needs and provide in-service training, continuing education and staff development activities. This process is reviewed during the annual CMHSP Site Review. Training issues for IPOS training continued to be an issue for FY19.
XIII. Written QAPIP must address how it will verify whether services reimbursed by Medicaid were actually furnished to enrollees by affiliates, providers, and subcontractors.	Met	The QAPIP includes the Medicaid Event Verification Process, and LRE implemented these activities according to its plan and in conformance to state requirements.
PIHP must annually submit its findings from this process and provide any follow up actions that were taken as a result of the findings.	Met	The LRE implemented these activities according to its policy and in compliance with MDHHS requirements.

QAPIP STANDARD	REVIEW FINDINGS	NOTES
XIV. Organization operates a UM program	Partially Met	While the details of the UM program are outside of the scope of this assessment, the LRE QAPIP does identify that LRE uses a UM policy, procedure, and annual UM Plan to assure appropriate delivery of services. Per the QAPIP, Utilization Management data is aggregated and reviewed by the QI ROAT for trends and service improvement recommendations. Findings from this review indicate that some data such as MMBPIS (service access), Medicaid Verification (services consistent with plan), and Site Review results that pertain to UM were reviewed in the QI ROAT. The QI ROAT did not review other typical utilization reports such as number of persons served, hospitalization rates, or clinical outcome measures. It is further noted that an Annual UM Program Plan was not completed for FY18/19. Beacon Health Options wrote a UM Plan that was approved in October 2019 for emergent service. Routine services authorizations and UM Monitoring occur at the member CMHSPs. CMHSP UM processes are monitored through the annual CMHSP site review.
XV. PIHP annually monitors its provider network(s), including any affiliates or subcontractors to which it has delegated managed care functions. PIHP shall review and follow-up on any provider network monitoring of its subcontractors.	Met	LRE/Beacon Health Options annually monitors its provider network including service and support provisions. 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. QAPIP provides a summary of this process.
XVI. PIHPs shall continuously evaluate its oversight of "vulnerable" people in order to determine opportunities for improving oversight of their care and their outcomes.	Met	QAPIP indicates LRE will “Conduct additional special targeted monitoring activities of people who are identified as vulnerable (as defined by MDHHS)” These cases are routinely identified during file reviews and outlier reviews.
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.	Met	The LRE/Beacon Health Options implemented this process according to the QAPIP

APPENDIX A

LAKESHORE REGIONAL ENTITY - QUALITY IMPROVEMENT PLAN

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

APPENDIX B

LAKESHORE REGIONAL ENTITY – FY 19 QUALITY IMPROVEMENT PLAN REVIEW

The following report provides an annual review of key performance areas for the Lakeshore Regional Entity and its CMHSP Partners. The first page is an overall summary of these key areas, while the rest of the report provides further explanation. There also may be a detailed report with all data points referenced in the review.

CMHSP Annual Site Review: References findings from the LRE's review of each CMHSP.

CMHSP's overall scores ranged from 93.3 to 96.7%. The LRE considers this to be an overall strength for the region. However, there are a few systemic issues that need ongoing attention: 1) Services provided are not consistent with the Individual Plan of Service (IPOS); 2) Goals and Objectives are not always clear and measurable; 3) Direct service staff are not always trained on implementation of the IPOS.

Performance Measures: References the required state performance indicators (MMBPIS).

The percentage of indicators by quarter that were met improved slightly from 71% in FY 2018 to 74% in FY 2019. Of particular concern continues to be the indicator measuring time from the assessment to the ongoing service. This was identified as a QAPIP Goal in FY2018 and continues as a QAPIP Goal for FY2020.

Medicaid Verification: References LRE review of Medicaid claims validation.

The LRE reviewed a total of 783 randomly sampled claims. 49 claims were found to require recoupment for a total of $6,904.52 (4.62% of claims reviewed). The major re asons for recoupment were issues with the service not being supported by a current IPOS, individual falling off Medicaid eligibility, and proof of service not being provided for the billed date of service.

Critical Incidents and Risk Events: References reporting of critical incidents (deaths, med errors, injuries – resulting in ED or Hospital), and Risk Events (Harm to self, others, police calls, physical management and frequent hospitalizations)

301 critical incidents, and 485 risk events were reported to the LRE. Data is reviewed by the LRE QI ROAT. There were no trends identified for immediate action, and monitoring will continue.

Satisfaction: References a regional survey, along with state required surveys for ACT and Home-Based services.

Overall, consumers are rating services over 4 on a 5-point scale. Consumers appear satisfied with services. The Consumer Advisory Panel is utilized to further strategize in these areas.

External Reviews (Health Services Advisory Group): References reviews for performance measure validation, performance improvement project validation, and overall LRE compliance review)

Validation of Measures: LRE performance measures, data and BH Teds were validated for FY19

Validation of Performance Improvement Project: The LRE PIP was validated at 100% for FY19

Compliance: The LRE received an overall score 65% on their 2019 HSAG Compliance Review. The most significant area of non-compliance centers on Confidentiality of Health Info, as the LRE did not have a written Policy.

SITE REVIEW

In FY2019, the LRE conducted the 5thAnnual Site Reviews for each of the five CMHSPs. The LRE CMHSP Site Review is an intensive and comprehensive review process. The following nine categories are included in the review process:

- Administration/Managed Care Functions
- Program Specific Reviews
- Information Technology
- Training and Credentialing
    - CMHSP Staff
    - Autism Staff (Added in FY16)
    - HabWaiver Staff (Added in FY17)
- Chart Review
    - CMHSP Charts (36)
    - Autism Charts Additional Questions (3 Autism Charts)
    - HabWaiver Charts Additional Questions (3 HabWaiver Charts)
- MMBPIS Source Documentation Validation
- Critical Incident & Risk Event Source Data Validation (Added in FY17)
- HCBS Review (Added in FY19)

Evaluation of Site Review Data

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

- CMHSP Site Review Overall Scores:

  Overall for FY19, each of the CMHSPs did well with their individual Site Review. Total CMHSP Site Review scores ranged from 93.3% to 96.7%. This is an improvement in the lowest score, but a slight decline in the highest score from last year's 90.9% to 98.8%. Allegan CMHSP received the lowest overall score for FY19 and Ottawa CMHSP the highest. It is further noted that Ottawa CMHSP achieved an overall CMHSP Site Review Score of over 95% for the last three years.

CMHSP Annual Site Review Overall Scores			
	FY17	**FY18**	**FY19**
Allegan	95.8%	94.4%	93.3%
HealthWest	94.0%	93.0%	93.8%
Network 180	94.5%	90.9%	94.2%
Ottawa	95.9%	98.8%	96.7%
West Michigan	97.4%	96.1%	94.2%

- CMHSP Site Review Administrative / Managed Care Functions Finding:

  The Administrative / Managed Care Function review from the CMHSP Site Review is completed as a desk audit. There are 20 different components which make up this review. For FY19 all five CMHSPs did well in this area achieving the following rating scores: Allegan 97.0%; HealthWest 94.2%; N180 97.9%; Ottawa 99.0% and West Michigan 98.2%. The CMHSPs have consistently did well in this area over the last three years.

CMHSP Site Review Administrative / Managed Care Functions:			
	FY17	**FY18**	**FY19**
Allegan	97.7%	97.3%	97.0%
HealthWest	96.5%	98.0%	94.2%
Network 180	98.6%	99.0%	97.9%
Ottawa	99.4%	98.6%	99.0%
West Michigan	98.9%	97.9%	98.2%

- Person Centered Plan and Documentation Standard and Chart Review:

  One of the Standards from the Administrative / Managed Care Function is the Person Centered Plan and Documentation Standards. This Standard also includes several chart review questions. If was found that all five CMHSPs Policy and written Procedures for this area include are well written and include needed components. The chart review however, did identify several issues especially concerning individualized, measurable goals and objectives. Person Centered Planning processes continues to be a priority of the Beacon QI Team for both CMHSPs and Provider reviews.

Chart Review Overall Findings: Person Centered Plan and Documentation Standards			
	FY17	**FY18**	**FY19**
Allegan	98.7%	98.8%	97.8%
HealthWest	96.3%	93.7%	93.3%
Network 180	99.8%	97.4%	100%
Ottawa	97.0%	99.6%	90.6%
West Michigan	98.0%	97.5%	90.6%

- Chart Review Question: Service Delivery Consistent With Plan Findings:

  Service Delivery Consistent with Plan was monitored closely in FY19. It is noted that three of the CMHSP's scores showed improvement from last year, however two of the five CMHSPs did not meet the required 95% Standard and required Plans of Correction in this area for FY19. There are several components to this review question. It is reviewing whether or not the individual is receiving services as authorized in IPOS for scope, amount, and duration.

Chart Review Findings: Service Delivery Consistent with Plan			
	FY17	**FY18**	**FY19**
Allegan	95.0%	92.5%	96.4%
HealthWest	89.5%	84.9%	98.7%
Network 180	90.0%	90.8%	90.2%
Ottawa	90.3%	100%	94.6%
West Michigan	100%	95.1%	97.4%

- Autism Specific Chart Review Questions Findings:

The Autism Specific Chart Questions were added to the Site Review Process in FY16. Findings from these indicate systematic issues for three of the five CMHSPs. Two CMHSPs made improvement in this area for FY19. Plans of Correction for were requested and completed by each of the five CMHSPs. The LRE Waiver Coordinator and Team will continue to monitor closely during FY20.

Chart Review Findings: Autism Specific Chart Questions Review			
	FY17	**FY18**	**FY19**
Allegan	93.3%	95.3%	95.0%
HealthWest	91.7%	92.9%	87.1%
Network 180	94.4%	91.0%	89.0%
Ottawa	89.7%	90.6%	89.8%
West Michigan	95.2%	88.2%	96.7%

- Staff Training and Credentialing Review

The Staff Training and Credentialing review is completed during the CMHSP Site Review. Beacon QI Specialist completes the internal CMHSP staff audits and the LRE Autism/HabWaiver Coordinator completes the Autism and HabWaiver Reviews. As the chart below indicates, issues have been found in the audit of staff training and credentialing for all five CMHSPs. There appears to be more issues with external, especially direct care worker staff, then internal CMHSP staff.

CMHSP Staff Review					Autism Staff Review				Hab Waiver Staff Review		
	FY17	**FY18**	**FY19**		**FY17**	**FY18**	**FY19**		**FY17**	**FY18**	**FY19**
Allegan	95.3%	97.4%	97.2%		88.0%	80.2%	94.8%		92.0%	88.9%	64.9%
HealthWest	82.8%	88.8%	89.2%		92.2%	87.8%	NA		90.5%	94.4%	88.9%
Network 180	77.9%	94.2%	98.8%		94.4%	75.9%	83.4%		97.0%	96.7%	87.1%
Ottawa	86.0%	100%	94.6%		95.3%	97.8%	98.0%		86.1%	97.1%	89.4%
West Michigan	92.4%	90.4%	99.2%		98.7%	100%	88.3%		94.5%	86.6%	78.8%

Some issues found during the Training / Credentialing Review:

- Not all Staff receive specific IPOS Training prior to working with the individual. This includes new staff and long-term staff not receiving an IPOS specific training following an annual IPOS
- Not all Staff receive annual updates for required trainings, such as, Grievance and Appeals, HIPPA, Universal Precautions, etc.
- Not all Staff have Background Checks completed prior to hire.

See the completed LRE *CMHSP Site Review FY17, FY18, & FY19 & the FY19 Agency Score Card Comparison Report* (dated 01/27/2020) for more details.

PERFORMANCE MEASURES (MMBPIS)

Overview:

MMBPIS Indicators have 19 MDHHS reportable Indicators quarterly, which equals 76 reported annually. The chart below shows the difference in the number of indicators in which the LRE met the MDHHS 95% Standards for FY16, FY17 and FY18. It is noted that some improvement occurred in FFY18, but not enough. LRE implemented a new process in FY18. CMHSPs are required to report monthly on any indicator that was not 5 out of the last nine quarters. CMHSPs are required to continue monthly reporting until Standards have been met for two consecutive quarters. LRE is working closing with the CMHSPs in this area.

MMBPIS Findings: Number / Percentage LRE Met MDHHS MMBPIS Standards			
	FY17	**F718**	**F719**
# of LRE Met MMBPIS Indicators	40/76	54/76	56/76
% of LRE Met MMBPIS Indicators	**52.6%**	**71.1%**	**73.6%.**

The most problematic MMBPIS Indicator for FY18 was Indicator #3, *Start of Ongoing Services Within 14 days of an Initial Assessment*. As illustrated in the chart below, CMHSPs did not consistently meet this indicator in FY18. LRE QI Staff Chairs quarterly MMBPIS meetings. During these meetings the reasons the CMHSPs did not meet the MDHHS 95% Standards for this indicator are discussed. It was found that CMHSPs do not ensure that an individual is provided with an appointment date following the Assessment. The CMHSPs then have difficulty reaching the individual to set up this appointment due to wrong phone numbers or the individuals not answering their phone or returning phone calls. Plans of Correction are required for any indicator not meeting MDHHS Standard and these continue to be monitored by the LRE. The chart below shows the number of quarters each CMHSP met the MDHHS Standards for Indicator 3 by Population Group.

15 MIC 8/20 MIA 12/20 DDC 14/20 DDA 13/20

MMBPIS Findings: Indicator 3 – Number of **Quarters** Indicator **Met** by CMHSP Per Population Group for FY19					
	MI Child	**MI Adult**	**DD Child**	**DD Adult**	**SUD**
Allegan	3 out of 4 (75%)	3 out of 4 (75%)	2 out of 2 (100%)	2 out of 4 (50%)	4 out of 4 (100%)
HealthWest	0 out of 4 (0%)	4 out of 4 (100%)	2 out of 4 (50%)	3 out of 4 (75%)	4 out of 4 (100%)
Network180	3 out of 4 (75%)	3 out of 4 (75%)	3 out of 4 (75%)	3 out of 4 (100%)	4 out of 4 (100%)
Ottawa	3 out of 4 (75%)	3 out of 4 (75%)	1 out of 1 (100%)	3 out of 4 (75%)	3 out of 4 (75%)
West Michigan	4 out of 4 (100%)	4 out of 4 (100%)	1 out of 1 (100%)	4 out of 4 (100%)	4 out of 4 (100%)

FY19 LRE MMBPIS Summary

The chart below shows the number and percentage of FY19 Quarters that LRE met MDHHS Standards for each indicator. It also shows the four quarter average LRE achieved for each indicator for FY19.

Indicator #	Indicator Description	Population Group	# Quarters MDHHS Standards Met	% of Quarters MDHHS Standards Met	LRE Annual Average Score Per Indicator
1	**Pre-admission Screening Disposition 3 hours or less**	Child	3 out of 4	50%	**96.5%**
		Adult	3 out of 4	50%	**95.9%**
2	**Request to Assessment within 14 days**	MI Child	4 out of 4	100%	**98.28%**
		MI Adult	4 out of 4	100%	**99.08%**
		DD Child	4 out of 4	100%	**98.88%**
		DD Adult	3 out of 4	75%	**98.37%**
		SUD	0 out of 4	0%	**92.08%**

Indicator #	Indicator Description	Population Group	# Quarters MDHHS Standards Met	% of Quarters MDHHS Standards Met	LRE Annual Average Score Per Indicator
		LRE Total	3 out of 4	75%	**96.36%**
3	**Assessment to Start of Ongoing Services within 14 days**	MI Child	0 out of 4	0%	**88.9%**
		MI Adult	4 out of 4	100%	**97.3%**
		DD Child	1 out of 4	25%	**93.2%**
		DD Adult	4 out of 4	100%	**96.1%**
		SUD	4 out of 4	100%	**98.4%**
		LRE Total	2 out of 4	50%	**95.1%**
4a	**Follow-up Within 7 Days of Inpatient Discharge**	Children	2 out of 4	50%	**87.8%**
		Adults	3 out of 4	75%	**95.3%**
4b	**Follow-up Within 7 Days of SUD Discharge**	SUD	3 out of 4	75%	**96.4%**
10	**Inpatient Recidivism**	Children	4 out of 4	100%	**6.18%**
		Adults	4 out of 4	100%	**8.83%**

MEDICAID VERIFICATION

For FY19, the LRE completed Medicaid Verification audits semi-annually. The LRE used Rat Stats software to complete a random sample for each CMHSP based on the total number of Medicaid billable claims submitted.

Date of Medicaid Verification Audit	Medication Verification Audit: Dates of Services Reviewed	Total Number of Claims Verified
June 2019	Oct 1, 2018 – March 31, 2018	406
November 2019	April 1, 2018--September 30, 2019	383

Information Data:

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The totals are an aggregate of all Medicaid Claims Verification Audits completed for FY19.

	Total $ Medicaid Claims in pulled MV Encounter File	Total $ Reviewed	$ Amount Recouped	% Recoupment
TOTAL Recoupment FY19 Report 1	$149,657,888.36	$97,132.43	$3,640.81	3.75%
TOTAL Recoupment FY19 Report 2	$116,246,736.43	$52,247.91	$3,263.71	6.25%
TOTAL Recoupment FY19		$149,380.34	$6,904.52	4.62%

The following chart shows the number of claims reviewed by service type for FY19.

SERVICE	NUMBER OF CLAIMS	SERVICE	NUMBER OF CLAIMS
ACT	56	Methadone Services	14
Assessment and Testing	44	OT/Speech Therapy	4
Autism	67	Outpatient Services	138
CLS	52	Peer-delivered services	11
Clubhouse	18	Personal Care	20
Crisis Intervention	3	Psychiatric Services	22
Crisis Residential & Detox	14	Supported Employment / Skill Building	44
Family training	13	Supports Coordination	31
Health / Nursing services	22	Targeted Case Management	61
Home Based	42	Treatment Planning	11
Inpatient Psychiatric	2	Wraparound & Recovery Services	11

The following shows the number of cases reviewed per population group for FY19

- MI 366
- DD 326
- SUD 97

Summary of Medicaid Verification Review Follow-up for FY19

Issues / Concerns Noted:

Based on our FY 19 reviews of the Medicaid Claims Verification audit report data, we discovered several areas of deficiencies which have been addressed on an ongoing basis throughout the year.

- Providers reviewed did not always have the most current IPOS or have the IPOS that was in effect on the Date of Service. There were 12 encounters reviewed in which the provided service was not included in the IPOS or the IPOS was missing.
- An Autism agency did not submit the requested documentation for four encounters reviewed. Recoupment was required.
- Four encounters reviewed did not have proof the service was provided on the billed date of service. Recoupment was required.
- Issues noted with CLS documentation
    - Some notes did not have a Start/Stop time or a signature / initials of the individual completing the service.
    - Billing Sheets were submitted as a proof of service, but these did not include a note and were missing signatures, units, times and descriptions of service provided.
- Providers not having the most current IPOS or the IPOS that was in effect on the Date of Service continued to be an issue during the FY19 Report 2 audit. There were 12 encounters reviewed in which the provided service was not included in the IPOS or the IPOS was missing. Providers report they do not always receive the updated IPOS which is developed by the CSM Provider Agency.
- Six of the encounters reviewed found that the individual was not Medicaid Eligible on the Date of Service.

Medicaid Verification Follow-up

- The LRE requires that any Medicaid Verification audit finding be reconciled. For those claims where a deficiency was discovered, the CMHSP's was responsible to recoup the Medicaid funds and notify the LRE in writing this has occurred. For services provided by a contractual provider, the CMHSP initiated a claims adjustment and took back the funds. For direct run services, claims incorrectly paid with Medicaid dollars were reversed and paid for with General Funds. Interim CFO of the LRE, Maxine Coleman will be responsible for assuring that all appropriate recoupments have been settled.
- Medicaid Claims Verification audit results are discussed first by the QI Team, then brought to the QI ROAT, which includes membership from all five CMHSP's as well as several provider agencies. Processes and issues are discussed, looking for overlaying issues across the region and the reason for outliers.
  Medicaid Claims Verification audit Medicaid results are reviewed / discussed by the LRE Leadership Team and the LRE Board.

CRITICAL INCIDENT AND RISK EVENT REPORTING

Critical Incident Reporting

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:

- There was a total of 301 Critical Incidents reported in FY19 compared to 361 in FY18, this is a difference of 60, improvement noted.
- In FY 19, there were 10 reported suicides which is an increase of 2 compared to FY18. Suicides were reported by HealthWest, N180, and West Michigan. There were 2 accidental deaths reported in FY19, which was 13 less than last year.
- The number of reported injuries requiring medical care decreased from 133 in FY17 to 165 in FY18.
- The number of reported medication errors requiring medical care showed much improvement with 0 reported in FY19, compared to 6 in FY18.
- The number of reported injuries requiring hospitalization showed some improvement in FY19 with 12 reported events compared to 15 reported in FY18.
- There were 0 med errors requiring hospitalization this year compared to 2 the last two years.
- There were less arrests reported in FY19, with 33 reported arrests compared to the 44 arrests reported in FY18.

  See the completed LRE *Critical Event Monitoring for Oct 2017 – Sept 2018 dated 12/18/18 for more details*.

Risk Events Reporting

Risk Events data is reported monthly on all individuals receiving services at the time of the Event, who received either Supports Coordination, Home Based Services (HBS) or Assertive Community Treatment (ACT) Services. Risk Event data includes the number of self-harm risk events, the number of harm to others risk events, the number of police calls, the number of emergency use of physical management and the number of individuals with 2 or more hospitalizations per year. Risk Event Data is not reported to MDCH, however the PIHP is required to have a process for collecting, aggregating, monitoring trending, and follow-up of the events. The LRE reviews the Risk Event process at annual CMHSP Site Review.

The data reviewed indicates the overall rates for the region on Risk Events decreased compared to last year's report:

- There were 565 reported Risk Events for FY19 compared to 764 reported in FY18.
- There were 247 unduplicated individuals who had a reported risk event in FY18 compared to 229 in FY18.

- There were 74 reported "self- harm" Risk Events reported in FY19 which was a decrease of 7 instances compared to the 81 reported in FY18.
- There were 19 "harm to others" Risk Events reported in FY19 which is an increase of 8 instances compared to the FY18 Report.
- The number of reported "police call" Risk Events increased for by three for FY19 with 126 events reported.
- The number of reported "physical management" Risk Events decreased significantly for FY19. There were 327 reported in FY19 compared to the 481 reported in FY18.
- The number of hospitalizations reported for individuals who had 2 or more hospitalizations within a 12 month period decreased from 78 reported in FY18 to 48 reported in FY19.

  See the completed LRE *Risk Event Monitoring for Oct 2018 – Sept 2019* dated 12/19/19.

SATISFACTION

LRE Satisfaction Survey

The LRE Satisfaction Survey Workgroup developed and implemented a regional a ten-question survey with Likert scoring of 1 to 5, with 5 as the best LRE Satisfaction Survey in FY17. This survey continues to be implemented for FY19. There were 2,518 surveys completed across the Region in FY19. This is a decrease of 1,000 completed surveys as compared to the 3518 completed in FY18. A Regional database allows CMHSPs to enter their survey data and the LRE QI Staff to run reports and monitor satisfaction. The decrease in number of completed surveys is attributed to missing data from two CMHSPs, West Michigan and HealthWest. The satisfaction survey process was completed however the data was not entered due to issues with data entry. This is the second year that HealthWest has not submitted all of their data. This year 12 surveys were reported and last year none. The Satisfaction Survey Reports were reviewed quarterly by the QI ROAT.

The satisfaction survey questions are separated into 3 reporting areas, including Access and Availability, Quality Measures and Outcome Measures. Report data is separated by CMHSP and aggregated for a LRE Total. FY19 survey scores ranged from 4.1 to 4.6, which is consistent with the FY18 results. The survey results indicate that individuals receiving LRE services are satisfied with the services they have received.

BEHAVIOR TREATMENT REVIEW COMMITTEE DATA

Behavior Treatment) data is collected at each of the CMHSP's Behavior Treatment Plan Review Committees. This data is submitted to the LRE quarterly, for aggregation, review and monitoring. LRE Behavior Treatment Data Review Workgroup, which has membership from all five of the CMHSPs, was put on hold in FY19 because of the transition to Beacon Health Options and time restraints setting up new processes. It has been decided to reinstate this workgroup in FY20. This workgroup has several purposes, one is to review and discuss data definitions to ensure that all five CMHSP's consistently use agreed upon data definitions in reporting the BTRC data. The Workgroup also discusses BTRC issues and concerns and reviews data reports for any changes or trends. MDHHS no longer requires quarterly BTRC data submission, instead MDHHS has delegated the monitoring responsibility to the PIHP. For FY19, Quarterly BTRC Reports were submitted and

reviewed by the QI ROAT. In addition to the QI ROAT quarterly review, the LRE/Beacon QI staff also monitor and review the Behavior Treatment Committee process at the annual CMIHSP Site Review.

In reviewing the BTRC data for individuals on the Hab Waiver from FY19 it was found that:

- The number of individuals on the Hab Waiver who had a Behavior Treatment Plan ranged from a low of 122 to a high of 151 between FY18 Quarter 1 and FY19 Quarter 4.
- For the eight quarters between FY18 Q1 and FY19 Q4, there were 21 Incidents of Harm to Others reported. This an increased in the number of reported instances from the 5 reported in the previous eight quarters.
- The number of incidents of physical management per quarter varied significantly over the 8 quarters between FY18 Q1 and FY19 Q4, with a low of 21 to a high of 54. This data is consistent with what was reported the previous 8 quarters. Ottawa CMHSP reports the most physical management incidents, although much improvement is noted compared to several years ago. LRE/Beacon QI will continue to closely monitor this area.
- For the eight quarters between FY18 Q1 and FY19 Q4, there were 22 Incidents of 911 calls reported. Thirteen of these instances were reported from West Michigan.

TIMELINESS OF DATA REPORTING

The LRE implemented a process to monitor the timeliness of report submission by the CMHSPs. Timeliness monitoring has been implemented for Critical Incident and Risk Events, MMBPIS Data, Substance Abuse Reports, CMHSP Site Review Audit Materials and Plans of Corrections. Timeliness Monitoring Reports are reviewed by the QI ROAT on a quarterly basis. CMHSPs continue to meet the report submission time frames for FY19, with the exception of SUD Reports. All report submissions are due by the 15th, however SUD Reports are still being submitted at the end of the month they are due. The explanation provided for this lateness, is that CMHSPs have to get the needed data for these reports from the SUD agencies. For FY19 the LRE was successful in submitting the all of MDHHS reports in a timely manner.

HSAG OVERVIEW

Performance Improvement Project (PIP)

A new Performance Improvement Project was developed and submitted to HSAG in 2018 and will continue through FY21. The current Lakeshore Regional Entity PIP for FY 2018 – FY 2020 is titled, "Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) ." This PIP, per contract with MDHHS, requires validation from HSAG annually. Lakeshore Regional Entity attained 100% validation for this PIP for FY2018 and again in FY2019.

The following is an from the FY19 HSAG Performance Improvement Project Validation Report: "*The PIP received an overall Met validation status, with Met scores for 100 percent of critical evaluation elements and 100 percent overall for evaluation elements across all activities completed and validated. Lakeshore Regional Entity's performance on this PIP suggests a thorough application of the PIP Design stage (Steps I through VI) and Implementation stage (Steps VII through VIII). The PIP included only baseline results for this year's validation and had not progressed to the Outcomes stage*."

See the complete *HSAG 2018-2019 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 2019. 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. Validation results are as follows:

- HSAG had no concerns with Lakeshore Regional Entity's receipt and processing of eligibility data.
- HSAG had no major concerns with how Lakeshore Regional Entity received and processed claim/encounter data for submission to MDHHS.
- HSAG found that Lakeshore Regional Entity had sufficient oversight of its five affiliated CMHSPs.
- HSAG validated Lakeshore Regional Entity's Performance Measures

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

- HSAG recommends that the PIHP provide greater oversight to ensure that accurate enrollment dates are stored within the CMHSPs' systems for the purposes of measure reporting.
- HSAG recommends that the PIHP and the CMHSPs perform additional data quality and completeness checks before the data are submitted to the State. Multiple BH-TEDS records in the CMHSPs' EHRs contained conflicting values (e.g., unemployed, but listed as earning minimum wage or more).
- HSAG states that even though the LRE has sufficient oversight of its five affiliated CMHSPs, areas for improvement still existed.

The above recommendations have been implemented at the Lakeshore Regional Entity.

See the complete *HSAG 2017-2018 Validation of Performance Measures report* for more details.

HSAG Compliance Monitoring Report

Lakeshore Regional Entity was reviewed by HSAG Compliance Staff in July 2019. Compliance reviews are on a three year cycle. HSAG reviews half of the Standards each year for two years and the third year is for Plan of Correction follow-up. 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 17 Standards. It is further noted that HSAG changed their review process. The review is no longer about written Policy and Procedures. It is now more about process and if the PIHP is implementing the process per Federal and State rules. In 2019, Lakeshore Regional Entity received an overall score of 65%. The review period selected was for Oct 1, 2018 through April 30, 2019 which was during the transition to Beacon Health Options, meaning many of the processes were not occurring at the LRE and had not yet started at Beacon. For a summary of the 2019 Compliance Monitoring Review see the following chart on the following page.

Table 1.1—Summary of 2018–2019 Compliance Monitoring Review Results

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—QAPIP Plan and Structure	8	5	3	0	63%
Standard II—Quality Measurement and Improvement	8	5	3	0	63%
Standard III—Practice Guidelines	4	3	1	0	75%
Standard IV—Staff Qualifications and Training	3	3	0	0	100%
Standard V—Utilization Management	16	9	7	0	56%
Standard VIII—Members' Rights and Protections	13	10	3	0	77%
Standard XI—Credentialing	9	5	4	0	56%
Standard XIII—Coordination of Care	11	11	0	0	100%
Standard XVI—Confidentiality of Health Information	10	2	8	0	20%
Total	82	53	29	0	65%

Lakeshore Regional Entity is currently in the process of completing the Plan of Correction for all Standards reviewed that received a score of Not Met. The Confidentiality of Health Information received the lowest rating score of the Standards reviewed for 2019. It is noted that all of the findings for this Standard were due to the fact that LRE did not have a formal written policy for Confidentiality of Health Information

Summary from the HSAG 2018-2019 External Quality Review Compliance Report

Lakeshore Regional Entity achieved full compliance in two of the nine standards reviewed, demonstrating performance strengths and adherence to all requirements measured in the areas of Staff Qualifications and Training, and Coordination of Care. The remaining seven standards have identified opportunities for improvement. The areas with the greatest opportunity for improvement were related to QAPIP Plan and Structure, Quality Measurement and Improvement, Practice Guidelines, Utilization Management, Members' Rights and Protections, Credentialing, and Confidentiality of Health Information, as these areas received performance scores under 90 percent.

Lakeshore Regional Entity demonstrated compliance in 53 of 82 elements, with an overall compliance score of 65 percent, indicating that some program areas had the necessary policies, procedures, and initiatives in place to carry out the required functions of the contract, while many other areas demonstrated significant opportunities for improvement to operationalize the elements required by federal and State regulations.

See the complete *HSAG 2018-2019 External Quality Review Compliance Monitoring Report* for more details.

APPENDIX C

LAKESHORE REGIONAL ENTITY

Executive Dashboard - CMHSP

Performance Summary by CMHSP

Data Ran on September 5, 2019

Data as of 8/17/2019

Measure	Page #	Measure Steward	Target*	Current LRE	Above/Below Target	Current Allegan	HealthWest	Network 180	Ottawa	West Michigan
Adults' Access to Preventive/Ambulatory Health Services	2		86%	88.6%	2.6%	87.9%	89.3%	88.7%	87.3%	88.6%
Children's and Adolescents' Access to Primary Care Practitioners	3		90%	93.0%	3.0%	93.5%	94.7%	92.4%	93.3%	91.4%
Follow-Up After Hospitalization for Mental Illness - Adults	4	Andrea	58%	64.8%	6.8%	63.1%	70.3%	61.6%	66.7%	81.8%
Follow-Up After Hospitalization for Mental Illness - Children	5	Andrea	70%	81.6%	11.6%	57.1%	92.0%	78.7%	75.0%	88.9%
Diabetes Screening for People with Schizophrenia/Bipolar Disorder Who Are Using Antipsychotic Medications	6	Andrea	83%	84.6%	1.6%	80.3%	83.5%	86.7%	83.1%	84.6%
Diabetes Monitoring for People with Diabetes and Schizophrenia	7	Deb	70%	45.9%	-24.1%	36.0%	49.4%	43.4%	49.2%	59.0%
Plan All-Cause Readmissions	8	Andrea	17%	10.1%	6.9%	9.4%	9.6%	9.9%	11.6%	12.0%
Cardiovascular Health Screening for People with Schizophrenia/Bipolar Disorder who are Prescribed Antipsychotic Medications	9		75%	47.1%	-27.9%	31.7%	60.5%	40.9%	38.7%	54.0%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	10		2.4%	2.0%	0.4%	3.3%	2.8%	1.1%	2.7%	0.0%
Antidepressant Medication Management Acute Phase	11		61%	30.4%	-30.6%	32.9%	30.2%	28.7%	38.1%	29.0%
Antidepressant Medication Management Continuation Phase	12		42%	24.2%	-17.8%	28.2%	24.4%	20.8%	38.1%	22.9%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	13		60%	51.9%	-8.1%	57.9%	49.5%	54.3%	28.6%	57.9%
Follow-Up Care for Children Prescribed ADHD Medication Initiation Phase	14		43%	64.7%	21.7%	58.3%	65.7%	66.1%	61.0%	56.5%
Follow-Up Care for Children Prescribed ADHD Medication Continuation and Maintenance Phase	15		55%	89.7%	34.7%	85.7%	87.0%	89.4%	95.7%	100.0%

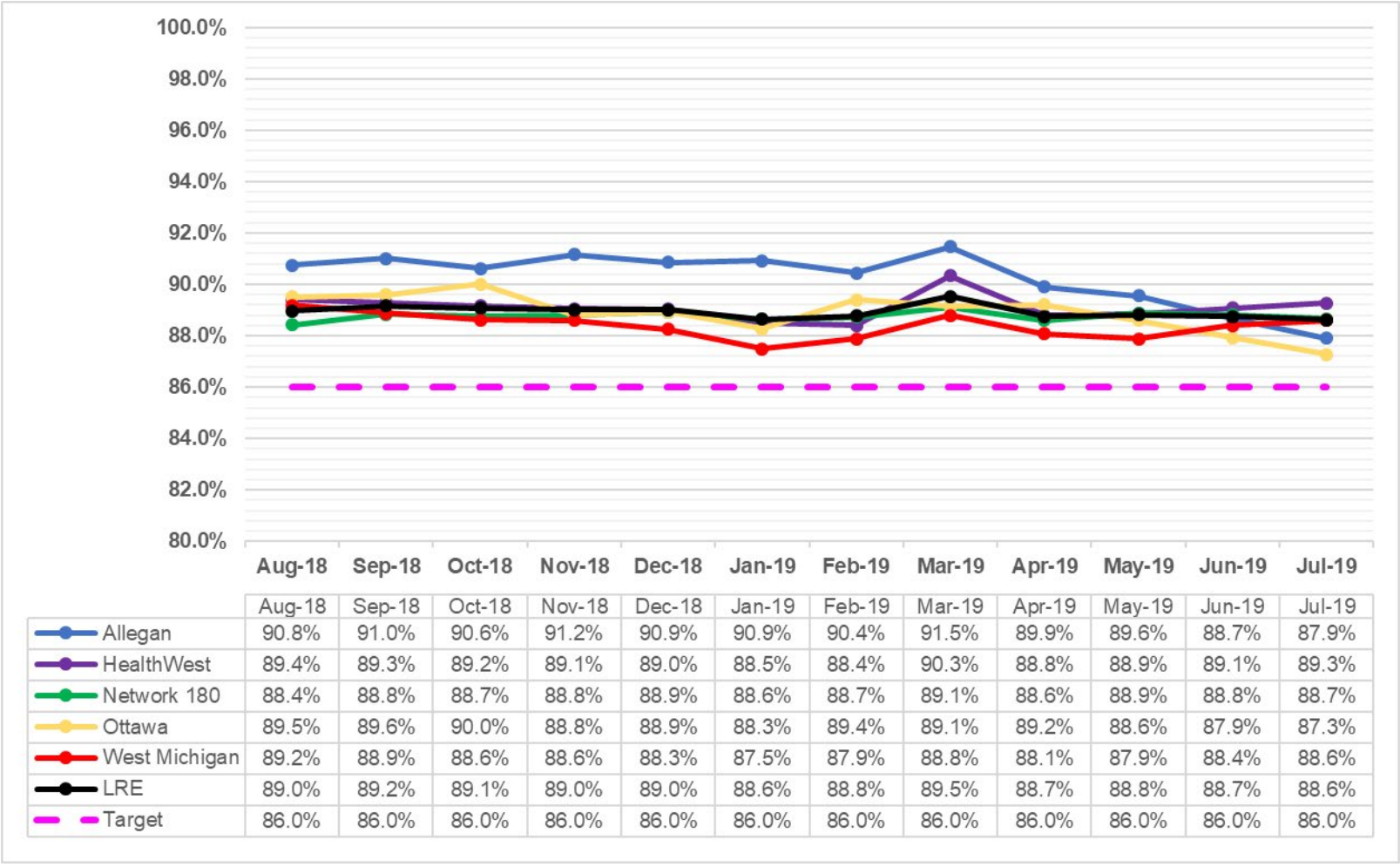
Shaded Grey are State Shared Metrics between PIHP and MHPs.

*Target in Red is **State Mandated Target** Target in Blue is **FY2016 State Average** Target in Green **is FY2016 NCQA National Average** Target in Black – **LRE set target**

Adults' Access to Preventive/Ambulatory Health Services (HEDIS® AAP):

The percentage of members 20 years and older who had an ambulatory or preventive care visit.

Numerator: One or more ambulatory or preventive care visits during the measurement year or the two years prior to the measurement year.
Denominator: Any consumer 20 years of age or older as of the end of the measurement year (e.g., December 31) who have at most one month gap in coverage during each year of continuous enrollment.



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Allegan	90.8%	91.0%	90.6%	91.2%	90.9%	90.9%	90.4%	91.5%	89.9%	89.6%	88.7%	87.9%
HealthWest	89.4%	89.3%	89.2%	89.1%	89.0%	88.5%	88.4%	90.3%	88.8%	88.9%	89.1%	89.3%
Network 180	88.4%	88.8%	88.7%	88.8%	88.9%	88.6%	88.7%	89.1%	88.6%	88.9%	88.8%	88.7%
Ottawa	89.5%	89.6%	90.0%	88.8%	88.9%	88.3%	89.4%	89.1%	89.2%	88.6%	87.9%	87.3%
West Michigan	89.2%	88.9%	88.6%	88.6%	88.3%	87.5%	87.9%	88.8%	88.1%	87.9%	88.4%	88.6%
LRE	89.0%	89.2%	89.1%	89.0%	89.0%	88.6%	88.8%	89.5%	88.7%	88.8%	88.7%	88.6%
Target	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%

FY 2018 Results:

State Average: 82.3%

Blue Cross: 78.6%
Meridian: 83.6%
McLaren: 82.4%
Molina: 83.0%
Priority: 84.5%
United: 82.7%

2017 State Avg: 84.7%
2016 State Avg: 85.6%
2015 State Avg: 86.1%
2014 State Avg: 86.8%
2013 State Avg: 86.7%

Children's and Adolescents' Access to Primary Care Practitioners (HEDIS® CAP):

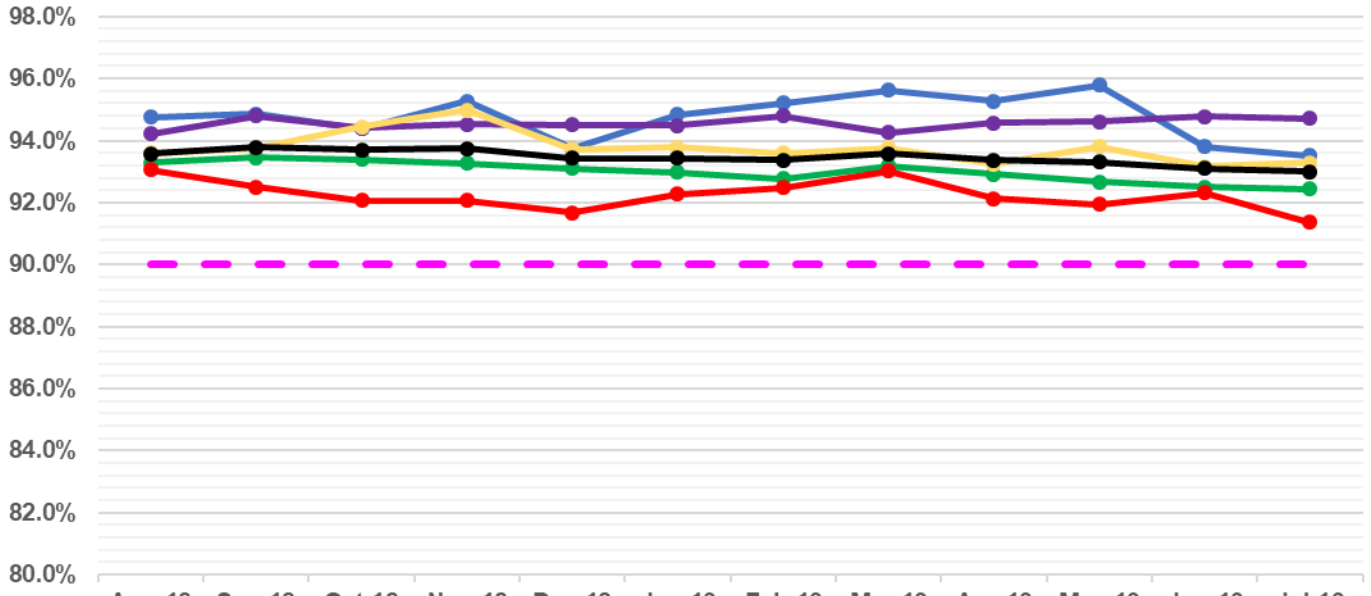
The percentage of members 12 months–19 years of age who had a visit with a PCP.

Numerator: For 12–24 months, 25 months–6 years: One or more visits with a PCP during the measurement year.
For 7–11 years, 12–19 years: One or more visits with a PCP during the measurement year or the year prior to the measurement year.

Denominator: Any consumer 12 months to 19 years of age as of the end of the measurement year (e.g., December 31) who have:

a) At most one month gap in coverage during the measurement year for ages 12 months to 6 years.

b) At most one month gap during the reporting year and the previous year for ages 7 years to 19 years.



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Allegan	94.8%	94.9%	94.4%	95.3%	93.8%	94.8%	95.2%	95.6%	95.3%	95.8%	93.8%	93.5%
HealthWest	94.2%	94.8%	94.4%	94.5%	94.5%	94.5%	94.8%	94.3%	94.6%	94.6%	94.8%	94.7%
Network 180	93.3%	93.4%	93.4%	93.3%	93.1%	93.0%	92.8%	93.2%	92.9%	92.7%	92.5%	92.4%
Ottawa	93.6%	93.8%	94.4%	95.0%	93.7%	93.8%	93.6%	93.8%	93.3%	93.8%	93.2%	93.3%
West Michigan	93.1%	92.5%	92.1%	92.1%	91.7%	92.3%	92.5%	93.0%	92.1%	91.9%	92.3%	91.4%
LRE	93.6%	93.8%	93.7%	93.7%	93.4%	93.4%	93.4%	93.6%	93.4%	93.3%	93.1%	93.0%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

FY 2018 Results:

State Average: 90.9%

Blue Cross: 87.8%
Meridian: 92.8%
McLaren: 86.7%
Molina: 90.7%
Priority: 89.9%
United: 91.2%

2017 State Avg: 90.7%
2016 State Avg: 90.2%
2015 State Avg: 90.4%

Follow-Up After Hospitalization for Mental Illness - Adults (HEDIS® FUH, NQF #0576):

The percentage of discharges for patients 21 years of age or older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. The percentage of discharges for which the patient received follow-up within 30 days of discharge.

Numerator: A follow-up visit with a mental health practitioner within 30 days after discharge. (A follow-up visit includes outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge).

Denominator: Discharges from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (ex: Jan1 to Dec 1) for patients 21 years or older.

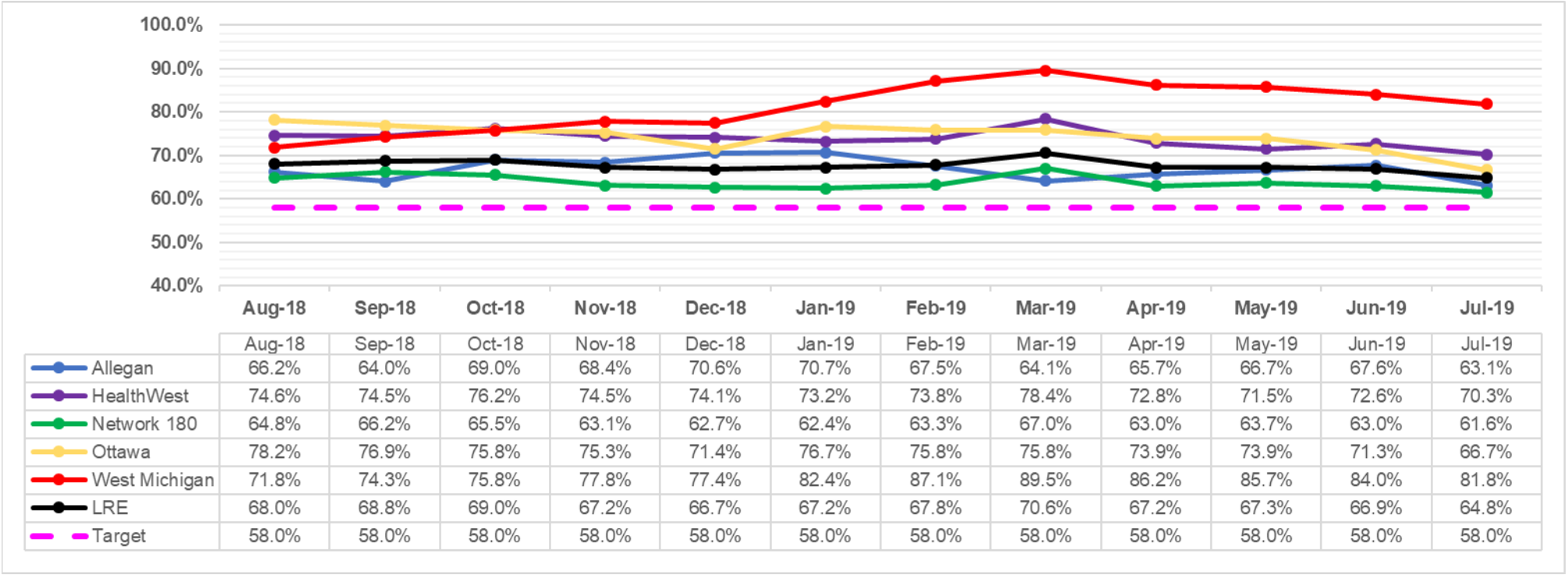
Exclusions:

Excludes from the denominator, patients who receive hospice services during the measurement year.

Excludes both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after Dec 1 of the measurement year.

Excludes discharges followed by readmission or direct transfer to a non-acute facility within the 30-day follow-up period, regardless of principal diagnosis for the readmission.

Excludes discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set).



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Allegan	66.2%	64.0%	69.0%	68.4%	70.6%	70.7%	67.5%	64.1%	65.7%	66.7%	67.6%	63.1%
HealthWest	74.6%	74.5%	76.2%	74.5%	74.1%	73.2%	73.8%	78.4%	72.8%	71.5%	72.6%	70.3%
Network 180	64.8%	66.2%	65.5%	63.1%	62.7%	62.4%	63.3%	67.0%	63.0%	63.7%	63.0%	61.6%
Ottawa	78.2%	76.9%	75.8%	75.3%	71.4%	76.7%	75.8%	75.8%	73.9%	73.9%	71.3%	66.7%
West Michigan	71.8%	74.3%	75.8%	77.8%	77.4%	82.4%	87.1%	89.5%	86.2%	85.7%	84.0%	81.8%
LRE	68.0%	68.8%	69.0%	67.2%	66.7%	67.2%	67.8%	70.6%	67.2%	67.3%	66.9%	64.8%
Target	58.0%	58.0%	58.0%	58.0%	58.0%	58.0%	58.0%	58.0%	58.0%	58.0%	58.0%	58.0%

Follow-Up After Hospitalization for Mental Illness - Children (HEDIS® FUH, NQF #0576):

The percentage of discharges for patients 6 years – 20 years of age who were hospitalized for treatment of selected mental illness diagnoses and who had follow-up visit with a mental health practitioner. The percentage of discharges for which the patient received follow-up within 30 days of discharge.

Numerator: A follow-up visit with a mental health practitioner within 30 days after discharge. (A follow-up visit includes outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge).

Denominator: Discharges from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (ex: Jan1 to Dec 1) for patients 6 years – 20 years of age.

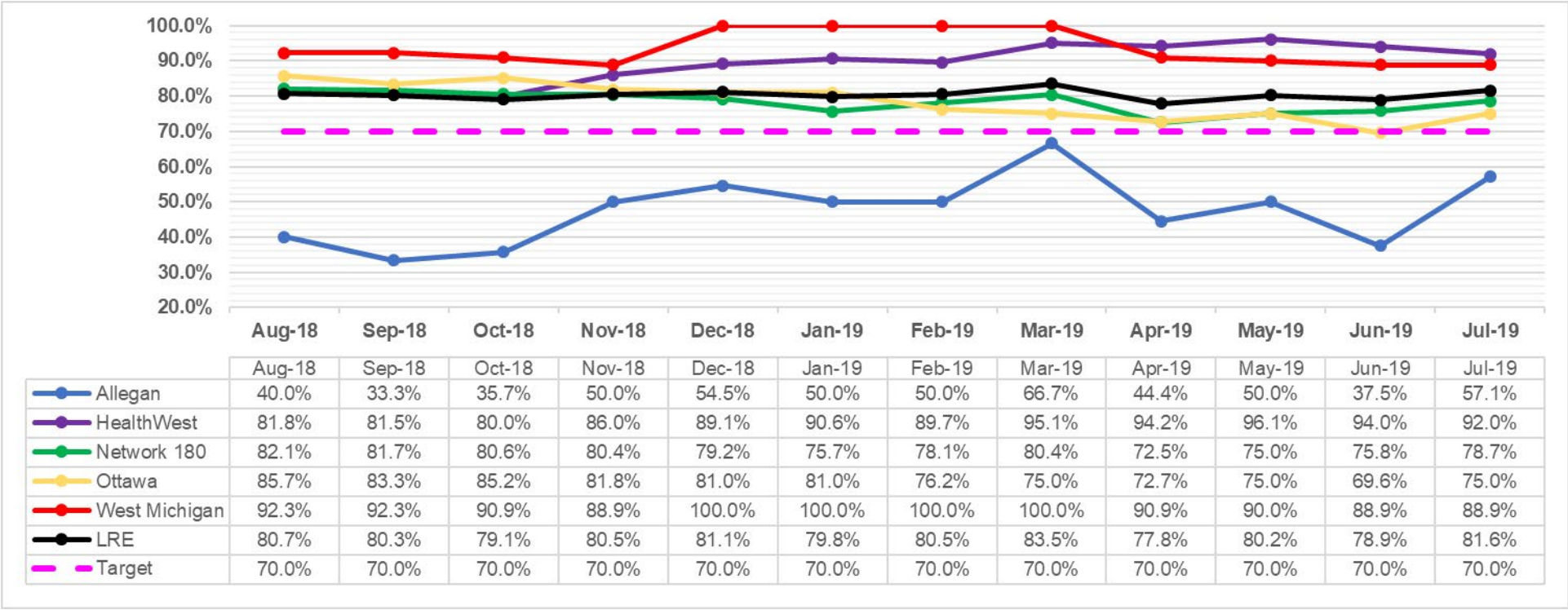
Exclusions:

Excludes from the denominator, patients who receive hospice services during the measurement year.

Excludes both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after Dec 1 of the measurement year.

Excludes discharges followed by readmission or direct transfer to a non-acute facility within the 30-day follow-up period, regardless of principal diagnosis for the readmission.

Excludes discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set).



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Allegan	40.0%	33.3%	35.7%	50.0%	54.5%	50.0%	50.0%	66.7%	44.4%	50.0%	37.5%	57.1%
HealthWest	81.8%	81.5%	80.0%	86.0%	89.1%	90.6%	89.7%	95.1%	94.2%	96.1%	94.0%	92.0%
Network 180	82.1%	81.7%	80.6%	80.4%	79.2%	75.7%	78.1%	80.4%	72.5%	75.0%	75.8%	78.7%
Ottawa	85.7%	83.3%	85.2%	81.8%	81.0%	81.0%	76.2%	75.0%	72.7%	75.0%	69.6%	75.0%
West Michigan	92.3%	92.3%	90.9%	88.9%	100.0%	100.0%	100.0%	100.0%	90.9%	90.0%	88.9%	88.9%
LRE	80.7%	80.3%	79.1%	80.5%	81.1%	79.8%	80.5%	83.5%	77.8%	80.2%	78.9%	81.6%
Target	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%

Diabetes Screening for People with Schizophrenia/Bipolar Disorder Who Are Using Antipsychotic Medications (HEDIS® SSD, NQF #1932):

The percentage of patients 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Numerator: Among patients 18-64 years old with schizophrenia or bipolar disorder, those who were dispensed an antipsychotic medication and had a diabetes screening testing during the measurement year.

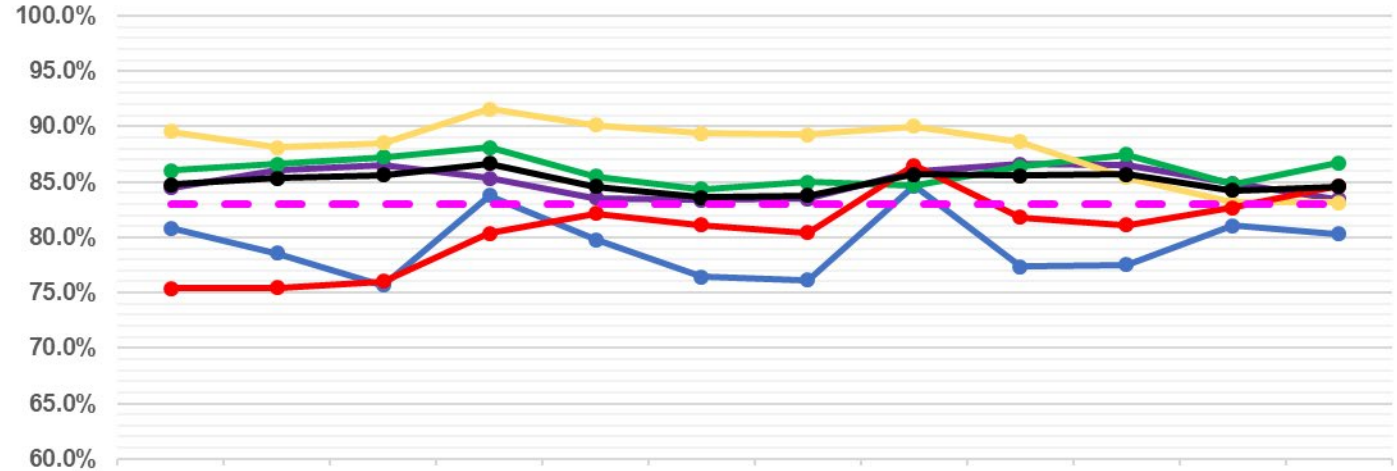
Denominator: Patients ages 18-64 years of age as of the end of the measurement year (ex: Dec 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.

Exclusions:

Excludes members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Excludes patients with diabetes during the measurement year or the year prior to the measurement year.

Excludes patient who had no antipsychotic medication dispensed during the measurement year.



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Allegan	80.8%	78.6%	75.7%	83.8%	79.8%	76.4%	76.1%	84.6%	77.4%	77.5%	81.1%	80.3%
HealthWest	84.5%	86.0%	86.5%	85.3%	83.5%	83.4%	83.5%	85.9%	86.6%	86.5%	84.9%	83.5%
Network 180	86.1%	86.6%	87.2%	88.1%	85.5%	84.3%	85.0%	84.7%	86.4%	87.5%	84.8%	86.7%
Ottawa	89.6%	88.1%	88.5%	91.6%	90.1%	89.4%	89.3%	90.0%	88.6%	85.4%	83.1%	83.1%
West Michigan	75.4%	75.4%	76.0%	80.4%	82.1%	81.1%	80.4%	86.5%	81.8%	81.1%	82.7%	84.6%
LRE	84.8%	85.3%	85.6%	86.7%	84.6%	83.6%	83.8%	85.7%	85.5%	85.7%	84.2%	84.6%
Target	83.0%	83.0%	83.0%	83.0%	83.0%	83.0%	83.0%	83.0%	83.0%	83.0%	83.0%	83.0%

FY 2018 Results:

State Average: 84.3%

Blue Cross: 81.6%
Meridian: 85.6%
McLaren: 82.1%
Molina: 85.9%
Priority: 84.6%
United: 85.3%

2017 State Avg: 83.1%
2016 State Avg: 82.6%
2015 State Avg: 83.8%
2014 State Avg: 83.5%
2013 State Avg: 83.5%

NCQA National Results:

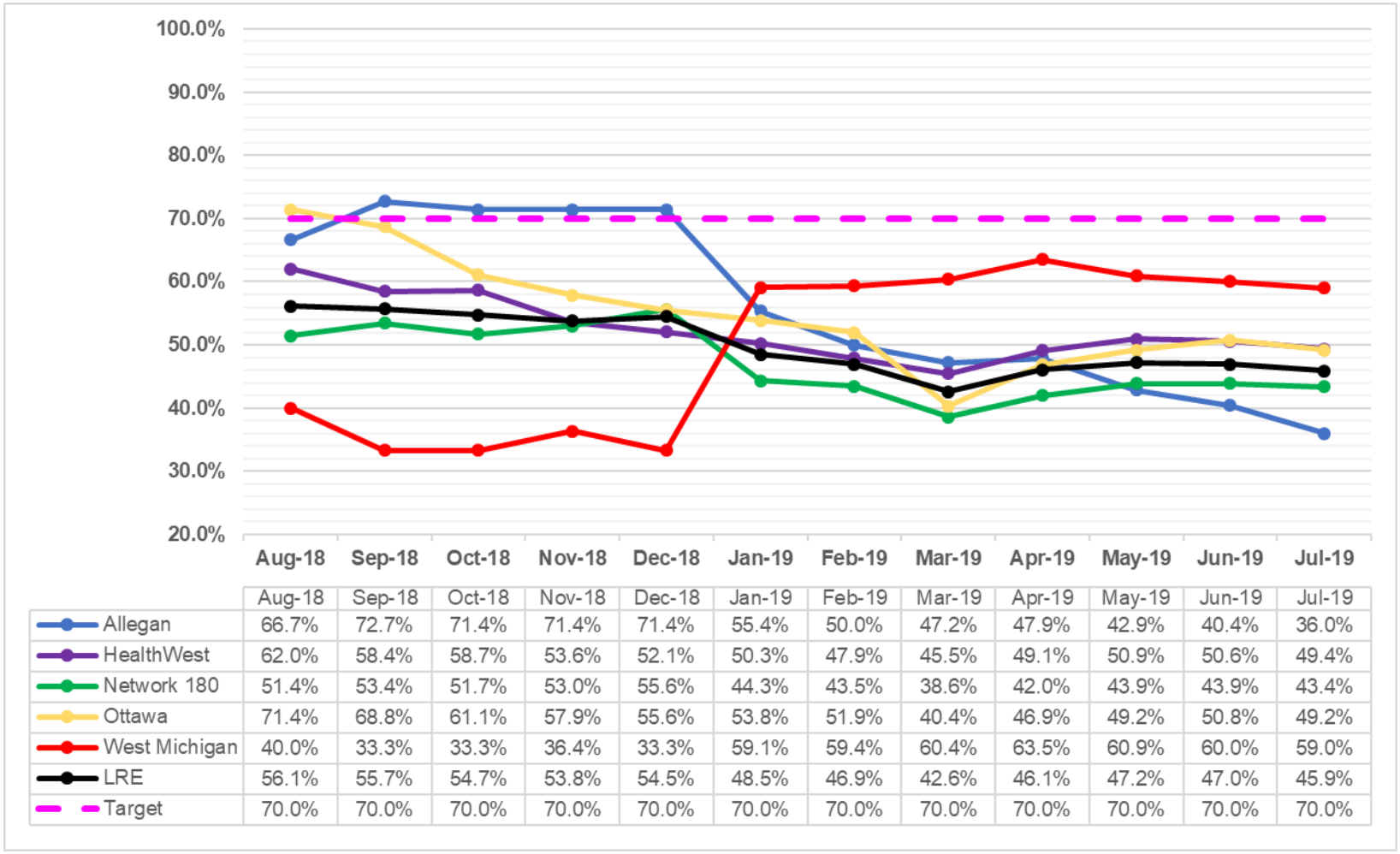
FY17: 80.8%

Diabetes Monitoring for People with Schizophrenia and Diabetes (HEDIS® SMD, NQF #1934):

The percentage of patients 18-64 years of age with schizophrenia and diabetes who had both and LDL-C test and a HbA1c test during the measurement year.

Numerator: One or more HbA1c tests and one or more LDL-C tests performed during the measurement year.

Denominator: Patients age 18-64 years of age as of the end of the measurement year (eg December 31) with a schizophrenia and diabetes diagnosis.



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Allegan	66.7%	72.7%	71.4%	71.4%	71.4%	55.4%	50.0%	47.2%	47.9%	42.9%	40.4%	36.0%
HealthWest	62.0%	58.4%	58.7%	53.6%	52.1%	50.3%	47.9%	45.5%	49.1%	50.9%	50.6%	49.4%
Network 180	51.4%	53.4%	51.7%	53.0%	55.6%	44.3%	43.5%	38.6%	42.0%	43.9%	43.9%	43.4%
Ottawa	71.4%	68.8%	61.1%	57.9%	55.6%	53.8%	51.9%	40.4%	46.9%	49.2%	50.8%	49.2%
West Michigan	40.0%	33.3%	33.3%	36.4%	33.3%	59.1%	59.4%	60.4%	63.5%	60.9%	60.0%	59.0%
LRE	56.1%	55.7%	54.7%	53.8%	54.5%	48.5%	46.9%	42.6%	46.1%	47.2%	47.0%	45.9%
Target	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%

FY 2018 Results:

State Average: 70.0%

Blue Cross: 63.0%
Meridian: 71.7%
McLaren: 77.6%
Molina: 70.7%
Priority: 57.0%
United: 71.1%

2017 State Avg: 69.0%
2016 State Avg: 70.0%
2015 State Avg: 72.7%

NCQA National Results:

FY17: 70.4%
FY16: 69.7%
FY15: 68.2%
FY14: 69.3%

Plan All-Cause Readmissions (HEDIS® PCR, NQF #1768):

For patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

a.) Count of Index Hospital Stays (denominator)*

b.) Count of 30-Day Readmissions (numerator)

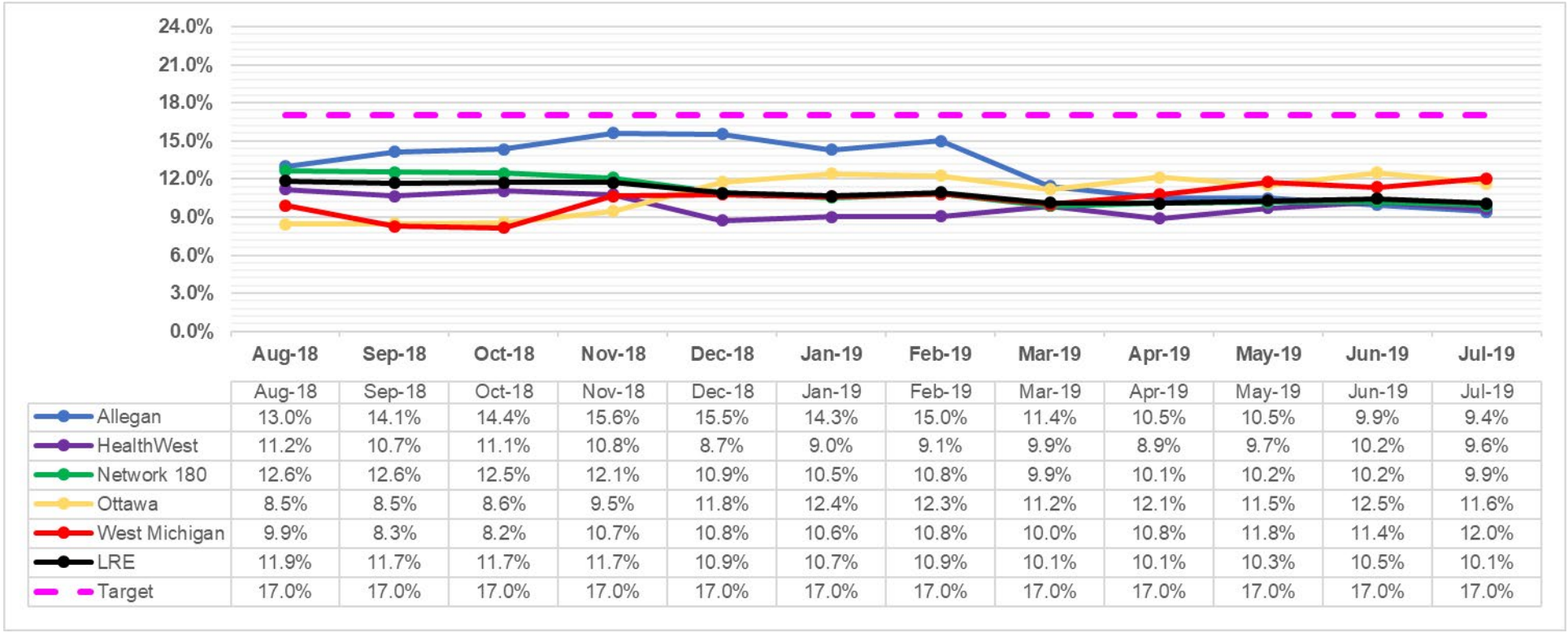
**An acute inpatient stay with a discharge during the first 11 months of the measurement year (ex. On or between Jan 1 and Dec 1)*

Numerator: At least one acute unplanned readmission for any diagnosis within 30 days of the date of discharge from the Index Hospital Stay, that is on or between the second day of the measurement year and the end of the measurement year.

Denominator: Patients age 18 and older with a discharge from an acute inpatient stay (Index Hospital Stay) on or between Jan 1 and Dec 1 of the measurement year.

Exclusions:

Exclusions are included in the definition of the denominator. They include discharges for death, pregnancy, prerinatal condition, or a discharge that is followed by a planned admission within 30 days.



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Allegan	13.0%	14.1%	14.4%	15.6%	15.5%	14.3%	15.0%	11.4%	10.5%	10.5%	9.9%	9.4%
HealthWest	11.2%	10.7%	11.1%	10.8%	8.7%	9.0%	9.1%	9.9%	8.9%	9.7%	10.2%	9.6%
Network 180	12.6%	12.6%	12.5%	12.1%	10.9%	10.5%	10.8%	9.9%	10.1%	10.2%	10.2%	9.9%
Ottawa	8.5%	8.5%	8.6%	9.5%	11.8%	12.4%	12.3%	11.2%	12.1%	11.5%	12.5%	11.6%
West Michigan	9.9%	8.3%	8.2%	10.7%	10.8%	10.6%	10.8%	10.0%	10.8%	11.8%	11.4%	12.0%
LRE	11.9%	11.7%	11.7%	11.7%	10.9%	10.7%	10.9%	10.1%	10.1%	10.3%	10.5%	10.1%
Target	17.0%	17.0%	17.0%	17.0%	17.0%	17.0%	17.0%	17.0%	17.0%	17.0%	17.0%	17.0%

Cardiovascular Health Screening for People with Schizophrenia/Bipolar Disorder who are Prescribed Antipsychotic Medications (HEDIS® SSC, NQF #1927):

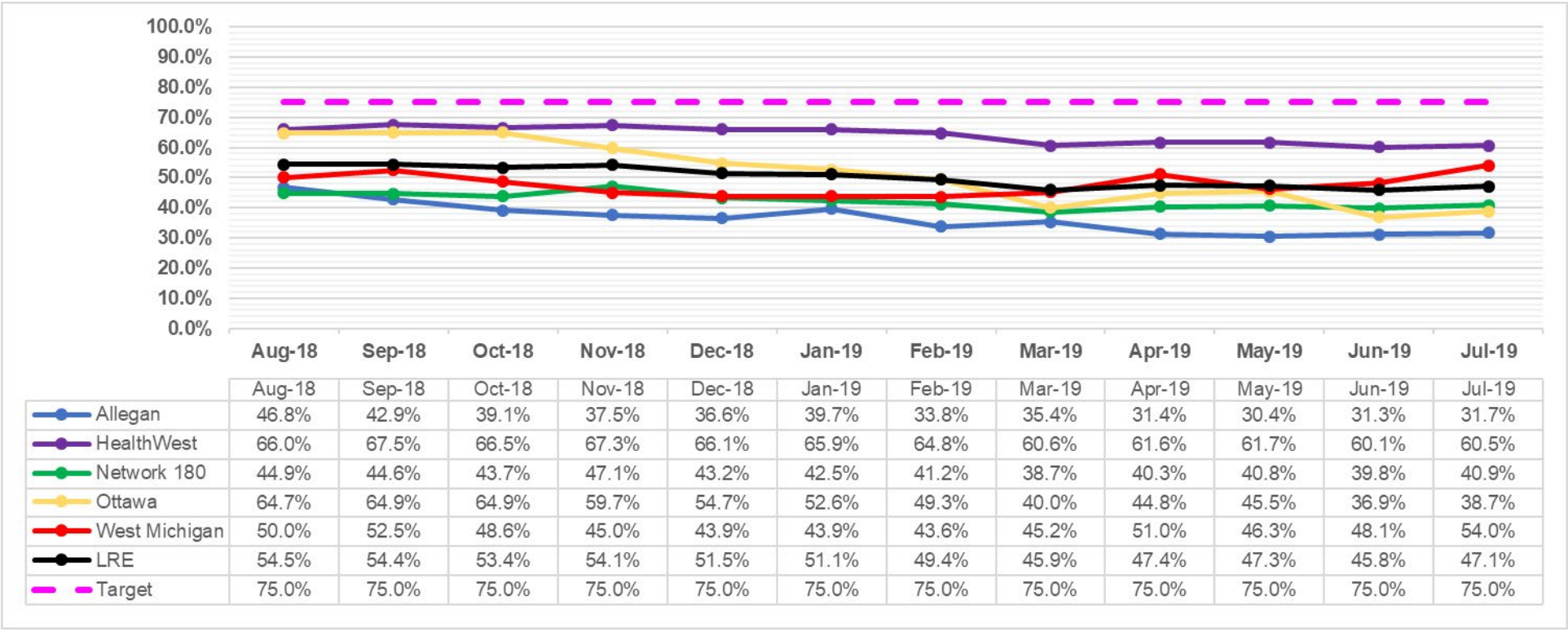
The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year.

Numerator: Individuals who had one or more LDL-C screenings performed during the measurement year.

Denominator: Individuals ages 25 to 64 years of age by the end of the measurement year with a diagnosis of schizophrenia or bipolar disorder who were prescribed any antipsychotic medication during the measurement year.

Exclusions:

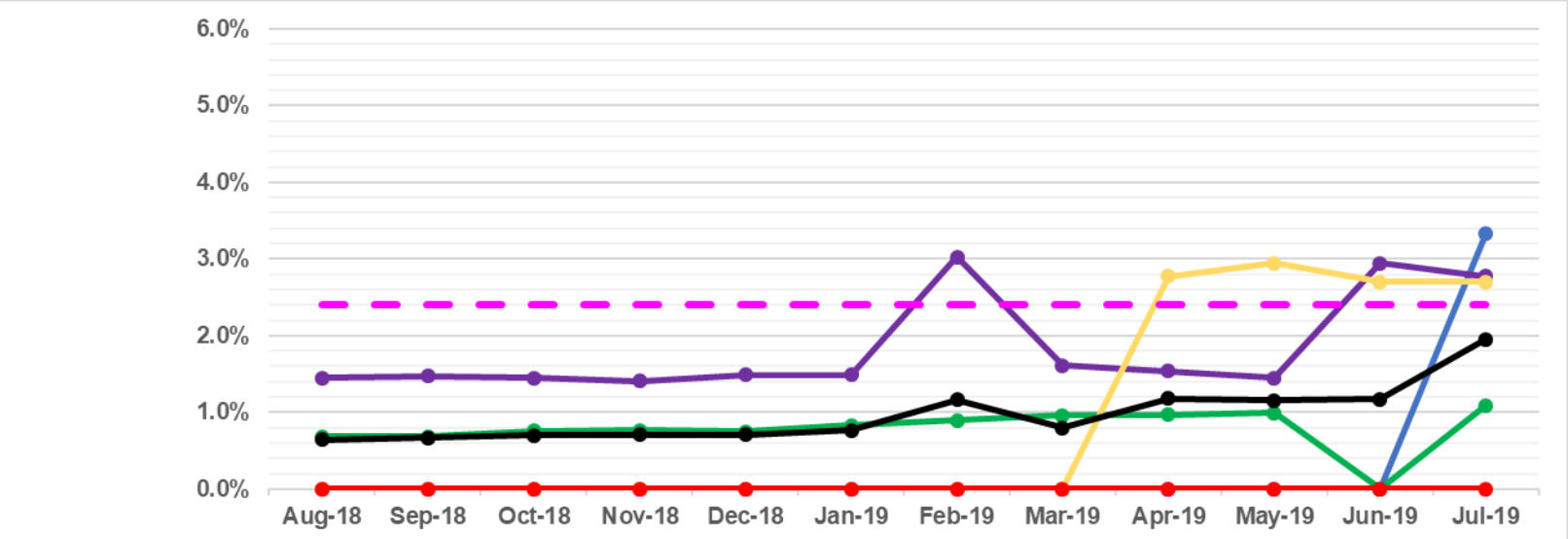
Individuals are excluded from the denominator if they were discharged alive for a coronary artery bypass graft (CABG) or percutaneous coronary intervention (PCI) (these events may occur in the measurement year or year prior to the measurement year), or diagnosed with ischemic vascular disease (IVD) (this diagnosis must appear in both the measurement year and the year prior to the measurement year), chronic heart failure, or had a prior myocardial infarction (identified in the measurement year or as far back as possible).



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Allegan	46.8%	42.9%	39.1%	37.5%	36.6%	39.7%	33.8%	35.4%	31.4%	30.4%	31.3%	31.7%
HealthWest	66.0%	67.5%	66.5%	67.3%	66.1%	65.9%	64.8%	60.6%	61.6%	61.7%	60.1%	60.5%
Network 180	44.9%	44.6%	43.7%	47.1%	43.2%	42.5%	41.2%	38.7%	40.3%	40.8%	39.8%	40.9%
Ottawa	64.7%	64.9%	64.9%	59.7%	54.7%	52.6%	49.3%	40.0%	44.8%	45.5%	36.9%	38.7%
West Michigan	50.0%	52.5%	48.6%	45.0%	43.9%	43.9%	43.6%	45.2%	51.0%	46.3%	48.1%	54.0%
LRE	54.5%	54.4%	53.4%	54.1%	51.5%	51.1%	49.4%	45.9%	47.4%	47.3%	45.8%	47.1%
Target	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%

Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS® APC):

The percentage of children and adolescents 1–17 years of age who were on two or more concurrent antipsychotic medications.
Numerator: Members on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year.
Denominator: Members with 90 days of continuous antipsychotic medication treatment during the measurement year.
Exclusions:
A member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled, therefore is not eligible.



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Allegan	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.3%
HealthWest	1.4%	1.5%	1.4%	1.4%	1.5%	1.5%	3.0%	1.6%	1.5%	1.4%	2.9%	2.8%
Network 180	0.7%	0.7%	0.8%	0.8%	0.7%	0.8%	0.9%	1.0%	1.0%	1.0%	0.0%	1.1%
Ottawa	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	2.9%	2.7%	2.7%
West Michigan	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
LRE	0.6%	0.7%	0.7%	0.7%	0.7%	0.8%	1.2%	0.8%	1.2%	1.2%	1.2%	2.0%
Target	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%

NCQA National Results:

FY17: 3.0%
FY16: 2.4%
FY15: 2.5%

Antidepressant Medication Management (Acute and Continuation Phases) (HEDIS® AMM, NQF #0105):

The percentage of patients 18 years of age and older with a diagnosis of major depression and were treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported:

a.) Effective Acute Phase Treatment – The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks)

b.) Effective Continuation Phase Treatment – The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months)

Numerator: Adults 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment.

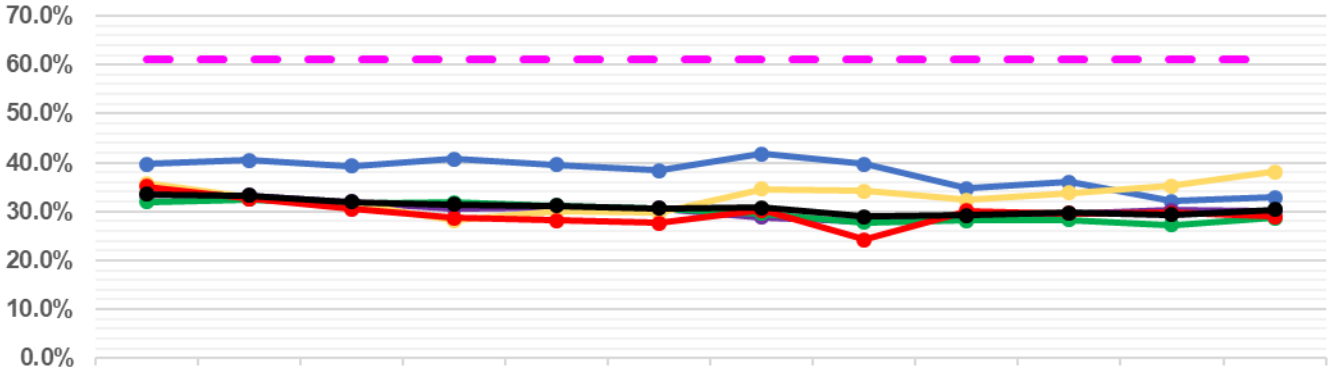
Denominator: Patients 18 years of age and older with a diagnosis of major depression and were **newly** treated with antidepressant medication.

Exclusions:

Excludes patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Excludes patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD.

Acute Phase:



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Allegan	39.7%	40.5%	39.3%	40.8%	39.5%	38.3%	41.8%	39.7%	34.7%	36.0%	32.0%	32.9%
HealthWest	33.4%	33.3%	31.9%	30.6%	30.9%	30.7%	28.9%	28.1%	28.5%	29.4%	30.2%	30.2%
Network 180	32.0%	32.5%	31.5%	31.8%	31.1%	30.5%	29.6%	27.8%	28.2%	28.2%	27.2%	28.7%
Ottawa	35.7%	32.9%	31.6%	28.2%	30.0%	29.8%	34.6%	34.2%	32.3%	33.8%	35.3%	38.1%
West Michigan	35.1%	32.7%	30.5%	28.7%	28.2%	27.6%	30.3%	24.2%	30.1%	29.6%	29.8%	29.0%
LRE	33.5%	33.2%	32.0%	31.4%	31.2%	30.7%	30.8%	28.9%	29.3%	29.8%	29.4%	30.4%
Target	61.0%	61.0%	61.0%	61.0%	61.0%	61.0%	61.0%	61.0%	61.0%	61.0%	61.0%	61.0%

FY 2018 Results:

State Average: 58.3%

Blue Cross: 77.1%
Meridian: 54.5%
McLaren: 58.1%
Molina: 54.5%
Priority: 71.3%
United: 61.7%

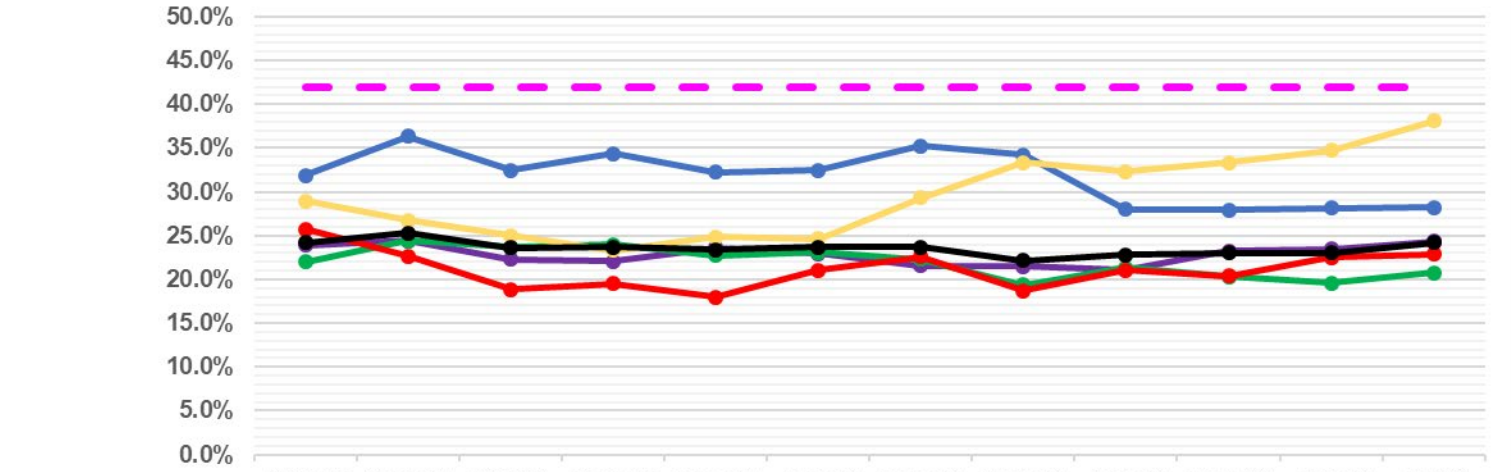
2017 State Avg: 52.7%
2016 State Avg: 60.4%

NCQA National Results:

FY17: 53.9%
FY16: 53.1%
FY15: 54.5%
FY14: 52.3%

Antidepressant Medication Management (Acute and Continuation Phases) (HEDIS® AMM, NQF #0105):

Continuation Phase:



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Allegan	31.9%	36.4%	32.5%	34.4%	32.3%	32.5%	35.2%	34.2%	28.0%	27.9%	28.2%	28.2%
HealthWest	23.9%	24.4%	22.3%	22.1%	23.6%	23.0%	21.5%	21.5%	21.1%	23.3%	23.5%	24.4%
Network 180	22.0%	24.4%	23.7%	23.9%	22.7%	23.1%	22.3%	19.3%	21.3%	20.3%	19.6%	20.8%
Ottawa	29.0%	26.8%	25.0%	23.3%	24.9%	24.7%	29.3%	33.3%	32.3%	33.3%	34.7%	38.1%
West Michigan	25.7%	22.7%	18.8%	19.5%	17.9%	21.1%	22.6%	18.7%	21.1%	20.4%	22.5%	22.9%
LRE	24.2%	25.3%	23.6%	23.7%	23.4%	23.6%	23.7%	22.1%	22.8%	23.0%	23.0%	24.2%
Target	42.0%	42.0%	42.0%	42.0%	42.0%	42.0%	42.0%	42.0%	42.0%	42.0%	42.0%	42.0%

FY 2018 Results:

State Average: 41.3%

Blue Cross: 61.9%
Meridian: 36.1%
McLaren: 40.1%
Molina: 37.5%
Priority: 41.1%
United: 46.9%

2017 State Avg: 36.0%
2016 State Avg: 42.2%

NCQA National Results:

FY17: 38.6%
FY16: 38.0%
FY15: 39.5%
FY14: 37.1%

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (HEDIS® SAA, NQF #1879):

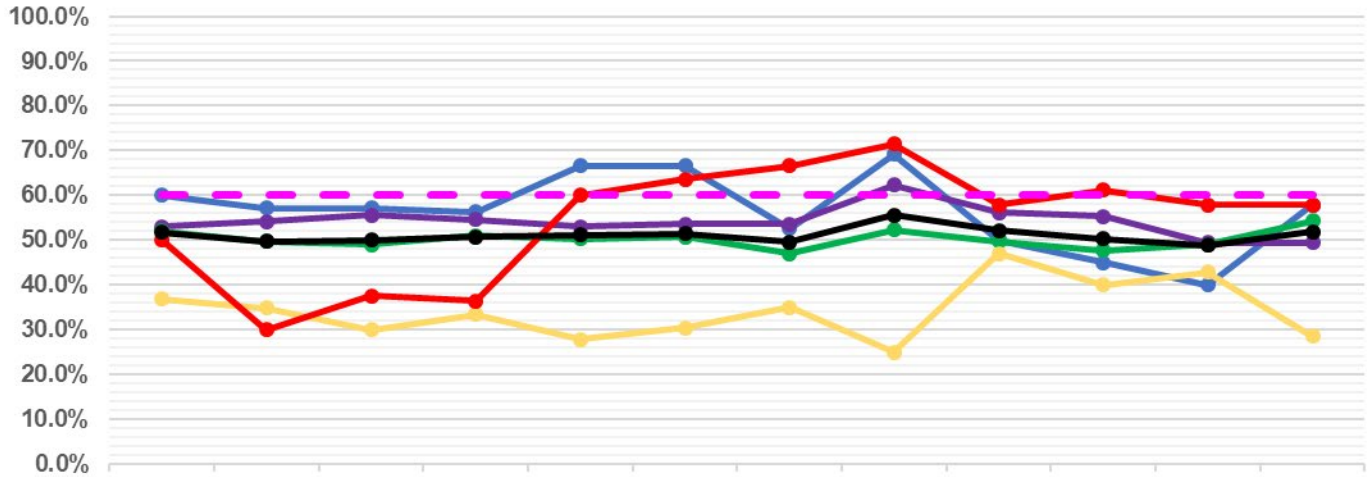
Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least 2 prescription drug claims for antipsychotic medication and had a Proportion of Days Covered (PDC) of at least .8 (80%) for antipsychotic medications during the measurement period (12 consecutive months.)

Numerator: Individuals with schizophrenia or schizoaffective disorder who had at least 2 prescription drug claims for antipsychotic medications and have a PCD of at least .8 for antipsychotic medications.

Denominator: Individual at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least 2 prescription drug claims for antipsychotic medications during the measurement period (12 consecutive months).

Exclusions:

Individuals with any diagnosis of dementia during the measurement period.



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Allegan	60.0%	57.1%	57.1%	56.3%	66.7%	66.7%	52.6%	69.2%	50.0%	45.0%	40.0%	57.9%
HealthWest	53.1%	54.2%	55.6%	54.5%	53.0%	53.5%	53.5%	62.3%	56.2%	55.3%	49.5%	49.5%
Network 180	52.0%	49.7%	49.0%	50.9%	50.3%	50.7%	47.0%	52.2%	49.7%	47.7%	48.9%	54.3%
Ottawa	36.8%	34.8%	30.0%	33.3%	27.8%	30.4%	35.0%	25.0%	47.1%	40.0%	42.9%	28.6%
West Michigan	50.0%	30.0%	37.5%	36.4%	60.0%	63.6%	66.7%	71.4%	57.9%	61.1%	57.9%	57.9%
LRE	51.7%	49.7%	50.0%	50.7%	51.2%	51.5%	49.5%	55.6%	52.1%	50.3%	48.8%	51.9%
Target	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%

FY 2018 Results:

State Average: 63.2%

Blue Cross: 56.0%
Meridian: 67.1%
McLaren: 70.6%
Molina: 64.7%
Priority: 64.3%
United: 55.0%

2017 State Avg: 61.2%
2016 State Avg: 58.8%
2015 State Avg: 59.2%
2014 State Avg: 60.5%
2013 State Avg: 52.7%

NCQA National Results:

FY17: 59.1%
FY16: 59.2%
FY15: 58.0%
FY14: 60.1%

Follow-Up Care for Children Prescribed ADHD Medication (HEDIS® ADD, NQF #0108):

Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least 3 follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed. An Inhiation Phase Rate and Continuation and Maintenance Phase Rate are reported.

Numerator: Among children newly prescribed ADHD medication, those who had timely and continuous follow-up visits.

Denominator: Children 6-12 years of age newly prescribed ADHD medication.

Exclusions:

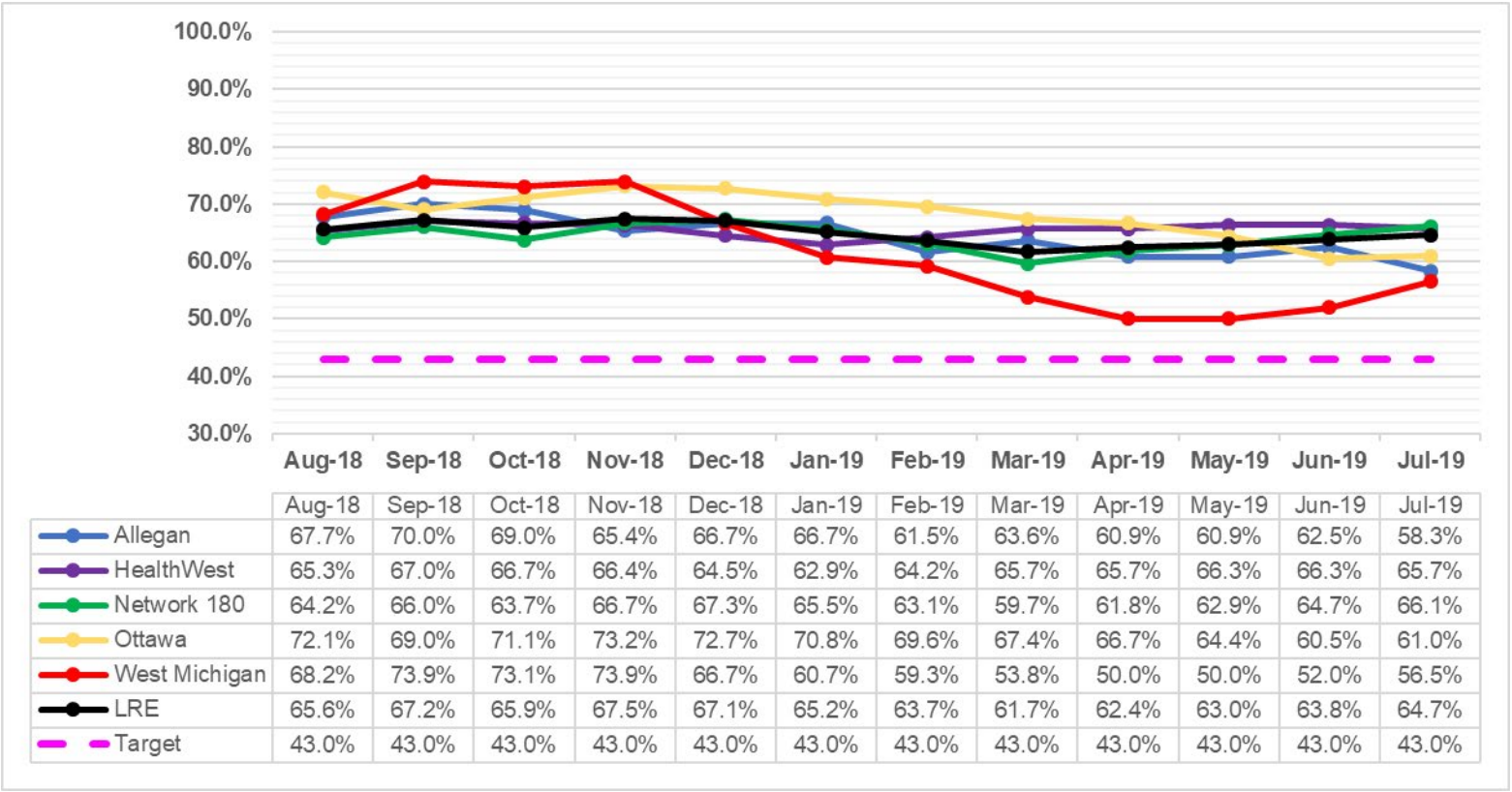
Children who had an acute inpatient encounter for mental health or chemical dependency following the Index Prescription Start Date.

Children with a diagnosis of narcolepsy: Many of the medication used to identify patients for the denominator of this measure are also used to treat narcolepsy.

Children with narcolepsy who are pulled into the denominator are then removed by the narcolepsy exclusion.

Children using hospice service during the measurement year. Children in hospice many not be able to receive the necessary follow-up care.

Initiation Phase:



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Allegan	67.7%	70.0%	69.0%	65.4%	66.7%	66.7%	61.5%	63.6%	60.9%	60.9%	62.5%	58.3%
HealthWest	65.3%	67.0%	66.7%	66.4%	64.5%	62.9%	64.2%	65.7%	65.7%	66.3%	66.3%	65.7%
Network 180	64.2%	66.0%	63.7%	66.7%	67.3%	65.5%	63.1%	59.7%	61.8%	62.9%	64.7%	66.1%
Ottawa	72.1%	69.0%	71.1%	73.2%	72.7%	70.8%	69.6%	67.4%	66.7%	64.4%	60.5%	61.0%
West Michigan	68.2%	73.9%	73.1%	73.9%	66.7%	60.7%	59.3%	53.8%	50.0%	50.0%	52.0%	56.5%
LRE	65.6%	67.2%	65.9%	67.5%	67.1%	65.2%	63.7%	61.7%	62.4%	63.0%	63.8%	64.7%
Target	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%

FY 2018 Results:

State Average: 43.9%

Blue Cross: 48.4%
Meridian: 40.7%
McLaren: 45.4%
Molina: 48.9%
Priority: 36.1%
United: 44.5%

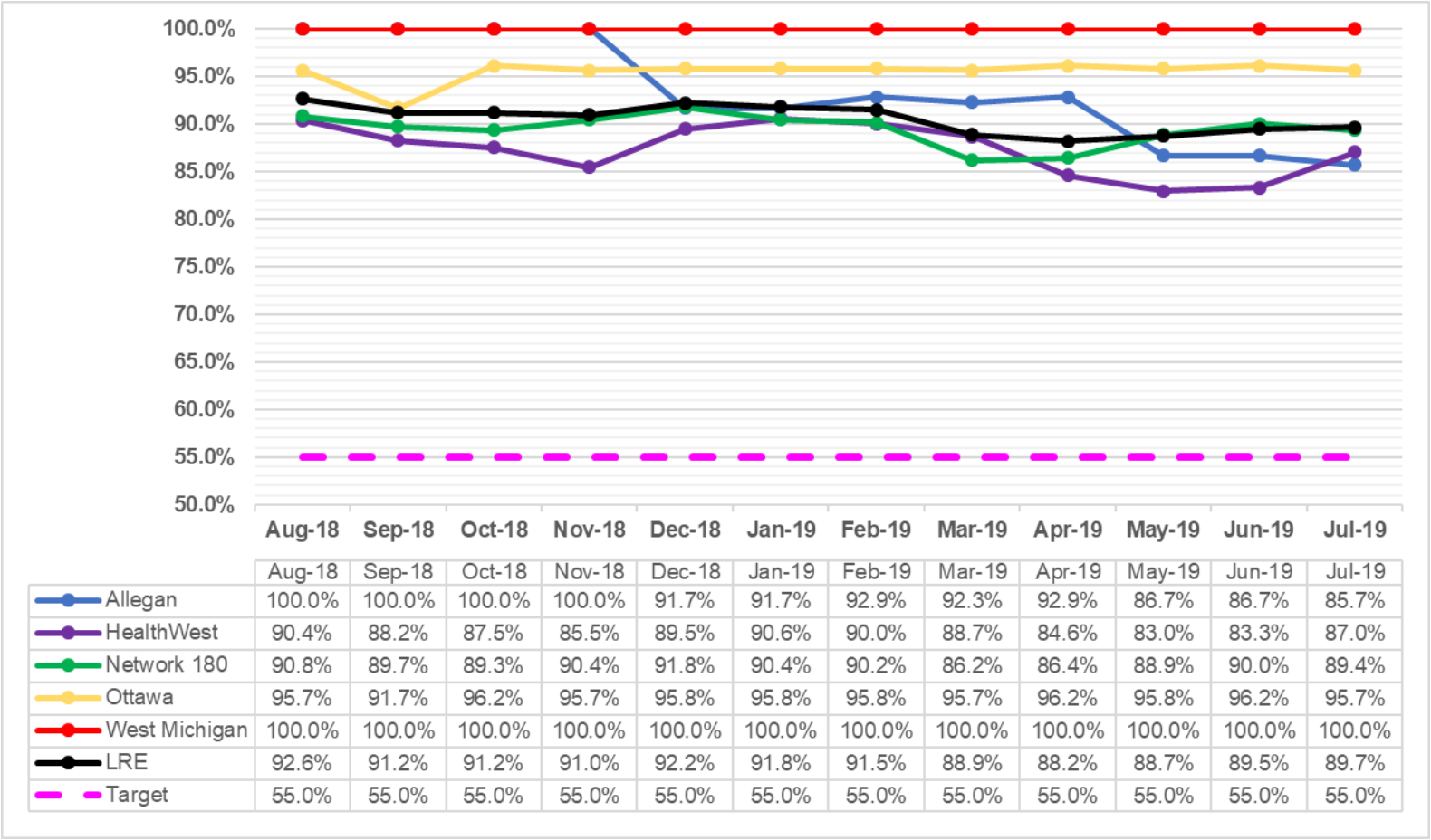
2017 State Avg: 42.5%
2016 State Avg: 42.6%
2015 State Avg: 38.9%
2014 State Avg: 40.2%
2013 State Avg: 39.1%

NCQA National Results:

FY17: 44.6%
FY16: 44.5%
FY15: 42.2%
FY14: 40.1%

Follow-Up Care for Children Prescribed ADHD Medication (HEDIS® ADD, NQF #0108):

Continuation and Maintenance Phase:



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Allegan	100.0%	100.0%	100.0%	100.0%	91.7%	91.7%	92.9%	92.3%	92.9%	86.7%	86.7%	85.7%
HealthWest	90.4%	88.2%	87.5%	85.5%	89.5%	90.6%	90.0%	88.7%	84.6%	83.0%	83.3%	87.0%
Network 180	90.8%	89.7%	89.3%	90.4%	91.8%	90.4%	90.2%	86.2%	86.4%	88.9%	90.0%	89.4%
Ottawa	95.7%	91.7%	96.2%	95.7%	95.8%	95.8%	95.8%	95.7%	96.2%	95.8%	96.2%	95.7%
West Michigan	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
LRE	92.6%	91.2%	91.2%	91.0%	92.2%	91.8%	91.5%	88.9%	88.2%	88.7%	89.5%	89.7%
Target	55.0%	55.0%	55.0%	55.0%	55.0%	55.0%	55.0%	55.0%	55.0%	55.0%	55.0%	55.0%

FY 2018 Results:

State Average: 53.6%

Blue Cross: 62.6%
Meridian: 47.9%
McLaren: 57.5%
Molina: 61.8%
Priority: 40.4%
United: 58.0%

2017 State Avg: 55.0%
2016 State Avg: 54.0%
2015 State Avg: 44.4%
2014 State Avg: 47.0%
2013 State Avg: 46.9%

NCQA National Results:

FY17: 55.0%
FY16: 54.5%
FY15: 50.9%
FY14: 47.5%

HEDIS® Website: http://www.ncqa.org/hedis-quality-measurement/hedis-measures

Agency for Healthcare Research and Quality
National Quality Measures Clearinghouse: https://www.qualitymeasures.ahrq.gov/

NQF Website:
http://www.qualityforum.org/QPS/QPSTool.aspx#qpsPageState=%7B%22TabType%22%3A1,%22TabContentType%22%3A1,%22SearchCriteriaForStandard%22%3A%7B%22TaxonomyIDs%22%3A%5B%5D,%22SelectedTypeAheadFilterOption%22%3Anull,%22Keyword%22%3A%22%22,%22PageSize%22%3A%2225%22,%22OrderType%22%3A3,%22OrderBy%22%3A%22ASC%22,%22PageNo%22%3A1,%22IsExactMatch%22%3Afalse,%22QueryStringType%22%3A%22%22,%22ProjectActivityId%22%3A%220%22,%22FederalProgramYear%22%3A%220%22,%22FederalFiscalYear%22%3A%220%22,%22FilterTypes%22%3A0,%22EndorsementStatus%22%3A%22%22%7D,%22SearchCriteriaForForPortfolio%22%3A%7B%22Tags%22%3A%5B%5D,%22FilterTypes%22%3A0,%22PageStartIndex%22%3A1,%22PageEndIndex%22%3A25,%22PageNumber%22%3Anull,%22PageSize%22%3A%2225%22,%22SortBy%22%3A%22Title%22,%22SortOrder%22%3A%22ASC%22,%22SearchTerm%22%3A%22%22%7D,%22ItemsToCompare%22%3A%5B%5D,%22SelectedStandardIdList%22%3A%5B%5D,%22StandardID%22%3A2605,%22EntityTypeID%22%3A1%7D

State Averages:
http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-39268--,00.html

National Average:
http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2017-table-of-contents

APPENDIX D

LRE PLAN DO STUDY ACT (PDSA) WORKSHEET

Initiation	
Metric (Standard and source)	
Report Steward	
Follow-Up Contact and Info	
CMHSP or SUD Provider	
Date of PDSA Assignment	
Due Date	

CMHSP Response	
Submitted Date	
Staff Name (completing form)	
Criteria Potentially Not Met	
Brief Description of Issue Being Addressed	
Plan: Specify questions and predictions that will drive the study; who, what, when, and where	
Attachments or References	☐ Yes ☐ No Link:
Do: Describe what happened (Data collected, documentation, and observations)	
Study: Analyze results; what was learned?	
Act: What action (best solution) is being put in place to address root cause?	
Changes Needed, If any?	☐ No Action Needed ☐ Change in Process
Description of Planned Changes in Process(es)	
Expected Timeframe for Planned Changes to Achieve Their Full Impact	
Other Comments	

LRE Measure Steward Follow-Up	
Date of Initial Review of PDSA by LRE Staff	
Additional Information Requested from the CMHSP or LRE Staff, if any	
Feedback or suggestions from LRE Staff, if any	
Next Planned Review Date (i.e., UM or Clinical ROAT, LRE/CMHSP contact or site review, etc.)	

PLAN DO STUDY ACT – STEWARD TRACKING FORM

Date of PDSA Initiation: *(insert date from PDSA worksheet)*

Review with: ☐ **LRE Staff** ☐ **UM ROAT** ☐ **QI ROAT**
☐ **Clinical Leadership ROAT** ☐ **Provider Network ROAT**

Measure/Metric: (*insert name of report or measure***)**

Data in review: (*paste image or include link to Period #1 data)* **Target:** *(insert performance target)*

Review Period #1: *(insert date)*

CMHSP	PDSA Update	Expected Timeframe for Plan
Allegan		
HealthWest		
Network 180		
Ottawa		
West Michigan		

Data in review: (*paste image or include link to most recent data)* **Target:** *(insert performance target)*

Review Period #2: *(insert date)*

CMHSP	PDSA Update	Expected Timeframe for Plan
Allegan		
HealthWest		
Network 180		
Ottawa		
West Michigan		

Data in review: (*paste image or include link to most recent data)* **Target:** *(insert performance target)*

Review Period #3: *(insert date)*

CMHSP	PDSA Update	Expected Timeframe for Plan
Allegan		
HealthWest		
Network 180		
Ottawa		
West Michigan		

Data in review: (*paste image or include link to most recent data)* **Target:** *(insert performance target)*