LAKESHORE REGIONAL ENTITY

Meeting Agenda
Board of Directors Work Session
November 15, 2023, 11:00 AM
GVSU Muskegon Innovation Hub
200 Viridian Dr, Muskegon, MI 49440

1. Welcome and Opening Comments – Mr. Stek
2. Public Comment
3. LRE 2024 Quality Assessment and Performance Improvement Program (QAPIP) – Wendi Price, CQO *(Attachment)*
4. Finance Module 2 Presentation – Kenyetta Brewer, Wesley Woods
5. Board Member Comment
6. Public Comment
7. Adjourn

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QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

Annual Plan FY2024

Prepared by LRE Chief Quality Officer: November 8, 2023
Reviewed by LRE Executive Team: November 13, 2023
Reviewed and Approved by LRE Board of Directors:
Submitted to MDHHS:

TABLE OF CONTENTS

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I. INTRODUCTION

Lakeshore Regional Entity ("LRE") is a regional entity under Section 1204(b) of the Michigan Mental Health Code and responsible for the financial and administrative management of Behavioral Health, Mental Health and Substance Use Disorder Services for adults and children who reside in one of our seven (7) county areas: Kent, Muskegon, Ottawa, Oceana, Lake, Mason, and Allegan.

LRE is comprised of five (5) Community Mental Health Service Providers ("CMHSPs"). LRE has the distinction of being the only regional entity where all of its CMHSPs are Michigan Certified Community Behavioral Health Clinic ("CCBHC") Demonstration Sites. With this distinction, LRE is tasked with integrating the CCBHC metrics with its already existing metrics, which may require LRE to archive certain quality metrics so as to not overburden the provider network with overlapping or duplicative monitoring and reporting.

This document outlines requirements for the annual QAPIP ("Quality Assessment and Performance Improvement Program") as set forth in the PIHP/MDHHS Medicaid Managed Specialty Supports and Services Program Contract Attachment and the MDHHS Policy - QAPIP for Specialty Prepaid Inpatient Health Plans.[1] It also describes how these functions are accomplished and the organizational structure and responsibilities relative to these functions.

II. PURPOSE

In addition to meeting contractual requirements, the QAPIP intends to outline functional requirements and provide guidance for operationalizing these requirements, including but not limited to:

1. Evaluating and enhancing, if appropriate, LRE's Quality Improvement ("QI") Processes and Outcomes.
2. Monitoring and evaluating 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 Member CMHSP.
3. Identifying and prioritizing opportunities for performance improvement.
4. Creating a culture that encourages stakeholder input and participation in problem solving.

III. QUALITY IMPROVEMENT AUTHORITY AND ORGANIZATIONAL STRUCTURE

The LRE Board of Directors, which serves as LRE's Governing Board, reviews and approves the

[1] MDHHS, BH and DD Administration, Quality Assessment and Performance Improvement Programs for Specialty Prepaid Inpatient Health Plans (michigan.gov).

QAPIP on an annual basis thereby giving authority for the implementation of this QAPIP and all the components necessary for continuous quality improvement.

A. Governing Body

1. ***Membership:*** The LRE 15-member Governing Board includes three representatives from each of the five (5) Member CMHSP Boards of Directors. Currently, the LRE Governing Board has no vacancies; however, seven of the fifteen Directors are new to the LRE Governing Board.

2. ***Responsibilities:*** The LRE Governing Board is responsible for monitoring, evaluating, and making improvement to care including, but are not limited to:

    a. ***Oversight of the QAPIP:*** This includes documented evidence that the Governing Board has approved the overall QAPIP and QI Plan.

    b. ***QAPIP Progress Reports:*** The LRE Governing Board routinely receives written reports from the Chief Quality Officer ("CQO") describing performance improvement initiatives undertaken, the actions taken, and the results of those actions.

    c. ***Annual QAPIP Review:*** The LRE Governing Board formally reviews a written report on the operation of the QAPIP, at least annually.

    d. ***Adopting and Communicating Process and Outcome Improvement:*** After presentation, the LRE Governing Board adopts the QAPIP via Board Motions and communicates the process and outcome improvement to stakeholders via Board of Directors meeting minutes, which are published on the LRE website for public consumption. LRE also publishes the QAPIP and QAPIP Annual Effectiveness Review on its website and provides electronic copies to the LRE Governing Board and all Member CMHSPs for distribution via CMHSP Newsletters to the provider network. LRE also distributes the QAPIP to LRE Regional Advisory Operations Teams, as applicable.

    e. ***Reporting Accountability:*** Following review and approval by the LRE Governing Body, the LRE CQO submits the QAPIP, QAPIP Annual Effectiveness Review, and MDHHS Governing Body Form to MDHHS on or before February 28th each year.

B. Organizational Structure

In Fiscal Year 2022, LRE reorganized its organization structure and added the role of Chief Quality Officer thereby enhancing LRE's organization structure to support the implementation, management, and oversight of the QAPIP.

In Fiscal Year 2023, LRE created the Home and Community Based Services ("HCBS") Manager role enhancing Regional compliance with the HCBS Final Rule, which went into full effect on March 17, 2023.

LRE's new organization structure allows for the clear and appropriate administration and evaluation of the QAPIP. Exhibit A.

C. Designated Senior Official

The LRE Chief Executive Officer ("CEO") has delegated to the Chief Quality Officer ("CQO") the responsibility for submitting a regional QAPIP to the LRE Board of Directors for final approval. LRE CEO also provides regular QAPIP updates to the Operations Advisory Council, which includes all Member CMHSP CEOs, where applicable. In addition, if issues or barriers to operational effectiveness are identified, these are escalated to the Operations Advisory Council and/or the LRE Board of Directors for input, resolution and/or awareness.

The LRE CQO has day-to-day administrative management and oversight of the QAPIP, including all of its components, and is responsible for keeping the LRE CEO informed of region-wide quality improvement activities and performance improvement projects. The LRE CQO also provides periodic updates to the Operations Advisory Council and LRE Board of Directors, when necessary.

D. Regional Operations Advisory Teams and Quality Improvement Council

LRE's overall structure supports the management and oversight of the QAPIP and all components necessary for its implementation. Exhibit B.

To facilitate the implementation and management of the QAPIP, LRE created the Quality Improvement Regional Operations Advisory Team ("QI ROAT"), which consists of representation from LRE, Member CMHSPs, and other stakeholders. The QI ROAT is responsible for regularly reviewing all activities within the QAPIP. The QI ROAT members also collaborate with one another and between ROATs when any systemic or performance issues are identified to resolve said issues as efficiently and effectively as possible.

For Fiscal Year 2023, LRE created the LRE Quality Improvement Council ("LRE QIC"), which consists of the LRE Executive Team and LRE Staff, with the purpose being to

1. Ensure effective oversight and monitoring of the LRE's managed care functions, both internal and delegated through the application of data reports.
2. Ensure all departments are collaboratively and consistently utilizing data and key performance indicators.
3. Ensure LRE departments are collaborating to foster open communication and

cross-pollination of information toward effective project completion.

When necessary, LRE QIC invites external stakeholders such as Member CMHSPs, ROAT members, providers, etc. to participate. Exhibit C.

IV. ACTIVE PARTICIPATION OF CONSUMERS AND PROVIDERS

LRE recognizes the importance of stakeholder input and its role in improving quality, customer experiences, and outcomes. Consumers and families are valued contributors into the Quality Improvement process. LRE supports an active Consumer Advisory Panel. There is a bi-directional feedback and input loop between LRE ROATs and the Consumer Advisory Panel to ensure consumer engagement on quality initiatives. There are multiple opportunities for consumers, or guardians, to respond to satisfaction surveys. Customer Services staff responds to any complaint, request for feedback, or request for assistance regardless of the means collected. LRE's website includes a link to allow interested parties to provide feedback on any areas of concern at any time (Contact - Lakeshore Regional Entity (lsre.org)).

Provider agency involvement is also important to the LRE Quality Improvement process. There are regular quarterly meetings open to all regional provider organizations, which allows an opportunity to share information and consider recommendations for quality improvement.

LRE monitors CMHSPs engagement in consumer and provider participation as part of its Member CMHSP Site Reviews.

V. QUALITY MANAGEMENT SYSTEM

LRE's Quality Management System combines the traditional aspects of quality assurance and adds the elements of continuous quality improvement by utilizing the Plan-Do-Study-Act process. Exhibit D.

The Quality Management System helps 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 *Quality Management System* includes:

1. Predefined quality standards,
2. Formal assessment activities,
3. Measurement of outcomes and performance, and
4. Strategies to improve performance that is below standards.

The various aspects of the Quality Management System are not mutually exclusive to just one category. The below table identifies 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 • Evidence Based Practices • Network Standards • Accreditation Standards • Network Policies/ Procedures • Delegation Agreement • Clinical Documentation Standards	• Quality Monitoring Reviews • Accreditation Surveys • Credentialing • Risk Assessment/ Management • Utilization Reviews • External Quality Reviews (HSAG) • Stakeholder Input • Sentinel Events • Critical Incident Reports • Documentation Reviews • Medicaid Verification of Service Reviews • Performance Improvement Projects • Critical Event Reporting	• MMBPIS Reports • Audit Reports • External Quality Reviews (HSAG) • MDHHS Site Reviews • Outcome Reports • Benchmarking • Grievance & Appeals	• Corrective Action Plans • Improvement Projects • Improvement Workgroups • Strategic Planning • Practice Guidelines • Organizational Learning • Administrative and Clinical Staff Training • Cross Functional Work Teams • Reducing Process Variation

VI. PERFORMANCE INDICATORS

A. Michigan Mission Based Performance Indicator System

LRE measures its performance using standardized indicators based on the systemic, ongoing collection, and analysis of valid and reliable data. Specifically, LRE utilizes the performance measure established by MDHHS, meaning the Michigan Mission Based Performance Indicator System ("MMBPIS") in the areas of access, efficiency, and outcomes, which LRE reports to MDHHS on a quarterly basis.

LRE takes great strides to ensure its Member CMHSPs MMBPIS data is valid and reliable. For every reporting quarter, LRE reviews each Member CMHSP's MMBPIS data and, while considering each submitted consumer's arc of treatment, selects samples for a quality check. Each Member CMHSP then submits its proofs for each sample selected to demonstrate compliance with the MMBPIS Code Book. Once LRE is confident its Member CMHSPs' MMBPIS data is valid and reliable, LRE directs each Member CMHSP to finalize its MMBPIS data, and LRE then aggregates the MMBPIS data for submission to MDHHS.

LRE utilizes its QAPIP to assure that each Member CMHSP meets the minimum MMBPIS performance thresholds set forth by MDHHS. On a quarterly basis, LRE aggregates, analyzes, and reviews the MMBPIS data with the MMBPIS Workgroup and QI ROAT while paying special attention to outliers and negative trends. This collaboration also seeks to identify possible causes for any outliers or negative trends. If a Member CMHSP is out of compliance in any given quarter, LRE issues a Corrective Action Plan ("CAP") and monitors the CAP through to remediation and validation ensuring quality improvement in access, efficiency, and outcomes.

Starting October 1, 2023, MDHHS implemented new compliance threshold for Indicators 2a, 2e, and 3. For FY24, LRE is focusing its efforts on supporting the CMHSPs in achieving compliance rates that align with MDHHS' new compliance thresholds.

B. Key Performance Indicators

LRE utilizes PowerBI to review its HEDIS® Key Performance Indicator ("KPI") Dashboard, with data sourced from the by Zenith Technology Services – ICDP – Integrated Care Delivery Platform, on a quarterly basis. LRE distributes and discusses the KPI Dashboard via the QI ROAT. Since February 2021, LRE has added two additional "slicers" to its KPI Dashboard PowerBI, the 1) Member CMHSP and 2) race/ethnicity categories in an effort to better understand the data on a Member CMHSP and race/ethnicity basis, which is necessary for the 2022 Race/Ethnicity Disparity PIP as directed by MDHHS.

For FY24, LRE worked with its Medical Director and CMHSPs selecting several KPIs to archive in order to incorporate new KPIs required by MDHHS for all CCBHC Demonstration Sites. LRE determined that archiving certain KPIs was necessary so as to not overburden CMHSPs with monitoring and reporting overlapping or duplicative metrics.

VII. PERFORMANCE IMPROVEMENT PROJECTS

LRE conducts performance improvement projects ("PIPs") 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 individual satisfaction.

LRE is required to conduct at least two PIPs each fiscal year. One of the two PIPs is mandated by MDHHS and is reviewed and evaluated by HSAG for compliance with the PIP requirements. The second PIP may be of the choosing of LRE and must be submitted to MDHHS along with the QAPIP.

LRE encourages all stakeholders to regularly submit improvement recommendations through local QI processes. During QI ROAT, LRE asks each Member CMHSP for ideas for performance improvement projects. LRE also relies upon LRE staff, ROATs, Workgroups, providers, consumers, etc. to generate ideas for potential PIPs.

LRE utilizes the Plan-Do-Study-Act process (Exhibit D) when conducting all PIPs to facilitate a statistically significant improvement that is sustainable over time.

For PIPs required by the state, LRE submits recommendations through the Operations Advisory Council. All identified PIPs will be reported through the QI ROAT, to the Operations Advisory Council and Consumer Advisory Panel.

For Fiscal Year 2024, LRE continues with conducting its two PIPs centered on improving the HEDIS® Follow-up After Hospitalization. LRE's research suggests that an increase in the FUH metric can improve outcomes, decrease suicides, decrease recidivism, and increase satisfaction.

A. FUH Metric: Improve FUH Data Distribution, Submission, and Tracking

In FY23, LRE determined it was necessary to standardize the process for distributing FUH data to the Medicaid Health Plans, submitting FUH data to MDHHS, and following up with consumers within the FUH population. LRE's PIPs intend to improve quality of care and outcomes for all consumers within the FUH population through ongoing collaboration with Medicaid Health Plans and operationalizing the standardized processes for the distribution, submission, and tracking of FUH data.

B. FUH Metric: Decrease in Racial Disparity between African Americans/Blacks and Whites

In accordance with MDHHS mandate, the LRE must choose a PIP centered on decreasing the race/ethnicity disparity in Region 3. LRE's MDHHS mandated PIP is whether targeted interventions result in significant improvement (over time) in the number of members who identify as African American/Black that receive follow-up within 30 days after an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm when compared to those similarly situated members who identify as White, meaning a decrease in the racial disparity between the two measurement groups, during the measurement period, without a decline in performance for the White members.

One risk is that LRE's interventions may raise the FUH metric for all races and may not improve the race disparity between African Americans/Blacks and White, but this is a risk that LRE is willing to accept given the positive impact that follow-up care after psychiatric hospitalization appears to provide to its members.

VIII. EVENT REPORTING AND NOTIFICATIONS

LRE requires each Member CMHSP with direct services as well as contracted, external providers

to record, assess, and report critical incidents, risk events, sentinel events, unexpected deaths, and immediately reportable events (a/k/a immediate event notification) according to LRE policies and procedures. LRE reports critical incidents, risk events, sentinel events, unexpected deaths, and immediately reportable events in accordance with MDHHS contractual requirements.

Beginning October 1, 2022, MDHHS required all critical incidents, sentinel events, and unexpected deaths be reported via the Customer Relationship Management ("CRM") platform. LRE utilizes the required field in the CRM platform to identify the provider and exact place where a critical incident occurs. LRE also incorporates programming to identify if a provider involved in a reportable event is a specialized residential provider. LRE analyzes this data with an eye towards protecting one of its most vulnerable populations, which is specialized residential consumers, that partake in Long Term Supports and Services ("LTSS"). LRE is an increase in reportable events as CMHSPs

LRE collects, aggregates, and analyzes all critical incidents and risk events on a quarterly basis. LRE CIRE Workgroup also reviews all sentinel events and unexpected deaths, and immediately reportable events on a monthly basis. LRE's analyses of the critical incidents, risk events, sentinel events, unexpected deaths, and immediately reportable events endeavor to determine what, if any, action is needed to remediate any problem or situation, prevent the occurrence of additional events and incidents, and ensure compliance with reporting requirements.

LRE reports these findings, outliers, and trends to QI ROAT, and, when necessary, to the Operations Advisory Council, on a quarterly basis via the LRE's Critical Incidents Monitoring Report, Risk Event Monitoring Report, Sentinel Event|Unexpected Death Timeliness Report, and Mortality Report. LRE also reports Event Reporting and Notifications to its Governing Board annually.

A. Critical Incidents

LRE captures data on critical incidents for mental health and SUD consumers, which are defined as:

1. Suicide
2. Non-Suicide Death
3. Emergency Medical Treatment due to Injury or Medication Error ("EMT")
4. Hospitalization due to Injury or Medication Error ("Hospital"),
5. Arrest of Consumer,
6. Death of Unknown Cause,
7. MAT Medication Error,
8. SUD Medication Error, and
9. Seriously Challenging Behavior.

LRE requires each Member CMHSP to submit its Critical Incidents by the 15th of each month. LRE reports to MDHHS the following Critical Incidents to MDHHS within sixty (60) days after the end of the month, except for Suicides which are reportable within thirty (30) days, in which the incident occurred for individuals who, at the time of the incident, were actively receiving services:

Service	Suicide (01)	Death (02)	EMT (03)	Hospital (04)	Arrest (05)	Death of Unknown Cause (06)	MAT Med Error (07)	SUD Med Error (08)	Serious Challenging Behaviors (09)
ACT	●	●				●			
CLS	●	●				●			
Case Management	●	●				●			
Homebased	●	●				●			
Support Coordination	●	●				●			
Wraparound	●	●				●			
Any other Service	●	●				●			
SUD Services	●	●				●	●		
Hab Waiver	●	●	●	●	●	●			
SED Waiver	●	●	●	●	●	●			
Child Waiver	●	●	●	●	●	●			
Living Situation									
Specialized Residential	●	●	●	●	●	●	●		
Child Caring Institution	●	●	●	●	●	●	●		
SUD Residential	●	●	●	●	●	●	●	●	●

B. Risk Events

LRE also captures data on events that put individuals at risk of harm, which are defined as:

1. Harm to Self,
2. Harm to Others,
3. Police Calls by Staff under Certain Circumstances,
4. Emergency Use of Physical Management, and
5. Two or More Unscheduled Admissions to a Hospital within a 12-month Period.

LRE requires each Member CMHSP to submit its Risk Event by the 15th of each month. LRE requires Member CMHSPs to report the following Risk Events to LRE 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	Harm to Self	Harm to Others	Police Calls	Physical Management	Hospitalization
Supports Coordination	●	●	●	●	●

Case Management	•	•	•	•	•
ACT	•	•	•	•	•
Home-Based	•	•	•	•	•

C. Sentinel Events and Unexpected Deaths

LRE reports sentinel events and unexpected deaths consistent with MDHHS contract requirements. Member CMHSPs, per contract, must notify LRE within 24 hours of learning of an Unexpected Death or possible Sentinel Event. Member CMHSPs have three (3) business days after the occurrence of a Critical Incident to determine if it is a Sentinel Event. If the Critical Incident is classified as a Sentinel Event, the Member CMHSP then has two (2) subsequent business days to commence a Root Cause Analysis ("RCA") of the event. LRE established that RCAs must be completed within 45 days.

The LRE CIRE Workgroup, which may include LRE's Medical Director, reviews all unexpected deaths of persons receiving specialty supports and services at the time of their death including medical examiner's reports, death certificates, and RCAs inclusive of findings and remediation recommendations, if applicable. LRE validates remediation efforts by collecting evidence from the CMHSPs and providers. The LRE CIRE Workgroup also aggregates all mortality data into the LRE Mortality Report to identify possible trends related to all deaths and address any issues related to quality of care.

D. Immediate Event Notification

LRE reports all Immediately Reportable Events to MDHHS according to contract and as follows:

1. Any death that occurs because of suspected staff member action or inaction or any death that is the subject of a recipient rights, licensing, or police investigation is reported to MDHHS within 48 hours of either the death, the PIHPs receipt of notification of the death, or the PIHPs receipt of notification that a rights, licensing, and/or police investigation has commenced to QMPMeasures@michigan.gov and include the following information:

    a. Name of Beneficiary,
    b. Beneficiary ID Number (Medicaid, MiChild),
    c. Consumer I (CONID) if there is no Beneficiary ID Number,
    d. Date, Time, and Place of Death (if a licensed foster care facility, include the license number),
    e. Preliminary Cause of Death, and
    f. Contact Person's Name and Email Address.

2. Relocation of a consumer's placement due to licensing suspension or revocation within five (5) business days of relocation.
3. An occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours within five (5) business days of relocation.
4. The conviction of a PIHP or provider panel staff members for any offense related to the performance of their job duties or responsibilities which results in exclusion from participation in federal reimbursement within five (5) business days of knowledge.
5. Any changes to the composition of the provider network organizations that negatively affect access to care within seven (7) days of any change.

IX. BEHAVIOR TREATMENT REVIEW

Member CMHSPs collect and submit Behavior Treatment data to LRE quarterly. The regional Behavior Treatment Plan Review Committee ("BTPRC"), with representation from each Member CMHSP and LRE, convenes quarterly to review and analyze the CMHSP BTPRC data. The committee ensures submitted data is correct and complete and reviews the data for any trends or areas of concern. Where intrusive or restrictive techniques have been approved for use and/or where physical management or 911 calls to law enforcement in an emergency have occurred, the BTPRC conducts quarterly analysis of the data submitted by Member CMHSPs to identify trends and subsequent actions that may need to be taken to reduce the potential for future events. The LRE Physical Management Episode Tracking Report is reviewed quarterly by both the LRE Behavior Treatment Plan Review Committee and the QI ROAT. This report allows for the review of the physical management data including the number of interventions and length of time the interventions were used per individual. LRE adheres to the provisions outlined in the MDHHS Technical Requirements for Behavior Treatment Plans Policy and the current MDHHS-PIHP Contract.[2]

X. CUSTOMER SATISFACTION ASSESSMENT

LRE requires its Member CMHSPs to deploy, at least annually, the Regional Customer Satisfaction Survey ("Survey") in a way that is representative of the individuals served, including individuals receiving long-term supports and services ("LTSS"), such as consumers receiving case management and supports coordination as well as other services and supports being rendered.

Currently, LRE Survey includes a section specifically designed for individuals within the LTSS

[2] MDHHS, Behavioral Health and Developmental Disabilities Administration, Technical Requirement for Behavior Treatment Plans (michigan.gov).

population in addition to questions on telehealth experiences given the new modality of service delivery due to the Public Health Emergency.

The current LRE Survey also provides space for individuals filling out the survey to provide comments. LRE requires Member CMHSP Customer Services staff to follow-up on any negative comments or less than desirable Survey score.

Member CMHSPs submit the Survey data to LRE and LRE aggregates and analyzes the data via a PowerBI Dashboard to identify strengths, areas for improvement, and make recommendations for action and follow up, as appropriate. LRE reviews and reports the Survey findings to the QI ROAT and Customer Services ROAT quarterly as well as the LRE Governing Board annually to improve services, processes, communication, and overall customer satisfaction.

As LRE's CMHSPs have become CCBHC Demonstration Sites, LRE is revising its current Survey to incorporate the Mental Health Statistics Improvement Program ("MHSIP") Adult Consumer Experience of Care Survey for Adult consumers and the Youth/Family Services Survey for Families ("YSS-F") Experience of Care Survey for Youth consumers and their families.

LRE monitors CMHSPs Survey deployment as part of its Member CMHSP Site Reviews.

XI. CLINICAL PRACTICE GUIDELINES

LRE supports the use of Clinical Practice Guidelines ("CPGs") in service provision. CPGs are available to assist practitioners and members in making decisions about appropriate health care for specific clinical circumstances. LRE endorses CPGs that have been adopted by the American Psychiatric Association. LRE adopted the American Psychiatric Association CPGs in concert with Member CMHSPs through the Clinical ROAT and Utilization Management ROAT. LRE disseminates the CPGs via its website and newsletter.

LRE along with its Member CMHSPs developed and approved an Inter-Rater Reliability Process ensuring that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. LRE reviews all Audit Summary results in the Clinical ROAT and Utilization Management ROAT.

LRE monitors the use of established guidelines as part of its Member CMHSP Site Reviews.

XII. CREDENTIALING

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: Organizational Credentialing and Recredentialing outlines the guidelines and responsibilities for credentialing and re-credentialing provider staff and agencies.

LRE conducts Organizational Credentialing to assure each organization maintains necessary licensure and meets basic expectation for contracting. LRE requires each organization to complete a Credentialing Application and provide proofs, such as state licensures, insurance certificates, W-9 or IRS letter, NPI enumerator documentation, accreditation certificates, fidelity bonding certificate, disclosure of ownership and controlling interest statement, etc. LRE also conducts OIG, SAM, MDHHS checks to ensure organizational providers are not excluded from doing business with LRE or its Member CMHSPs.

LRE also conducts credentialing and recredentialing for any individual or professional staff with which it directly contracts.

LRE delegates the credentialing of individual and professional staff to its Member CMHSPs. LRE oversees the Member CMHSPs' credentialing/recredentialing efforts in two ways. Quarterly, MDHHS requires LRE to submit credentialing reports for both Organizational and Individual Providers. In turn, LRE requires each Member CMHSP to submit credentialing/recredentialing data on a quarterly basis. LRE then aggregates and analyzes the credentialing/recredentialing data. LRE may, at times, collaborate with CMHSPs to ensure data integrity. Once assured the credentialing/recredentialing data is integrous, LRE submits LRE's credentialing/recredentialing data to MDHHS. Secondly, LRE also provides oversight of appropriate credentialing/ qualifications by auditing a sample of credentialed staff during its Member CMHSP Site Reviews. If LRE finds gaps in a Member CMHSP's credentialing/recredentialing efforts, LRE assigns the Member CMHSP a plan of correction. These findings are reported to LRE Executive Team, CMHSP Leadership, Provider Network ROAT, Clinical ROAT, Utilization Management ROAT, and the Quality Improvement ROAT.

LRE is attempting to incorporate quality measures into its recredentialing process by considering the extent an organization or a practitioner has been grieved, has received a less than desired Survey score, has fallen below performance indicator thresholds, which could include CMHSP Site Review results for clinical and credentialing audits, or has experienced a rise in critical incident or sentinel events. Prior to being able to implement such quality measures into the recredentialing process, LRE requires reprogramming of its EMR. Currently, LRE is developing the technical requirements for such reprogramming.

XIII. STAFF TRAINING AND DEVELOPMENT

LRE and its Member CMHSPs 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 Member CMHSPs.

LRE requires its Member CMHSPs to identify staff training needs and provide in-service training,

continuing education, and staff development activities. A regional Training Workgroup is responsible for the development of staff training and education standards to support reciprocity and efficiencies across the region.

During CMHSP and Substance Use Disorder ("SUD") Site Reviews, LRE audits each Member CMHSPs' adherence to LRE policies and procedures related to staff possessing the appropriate qualifications as outlined in their job descriptions and required by contract, policy, or regulations, including the qualifications such as:

1. Educational Background,
2. Relevant Work Experience,
3. Certification, Registration, and Licensure as Required by Law,
4. Criminal Background, Convictions, and SOR Checks,
5. Sanctions Checks,
6. Population Specific Qualifications,
7. General and Specific Trainings,
8. Training of New Personnel Regarding their Responsibilities, Program Policy and Staff Development Activities.

LRE monitors corrective action plans to ensure that the plans are implemented, and provider and agency staff are meeting training requirements.

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

XIV. MEDICAID SERVICES VERIFICATION

MDHHS requires all PIHPs to submit an annual report, due December 31, covering the claims/encounters verification process for the prior fiscal year and must describe the PIHP's Medicaid Services Verification methodology and summarize the audit results, which must contain the following required elements:

1. Population of providers,
2. Number of providers tested,
3. Number of providers put on corrective action plans,
4. Number of providers on corrective action for repeat/continuing issues,
5. Number of providers taken off corrective action plans,
6. Population of claims/encounters tested (units & dollar value),
7. Claims/Encounters tested (units & value), and
8. Invalid claims/encounters identified (units & dollar value).

LRE has a written policy and procedure for monitoring and evaluating the claims/encounters submitted by its Member CMHSPs ensuring compliance with federal and state regulations as well as the MDHHS Medicaid Verification Process technical requirements.[3]

LRE's policy and procedure consider conflicts of interest, validation of claims/encounters data, sampling methodology, audit criteria, review and reporting standards, recoupment procedures, corrective action plan procedures, and documentation standards, as required by the MDHHS Medicaid Verification Process policy.

LRE conducts its Medicaid Services Verification audits quarterly across all service types.

LRE's dedicated staff conducts all Medicaid Services Verification audits to verify that adjudicated claims for services rendered are sufficiently supported by clinical documentation.

XV. UTILIZATION MANAGEMENT

At the LRE, Utilization Management ("UM") is guided by LRE policy and procedure and an annual UM Plan. UM 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. LRE leverages PowerBI Dashboards to the review and analysis under and over utilization. LRE also conducts Utilization Reviews that include the review and monitoring of individual consumer records, specific provider practices, and system trends. UM data is aggregated and reviewed by the UM ROAT to identify trends and make service improvement recommendations. Findings are reported to the LRE CEO and Operations Advisory Council.

XVI. OVERSIGHT OF PROVIDER NETWORK

A. CMHSP Site Reviews

LRE maintains oversight of its Provider Network by conducting annual CMHSP Site Reviews that ensure compliance with federal, state, and regional regulations and requirements. The LRE CMSHP Site Review process is a systematic and comprehensive approach to monitor, benchmark, and improve the quality of care and delivery of mental health and substance use disorder services.

During the CMHSP Site Review Process, LRE evaluates the Member CMHSPs' and external providers' compliance is the areas of

1. Federal Regulations, State Requirements, and Regional Policies.
2. Contractual Obligations.

[3] MDHHS, Behavioral Health and Developmental Disabilities Administration, Medicaid Services Verification (michigan.gov).

3. Delegated Managed Care Functions.
4. Clinical Documentation Standards.

As a result of the CMHSP Site Reviews, LRE is able to

1. Establish prioritized clinical and non-clinical priority areas for improvement.
2. Analyze the delivery of services and quality of care using a variety of audit tools.
3. Develop performance goals and compare findings with past performance.
4. Provide performance feedback through exit conferences and written reports.
5. Conduct targeted monitoring of consumers defined to be vulnerable by MDHHS.
6. Require improvements from providers via CAPs for areas that do not meet predetermined thresholds or are not compliant with defined standards.
7. Ensure CAP remediation by providers.
8. Identify systemic, regional issues and develop improvement plans to improve quality of care and delivery of services.

If LRE requires a CAP, the Member CMHSP or provider has 30 days to respond. LRE either approves the CAP as written or denies it and requests more information and/or recommends additional changes. LRE has a process to review the CAP during the following year's CMHSP Site Review.

B. MDHHS Site Reviews

LRE participates in site reviews conducted by MDHHS to monitor CMHSP member performance. Upon completion of the MDHHS Site Review a CAP report, MDHHS provides LRE with its findings. When LRE receives the CAP report, it distributes to all applicable stakeholders for CAP development.

To best address local concerns, each Member CMHSP drafts CAPs for all citations for which the Member CMHSP has been identified as being out of compliance. LRE ensures that CAPs and remedial actions are implemented. LRE may rely upon Workgroups and consult with ROATS to address systemic issues that are identified by the MDHHS reviewers.

C. External Quality Reviews

LRE participates in External Quality Reviews ("EQRs"), which are conducted by Health Services Advisory Group ("HSAG") and required under The Balanced Budget Act of 1997 ("BBA"). Generally, HSAG evaluates the quality and timeliness of, and access to, health care services provided to consumers. HSAG's stated objective for the EQR is to provide meaningful information that MDHHS and the LRE can use for

1. Evaluating the quality, timeliness, and access to mental health and substance abuse care furnished by the LRE.

2. Identifying, implementing, and monitoring system interventions to improve quality.
3. Evaluating one of the two performance improvement projects of the LRE.
4. Planning and initiating activities to sustain and enhance current performance processes.

D. Facility Reviews

LRE conducts annual Facilities Reviews for all contracted, external providers within LRE's catchment area to ensure compliance with the following requirements:

1. General Health and Safety Standards,
2. Emergency Procedures,
3. Medication Reviews,
4. Resident Funds Reviews,
5. Policies and Procedures, and
6. HCBS Final Rule.

E. Miscellany Site Reviews

LRE conducts annual Site Reviews for the following provider types:

1. Crisis Residential Providers,
2. In-Patient Provider
3. SUD Treatment Providers

During the Site Review Process, LRE evaluates these providers' compliance is the areas of

1. Federal Regulations, State Requirements, and Regional Policies.
2. Contractual Obligations.
3. Clinical Documentation Standards.

LRE works hand-in-hand with providers to develop CAPs for non-compliant findings and assists providers in remediating these findings as efficiently as possible. LRE utilizes the aggregate data from these Site Reviews to determine what trainings and tools are needed at the provider level to improve the quality of care of and delivery of services to consumers.

XVII. LONG TERM SERVICES AND SUPPORTS

During the CMHSP Site Reviews, LRE ensures its sampling methodology used to select consumers for clinical chart audits is a representative cross-section of the overall distribution of service types provided in Region 3 by distinct consumer. For example, for FY22, LRE served almost 70% of its distinct consumer count with services defined by 1115 Pathway to Integration

Waiver as Long-Term Services and Supports ("LTSS").[4] Hence, when LRE selects its random sample for its clinical chart audits, most of the samples selected tether to individuals receiving LTSS. LRE's sampling methodology is the first step ensuring that LRE is able to assess the quality and appropriateness of care furnished to individuals receiving LTSS.

Secondly, LRE's Clinical Chart Audit Tool, which is used during CMSHP Site Reviews, is the mechanism used to assess the quality and appropriateness of care furnished to individuals receiving LTSS. Specifically, LRE's Clinical Chart Audit Tool contains sections on Person-Centered Planning ("PCP"), which allows LRE to assess member care between care settings, and Service Delivery, which allows LRE to compare the services received by the individual compared to the services identified in the individuals treatment/service plan. LRE's Clinical Chart Audit Tool is compliant with MDHHS' PCP Guidelines Policy and the Medicaid Provider Manual ensuing LRE assesses the quality and appropriateness of care furnished to individuals receiving LTSS.[5]

LRE also ensures all individuals, including those receiving LTSS, receive a LOCUS/CAFAS upon admission, annually, and when there has been a significant change in consumer's presentation. In an effort to improve visibility of LOCUS utilization, LRE has developed PowerBI Dashboards. Additionally, LRE has contracted with an agency to conduct SIS training for all interested parties in Region 3, which will only strengthen LRE's commitment to ensuring individuals receiving LTSS receive quality, appropriate care over the long-term.

Finally, LRE has created a Personal Emergency Response System Workgroup encouraging independence among all consumers, including those receiving LTSS.[6]

[4] 1115 Pathway to Integration defines Long-Term Services and Supports as Community Living Supports, Enhanced Medical Equipment and Supplies, Enhanced Pharmacy, Environmental Modification, Family and Support Training, Fiscal Intermediary, Goods and Services, Non-Family Training, Out-of-Home Non-Vocational Habilitation, Personal Emergency Response System, Prevocational Services, Skill Building Assistance, Specialty Services/Therapies (Music Therapy, Recreation Therapy, Art Therapy, and Massage Therapy), Supports and Service Coordination, Respite, Private Duty Nursing, Supported/Integrated Employment Services, Child Therapeutic Foster Care, Therapeutic Overnight Camping, Transitional Services.

[5] Person-Centered Planning section comports with the MDHHS Person-Centered Planning Guidelines Policy. MDHHS, Behavioral Health and Developmental Disabilities Administration, Person-Centered Planning Practice Guideline (michigan.gov). Service Delivery section comports with the Medicaid Provider Manual.

[6] LRE co-leads a Regional Emergency Response System Workgroup initiated by Lynne Doyle Ottawa CMH, CEO.

XVIII. FISCAL YEAR 2024 QAPIP WORKPLAN

QAPIP Component	Goal / Opportunity	Objectives (Specific Actions to be taken)	Responsible Party	Barrier Analysis	Deadline
Performance Measures	LRE will meet and maintain the performance standards as set by the MDHHS / PIHP Contract for Indicators 1, 4a, 4b, and 10	1. CMHSPs will consistently meet all MDHHS MMPBIS 95% Standards for Indicator 1, 4a, & 4b, and the less than 15% Standard for Indicator 10. 2. LRE will require Plans of Correction from each CMHSP for each Indicators not meeting MDHHS Standards.	CQO Monitored By: 1. MMBPIS Workgroup 2. QI ROAT	Staffing Shortage	Ongoing
Performance Measures	LRE will meet and maintain the performance standards as set by the MDHHS / PIHP Contract for Indicators 2a, 2e, and 3	1. CMHSPs will consistently meet all MDHHS MMPBIS 62% Standards for Indicator 2a and 72.9% for Indicator 3. 2. LRE will require Plans of Correction from each CMHSP for each Indicators not meeting MDHHS Standards.	CQO Monitored By: 1. MMBPIS Workgroup 2. QI ROAT	Staffing Shortage	Ongoing

Performance Improvement Projects	LRE will implement two PIP projects that meet MDHHS Standards. <u>Formal PIP</u>: FUH Metric: Decrease in Racial Disparity between Whites and African American/ Blacks Baseline Data for FY2022: submitted to HSAG July 2022 FUH_ Adults and Children who identify as African American/Black: 60.2% FUH_Adults and Children who identify as While: 70.9%	1. The objective for the PIP is that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African-Americans/ Blacks) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (Whites). 2. LRE will develop improvement strategies and interventions to impact this performance indicator outcomes and achieve significant improvement. 3. LRE will work with the five CMHSPs within Region 3 to implement agreed upon interventions	CQO Monitored By: 1. QI ROAT	Data Integrity Lag in Data Availability	9/30/2024

Performance Improvement Projects	LRE will implement two PIP projects that meet MDHHS Standards. 2nd PIP: FUH HEDIS Measure: The percentage of discharges for patients 6 years of age or older who were hospitalized for treatment of selected mental illness or intentional self harm diagnoses and who had follow-up visit with a mental health provider within 30 days of discharge.	1. LRE will develop workflows for ADT data dissemination, follow-up after discharge, and CMHSP weekly data submission requirements. LRE will also develop an FUH error report for dissemination to and remediation by its CMHSPs at least bi-monthly. 2. The objective for the PIP is to demonstrate a significant increase over the baseline rate for all consumers to which FUH applies. 3. LRE will develop improvement strategies and interventions to impact this performance indicator outcomes and achieve significant improvement. 4. LRE will work with the five CMHSPs within Region 3 to implement agreed upon interventions.	Provider Network Staff (#1) CQO (#2-#4) Monitored By: 1. FUH Workgroup (#1) 2. UM/Clinical ROAT (#1) 3. QI ROAT (#2-#4)	Data Integrity Lag in Data Availability	9/30/2024
Critical Incidents, Sentinel Events, Unexpected Deaths, and Risk Management	Ensure contractual requirements are being met in Sentinel Events, Critical Incidents, and Risk Events.	LRE will 1. Analyze and monitor CIRE data to ensure data completeness, accuracy, and timeliness. 2. Determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence	CQO Monitored By: 1. CIRE Workgroup 2. QI ROAT	Extracting Data out of CRM for Analysis and Trending Data Integrity	Ongoing

		of additional events and incidents. 3. Monitor CMHSPs for follow-up of remediations efforts with providers, as needed.			
Critical Incidents, Sentinel Events, Unexpected Deaths, and Risk Management	LRE delegates the process of review and follow-up of sentinel events to the CMHSP.LRE will continually monitor the five regional CMHSP's sentinel event and unexpected death processes ensuring timeliness of reporting, completion of RCAs and follow up as required per contract.	LRE will monitor the following:1. CMHSPs will notify the LRE of a possible sentinel event / unexpected death within 24 hours of their knowledge of event.2. CMHSPs have 3 business days to determine if the event is a sentinel event.3. CMHSPs have 2 business days to commence an RCA if the event was determined to be a possible sentinel event / unexpected death.4. CMHSPs have 48 ours to submit the completed unexpected death/ SE form to the LRE following completion of the RCA.5. LRE will follow-up to ensure remediation of issues found through the RCA within 90 days following receipt of the RCA.	CQO (#1-#4)Provider Network Staff (#5)Monitored By:1. CIRE Workgroup2. QI ROAT	Extracting Data out of CRM for Analysis and TrendingData Integrity	Ongoing
Critical Incidents, Sentinel Events, Unexpected Deaths, and Risk Management	LRE will review and monitor CIRE events by type of incident and facility incident occurred.	MDHHS implemented a new CIRE process using MiCAL/CRM for FY23. 1. LRE will monitor CIRE data using the Power BI report looking for trends with incident types and /or facilities. 2. LRE will use the Specialized Residential	IT Staff (#1) CQO (#2-#4) Monitored By: 1. CIRE Workgroup 2. QI ROAT	Extracting Data out of CRM for Analysis and Trending Data Integrity	Ongoing

		filter to analyze trends among consumers receiving LTSS.			
Critical Incidents, Sentinel Events, Unexpected Deaths, and Risk Management	LRE will monitor mortality data over time.	MDHHS implemented a new UD|SE process using MiCAL/CRM for FY23. 1. LRE QI Staff will review mortality data looking for trends in the causes of natural deaths and unexpected deaths. (suicide, accidental, homicide) 2. Mortality data report trends and issues will be discussed quarterly at the CIRE Workgroup and semi annually at the QI ROAT.	CQO Monitored By: 1. CIRE Workgroup 2. QI ROAT	Extracting Data out of CRM for Analysis and Trending Data Integrity	Ongoing
Behavior Treatment Review	LRE will review and analyze behavior treatment review committee physical management data by individual and length of time for each instance of physical management used in an emergency behavioral crisis.	1. CMHSPs will submit physical management data for every instance of physical management used in an emergency behavioral health crisis to the LRE at least quarterly. This data will be reported by: • individual (separately for each instance), • include demographics of population, • Hab Waiver: Yes/No, • Behavior Plan: Yes/No, and • Time per instance will be reported in minutes and seconds. 2. LRE QI Staff will aggregate physical management data quarterly. • quarterly data will be	CQO (#1-#2) IT Staff (#3) Monitored By: 1. LRE Behavior Treatment Workgroup 2. QI ROAT	LRE IT Project Priority	Ongoing

		reviewed for trends, issues, and performance improvement opportunities. • quarterly reports and analysis will be reviewed and discussed by Behavior Treatment Workgroup and QI ROAT. 3. LRE QI Staff will work with IT staff to have the Physical management data in Power Bi by 9/30/2024			
Member Experience with Services	LRE will complete quantitative and qualitative assessments of member experiences with its services that align with the CCBHC and non-CCBHC survey requirements.	1. Implement new Customer Satisfaction Surveys (Adult and Child) that align CCBHC and non-CCBHC requirements. CMHSPs will collect satisfaction survey data using new Surveys2. Customer Services Staff will run quarterly satisfaction survey reports using Power BI.3. Customer Services Staff will review the quarterly satisfaction survey data, analyzing for trends/ issues. Customer Services Staff will present quarterly reports to CS ROAT and QI ROAT.4. Customer Services Staff will review all survey comments and follow up with the individual who completed the survey. Follow up will be documented and reviewed for trends / issues.5. Annually, LRE will collect information from CMHSPs on any	Customer Services StaffMonitored By:1. CQO2. QIC3. Customer Services Workgroup4. QI ROAT	MDHHS Guidance Delay	9/30/2024Ongoing

		focus groups held during the year and the results/ findings from the group.			
Grievance and Appeals	Provider grievances, appeals and NABD's will be compliant with MDHHS Standards and Policy.	1. Conduct quarterly grievance, appeals, and NABDs audit at the CMHSP level to ensure compliance with Federal regulations and State requirements. 2. Issue CAPs, as required. 3. Approval CAPs and validate CAP remediation	Customer Services Staff Monitored By: 1. CQO 2. QIC 3. Customer Services Workgroup 4. QI ROAT		9/30/2023
Practice Guidelines	Ensure continued education and monitoring of Clinical Practice Guidelines while improving dissemination and education to the LRE Provider network. Adopt new/alternate practice guidelines as necessary.	1. CPGs will be reviewed and updated two times a year by the LRE Medical Director and the Clinical / UM Department staff. 2. CPG information will be disseminated to the provider network through various educational opportunities as well as links to the LRE CPGs via CMHSP and LRE Websites. 3. Disseminate the Clinical Practice Guidelines to its Regional Provider Network via LRE newsletter at least annually.	UM Staff Monitored By: 1. CQO 2. QIC 3. Clinical ROAT 4. QI ROAT		Ongoing

Credentialing and Re-Credentialing	Enhance the credentialing/recredentialing process through successful implementation of the MDHHS CRM Universal Credentialing Module.	QAPIP Standards require that credentialing data be regularly reviewed 1. A credentialing data report will be developed by January 2023. 2. QI with LRE Credentialing Staff will review and monitor the credentialing data report monthly to identify trends and areas of concern. 3. Credentialing data report will be presented to the QI ROAT quarterly to discuss trends and areas of concerns. 4. Identified trends and areas of concern will be discussed with Provider Network Managers and a improvement plan to address and work on these with the Providers and CMHSPs will be developed as needed.	Credentialing Staff Monitored By: 1. QIC 2. QI ROAT	MDHHS delay in Universal Credentialing module deployment MDHHS not including all individual provider types in Universal Credentialing module	9/30/2024
Credentialing and Re-Credentialing	Develop specifications for developing a credentialing/recredentialing module within LIDS and reports with the assistance of PCE Systems that complies with MDHHS Provider Credentialing Policy.	1. Work with Stakeholder to identify unmet needs related to Master Provider Database. 2. Interface with PCE to ensure tranfer of technical requirements to functional module.	IT Staff CQO Monitored By: 1. Credentialing Staff 2. QI ROAT	LRE IT Project Prioritization PCE Project Bandwidth balance with MDHHS CRM work	9/30/2024

Credentialing and Re-Credentialing	Develop a process for integrating grievances, appeals, performance indicators, critical incidents, etc. into the recredentialing process.	1. Establish procedures to integrating grievances, appeals, performance indicators, critical incidents, etc. into the recredentialing process.	CQO Monitored By: 1. QIC 2. Credenialing Staff 3. QI ROAT	LRE IT Project Prioritization PCE Project Bandwidth balance with MDHHS CRM work	9/30/2024
Verification of Services	The LRE will complete Medicaid Verification of services reimbursed by Medicaid as required by MDHHS Contract.	LRE will:1. Complete quarterly Medicaid Verification Reviews based on a sample of Medicaid paid claims from each of the five regional CMHSPs and their larger providers.2. Complete quarterly Medicaid Verifications reports with analysis of findings. (reviewed by the QI ROAT).3. Prepare and submit an annual Medicaid Verification report to MDHHS that includes claim verification methodology, findings, and actions taken in response to findings.	CQOMonitored by1. MEV Staff2. QI ROAT		Ongoing
Utilization Management	LRE continue to audit over and under utilization for HLOC/IP/CR	1. Continue UM Auditing as is 2. Utilize UM audit data to identify opportunities for improved authorization and utilization opportunities	UM Staff Monitored by: 1. UM/Clinical ROAT 2. CQO		9/30/2024
Utilization Management	Implement MIiCANs successfully	Implement MIiCANs successfully	UM Staff Monitored by: 1. UM/Clinical ROAT 2. CQO		9/30/2024

Oversight of Provider Network	LRE will ensure CMHSP Site Review Tools comply with Federal regulations and State requirement.	1. Review 42 CFR 438 monthly to ensure Federal regulations have not changed and if they do, document such changes so as to incorporate in the CMHSP Site Review Tools for the following audit year.	CQO		Ongoing
Long Term Services and Supports (LTSS)	LRE will monitor services and supports for individuals receiving Long Term Services and Supports (LTSS)	1. A section of the LRE Satisfaction Survey has questions specifically for individuals receiving LTSS. Surveys questions will be aggregated and monitored quarterly using the Power BI platform. Survey data will be analyzed for trends and issues. Any issues found will be addressed. 2. LRE QI staff complete an annual CMHSP Site Review of each of the five CMHSPS in Region. 3. Clinical chart reviews are completed as part of this process, including specific Waiver Review Questions. Waiver questions will be aggregated by question and reviewed/analyzed for trends and issues. These trends /issues will be addressed with the responsible CMH with a required CAP with individualized remediation required. 4. QI I Staff complete	CQO UM Staff Monitored By: 1. UM ROAT 2. Clinical ROAT 3. QI ROAT		Ongoing

		annual facility reviews of specialized residential facilities. Specialized Residential facilities will be reviewed and monitored for HCBS required Standards. 5. Incorporate LTSS into UM Plan.			

XIX. MDHHS GOVERNING BODY FORM

Governing Body Form

To be completed by the PIHP and submitted to MDHHS along with its annual QAPIP submission no later than February 28th of each year.

Name of PIHP		
Lakeshore Regional Entity		
List of members of the Governing Body (add additional rows as needed)		
Name	**Credentials**	**Organization** (if applicable)
1. Jim Storey	LRE Board Co-Chair, Allegan County Commissioner, Allegan CMH Board, LRE OPB	OnPoint CMH (f/k/a Allegan CMH)
2. Alice Kelsey	LRE Board Member	OnPoint CMH (f/k/a Allegan CMH)
3. Pastor Craig Van Beek	LRE Board Member, Pastor	OnPoint CMH (f/k/a Allegan CMH)
4. Janet Thomas	LRE Board Member, Lawyer, HW Board Chair	HealthWest
5. Linda Dunmore	LRE Board Member, Registered Nurse	HealthWest
6. Janice Hileary	LRE Board Member, HealthWest Board	HealthWest
7. Patricia Gardner	LRE Board member, Kent County Judge	Network180
8. Stan Stek	LRE Board Chair, Kent County Commissioner, N180 Board Member	Network180
9. Jon Campbell	LRE Board member, State Division Administrator LARA	Network180
10. Sara Hogan	LRE Board Member, Director of Administration (Benjamin's Hope) Provider Network,	Ottawa CMH
11. Richard Kanten	LRE Board Member, LRE OPB	Ottawa CMH

12. Susan Meston	LRE Board Member, Superintendent of schools	Ottawa CMH
13. Ron Bacon	LRE Board Member, WM CMH Board Member	West Michigan CMH
14. Ron Sanders	LRE Board Member	West Michigan CMH
15. Andrew Sebolt	LRE Board Member, LRE OPB, WM CMH Board, MDHHS County Board, Veteran	West Michigan CMH
Changes to membership during the past year: **Directors no longer on LRE Board:** Linda Garzelloni, Mark DeYoung, Jack Greenfield, Jane Verduin, Dawn Rodgers-DeFouw, John Snider, Lindell Herrick, Matt FenskeClick or tap here to enter text.		
Date the Governing Body approved the annual QAPIP (prior SFY QAPIP evaluation, current SFY QAPIP description, and current SFY QAPIP work plan)*		
Date: November 15, 2023.		
Dates the Governing Body received routine written reports from the QAPIP (during the prior SFY; add additional rows as needed)*		
Date: January 25, 2023 - Chief Quality Officer Board Report (written form) reviewed QAPIP components		
Date: March 22, 2023 – Chief Quality Officer Board Report presented FY23 QAPIP and FY22 QAPIP Annual Effectiveness Review		
Date: April 26, 2023 – Chief Quality Officer Board Report (written form) reviewed QAPIP components		
Date: May 24, 2023 – Chief Quality Officer Board Report (written form) reviewed QAPIP components		
Date: June 28, 2023 – Chief Quality Officer Board Report (written form) reviewed QAPIP components		
Date: July 26, 2023 – Chief Quality Officer Board Report (written form) reviewed QAPIP components		
Date: August 23, 2023 – Chief Quality Officer Board Report (written form) reviewed QAPIP components		
Date: September 27, 2022 – Chief Quality Officer Board Report (written form) reviewed QAPIP components		
MDHHS Feedback		

*The PIHP should be prepared to submit Governing Body meeting minutes and written reports to MDHHS upon request.

XX. ACRONYMS

BBA – Balanced Budget Act

BTC – Behavior Treatment Committee

BTP – Behavior Treatment Plan

CAP – Corrective Action Plan

CAFAS – Child and Adolescent Functional Assessment Scale

CEO – Chief Executive Officer

CIRE – Critical Incidents & Risk Events

CQO – Chief Quality Officer

CMHSP – Community Mental Health Service Provider

CMS – Centers for Medicare and Medicaid Services

COO – Chief Operations Officer

CPG – Clinical Practice Guideline

CRM – Customer Relationship Management

CS – Customer Satisfaction

EQR – External Quality Review / External Quality Review Organization

HSAG – Health Services Advisory Group (External Quality Review Organization contracted by MDHHS to conduct annual reviews of each PIHP)

HCBS – Home and Community-Based Services

HIPAA – Health Insurance Portability and Accountability Act

HMP – Healthy Michigan Plan

ICO – Integrated Care Organization

I/DD – Intellectual/Developmental Disability

IPOS – Individual Plan of Service

KPI – Key Performance Indicator

LOCUS – Level of Care Utilization System

LTSS – Long-Term Services and Supports

LRE – Lakeshore Regional Entity

MDHHS – Michigan Department of Health and Human Services

MHL – MI Health Link Demonstration Program

MHP – Medicaid Health Plan

MI – Mental Illness

MHSIP – Mental Health Statistics Improvement Program Adult Consumer Experience of Care Survey

MMBPIS – Michigan Mission Based Performance Indicator System

PCP – Person-Centered Planning

PIHP – Prepaid Inpatient Health Plan

PIP – Performance Improvement Project

QAPIP – Quality Assessment and Performance Improvement Plan

QIC – Quality Improvement Council

QI – Quality Improvement

ROAT – Regional Operations Advisory Team

Survey – Customer Satisfaction Survey

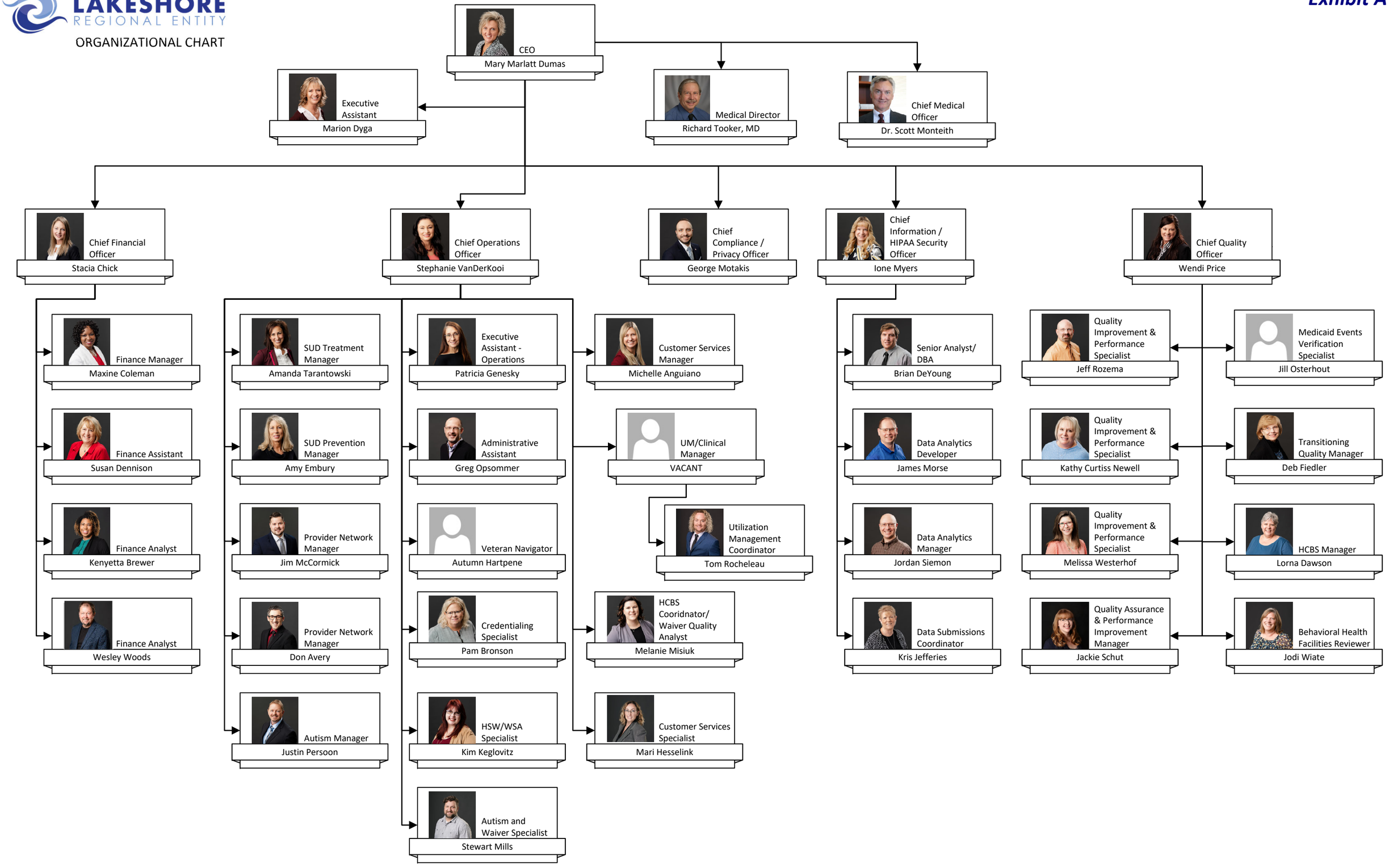
UM – Utilization Management

YSS-F – Youth/Family Services Survey for Families Experience of Care Survey

LAKESHORE REGIONAL ENTITY

ORGANIZATIONAL CHART

Exhibit A



LAKESHORE REGIONAL ENTITY

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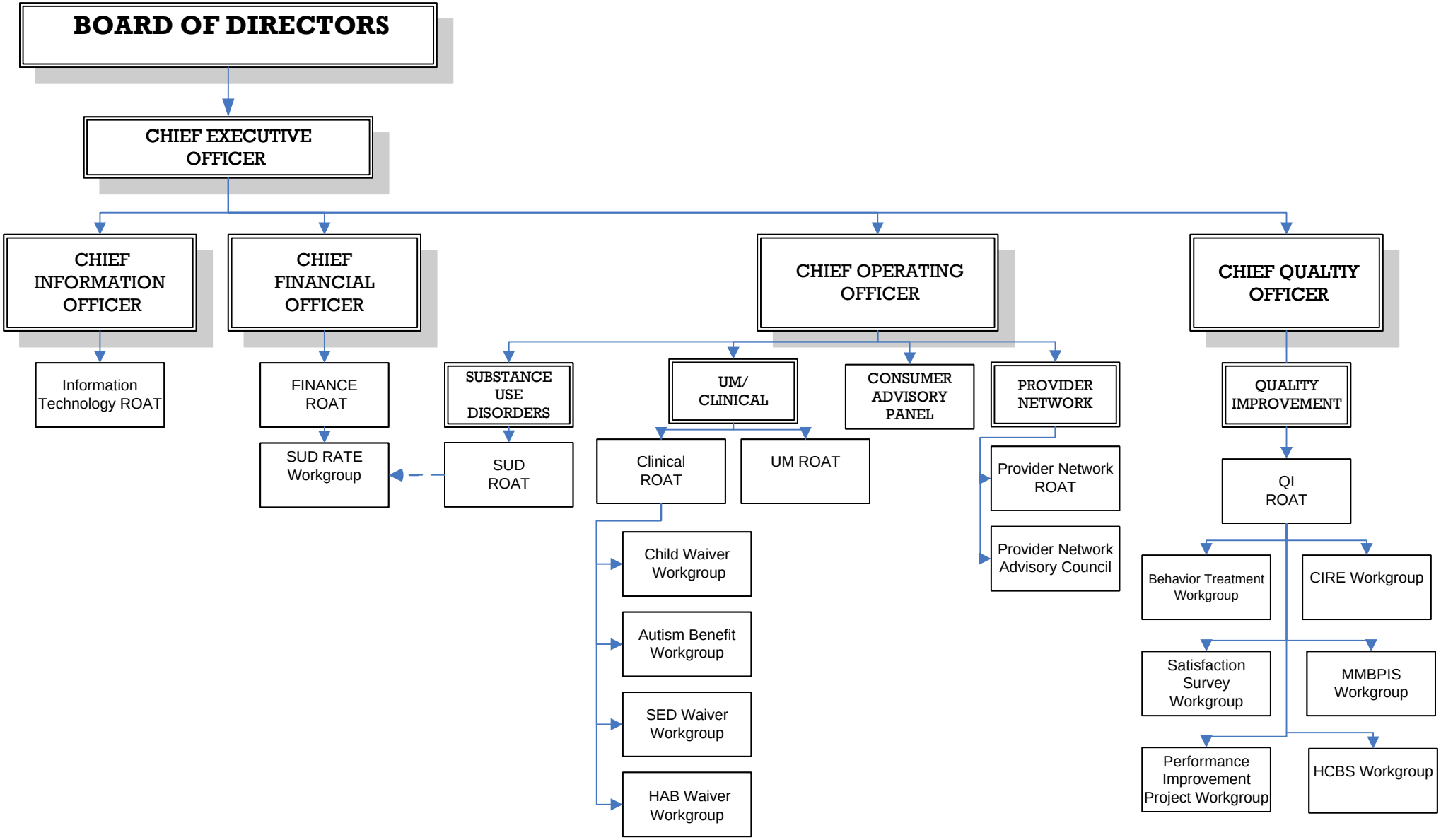
ROAT STRUCTURE



LAKESHORE REGIONAL ENTITY

Exhibit C

Quality Improvement Committee CHARTER

COMMITTEE LEAD: LRE CQO and LRE COO
ADOPTED: 8/4/2023
REVIEWED:

This charter shall constitute the structure, operation, membership, and responsibilities of the Lakeshore Regional Entity (LRE) Quality Improvement Committee (QIC).

Purpose:
The LRE QIC:

- Ensures effective oversight and monitoring of the Lakeshore Regional Entity's managed care functions, both internal and delegated through the application of data reports.
- Ensures all departments are collaboratively and consistently utilizing data and key performance indicators.
- Ensures LRE departments are collaborating to foster open communication and cross-pollination of information toward effective project completion.

Responsibilities and Duties: The responsibilities and duties of the LRE QIC shall include the following:

- Ensure managed care functions are being appropriately monitored and in compliance with MDHHS and HSAG standards.
- Ensure coordination and information sharing between LRE departments.
- Recommend improvement strategies where adverse trends are identified by the Data Analytics Steering Committee

Membership: LRE QIC membership is determined by the LRE Chief Operating Officer and Chief Quality Officer, including but not limited to department managers responsible for Managed Care Functions (Utilization Management, Customer Services, Provider Network, Finance, Quality, Information Technology).

Reporting Expectations: At a minimum, subject matter experts (SMEs) are expected to present the performance metrics as follows:

1. Overview of metric by region and by CMHSP
2. Identification of any outliers and reason for data anomaly
3. Comparison of quarter over quarter metric performance by region and by CMHSP
4. Comparison of year over year metric performance by region and by CMHSP
5. Trend analysis by metric by region and by CMHSP
6. Identify reason why the metric is trending up or down by region and by CMHSP
7. Present recommendations if metric is trending downward
8. Present recommendation if a CAP is necessary
9. Present recommendation if a training opportunity exists

LAKESHORE REGIONAL ENTITY

Reporting Schedule:

REPORTING AREA	SME	JAN	FEB	MAR	APRIL	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
iSPA	Melanie			X			X			X			X
Waiver	Kim			X			X			X			X
Credentialing	Pam			X			X			X			X
Autism	Justin	X			X			X			X		
Customer Services - Grievance/NABDs	Michelle	X			X			X			X		
Customer Services - CS Survey	Mari	X			X			X			X		
Clinical/UM	Tom		X			X						X	
PNM - Network Adequacy	Jim/Don					X			X			X	
PNM - CAP Completion	Jim/Don		X			X			X			X	
PNM - Timeliness Standards	Jim/Don		X			X			X			X	
Quality - MMBPIS	Wendi	X			X			X			X		
Quality - CIRE	Wendi	X			X			X			X		
Quality - UD/SE	Wendi	X			X			X			X		
Quality - CMHSP Site Reviews	Wendi					X						X	
Quality - SUD/InPatient Site Reviews	Wendi					X						X	
Quality - Facility and HCBS Reviews	Wendi			X			X			X			X
Quality - HCBS	Wendi			X			X			X			X
Quality – BTPRC & Physical Mgmt	Wendi			X			X			X			X
IT	Ione												
Finance	Stacia	X			X			X			X		
Compliance	George												
SUD	Amanda/Amy		X										
Veterans Navigator	Autumn		X										
Quality - HSAG (PIP, CR, PMV)	Wendi		X			X			X			X	
		7	6	6	7	7	6	7	4	6	7	7	6

LAKESHORE REGIONAL ENTITY

Change Log:

Description of Change	Reason for Change	Date of Change	Change made By
Moved BTP and PM out 1 month	BTP and PM data not ready for initial reporting cadence	11/02/2023	Wendi Price - CQO

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.