Quality Assessment and Performance Improvement Program

REGIONAL QUALITY IMPROVEMENT PLAN

Fiscal Year 2016
Lakeshore Regional Partners
Quality Assessment and Performance Improvement Program

Table of Contents

Section I: Overview
Acronym List ........................................................................................................ 4
Introduction ........................................................................................................... 5
Purpose .................................................................................................................. 5
Performance Improvement Goals/Objectives ......................................................... 5

Section II: Quality Improvement Process, System, Standards and Strategies
Quality Improvement Authority and Structure ...................................................... 6
Governance .......................................................................................................... 6
Management Structure ......................................................................................... 7
Quality Improvement Regional Operations Advisory Team (ROAT) ...................... 7
Summary of Additional ROATs and Workgroups ................................................ 9
  Autism Workgroup ............................................................................................. 9
  Clinical ROAT ................................................................................................. 9
  Consumer Advisory Council .......................................................................... 9
  Corporate Compliance ROAT ....................................................................... 9
  Customer Services Workgroup ...................................................................... 10
  Finance ROAT ............................................................................................... 10
  Hab Waiver Workgroup .................................................................................. 10
  Healthcare Integration ROAT ....................................................................... 10
  Information Technology ROAT .................................................................... 10
  MMBPIS Workgroup ..................................................................................... 10
  Provider Network ROAT ............................................................................... 10
  Provider Network Advisory Council ............................................................. 11
  SUD Implementation ROAT ....................................................................... 11
  Utilization Management ROAT .................................................................... 11
Incorporation of ROAT Activities ...................................................................... 11
QI Team ............................................................................................................. 11
Quality Management System .......................................................................... 12
Quality Standards .............................................................................................. 14
Quality Assessment Activities .......................................................................... 14
  Stakeholder Input .......................................................................................... 15
  Quality Monitoring Reviews ....................................................................... 15
  MDHHS Site Reviews .................................................................................... 16
  External Quality Reviews ............................................................................. 17
  Critical Incident Reporting and Risk Events Management ............................ 17
  Reporting of Sentinel Events and Unexpected Deaths ................................... 18
  Behavior Treatment Review Analysis of Data .............................................. 19
  Credentialing ................................................................................................. 19
  Staff Training, Development and Qualifications ......................................... 20
  Quality Assessment of Contract Providers .................................................... 20
Performance Measurement .................................................................................. 20
  Michigan Mission-Based Performance Indicator System ............................ 21
  Dashboard and Outcome Reports .................................................................. 21
  Utilization Management ............................................................................... 21
  Verification of the Delivery of Medicaid Services ........................................ 21
<table>
<thead>
<tr>
<th>Section III: Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and Accountability</td>
</tr>
<tr>
<td>Quality Improvement Regional Operations Advisory Team (ROAT)</td>
</tr>
<tr>
<td>Accountability and Reporting</td>
</tr>
<tr>
<td>Key Reports and Deliverables</td>
</tr>
<tr>
<td>Attachments to the QAPIP</td>
</tr>
<tr>
<td>Evaluation of FY2015 Goals</td>
</tr>
<tr>
<td>Summary of the Annual QI-ROAT Self-Assessment</td>
</tr>
</tbody>
</table>

| Appendix A: FY2016 QAPIP Goals | 30 |
| Appendix B: Priorities for Performance Oversight and Improvement Activities | 34 |
| Appendix C: QAPIP Self-Assessment | 35 |
| Appendix D: FY2016 QI-ROAT Agenda Content Schedule | 38 |
| LRP Board and Consumer Advisory Council QI Reporting Schedule | 39 |
| Appendix E: QAPIP Annual Self-Assessment Question Specific Results | 40 |
| Appendix F: Annual Data Review | 43 |
Lakeshore Regional Partners
Quality Assessment and Performance Improvement Program

Section 1: Overview

ACRONYM LIST

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

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

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

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

PURPOSE

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

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

PERFORMANCE IMPROVEMENT GOALS/OBJECTIVES

The FY2016 LRP quality improvement goals and objectives are outlined at the end of this document (beginning on page 30).
Section II: Quality Improvement Process, System, Standards and Strategies

QUALITY IMPROVEMENT AUTHORITY AND STRUCTURE

I. Governance

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

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

II. Management Structure

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

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

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

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

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

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

- The annual review of the PIHP’s QAPIP.
- The mid-year and year-end 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 LRP 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., MDCH Site Review, External Quality Review) and facilitate corrective action and follow-up where indicated.
- Work closely with other PIHP Teams such as the Customer Services and Utilization Management Teams as well as the Provider Network and Corporate Compliance Committees to analyze aggregate performance data.
- Developing polices, standards and related legal, regulatory and accreditation requirements pertaining to quality management.
- Identifying trends key indicators related to persons-served and specialty benefit behavioral health care services.
Lakeshore Regional Partners
Quality Assessment and Performance Improvement Program

- Reviewing ongoing reports from the LRP’s quality improvement activities, advising on standards and requirements, as defined in the PIHP’s QAPIP.
- Monitoring organizational progress in meeting the quality management program goals and objectives, and evaluates the overall effectiveness of the PIHP’s QAPIP on an annual basis.
- Revising processes and tools for monitoring the provider network system on an annual basis.
- Recommending quality initiative when performance does not meet established quality standards or other requirements.

In addition to the above, each member can refer systemic processes or performance issues to the QI-ROAT. In those instances where desired process / outcome gain can only be achieved through collaboration of more than one LRP member, the QIROAT may establish a regional Performance Improvement Project (PIP). Members of the QIROAT shall help coordinate ad hoc teams and IPs 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 and provider monitoring review tools) and policies (i.e., Quality Management, Performance Improvement, and Critical Incidents/Event Reporting).

IV. Summary of Additional ROATS/Workgroups

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

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

Corporate Compliance ROAT
The Corporate Compliance ROAT provides advisory input to the LRP around the compliance plan, policies and procedures, training and education efforts and processes for reporting compliance to the LRP Compliance Officer. The group also reviews reporting trends, received information on national and state priorities, and used the ROAT to discuss local compliance issues that may have impact on the region as a whole.

Customer Services Workgroup
The Customer Services Workgroup meets on a regular basis to review customer services data, update the Guide to services and address regional issues surrounding customer services.
**Consumer Advisory Council**
The LRP Consumer Advisory Council is an advisory group of primary and secondary consumers served by the CMHSPs within the Region. This council assists and advises LRP staff in identifying issues and areas of concern related to regional service delivery and managed care operations. It is a primary source of consumer input into the development of policies, procedures and operations where recipients of service may make recommendations for quality improvement. The LRP Consumer Advisory Council will focus on region-wide political and advocacy issues and inform the efforts of the LRP Legislation and Advocacy Committee along with region-wide opportunities for stigma reduction related to mental health and substance use disorders. “Mental health” includes children with severe emotional disturbances, adults with mental illness, and persons with intellectual and/or developmental disabilities.

**Finance ROAT**
Helps to keep members up on current Finance related topics at MDHHS and within the Region. Advises in looking at 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.

**Healthcare Integration ROAT**
The purpose of this ROAT is to act in an advisory capacity for the development of integrated healthcare with the Health Plans assigned to our Region. The group may also advise on potential service models, needed healthcare data, and desired outcomes for integrated care. This is a new ROAT, so a more formal ROAT charge will be developed.

**Information Technology ROAT**
Help develop I.T. strategies for the Region. Projects include Regional IT efficiencies, implementation of the Zenith system.

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

**Provider Network ROAT**
The Provider Network ROAT provides advisory input to the LRP around the development of a strong and viable provider network. This includes contract development, determination of network adequacy and making recommendations to the LRP for changes in services.
**Provider Network Advisory Council**
The Provider Network Advisory Council is an open meeting for all providers of Medicaid billable services throughout the Region. The Council meets on a monthly basis.

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

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

**V. Incorporation of ROAT Activities**
Updates from each of the ROATs will be provided in LRP Executive Team and LRP Leadership team to ensure consistency, transparency and assist with ongoing planning. Copies of meeting minutes from all ROATs and Workgroups will be available on the LRP Intranet.

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

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

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

A graphical representation of the PDCA process is described below:
The *Quality Management System* includes:
- Predefined quality standards
- Formal assessment activities
- Measurement of outcomes and performance
- Strategies to improve performance that is below standards

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

<table>
<thead>
<tr>
<th>Quality Standards</th>
<th>Assessment Activities</th>
<th>Performance Measurements</th>
<th>Improvement Strategies</th>
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<tbody>
<tr>
<td>• Federal &amp; State Rules/Regulations</td>
<td>• Provider Monitoring Reviews</td>
<td>• MDCH MMBPIS</td>
<td>• Corrective Action/ Improvement Plans</td>
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<tr>
<td>• Stakeholder Expectations</td>
<td>• Accreditation Surveys</td>
<td>• LRP Outcomes Management System</td>
<td>• Improvement Projects</td>
</tr>
<tr>
<td>• MDCH/PIHP Contract</td>
<td>• Credentialing</td>
<td>• LRP Dashboards</td>
<td>• Improvement Teams</td>
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<td>• Provider Contracts</td>
<td>• Risk Management</td>
<td>• Benchmarking</td>
<td>• Strategic Planning</td>
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<td>• Practice Guidelines</td>
<td>• Utilization Reviews</td>
<td>• Status Reports on Strategic Planning</td>
<td>• Adherence to Practice Guidelines</td>
</tr>
<tr>
<td>• Accreditation Standards</td>
<td>• External Quality Reviews</td>
<td>• Audit Reports</td>
<td>• Organizational Learning</td>
</tr>
<tr>
<td>• LRP Policies and Standards</td>
<td>• Stakeholder Input</td>
<td>• Grievances &amp; Appeals</td>
<td>• Staff Development and Training</td>
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<tr>
<td>• Evidence Based Practices</td>
<td>• Sentinel Events</td>
<td>• Board Ends Report using LRP Dashboards</td>
<td>• Improvements through Root Cause Analysis</td>
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<td>• Promising Practices</td>
<td>• Critical Event Reports</td>
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I. Quality Standards

*Quality Standards* provide the specifications, practices, and principles by which a process may be judged or rated. The LRP 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 LRP'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 Partners is absolutely committed to maintaining the confidentiality of persons served in our organization. The following statements below reflect specific tenet of this commitment. Specific details are reflected in the Lakeshore Regional Partner’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 QOC may review specific individually-identifiable information. In those situations, the confidentiality of the information will be protected.
3. Access to confidential quality improvement or quality oversight information (i.e. clinical information, customer history, credentialing information) shall be restricted to those individuals and/or committees charged with the responsibility/accountability for the various aspects of the program.
4. Individual provider information may be utilized and/or evaluated at the time of re-credentialing or contracting.
5. All customers and/or individual provider-specific information will be kept in a confidential manner in accordance with applicable federal and state laws and will be used solely for the purposes of quality oversight and/or directly related activities. Disclosing confidential customers and/or provider information internally or externally may be grounds for immediate dismissal from the committee.

II. Quality Assessment Activities

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

All members of the Lakeshore Regional Partners 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 LRP members are service consumers, staff, contract service providers, families/advocates, and the local communities.

Stakeholder input is gathered from a variety of methods. These methods include:

1. Satisfaction Surveys
2. Consumer Advisory Council
3. Scheduled and ad-hoc interviews
4. Needs Assessments
5. Case Reviews
6. Provider Surveys
7. Public Comment at Board Meetings

Input is collected to better understand how the LRP 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 LRP. As a result of input from stakeholders, the LRP:

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

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

**Quality Monitoring Site Reviews**

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

- Establishes clinical and non-clinical priority areas for improvement
- Uses a number of measures to analyze the delivery of services and quality of care
- Analyzes both the processes and outcomes of care using currently accepted standards.
Lakeshore Regional Partners
Quality Assessment and Performance Improvement Program

- Establishes performance goals and compares findings and ratings with past performance
- Conduct additional special targeted monitoring activities of people who are identified as vulnerable (as defined by MDCH)
- Provides performance feedback to providers through both an exit conference and written report
- Requires an improvement plan (plan of correction) from providers for areas under goal and in non-compliance with accepted standards
- Review and approve improvement plans
- Ensures implementation of each submitted improvement plan.

The Plan-Do-Check-Act process for Quality Monitoring Reviews is designed so each CMHSP is reviewed on an annual basis. If a plan of correction is required, then CMHSP has 30 days to respond. The LRP either accepts the plan of correction as written or requests more information and/or recommends additional changes. Once the plan of correction is approved by the LRP, the CMHSP is required to submit an update 6-months detailing progress on planned changes. The plan of correction is reviewed at the following year’s CMHSP Quality Monitoring Site Review.

**MDHHS Site Reviews**
The LRP will monitor LRP member performance on site reviews conducted by MDCH. To best address local concerns, each LRP member will draft remedial action for all citations for which the LRP member has been identified as being out of compliance. The QROAT will be informed of all findings and provide input into the LRP response.

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

**External Quality Reviews**
The Balanced Budget Act (BBA) of 1997 requires that states contract with an External Quality Review Organization (EQRO) for an annual independent review of each Pre-paid Inpatient Health Plan (LRP) to evaluate the quality and timeliness of, and access to, health care services provided to Medicaid enrollees. MDCH 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 MDCH and the LRP can use for:

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

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

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Suicide</th>
<th>Death</th>
<th>EMT</th>
<th>Hospital</th>
<th>Arrest</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLS</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supports Coordination</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td>●</td>
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<td></td>
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</tr>
<tr>
<td>Home-Based</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wraparound</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hab. Waiver</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>SED Waiver</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Child Waiver</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
</tbody>
</table>
The LRP Behavior Treatment Work Group will also be responsible to monitor the additional five (5) critical events identified by MDCH which put individuals at risk of harm. The analysis is used to determine what actions need to be taken to remediate the problems or situation and to prevent the occurrence of additional events and incidents.

### Risk Event Monitoring

<table>
<thead>
<tr>
<th>Service</th>
<th>Harm to Self</th>
<th>Harm to Others</th>
<th>Police Calls</th>
<th>Physical Management</th>
<th>Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supports Coordination</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Case Management</td>
<td>●</td>
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<td>●</td>
</tr>
<tr>
<td>Home-Based</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
</tbody>
</table>

Other events requiring notification of MDCH 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 MDCH’s Mental Health and Substance Abuse Administration.

### Reporting of Sentinel Events and Unexpected Deaths

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

- Identifies when a Sentinel Event must be reported to the LRP 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 LRP; and
Stipulates that persons involved in the review of Sentinel Events must have the appropriate credentials to review the scope of care.

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

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

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

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

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

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

Credentialing
The members of the LRP will ensure that services and supports are consistently provided by staff (contracted or directly operated) who are properly and currently credentialed, licensed, and qualified. The LRP Credentialing and Re-Credentialing policy outlines the guidelines and responsibilities for credentialing and re-credentialing for the LRP, and as delegated to the CSSNs and contract service providers.
Staff Training, Development and Qualifications:
This function is performed across the region with materials and processes that are developed to be uniformly compliant with regulations but using procedures developed by the LRP members. The LRP Regulatory Compliance Unit reviews on an annual basis each member’s adherence to LRP policies and procedures related to staff possessing the appropriate qualifications as outlined in their job descriptions, including the qualifications for all of the following:

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

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

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

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

III. Performance Measurement

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

By using performance indicators, the variation between the target desired and current status of the item(s) being measured can be identified. Indicators are used to alert the LRP 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 LRP. 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 MDCH on October 1, 1998 and is in its 6\textsuperscript{th} revision. There are both the PIHP and CMHSP level indicators within the system. The LRP and each of the member partners submit data to MDCH on a quarterly basis. MDCH collects, aggregates, trends and publishes the MMBPIS information on the indicators that MDCH has determined would best monitor the implementation of managed care throughout the state. The QIROAT 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. QIROAT reviews MMBPIS results. LRP Member Boards who are out of compliance with MDCH standards work with the LRP Quality Improvement Coordinator and QIROAT to ensure the implementation of effective improvement plans.

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

C. Utilization Management
Utilization Management is guided by LRP policy and procedure and an annual Utilization Management Plan. Utilization Management activities are conducted across the region to assure the appropriate delivery of services. Utilization mechanisms identify and correct under-utilization as well as over-utilization. Utilization Reviews include the review/monitoring of individual consumer records, specific provider practices and system trends. Utilization Management data will be aggregated and reviewed by the LRP Utilization Management Committee as well as QI-ROAT for trends and service improvement recommendations.
D. Verification of the Delivery of Medicaid Services
MDHHS requires each PIHP to establish a process for the Verification of the Delivery of Medicaid Services (as defined in Attachment P.x.x.x of the MDHHS/PIHP contract). The purpose of the process is to verify that adjudicated claims are for services identified by MDHHS as Specialty Mental Health and/or Substance Abuse services, and that the services are sufficiently supported by case record documentation. The Verification of the Delivery of Medicaid Services will be completed by qualified PIHP staff. Verification procedures will not be delegated to providers, Core Providers, CMHSPs or MCPNs. The PIHP will perform this function for ALL Providers. Since this is a new contractual requirement beginning FY2016, the LRP is developing a common methodology for verification that will meet all contractual standards including verification procedures, corrective action and recoupment procedures, reporting procedures and documentation standards.

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

IV. Improvement Strategies

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

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

Stakeholders will be encouraged to regularly submit improvement recommendations through local QI processes. Each member partner will provide input to the QIROAT on LRP 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 LRP. One of the two projects conducted will be a project that is mandated by
MDCH and will be reviewed and evaluated by HSAG for compliance with requirements.

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

C. Annual Self-Assessment
In order to determine the committee’s own effectiveness, continuously improve the QAPIP and include committee member input into the ongoing development of the process, the QIROAT uses an annual QAPIP Self-Assessment (Appendix C). The annual assessment is provided to all committee members for confidential completion, the results are aggregated, and the committee reviews the resulting data in order to develop recommendations directly to the LRP COO. The results of the self-assessment are also presented to the LRP CEO Ops and the LRP Board of Directors as a component of the annual evaluation of the QAPIP.

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

Documentation of the QAPIP annual review, its findings and recommendations are forwarded to the LRP COO and the LRP Board of Directors. The annual review may lead to:
1. Identification of educational/training needs;
2. Establishment and revision of policies and procedures related to quality initiatives;
3. Recommendations regarding credentialing of practitioners;
4. Changes in operations to minimize risks in the delivery of quality services, and;
5. Development of objectives for the coming year.
COMMUNICATING QUALITY IMPROVEMENT ACTIVITIES

The LRP 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 LRP Board Meetings
2. Annual CMHSP Performance Reports
3. Policy/Procedure changes
4. The LRP website
5. ROAT meetings
6. Consumer Advisory Council meetings
7. Provider Network Advisory Council meetings
Lakeshore Regional Partners
Quality Assessment and Performance Improvement Program

Section III: Evaluation and Accountability

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

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

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

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

D. Attachments to the QAPIP
   Each Partner CMHSP shall have a unique QIP that specifies their local system for quality assurance and performance improvement.
Evaluation of FY2015 Goals

In FY2015, the QAPIP had identified seven goals to focus on. The following is the summary of these goals, the progress on the goals and the final evaluation of the goal (as defined as either completed, partial completion or needs to continue as a goal in FY2015).

Goal 1: LRP will develop a plan for involvement of consumers in the design, delivery, and assessment of services.

Progress on Goal: During FY2015, the LRP created a Consumer Involvement Plan and policy. A Consumer Advisory Council was created and meetings scheduled. In addition, the LRP has developed a process to involve Consumers in the various ROATS.

Final Evaluation: Completed.

Goal 2: Develop process to monitor trends related to CMHSP Plans of Correction.

Progress on Goal: LRP staff created a database to be used to monitor trends related to various CMSHP Plans of Correction. Data from this database is monitored quarterly.

Final Evaluation: Completed.

Goal 3: Review and explore common outcome measurement tools currently utilized in the region for the adult population (MI and SUD).

Progress on Goal: Prior to beginning to work on this goal, the LPR was notified that the State was setting up a workgroup to identify a tool to be used statewide. Therefore, this project was put on hold until the statewide group could convene. The LRP UM Coordinator attended these meetings. MDHHS decided the LOCUS will be the tool used state-wide. However, it is widely acknowledged that the LOCUS is not an outcome measurement tool. The LRP will await further insight from MDHHS regarding outcome measurement tools, there has been an indication that MDHHS will be looking to identify an Outcome Measurement tool for the State.

Final Evaluation: Not completed. On hold for further development pending clarification from MDHHS.

Goal 4: The RSA will be implemented across the Region.

Progress on Goal: The RSA was implemented throughout the Region in May. Results were presented to the QI-ROAT and the Consumer Advisory Council. Two areas of improvement identified related to outcomes and community integration. The LRP will continue to conduct this survey on an annual basis.

Final Evaluation: Complete.
Goal 5: Issues identified in the 2014 QAPIP self-assessment are addressed

Progress on Goal: There were three areas of concern identified in the FY2014 QAPIP self-assessment. These issues include: the committee did not consistently evaluate its own performance and the individual performance of each committee member; Committee members did not consistently receive the agenda and back-up materials well in advance of the QI-ROAT meeting; and Committee members did not consistently receive an orientation program and ongoing education about the work of the committee. For the first issue, the QI-ROAT decided to not implement a strategy related to evaluating members. It was decided this would not be a productive exercise. The standard of sending out agendas one week prior to the meeting was established. This was consistently met over the course of the year. An orientation process was developed for new members and implemented as there were two new members to the QI-ROAT this year.

Final Evaluation: Completed.

Goal 6: Reporting calendar will be created

Progress on Goal: A reporting calendar was created and posted on the LRP website.

Final Evaluation: Completed.

Goal 7: Assess for Provider Network Adequacy

Progress on Goal: The LRP contracted with TBD Solutions to complete this assessment. Several recommendations for improvement projects came from this report. It was decided the LRP will complete an assessment for Provider Network Adequacy on an annual basis.

Final Evaluation: Completed.

Goal 8: The QI-ROAT will develop two processes designed to improve administrative efficiency

Progress on Goal: Two processes were identified: common contract and training reciprocity. Workgroups were created to work on these two projects.

Final Evaluation: Both projects are partially completed. The Common Contract has been moved to the LRP for primary responsibility with a target completion date of May, 2016. Training Reciprocity continues to be address in the Training Reciprocity Workgroup. Target completion of the first phase of this project (group home curriculum training) is targeted to be completed by December, 2015.

Goal 9: Comply with new MDCH rules surrounding Home and Community-Based Services Waivers

Progress on Goal: LRP staff attended meeting with MDHHS surrounding the HCBS rule changes. All information was shared with member CMHSPs in HSW Meetings run by LRP staff. The Provider Network is also regularly updated in Provider meetings.
Final Evaluation: Completed. However, new information is consistently flowing from MDHHS, so it is an evolving and ongoing project.

Goal 10: Develop Regional Consumer Satisfaction Survey

Progress on Goal: A workgroup has been created and are working on a document to be implemented in FY2016.

Summary of the Annual QI-ROAT Self-Assessment

Per the QAPIP, QI-ROAT members are asked, on an annual basis, to complete a self-assessment on the effectiveness of the QI-ROAT. The Self-Assessment tool is a 31 question survey with responses based on a 4-point Likert type scale (options are Very Good, Good, Fair and Poor). It was determined any aggregate score less than a “Good” (which in numerical terms is defined as less than 3.0) were to result in a goal for improvement in FY2015. Of the 31 questions, there was one which scored less than 3.0:

- We periodically review feedback from persons our members serve and organizations or community partners that we coordinate services with (satisfaction surveys, community meetings, stakeholder meetings)

To view the actual tool, please refer to Appendix C. For more details on the results of this self-assessment, please refer to Appendix E.
<table>
<thead>
<tr>
<th>Committee Goals &amp; Goal Driver*</th>
<th>Operational Initiatives &amp; Committee Tasks to Accomplish Goal/Project</th>
<th>Key Deliverables (or Anticipated Outcomes)</th>
<th>Lead Staff (Champion)/Other Lead Staff</th>
<th>Timeframe</th>
</tr>
</thead>
</table>
| **Goal #1** Develop Regional Consumer Satisfaction Survey. | Currently, each CMSHP conducts consumer satisfaction surveys on an annual basis. The charge is for the workgroup to come up with 4 to 6 questions which will be consistently used across the Region. | ▪ Questions are identified.  
▪ Approved for implementation by the LRP Board. | Quality and Operations Specialist | ▪ Recommendation for tool completed by 3/31/2016  
▪ Tool taken to the LRP Board for FY2017 implementation by 7/31/2016 |
| **Goal #2** Complete the Quality Management and Oversight Project Management Plan | The LRP Operations Committee has charged the QI/PN Coordinator with a Quality Management and Oversight Project Management project. | ▪ Committee formed  
▪ Recommendation created for creating efficiency in the region by developing a common Quality Management and Oversight process | QI/PN Coordinator | ▪ Committee formed by 11/15/2015  
▪ Recommendations prepared for LRP Executive Team and Operations Committee completed by 12/31/2015 |
<p>| <strong>Goal #3</strong> Revise LRP Site Review Process to better line up with all regulatory requirements. | The LRP will redesign the Site Visit process to make the elements reviewed to mirror the elements required by HSAG. | ▪ Site Review process is revised to mirror the HSAG review tool. | Quality and Operations Specialist | Ongoing |</p>
<table>
<thead>
<tr>
<th>Committee Goals &amp; Goal Driver*</th>
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<th>Lead Staff (Champion)/Other Lead Staff</th>
<th>Timeframe</th>
</tr>
</thead>
</table>
| **Goal #4** Develop process to identify and define MDHHS Practice Guidelines and develop a process to ensure the Region is adhering to all Practice Guideline Standards. | The LRP will develop a Practice Guidelines policy and develop a process to monitor the policy’s adherence throughout the Region | • Practice Guidelines policy created  
• Process to monitor adherence created. | UM Coordinator | • Process identified by 1/31/2016 |
| **Goal #5** Develop Annual Performance Reports for CMHSPs | In an effort to increase transparency, the LRP will create an Annual Performance Report for each of the member CMHSPs. | • Key indicators for the Performance Report are identified.  
• Performance Reports are created  
• Performance Reports are presented at the LRP Board and posted on the LRP website | Quality and Operations Specialist | Completed for LRP Board presentation in January, 2016. |
| **Goal #6** Develop plan for receiving input from advocacy groups | In an effort to increase communication across the Region, the area of communication with advocacy groups is one the LRP could improve on. | • Identify key advocacy groups for the LRP to communicate with  
• Develop process for communication  
• Organize meetings | COO | Target Completion Date: 1/31/2016 |
<table>
<thead>
<tr>
<th>Committee Goals &amp; Goal Driver*</th>
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<th>Timeframe</th>
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<tr>
<td><strong>Goal #7</strong></td>
<td>The LRP is looking at ways to increase consumer and Provider Network input into LRP processes. One way to do this is to invite Consumers and Providers to participate in ROATs and Workgroups.</td>
<td>• Organize process to incorporate Provider Network and Consumers into the ROATs/Workgroups • Design process to select new members • Invite new members to the meetings</td>
<td>COO and QI/PN Coordinator</td>
<td>Target Completion Date: December 31, 2015</td>
</tr>
<tr>
<td><strong>Goal #8</strong></td>
<td>Review of all applicable policies should be reviewed in ROATs on an annual basis to determine if changes to policies need to be made or new policies developed.</td>
<td>• Develop process to review policies in ROATs • Implement process • Ensure all applicable policies are reviewed in ROATS</td>
<td>COO and QI/PN Coordinator</td>
<td>Target Completion Date: March 31, 2016</td>
</tr>
<tr>
<td><strong>Goal #9</strong></td>
<td>Committee charges will be updated and placed on the LRP website for easy access</td>
<td>• ROAT charges updated • ROAT charges placed on LRP website</td>
<td>COO</td>
<td>Target Completion Date: 2/28/2016</td>
</tr>
<tr>
<td><strong>Goal #10</strong></td>
<td>Two new ROATS will be created to meet the needs of the changing environment within the LRPS</td>
<td>• Clinical ROAT developed • Integrated Care ROAT developed</td>
<td>COO</td>
<td>Target Completion Date: 1/31/2016</td>
</tr>
<tr>
<td>Committee Goals &amp; Goal Driver*</td>
<td>Operational Initiatives &amp; Committee Tasks to Accomplish Goal/Project</td>
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</table>
| Goal #11 Standardize Risk Events reporting requirements | The LRP wants to ensure definitions for risk events are standardized throughout the region to ensure consistent data collection. CMHSP staff will be trained on these standards. | • Committee formed  
• Risk Events data reviewed and standardized definitions are developed | Quality and Operations Specialist | Target Completion Date: 3/31/2016 |
| Goal #12 Standardize Behavior Treatment Review Committee reporting requirements | The LRP wants to ensure definitions for Behavior Treatment Review data are standardized throughout the region to ensure consistent data collection. CMHSP staff will be trained on these standards. | • Committee reconvened  
• Risk Events data reviewed and standardized definitions are developed | Quality and Operations Specialist | Target Completion Date: 3/31/2016 |
| Goal #13 Develop standards for Timeliness of data submissions | The LRP wants to ensure definitions for timeliness of data submissions are standardized throughout the region to ensure consistent data collection. CMHSP staff will be trained on these standards. | • Committee formed  
• Risk Events data reviewed and standardized definitions are developed | Quality and Operations Specialist | Target Completion Date: 3/31/2016 |
APPENDIX B

LRP QAPIP
Priorities for Performance Oversight and Improvement Activities

In the event we need 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 LRP’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 C

Lakeshore Regional Partners
QAPIP
Self-Assessment

There are three basic reasons for committees in healthcare organizations to perform periodic self-evaluations. The first is that today's health-care environment demands nothing less than excellence in healthcare. The second is that a well-constructed, self-evaluation process can help a committee improve its performance and achieve and maintain excellence in quality oversight. The third is that regulatory organizations specifically require that committees evaluate their own performance.

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

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

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

The development of the action plan and strategies for its implementation mark the end of the committee self-assessment discussion. It is then up to the committee and Quality Improvement/Provider Network Coordinator to implement the action plan.
**Instructions:** Please read each item in the left column and indicate in 1 of the 4 right columns your rating for our committee’s performance in this area (Note: in the last section, please rate only your own personal performance).

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

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<td>D.</td>
<td>All members of the committee participate in an orientation program and receive ongoing education about the work of the committee.</td>
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<td>E.</td>
<td>The frequency and duration of committee meetings are adequate to conduct the committee’s oversight responsibilities.</td>
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<td>F.</td>
<td>Our committee facilitator exercises a firm and fair hand with individual members to ensure that all have equal opportunity to participate, time is not monopolized by a few, and agenda items are dispatched after reasonable discussion.</td>
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<td>G.</td>
<td>The committee members receive the agenda and back-up materials well in advance of meetings.</td>
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<td>H.</td>
<td>Our committee members come to meetings well prepared to discuss agenda items.</td>
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<td>I.</td>
<td>The LRP maintains an up-to-date policy manual which includes specific policies covering our oversight role in quality and performance management.</td>
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### Section 5: Individual Self-Assessment

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

Lakeshore Regional Partners QAPIP
FY 2016 QI-ROAT Agenda Content Schedule (subject to change due to availability of data and scheduling)

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<td>Substance Abuse Reports</td>
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## APPENDIX E

### QI-ROAT Self-Assessment Results

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<th>Section</th>
<th>Question</th>
<th>Average of Score</th>
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| **Section 1 - Mission and Planning Oversight** | Each committee member has received a copy of our committee charge.  
Proposals brought before our committee are evaluated to ensure that they are consistent with our committee’s charge.  
Our committee monitors the programs and activities of our partners and coordinating agency to ensure they are consistent with our committee’s charge.  
We periodically review, discuss, and if necessary recommend amendment of our committee’s charge to ensure that it remains current and relevant.  
Our committee has approved a comprehensive, system-wide QAPIP and supportive policy statements.  
Our committee monitors the programs and initiatives of our organization to ensure they are consistent with the committee’s plan.  
Our committee assesses the extent to which we’ve met our goals and objectives.  
We periodically review, discuss, and if necessary amend our QAPIP to ensure it remains current and relevant.  
Our committee’s members are active and effective in representing the LRP’s behavioral healthcare quality oversight interests. | 3.20 |
| **Section 1 - Mission and Planning Oversight Total** | | **3.36** |
| **Section 2 - Quality Oversight** | Our committee approves an LRP-wide QAPIP plan  
We review and carefully discuss quality reports that are part of an LRP-wide QAPIP plan which provides comparative statistical data about our member partner’s services  
We periodically review feedback from persons our members serve and organizations or community partners that we coordinate services with (satisfaction surveys, community meetings, stakeholder groups)  
We fully understand our responsibilities and relationships with the member partners and CAs, and have effective mechanisms for communicating with them. | 3.80 |
| **Section 2 - Quality Oversight Total** | | **3.45** |
| **Section 3 - Management Oversight** | Our committee approves management performance policies for the LRP that are consistent with system policies and directives. | 3.40 |
Our committee supports and assists the LRP Chief Executive Officer to achieve the Lakeshore Regional Partner’s mission.  

<table>
<thead>
<tr>
<th>Section 3 - Management Oversight Total</th>
<th>3.40</th>
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<tbody>
<tr>
<td>Section 4 - Committee Effectiveness Total</td>
<td>3.51</td>
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### Section 4 - Committee Effectiveness

- Our committee evaluates its’ own performance and the individual performance of each committee member.  
  - QOC members understand their roles as committee members and contribute their unique expertise for the overall good of the organization and the individuals we serve.  
  - All members of the committee understand and fulfill their responsibilities and each committee member has received written descriptions of the committee’s duties.  
  - All members of the committee participate in an orientation program and receive ongoing education about the work of the committee.  
  - The frequency and duration of committee meetings are adequate to conduct the committee’s oversight responsibilities.  
  - Our committee facilitator exercises a firm and fair hand with individual members to ensure that all have equal opportunity to participate, time is not monopolized by a few, and agenda items are dispatched after reasonable discussion.  
  - The committee members receive the agenda and back-up materials well in advance of meetings.  
  - Our committee members come to meeting well prepared to discuss agenda items.  
  - The LRP maintains an up-to-date policy manual which includes specific policies covering our oversight role in quality and performance management.  

### Section 5 - Individual Self-Assessment

- Continuing Education. I participate in education opportunities outside the organization to remain current on changing trends and issues affecting our charge and responsibilities and/or I receive regular updates from individuals who attend such opportunities in order to keep myself current.  
- Demonstrated Interest. I prepare for, attend, participate and assume a fair workload at committee and committee meetings.  
- Interpersonal Relations. I deal fairly and appropriately with other committee members.  
- Relations with Management. I support the Quality Improvement Coordinator in achieving the mission of the Committee.  
- Confidentiality. I understand the confidential nature of committee deliberations and maintain privacy regarding issues and information discussed in committee and committee meetings.
Conflict of Interest. I am satisfied that no conflict-of-interest exists in my service as committee member. 3.60

Community Representation. As an LRP committee member, I strive to represent the behavioral healthcare needs of the region and share the organization’s needs and concerns with external constituencies. 3.60

<table>
<thead>
<tr>
<th>Section 5 - Individual Self-Assessment Total</th>
<th>3.57</th>
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</thead>
<tbody>
<tr>
<td>Grand Total</td>
<td>3.46</td>
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APPENDIX F

Lakeshore Regional Partners QAPIP
Annual Data Review

- **Site Review**
  In FY2015, the LRP conducted Site Reviews at each of the 5 CMHSPs. Eight specific indicators were evaluated (Admin/Managed Care Functions, Program Specific Reviews, Information Technology, Staff Training and Credentialing, Grievance and Appeal Audit, Chart Review, MMBPIS Source Document Review, Medication Verification Spot Check Review). Using 95% as a performance benchmark, a review of the summary of each of the CMHSPs yields the following:
  - Overall, each of the CMHSPs did well with their individual Site Review. Total scores ranged from 93.0% to 97.4% compliance.
  - There were specific indicators which required corrective action. Plans of correction were requested and completed. A systemic review of the findings indicates the Staff Training and Credentialing indicator was the only one with findings below 95% across multiple CMHSPs (even then that was only 2 CMHSPs total). No single systemic issue was identified, however, the LRP will continue to monitor in Annual Site Reviews for additional efficiencies.

  See the completed LRP **CMHSP Site Review Report** (dated 10/10/2015) for details.

- **MMBPIS**
  Overall, the CMHSPs are meeting the performance standards for this indicator over the last four quarters of data reviewed with a couple of exceptions:
  - During the first quarter of FY2015, inpatient screenings for children (disposition within 3 hours) was not met as a Region (standard is 95% and the Regional score was 94.5%). Subsequent quarter’s reviewed show the standard was met. We will continue to monitor this quarterly.
  - During the last quarter of FY2014, there was a systemic issue identified. That issue was the percentage of new persons during the quarter starting any needed on-going service within 14 calendar days of a non-emergent face-to-face assessment with a professional. A drill down of this data reveals that the primary issue surrounded individuals seeking SUD services through the Methadone Clinic in Kent County.
  - During the first quarter of FY2015, the percentage of readmission of adults during the quarter to an inpatient psychiatric unit within 30 days of discharge did not meet the standard (standard is less than 15% and the overall score was 15.3%). Subsequent quarter’s reviewed show the standard was met. We will continue to monitor this quarterly.

  See the completed **LRP CMHSP MMBPIS Report** (dated 10/21/2015) for details.
• **Medicaid Verification**
  A review of data from January 2014 through June 2015 reveals that two of the five Member Boards had a lower percentage on claims verified due to claims being submitted for services which are not identified in the individual’s person centered plan. Corrective actions plans are in process, and all claims requiring payback have been, or will be corrected. Improvement has been made over time, but this will be an emphasis during FY2016.

  FY2016, the LRP is in process of moving this review from a delegated function to the LRP for completion. This is due to contractual changes in the LRP’s contract with MDHHS. It has been determined the methods used to score for compliance were not consistently used across the Region. With the LRP assuming the responsibly for completing this indicator, a standard process will be consistently implemented. After the process has been developed, the LRP will initiate evaluations particularly with CMHSPs who have shown historical issues with this indicator. As stated above, the most frequent systemic issue relates to services provided that were not in the plan of service.

  See the completed Medicaid Claims Verification Monitoring Report for details.

• **Critical Incident Report**
  Critical Incident Events are gathered on a monthly basis. 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. The data reviewed indicates rates consistent with data from the previous year. 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.


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

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

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

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

- **BTRC Data**
  Behavior Treatment Review Committee data is submitted by the CMHSPs on a quarterly basis, gathered by the LRP and submitted to MDHHS. One QAPIP goal for FY2016 is to standardize the data reporting for the Region.

- **Timeliness**
  With only a few exceptions, the LRP was successful in submitting all reports in a timely manner. It is our goal to more formally track this indicator in FY2016 and this will be a QAPIP goal in FY2016.

- **Data Completeness**
  CMHSP’s report Quality Improvement/Demographic data files to MDHHS monthly. This file contains 52 data elements, many of which have a 95% data completeness standard. A few examples of some of the data elements are Medicaid Id, Employment Status, Disability Designation, Minimum Wage, and Health Conditions. LRP QI Staff have been monitoring the QI/Demographic data reports for completeness on a quarterly basis. In reviewing the data it is noted that submitting complete data on each individual served is a struggle for 4 out of 5 of the CMHSP’s. There are some data elements such as Date of Birth, Gender, Race, and Disability Designation that all five CMHSP’s are at 98% - 100%, and have been
for the whole six quarters. There are also some, such as Medicaid ID and Total Annual Income, where there has been progress in data completion has been made over the six quarters. LRP QI staff note that three of the five CMHSP’s struggle most with the Health Condition Indicators and the DD Proxy Measures (Note: DD Proxy Measures are 11 data elements reported only on individuals with a developmental disability on their abilities, assistance needed and community support). The majority of scores for these two areas were over 90%, however there are some in the 70% and 80% range.

In October 2015, the Quality Improvement / Demographic data file was replaced with the BH Teds file. The BH Teds file is required to be 100% complete to be accepted by MDHHS so there is no issue or concern for the completeness of this file. For FY 2016, LRP QI staff will develop a process to monitor and report the accuracy of the data reported in the BH Teds file. MDHHS still requires the submission of a small demographic file which contains a few demographic data elements and the DD Proxy Measures for Individuals with a Developmental Disability. QI Staff will continue to monitor the completeness of the reported DD Proxy Measures. A Plan of Correction will be required from CMHSP’s not meeting the 95% completeness standard for the DD Proxy Measures.

See the completed LRP Demographic File Monitoring Report for details.

- **HSAG Overview**

  - **Performance Improvement Project (PIP)**
    The current Lakeshore Regional Partners PIP for FY 2014 – FY 2016 is titled, “Increasing the Number of Medicaid Eligible Adults Who Filled at Least One Prescription for a Second-Generation Antipsychotic Medication and Received an HbA1c, Lipid Panel or Fasting Panel Glucose.” This PIP, per contract with MDHHS, requires validation from HSAG annually. Lakeshore Regional Partners attained 100% validation for this PIP for FY2014 and FY2015. PIP Baseline data was collected and submitted to HSAG for FY2015, this data will be compared with the FY2016 data. For FY2016 validation to occur, the LRP must show a statistically significant increase in the number of Medicaid Eligible adults age 18 – 64 with at least one Medicaid LRP PIHP service who filled at least one prescription for a Second-generation Antipsychotic medication and received lab work for an HbA1c, Lipid Panel or FPG during the measurement period. Baseline data shows that for FY 2015, 49.5% of individuals meeting the criteria for the PIP had one of the labs completed. Lakeshore Regional Partners goal is to increase the number of individuals prescribed a second generation antipsychotic medication who receive lab work for a diabetic screening to at least 70% for FY2016.

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

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

i. Work closely with the State to investigate the reason there was an increase in refection files for encounters.

ii. Develop a summary report that includes information on all CMHSP’s performance.

iii. Investigate the reasons MMBPIS Indicators #1 and #10 did not meet MDHHS standards for FY15 Quarter 1 and explore options for rate improvement.

LRP QI Staff completed a plan of correction for the three HSAG PMV Report recommendations. This plan of correction will be implemented and completed during FY2016.

- **HSAG Compliance Monitoring Report**
  Lakeshore Regional Partners was reviewed by HSAG Compliance Staff in July 2015. MDHHS has contracted with HSAG, as required by the Balanced Budget Act, to conduct an external quality review to ensure the PIHP’s compliance with Medicaid managed care standards and the state contract. This quality review focuses on evaluating quality outcomes and the timeliness of, and access to care and services proved to Medicaid beneficiaries. The Compliance review has numerous regulations/requirements within 15 Standards. Lakeshore Regional Partners received an overall score of 95%. Deficiencies were found in each of the following Standards.

  i. Quality Assessment and Performance Improvement Program Plan and Structure
  
  ii. Performance Measurement and Improvement
  
  iii. Utilization Management
  
  iv. Subcontracts and Delegation
  
  v. Provider Network
  
  vi. Credentialing
  
  vii. Access And Availability
  
  viii. Appeals
  
  ix. Disclosure of Ownership, Control, and Criminal Convictions

Lakeshore Regional Partners Compliance Report indicated there were 22 regulations / requirements with deficiencies. The majority of the standards found to have deficiencies were scored as “partially met”. (9 /22) Five regulations / requirements received a “substantially met” and four received a “not met”. Standard 15: Disclosure of Ownership, Control, and Criminal Convictions received most of the “not met” scores. Standard 15 is new for FY2015, and per HSAG’s verbal report during the site review most of the PIHP’s across the state did not do well in this area. LRP QI staff have completed a Plan of Correction for all citations and this POC will be implemented and completed during FY2016.