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DETROIT WAYNE COUNTY MENTAL HEALTH AUTHORITY

FY 2019-2021

QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PROGRAM

(QAPIP)

Presented to QISC on 1/23/19 and Approved

Presented to PCC on 3/13/19 and Approved

Presented to the Full Board on 3/20/19 and Approved

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Detroit Wayne Mental Health Authority (DWMHA)

Quality Improvement Plan

October 1, 2018 – September 30, 2021

SECTION 1: Purpose

The Detroit Wayne Mental Health Authority (DWMHA) is the Pre-Paid Inpatient Health Plan (PIHP) and Community Mental Health Service Provider (CMHSP) for Detroit and Wayne County. It is the largest community mental health service provider in the State of Michigan. The Quality Assessment and Performance Improvement Program (QAPIP) provides assurance that the DWMHA achieves in alignment with healthcare reform. The QAPIP demonstrates to members, advocates, community organizations, health care providers and State policy makers that it has a distinct competency as a high-performing, member-focused, quality-focused, and evidence-based efficient provider of mental health and substance use disorder services and is an essential partner in helping healthcare reform to succeed. DWMHA focus for FY 2018-2019 is to move forward with true system transformation, DWMHA has transitioned from a "funder" of care into a "manager" of care that includes managing the Provider Network and the Provider Reimbursement system. The QAPIP is the vehicle for improving the quality of care to members and improving methods of service delivery to ensure desired member health status, quality of life and member satisfaction.

Introduction

The DWMHA's QAPIP details the structure, scope, activities and functions of the DWMHA's overall Quality Improvement Plan (QIP). The QAPIP description will contain core functions of the DWMHA Board approved Strategic Plan, which contains (6) pillars and (7) focus areas. These functions will be conducted by the DWMHA and its network of contracted service providers, it is the responsibility of the DWMHA to ensure that the QAPIP meets applicable Federal and State laws, contractual requirements and regulatory standards.

The term of the QAPIP begins October 1, 2018 and ends September 30, 2021. Upon expiration of the term, the QAPIP shall remain in effect until the DWMHA's Board of Directors approves a new QAPIP. The QAPIP incorporates by reference, any and all policies and procedures necessary to operate as a Prepaid Inpatient Health Plan and Community Mental Health Services Program. The DWMHA's Board of Directors hereby approves all current and subsequent policies and procedures through the approval of the QAPIP.

Mission, Vision and Values

Mission

We are a safety net organization that provides access to a full array of services and supports to empower persons within the Detroit Wayne County behavioral health system.

Vision

To be recognized as a national leader that improves the behavioral and overall health status of the people in our community.

Values

- We are a person centered, family and community focused organization.
- We are an outcome, data driven and evidence-based organization.
- We respect the dignity and diversity of individuals, providers, staff and communities.
- We are culturally sensitive and competent.
- We are fiscally responsible and accountable with the highest standards of integrity.
- We achieve our mission and vision through partnerships and collaboration

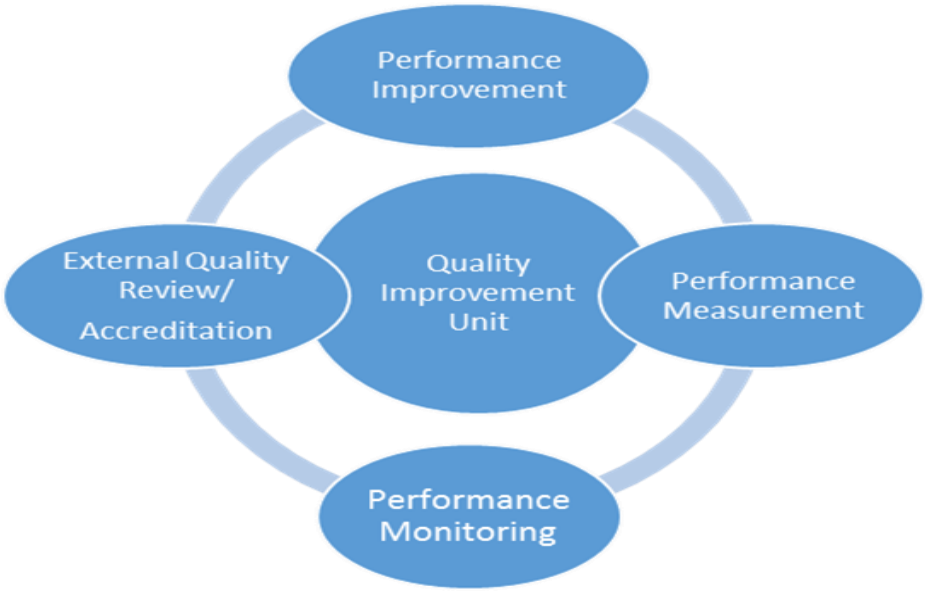
Scope of the QAPIP

The scope of the quality improvement activity includes the DWMHA contracted service providers. It identifies the important processes and aspects of care, both clinical and non-clinical, required to ensure quality supports and services for persons in the system. The DWMHA requires all contracted service providers to have a mental health and substance use disorder quality improvement plan relevant to the services they provide. The DWMHA assures that all demographic groups, care settings and types of services are included in the scope of the QAPIP by including members, advocates, contracted service providers and community groups in the quality improvement process using a Continuous Quality Improvement (CQI) perspective.

Quality Improvement Program

The Centers for Medicare and Medicaid Services (CMS) Medicaid Bureau mandates that Quality Improvement programs be a part of Pre-Paid Inpatient Health Plans (PIHP). The DWMHA has several contracts with the Michigan Department of Health and Human Services (MDHHS) for the provision of Managed Specialty Supports and Services (Medicaid), General Fund and waiver services for mental health and substance abuse and must comply with Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY17 Attachment P7.9.1 and CMHSP Managed Mental Health Supports and Services Contract FY17: Attachment C6.8.1.1 “Quality Assessment

and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans" and the "Department of Community Health Michigan Mission Based Performance Indicators", the Balanced Budget Act, External Quality Review, and the Application for Renewal and Recommitment.



Quality Assessment Performance Improvement Program Description (QAPIP)

The following Quality Improvement Plan will implement the DWMHA Board approved Strategic Plan using the (6) pillars and (7) focus areas which serve as the foundation of the commitment of the DWMHA to continuously improve the quality of the treatment, supports and services it provides. DWMHA focus is to establish a provider network that recognizes and treats holistic needs of individuals. The approach is to provide quality services that are safe, effective, person-centered, timely, equitable, and recovery-oriented.

Quality Improvement Program Governance

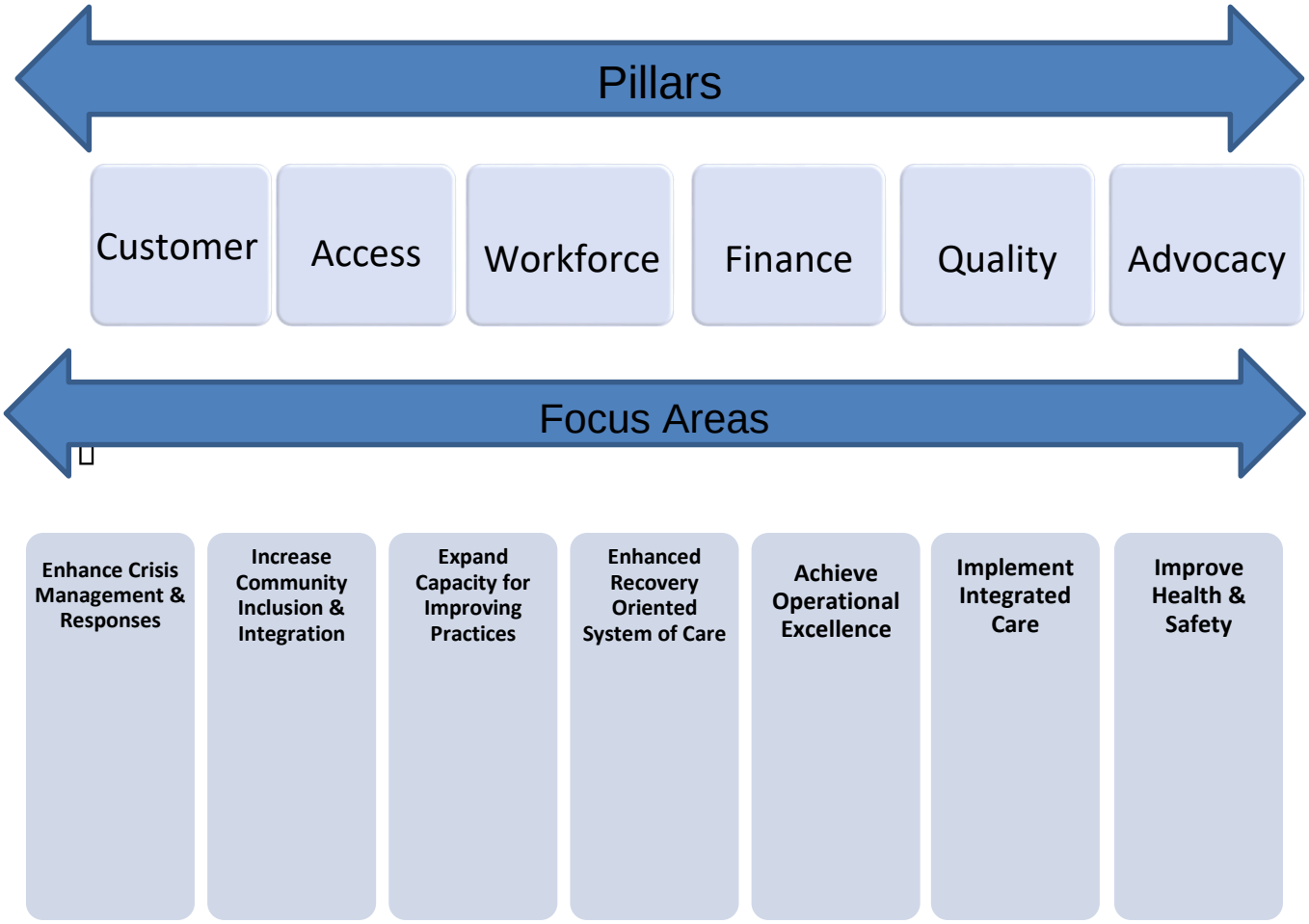
The DWMHA Board's Strategic Plan is an overarching process that working toward common goals, establish agreement around intended outcomes/results, and assess and adjust the organization's direction in response to a changing environment. The Quality Improvement Program provides a systematic approach to assessing services and improving them on a priority basis. The DWMHA's approach to quality improvement is based on the following six pillars with support from seven focus areas under each pillar in the DWMHA's Board approved Strategic Plan.

Strategic Plan Pillars by Definition:

- Customer: Services should be designed to meet the needs and expectations of members. An important measure of quality is the extent to which customer needs and expectations are met.
- Access: Provide affordability of the services provided to the customer. To ensure availability and accessibility of the services.
- Workforce: Provide staff development activities while empowering staff in the competitive and market-driven workforce.
- Finance: Ensure the Administrative Cost as a portion of the Total Cost is low and reasonable.
- Quality: Deliver a robust decision support system as DWMHA will be recognized as the Behavioral Health Subject Matter expert through the use of standardized treatment protocols and guidelines.
- Advocacy: Establish leadership in shaping public policy for Behavioral Health in Michigan that fosters regional cooperation and informs and engages local and state resources as well as stakeholders.

Strategic Plan Focus Areas by Definition:

- Increase community inclusion and integration
- Enhance crisis management and response
- Expand capacity for improving practices
- Enhanced recovery oriented system of care
- Achieve operational excellence
- Implement integrated care
- Improve health and safety



Linguistic and Cultural Competence:

DWMHA is committed to exploring and incorporating concepts that ensure a system designed to provide holistic care and services that are culturally competent and sensitive. We will provide culturally sensitive care services to all ethnic groups regardless of ethnocentric differences. DWMHA includes the following principles into its quality improvement program:

- The importance of culture
- The assessment of cross-cultural relations
- Expansion of cultural knowledge, and
- The adaptation of services to meet the specific needs of our members.

DWMHA and its Provider Network shall demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all individuals receiving mental health services. Such commitment includes acceptance and respect for the cultural values, beliefs and practices of the community, as well as the ability to apply an understanding of the relationship of language and culture to the delivery of supports and services.

Competence includes a general awareness of the cultural diversity of the service area including race, culture, religious beliefs, regional influences in addition to the more typical social factors such as gender, gender identification, sexual orientation, marital status, education, employment and economic factors, etc.

System Transformation into Holistic Care

DWMHA has begun transforming its role in the behavioral health system from “funder of care’ to “manager of care”. This system transformation will ensure more efficient and effective, person centered services by removing administrative layers that have existed. In addition, the new approach allows for more comprehensive care that positively impacts the members we serve. DWMHA’s Systems Transformation process will include utilizing a Holistic Care approach which will continue to provide behavioral and physical health interventions and also focus on social, economic, spiritual" and housing services. These interventions will improve and expand core mental health and substance use services within Wayne County assuring that a continuum of care is appropriately available through the monitoring of Needs Assessment, GEO Access mapping, and provider trainings.

Together with our stakeholders, including enrollees/members, family, advocates, peer support specialists, peer mentors, recovery coaches, youth advocates, parent partners, and contracted providers, DWMHA is committed to engaging in systems transformation process aimed at achieving this vision. Our goal is to achieve these outcomes in alignment with our Mission, Vision and Values. Utilizing a Holistic Care approach will allow for enhancement of Member and Provider experiences while ensuring consistent quality improvement outcomes.

Within the framework of efficient quality improvement and effective outcomes the objectives of the QAPIP include opportunities to:

- Encompass the six Pillars and Focus Areas in the Board’s Strategic Plan;
- Provide an objective and systematic approach to the ongoing monitoring and continuous improvement of processes based on the collection, review and analysis of data relative to indicators of importance to DWMHA functions,
- Ensure accountability,
- Assure an objective, systematic and fair method for monitoring performance of network providers against contract obligations and service outcomes,
- Support a system in which consumers and advocates have input into the evaluation of the system of care.

Philosophical Framework:

The framework for the DWMHA QAPIP quality improvement process is to:

- **F**ind a Process to Improve
- **O**rganize to Improve
- **C**larify Current Knowledge of the Process
- **U**ncover Causes of Process Variation or Poor Quality
- **S**tate Plan Do Check Act (PDCA)

- **P**lan the Improvement Process
- **D**o the Improvement, Data Collection, and Analysis
- **C**heck the Results and Lessons Learned
- **A**ct by Adopting, Adjusting, or Abandoning the Change

To ensure compliance of the QAPIP methodology, the use of quality improvement process management/improvement tools and techniques will consistently be included using the following four steps:

- Identify - Determine what to improve
- Analyze - Understand the problem
- Develop - Hypothesize what changes will improve the problem
- Test/Improvement - Test the hypothesized solution to see if it yields improvement. Based on the results, decide whether to abandon, modify, or implement the solution.

Key cultural components also ensure the success of improvement efforts include: leadership involvement, data informed practice, use of statistical tools, prevention over correction, and continuous quality improvement. Strong leadership, direction and support of quality improvement activities by the governing body and CEO are key to performance improvement and audit readiness. This involvement of organizational leadership assures that quality improvement initiatives are consistent with the DWMHA mission, vision and values and/or strategic plan.

Successful QI processes create feedback loops, using data to inform practice and measure results. Fact- based decisions are likely to be correct decisions, for continuous improvement of care, tools and methods needed to foster knowledge and understanding. Processes must be continually reviewed and improved. Small incremental changes do make an impact, and providers can almost always find an opportunity to make things better.

Continuous Quality Improvement Activities

Quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by the leadership, is understood, accepted and utilized throughout the system, as a result of continuous education and involvement of staff at all levels in performance improvement. Quality Improvement involves two primary activities:

- Measuring and assessing the performance of processes and services through the collection and analysis of data.
- Conducting quality improvement initiatives and taking action where indicated, including the redesign of processes, design of new services, and/or improvement of existing services.

MDHHS requires that DWMHA provide a written description of the QAPIP plan for approval by the Board of Directors. The written plan is reviewed for the effectiveness of the methods used to implement, monitor and evaluate the quality improvement processes and for any necessary revisions and adjustments on a monthly basis. The review of the written plan includes members, providers, Quality Improvement Steering Committee (QISC), Program Compliance Committee (PCC) of the DWMHA's Board of Directors, and other stakeholders.

At a minimum, the plan must specify the following elements below:

A. An adequate organizational structure that allows for clear and appropriate administration and evaluation of the QAPIP.

B. Responsibilities of the governing body for monitoring, evaluation and making improvements to care.

C. Objectives and timelines for implementation and achievement.

D. Role of recipients of services and other stakeholders in the QAPIP plan.

E. Mechanisms or procedures used for adopting and communicating process and outcome improvements.

F. Description of a designated senior official responsible for QAPIP implementation.

G. Performance measures to address access, availability, quality, efficiency and outcome of services, using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data.

H. Performance improvement projects that address clinical and non-clinical aspects of care that are directed as the state and the DWMHA established aspects of care. Clinical areas include high volume services, high-risk services and continuity and coordination of care. Non-clinical areas include grievances and appeals, complaints and access to and availability of services.

I. Process from the review and follow-up of Critical/ Sentinel Events and events that place members at risk of harm.

J. Periodic quantitative (i.e., survey) and qualitative (i.e., focus group) assessments of member experiences with services. These assessments must address issues of quality, availability and accessibility of care.

K. Process for the incorporation of members receiving services into the review and analysis of the information obtained from quantitative and qualitative reviews.

L. Written procedures to determine whether physicians and other licensed health care professionals are qualified to perform their services.

M. Written procedures to ensure non-licensed providers of care or support are qualified to perform their jobs.

N. The organization's process for the initial credentialing and re-credentialing of providers.

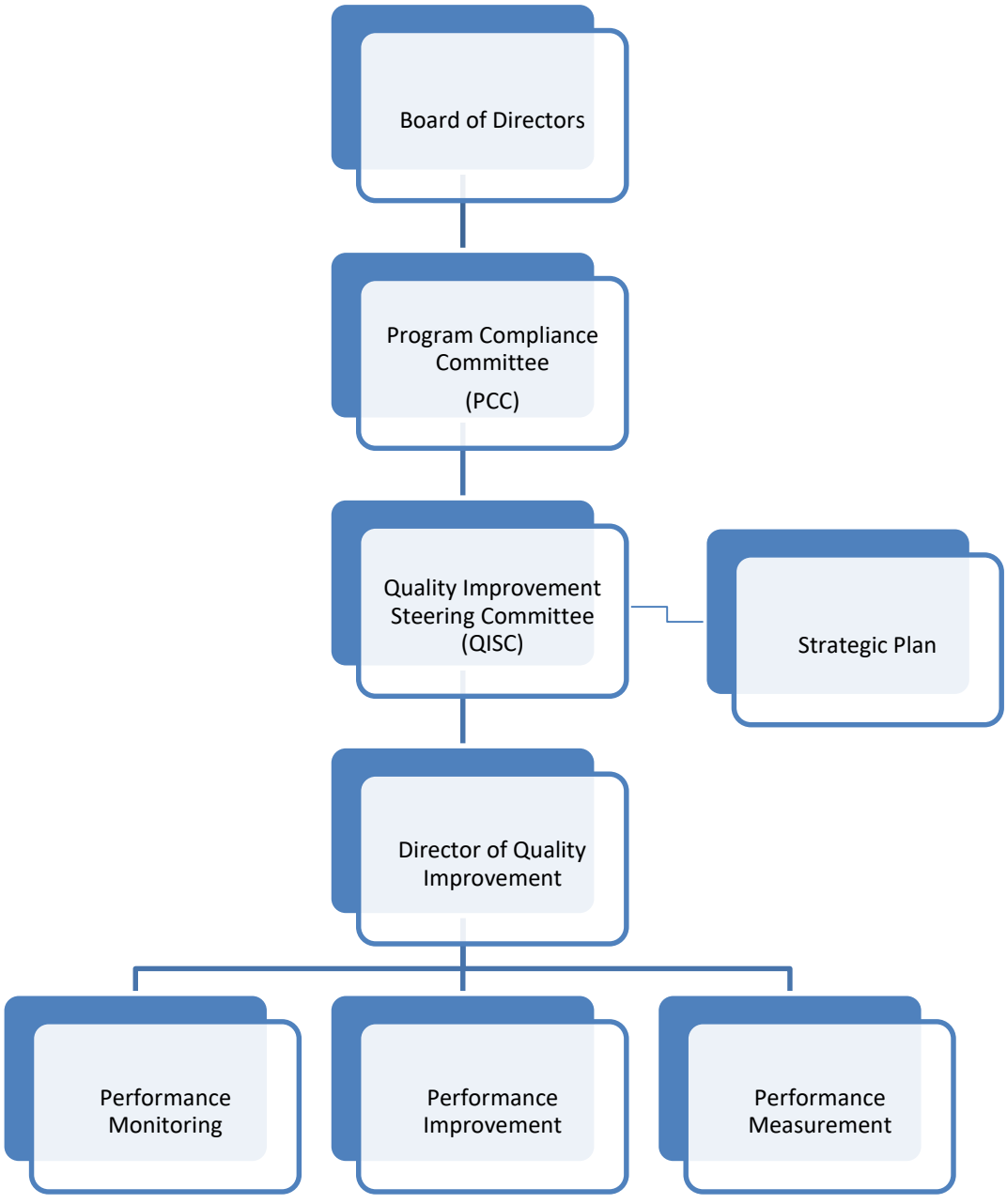
O. Identification of staff training needs and provision of in-service training, continuing education and staff development activities.

P. The DWMHA’s process to verify whether services reimbursed by Medicaid were actually provided to enrollees by affiliates, providers and subcontractors.

The Quality Improvement Unit reviews the response received regarding the effectiveness of the methods proposed or used to implement, monitor and evaluate the quality improvement processes. The results and recommendations are incorporated in the QAPIP for the next fiscal year cycle.

SECTION 2: Leadership and Structure

Leadership. The key to the success of the Continuous Quality Improvement (CQI) process is leadership. Consistent with a total quality Improvement philosophy, the following is the structure of the organization in which the Quality Improvement Unit resides.



Descriptive Elements of the QAPIP

GOVERNING BODY

The QAPIP must be accountable to the Governing Body. Responsibilities of the Governing Body for monitoring, evaluating and making improvements to care include the following:

1. The Governing Body formally reviews on a periodic basis, but no less than annually, a written report on the operation of the QAPIP, including studies undertaken, results, unit and committee activities, subsequent actions and aggregate data on utilization and quality of services rendered to assess the QAPIP's effectiveness.
2. Documentation in board meeting minutes that there is approval of the overall QAPIP and review of periodic reports.
3. Approval of policies and procedures has been delegated to the Chief Operating Officer; however, approval of the QAPIP is retained by the DWMHA Board of Directors.

Director of Quality Improvement

The Director of Quality Improvement has the overall responsibility for implementation of the QAPIP. Under the Director of Quality Improvement's leadership, an integrated interdivisional approach to improving DWMHA services and systems is undertaken. The Director of Quality Improvement is also responsible for the following:

1. Assisting staff in understanding and participating in the Continuous Quality Improvement (CQI) process.
2. Establishing regular communication throughout the DWMHA network about CQI issues, problems, status and progress.
3. Assisting the PCC Committee and the Board of Director's understanding of the CQI process.
4. Developing and implementing a data collection system that yields real-time meaningful data for needs assessment, program planning, outcome evaluations and operationalizing quality improvement opportunities.
5. Pursuing opportunities for partnership between the DWMHA and other public and private entities involved in quality improvement efforts.
6. Participating on quality improvement teams and work groups at DWMHA and state levels.
7. Assisting in the Strategic Planning process
8. Developing a DWMHA Audit Ready philosophy

SECTION 3:

Quality Improvement (QI) Unit

The Quality Improvement Unit (QIU) is the department responsible for performing quality improvement functions and assuring that program improvements are occurring within the Pre-Paid Inpatient Health Program (PIHP) and the Community Mental Health Services Program (CMHSP). The QI Unit puts the QAPIP into practice and has direct and/or oversight responsibility for monitoring the DWMHA's quality improvement program.

QI Unit operates in partnership with stakeholders, members, advocates, contracted providers, and DWMHA staff.

The QI Unit achieves the scope of continuous quality improvement through three functions: performance monitoring, performance measurement and performance improvement.

Performance Improvement

Performance improvement is a formal approach to the analysis of performance and systematic efforts to prevent, reduce or eliminate waste, and problems that will lead to improvement in service quality. As the steward of the system, the Performance Improvement component ensures guidance is provided to the system through the provisions of policy directives. This approach is system-wide, and addresses the DWMHA and its provider network. All service providers are required to have certain policies in place which mirror DWMHA policies. The policies address those areas that are contractually mandated in the contract with MDHHS, and describes the process for ensuring compliance with those policies. The policies are disseminated to DWMHA providers and are located on DWMHA's website.

To meet the regulatory requirements for MDHHS and NCQA requirements, the DWMHA conducts all Performance Improvement Projects (PIPs) that are approved through the Improving Practices Leadership Team (IPLT) and the Quality Improvement Steering Committee (QISC) during the waiver renewal period. The purpose of the PIPs is to provide and promote continuous quality improvement through on-going measurement and interventions that are clinical and/or non-clinical services with beneficial effect on health outcomes and member satisfaction. The DWMHA requires its provider network to participate in the PIPs related to their respective programs and services. In addition, each of the providers in the network are expected to conduct PIPs based on their own self-assessment of need, risk, frequency, performance, etc. includes State mandated performance improvement activity as well as, activities identified by the Quality Improvement Steering Committee (QISC).

The DWMHA must have at least two affiliation-wide Performance Improvement Projects (PIPs) during the waiver renewal period. These are conducted to promote continuous quality improvement through on-going measurement, intervention as well as verifiable and sustained improvement in significant aspects of clinical care and/or non-clinical services. These projects are expected to have a beneficial effect on health outcomes and member satisfaction.

The MDHHS Quality Improvement Council identifies the project topic on at least one of the PIPs and the DWMHA identifies at least one project topic. The DWMHA PIP topic is to address performance issues that have been identified through the External Quality Review (EQR), the Medicaid site reviews, the Needs Assessment, the performance indicator system, the performance monitoring and measurement system.

Once the performance of *a* selected process has been measured, assessed and analyzed, the information gathered by the above performance indicator(s) is used to identify the DWMHA defined continuous quality improvement initiative to be undertaken. The decision to undertake the initiative is based upon DWMHA priorities. The purpose of an initiative is to improve the performance of existing services or to design new ones. The model utilized by the DWMHA is called Focus-Plan-Do-Check-Act (PDCA).

The Substance Abuse Providers and Contracted Providers are expected to participate in the DWMHA PIPs related to their programs and services. They are also expected to conduct PIPs based on their own self-assessment of need, risk, frequency, performance, etc.

Oversight of the quality improvement infrastructure is achieved through collaboration with members, advocates, providers, the DWMHA Chief Medical Officer (CMO), and other stakeholders. Planned, systematic activities are implemented so that quality requirements for community mental health services are fulfilled by the DWMHA and contracted providers.

In partnership with stakeholders Quality Improvement activities include:

- Assessment of needs, quality of services, accessibility of care, availability of care, outcomes of services provided and beneficiary experiences with services
- Evaluation of systems, programs and services
- Collect performance data utilizing effective quantitative metrics that are specific, measurable, actionable, relevant and timely for Michigan Mission Based Performance Indicator System Version 6.0, MDHHS and DWMHA Performance Improvement Projects, QAPIP Status/Outcomes, Satisfaction Surveys (Member and Provider), Standardized HCPCS Code Utilization, Medicaid and Other Claim Verification, MDHHS and DWMHA Needs Assessments, and Network Policies
- Identification of positive and negative process trends

- Analysis of causes of positive and negative statistical variation and outliers
- Identification of opportunities for improvement
- Determination of goals and objectives
- Decision making and planning
- Stakeholder education/information sharing
- information and technical assistance regarding the quality improvement issues, trends, techniques and proposed outcomes
- Implementation of performance improvement activities
- Measure and monitor progress toward goal achievement
- Evaluate outcomes and modify performance improvement process as needed
- Implementation of standardized performance improvement activities
- Strategic and annual planning

Some of the tools and techniques used in the continuous quality improvement process include Problem Solving Methodology, Process Mapping, Force Field Analysis, Cause and Effect Diagrams, Brainstorming, Pareto Analysis, Control Charts, Check Sheets, Bar Charts, Scatter Diagrams, Matrix Analysis and Tally Charts.

Quality Assurance and Improvement functions include informing practitioners, providers, members, and the Governing body of assessment results, and facilitates a process of evaluating the effectiveness of the assessments and outlining systematic action steps to follow-up on findings.

The Leaders support QI activities through the planned coordination and communication of the results of measurement activities related to QI initiatives and overall efforts to continually improve the quality of care provided. This sharing of QI data and information is an important leadership function. Leaders, through a planned and shared communication approach, ensure the Board of Directors, staff, recipients and family members have knowledge of and input into ongoing QI initiatives as a means of continually improving performance.

This planned communication may take place through the following methods:

- Story boards and/or posters displayed in common areas
- Recipients participating in QI Committee reporting back to recipient groups
- Sharing of the annual QI Plan evaluation
- Newsletters and or handouts
- Dashboards
- DWMHA website

Performance Monitoring

The continuous monitoring of the DWMHA provider network includes any affiliates or subcontractors to which it has delegated managed care functions. The standards used to assess contractors are the applicable sections of the Social Security Act, the Code of Federal Regulations (CFR), the Center for Medicare and Medicaid (CMS), MDHHS Operations Manuals, Michigan's Medicaid State Plan, and the Michigan Medicaid Provider Manual.

In an ever-changing economy, quality services and supports that result in positive outcomes for persons that receive services in a cost-effective manner are crucial. DWMHA continues to move toward a system that ensures accountability and transparency relative to service quality and cost. As a result, the DWMHA QI Unit will continue to develop, train and implement a standardized system in which to measure performance and outcomes. These measurements will ensure accountability and transparency relative to the quality of services and cost. The DWMHA's self-monitoring/self-regulating plan is a component of the CQI process. This process is designed to provide an organized documented process for assuring that eligible Detroit and Wayne County residents are receiving quality services for members with Serious Mental Illness, Severe Emotional Disturbance, Substance Use Disorders, Developmental Disabilities, and Co-Occurring Disorders that are both medically necessary and appropriate, conform to accepted standards of care, and achieve the member desired outcomes.
The DWMHA has adopted a performance monitoring process to support a CQI process in an on-going effort to improve services through consistent evaluation, resulting in process/procedure/program refinements by on-going monitoring improvements as seen in Figure 1.

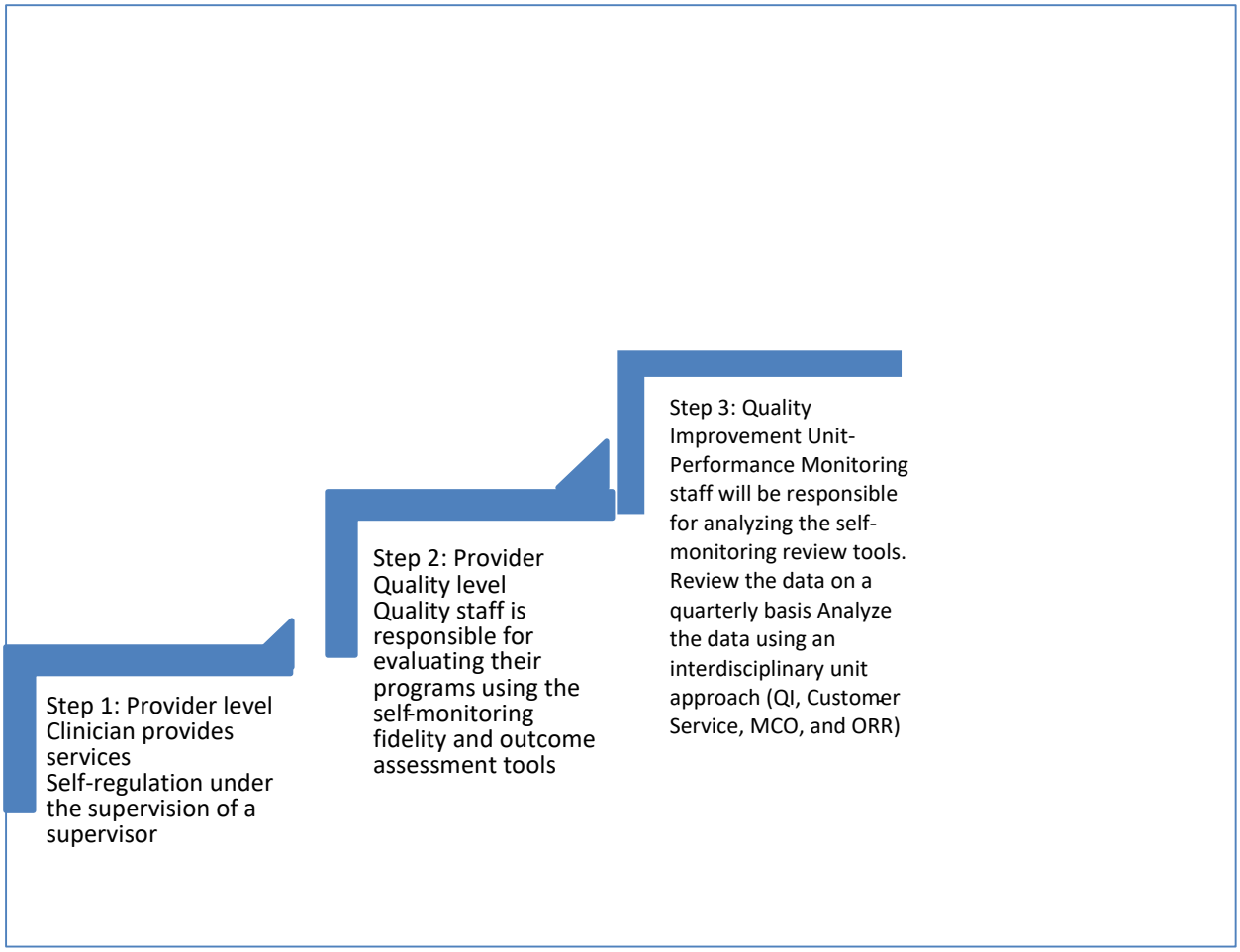
Figure 1.

The Performance Monitoring Plan is geared to improve quality and measure our performance in the delivery of service and compliance with required standards. This plan requires the involvement, skills, expertise and input from Contract Providers Direct and DWMHA staff. Requiring self-regulation and monitoring by all partners (DWMHA, Contracted Providers, practitioner and members).

As part of the monitoring process, DWMHA developed multiple levels using a standardized self-monitoring/self-regulating approach. This multilevel monitoring approach begins at the service provider level and cascades up to the DWMHA's Quality Improvement Team. The "Monitoring Process" standardized tools assist in the documentation to ensure that:

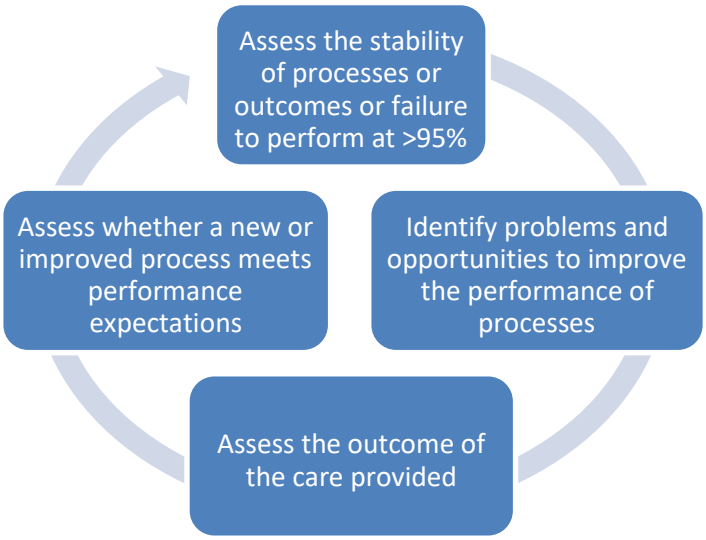
- Actions and/or process requirements are not open to different interpretations;
- The process is made easier to understand;
- Non-value added steps are eliminated;
- Effectiveness and efficiency is increased;
- The process can be benchmarked to determine if it is excellent or to set new performance goals;
- The DWMHA and Contracted Provider staff can collect evidence relying on process conformity to increase validity and reliability in findings.

Process Steps of Performance Monitoring Pathway (defined by QI)

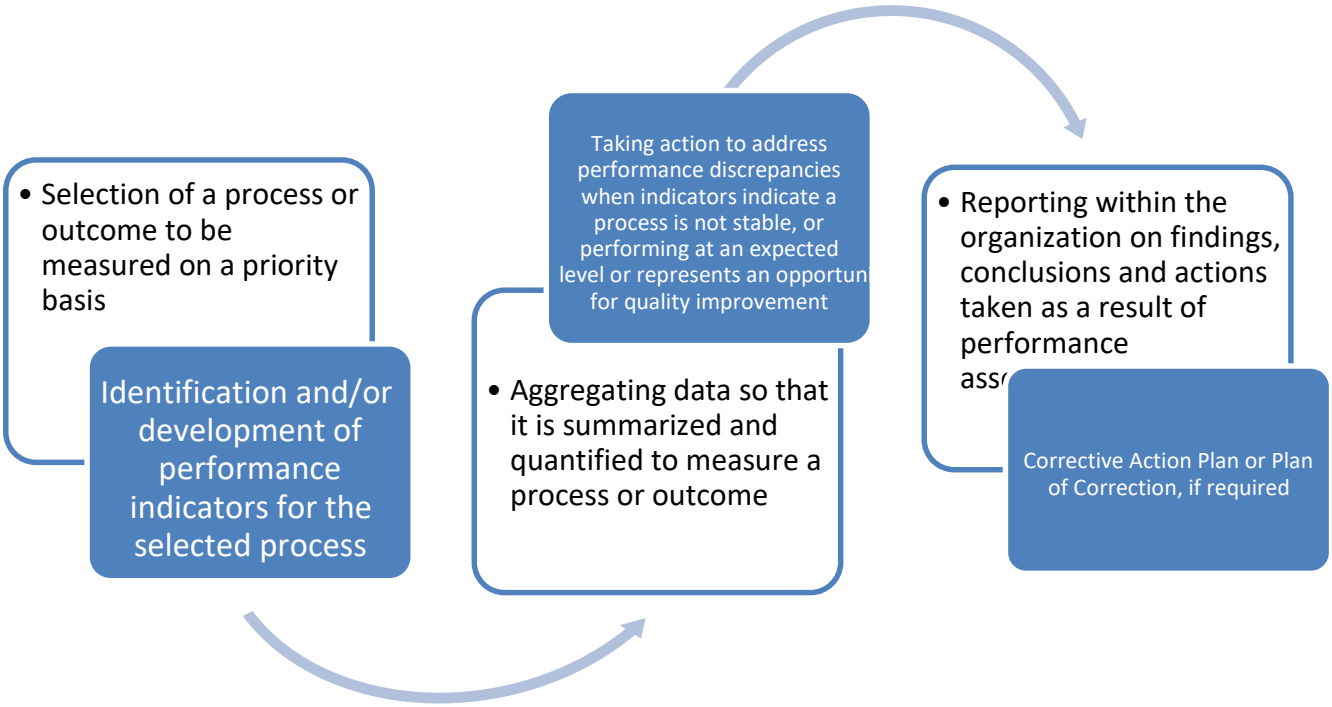


Performance Measurement

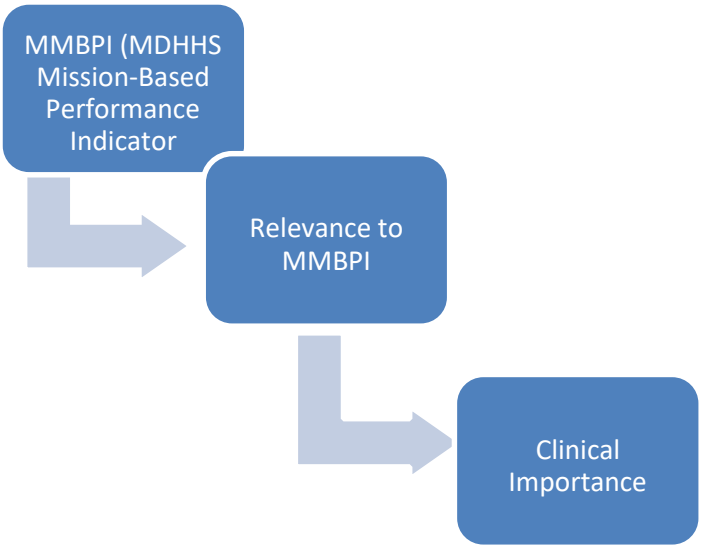
Performance measurement is a critical component of the PDSA cycle. Performance Measurement is the process of regularly assessing the data results produced by a program. The ***purpose*** of measurement and assessment is to:



Measurement and assessment ***involves***:

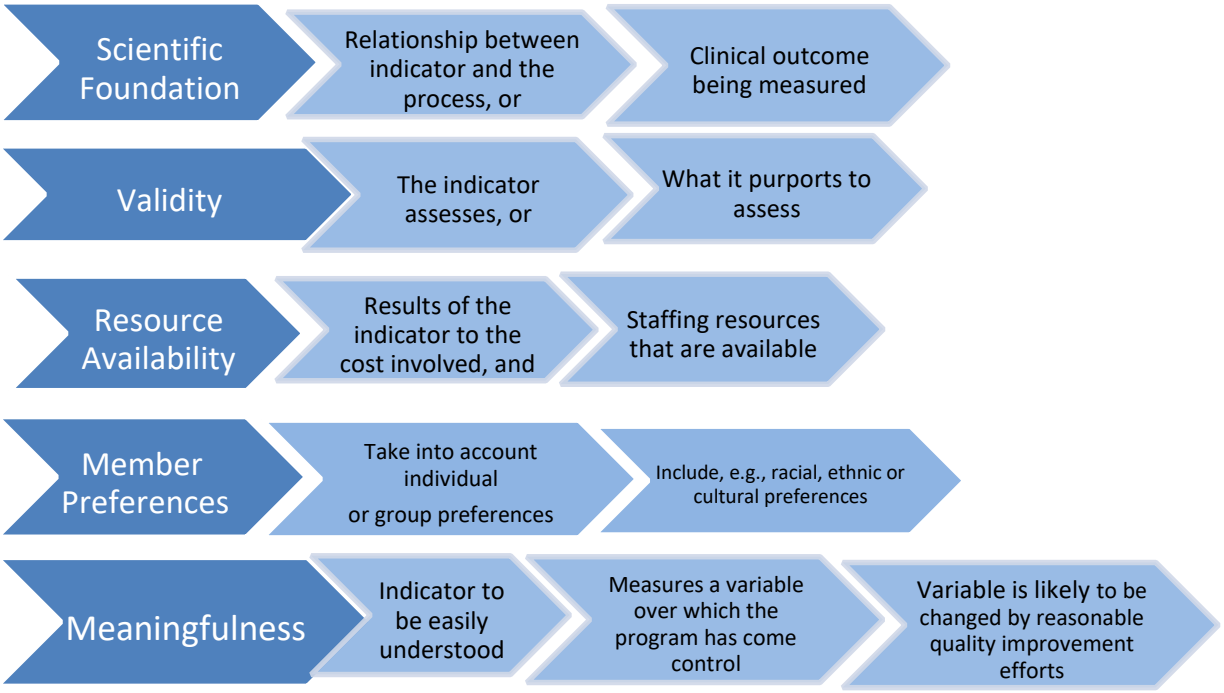


Selection of a Performance Indicator



Characteristics of a Performance Indicator

Factors to consider in determining which indicator to use include:



The Performance Indicators Selected for the DWMHA'S Quality Improvement Plan FY 19-21 from the Strategic Plan

For purposes of this plan, an indicator(s) comprises of five key elements: name, definition, data to be collected, the frequency of analysis or assessment, and preliminary ideas for improvement. The following nine performance indicators will be the focus using the Board approved Strategic Plan, Pillars and Focus Areas.

Measure of Service	
Name	***Michigan Mission Base Performance Indicators (MMBPI)***
Definition	*This includes the indicators found in the MDHHS Code Book***.**
Data Collection	*The data is collected through MH-WIN, and the remainder is submitted to Quality by the Contracted Providers.*
Assessment Frequency	*The Quality Improvement Committee will assess information associated with the indicator on a Quarterly basis.*
Measure of Service	
Name	***Service Denials***
Definition	*Any service denial made by the DWMHA Centralized Access Center, or the Contracted Service Provider (clinically responsible).*
Data Collection	*Primarily collected through MHWIN*
Assessment Frequency	*The Quality Improvement Committee will assess information associated with the indicator on a Quarterly basis.*
Measure of Service	
Name	***Member Satisfaction***
Definition	*Measure of how services meet or exceed member expectation.*
Data Collection	*MH-WIN, Survey, Member Questionnaire*
Assessment Frequency	*The Quality Improvement Committee will assess information associated with the indicator on a Quarterly basis.*
Measure of Service	
Name	***Practice Improvement***
Definition	*Measure of Model Fidelity or Measure of outcomes of persons served within various Best Practices.*
Data Collection	*Through Provider Data, MH-WIN Data*
Assessment Frequency	*The Quality Improvement Committee will assess information associated with the indicator on a Quarterly basis.*
Measure of Service	

Name	***Finance***
Definition	*Definition. Compare budget to actual expenditure by Contracted Providers.*
Data Collection	*Audits, Financial Reports*
Assessment Frequency	*The Quality Improvement Committee will assess information associated with the indicator on a Quarterly basis.*
Measure of Service	
Name	***Crisis Services***
Definition	*Definition. Completion of Crisis/Safety Plans for each member by Contracted Providers.*
Data Collection	*Crisis Plans in MH-WIN*
Assessment Frequency	*The Quality Improvement Committee will assess information associated with the indicator on a Quarterly basis.*
Measure of Service	
Name	***7 Day Follow-up***
Definition	*Definition. Ensure appointments are scheduled and attended by members.*
Data Collection	*Appointments scheduled with follow-up in MH-WIN*
Assessment Frequency	*The Quality Improvement Committee will assess information associated with the indicator on a Monthly basis.*
Measure of Service	
Name	***14 Day Follow-up***
Definition	*Definition. Ensure appointments are attended with follow-up appointment by Contracted Providers.*
Data Collection	*MH-WIN*
Assessment Frequency	*The Quality Improvement Committee will assess information associated with the indicator on a Monthly basis.*
Measure of Service	
Name	***Critical Event/Sentinel Event/Death Reporting***
Definition	*Definition. Reporting of health and safety incidents by Contracted Providers*
Data Collection	*MH-WIN*
Assessment Frequency	*The Quality Improvement Committee will assess information associated with the indicator on a Monthly basis.*

Measure of Service	
Name	***Advocacy***
Definition	*Definition. Identify ways to improve community inclusion and integration*
Data Collection	*MH-WIN, Site Review, Performance Monitoring*
Assessment Frequency	*The Quality Improvement Committee will assess information associated with the indicator on a Quarterly basis.*

Performance Indicators Assessment

The Assessment of the Performance Indicators is accomplished by comparing actual performance on an indicator with:

- Self over time
- Pre-established standards, goals or expected levels of performance;
- Information concerning evidence based practices;
- Other systems or similar service providers

Specific, measurable, actionable, relevant and timely data is a critical element of Quality Improvement operations. Quality Improvement unit staff is engaged in on-going processes for identification of data process deficiencies and opportunities to improve accuracy and completeness of the DWMHA's datasets in MH-WIN and in the state's data warehouse.

The Quality Improvement Unit has responsibility for oversight of the Michigan Mission Based Performance Indicator (MMBPI) System data. Standardized indicators, based on the systematic, on-going collection and analysis of valid and reliable data are utilized. Performance measures utilized have been established by MDHHS in the areas of access, efficiency and outcome. This data is reported to MDHHS according to established timelines and formats. Data is also reported quarterly to various factions of the quality Improvement infrastructure (i.e., Program Compliance Committee, Quality Improvement Steering Committee, Quality Operations Technical Assistance Workgroup, etc.).

The quality improvement activities are achieved through a complex infra-structure which includes key stakeholders and process owners, and cross-functional units and committees. The structure is depicted below:

Program Compliance Committee (PCC)

Purpose of the PCC:

The Program Compliance Committee (PCC) is a committee of the ***Board of Directors,*** *and* provides leadership for the Quality Improvement process through supporting and guiding implementation of quality improvement activities at the DWMHA; and reviewing for changes, evaluating, need for Board Actions and approving the Quality Improvement Plan annually.

Membership:

The DWMHA's PCC Committee consists of members of the Board of Directors. The Chief Operating Officer is the DWMHA liaison to the committee. Meeting notices are posted in public places and DWMHA website. Meetings are open to the public.

Function of the PCC:

The committee monitors the effectiveness of the QAPIP and makes recommendations for:

- Annual evaluation of the effectiveness of the QAPIP and recommends approval of reports to the Board;
- System-wide trends and patterns of key indicators;
- Opportunities for improvement;
- Studies in areas identified from data review as having the potential for affecting the outcomes of care and related quality concerns;
- Policy or procedure;
- System-wide attainment of goal(s) and objective(s).

The responsibilities of the Committee include:

- Developing and approving the Quality Improvement Plan
- As part of the Plan, establishing measurable objectives based upon priorities identified through the use of established criteria for improving the quality and safety of clinic services
- Developing indicators of quality on a priority basis
- Periodically assessing information based on the indicators, taking action as evidenced through quality improvement initiatives to solve problems and pursue opportunities to improve quality
- Establishing and supporting specific quality improvement initiatives
- Reporting to the Board of Directors on quality improvement activities of the clinic on a regular basis
- Review of program operations
- Recommend Board Actions to the Full Board relative programs

Quality Improvement Steering Committee (QISC)

Purpose of the Quality Improvement Steering Committee:

The DWMHA's Quality Improvement Steering Committee (QISC) is an advisory group with responsibility for ensuring system-wide representation in the planning, implementation, support and evaluation of the DWMHA's continuous quality improvement program. The QISC provides ongoing operational leadership of continuous quality improvement activities for the DWMHA. It meets at least monthly or not less than nine (9) times per year. The QISC provides leadership in practice improvement projects and serves as a vehicle to communicate and coordinate quality improvement efforts throughout the quality Improvement program structure.

Membership:

Membership must include the Medical Director and is composed of directors of the DWMHA's units or designee, chairpersons of the committees within the Quality Improvement structure or designee, members, advocates and Contracted Providers of services to members with Serious Mental Illness, Severe Emotional Disturbance, Substance Use Disorders, Developmental Disabilities, and Co-Occurring Disorders.

Function of the Quality Improvement Steering Committee:

- Establish and annually review committee operational guidelines, such as confidentiality, meeting frequency, management of information requests, number of members required for a quorum, membership, etc.
- Establish committee goals and timelines for progress and achievement
- Participate in the development and review of quarterly/annual reports to the Program Compliance Committee and the Board of Directors regarding the Quality Improvement System
- Annually review and evaluate the effectiveness of the Quality Assessment Performance Improvement Program
- Oversee a circular communication process in order to ensure that all involved constituencies, including the Board of Directors, DWMHA staff, and members, providers and other stakeholders are a part of the Quality Improvement Process
- Provide recommendations and feedback on process improvement, program implementation, program results and program continuation or termination
- Examine quantitative and qualitative aggregate data at predetermined and critical decision making points and recommend courses of action
- Review reports from regulatory DWMHA reviews

- Review of DWMHA improvement plans and make recommendations based on these reviews
- Monitor progress and completion of plans of correction in response to recommended remedial actions identified for the DWMHA or by regulatory organizations
- Review quality Improvement operating procedures and propose changes in procedures as needed
- Oversee a process for establishing, continuing or terminating subcommittees, standing committees, improvement teams, task groups and work groups
- Identify training needs and opportunities for staff development in the quality Improvement process
- Identify future trends and make recommendations for next steps
- Develop standardized forms required for the work of the Steering Committee
- Initiate and participate in recognition and acknowledgement of successes in quality Improvement for the DWMHA and the community mental health system
- Leadership in practice improvement projects

Standing Committees

The DWMHA's quality Improvement system consists of standing committees that oversee on-going monitoring, peer evaluation, and improvement functions, including receipt and review of data related to their identified areas of responsibility. This structure is designed to improve quality of care to members, improve operations of providers and promote efficient and effective internal operations. Standing Committees may be assigned quality indicators to use in monitoring aspects of care and service or may establish indicators for which data will be collected and monitored.

The standing committees consist of qualified representatives of DWMHA units, providers and in some cases, stakeholders and members. The committees define aspects of services and supports to be monitored for opportunities to improve, based on priorities established in the MDHHS contract and on the needs of high-risk members and high volume/problem-prone programs. Results from the DWMHA's Performance Indicators System, which is an extension of the MDHHS data collection program, are a key source for identification of aspects to be monitored. The committees develop plans by which data for their scope of responsibility will be reviewed and opportunities for improvement identified. QM staff work with the committees and assure that the principles of data based continuous quality improvement are followed. The standing committees monitor improvements that are implemented for effectiveness and improved outcomes.

Standing committees identify and recommend needs for quality improvement teams, as appropriate, and may bring in outside resources, if needed, to facilitate the work of teams and to facilitate involvement of internal staff, providers, members, stakeholders and various outside groups, as needed. The standing committees are:

Utilization Management Committee (UM) – see UM Program Description for further information

Critical/Sentinel Events Committee (CSEC)

Purpose of the Critical/Sentinel Event Committee:

The Critical/Sentinel Event process involves the reporting of all unexpected incidents involving the health and safety of the members within the DWMHA's service delivery area. Incidents include, at a minimum, member deaths, medication errors, behavioral episodes, arrests, convictions, physical illness and injuries. The CSEC retains the right to make the final decision whether an incident is a Critical/ Sentinel Event.

Membership:

Membership consists of core group members:

- Chief Medical Officer
- Utilization Management
- Managed Care Operations
- Quality Improvement
- Substance Use Disorders Initiatives
- Office of Recipient Rights

As applicable, when necessary to respond to questions/concerns of the CSEC others will be requested to attend.

Function of the Critical/Sentinel Event Committee (CSEC):

The mission and goal of the CSEC is to ensure the Contracted Providers and/or clinically responsible service providers conduct a thorough review of incidents with an action plan to ensure the incident does not reoccur or the risk of the incident reoccurring is minimized.

The CSEC uses a four-tiered system of peer review activity. In the first tier, the Critical Events are reviewed by QI Critical/Sentinel Event Liaison for data collection, reviewed for quality of care issues, request for additional documents, completeness of the information and notification of high risk critical incidents to the DWMHA's QI Director and the DWMHA's Administration.

In the second tier, the Critical/Sentinel Events are reviewed by the Chief Medical Officer and QI Critical/Sentinel Event Liaison for clinical issues, standards of care and potential Sentinel Events.

In the third tier, the Critical/Sentinel Events are reviewed by the DWMHA's Peer Review Committee, if needed, as a peer review activity. Findings can include requests for corrective action plans, if needed. Repeated deficits or failures to correct identified deficits may result in recommendations for performance sanctions as defined by DWMHA policy, procedures and contracts.

In the fourth tier, the data collection is reviewed by the DWMHA's Critical/Sentinel Event Committee for policy review and implementation, patterns, trends, compliance, education and improvement and presentation to the DWMHA PCC.

Death Review Committee (DRC)

Purpose of the Death Review Committee:

All unexpected* deaths of Member who at the time of their deaths were receiving specialty supports and services must be reviewed and must include:

- Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
- Involvement of medical personnel in the mortality reviews
- Documentation of the mortality review process, findings, and recommendations
- Use of mortality information to address quality of care
- Aggregation of mortality data over time to identify possible trends.

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

Membership:

Membership consists of core group members:

- Chief Medical Officer
- Clinical Practice Improvement
- Managed Care Operations
- Quality Improvement
- Office of Recipient Rights
- Integrated Care
- Substance Use Disorders

As applicable, when necessary to respond to questions/concerns of the DRC other persons will be requested to attend.

Function and the Death Review Committee

The mission and goal of the DRC is to ensure a thorough review of the Member's death has been conducted by the Member's respective Direct Contractor and/or clinically responsible service provider, the DWMHA's Recipient Rights Unit and the DWMHA's Clinical Practice Improvement Unit in accordance with the DWMHA's Death Reporting Policy and procedures

Peer Review Committee (PRC)

Purpose of the Peer Review Committee

The PRC Committee is a peer review activity responsible for the clinical peer review of critical incidents involving, at a minimum, Member deaths, Critical/ Sentinel Events, incidents involving the media or special requests from the DWMHA's Chief Medical Officer or DWMHA Administration. All peer review activities are privileged, confidential and are in accordance with the state and federal laws and regulations that govern peer review activities.

Membership:

Membership consists of core group members:

- Chief Medical Officer
- Clinical Practice Improvement
- Managed Care Operations
- Quality Improvement
- Office of Recipient Rights
- Integrated Care
- Substance Use Disorders

As applicable, when necessary to respond to questions/concerns of the PRC Committee other persons will be requested to attend.

Function of the Peer Review Committee:

The mission and goal of the PRC Committee is to ensure the Direct Contractors and/or clinically responsible service providers conduct a thorough review of incidents and provide an action plan that will ensure similar incidents do not reoccur and that the risk of reoccurring is minimized. The goal of the PRC Committee is to review the processes at

the Direct Contractors and/or clinically responsible service providers when conducting a thorough clinical review of the incident in accordance with the DWMHA's Peer Review Policy and Procedures. All Peer Review activities are privileged, confidential and are in accordance with state and federal laws and regulations that govern Peer Review activities.

Improving Practices Leadership Team (IPLT)

Purpose of the Improving Practice Leadership Team

The Detroit Wayne Mental Health Authority (DWMHA) endeavors to implement and support Evidence-Based Practices (EBP), Promising and Emerging Practices. The Michigan Department of Community Health (MDHHS) defined the elements of the Improving Practices Leadership Team (IPLT), whose purpose is to oversee and monitor these practices. These teams were charged with developing work plans, coordinating the regional training and technical assistance plan, working to integrate data collection, developing financing strategies and mechanisms, assuring program fidelity, evaluating the impact of the practices, and monitoring clinical outcomes.

DWMHA will gather a number of previously operating committees and work groups into one coordinated IPLT which will serve as liaison between the DWMHA Quality Improvement Steering Committee (QISC) and the groups developing and monitoring the clinical practice standards. It will envelop and reorganize the following groups:

- Developmentally Disabled Systems of Care Work Group
- Children's Cross-Systems Management Committee
- Standards of Care-Adult Committee,
- Substance Use Disorder Services Group
- Integrated Health Work Group
- Peer and Member Group (previously three groups: Member Empowerment and Engagement, Peer Promotion and Utilization, and Prevention and Education).

Membership:

The IPLT committee Membership includes: Improving Practice Leadership Specialists in the following areas:

- Individuals with Serious Mental Illness (SMI)
- Children with Serious Emotional Disturbance (SED)
- Individuals with Intellectual and/or Developmental Disabilities (I/DD)
- Individuals with Substance Use Disorders (SUD)
- Quality Improvement
- Finance
- Data Evaluation

- Member employed by the system
- Family Member of a child receiving PIHP services Peer support specialist
- An identified program leader for each practice being implemented
- Identified program leader for peer-directed or peer-operated services

Function of the Improving Practice Leadership Team

Develop and communicate a strategy that is tailored to the context and the roles, capabilities, and interests of the stakeholder groups involved in the public mental health system:

- Identify and mobilize program leaders or change agents within the organization to implement the activities required to achieve the desired outcomes
- Develop an on-going process to maximize opportunities and overcome obstacles
- Monitor outcomes and adjust processes based on learning from experience
- Align relevant persons, organizations, and systems to participate in the transformation process
- Support Membership of a Member/Certified Peer Support to represent the PIHP/CMHSP on the Recovery Council of Michigan
- Assess parties' experience with change
- Establish effective communication systems
- Ensure effective leadership capabilities
- Enable structures and process capabilities
- Improve cultural capacity
- Demonstrate their progress in system transformation by implementing evidence based, promising and new and emerging practices

Behavior Treatment Oversight Committee on Behavior Treatment Plan Review Requirements

Purpose of the DWMHA Behavior Treatment Oversight Committee:

The DWMHA's Behavior Treatment Oversight Committee on Behavior Treatment Plan is charged with reviewing and approving/disapproving any plans that propose to use restrictive or intrusive interventions with individuals served by the public mental health system who exhibit seriously aggressive, self-injurious or other challenging behaviors that place the individual or others at imminent risk of physical harm. The committee review requirements, performs analysis of the Contract Provider data from their respective Behavior Treatment Review Committees where intrusive or restrictive techniques have been approved for use and where physical management has been used in an emergency or nonemergency situation.

Membership:

The committee consists of a psychiatrist, licensed psychologist, Member, DWMHA staff, provider representatives and ORR. A representative of the DWMHA's Office of Recipient Rights (ORR) is required to attend each Behavior Treatment Committee on Behavior Treatment Plan Review Requirement meetings in the Provider network.

Each of the provider Behavior Treatment Review Committees consist of a licensed psychologist, a licensed physician/psychiatrist and the DWMHA's Office of Recipient Rights who assigns a representative. Each committee sends representative(s) to the monthly DWMHA's Behavior Treatment Oversight Committee.

Function of the Behavior Treatment Oversight Committee:

The DWMHA's Committee collects data and information on implementation issues including:

- Percent of provider Behavior Management committees with active Recipient Rights representation;
- Types of challenging behaviors resulting in intrusive and/or restrictive interventions;
- Percent of Member exhibiting challenging behaviors per the client record with behavior treatment plans;
- Types of interventions used;
- Frequency and duration of interventions used;
- Frequency of review of behavior management plans;
- Percent of interventions matching behavior management plans;
- Percent of charts labeled appropriately;
- Number of Critical/Sentinel Events involving challenging behaviors;
- Percent of care staff at all levels trained in behavior management (i.e., positive behavior management, the culture of gentle teaching, management of challenging behaviors, etc.);
- Percent of care staff at all levels who demonstrate the required behavior management competencies;
- Number of behavior management related Office of Recipient Rights complaints.

Constituent's Voice

Purpose of the Constituent's Voice:

The Constituents' Voice (also known as the "CV") is a Detroit Wayne Mental Health Authority Member advisory group. The body is charged with advising the Authority, and specific to driving policies and agendas that facilitate community inclusion.

Membership:

The diverse group of Member, advocates and providers meets monthly. Generally, meetings are held at the Detroit Recovery Project on the third Friday of each month from 10:00am -12:00pm.

Function of the Constituent's Voice:

The CV provides oversight for hosting an annual conference that focuses on trending community inclusion issues. The education of stakeholders about community inclusion, i.e. personally valued participation and interactions with others. The solicitation of funds and sponsorships for the mini-grant project – The George Gaines & Roberta Sanders Fund for Community Inclusion, which was established in 2015. The body also sponsors various advocacy and community efforts to advance inclusion. Events include the annual Michigan Walk-A-Mile in My Shoes event and voter registration drives.

Credentialing Committee

Purpose of the Credentialing Committee

The purpose of the committee is to delineate and describe the functions and oversight of DWMHA, DWMHA Credentialing Verification Organization (CVO) and the responsibilities of the Contracted Providers, and to implement credentialing/re-credentialing functions. In compliance with MDHHS' Credentialing and Re-credentialing processes, DWMHA has established written policy and procedures for ensuring appropriate credentialing and re-credentialing of the provider network. Quality Improvement monitors the provider network qualification of staff to ensure compliance with federal, state, and local regulations. Performance monitoring is completed no less than annually through an established process to ensure providers of care or support are qualified to perform their jobs.

Membership:

- DWMHA Chief Medical Director
- DWMHA Staff
- DWMHA Network Providers

Risk Management

Purpose of the Risk Management Committee:

The purpose of the committee is to review incidents involving Member and the provider system under the protection of protected information. The Risk Management Committee is an ad-hoc committee and meets as required.

Membership:

- Chief Operating Officer
- Chief Medical Officer
- Corporate Compliance Officer
- Legal Counsel
- Others as needed

Function of the Risk Management Committee:

- Continuously improve patient safety and minimize and/or prevent the occurrence of errors, events, and system breakdowns leading to harm to patients, staff, volunteers, visitors, and others through proactive risk management and patient safety activities.
- Minimize adverse effects of errors, events, and system breakdowns when they do occur.
- Minimize losses to the organization overall by proactively identifying, analyzing, preventing, and controlling potential clinical, business, and operational risks.

Customer Service Committee

Purpose of the Customer Service Committee:

The purpose of the committee is to provide procedural and operational guidance on Customer Service functions to DWMHA, the Access Center, Crisis services vendor, and Contracted Providers. The Customer Service Committee meets on a quarterly basis.

Membership:

- DWMHA Customer Services Director
- DWMHA Grievance Coordinator
- DWMHA Appeals Coordinator
- Provider Customer Services, Grievance, and Appeal staff

Function of the Customer Service Committee:

The quarterly meetings are facilitated by the DWMHA Customer Services Department to coordinate with the Customer Services, Grievance and Appeals management at the MCPN/Service Provider levels that addresses Customer Service, Grievance and Appeals related updates and issues. It also provides for a venue to network and share programs, processes and upcoming events that are occurring in their respective networks.

Recipient Rights Advisory Council (RRAC)

Purpose of the Recipient Rights Advisory Council:

The RRAC is mandated by the Michigan Mental Health Code (MCL 330.1757).

Membership:

Is broadly based so as to best represent the varied perspectives of the CMHSP's geographical area. At least 1/3 of the Membership shall be primary Member or family Member, and of that 1/3, at least ½ shall be primary Member.

Function of the committee:

- Protect the Office of Recipient Rights (ORR) from pressures that could interfere with the impartial, even-handed, and thorough performance of its functions
- Serve in an advisory capacity to the executive director and the director of ORR Other specific functions include:
- Review the process for funding ORR
- Recommend candidates for the Director of ORR to the Executive Director
- Consult with the Executive Director regarding any proposed dismissal of the Director of ORR
- Receive education and training in ORR policies and procedures
- Review the Semi-Annual report submitted to the State (due June 30)
- Review the Annual report submitted to the State (due December 31)
- Provide "Goals for ORR" and "Recommendations for ORR" for the Annual Report
- For DWMHA, the RRAC also serves as the Recipient Rights Appeals Committee

The DWMHA RRAC meets bi-monthly, on the first Monday of every odd-numbered month, from 1:00 – 3:00. The meetings are governed by the Open Meetings Act and the public is welcome to attend.

Compliance Committee

Purpose of the Compliance Committee:

The Compliance Committee shall meet, at a minimum, on a bi-annual basis during the fiscal year. However, the Compliance Officer can schedule additional meetings as deemed necessary. A majority of the Committee constitutes a quorum for the transaction of business. The Committee may take action by the affirmative vote of a majority of the Committee Member present at a duly held meeting.

Membership:

- Compliance Officer- Chair
- Chief Operating Officer
- Chief Financial Officer
- Chief Medical Officer
- Chief Strategic Officer

Function of the Compliance Committee:

- Assist the Compliance Officer with risk assessment and the need for and design of compliance reviews within the organization;
- Advise the Compliance Officer on compliance training needs within the organization and assist in arranging for and conducting such compliance training;
- Assist the Compliance Officer with developing organizational policies supporting the Compliance Plan;
- Assist the Compliance Officer with implementation of the Compliance Plan;
- Assist the Compliance Officer with evaluation of the effectiveness of the Compliance Plan; and
- Refer all matters to the Total Quality Management and Program Compliance Committee and the Board for review that relate to the following:
- Violations that require notification to federal, state, and/or local agencies;
- (ii)Violations that have an economic impact (i.e. budgetary) on the Authority and/or require funds to be returned to federal or state agencies; or
- (iii) Any other information that the Compliance Committee deems appropriate for Board notification

Cost Utilization Steering Committee

Purpose of the Cost Utilization Steering Committee:

The utilization, standards, access etc. to clinical services, Cost Utilization looks at where our spending is occurring, analyzes the trends, and makes recommendations for the system based on Strategic Initiatives, Market Forecasts, and our historical data.

Membership:

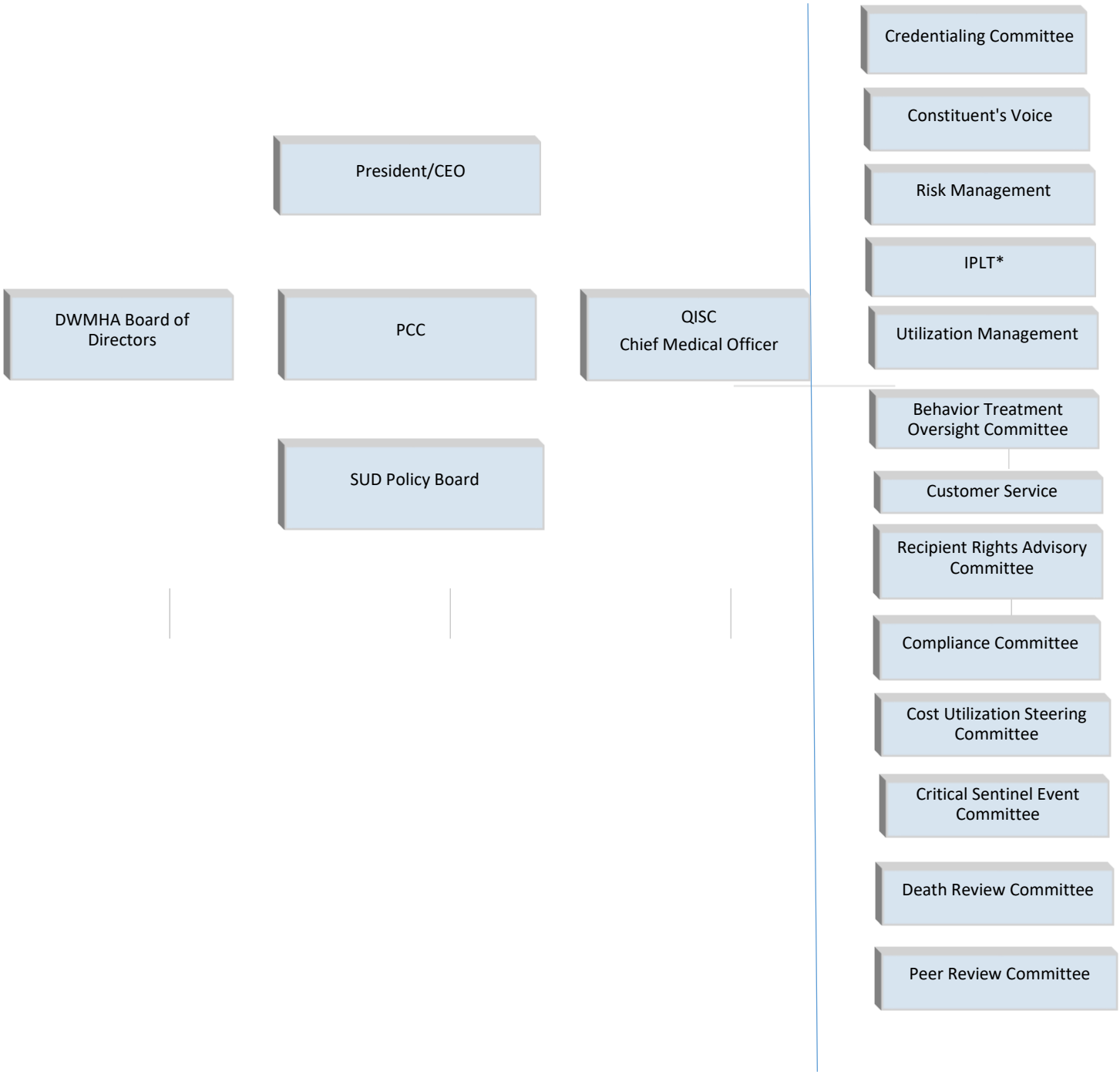
- Chief Financial Officer
- Deputy Chief Financial Officer
- Chief Information Officer
- Chief Operating Officer
- Chief Medical Officer

Function of the Cost Utilization Steering committee:

- To receive data from the Cost Integrity Group (CIG), Procedure Code Work Group, along with the contractual expectations
- Review the needs for improved clinical outcomes (UM/QM/CPI data or input), state mandates (such as EBPs...)
- Finds ways fund necessary functions or services. It contemplates state funding (revenue) and network funding (costs) and fund source management along with cost and utilization data integrity and even system processes.
- As a steering committee it would set the priorities for managing our funding to achieve our operating expectations.

Quality Improvement Teams, Ad Hoc Committees and Workgroups

The DWMHA may identify opportunities for improvement that do not fit into the existing standing committee structure. Ad hoc teams, workgroups and quality circles are appointed for a limited period of time for a specific task by the Quality Improvement Steering Committee, Quality Improvement or a Standing Committee based on organizational need. Reports from the various Committee(s), Ad hoc team(s), DWMHA Unit(s) and workgroup(s) will include outcome measures and are forwarded to the Quality Improvement Steering Committee (QISC).


President/CEO
DWMHA Board of Directors
PCC
QISC
Chief Medical Officer
SUD Policy Board
Credentialing Committee
Constituent's Voice
Risk Management
IPLT*
Utilization Management
Behavior Treatment Oversight Committee
Customer Service
Recipient Rights Advisory Committee
Compliance Committee
Cost Utilization Steering Committee
Critical Sentinel Event Committee
Death Review Committee
Peer Review Committee

SECTION 4: Evaluation

An evaluation is completed at the end of each fiscal year. The annual evaluation is conducted by the DWMHA and submitted to MDHHS and kept on file at the DWMHA, along with the Quality Improvement Plan. These documents will be reviewed by Health Services Advisory Group (HSAG) and MDHHS as part of the certification process. The evaluation summarizes the goals and objectives of the DWMHA's Quality Improvement Plan, the quality improvement activities conducted during the past year, including the targeted process, systems and outcomes, the performance indicators utilized, the findings of the measurement, data aggregation, assessment and analysis processes, and the quality improvement initiatives taken in response to the findings.

- Summarize the progress towards meeting the Annual Goals/Objectives.
- For each of the goals, include a brief summary of progress including progress in relation to training goal(s).
- Provide a brief summary of the findings for each of the indicators used during the year. These summaries should include both the outcomes of the measurement process and the conclusions and actions taken in response to these outcomes. Summarize progress in relation to Quality Initiative(s). For each initiative, provide a brief description of what activities took place including the results on indicators. What are the next steps? How will we "hold the gains?" Describe any implications of the quality improvement process for actions to be taken regarding outcomes, systems or outcomes in the coming year.
- Recommendations: Based upon the evaluation, state the actions necessary to improve the effectiveness of DWMHA, the Strategic Plan and the QI Plan.

QAPIP Goals and Objectives and Work Plan FY 2018-2019

Goal I. **Customer**

- Assure Active Member Engagement/Satisfaction
    - I.1 Member Echo Survey
    - I.2 National Core Indicator Survey (NCI)
    - I.3 Grievance and Appeals
    - I.4 Cultural Competency/Culturally and Linguistically

Goal II. **Access/Capacity**

- Assess Needs and Manage Demand, Implement Holistic Care Model
    - II.1 Michigan Mission Based Performance Indicators (MMBPI)
    - II.2 Annual Needs Assessment
    - II.3 Ensure consistent and standardized model of care
    - II.4 Ensure model fidelity to best practices
    - II.5 Standardized Clinical Guidelines
    - II.6 Medversant

Goal III. **Workforce**

- Develop and Maintain a Competent Workforce and Improve Practices
    - III.1 Develop partnerships with key providers to assure a holistic environment

Goal IV. **Finance**

- Achieve and Maintain Administrative Efficiencies
    - IV.1 Capitation PMPM Model

Goal V. **Quality**

- Improve Quality Performance, Member Safety and Member Rights
    - V.1 Performance Monitoring Case Record Reviews
    - V.2 Performance Monitoring – Specialized Residential Settings
    - V.3 Performance Monitoring (Inter-Rater Reliability)
    - V.4 Autism Benefit

- Improve reporting and data analysis
    - V.5 Enhancement of Critical/Sentinel Event Modules
    - V.6 Enhancement of Incident Reporting Modules

- Improve/Increase Accuracy of Behavior Treatment Plan
    - V.7 Behavior Treatment Plan Oversight
    - V.8 Quality Improvement Projects (QIPs)

- Crisis Continuum
    - V.9 High Frequency of ED Usage and Recidivism
    - V.10 Review of Service Denials

Goal VI. **Advocacy**

- Increase Community Inclusion and Integration
    - VI.1 Home and Community Based Services (HCBS)

Goal VII. Assure Compliance with Applicable National Accreditation, Legislative, Federal/State

- VII.1 MDHHS Certification
- VII.2 NCQA Accreditation
- ECQ/HSAG