



QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP) *Annual Plan FY2022*

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I. OVERVIEW/MISSION STATEMENT

Mid-State Health Network (MSHN) is a regional entity, which was formed pursuant to 1974 P.A. 258, as amended, MCL §330.1204b, as a public governmental entity separate from the CMHSP Participants that established it. The CMHSP Participants formed Mid-State Health Network to serve as the prepaid inpatient health plan (“PIHP”) for the twenty-one counties designated by the Michigan Department of Health and Human Services as Region 5. The CMHSP Participants include Bay-Arenac Behavioral Health Authority, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network , Huron County Community Mental Health Authority, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health Authority, Saginaw County Community Mental Health Authority, Shiawassee Health and Wellness, The Right Door and Tuscola Behavioral Health Systems. In January 2014, MSHN entered into its first contract with the State of Michigan for Medicaid funding, and entered into subcontracts with the CMHSPs in its region for the provision of Mental Health, Substance Use Disorder, and Developmental Disabilities services. The contract was expanded in 2014 to include an expanded Medicaid benefit, the Healthy Michigan Plan. As of October 1, 2015, MSHN took over the direct administration of all public funding for substance use disorder (SUD) prevention, treatment and intervention within the region and expanded the provider network to include SUD providers. Beginning in FY22 Michigan was identified as a Certified Community Behavioral Health Clinic Demonstration State. October 1, 2021 MSHN became responsible for the PIHP requirements related to CCBHC. Three CMHSP Participants within the MSHN region have received the certification to become a Certified Community Behavioral Health Clinic (CCBHC), CEI, The Right Door, and SCCMH. Lifeways currently has an expansion grant directly with Substance Abuse and Mental Health Services Administration (SAMHSA). MSHN will adhere to contractual and policy requirements related to CCBHC.

The mission of MSHN is to ensure access to high-quality, locally delivered, effective and accountable public behavioral health and substance use disorder services provided by its participating members. The vision of MSHN is to continually improve the health of our communities through the provision of premiere behavioral healthcare and leadership.

II. SCOPE OF PLAN

The scope of MSHN’s QAPIP is inclusive of all CMHSP participants, substance use disorder providers and their respective provider networks, and Certified Behavioral Health Clinics (CCBHC) within the MSHN Region.

Performance monitoring covers all important organizational functions, aspects of care, and service delivery systems. Performance monitoring is accomplished through a combination of well-organized and documented retained, contracted, and delegated activities. Where performance monitoring activities are contracted or delegated, MSHN assures monitoring of reliability and compliance.

III. DEFINITIONS/ACRONYMS

BTPRC: Behavior Treatment Plan Review Committee reviews, approves, or disapproves any plans that propose to use restrictive or intrusive intervention, with as defined in the Technical Requirement for Behavior Treatment Plans.

Behavioral Health: An individual with a mental illness, intellectual developmental disability and/or substance use disorder or children with a serious emotional disturbance.

CMHSP: Community Mental Health Services Program is a program operating under Chapter 2 of the Michigan Mental Health Code - Act 258 of 1974 as amended.

CMHSP Participant refers to one of the twelve-member Community Mental Health Services Program (CMHSP) participant in the Mid-State Health Network.

Contractual Provider: refers to an individual or organization under contract with the MSHN Pre-Paid Inpatient Health Plan (PIHP) to provide administrative type services including CMHSP participants who hold retained functions contracts.

CIRS: Critical Incident Reporting System includes events required to be monitored and reported to MDHHS and the process in which this is completed. The current critical incidents categories include suicide death; non-suicide death; arrest of consumer; emergency medical treatment due to injury or medication error; and type of injury. Subcategories include injuries that resulted from the use of physical management; hospitalization or emergency treatment due to injury or medication error; emergency medical treatment of hospitalization due to injury related to the use of physical management.

Customer: For MSHN purposes customer includes all Medicaid eligible individuals (or their families) located in the defined service area who are receiving or may potentially receive covered services and supports. The following terms may be used within this definition: clients, recipients, enrollees, beneficiaries, consumers, primary consumer, secondary consumer, individuals, persons served, Medicaid Eligible.

EQR: External Quality Review is conducted quarterly by CMS and MDHHS.

LTSS: Long Term Supports and Services are provided to older adults and people with disabilities who need support because of age; physical, cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves, and who receive care in home-community based settings, or facilities such as nursing homes.(42 CFR §438.208(c)(1)(2)) MDHHS identify the Home and Community Based Services Waiver. MI-Choice as recipients of LTSS.

CQS: Comprehensive Quality Strategy provides a summary of work done to assess and improve the quality of care and services provided and reimbursed by Michigan's Medicaid programs, in accordance with State and Federal laws and regulations. The CQS provides a framework to accomplish its overarching goals of designing and implementing a coordinated and comprehensive system to proactively drive quality across Michigan Medicaid managed care programs.

MEV: Medicaid Event Verification is a process which verifies services reimbursed by Medicaid.

MMBPIS: Michigan Mission Based Performance Indicator System includes domains for access to care, adequacy and appropriateness of services provide, efficiency (administrative cost vs. service costs), and outcomes (employment, housing inpatient readmission).

MDHHS CQS: Michigan Department of Health and Human Services Comprehensive Quality Strategy

MDHHS: Michigan Department of Health and Services

PIP: Performance Improvement Projects must be conducted to address clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes.

PIHP: Prepaid Inpatient Health Plan is a managed care organization responsible for administering specialty services for the treatment of mental health, intellectual and developmental disabilities and substance use disorders in accordance with the 42 CFR part 401 et al June 14, 2002, regarding Medicaid managed care, Medicaid regulations, Part 438, MHC330.1204b.

Provider Network: Refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP subcontractors.

QAPI: Quality Assurance Performance Improvement

QAPIP: Quality Assessment and Performance Improvement Program includes standards in accordance with the Guidelines for Internal Quality Assurance Programs as distributed by the Health Care Financing Administration Medicaid Bureau guide to states in July of 1993, the Balanced Budget Act of 1997, Public Law 105-33, and 42 Code of Federal Regulations (CFR)438.358 of 2002.

Research: (as defined by 45 CFR, Part 46.102) means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.

Root Cause Analysis (RCA): A root cause analysis (JCAHO) or investigation (per CMS approval and MDHHS contractual requirement) is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance." (JCAHO, 1998)

Sentinel Event (SE): A sentinel event is an "unexpected occurrence" involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1998). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event

Stakeholder: A person, group, or organization that has an interest in an organization, including consumer, family members, guardians, staff, community members, and advocates.

Subcontractors: Refers to an individual or organization that is directly under contract with CMHSP and/or SRE to provide services and/or supports.

SUD Providers: Refers to substance use disorder (SUD) providers directly contracted with MSHN to provide SUD treatment and prevention services.

Veteran Navigator (VN): The role of the Veteran Navigator is to listen, support, offer guidance, and help connect Veterans to services they need.

Vulnerable Person: An individual with a functional, mental, physical inability to care for themselves.

IV. PHILOSOPHICAL FRAMEWORK

The MSHN utilizes the National Healthcare Reform Framework the “Quintuple Aim”. For MSHN, the quintuple aim includes five strategic priorities: “Better Health”, “Better Care”, “Better Value”, “Better Provider Systems” and new for the MSHN FY22 Strategic Plan, “Better Equity”. MSHN organizes and empowers a network of publicly funded community partnerships essential to ensure quality of life while efficiently and effectively addressing the complex needs of the most vulnerable citizens in our region.

The MSHN Quality Assessment and Performance Improvement Program (QAPIP) provides a structure for quality improvement in alignment with the MSHN Strategic Plan through performance monitoring. Additionally, the MSHN QAPIP aligns with the quality assessment and performance improvement program interventions as identified in the Michigan Department of Health and Human Services (MDHHS) Comprehensive Quality Strategy (CQS). Responsibilities of the quality management program are outlined in the QAPIP Plan.

The program design is based on the Continuous Quality Improvement (CQI) model of Shewhart, Deming and Juran. The key principles of the CQI model, as recently updated by Richard C. Hermann ("Developing a Quality Management System for Behavioral Health Care: The Cambridge Health Alliance Experience", November 2002), are:

- Health care is a series of processes in a system leading to outcomes.
- Quality problems can be seen as the result of defects in processes.
- Quality improvement efforts should draw on the knowledge and efforts of individuals involved in these processes, working in teams.
- Quality improvement work is grounded in measurement, statistical analysis and scientific method.
- The focus of improvement efforts should be on the needs of the customer; and
- Improvement should concentrate on the highest priority problems.

Performance improvement is more narrowly defined as, “the continuous study and adaptation of health care organization’s functions and processes to increase the probability of achieving desired outcomes, and to better meet the needs of clients and other users of services” (The Joint Commission, 2004-2005). MSHN employs the Plan-Do- Study-Act (PDSA) cycle, attributed to Walter Shewhart and promulgated by Dr. W. Edwards Deming, to guide its performance improvement tasks (Scholtes P. R.,1991).

Performance measurement is a critical component of the PDSA cycle. Measures widely used by MSHN for the ongoing evaluation of processes, and to identify how the region can improve the safety and quality of its operations, are as follows:

- A variety of qualitative and quantitative methods are used to collect data about performance.

- Well-established measures supported by national or statewide databases are used where feasible and appropriate to benchmark desired performance levels; if external data is not available, then local benchmarks are established.
- Statistically reliable and valid sampling, data collection and data analysis principles are followed as much as possible; and
- If the nature of the data being collected for a measure limits the organization's ability to control variability or subjectivity, the conclusions drawn based upon the data are likewise limited.

Data is used for decision making throughout the PIHP and its provider network through monitoring treatment outcomes, ensuring timeliness of processes, optimizing efficiency and maximizing productivity, and utilizing key measures to manage risk, ensure safety, and track achievement of organizational strategies. MSHN's overall philosophy governing its local and regional quality management and performance improvement can be summarized as follows:

- Performance improvement is dynamic, system-wide and integrated.
- The input of a wide-range of stakeholders – board members, advisory councils, consumers, providers, employees, community agencies and other external entities, such as the Michigan Department of Health and Human Services, are critical to success.
- An organizational culture that supports reporting errors and system failures, as the means to improvement, and is important and encouraged.
- Improvements resulting from performance improvement must be communicated throughout the organization and sustained; and
- Leadership must establish priorities, be knowledgeable regarding system risk points, and act based upon sound data.

V. ORGANIZATIONAL STRUCTURE AND LEADERSHIP

a) Structure

The structure of the QAPIP allows each contracted behavioral health provider to establish and maintain its own unique arrangement for monitoring, evaluating, and improving quality. The MSHN Quality Improvement Council, under the direction of the Operations Council, is responsible for ensuring the effectiveness of the QAPIP. Process improvements will be assigned under the auspices of MSHN to an active PIHP council, committee, workgroup, or task specific Process Improvement Team.

b) Governance

Board of Directors

The MSHN's Board of Directors employs the Chief Executive Officer (CEO), sets policy related to quality management, and approves the PIHP's QAPIP, including quality management priorities as identified in this plan. The QAPIP Plan is evaluated and updated annually, or as needed, by the MSHN Quality Improvement Council.

Through the Operations Council, Substance Use Disorder Oversight Policy Board and MSHN CEO, the MSHN's Board of Directors receives an Annual Quality Assessment and Performance Improvement Program Report evaluating the effectiveness of the quality management program and recommending priorities for improvement initiatives for the next year. The report describes quality management

activities, performance improvement projects, and actions taken to improve performance. After review of the Annual Quality Assessment and Performance Improvement Program inclusive of a list of the Board of Directors', the QAPIP Report will be submitted to the Michigan Department of Health and Human Services (MDHHS).

Chief Executive Officer

MSHN's CEO is hired/appointed by the PIHP Board and is the designated senior official with responsibility for ensuring implementation of the regional QAPIP. The MSHN CEO has designated the Quality Manager as the chair of the MSHN Quality Improvement Council, and a member of the MDHHS Quality Improvement Council. In this capacity, the Quality Manager under the direction of the Chief Compliance and Quality Officer, is responsible for the development, review, and evaluation of the Quality Assessment and Performance Improvement Program in collaboration with the MSHN Quality Improvement Council.

The MSHN CEO allocates adequate resources for the quality management program and is responsible for linking the strategic planning and operational functions of the organization with the quality management functions. The CEO assures coordination occurs among members of the Operations Council to maintain quality and consumer safety. Additionally, the CEO is committed to the goals of the quality improvement plan and to creating an environment that is conducive to the success of quality improvement efforts, ensuring affiliation involvement, removing barriers to positive outcomes, and monitoring results of the quality improvement program across the PIHP. The CEO reports to the PIHP Board of Directors recommending policies and/or procedures for action and approval. The CEO is responsible for managing contractual relationships with the CMHSP Participants and Substance Use Disorder Providers and for issuing formal communications to the CMHSP Participants/SUD Providers regarding performance that does not meet contractual requirements or thresholds. Similarly, the CEO is responsible for assuring ongoing monitoring and compliance with its MDHHS contract including provision of quality improvement plans as required.

Medical Director

The MSHN Medical Director and MSHN Addictions Treatment Medical Director consults with MSHN staff regarding service utilization, eligibility decisions, performance improvement projects and is available to provide additional input as required for the regional QAPIP.

The MSHN Medical Director is an ad hoc member of the MSHN Quality Improvement Council and demonstrates an ongoing commitment to quality improvement; participating on committees and work teams as needed, reviewing quality improvement reports, sentinel events, and critical incidents; and assisting in establishing clinical outcomes for the PIHP.

c) Components

Recipients

MSHN continues the legacy of its founding CMHSP Participants by promoting and encouraging active consumer involvement and participation within the PIHP, the respective CMHSPs and their local communities. Recipients of services participate in the QAPIP through involvement on workgroups, process improvement teams, advisory boards, and Quality Improvement (QI) Councils at the local and regional level. Recipients provide input into policy and program development, performance indicator monitoring, affiliation activities/direction, self-determination efforts, QI projects, satisfaction findings, consumer advocacy, local access and service delivery, and consumer/family education, etc. In addition to the participation of recipients of services in quality improvement activities, MSHN and the CMHSP

Participants/ SUD Providers strive to involve other stakeholders including but not limited to providers, family members, community members, and other service agencies whenever possible and appropriate. Opportunities for stakeholder participation include the PIHP governing body membership; PIHP Quality Improvement Council; PIHP Customer Services Committee; Consumer Advisory activities at the local, regional, and state levels; completion of satisfaction surveys; participation on quality improvement work teams or monitoring committees; and focus group participation. Stakeholder input will be utilized in the planning, program development, and evaluation of services, policy development, and improvement in service delivery processes.

MSHN will provide oversight and monitoring of all members of its contracted behavioral health network in compliance with applicable regulatory guidance. For the purposes of the Quality Management functions germane to successful PIHP operations, the following core elements shall be delegated to the Community Mental Health Services Programs and SUD Providers within the region:

- Implementation of Compliance Monitoring activities as outlined in the MSHN Corporate Compliance Plan
- Develop and Implementation of Quality Improvement Program in accordance with PIHP Quality Assessment and Performance Improvement Plan
- Staff Oversight and Education
- Conducting Research (if applicable)

MSHN will provide guidance on standards, requirements, and regulations from the MDHHS, the External Quality Review, the Balanced Budget Act, and/or other authority that directly or indirectly affects MSHN PIHP operations. Communication related to standards and requirements will occur through policy and procedure development, constant contact, training, and committees/councils.

MSHN will retain responsibility for developing, maintaining, and evaluating an annual QAPIP and report in collaboration with its CMHSP Participants and Substance Use Disorder Providers. MSHN will comply with 42 CFR Program Integrity Requirements, including designating a PIHP Compliance Officer. Assurances for uniformity and reciprocity are as established in MSHN provider network policies and procedures.

Communication of Process and Outcomes

A quality structure identifies clear linkages and reporting structures. The MSHN Quality Improvement Council (QIC), in coordination with the CMHSP Participants and SUD Providers through regional committees and councils, is responsible for monitoring and reviewing performance measurement activities including identification and monitoring of opportunities for process and outcome improvements. After committee/council meetings, the status of key performance indicators, consumer satisfaction survey results, and performance improvement (PI) projects are reported to consumers and stakeholders are communicated through Operations Council, and Consumer Advisory Council meetings. Final performance and quality reports are available to the stakeholders and the general public as requested, and through the MSHN website. The Board of Directors receives periodic and an annual report on the status of organizational performance.

d) MSHN Provider Network

MSHN Councils and Committees are responsible for providing recommendations and reviewing regional policy's regarding related managed care operational decisions. Each council/committee develops and annually reviews and approves a charter that identifies the following: Purpose, Decision Making Context and Scope, Defined Goals, Monitoring, Reporting and Accountability, Membership, Roles and

Responsibilities Meeting Frequency, Member Conduct and Rules, and Upcoming Goals supporting the MSHN Strategic Plan. The Operations Council approves all council/committee charters. Each council/committee guides the Operations Council who advises the MSHN CEO. These recommendations are considered by the Operations Council on the basis of obtaining a consensus or simple majority vote of the twelve CMHSPs. Any issues remaining unresolved after Operations Council consideration will be subject to a vote with the minority position being communicated to the MSHN Board. The MSHN CEO retains authority for final decisions or for recommending action to the MSHN Board.

Among other duties, these councils/committees identify, receive, and respond on a regular basis to opportunities and recommendations for system improvements arising from the MSHN Quality Assessment and Performance Improvement Program and reports annually on the progress of accomplishments and goals.

CMHSP Participant/SUD Provider staff have the opportunity to participate in and to support the QAPIP through organization wide performance improvement initiatives. In general, the CMHSP Participant/SUD Provider staff's role in the PIHP's performance improvement program includes:

- Participating in valid and reliable data collection related to performance measures/indicators at the organizational or provider level.
- Identifying organization-wide opportunities for improvement.
- Having representation on organization-wide standing councils, committees, work groups.
- Reporting clinical care errors, informing consumers of risks, and making suggestions to improve the safety of consumers.
- Responsible for communication between the PIHP QIC and their local organization.

Quality Improvement Council

A quality representative from each CMHSP is appointed by the CMHSP CEO to participate in the MSHN Quality Improvement Council. Primary and/or secondary consumer representatives are appointed through an application process. Substance Use Disorder (SUD) Treatment Providers are represented on the Council by MSHN SUD Staff on an as needed basis.

Regional Medical Directors

The Regional Medical Directors Committee, which includes membership of the MSHN Medical Director and the CMHSP participant Medical Directors, provide leadership related to clinical service quality and service utilization standards and trends.

SUD Oversight Policy Board

Pursuant to section 287 95) of Public Act 500 of 2012, MSHN established a Substance Use Disorder Oversight Policy Board (OPB) through a contractual agreement with and membership appointed by each of the twenty-one counties served. The SUD-OPB is responsible to approve an annual budget inclusive of local funds for treatment and prevention of substance use disorders; and serves to advise the MSHN Board on other areas of SUD strategic priority, local community needs, and performance improvement opportunities.

SUD-Advisory Councils

The MSHN SUD provider network utilizes work groups to serve in an advisory capacity to MSHN to represent SUD providers and to offer input regarding SUD policies, procedures, strategic planning, quality improvement initiatives, monitoring and oversight processes, and to support MSHN's focus on evidence-based, best practice service and delivery to persons served. Each SUD provider work group is

specific to a Level of Care (LOC) and functional area including, Women’s Specialty Services, Medication Assisted Treatment, Residential, Recovery Housing, and Outpatient work groups.

Regional Consumer Advisory Council (RCAC)

The RCAC is charged with serving as the primary source of consumer input to the MSHN Board of Directors related to the development and implementation of Medicaid specialty services and supports requirements in the region.

Operations Council (OC)

The OC was established to advise the Pre-paid Inpatient Health Plan’s (PIHP) Chief Executive Officer (CEO) concerning the operations of the Entity. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the MSHN CEO to bring local perspectives, local needs, and greater vision to the operations of the Entity so that effective and efficient service delivery systems are in place that are accountable to the entity board, funders and the citizens who make our work possible.

Finance Council (FC)

The FC will make recommendations to the Mid-State Health Network (MSHN) Chief Finance Officer (CFO), Chief Executive Officer (CEO) and the Operations Council (OC) to establish all funding formulas not otherwise determined by law, allocation methods, and the Entity’s budgets. The FC may advise and make recommendations on contracts for personnel, facility leases, audit services, retained functions, and software. The Finance Council may advise and make recommendations on policy, procedure, and provider network performance. The Council will also regularly study the practices of the Entity to determine economic efficiencies to be considered.

Information Technology Council (ITC)

The ITC was established to advise the Operations Council (OC) and the Chief Executive Officer (CEO) and will be comprised of the Chief Information Officer (CIO) and the CMHSP Participants information technology staff appointed by the respective CMHSP CEO/Executive Director. The IT Council will be chaired by the MSHN CIO.

Clinical Leadership Committee (CLC)

The CLC was established to advise the Prepaid Inpatient Health Plan’s (PIHP) Chief Executive Officer (CEO) and the OC concerning the clinical operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CEO and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

Regional Medical Directors Committee (RMDC)

The RMDC was established to advise the MSHN Chief Medical Officer (CMO), the MSHN Chief Executive Officer (or designee), the MSHN Chief Behavioral Health Officer (CBHO), and the OC concerning the behavioral health operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CMO, CEO (or designee), CBHO, and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

Utilization Management Committee (UMC)

The UMC was established to assure effective implementation of the Mid-State Health Network's UM Plan and to support compliance with requirements for MSHN policy, the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract and related Federal & State laws and regulations.

Compliance Committee (CC)

The CC was established to ensure compliance with requirements identified within MSHN policies, procedures and compliance plan; the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract; and all related Federal and State laws and regulations, inclusive of the Office of Inspector General guidelines and the 42 CFR 438.608.

Customer Services Committee (CSC)

The CSC was established to draft the Consumer Handbook and to develop policies related to the handbook, the Regional Consumer Advisory Council (RCAC), and Customer Services (CS). The Customer Services Committee (CSC) will continue as a standing committee to assure the handbook is maintained in a compliant format, and to support development and implementation of monitoring strategies to assure regional compliance with CS standards. This committee will be supported by the Director of Quality, Compliance, and Customer Service and will report through the Quality Improvement Council (QIC).

Provider Network Management Committee (PNMC)

PNMC was established to provide counsel and input to Mid-State Health Network (MSHN) staff and the Operations Council (OC) with respect to regional policy development and strategic direction. Counsel and input will typically include: 1) network development and procurement, 2) provider contract management (including oversight), 3) provider qualifications, credentialing, privileging and primary source verification of professional staff, 4) periodic assessment of network capacity, 5) developing inter- and intra-regional reciprocity systems, and 6) regional minimum training requirements for administrative, direct operated, and contracted provider staff. In fulfilling its charge, the PNMC understands that provider network management is a Prepaid Inpatient Health Plan function delegated to Community Mental Health Service Programs (CMHSP) Participants. Provider network management activities pertain to the CMHSP direct operated and contract functions.

Regional Equity Advisory Committee for Health (REACH)

To address MSHN's strategic priority of better equity, MSHN has established a Regional Equity Advisory Committee for Health (REACH), an advisory body comprised of Region 5 stakeholders and community partners from historically marginalized populations with lived experience. REACH goals are 1) to ensure attention to issues of equity, including reducing health disparities in access and delivery of quality behavioral health and substance use disorder (SUD) prevention, treatment and recovery programs; 2) to inform development and review of MSHN policies, procedures and practices through the lens of diversity, equity and inclusion (DEI); 3) to incorporate a trauma-informed perspective that accounts for historical and racialized trauma; 4) to address stigma and bias that may impact health outcomes.

VI. PERFORMANCE MANAGEMENT

Performance Management is defined as “a forward-looking process used to set goals and regularly check progress toward achieving those goals. In practice, an organization sets goals, looks at the actual data from its performance measures, and acts on results to improve the performance toward its goals.”¹ MSHN utilizes the Balanced Score Card (BSC) to provide a comprehensive view of the organizational performance.

a) Establishing Performance Measures

MSHN encourages the use of objective and systematic forms of measurement. MSHN utilizes performance measurement to monitor system performance, promote improved performance, identify opportunities for improvement and best practices, and to ensure compliance with PIHP contract requirements and State and Federal processes and requirements.

Performance measures are developed through the regional committees/councils and align with the MSHN strategic priorities of Better Health, Better Care, Better Value, Better Provider System, and Better Equity.

The measures established can be clinical and non-clinical, have clear expectations, promote transparency, and are accountable through ongoing monitoring. Information is a critical product of performance measurement that facilitates performance improvement, and priorities for risk reduction. Data must be systematically aggregated and analyzed to become actionable information. Data is used for clinical decision-making, and organizational decision-making (e.g., strategic planning and day-to-day operations).

The PIHP quality management program uses but is not limited to the following means for identification of system issues and opportunities for improvement through performance measurement:

- growth areas identified from performance summaries and reports.
- stakeholder feedback from providers and member experiences.
- oversight and monitoring reviews from external and internal processes.
- appeals/grievance, customer service complaints.

Once an opportunity is identified a quality improvement process may be initiated.

b) Prioritizing Measures

Measures are chosen by MSHN leadership in collaboration with MSHN committees, councils, and work groups based on the needs of the organization, with consideration given to the following three factors:

Focus Area: Clinical (high volume or high-risk services; continuity and coordination of care), or Non- Clinical include but are not limited to appeals, grievance, trends, and patterns of substantiated member rights complaints as well as access to, and availability of services that can be expected to have a beneficial effect on health outcomes and individual satisfaction. Qualitative and quantitative assessment; internal performance)

¹ (U.S. Department of Health & Human Services, Health Resources & Services Administration. Performance Measurement and Management, 2011)

Impact: The effect on a significant portion of consumers served with potentially significant effect on quality of care, services, or satisfaction.

Compliance: Adherence to law, regulatory, accreditation requirement and/or clinical standards of cares.

c) Data Collection, Analysis, and Reporting

The purpose of data collection is to monitor performance, identify growth areas, and monitor the effectiveness of interventions. A description of the measure is written and may include, but is not limited to the following:

- Baseline
- Standard/Target/Goal
- Data collection timeframe, and remeasurement periods,
- Frequency of data analysis
- Population/sample
- Use of standardized data collection tools,
- Data source, and
- Consistent data collection techniques.
- Strategies to minimize inter-rater reliability concerns and maximize data validity.
- Measure Steward

Additionally, if a sampling method is used, the population from which a sample is pulled, and appropriate sampling techniques to achieve a statistically reliable confidence level are included in the project/study description. The default confidence level for MSHN performance measurement activity is a 95% confidence level with a 5% margin of error.

Data is aggregated at a frequency appropriate to the process or activity being studied. Statistical testing and analysis are used as appropriate to analyze and display the aggregated data. PIHP data is analyzed over time to identify patterns and trends, and are compared to established performance targets and/or externally derived benchmarks when available. Performance targets are set through established contract requirements and/or externally derived benchmarks. If there is no set performance target, baseline data should be considered prior to setting a target.

Baseline data is data that is collected for a period of time, typically up to one year, prior to establishing a performance target. Historical data, when available may be used for baseline. When collecting baseline data, it is important to establish a well- documented, standardized, and accurate method of collecting the data and set ongoing frequencies to review the data (monthly, quarterly, etc.).

Once the baseline has been collected for a measure, it can be determined if a performance target should be established or not. If the baseline data is at or above the state and national benchmarks when available, and deemed to be within acceptable standards, it is up to the monitoring committee or team to determine if a performance measure should be established or if the measure should continue to be monitored for variances in the baseline data. If the baseline data is below the state and national benchmarks when available, a performance target should be established that is at, or greater than, the state and national average.

Targets may be defined by a set percentage for achievement to meet the outcome being measured or a percentage increase/decrease change to be achieved. When establishing performance targets, the

following should be considered (as defined in the Health Resources and Service Administration (HRSA) Quality Tool Kit):

- *Minimum or Acceptable Level.* Performance standards can be considered "minimum" or "acceptable" levels of success.
- *Challenge Level.* This level defines a goal toward which efforts are aimed. Performance results below this level are acceptable because the level is a challenge that is not expected to be achieved right away.
- *Better Than Before.* The performance measurement process is comparative from measurement period to measurement period. Success is defined as performance better than the last period of measurement. This definition comes out of the continuous quality improvement (CQI) perspective.

The data is reviewed at the established intervals by the appropriate council, committee, or workgroup, in collaboration with QIC. The data is analyzed for undesirable patterns, trends, or variations in performance. In some instances, it may be necessary to complete further data collection and analysis to isolate the causes of poor performance or excessive variability, proceeding with performance improvement action steps until the performance target is met.

d) Performance Improvement Action Steps

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

- Develop a step-by-step action plan, limiting the number of variables impacted.
- Implement the action plan, preferably on a small or pilot scale initially, and
- Study the data to check for expected results.
- Modify or develop interventions to obtain expected result.

The process of measurement, data collection, data analysis and action planning are repeated until the desired level of performance/improvement is achieved. Sustained improvement is sought for a reasonable period (such as one year) before the measure is discontinued. When sustained improvement is achieved, measures move into a maintenance modality, with a periodic reassessment of performance to ensure the desired level of quality is being maintained, as appropriate, unless the measure(s) mandated by external entities such as the MDHHS require further measurement and analysis.

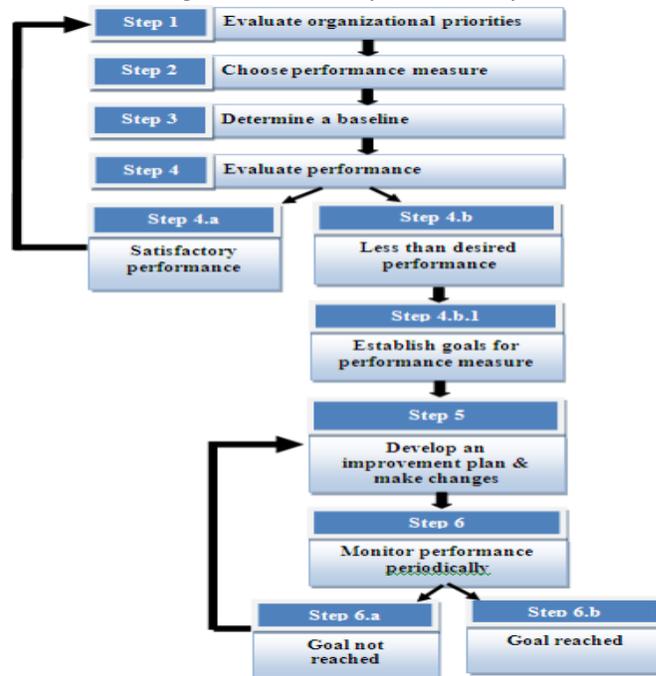
When the established minimum performance targets or requirements are not met, CMHSP Participants/SUD Providers may need to submit a quality improvement plan that includes the following:

- Causal factors that caused the variance (directly and/or indirectly)
- Interventions that will be implemented to correct the variance
- Timelines for when the action will be fully implemented
- How the interventions will be monitored
- Any other actions that will be taken to correct undesirable variation

The appropriate MSHN staff, council, committee, workgroup, etc. will monitor the implementation and effectiveness of the quality improvement plan (QIP). The effectiveness of the QIP will be monitored based on the re-measurement period identified.

In some instances, region wide quality improvement efforts may be developed based on the patterns and trends identified through data analysis, in lieu of provider level improvement plans. Region wide efforts will be reviewed for effectiveness at established intervals within the appropriate MSHN council, committees, workgroups.

Process Map of Performance Management Pathway (defined by HRSA)



e) Performance Indicators²

The Michigan Department of Health and Human Services (MDHHS), in compliance with Federal mandates, establishes measures in access, efficiency, and outcomes. Pursuant to its contract with MDHHS, MSHN is responsible for ensuring that it’s CMHSP Participants and Substance Use Disorder Providers are measuring performance using standardized performance indicators and participate in the Michigan Mission Based Performance Improvement System (MMBPIS).

When minimum performance targets or requirements are not met, CMHSP participants/SUD providers develop a quality improvement plan documenting causal factors, interventions, implementation timelines, and any other actions taken to correct undesirable variation. The plan will be reviewed by the designated MSHN content expert to ensure sufficient action planning. Regional trends are identified and discussed at the QIC or relevant committee/council for regional planning efforts and coordination. The effectiveness of the action plan will be monitored based on the re-measurement period identified.

² [Quality-Michigan Mission Based Performance Indicator System](#)

f) Performance Improvement Projects³

MDHHS requires the PIHP to complete a minimum of two performance improvement projects per year. The QIC chooses performance improvement projects based on the methodology described in section VI Performance Management of this document which includes but is not limited to the analysis of data, analysis of process, satisfaction, and/or outcome trends that may have an impact on the quality of service provided. Once chosen a recommendation is made to the MSHN Operations Council for approval. The PIP is presented to relevant committees and councils for collaboration during the duration of the PIP. One of the two is chosen by the department based on Michigan's Quality Improvement Council recommendations. This project is approved by MDHHS and subject to validation by the external quality review (EQR) organization, requiring the use of the EQR's form. In alignment with the MDHHS Comprehensive Quality Strategy, MDHHS has elected the focus of the PIP topic for FY22-FY25 to include the reduction of existing racial or ethnic disparities in access to healthcare or health outcomes. MSHN has approved the following Non-clinical Performance Improvement Project to address access to services for the historically marginalized groups within the MSHN region:

Study Topic-The racial or ethnic disparities between the minority penetration rate and the index (white) penetration rate will be reduced or eliminated.

Study Questions-Do the targeted interventions reduce or eliminate the racial or ethnic disparities in the penetration rate between the minority penetration rate and the index (white) penetration rate?

The second or additional PI project(s) is chosen by the PIHP. MSHN QIC has recommended and MSHN Operations Council has approved the following Non-clinical Performance Improvement Project to ensure time access to treatment:

Study Topic-The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.

Study Question-Do the targeted interventions increase the percentage of new consumers who receive a completed biopsychosocial assessment within 14 calendar days.

VII. STAKEHOLDER EXPERIENCE/ENGAGEMENT ⁴

MSHN values the opinions of consumers, their families, and other stakeholders as essential to identify ways to improve processes and outcomes. Surveys and focus groups are an effective means to obtain input on both qualitative and quantitative experiences. Consumers receiving services funded by the PIHP, and organizations providing services to consumers are surveyed by MSHN at least annually using a standardized survey or assessment tool. The tools vary in accordance with service population needs, address quality, availability, and accessibility of care. Focus groups are conducted as needed to obtain input on specific issues. Consumers may also be queried by the CMHSP participants/SUD providers regarding the degree of satisfaction via periodic reviews of the status of their person-centered plans, as well as during discharge planning for the cessation or transition of services.

Surveys used to assess stakeholder and member experiences include but are not limited to the following:

³ [Quality-Performance Improvement](#)

⁴ [Quality-Consumer Satisfaction Survey Policy](#)

- Mental Health Statistics Improvement Program (MHSIP)-Adults with a Mental Health illness
- Youth Satisfaction Survey (YSS) Youth with a Severe Emotional Disturbance
- Substance Use Disorder Satisfaction Survey-Individuals with a substance use disorder
- Home and Community Based Services Survey-Individuals receiving Long Term Supports and Services
- Provider Network Survey-Organizations who contract with MSHN
- Committee/Council Survey-Provider representatives on MSHN committees/ councils
- National Core Indicator Survey-Individuals receiving LTSS
- Supports Intensity Scale- Individuals receiving LTSS

The aggregated results of the surveys and/or assessments are collected, analyzed and reported by MSHN to the QI Council, Regional Consumer Advisory Council, and other relevant committees/councils, who identify strengths, areas for improvement and make recommendations for action and follow up as appropriate. Regional benchmarks and/or national benchmarks are used for comparison when available. The data is used to identify best practices, demonstrate improvements, or identify growth areas. The QI Council determines appropriate action for improvements. The findings are incorporated into program improvement action plans as appropriate. The CMHSP participant/SUD providers take action on individual cases, as appropriate, to identify and investigate sources of dissatisfaction and determine appropriate follow-up.

Survey or assessment results are included in the annual PIHP QAPIP Report and presented to the MSHN governing body, the Operations Council, Regional Consumer Advisory Council, CMHSP Participants, SUD Providers and is accessible on the MSHN website. Findings are also shared with stakeholders on a local level through such means as advisory councils, staff/provider meetings and printed materials.

VIII. ADVERSE EVENTS

Adverse Events include any event that is inconsistent with or contrary to the expected outcomes of the organization's functions that warrant a PIHP review. A subset of the adverse events will qualify as "reportable events" according to the MDHHS Critical Event Reporting System. These include MDHHS defined sentinel events, critical incidents, and risk events. MSHN also ensures that each CMHSP participant/SUD provider has a system in place to monitor these events, utilizing staff with appropriate credentials for the scope of care, and reporting or follow up within the required timeframes.

MSHN submits and/or reports required events to MDHHS including events requiring immediate notification as specified in the MDHHS PIHP FY22 contract within the timelines required by MDHHS.

MSHN delegates the responsibility of the review and follow-up of sentinel events, critical incidents, and other risk events that put people at risk of harm to the CMHSP participants and SUD providers. Risk events are monitored by the providers and include actions taken by individuals receiving services as defined by MDHHS, that may cause harm to self or others, and have had two or more unscheduled admissions to a medical hospital within 12 months. CMHSP Participants report suicide deaths, non-suicide deaths, arrests, emergency medical treatment and/or hospitalization for injuries and medication errors for required populations as defined by MDHHS.⁵ Additionally, subcategories reported for deaths include accidental/unexpected and homicide. Subcategories for emergency medical treatment and

⁵ [Quality-Critical Incidents](#)

hospitalizations include those injuries from the use of physical management. SUD Providers, including but not limited to residential providers, review and report deaths, injuries requiring emergency medical treatment and/or hospitalization, physical illness requiring hospitalization, serious behavioral issues, medication errors, and arrests and/or convictions as defined by MDHHS.⁶ All MSHN providers are responsible to review critical incidents to determine if the incident is sentinel within three days of the occurrence. Once appropriately qualified and credentialed staff identify an incident as sentinel, a root cause analysis/investigation is to commence within 2 business days of the identification of the sentinel event. Following completion of a root cause analysis, or investigation, the CMHSP will develop and implement either a plan of action to address immediate safety issues, an intervention to prevent further occurrence or recurrence of the adverse event, or documentation of the rationale for not pursuing an intervention. The plan shall address the staff and/or program/committee responsible for implementation and oversight, timelines, and strategies for measuring the effectiveness of the action. ⁷MSHN providers are responsible to report any death that occurs as a result of staff action or inaction, subject to recipient rights, licensing, or police investigation within 48 hours of the death or receipt of the notification of the death and/or investigation.

MSHN provides oversight and monitoring of the CMHSP participant/SUD provider processes for reporting sentinel events, critical events, events requiring immediate notification to MDHHS, and monitoring of risk events. In addition, a quarterly analysis of the events, identified patterns or trends, the completion of identified actions, and recommended prevention strategies for future risk reduction is reviewed with the relevant committees and councils. The goal of reviewing these events is to focus the attention of the CMHSP participant/SUD providers on potential underlying causes of events so that changes can be made in systems or processes in order to reduce the probability of such events in the future.

IX. CLINICAL QUALITY STANDARDS

a) Utilization Management ⁸ -

MSHN ensures access to publicly funded behavioral health services in accordance with the Michigan Department of Health and Human Services contracts and relevant Medicaid Provider Manual and Mental Health Code requirements.

MSHN directly or through delegation of function to the CMHSP Participants/SUD Providers acting on its behalf, is responsible for the overall network's utilization management (UM) system. Each CMHSP Participant/SUD Provider is accountable for carrying out delegated UM functions and/or activity relative to the people they serve through directly operated or contracted services.

Initial approval or denial of requested services is delegated to CMHSP Participants/SUD Providers, including the initial screening and authorization of psychiatric inpatient services, partial hospitalization, and initial and ongoing authorization of services for individuals receiving community services. All service authorizations are based on medical necessity decisions that establish the appropriate eligibility relative to the identified services to be delivered.

⁶ Quality-Critical Incident Review for SUD Providers

⁷ Quality-Sentinel Events

⁸ Utilization Management Plan

Communication with individuals regarding UM decisions, including adverse benefit determination notice, right to second opinion, and grievance and appeals will be included in this delegated function.

Utilization review functions are delegated to CMHSP Participants in accordance with MSHN policies, protocols, and standards. This includes local-level prospective, concurrent and retrospective reviews of authorization and utilization decisions and/or activities regarding level of need and level and/or amount of services, consistent with PIHP policy, standards, and protocols. A Regional Utilization Management Committee comprised of each CMHSP Participant assists in the development of standards and reviews/analyzes region-wide utilization activity and trends.

MSHN retains utilization review functions for substance use disorder (SUD) services in accordance with MSHN policies, protocols, and standards. This includes local-level prospective, concurrent and retrospective reviews of authorization and utilization decisions and/or activities regarding level of need and level and/or amount of services, consistent with PIHP policy, standards, and protocols. Initial service eligibility decisions for SUD services are delegated to SUD providers through the use of screening and assessment tools.

MSHN ensures that screening tools and admission criteria are based on eligibility criteria established in contract and policy and are reliably and uniformly administered. MSHN policies are designed to integrate system review components that include PIHP contract requirements and the CMHSP Participant's/SUD Provider roles and responsibilities concerning utilization management, quality assurance, and improvement issues.

MSHN has established criteria for determining medical necessity, and the information sources and processes that are used to review and approve provision of services. MSHN and its CMHSP Participants/SUD Providers use standardized population-specific assessments or level of care determination tools as required by MDHHS. Assessment and level of care tools guide decision making regarding medical necessity, level of care, and amount, scope, and duration of services. No one assessment shall be used to determine the care an individual receives, rather it is part of a set of assessments, clinical judgment, and individual input that determine level of care relative to the needs of the person served.

MSHN has mechanisms to identify and correct under-and over-utilization of services as well as procedures for conducting prospective, concurrent, and retrospective reviews. MSHN ensures through policy and monitoring of the CMHSP Participants/SUD Providers that qualified health professionals supervise review decisions and any decisions to deny or reduce services are made by health care professionals who have appropriate clinical licensure and expertise in treating the beneficiary's condition. Through policy and monitoring of CMHSP Participants/SUD Providers, MSHN shall ensure that reasons for treatment decisions are clearly documented and available to persons served; information regarding all available appeals processes and assistance through customer services is communicated to the consumer; and notification requirements are adhered to in accordance with the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Health and Human Services.

b) Practice Guidelines⁹

MSHN supports and requires the use of nationally accepted and mutually agreed upon clinical practice guidelines including Evidenced Based Practices (EBP) to ensure the use of research -validated methods

⁹ Service Delivery-Clinical Practice Guidelines and Evidence Based Practices

for the best possible outcomes for service recipients as well as best value in the purchase of services and supports. Practice guidelines include clinical standards, evidenced-based practices, practice-based evidence, best practices, and promising practices that are relevant to the individuals served.

The process for adoption, development, and implementation is based on key concepts of recovery, and resilience, wellness, person centered planning/individual treatment planning and choice, self-determination, and cultural competency. Practices will appropriately match the presenting clinical and/or community needs as well as demographic and diagnostic characteristics of individuals served. Practice guidelines utilized are a locally driven process in collaboration with the MSHN Councils and Committees. Practice guidelines are chosen to meet the needs of persons served in the local community and to ensure that everyone receives the most efficacious services. Clinical programs will ensure the presence of documented practice skills including motivation interviewing, trauma informed care and positive behavioral supports.

Practice guidelines will be monitored and evaluated through data analysis and MSHN's site review process to ensure CMHSP participants and SUD providers, at a minimum, are incorporating mutually agreed upon practice guidelines within the organization. Additionally, information regarding evidenced based practices is reported through the annual assessment of network adequacy. Fidelity reviews shall be conducted and reviewed as part of the local quality improvement program or as required by MDHHS.

The use of practice guidelines and the expectation of use are included in provider contracts. Practice guidelines are reviewed and updated annually or as needed and are disseminated to appropriate providers through relevant committees/councils/workgroups. All practice guidelines adopted for use are available on the MSHN website.

c) Oversight Of “Vulnerable People”

MSHN assures the health and welfare of the region's service recipients through service delivery by establishing standards of care for individuals served. MSHN defines vulnerable people as individuals who have functional limitation and/or chronic illnesses. Each CMHSP Participant/SUD Provider shall have processes for addressing and monitoring the health, safety and welfare of all individuals served.

MSHN ensures that long term supports, and services are consistently provided in a manner that considers the health, safety, and welfare of consumers, family, providers, and other stakeholders. When health and safety, and/or welfare concerns are identified, those concerns will be acknowledged, and actions taken as appropriate. MSHN assesses the quality and appropriateness of care furnished by monitoring of population health through data analytics software to identify adverse utilization patterns and to reduce health disparities, and by conducting individual clinical chart reviews during program specific reviews to ensure assessed needs are addressed and in the individual's treatment plan and during transitions between care settings.

MSHN monitors compliance with federal and state regulations annually through a process that may include any combination of desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies, as necessary. CMHSP organizations and SUD Providers that are unable to demonstrate acceptable performance may be subject to additional PIHP oversight and intervention.

d) Cultural Competence

MSHN and its Provider Network shall demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area. 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 relationships 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.

With MSHN's added strategic priority in its FY22-23 strategic plan of "better equity," MSHN is seeking to expand its scope of activity beyond cultural competence with an added focus on actively seeking to address implicit bias and to reduce health disparities.

e) Autism Benefit

MSHN oversees provision of the autism benefit within its region. MSHN delegates to the CMHSPs the application of the policies, rules and regulations as established. MSHN assures that it maintains accountability for the performance of the operational, contractual, and local entity efforts in implementation of the autism program. MSHN tracks program compliance through the MSHN quality improvement strategy and performance measures required by the benefit plan. MSHN collects data on the performance of the autism benefit consistent with the EPSDT state plan and reviews this data monthly with the CMHSPs within its region and calls for ongoing system and consumer-level improvements. This data is shared with the MDHHS as required, for reporting individual-level and systemic-level CMHSP quality improvement efforts.

Autism Benefit Review

Initial eligibility is managed through MSHN in a review of clinical content and then submitted to MDHHS for ABA service approval. Re-evaluations shall address the ongoing eligibility of the autism benefit. Continuing eligibility determination is completed every three years. All providers of ABA services shall meet credentialing standards as identified in the EPSDT benefit and Michigan Medicaid Manual to perform their function.

f) Behavior Treatment¹⁰

MSHN delegates the responsibility for the collection and evaluation of data, and the evaluation of the effectiveness of the Behavior Treatment Committee by stakeholders to each local CMHSP Behavior Treatment Review Committee. Behavior treatment data is reviewed as part of the each CMHSP Quality Program. Only those (restrictive and/or intrusive) techniques that are included in the individual's plan of service and contained in a Behavior Treatment plan that addresses all standards will be reviewed and approved by the BTPRC prior to plan implementation. Data is collected, reviewed, and reported to MSHN quarterly by the CMHSP where intrusive and restrictive techniques have been approved for use with individuals, and where physical management or 911 calls to law enforcement have been used in an emergency behavioral situation. Data shall include numbers of interventions and the length of time the interventions were used per person. By asking the behavior treatment committees to track this data, it provides important oversight to the protection and safeguard of vulnerable individuals including those receiving long term supports and services.

¹⁰ Quality-Behavior Treatment Plan Review Committee

MSHN provides oversight through analysis of the data on a quarterly basis to address any trends and/or opportunities for quality improvements. MSHN also uses this data during the delegated managed care site reviews to ensure accurate reporting and adherence to the Behavioral Treatment Standards¹¹ by each CMHSP. MSHN also conducts clinical chart reviews for those with recommended restrictive and/or intrusive interventions, in addition to the annual review of BTPRC policy and procedures. The clinical chart reviews address each of the behavior treatment standards and overall compliance is determined based on implementation of those standards. This data is available to MDHHS upon request.

g) Trauma

MSHN and its Provider Network shall adopt a trauma informed culture including the following: values, principles and development of a trauma informed system of care ensuring safety and preventing re-traumatization. In compliance with the MDHHS Trauma Policy MSHN has delegated the responsibility to the network providers to ensure development of a process for screening and assessing each population for trauma. Providers shall adopt approaches to address secondary trauma for staff and utilize evidenced based practices or evidence informed practice to support a trauma informed culture. An organizational assessment shall be completed to evaluate the extent to which the organizations policies are trauma informed. Organizational strengths and barriers, including an environmental scale to ensure the building and environment does not re-traumatize will be identified and utilized for improvement efforts. The assessment should occur every three years.

Consistent with MSHN’s broader agenda to address racial disparities and cultural competence, efforts around being trauma-informed will necessarily be expanded to incorporate competency and awareness around racialized and historical trauma for certain demographics that have historically faced discrimination, marginalization, and violence.

X. PROVIDER STANDARDS

a) Provider Qualifications ¹²¹³

MSHN has established written policy and procedures, in accordance with MDHHS’s Credentialing and Re-Credentialing Processes, for ensuring appropriate credentialing and re-credentialing of the provider network. Whether directly implemented, delegated or contracted, MSHN shall ensure that credentialing activities occur upon employment/contract initiation, and minimally every two (2) years thereafter. MSHN written policies and procedures also ensure that non-licensed providers of care or support are qualified to perform their jobs, in accordance with the Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes chart.

Credentialing, privileging, primary source verification and qualification of staff who are employees of MSHN, or under contract to the PIHP, are the responsibility of MSHN. Credentialing, privileging, primary source verification and qualification of CMHSP Participant/SUD Provider staff and their contractors is delegated to the CMHSP Participants/SUD Providers. MSHN monitors the CMHSP Participant and SUD Provider compliance with federal, state, and local regulations and requirements annually through an

¹² Provider Network-Provider Network Credentialing/Re-Credentialing

¹³ Provider Network-Non-licensed Provider Qualifications

established process including desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies.

MSHN policies and procedures are established to address the selection, orientation, and training of directly employed or contracted staff. PIHP employees receive annual reviews of performance and competency. Individual competency issues are addressed through staff development plans. MSHN is responsible for ensuring that each provider, employed and contracted, meets all applicable licensing, scope of practice, contractual, and Medicaid Provider Manual requirements, including relevant work experience and education, and cultural competence. The CMHSP Participants/SUD Providers are likewise responsible for the selection, orientation, training and evaluation of the performance and competency of their own staff and subcontractors.

b) Medicaid Event Verification ¹⁴

MSHN has established a written policy and procedure for conducting site reviews to provide monitoring and oversight of the Medicaid and Healthy Michigan funded claims/encounters submitted within the Provider Network. MSHN verifies the delivery of services billed to Medicaid and Healthy Michigan in accordance with federal regulations and the state technical requirement.

Medicaid Event Verification for Medicaid and Healthy Michigan Plan includes testing of data elements from the individual claims/encounters to ensure the proper code is used for billing; the code is approved under the contract; the eligibility of the beneficiary on the date of service; that the service provided is part of the beneficiaries individualized plan of service (and provided in the authorized amount, scope and duration); the service date and time; services were provided by a qualified individual and falls within the scope of the code billed/paid; the amount billed/paid does not exceed the contract amount; and appropriate modifiers were used following the HCPCS guidelines.

Data collected through the Medicaid Event Verification process is aggregated, analyzed, and reported for review at the QI Council and Regional Compliance Committee meetings, and opportunities for improvements at the local or regional level are identified. The findings from this process, and any follow up needed, are reported annually to MDHHS through the Medicaid Event Verification Service Methodology Report.

c) Financial Oversight

MSHN has established written policies and procedures to ensure appropriate financial management. MSHN will conduct a financial oversight review of the SUD provider network. The review will be based on eight standards used to assure regulatory compliance by reviewing the following: Certified Public Accountant (CPA) Audit, compliance with previous corrective action; financial management policies and procedures; documents to ensure proper segregation of duties; evidence to support the Financial Status Report (FSR) billing; verification of board approved sample financial reports; and evaluation of Risk Management Plan. Information obtained from the review will be used to identify focus areas for improvement efforts, in accordance with the oversight monitoring corrective action process.

All CMHSP Participants and MSHN have implemented the generation of a summary of Explanations of Benefits in accordance with the MDHHS Specialty Mental Health Services Program contract. This will provide an additional step to ensure that consumers are aware of service activity billed to their insurance.

¹⁴ Quality-Medicaid Event Verification

d) Provider Monitoring and Follow-Up¹⁵¹⁶

MSHN uses a standard written contract to define its relationship with CMHSP Participants/SUD Providers that stipulates required compliance with all federal and state requirements, including those defined in the Balance Budget Act (BBA), the Medicaid Provider Manual, and the master contract between the PIHP and MDHHS. Each CMHSP Participant/SUD Provider is contractually required to ensure that all eligible recipients have access to all services required by the master contract between the PIHP and MDHHS, by either direct service provision or the management of a qualified and competent provider panel. Each CMHSP Participant/SUD Provider is also contractually required to maintain written subcontracts with all organizations or practitioners on its provider panel. SUD Providers, however, must first obtain written authorization from MSHN in order to subcontract any portion of their agreement with MSHN. These subcontracts shall require compliance with all standards contained in the BBA, the Medicaid Provider Manual, and the Master Contract between the PIHP and the MDHHS.

Each CMHSP Participant/SUD Provider is required to document annual monitoring of each provider subcontractor as required by the BBA and MDHHS. The monitoring structure shall include provisions for requiring corrective action or imposing sanctions, up to and including contract termination if the contractor's performance is inadequate. MSHN continually works to assure that the CMHSP Participants support reciprocity by developing regionally standardized contracts, provider performance protocols, maintain common policies, and evaluate common outcomes to avoid duplication of efforts and reduce the burden on shared contractors. MSHN monitors compliance with federal and state regulations annually through a process that includes any combination of desk review, site review verification activities, and/or other appropriate oversight and compliance enforcement strategies. CMHSPs Participants/SUD Providers that are unable to demonstrate acceptable performance may be required to provide corrective action, may be subject to additional PIHP oversight and interventions, and may be subject to sanctions imposed by MSHN, up to and including contract termination.

e) External Reviews¹⁷

The PIHP is subject to external reviews through MDHHS and/or an external quality reviewer contracted by MDHHS to ensure quality and compliance with all regulatory requirements. MSHN collaborates with MDHHS and the external quality reviewer to provide relevant evidence to support compliance. In accordance the MDHHS-PIHP, all findings that require improvement based on the results of the external reviews are incorporated into the QAPIP Priorities for the following year. An action plan will be completed that includes the following elements: improvement goals, objectives, activities, timelines, and measures of effectiveness in response to the findings. The improvement plan will be available to MDHHS upon request.

¹⁵ Quality-CMHSP Participant Monitoring & Oversight

¹⁶ Quality-Monitoring & Oversight of SUD Service Providers

¹⁷ Compliance-External Quality Review

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XI. Quality Assessment and Performance Improvement Program Priorities (QAPIP) FY2022

The QAPIP priorities shall guide quality efforts for FY22. Figure 1 provides the QAPIP Priorities and Quality Work Plan for FY22. The FY22 QAPIP Priorities include completion of required elements of the QAPIP, growth areas based on external site reviews and the review of effectiveness. QAPIP activities are aligned with the MSHN Strategic Plan contributing to Better Health, Better Care, Better Provider Systems, and Better Equity for the individuals we serve.

Figure 1. QAPIP Priorities and Work Plan

Organizational Structure and Leadership	Objectives/Activities	Assigned Person or Committee/Council	Frequency / Due Date
MSHN will have an adequate organizational structure with clear administration and evaluation of the QAPIP	To develop in collaboration with the QIC the annual QAPIP evaluation and QAPIP plan. (QAPIP Description, QAPIP Work Plan and Organizational Chart of the QAPIP).	Quality Manager	11.30.2022
	Development of a process to monitor the progress of the quality workplan performance measures inclusive of other departments designated responsibilities in the QAPIP (UM, PNM, CC, Clinical-SUD, IT).	Quality Manager	9.30.2021
Governance	Objectives/Activities	Assigned Person or Committee/Council	Frequency / Due Date
Board of Directors will approve the QAPIP Plan and Report	To submit the annual QAPIP Plan and Report to the board.	MSHN Deputy Director MSHN-CCQO	1.1.2022 1.31.2023
Board of Directors review QAPIP Progress Reports	To submit QAPIP progress reports to the Board.	MSHN Deputy Director MSHN CCQO	Quarterly
QAPIP will be submitted to Michigan Department of Health and Human Services	To submit the Board approved QAPIP Report and Plan to MDHHS. (via MDHHS FTP Site)	MSHN Quality Manager QIC	1.31.2022 1.31.2023
	Review reporting timeframes and submission deadline for QAPIP submission to MDHHS with contract negotiating team.	MSHN CEO	10.1.2021
Include the role of recipients of service in the QAPIP	QAPIP Description, and Organizational Chart of the QAPIP.	MSHN Quality Manager	1.31.2022 1.31.2023

Communication of Process and Outcome Improvements	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
The QAPIP Plan and Report will be provided annually to network providers and to members upon request.	To distribute the completed Board approved QAPIP Effectiveness Review (Report) through committee/councils, MSHN Constant Contact, and email. To post to the MSHN Website. To ensure CMHSP contractors receive the QAPIP.	MSHN Quality Manager	3.2.2022 2.28.2023
Guidance on Standards, Requirements, and Regulations	To complete MSHN Contract Monitoring Plan and Medicaid Work Plan, post updates to MSHN Website, and distribute through committee/councils, MSHN Constant Contact.	MSHN CCQO QIC, CLC, UM, ITC, CSC, SUDP, FC, OC	As needed, minimum annually
Consumers & Stakeholders receive reports on key performance indicators, consumer satisfaction survey results and performance improvement projects	To present reports on Consumer Satisfaction Survey Results, Key Priority Measures, MMBPIS, Behavior Treatment Review Data, Event Data, Quality policies/procedures and Customer Service Reports to RCAC.	MSHN Customer Services Manager	Quarterly
Performance Measurement and Quality reports are made available to stakeholders and general public	To upload to the MSHN website the following documents: QAPIP Plan and Report, Satisfaction Surveys, Performance Measure Reports; MSHN Scorecard, and MSHN Provider Site Review Reports, in addition to communication through committees/councils.	MSHN CCQO CC, QIC, UM, CLC, ITC, CSC, SUDP, FC, OC	Quarterly
MDHHS Performance Indicators	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
MSHN will meet or exceed the MMBPIS standards for Indicators 1, 4, 10 as required by MDHHS. (PM)	Complete quality checks on data prior to submission through affiliate uploads in REMI. (Verify Medicaid Eligibility, Data Accuracy)	CMHSP Participants	Q1-3.15.2022 Q2-6.15.2022 Q3-9.15.2022 Q4-12.15.2022
	Submit MMBPIS data as required to MDHHS quarterly.	MSHN-Quality Manager	Q1 3.31.2021 Q2 6.30.2021 Q3 9.30.2021 Q4 12.31.2021
	Complete performance summary, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees/councils.	MSHN-Quality Manager QIC, RMDC, CLC/UM	Q1 April Q2 July Q3 October Q4 January

MDHHS Performance Indicators	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
MSHN will meet or exceed the MMBPIS standards for Indicators 1, 4, 10 as required by MDHHS. (PM)	Document causal factors and interventions quarterly when performing below the standard.	CMHSP Participants SUD Providers	Q1-3.15.2022 Q2-6.15.2022 Q3-9.15.2022 Q4-12.15.2022
	Complete primary source verification of submitted records during the DMC review.	MSHN-Quality Assurance Performance Improvement (QAPI) Manager	Annually (Interim or Full Review)
MSHN to verify Medicaid eligibility prior to MMBPIS submission to MDHHS (PMV-2021)	Validate logic in REMI for Medicaid Enrollment Dates /Medicaid Eligibility in the PI Output Report.	MSHN-QM MSHN-CIO	3.31.2022
MSHN will demonstrate an increase in compliance with access standards for the priority populations. (in addition to those included in the MMBPIS) (Compliance Review) (PM)	Establish a mechanism to monitor access requirements for priority populations.	MSHN-QM MSHN-UCM Director	4.30.2022
	Establish a mechanism to monitor access requirements for Individuals enrolled in CCBHC.	MSHN-QM MSHN-UCM Director	4.30.2022
BH-TEDS	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
MSHN will demonstrate an improvement or maintain data quality for the BH-TEDS. (PM)	MSHN will identify areas of discrepancy for the BH-TEDS data for FY22. Veterans' data (military fields), Employment data-minimum wage, Living arrangements, LOCUS records, Medicaid IDs on update and M records.	MSHN-CIO ITC	6.30.2022
	Causal factors with action steps will be determined to address incomplete data and/or illogical combination based on review BH-TEDS data. Veterans' data (military fields), Employment data-minimum wage, Living arrangements.	MSHN-Quality Manager MSHN CIO QIC/ITC	9.30.2022
	Narrative completed comparing BH-TEDS (veteran's military fields) and VN Report for FY21/22 data, including actions steps.	MSHN QM-QIC MSHN CIO MSHN VN	1.31.2022 7.1.2022

Performance Improvement Projects	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
Will engage in two performance improvement projects during the waiver renewal period. PIP 1: The racial or ethnic disparities between the minority penetration rate and the index (white) penetration rate will be reduced or eliminated. (PM) PIP 2: The percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergency biopsychosocial assessment will demonstrate an increase. (PM)	Complete the design of the Required PIP addressing disparities- Penetration Rate. Identify baseline data, causal factors, and interventions. Submit to HSAG as required. Complete the design of the Optional PIP MMBPIS Indicator 3. Identify baseline data, causal factors and interventions	MSHN-QM MSHN-UM/Integrated Care Director QIC, UMC/CLC	6.30.2022
	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees/councils. Submit PIP 1 to HSAG as required for validation.	MSHN-QM MSHN-UM/Integrated Care Director QIC, UMC/CLC	12.31.2022 3.31.2023 6.30.2023 9.30.2023
Quantitative and Qualitative Assessment of Member Experiences	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
MSHN will obtain a qualitative and quantitative assessment of member experiences for all representative populations, including members receiving LTSS, and take specific action as needed, identifying sources of dissatisfaction, outlining systematic action steps, monitoring for effectiveness, communicating results. (PM)	Identify a qualitative process and distribute surveys and assessments based on the population and services received. (MHSIP/YSS) (SUD Satisfaction). Complete an annual report to include the trends, causal sources of dissatisfaction, and interventions in collaboration with relevant committees/councils. Develop proposal for the administration of qualitative and quantitative assessment of member experience, and provider satisfaction for the region.	MSHN-Customer Services Manager MSHN-Quality Manager QIC/CSC/SUDP/PNMC/QMT/RCAC/CLC	9.30.2022
	Utilize the analysis of the National Core Indicator Data, provided by MDHHS, to identify trends and areas for improvement.	MSHN-QM MSHN-CBHO QIC, CLC, Waiver Work Groups	Annual as available
MSHN will demonstrate an increase in applicable providers within the network that are "in compliance" with the HCBS rule. (PM)	Evaluate/remediate compliance with the HCBS Rule for individuals receiving services. Identify causal factors for not meeting the standard and remediate based on the results.	MSHN-Waiver Managers	Quarterly

Quantitative and Qualitative Assessment of Member Experiences	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
MSHN will demonstrate full compliance with the completion of a SIS assessment in accordance with the MDHHS required guidelines. (1x every three years) (PM)	Review internal report for compliance rate, identify causal factors and interventions for not meeting the standard. (How many have received a SIS within 3 years. How many meet the criteria for the completion of a SIS assessment.) (Power Bi report)	MSHN-CBHO/SIS Assessor CMHSP Participants CLC	Quarterly
MSHN will meet or exceed the standard for Appeals and Grievance resolution in accordance with the MDHHS standards. (PM)	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations).	MSHN-Customer Services Manager CSC	Quarterly
Event Monitoring and Reporting	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
MSHN will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored, reported, and followed up on as specified in the PIHP Contract.	Submit Critical Events monthly.	CMHSP Participants MSHN-QM	Last business day of each month
	Submit Sentinel Events (Provider Portal)	SUDPs (Residential Recovery Housing)	1.15.2022 4.15.2022 7.15.2022 10.15.2022
	Submit Sentinel Events to MDHHS as required. (egram)	MSHN-QM	4.30.2022 10.30.2022
	Submit Sentinel Events (immediate notification) to MSHN based on notification requirements of the event. (24 hour, 48 hours, 5 days)	CMHSP Participants SUDPs (Residential)	As Needed
	Develop Dashboard for tracking and monitoring timeliness.	MSHN-QM	9.30.2022
	Conduct oversight through the DMC review, ensure appropriate follow up is occurring for all events dependent on the type and severity of the event, including a root cause analysis, mortality review, immediate notification to MDHHS as applicable. Conduct primary source verification of critical incidents and sentinel events.	MSHN-QM MSHN-QAPI	Annually (Interim or Full Review)
CMHSP Participants and SUD Treatment Providers will demonstrate a decrease in the rate of adverse events from previous reporting period. (PM)	Complete the CIRS Performance Reports (including standards, trends, barriers, improvement efforts, recommendations, and status of recommendations to prevent reoccurrence) quarterly.	MSHN-QM QIC, CLC/UM, RMDC, RCAC, Focused work groups	1.31.2022 4.30.2022 7.31.2022 10.31.2022

Medicaid Event Verification	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
MSHN will meet or exceed a 90% rate of compliance of Medicaid delivered services in accordance with MDHHS requirements.	Complete Medicaid Event verification reviews in accordance with MSHN policy and procedure.	MSHN-MEV Auditor	See annual schedule for each provider
	Complete The MEV Annual Methodology Report identifying trends, patterns, strengths and opportunities for improvement.	MSHN-CQCO MSHN MEV Auditor CCC, QIC	12.31.2022
	Submit the Annual MEV Methodology Report to MDHHS as required.	MSHN-CQCO	12.31.2022
Utilization Management Plan	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
MSHN will establish a Utilization Management Plan in accordance with the MDHHS requirements	Complete/review the MSHN Utilization Management Plan.	MSHN-UCM Director	Bi-Annually 2023
	MSHN to complete performance summary quarterly reviewing trends, patterns of under / over utilization, medical necessity criteria, and the process used to review and approve provision of medical services. Identify CMHSPs/SUDPs requiring improvement and present/provide to relevant committees/councils.	MSHN-UCM Director	Quarterly/ Annually See UM Reporting Schedule
	Utilize uniform screening tools and admission criteria. LOCUS, CAFAS, MCG, ASAM, SIS, DECA	MSHN-UCM Director	Quarterly/ Annually
MSHN will demonstrate full compliance with timeframes of service authorization decisions in accordance with the MDHHS requirements. (PM)	Oversight of compliance with policy through primary source verification during Delegated Managed Care Reviews.	MSHN-UCM Director MSHN-QAPI Managers	Annually (Interim or Full Review)
	Development of REMI process for tracking timeliness of authorization decisions.	MSHN-UCM Director	3.31.2022
MSHN will meet or exceed the standard for compliance with the adverse benefit determination notices completed in accordance with the 42 CFR 438.404.(PM)	Develop ABD training for staff. Staff to complete training.	MSHN-Customer Service Manager CMHSP Participants, CSC	5.31.2022 9.30.2022
	Oversight of compliance during Delegated Managed Care Reviews.	MSHN-Customer Service Manager MSHN-QAPI Managers	Annually (Interim or Full Review)

Practice Guidelines	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
MSHN will adopt, develop, implement nationally accepted or mutually agreed upon (MSHN/MDHHS) clinical practice guidelines/standards, evidenced based practices, best practice, and promising practices relevant to the individual served.	Identify practice guidelines adopted/required for use in the MSHN region. Review guidelines currently in policy/procedure.	MSHN-CBHO MSHN-UCM Director CLC/UMC, RMDC	6.30.2022
	MSHN will communicate and disseminate the practice guidelines accepted for use on the MSHN website, as requested, and through regional committees/councils.	MSHN-CBHOMSHN-UCM DirectorCLC/UMC, RMDC	1.31.2022 1.31.2023
MSHN will demonstrate full compliance with the MDHHS required practice guidelines. (PM)	Oversight during DMC Review to ensure providers adhere to practice guidelines as required.	MSHN-CBHO MSHN-QAPI MSHN-CCO	Annually (Interim or Full Review)
MSHN will demonstrate an increase for individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan. (PM BSC)	MSHN will complete and implement a regional training plan to address Person Centered Planning and the development of the Individual Plan of Service. The following elements will be incorporated into the planning process and document: · -Choice voucher/self-determination arrangements offered -Assessed needs in IPOS -Strategies adequately address health and safety and primary care coordination -Goals are measurable and include amount, scope and duration -Prior authorization of services corresponds to services in IPOS -IPOS is reviewed and updated no less than annually -Include guardian in PCP process -Category/intensity of Care (CWP)	MSHN-CQCO MSHN-UCM Director	2.17.2021 4.1.2022
MSHN will demonstrate an increase in fidelity to the Evidenced Based Practice-Assertive Community Treatment Michigan Field Guide, for average minutes per week per consumer. (PM)	Complete a quarterly utilization summary of the average minutes per week/per consumer that will include the identification of barriers, interventions, and progress.	MSHN-UCM DirectorUMC	Quarterly

Oversight of "Vulnerable People"/Long Term Supports and Services	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
MSHN will evaluate health, safety and welfare of individuals "vulnerable people" served in order to determine opportunities for improving oversight of their care and their outcomes.	MSHN will analyze performance measures-Behavior Treatment, Integrated Population Health Report, Key Performance Measures, Behavioral Health Report for trends and patterns and develop action for areas of concern.	MSHN-UCM Director MSHN-CBHO MSHN- Waiver Managers/Coordinators	Annually/ Quarterly
	Complete clinical record reviews during the delegated managed care review.	MSHN-QAPI Manager MSHN-Waiver Managers/ Coordinators	Annually (Interim or Full Review)
MSHN will assess the quality and appropriateness of care furnished to members(vulnerable people) receiving LTSS including an assessment of care between care settings, a comparison of services and supports received with those set forth in the members treatment/service plan. (PM)	Analyze performance reports (including barriers, improvement efforts, recommendations, and status of recommendations) completed for Behavior Treatment, Integrated Population Health Report, Key Performance Measures for efforts to support community integration.	MSHN-UCM Director MSHN-CBHO MSHN- Waiver Managers/Coordinators MSHN-QAPI	Annually/ Quarterly
MSHN will establish conflict of interest standards for assessments and IPOS development.	Establish a board approved regional conflict free policy.	MSHN-UCM Director	5.31.2022
Behavior Treatment	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
MSHN will demonstrate an increase in compliance with the MDHHS Behavior Treatment Standards. (PM)	Oversight will occur during Delegated Managed Care Site Reviews. Including primary source verification of reported incidents.	MSHN-Waiver Managers	Annually (Interim or Full Review)
Behavioral treatment plans are developed, approved or disapproved in accordance with the Standards for Behavior Treatment Plan Review Committees.	Submit data on Behavior Treatment Plans where intrusive and or restrictive techniques have been approved by the behavior treatment committee and where emergency interventions have been used (physical management, 911 calls for behavioral assistance).	CMHSP Participants BTPR Work Group	Q1-1.31.2021 Q2-4.30.2021 Q3-7.31.2021 Q4-10.31.2021
	Complete Behavior Treatment Performance Reports that analyze the use of emergency interventions, plans approved with restrictive and/or intrusive interventions, and adherence to the BTPR Standards (including barriers, improvement efforts, recommendations, and status of recommendations).	MSHN-QM MSHN-Waiver Manager QIC, CLC/UM	Q1-2.27.2022 Q2- 5.31.2022 Q3- 8.31.2022 Q4-11.30.2022

Provider Monitoring	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
MSHN will be in compliance with PIHP Contract Requirements.	Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	MSHN-QAPI MSHN Content Experts	Annually (Interim or Full Review)
	Coordinate quality improvement plan development, incorporating goals and objectives for specific growth areas based on the site reviews, and submission of evidence for the follow up reviews.	MSHN-QM Relevant committees/councils	9.30.2022 9.30.2023
MSHN will demonstrate an increase in compliance with the External Quality Review (EQR)-Compliance Review. (PM-specific to CAP areas)	Implement corrective action plans for areas that were not in full compliance, and quality improvement plans for recommendations. See CAP for specific action steps. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	MSHN-CBHO MSHN-UCM Director MSHN-Customer Services MSHN-QM MSHN-Contract Manager MSHN-Lead QAPI Manager	9.30.2022 9.30.2023
MSHN will demonstrate full compliance with the EQR-Performance Measure Validation Review.	Implement quality improvement plans for recommendations provided by the external quality review team. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	MSHN-QM-QIC CMHSP Participants MSHN-CIO-ITC MSHN-IT Manager	9.30.2022 9.30.2023
MSHN will receive a score of "Met" for the EQR-Performance Improvement Project Validation.	No action needed at this time.	MSHN-Quality Manager CMHSP Participants	9.30.2022 9.30.2023
MSHN will demonstrate an increase in compliance with the MDHHS 1915 Review. (SEDW, CWP, HSW, HCBS, Autism)	Monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data.	MSHN-QM MSHN-Waiver Managers/ Coordinators MSHN- CBHO	9.30.2022 9.30.2023
MSHN will demonstrate full compliance with the MDHHS Substance Use Disorder Protocols.	Provide evidence to support SUD requirements	MSHN-Quality Manager MSHN-CCO; SUD Tx Team	9.30.2022
MSHN will demonstrate full compliance with the Autism Benefit Standards. (PM)	Monitor systematic remediation for effectiveness through DMC reviews and performance monitoring through data.	MSHN-Waiver Manager MSHN-QAPI Managers	9.30.2022
MSHN will demonstrate assurances of adequate capacity and services for the region, in accordance with the MDHHS Network Adequacy standards.	Complete Network Adequacy Assessment including all required elements	MSHN-Contract Manager	9.30.2022

Provider Qualifications	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
<p>MSHN will ensure physicians, other healthcare providers, and non-licensed individuals are qualified to perform their jobs.</p> <p>MSHN will have credentialing policies/ procedures, in accordance with MDHHS Credentialing and Re-Credentialing Process, for ensuring that all providers rendering services to individuals are appropriately credentialed within the state and are qualified to perform their services.</p> <p>MSHN ensures all delegates performing credentialing functions comply with all initial (including provisional/temporary) credentialing requirements according to the Initial Credentialing Audit Tool, re-credentialing, and organizational credentialing tool.</p> <p>Clinical service providers are credentialed by the CMHSP prior to providing services and ongoing.</p>	<p>An analysis will be completed to identify trends, and progress of the performance measure, including barriers and interventions.</p> <p>Primary Source Verification and credentialing and recredentialing policy and procedure review will occur during the DMC Review. MSHN will increase monitoring for providers scoring less than 90% on the file review and will be subject to additional review of credentialing and re-credentialing records.</p> <p>Review semi-annual credentialing and re-credentialing report to ensure credentialing within the appropriate timeframes.</p>	<p>MSHN-QAPI Lead Manager</p> <p>MSHN QAPI Managers</p> <p>MSHN-QAPI Lead Manager</p>	<p>Quarterly</p> <p>Annually (Interim or Full Review) Report-Quarterly</p> <p>Semi-Annually (include months)</p>
<p>Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements. (PM)</p>	<p>Will conduct oversight during the DMC-Program Specific Review</p>	<p>MSHN-Autism Coordinator MSHN-Waiver Manager</p>	<p>Annually (Interim or Full Review)</p>
<p>Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements. (PM)</p>	<p>Will conduct oversight during the DMC-Program Specific Review</p>	<p>MSHN-Autism Coordinator MSHN-Waiver Manager</p>	<p>Annually (Interim or Full Review)</p>

An effective performance measurement system allows an organization to evaluate the safety, accessibility and appropriateness, the quality and effectiveness, outcomes, and an evaluation of satisfaction of the services in which an individual receives. MSHN utilizes a balanced score card to monitor organizational performance. Those areas that perform below the standard are included in the annual QAPIP Work Plan. Figure 2 demonstrates indicators used to monitor the performance of MSHN.

Figure 2. FY22 Performance Measures

Strategic Priority	Michigan Mission Based Performance Indicator System	Committee / Council	FY21
Better Care	MSHN will meet or exceed the standard for indicator 1: Percentage of Children who receive a Prescreen within 3 hours of request (Standard is 95% or above)	QIC	99.58%
Better Care	MSHN will meet or exceed the standard for indicator 1: Percentage of Adults who receive a Prescreen within 3 hours of request (Standard is 95% or above)	QIC	99.22%
Better Care	Indicator 2. a. <u>Effective on and after April 16, 2020</u> , the percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children). (No Standard)	QIC	63.69%
Better Care	Indicator 2 b. <u>Effective April 16, 2020</u> , the percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders. (No Standard)	QIC/SUD	**80.98%
Better Care	Indicator 3: <u>Effective April 16, 2020</u> , percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children). (No Standard)	QIC	71.34%
Better Care	MSHN will meet or exceed the standard for indicator 4a1: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (Standard is 95% or above) (Child)	QIC	98.90%
Better Care	MSHN will meet or exceed the standard for indicator 4a2: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (Standard is 95% or above) (Adult)	QIC	97.02%
Better Care	MSHN will meet or exceed the standard for indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (Standard is 95% or above)	QIC/SUD	96.68%
Better Care	MSHN will meet or exceed the standard for indicator 10: Re-admission to Psychiatric Unit within 30 Days (Standard is 15% or less) (Child)	QIC	7.97%
Better Care	MSHN will meet or exceed the standard for indicator 10: Re-admission to Psychiatric Unit within 30 Days (Standard is 15% or less) (Adult)	QIC	12.62%
Better Care	MSHN will demonstrate and increase in compliance with access standards for the priority populations. (Baseline)	UMC	New

Strategic Priority	BH-TEDS Data	Committee /Council	FY21
Better Care	MSHN will demonstrate an improvement with the data quality on the BH-TEDS living arrangements fields. (Baseline)	QIC	New
Better Care	MSHN will demonstrate an improvement with the data quality on the BH-TEDS employment fields. 3 categories. (Baseline)	QIC	New
Better Care	MSHN will demonstrate an improvement with the data quality on the BH-TEDS LOCUS fields. (Baseline)	QIC	New
Better Care	MSHN will increase access and service utilization for Veterans and Military members. (Baseline)	QIC	New
Strategic Priority	Performance Improvement Projects	Committee /Council	FY21
Better Care	PIP 1: The racial or ethnic disparities between the minority penetration rate and the index (white) penetration rate will be reduced or eliminated. (Baseline)	QIC	New
Better Care	PIP 2: The percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergency biopsychosocial assessment will demonstrate an increase. (Baseline)	QIC	New
Strategic Priority	Assessment of Member Experiences	Committee /Council	FY21
Better Care	Percentage of consumers indicating satisfaction with SUD services. (Standard 80%/3.50)	QIC	95%/4.61
Better Care	Percentage of children and/or families indicating satisfaction with mental health services. (Standard 80%/3.50)	QIC	87%/4.18
Better Care	Percentage of adults indicating satisfaction with mental health services. (Standard 80%/3.50)	QIC	85%
Better Care	Percentage of individuals indicating satisfaction with long term supports and services. (Standard 80%/3.50)	QIC	85%
Better Care	MSHN will demonstrate an increase in applicable providers within the network that are "in compliance" with the HCBS rule. (Baseline)	CLC	New
Better Care	MSHN will demonstrate full compliance with the completion of a SIS assessment in accordance with the MDHHS required guidelines. (1x every three years) (Baseline)	CLC	New
Strategic Priority	Member Appeals and Grievance Performance Summary	Committee /Council	FY21
Better Care	Percentage (rate per 100) of Medicaid consumers who are denied overall eligibility were resolved with a written notice letter within 14 calendar days for a standard request of service. (Standard 95%)	CSC	98.27%
Better Care	The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness standards including the written disposition letter (30 calendar days) of a standard request for appeal. (Standard 95%)	CSC	98.82%
Better Care	The percentage (rate per 100) of Medicaid grievances are resolved with a written disposition sent to the consumer within 90 calendar days of the request for a grievance. (Standard 95%)	CSC	98.72%

Strategic Priority	Adverse Event Monitoring and Reporting	Committee /Council	FY21
Better Care	The rate of critical incidents, per 1000 persons served will demonstrate a decrease from previous year. (CMHSP) (excluding deaths)	QIC	8.343
Better Health	The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous year. (CMHSP)(Natural Cause, Accidental, Homicidal)	QIC	2.96
Better Care	The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from previous year. (SUDP)	SUD	0.014
Strategic Priority	Joint Metrics	Committee /Council	FY21
Better Care	Percent of care coordination cases that were closed due to successful coordination (Standard-<= to 50%)	UMC/IC	100%
Better Value	Reduction in number of visits to the emergency room for individual in care coordination. (Standard 100%)	UMC/IC	75%
Better Care	J.1 Implementation of Joint Care Management Processes	UMC	Complete
Better Care	J.2 The percentage of discharges for adults (18 years or older) who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. FUH Report, Follow-Up After Hospitalization Mental Illness Adult (Standard-58%)	QIC	75.34%
Better Care	J.2 The percentage of discharges for children (6-17 years) who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. Follow-Up After Hospitalization Mental Illness Children (Standard-70%)	QIC	89.32%
Strategic Priority	Joint Metrics	Committee /Council	FY21
Better Care	J.2 Racial/ethnic group disparities will be reduced. (*Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences) <i>Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following a psychiatric hospitalization (adults and children)</i>	QIC	0
Better Care	J.3 Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Standard 27%) based on CY21	UMC/IC	28%
Better Care	J.3 Reduce the disparity BSC Measures for FUA. <i>Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following an emergency department visit for alcohol or drug use.</i>	UMC	1

Strategic Priority	Performance Based Incentive Payments	Committee /Council	FY21
Better Care	P.1 Identification of beneficiaries who may be eligible for services through the Veterans Administration. a. MSHN will demonstrate an improvement or maintain data quality on the BH-TEDS military and veteran fields. b. Monitor and analyze data discrepancies between VN and the BH-TEDS data.	ITC/QIC	Complete
Better Health	P.2 Increased data sharing with other providers (narrative report) (include action steps in work plan)	ITC	Complete
Better Care	P.3 The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: -Initiation of AOD Treatment: The percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis. (Completion of the Validation only)	SUDT	Complete
Better Health	P.4 Increased participation in patient centered medical homes (Narrative)	UMC	Complete
Strategic Priority	Priority Measures	Committee /Council	FY21
Better Care	MSHN will demonstrate improvement from previous reporting period (79%) of the percentage of patients 8-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Diabetes Screening Report (Data Source-ICDP) Michigan 2020-84.43%	QIC	84.68%
Better Health	The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar who were prescribed any antipsychotic medication and who received cardiovascular health screening during the measurement year. Cardiovascular Screening (Data Source-ICDP) Standard-Incremental progression toward meeting the performance rate of Michigan 2020-73.16%	CLC	54.88%
Better Health	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. (Data Source-ICDP) Standard- Incremental progression toward meeting the performance rate of Michigan 2020-44.44%	CLC	60.52%
Better Health	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. (Data Source-ICDP) Standard- 2020 54.65%	CLC	97.12%
Better Care	Plan All-Cause Readmissions-The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (<=15%) (Data Source-ICDP) Standard-Michigan 2020 9.09%	UM	11.59%
Better Care	The percentage of members 20 years and older who had an ambulatory or preventative care visit. Adult Access to Care (>=75%) (Data Source – ICDP) Standard-Michigan 2020 82.49%	UM	91.69%
Better Care	The percentage of members 12 months-19 years of age who had a visit with a PCP. Children Access to Care (>=75%) (Data Source-ICDP) Standard-Michigan 2020 89.64%	UM	95.68%

Strategic Priority	Priority Measures	Committee /Council	FY21
Better Care	MSHN will demonstrate an increase over previous reporting period of Initiation in Treatment (IET) of Alcohol and Other Drug Dependence.	SUDT	57.48%
Better Care	MSHN will demonstrate an increase over previous reporting period of Engagement in Treatment (IET) of Alcohol and Other Drug Dependence.	SUDT	50.12%
Strategic Priority	Utilization Management/LTSS	Committee /Council	FY21
Better Care	Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines. (Target 100%)	UM	98.50%
Better Care	Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan. (Standard 100%)	UM	81.50%
Better Care	Service utilization remains consistent or increases over previous year due to improved access to services through the use of telehealth. (Standard 0% decrease over previous fiscal year) standard is 1-10% decrease.	UM	6%
Better Value	Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages (Standard <=5%)	UM	1%
Better Care	MSHN's Habilitation Supports Waiver slot utilization will demonstrate a consistent minimum or greater performance of 95% or greater HSW slot utilization.	CLC	94.90%
Better Care	Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS. (Standard 95%)	CLC	89%
Better Care	MSHN's provider network will demonstrate 95% compliance with trauma-competent standard in the site review chart tool. (Standard increase over 2016 or 95%?)	CLC	99.07%
Better Care	MSHN will demonstrate full compliance with timeframes of service authorization decisions in accordance with the MDHHS requirements. (Baseline)	UMC	New
Strategic Priority	Behavior Treatment	Committee /Council	FY21
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOSs reviewed during the reporting period. (95%)	QIC/CLC	61% (2 quarters)
Better Care	The percent of individuals who have an approved Behavior Treatment Plan which includes restrictive and intrusive techniques. (Track and trend)	QIC	1.16%
Better Care	The percent of emergency interventions (911 calls, physical management) during the reporting period will decrease from previous year.	QIC	0.59%

Strategic Priority	Trauma	Committee /Council	FY21
Better Care	MSHN will demonstrate a 95% rate for the completion of Trauma Organizational Assessments every three years.	CLC	99.07%
Strategic Priority	Clinical Practice Guidelines	Committee /Council	FY21
Better Care	MSHN will demonstrate full compliance with the use of MDHHS required practice guideline. (PM) Inclusion, Consumerism, Personal Care in Non-Specialized Residential Settings, Family Driven and Youth Guided, Employment Works Policy and Practice Guidelines. (Baseline Development)	CLC	New
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period.	CLC	61%
Better Care	MSHN's ACT programs will demonstrate an increase in fidelity for average minutes per week per consumer (120 minutes). (BSC)	UMC	
Strategic Priority	Provider Monitoring	Committee /Council	FY21
Better Provider System	Provider surveys demonstrate satisfaction with REMI enhancements - Provider Portal (SUD Network) (Standard 80%)	PNMC	73%
Better Provider System	SUD providers satisfaction demonstrates 80% or above with the effectiveness and efficiency of MSHN's processes and communications (SUD Network) (Standard 80%)	PNMC	79%
Better Provider System	Autism/ABA provider network will demonstrate satisfaction with regionally organized performance monitoring procedures (CMHSP Network) (Standard 80%)	PNMC	73%
Better Provider System	MSHN will demonstrate an increase in compliance with the External Quality Review-Compliance Review. (PM) Comprehensive Score.	QIC/CLC	85%
Better Provider System	All CMHSP participants (12) will have 100% of applicable trainings vetted in accordance with the training reciprocity plan (CMHSP Network) (Standard 12)	PNMC	8
Better Provider System	MSHN will demonstrate full compliance for the Autism Benefit Standards. (Regional Monitoring) (Program Specific Monitoring).	CLC	84.43% 82.72%
Better Provider System	Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements. MDHHS Review 95.51%	PNMC	FY20 95.51%
Better Provider System	Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements. MDHHS Review 72.52%	PNMC	FY20 72.52%

	Clinical SUD	Committee /Council	FY21
Better Care	Initiation of AOD Treatment. Percentage who initiated treatment within 14 days of the diagnosis. (Inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, medication treatment). Standard above 2020 Michigan levels I: 40.8%)	SUD Clinical	55.52%
Better Care	Engagement of AOD Treatment-Percentage who initiated treatment and who had 2 or more additional AOD services or medication treatment within 34 days of the initiation visit. (Standard above Michigan 2020 levels. E: 12.5% 2016 needs clarification)	SUD Clinical	38.27%
	Certified Behavioral Health Clinic (CBHC) Performance Measures	Committee /Council	FY21
Better Care	Follow-Up After Hospitalization for Mental Illness ages 18+ (adult age groups) (FUH-BH-A) Standard-58%	QI	New
Better Care	Follow-Up After Hospitalization for Mental Illness ages 6-17 (child/adolescents) (FUH-BH-A) Standard- 70%	QI	New
Better Health	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-BH) Standard 58.50%	QI	New
Better Care	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH) Standard I-42.5%; E-18.5%	QI	New
Better Health	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A) Standard 13%	QI	New
Better Health	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C) Standard 23.9%	QI	New
Better Health	Depressions Remission at Twelve Months (DEP-REM-12)	QI	New
Better Care	Preventative Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI_SF)	QI	New
Better Care	Preventative Care and Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	QI	New
Better Care	Preventative Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	QI	New
Better Care	Screening for Depression and Follow-Up Plan. Age 18 and older (CDF-AD)	QI	New
Better Care	Time to initial Evaluation (I-EVAL)	QI	New
Better Care	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-BH)	QI	New
Better Care	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are using Antipsychotic Medications (SSD)	QI	New
Better Care	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	QI	New
Better Care	Follow-Up Care for Children Prescribed ADHD Medication (ADD-BH)	QI	New
Better Health	Housing Status (HOU)	QI	New
Better Care	Patient Experience of Care Survey (PEC)	QI	New
Better Care	Youth/Family Experience of Care Survey (Y/FEC)	QI	New
Better Health	Plan All-Cause Readmission Rate (PCR-AD)	QI	New
Better Care	Antidepressant Medication Management (AMM-AD)	QI	New

