Quality Improvement Program/Plan

FY 2026

St. Clair County Community Mental Health Authority

QUALITY IMPROVEMENT PROGRAM-PLAN
FY 2026

St. Clair County Community Mental Health Services has had a long tradition of providing quality services to the community. The Quality Improvement (QI) Program-Plan is written to continue and/or improve current Quality Improvement structures and systems used to monitor, maintain, and improve quality care throughout all programs.

The Quality Improvement Program-Plan is broad in scope, covering both the quality of clinical care and the quality of administrative and non-clinical aspects of the organization, which support services to individuals served and their families and to the community. All services provided by St. Clair County Community Mental Health Authority (SCCCMH) are included within this scope, which includes services provided by St. Clair County Community Mental Health staff as well as by individuals and organizations under contract to the Board.

All population groups are included within the Quality Improvement Program-Plan. Clinical outcomes and organizational process reviews may be system-wide or population-specific.

I. Written Description

A. Organizational Structure

The St. Clair County Community Mental Health Board has responsibility for the approval and monitoring of the QI Program-Plan implementation via direct oversight by the Chief Executive Officer/Designee. The Chief Executive Officer/Designee uses the Quality Improvement Council (QIC) to implement the QI Program-Plan. The Quality Improvement Council develops the Quality Improvement Program-Plan content, works with staff to fulfill the plan and evaluates periodic status reports on the plan's progress.

B. Components and Activities

Design and planning, performance measurement, intervention strategies and outcome evaluation are components of the quality improvement process. Quality improvement activities are determined by SCCCMH's mission, vision, contractual requirements, strategic plan and historical data. Along with standards of care and markers developed from external data sources (e.g., reports, accreditation standards and state and federal reports), components and activities occur in response to demographic data, individual's needs, ethical guidelines, cultural considerations, clinical standards, good business practices and within the context of reference databases.

Indicators - the activities, events, occurrences or outcomes for which data is collected allow for the tracking of performance and improvement over time. The quality indicators employed are objective, measurable and based on current knowledge and clinical experience in order to monitor and evaluate key aspects of care and service.

Performance Goals, defined as the "desired level of achievement of the standard of care", are instrumental, as are benchmarks for measuring the best performance for a particular indicator.

C. Role for Recipients of Services

Participation on CMH Committees - including the Quality Improvement Council organizational structure, various Advisory Councils and any other Committees/Workgroups, as needed and deemed appropriate - provides a significant role for recipients of services in the Quality Assessment and Performance Improvement Program (QAPIP). Additionally, recipient representatives serve on the SCCCMH Board. Qualitative and quantitative assessments of satisfaction are utilized as part of the process that gives recipients of services input into programming and policy issues in SCCCMH.

D. Mechanisms for Adopting and Communicating Process and Outcome Improvements

Opportunities for quality improvement activities are discussed at the Quality Improvement Council meetings that occur quarterly. These activities can arise from the discussion of problematic areas or from the identification of processes that need to be improved and/or streamlined. Each Quality Improvement Council Standing Committee / Workgroup is responsible for identified performance indicators that are a part of the QAPIP structure.

Two regional Performance Improvement Projects (one state-mandated and one regionally selected) are being implemented at SCCCMH. Progress reports on these projects are submitted to MDHHS on a semi-annual basis. Information on the results of these projects is communicated to the Board and Advisory Groups that work with SCCCMH.

II. Governing Body Responsibilities

A. Oversight of QAPIP

The St. Clair County Community Mental Health Board is ultimately responsible for the approval and monitoring of the Quality Improvement Program-Plan. The Board delegates authority for the direct oversight of the program-plan implementation to the Quality Improvement Council. The Quality Improvement Council develops the Quality Improvement Program-Plan content, works with staff to fulfill the QI Program-Plan, and evaluates periodic status reports on the Quality Improvement Program-Plan progress.

B. QAPIP Progress Reports

A Quality Improvement Program-Plan that directs the activities of focus for the quality improvement efforts for the coming year is created annually and updated as needed. Quality Improvement Council meets on a quarterly basis to monitor progress regarding planned quality improvement activities, as well as update the QI Program-Plan as necessary to reflect progress on quality improvement activities throughout the year. This report is shared with the SCCCMH Board, the Advisory Council, individuals served, staff and other outside stakeholders (via website).

C. Annual QAPIP review

At year-end, an annual report is prepared that summarizes SCCCMH quality improvement efforts / accomplishments for the year. This report is also shared with the SCCCMH Board, various Advisory Councils, staff, Contract Management and other outside stakeholders (via website).

III. Designated Senior Official

The St. Clair County CMH Chief Executive Officer has the responsibility to oversee and implement the organization's QAPIP. The St. Clair County CMH Medical Director provides additional oversight.

IV. Active Participation of Providers and Individuals Served

Providers and persons served are encouraged to contribute suggestions relating to potential areas for investigation and/or improvement. Part of the process of identifying and resolving specific problems is accomplished through the participation of persons receiving services and providers on Advisory Groups, SCCCMH Committees, Focus Groups and surveys.

SCCCMH utilizes a variety of mechanisms to identify important areas for improvement and to set meaningful priorities. The voices of its recipients are legitimate sources of information in formulating quality improvement efforts, and satisfaction is indicative of quality services. The monitoring and evaluation of important aspects of care and service include services provided to high-volume and high-risk individuals.

Quality Assessment and Performance Improvement Program (QAPIP) standards, as outlined in the Quality Assessment and Performance Improvement Program Requirements of Michigan's Waiver renewal, are utilized throughout the process of analyzing and prioritizing key areas for quality improvement. The Quality Improvement Council monitors compliance with the Michigan QAPIP standards.

In addition to seeking input from persons served, SCCCMH solicits input from providers and stakeholders. Information gathered is used to determine satisfaction among these groups and to identify methods of addressing concerns and increasing satisfaction with service delivery.

V. Performance Measurement

A. State Performance Measures

SCCCMH measures its performance using standardized performance indicators based upon the systematic, ongoing collection and analysis of valid and reliable data. A crucial part of the member satisfaction / data collection piece involves striving to surpass the benchmarks set for performance indicators established by the Michigan Department of Health and Human Services (MDHHS) in the areas of access, adequacy / appropriateness, efficiency and outcomes (satisfaction).

B. Other Performance Indicators

The centerpiece to the St. Clair County Community Mental Health Services quality improvement process originates in the Quality Improvement Council and its Standing Committees. These various Committees provide important sources of information about improvement opportunities and activities. The Quality Improvement Council and the Standing Committees are described below.

Performance indicators have been established by SCCCMH for a number of key areas. Each CMHSP site has tools for promoting compliance which is monitored by SCCCMH. Indicators target the following areas:

- Employee & Community Relations – Employee & Community Relations includes activities intended to foster a positive, inclusive, and well-informed organizational and community environment. Employee Relations focuses on ensuring compliance with federal, state, accreditation, and regulatory training requirements while promoting professional growth and staff development. Community Relations activities are intended to increase public awareness of services, promote access to care, educate about mental wellness, and reduce stigma surrounding mental health and substance use disorders. Together, these activities aim to create a visible, positive, and inclusive presence-both within SCCCMH and throughout the broader community.
- Corporate Compliance – The primary purpose of Corporate Compliance is to integrate compliance components, implementation strategies and expected outcomes into our service delivery system, while monitoring/investigating compliance to the same. This area includes Complaints and Investigations, Training and Communications, Risk Monitoring and Prevention, Grievance and Appeals and Medicaid-Administrative Tribunal Hearings.
- Finance – A key role that Finance plays is improving the efficiencies of the direct-operated service system. This is done by closely monitoring revenues and expenditures, and sharing and exchanging information with regional partners.
- Human Resource and Development –The primary purpose of the Human Resource Department is to advance the agency's quality improvement program by fostering a culture of excellence and accountability. The Human Resource Department ensures alignment between workforce development and organizational performance by promoting staff competency, professional growth, and continuous learning through structure training, education, and development initiatives. The Human Resource department oversees the entire employee lifecycle including but not limited to: recruiting, onboarding, training, benefits management, and employee relations.

- Safety – The primary purpose of the Safety Committee is to provide an effective safety management program for the agency. It is the Committee's objective to minimize the risk of injury to employees, clients, and the general public by ensuring that our environment is safe and free of hazards. In addition, the Safety Committee continually educates employees on safety equipment, protocols, and procedures, our goal being all CMH employees practice safety as an ongoing value.

- Privileging & Credentialing – The primary purpose of the Privileging and Credentialing Committee is to operate a system for granting clinical privileges for practitioners within the CMH System, including associated inpatient units.

- Program Development – The primary purpose of the Program Development Committee is to implement programs such as Evidence Based Practices, to improve outcomes for persons served receiving services, and to promote a recovery environment within the CMH system.

- Recipient Rights – The Recipients Rights Committee serves to protect the Office of Recipient Rights from pressures that could interfere with the impartial, even-handed and thorough performance of its functions. The Committee acts in an advisory capacity to the Chief Executive Officer and the Director of the Recipient Rights, as the Appeals Committee for a recipient's appeal under Section 784, and to review and provide comments on the Annual and Semi-Annual Report submitted by the Chief Executive Officer to the Community Mental Health Services Program Board.

- System Improvement – System Improvement provides oversight to the following areas as assigned by the QIC. (Oversight is defined as the monitoring of activities, key performance indicators, review of meeting minutes and providing technical assistance.) This area includes Maintaining Agency Accreditation (CARF) and Performance Indicators. The primary purpose of Performance Indicators is to monitor the agency's overall performance with established performance indicators with set standards.

- Information Technology – A key role that Information Technology plays is to ensure that all systems, assets, data and infrastructure utilized by the agency are implemented and maintained in a method to optimize data availability, reliability and security. The method for doing this will be to implement best practices in technical requirements, policies and procedures, as prescribed by industry standards and mandated regulations.

- Facilities- The key role of the Facilities Department is to ensure all SCCCMH buildings and grounds, including five (5) service locations and 17 group homes, are safe, secure, and well-maintained for the individuals we serve, employees, visitors, and community members. To achieve this, best practices in facilities maintenance will be implemented, along with policies and procedures that comply with established standards and mandated regulations.

- Utilization Management - The Utilization Management Committee (UMC) reviews the agency's overall performance against established key Performance Indicators that fall into the performance outcome areas of access, adequacy / appropriateness, efficiency and outcomes.

    - Case Record Monitoring - The primary purpose of the UMC is to ensure high quality care, effective utilization of resources and cost efficiency through case record reviews conducted by an interdisciplinary team. The purpose of the case record review (clinical practices, documentation and claims verification) is to monitor and improve the overall compliance for the direct-operated programs and contract agencies with regard to clinical case record standards and billing procedures. This is accomplished by completing case record reviews at select direct-operated programs and contract agency locations. The Case Record Monitoring

Sub-Committee is responsible to report any case record compliance concerns to determine appropriateness for action.

- Trend Analyses - an additional purpose of the UMC is to track select service utilization trends not within the audit-scope of per-case UR (e.g. psychiatric inpatient utilization) to identify service system improvement opportunities.

- Provider Network Management – The purpose of the Contract and Provider Network Management Department is to build, optimize, and sustain a high-performing provider network through strategic contracting, collaborative relationships, and data-driven oversight. The department ensures that provider agreements support organizational goals, regulatory requirements, financial sustainability, and high quality, accessible programs and treatment options for individuals in St. Clair County. The department provides oversight, negotiations, and administration of most organizational contracts including, but not limited to, vendor services, leases, IT solutions and maintenance contracts in addition to provider network management.

VI. QAPIP Utilization to Assure Achievement of Performance Levels

The cornerstone of the system for assuring QAPIP utilization is the monitoring process. Each contract includes specific outcome requirements that are reviewed in the monitoring process. The monitoring is a collaborative effort between CMH staff and provider staff to monitor and assure quality of care on a regular basis. Policies and audit tools have been developed by staff to guide the monitoring and evaluation process.

The SCCCMH reports its performance to MDHHS via the Michigan Mission Based Performance Indictors System (MMBPIS), which provides performance data on a number of indicators related to access, adequacy / appropriateness, efficiency and outcome measures. Quality Improvement assures that quality measurements are in place to continuously monitor performance and to identify problems as they occur. This information is shared with management on a regular basis. Also, specific problem analysis is conducted as requested or as problems are identified in the monitoring process.

VII. Performance Improvement Projects

Performance improvement projects included in the QAPIP will focus on achieving demonstratable and sustained improvement in services likely to have beneficial effects on outcomes for well-being and customer satisfaction.

A. Clinical and Non-Clinical Projects

1. Clinical Services
   Clinical areas to be targeted include high-volume / high-risk / continuity and coordination of care services such as successful implementation of Person-Centered Planning and Self--Determination.

2. Non-Clinical Services
   Non-clinical areas to be targeted include appeals, grievances and complaints and access to, and availability of, services.

B. Project Topics
Selection of project topics will be based on the number of occurrences, high-risk nature or presence of sentinel events among the individuals served. The need for a specific service, demographic characteristics, health risks and the interest of individuals in the aspect of service to be addressed will also be part of the selection criteria.

C. MDHHS and Pre-Paid Inpatient Health Plan (PIHP)-Established Aspects of Care

Aspects of care established by MDHHS and the PIHP will be used to identify performance improvement projects.

VIII. Review and Follow-Up of Sentinel Events

A. Ensuring Appropriate Action

The SCCCMHA policy, *Sentinel Events, Critical Incidents, and Risk Event*s (05-001-0016), establishes the guidelines for reporting and reviewing possible Sentinel Events, Critical Incidents and Risk Events. The policy states that the Office of Recipient Rights will screen all Critical Incident Reports for the possibility of a Sentinel Event. Sentinel Events are submitted to the Behavior Treatment Plan Review Committee (BTPRC) and its Chairperson/designee for review, as required by MDHHS practice guidelines. The Medical Director, through the oversight role to the BTPRC, may assist in making the final decision as to whether these incidents meet the definition of a Sentinel Event. An "appropriate response" to the Sentinel Event is developed by the BTPRC which "includes a thorough and credible root cause analysis, implementation of improvements to reduce risk, and monitoring of the effectiveness of those improvements." Following completion of a root-cause analysis or investigation, the BTPRC develops and implements either a) a plan of action or intervention to prevent further occurrence of the Sentinel Event or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement and when and how implementation will occur. Improvement recommendations are submitted to the QI Council.

Credentials of Reviewers

Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. Sentinel Event findings and recommendations are reviewed by the Medical Director, BTPRC chairperson/designee, and the Office of Recipient Rights. The Medical Director is a medical doctor.

Critical Incidents Reporting System

The critical incident reporting system, which was implemented in FY2011, collects information on critical incidents that can be linked to specific service recipients. The Critical Incident Reporting System captures information on five specific reportable events: suicide, non-suicide, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error and arrest of recipient. The populations on which these events must be reported differ slightly by type of event. All critical incidents are reviewed by the Office of Recipient Rights.

Risk Events Management

SCCCMHA has a process for analyzing additional critical events that put individuals (in the same population categories as the critical incidents above) at risk of harm. This analysis is used to determine what action needs to be taken to remediate the problem or situation, and to prevent the occurrence of additional events and incidents. This documentation will be available to MDHHS at site visits. These events minimally include:

- actions taken by individuals who receive services that cause harm to themselves,
- actions taken by individuals who receive services that cause harm to others,
- two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period,
- police calls by staff of specialized residential setting or general (AFC) residential homes or other provider agency staff for assistance with an individual during a behavioral crisis situation, and
- emergency use of physical management by staff in response to a behavioral crisis.

IX. Behavior Treatment Plans Reviewed

SCCCMH provides quarterly review analyses of data through the PIHP Behavior Treatment Review Committee (BTPRC) where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plan Review Committees and that have been approved during person-centered planning by the beneficiary or his/her guardian, may be used with beneficiaries. Data shall include numbers of interventions and length of time the interventions were used per person.

X. Periodic Quantitative (e.g., surveys) and Qualitative (e.g., focus groups) Assessments of Member Experiences with Services

A. Issues Addressed in Assessments

The purpose of a QI Program-Plan is to improve the quality of care and service provided to those receiving services. An effective QI Program-Plan demonstrates that its activities have resulted in significant improvements in the care or services being delivered. Improvements of the QI process are demonstrated by improvements in either the processes through which care and services are delivered or in the outcomes of care.

The CMH evaluates the overall effectiveness of the QI Program-Plan annually. The evaluation reviews all aspects of the QI Program-Plan with emphasis on determining whether the QI Program-Plan has demonstrated improvement in the quality of care and services provided. The QI Department develops an annual written report on quality, included in this report is all completed QI activities, trending of clinical and service indicators and other performance data and demonstrating improvements in quality. This report is presented to the Quality Improvement Council and the SCCCMH Board for review.

Issues of quality, availability, and accessibility of care are evaluated through periodic quantitative (e.g., surveys) and qualitative (e.g., Focus Groups) assessments regarding experiences with services. The assessments will be representative of persons served and supports offered.

B. Actions Resulting from Assessments

The PIHP will use the assessment results to improve services. Processes found to be effective and positive will be continued, while those with questionable efficacy or low satisfaction will be revised using the following:

1. Take specific action on individual cases as appropriate.
2. Identify and investigate sources of dissatisfaction.
3. Outline systemic action steps to follow-up on the finding.
4. Inform practitioners, providers, recipients of service and the governing body of assessment results.

C. Evaluation of the Effects of Actions

Just as the original processes must be evaluated, so must the interventions used to increase quality, availability, and accessibility of care. Therefore, all actions taken as a result of assessments will be evaluated periodically. Quality Improvement is never static and it is an expectation that all evaluation efforts will be examined on an ongoing basis.

D. Incorporation of Persons Served in the Evaluation Process

Persons served receiving services are included in the quality improvement process as survey participants, as members of Advisory Councils and as members of the SCCCMH Board. In this way, persons served are incorporated into the review and analysis of information obtained from quantitative and qualitative methods.

XI. Monitoring of Practice Guidelines

The SCCCMHA monitors quality of care on a regular basis. All CMH contracts with Providers require that Contractors adhere to accrediting bodies, state and federal agency requirements and all relevant regulatory documents.

Clinical protocols have been developed to determine the appropriate level of care to certify. The Clinical Protocols, which are based upon reasonable medical evidence and reflect community standards of care, will be reviewed annually or on an as-needed basis. A copy of these guidelines has been made available to staff and providers.

The CMH implements the use of practice guidelines. These practice guidelines are based on reasonable, scientific evidence and reviewed with the Providers. Practice Guidelines are systematically developed statements to assist providers regarding appropriate health care for specific clinical circumstances. The Guidelines are based upon national Guidelines, when available, but modified to fit community practice patterns.

The Utilization Management policy (02-003-0011) details how the agency reviews aggregate utilization reports of clinical services provided to individuals to ensure they are delivered in the most effective and efficient manner possible for the benefit and welfare. The UMC reviews aggregate clinical service reports of all contracted services and compares them with state and national benchmark standards of best practice, utilization expectations from MDHHS, accrediting bodies, state and federal agencies and professional associations.

XII. Assurance of Practitioner Licensure, Credentialing, Staff Qualification and Staff Training

The qualifications of physicians and other licensed health care professionals employed by or under contract to SCCCMHA are reviewed by following the guidelines in the Provider Enrollment and Credentialing policy, (01-003-0011).

XIII. Verification of Medicaid Services

All program and clinical case records will comply with existing standards, rules or interpretative guidelines as defined by the Michigan Department of Community Health, Medicaid, Medicare and other insurance companies. Verification of services will occur on an ongoing basis with a set percentage of Medicaid cases monitored annually through the PIHP. Special Program reviews or staff reviews may be requested more frequently as determined necessary by Supervisors or Directors.

XIV. Utilization Management Program

The Utilization Review process is delineated in the policy Utilization Management (02-003-0011) and includes procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.

Utilization Management (UM) functions are required by a number of outside governing and accrediting organizations such as MDHHS, Commission on Accreditation of Rehabilitative Facilities (CARF), Centers for Medicare & Medicaid Services (CMS) and various insurance companies.

Membership in the UM Team consists of Licensed Master Social Workers and Master Level Administrative Staff along with technical data management support staff.

XV. Organizational Involvement

Persons Served Receiving Services - Input is sought at all levels; from customer satisfaction surveys conducted and through input sought during the Person-Centered Planning process. Customer oversight into

the quality improvement process occurs through the Quality Improvement Council, CMH Advisory Council and through the Community Mental Health Board which receives the results of satisfaction surveys and reports.

St. Clair County Community Mental Health Board

- Annually review and approve the QI Plan and make recommendations to the QIC
- Apply quality improvement principles to Board activities
- Accept the long-term commitment required by the quality improvement process
- Establish policy based upon quality improvement findings
- Review Annual "Summary of Accomplishments" of goals

Chief Executive Officer

- Annually recommend key performance indicators for the CMH System, using the process within the Quality Improvement Council
- Recommend quality improvement policies to the Board
- Create a positive environment for quality improvement and provides support to the process
- Monitor quality improvement results
- Establish regular communications with the various Quality Improvement Committees
- Participate in the recognition of quality improvement efforts

Medical Director

- Provide clinical leadership for the organization
- Create positive environment for quality improvement
- Monitor quality improvement results
- Member of BTPRC

Directors / Supervisors (Direct-Operated and Contract Programs)

- Implement Quality Improvement Plans within Department
- Develop and modify systems
- Coach staff in the quality improvement process
- Participate on Quality Teams and Workgroups
- Communicate results to staff
- Monitor Advisory Councils
- Assess organizational readiness
- Identify improvement opportunities
- Monitor results
- Provide data to the Quality Improvement Council
- Obtain and update their working knowledge of the quality improvement process
- Attend quality improvement training, as required

Staff

- Utilize the system
- Participate on Quality Teams, Workgroups and Committees
- Participate in skill-building activities
- Identify barriers in the process
- Suggest process / system improvements and identify improvement projects

Contract Agencies

- Provide data to the Quality Improvement Council
- Participate on Workgroups and Committees
- Obtain a working knowledge of the quality improvement process

- Identify barriers to the process
- Attend quality improvement training
- Operate their own QI system

Contract Agency Staff Responsibilities

- Contract agency staff participate on quality related workgroups
- All contract agencies submit service/outcome data to the QIC, via Performance Indicators
- All contract agencies are required to have their own QI Plans, as aligned with annual improvement to this QI Program-Plan

Quality Improvement Program Staff Responsibilities

The Quality Management Department is comprised of administrative staff who are designated the responsibilities of coordination, tracking and reporting of all activities related to the organization-wide quality improvement system.

Chief Executive Officer

- Assists in and ensures the development and coordination of quality improvement plans for St. Clair County Community Mental Health Services system
- Assists in and ensures the design of the quality improvement program for implementation of processes to accomplish the goals within its key component areas

Support Services Director

- Assists in and ensures the provision of competent staff support and administrative liaison for Committees and Workgroups established to assist in accomplishing the work of the QI Program-Plan
- Provides technical assistance and consultation for quality improvement policy development
- Assists in monitoring and compliance assessment activities
- Assists in quality improvement data collection, data management and data analysis
- Establishes mechanisms and systems for needs assessment, data collection and data management
- Chair of the Quality Improvement Council
- Ensures maintenance of agency accreditation
- Develops agency's annual "Strategic Plan"

Quality Improvement Specialist

- Develops procedures and methods for satisfaction assessments for individuals being served, community and interest groups
- Assists in and ensures the development, implementation and monitoring of program evaluation components
- Assists in monitoring and compliance assessment activities
- Researches, analyzes, compiles and compares standards, guidelines and requirements related to St. Clair County CMH program components
- Reports on System Improvement Committee (SIC)

Reference	FY2026 Employee & Community Relations Karen Zultak
	Priority Goals/Key Tasks
Strategic Plan Education #2	**1. PAID ADVERTISING & SPONSORSHIPS** • Promotion of CMH services through paid advertisement or sponsorship of an external event. ○ Ex: Billboards, boosted social media posts, mental health minutes, Thumbcoast TV interviews.
Strategic Plan Education #2	**2. OUTREACH & SPEAKERS' BUREAU ACTIVITIES** • Participation in another organization's event by attending in-person or providing materials for their distribution per their request. • Presentations made to community organizations for general community members. • Includes trainings and presentations that are not exclusive to CMH staff only. ○ Ex: Resource table to promote CMH services and provide mental health information; Presentations made in the community or for outside community agencies, including MHFA, presentations at school, law enforcement trainings.
Strategic Plan Education #2	**3. PUBLIC RELATIONS & EXTERNAL COMMUNICATIONS** • Activities that benefit the community and/or enhance our image through the community and are hosted/lead by CMH. ○ Ex: Run for Recovery, Trunk or Treat, Unpaid Media (Paul Miller radio interviews, press releases, PSAs, responding to media inquiries), Social Media Posts, Monthly Communication Newsletter, Website.
Strategic Plan Education #2	**4. MARKETING** • Unsolicited information about CMH to create and provide information about access or mental health education to community organizations, which includes creating brochures and other materials to be shared externally. ○ Ex: Information packets to be sent to schools; outreach made to primary care physicians.
Strategic Plan Workforce #3	**5. STAFF TRAINING/PROFESSIONAL DEVELOPMENT** • Non-required trainings offered to staff/contract agencies to increase competency and promote professional development.
Good Business Practice CARF Sec.1.1.d-e Sec.1.1.9.f b) Sec.10, Goal 2 b) Sec.10, Goal 1 Strategic Plan Workforce #3	**6. STAFF TRAINING/REQUIRED TRAININGS** Ensure staff are trained in topics required by local, state, federal, and accrediting bodies. • Provide a centralized training calendar identifying topic/date/location for all trainings. • Update/modify required training grid based on regulatory requirements and ensure staff compliance. • Offer/mandate supervisory courses to current/potential supervisors via MyLearningPointe. • Administer "Training Needs" survey at each CMH sponsored training.
Strategic Plan Workforce #3	**7. EMPLOYEE ENGAGEMENT & INTERNAL COMMUNICATIONS** • Activities and communication aimed at fostering a positive, informed and engaged workforce. ○ Ex: Monthly "In the Know" Newsletter, Pop-Up, Employee/Team of the Month, group photos for awareness days, staff appreciation lunches, staff emails.
Strategic Plan Education #2	**8. LEGISLATIVE & ADVOCACY EFFORTS** • Communication with legislators or others who make policy decisions, encouraging stakeholders to advocate for/against policies that affect the mental health systems. ○ Ex: Attending Eggs & Issues, sending letters to legislators, emails to staff with advocacy alert information.

Reference	FY2026 Corporate Compliance Joy Vittone
	Priority Goals/Key Tasks
Medicaid Integrity Program Corporate Compliance Plan	1. Report monthly on corporate compliance complaints; identify trends (SCCCMH).
Corporate Compliance Plan	2. Report quarterly on Program Integrity Activities (i.e., tips/grievances received, data mining, claims analysis, audits, overpayments collected, identification and investigation of fraud, waste, abuse, etc.).
Corporate Compliance Plan	3. Develop a work plan that includes auditing and monitoring, based on compliance risk assessment.
Corporate Compliance Plan	4. The SCCCMH Corporate Compliance Committee meets quarterly or more frequently as deemed necessary.
Good Administrative Practice	5. Monitor and report any legal/regulatory changes related to regulatory compliance.
CFR Requirement 438.610	6. Monitor and report on debarred, suspended, or otherwise excluded (from participation in any federal healthcare program) providers.
Good Clinical Practice	7. Provide training and education on corporate compliance, including HIPAA.
Corporate Compliance Plan	8. Monitor technology use and needs as they relate to PHI and HIPAA.
Corporate Compliance Plan	9. Monitor subnetwork providers' corporate compliance activities.
Corporate Compliance Plan	10. Conduct an annual evaluation of the Compliance Plan and report to the SCCCMH Board.
Region 10 PIHP Contract Terms	11. Report quarterly on grievances and appeal activities.

Note: Claim verification and under/over utilization are reported under Utilization Management, although also part of the Compliance Plan and Program Integrity Reports (quarterly and monthly).

Reference	FY2026 Finance Karen Farr & Danielle Hazlewood
	Priority Goals/Key Tasks
Good Administrative Practice	1. Implement budget and financial risk strategies to maintain a balanced budget. Objectives: • Establish procedures for timely identification and communication of areas of concern.
Good Administrative Practice	2. Provide CEO, Management Team and Board of Directors with timely financial information to be used for decision making and strategic planning. Objectives: • Identify fiscal concerns through monthly analysis of revenues and expenditures. • Analyze trends and provide revenue forecasts. • Prepare annual budget and provide comparison of budget to actual revenue and expenditures on a monthly basis. • Prepare amended budget to reflect significant changes in revenues and expenditures of the agency, as needed. • Make recommendations about how to best utilize agency resources. • Interact with other managers to provide consultative support to planning initiatives through financial information analyses, reports, and recommendations.
MDHHS	3. Ensure compliance with local, state, and federal budgetary reporting requirements. Objectives: • Coordinate and ensure completion of the annual Financial, Compliance, and Single Audits. • Complete all required Federal, State, and Local financial reporting per the Regional Medicaid, MDHHS General Fund contracts and grants. • Coordinate and ensure compliance with the MDHHS Standard Cost Allocation Methodology and the CCBHC Demonstration.
ARR 7/3	4. Promote collaboration, efficiency, and uniformity between PIHP members. Objectives: • Utilize the Region 10 Finance Officer's workgroup to share information and identify best practice strategies. • Participate in Regional CFO goals.
Good Administrative Practice	5. Establish and maintain appropriate internal controls over record keeping and safeguarding of assets. Objectives: • Establish, review and update policies and procedures for record keeping, handling of cash, and tracking of assets. • Ensure separation of duties to reduce risk of fraudulent activity. • Develop and monitor effective cross-training among staff and continued succession planning. • Research and recommend technology enhancements to ensure efficient and accurate financial information. • Establish, review, and update policies and procedures related to our CMHSP Local Fund Balance

Reference	FY2026 Human Resources Stephanie Shank
	Priority Goals/Key Tasks
Good Business Practice	**1. Access and improve upon current Human Resource related practices and software updates including:** a. Ongoing improvement and enhanced use of the ADP Human Resources Information System (HRIS). b. Continuous improvement efforts and building of the ADP module to create HR process efficiencies. c. Ongoing improvement efforts of the Annual Employee Assessment tool. d. Enhance recruitment efforts through utilization ADP and other new sources as identified. e. Work towards complete move to electronic personnel records. f. Evaluate and establish best practice model of interview/selection process. g. Review and amend as appropriate the CMH Job Descriptions annually. h. Evaluate and assist in the development of an agency-wide succession planning and opportunities for future agency leaders. i. Enhance diversity, equity, and inclusion (DEI) based practices. j. Strengthen engagement and alignment across satellite locations.
Good Business Practice	**2. Provide opportunities for professional growth to enhance staff performance, skill development, and cross training.** a. Evaluate and improve "New Employee Orientation" process. b. Collaborate with Regional HR staff, as appropriate, to offer/develop regional training options. c. Work with identified employee groups to address improvement opportunities. d. Develop a robust retention plan. e. Develop effective recruitment plan. f. Continue to strengthen and grow the CMH Mentorship Program.
Good Business Practice	**3. Reward employees for performance that meets and exceeds defined expectations and recognize continued efforts.** a. Continue to evaluate CMH "C.A.R.E.S Champion" recognition program. b. Continue to evaluate CMH staff recognition and enrichment process and explore cost-effective options. c. Continue yearly CMH anniversary recognition. d. Continue CMH "Years of Service" recognition. e. Assist with/Sponsor Wellness Activities.
Good Business Practice	**4. Utilize the Employee Culture & Wellness Committee to assess and address staff needs in areas such as professional growth, recognition, wellness, and personal enrichment.** a. Work collaboratively with the CMH Culture & Wellness Committee to support and advise in the areas of staff wellness and development.

Reference	FY2026 Safety Jennifer Dugger
	Priority Goals/Key Tasks
OSHA 08.450	1. **Report Employee Accidents with 24 hours.** Target Compliance 100% a. Advise on issues of compliance difficulty with Program Supervisors to develop and implement improvement activities. b. Report all findings and improvement activities to the QIC. "Workers Compensation: Accident Reporting and OSHA Recordkeeping"
Good Administrative Practice	2. **Report all Non-Employee Accidents within 24 hours.** Target Compliance 100%
CARF Health & Safety	3. **Ensure easy access to First Aid.** a. Expertise b. Equipment c. Supplies d. Inspections
CARF Health & Safety	4. Quarterly, completed **Building Inspections.** a. Site Participation, (5) locations. Target Compliance 100% b. Safety/Infection Control Checklist, Target Compliance: 95%.
Good Administrative Practice	5. Quarterly, complete **Kitchen Inspections**; via the Kitchen Safety Inspection Checklist and the Kitchen Classroom Safety Checklist. Target Compliance: 95%.
CARF Health & Safety	6. Annually, complete **Emergency/Event Procedures** (8 types) at all locations. Completion may be per "actual event" or drill. Target Compliance: 95% *Conducted, monitored, recorded, and recorded quarterly. a. Bomb Threat b. Chemical-Biological c. Fire d. Dangerous Person e. Medical Emergency f. Natural Disaster g. Suspicious Mail/Parcel h. Utility Failure

Reference	FY2026 Safety Jennifer Dugger
	Priority Goals/Key Tasks
CARF Health & Safety	7. Annually, **all full time and part-time employees** will *participate* as applicable in at least one (1) of the eight (8) types of Emergencies via "actual event" or emergency drill. Target Compliance: 95% Participation visitors and recipients of services will be included (counted) and identified as "V" on the report table. a. Quarterly, track/record/report emergency event participation. b. Supervisors to receive notification during Q3 of staff that have not participated in an emergency drill or actual emergency event. c. Annually, Supervisors of employees **who did not participate** in at least one emergency event (drill or actual) are required to review safety protocol, via the Building Health and Safety policy #09-001-0005 or Emergency Procedures Handbook, with applicable staff.
Good Administrative Practice	8. Quarterly, count the number of **Green Button & Panic Button** activations. a. Number of Actual Alarms b. Number of False Alarms
CARF Health & Safety Emergency Procedures 1.H.5.c.5.	9. Supervising staff to ensure **Staff Accountability** during large evacuation drills and actual events (i.e., Fire, Bomb Threat, Chemical-Biological, Tornado, etc.). a. Supervisors to ensure use of sign in/out binders, roll call, and/or text messaging when applicable.
CARF Health & Safety, Medication Use MHC R330.1719 R330.2813 R330.7158	10. Quarterly, Review of "**Medication Errors**" reports. a. Error Type b. Error Location c. Trends d. Improvement Opportunities via Error Type
MIOSHA R325.70001	11. Annually, review the "**Exposure Control Plan**," update as needed. (Blood Borne Pathogens Exposure and Infection Control Plan)
CARF Health & Safety	12. Annually, complete (update/revise) **Board Statement** "Health & Safety Work Plan."
CARF	13. Promote Safety by ensuring current **Written Safety Procedures** as applicable.

Reference	FY2026 Safety Jennifer Dugger
	Priority Goals/Key Tasks
N/A	14. Promote implementation of **"Risk Awareness List" (formerly Threat List)**
CMH Policy	15. Address other safety-related items as needed.
Good Administrative Practice	16. Maintain a Safety Data Sheet (SDS) manual, including pictures of products, and completed training with staff concerning use of products and appropriate storage.
Good Administrative Practice CARF Health & Safety	17. Implementation of Disaster Recovery/Business Resumption Plan meeting CMS requirements. *coordinate with Region 2 North. a. Build on existing Disaster Recovery/Business Resumption Plan (DR/BRP) with the following activities: i. Continue participation in MiHAN (Health Alert Network) ii. Implement CMH closed WINS group for staff notifications. iii. Update existing document to include the Pandemic Plan and also update to reflect any changes in process, advances in technology, etc. iv. Complete planning process documents for each program. Documents identify: • Possible alternative locations • Prioritization of essential functions • Order of succession • Vital information/records v. Identify process for addressing internal disaster (small and large scale). vi. Identify process for addressing community disaster (working with EOC, Homeland Security, etc.). b. Disseminate updated DR/BRP to key staff. c. Train staff on the DR/BRP. d. Periodically conduct tabletop exercises/drills

Reference	FY2026 Privileging & Credentialing Amy Kandell
	Priority Goals/Key Tasks
MDHHS/PIHP Contract	1. Maintain and update the following as applicable: a. Provider Enrollment and Credentialing Policy #01-003-0011 b. Credentialing Application
State Licensing MDHHS Requirement	2. Credentials for Privileged Staff and Organization: a. Monitor the credentials of all staff requesting privileges to provide services to individuals b. Monitor the credentials of all organizations requesting to provide services to individuals
MDHHS Requirement	3. Organization Applications: a. Review and privilege organizational applications of providers agencies, as appropriate.
MDHHS Requirement	4. SCCCMH list of Credentialed Positions: a. Oversee and/or maintain the SCCCMH list of credentialed positions and coordinate with Medicaid/Medicare/MDHHS definitions. b. Monthly update Provider Registry Reports to ensure compliance with credentialing timeframes. c. Ensure list of practitioner and organizational provides is available upon request.
Good Clinical Practice	5. Training Requirements: Make recommendations for training and direction as needed.
Good Clinical Practice	6. Contract Agencies: Monitor delegated provider credentialing processes. a. Practitioner Credentials – via monthly audits at time of P&C Committee meeting.

Reference	FY2026 Program Development Kathleen Gallagher Priority Goals/Key Tasks
Best Practice	**1. Evidence Based Practices (EBPs):** a. Sustain current Evidence-Based Practices (EBP). b. Expand number of CMH staff trained in an applicable EBP. c. Continue to monitor current EBPs for fidelity. d. Expand number of individuals receiving EBPs through the CMH system
Best Practice Strategic Plan Program Excellence #4	**2. Trauma Informed Care: Implement a trauma informed system of care across all of SCCCMH and its contract system.** a. Continue to provide Trauma Informed Care (TIC) to new staff at orientation and refresher trainings to existing staff. b. Expand TIC to contract system so that all are Trauma Informed. c. Survey current perceptions from staff and those served regarding our current standing with regard to TIC
Grant FY19-20 CCBHC	**3. Veterans Services:** Continue to provide services for Veterans a. Be in compliance with work plan as outlined in grant. b. Continue to advocate at a regional and state level to get Veterans access to needed care
Best Practice	**4. Explore Evidence Based Practices for SUD Services.** a. Train staff identified in EBPs for SUD Services. b. Additional staff to obtain their substance use credential. c. SUD services to continue to expand agency wide. d. SUD groups to be developed and implemented.
Best Practice	**5. To Provide State-of-the-Art, Evidence-Based Assessment and Treatment to Individuals at Risk of Suicide** a. Train staff system wide in Zero Suicide EBP for treatment for individuals at risk for suicide. b. Train staff system-wide on the use of the Columbia-Suicide Severity Rating Scale (C-SSRS) and other applicable clinical tools for treatment. c. Assess current EBPs for effectiveness. d. Research other EBPs that may be beneficial to implement throughout the system.
Staff Recruitment Program Staff Training Expand Programs	**6. Develop and Implement a Plan to Recruit & Maintain Quality Staff** a. Work with HR and Program Supervisors to identify targeted problem areas in hiring and retention and develop an action plan. b. Develop and implement a plan to offer comprehensive training and support to both new hires in operations and existing employees. c. Identify training areas for program staff and develop training modules/online assistance/mentors for staff. d. Develop programs to fill gap need areas of persons served. e. Work with supervisors to identify need areas and complete work plans to address those need areas.
Strategic Plan Program Excellence #4	**7. Community Based Crisis Services** a. Behavioral Health Urgent Care (BHUC) b. Children's Crisis Residential Home c. Crisis Stabilization Unit (CSU)

Reference	FY2026 Recipient Rights Sandy O'Neill Priority Goals/Key Tasks
MI MHC MDHHS	**1. ADMINISTRATIVE FUNCTION:** a. Submit the SCCCMH Semi-Annual Report to the MDHHS-ORR by June 30th of each year. b. Submit the SCCCMH Annual Report to the MDHHS-ORR by December 30th of each year.
MDHHS GF Contract	**2. COMPLAINT RESOLUTION SYSTEM FUNCTION:** a. Report the number of substantiated Recipient Rights violations in St. Clair Country by classification and provider location (identified by month/quarter).
MI MHC MDHHS	**3. MONITORING & PREVENTION FUNCTION: SITE VISITS** a. On an annual basis, ensure a Recipient Rights site review is completed at each direct-operated service location and each contracted service location.
Strategic Plan Organizational Efficiency	**4. MONITORING FUNCTION: INCIDENT REPORT SYSTEM** a. Review Incident Reports within 10 business days of each reported incident. b. Identify and forward potential Critical Incidents to the Chief Clinical Officer/Designee within 3 days of the incident to determine if the event meets Sentinel Event criteria. c. Enter "Critical Events" meeting MDHHS established criteria in OASIS on a monthly basis (Event Reporting) d. Identify potential Risk Events per MDHHS established guidelines.
MI MHC	**5. PREVENTION FUNCTION:** a. Review and update, as necessary, all SCCCMH recipient rights related policies and procedures to ensure compliance with the Michigan Mental Health Code, MDHHS & PIHP Contracts, and requirements established by other regulatory and accrediting bodies.
MI MHC MDHHS GF Contract	**6. EDUCATION/TRAINING FUNCTION:** a. Monitor training data to determine if staff members/ volunteers (direct-operated & contract system) completed in-person Recipient Rights training within 30 days of hire. i. Provide in-person/virtual New Hire Recipient Rights training at least two times per month. ii. Report the number of staff trained compared to the number of staff hired. 1. Direct-Operated staff member/volunteers 2. Contract System staff members/volunteers b. Monitor training data to identify the staff members/volunteers (direct-operated & contract system) who completed in-person/online Recipient Rights Refresher training on an annual basis. i. Provide in-person Recipient Rights Refresher training at least two times per month or ensure online training is accessible through MyLearningPointe or the SCCCMH website. ii. Report the number of staff trained. 1. Direct-Operated staff members/volunteers 2. Contract System staff members/volunteers
Good Clinical Practice	**7. MONITORING & OVERISGHT: BTPRC** a. Conduct quarterly oversight of the Behavior Treatment Plan Review Committee's (BTPRC) activities with the use of the Quarterly Risk Events Analysis Report. i. Emergency use of Physical Management tracking. ii. Systems Improvements identified at BTPRC to provide additional training opportunities for staff and/or opportunities to reduce risk factors for individuals served.

Reference	FY2026 System Improvement Denise Choiniere & Michelle Measel-Morris Priority Goals/Key Tasks
CARF	**1. Maintain agency accreditation.** a. CARF
Regulatory Requirement	**2. Ensure compliance with applicable Corrective Action Plans** a. Region 10/PIHP b. MDHHS c. HSAG
Regulatory Requirement	**3. Ensure compliance with annual MDHHS Waiver Review** a. BH 1915(i) State Plan Amendment (ISP) b. CWP c. HSW d. SEDW
MDHHS Strategic Plan Organizational Efficiency #1	**4. Monitor (local) performance of each direct and contract program through program performance indicators (PIs).** a. Direct Program b. Contract
MDHHS CARF Strategic Plan Organizational Efficiency #1	**5. Achieve overall satisfaction through annual surveys:** a. Customer Experience b. Provider Satisfaction c. Post Discharge d. Prescriber Satisfaction e. NCI Project
Quality Initiatives	**6. Fidelity Reviews:** a. ACT b. DBT c. IDDT d. Employment Services

Reference	FY2026 System Improvement Denise Choiniere & Michelle Measel-Morris Priority Goals/Key Tasks
Quality Initiatives	**7. Quality Initiatives:** a. Implement technology to improve patient access and quality of service. b. Establish routine reports and set up report automation. c. Audit of database (i.e., identifying data errors that occur in our system and implement corrective actions). d. Provide support to assist in special projects. e. Provide support to assist in special projects.
Region 10 Contract Requirement	**8. Enhance Dashboard Indicators and other data mining capabilities that facilitates population management/analysis.** a. Utilize CC360 or other population analytics. b. Utilize Dashboard for Quality Improvement Projects c. Monitor CCBHC metrics monthly.
CCBHC	**9. Review and monitor the CCBHC Report at least quarterly.** a. FY26,1Q b. FY26,2Q c. FY26,3Q d. FY26,4Q
Strategic Plan Organizational Efficiency #1	**10. Support administrative and clerical workflows and agencies processes to maximize time, resources, and improve performance.** a. Hospital Follow Up b. Racial/Ethnic Disparities
Good Clinical Practice	**11. Support administrative and clerical workflows and agencies processes to maximize time, resources, and improve performance.** a. ELEOS b. Mend c. OASIS Updates d. OASIS Initial & Refresher Training
MDHHS Audit Requirement	**12. To participate in the MDHHS Quality Improvement Project for HSW, CWP, and SEDW.** a. Staff training compliance b. Service provision compliance

Reference	FY2026 Information Technology Dann Hayes
	Priority Goals/Key Tasks
Good Administrative Practice 45 CFR 164.308	**1. Continuous improvement of customer service.** a. Review IT Department Written Plan to ensure it addresses ongoing software/hardware solutions and process changes. b. Complete annual simulated Disaster Recovery Test and implement corrective actions and/or compensating controls, where appropriate. c. Complete HIPAA Risk Assessment and develop/implement plan (45 CFR 164).
Good Administrative Practice	**2. Promote efficient use of existing technology.** Replace/upgrade hardware related to IT Equipment Replacement Schedule to remain current with technology and support agreements. a. Provide training for all staff as it pertains to new and existing applications. b. Provide training and implement stronger security strategies pertaining to social engineering, including phishing c. Network Security Assessment (3/31/26) and Remediation of any vulnerabilities found. d. Review and Cleanup Fileshare Permissions e. Review and update backup strategy
Good Administrative Practice Strategic Plan Organizational Efficiency #1	**3. Improving technology to increase operational efficiency.** a. Replace Resource Scheduler with a new room scheduling app (Skedda). b. Purchase and roll out 100 replacement laptops. c. Upgrade agency phone system d. Upgrade Variphy phone reporting software e. Upgrade Informacast f. Assist with replacement of the current Green Button solution for staff safety.

Reference	FY2026 Facilities James Krzywiecki
	Priority Goals/Key Tasks
Good Administrative Practice	1. **Continuous improvement of customer service:** a. Review/revise Department written procedures, as appropriate. b. Complete Annual Simulated Disaster Recovery Test and implement corrective actions/compensating controls, where appropriate; perform periodic testing of generators and emergency lighting at Electric Avenue, Marine City, Children's & Capac offices.
Good Administrative Practice	**2. Promote efficient use of existing facilities:** a. Complete comprehensive updates to the Facilities Operations Manual, detailing responsibilities, functions, vendor contacts and maintenance/replacement schedule of all CMH facilities for preventative maintenance. b. Develop and maintain a Facilities Procedure Manual, identifying and documenting all "key" tasks in the department; use for staff training and reference. c. Deep cleaning of the bathrooms at Electric & Capac with color seal being applied on the grout lines.
Good Administrative Practice	**3. Improvements to increase operational efficiency:** a. Monitor and maintain existing CMH facilities. b. Utilize the Kace System (Help Desk) to document and monitor maintenance requests. c. Hopps group home renovation: • Encapsulate the crawl space • New HVAC • Cement deck • Bathroom renovation • Plank flooring • Insulate garage & move water tank and washer/dryer into own space • Add two bedrooms (making it a six-bedroom home) d. Children's 24th Street: Renovate the existing garage to create five offices. e. Children's 24th Street: Main entrance, install a door and card swipe by reception and card swipe on the existing door going into the back offices. f. Activate and utilize the security system at Capac, Broadway, King Rd., arming/disarming and assigning a four-digit pin for associates. g. Work to have the five commercial sites generators on on-line reporting to the Power Commend web application verifying generator test every week.

Reference	FY2026 Utilization Management Amy Kandell
	Priority Goals/Key Tasks
Region 10 Delegation Contract Requirement	1. **Utilization Management Committee:** The UM committee will meet once a quarter to discuss findings, trends, and recommendations from chart record reviews and audits for direct run programs and contract agencies.
Good Clinical Practice CARF Recommendation	2. **Utilization Review for Direct Care & Contract Providers:** Conduct quarterly clinical case record review analyses on select General Fund and Medicaid medical records. a. Clinical review to ensure adherence to clinical protocol for cost-effective and well-coordinated services. b. Conduct claims verification associated with clinical case record reviews. Report on claims discrepancies. Identify and address over/underutilization. c. Complete special UM reviews upon request/need. d. Produce and distribute annual reports at minimum.
Good Business Practice	3. **Claims Verification:** Conduct claims verification reviews on select medical records in the Provider Network to determine whether customer services/supports are appropriately delivered by all providers (i.e., all program clinical case records/recording comply with all applicable internal and external customer requirements) at a 95% compliance rate (no more than 5% errors). Complete Claims Verification Reviews on up to 2.5% of Medicaid individuals receiving services through Contract Agencies. a. Complete primary and non-primary case holder reviews which may be concurrent with Contract Management site visits for Residential, CLS, and other community providers. b. Complete annual Medicaid Claims Verification Methodology report.

Reference	FY2026 Provider Network Management Kimberly Prowse
	Priority Goals/Key Tasks
Strategic Plan Organizational Efficiency	**1. Establish and maintain positive working relationships throughout the Provider Network through more enhanced communication efforts, primarily focusing on informal on-site visits in addition to the formal contract monitoring process.** a. Report the following numbers for the quarter: i. New/Potential provider site visits (in-person & virtual) participated in for the quarter. ii. Informal visits to existing providers iii. Informal meetings with existing providers where there was a change in the CMH Contract Manager for that agency
Strategic Plan Organizational Efficiency	**2. Timely desk and onsite compliance monitoring for Provider Network Agencies.** a. Report the following numbers and/or types for the quarter: i. Agencies that participated in the contract monitoring process. ii. Agencies that met the identified standards (%). iii. Agencies that had corrective action item(s) & follow-up steps taken.
Strategic Plan Organizational Efficiency	**3. Provider Contract Monitoring Tool revisions.** a. Report the following information for the quarter. i. Status update ii. Significant changes
Strategic Plan Organizational Efficiency	**4. Enhanced utilization of Contract Safe – Contract Management Software.** a. Report the following information for the quarter. i. Status update