Quality Improvement Program/Plan

FY 2022

St. Clair County Community Mental Health Authority

QUALITY IMPROVEMENT PROGRAM/PLAN
FY 2022

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 (SCCCMHA) 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 Executive Director/Designee. The Executive Director/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 SCCCMHA'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 SCCCMHA 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 SCCCMHA.

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 SCCCMHA. 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 SCCCMHA.

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 SCCCMHA 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 SCCCMHA quality improvement efforts / accomplishments for the year. This report is also shared with the SCCCMHA Board, various Advisory Councils, staff, Contract Management and other outside stakeholders (via website).

III. Designated Senior Official

The St. Clair County CMH Executive Director 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, SCCCMHA Committees, Focus Groups and surveys.

SCCCMHA 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, SCCCMHA 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

SCCCMHA 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 SCCCMHA for a number of key areas. Each CMHSP site has tools for promoting compliance which is monitored by SCCCMHA. Indicators target the following areas:

- Community Activities – Community Activities includes marketing, public relations and customer service which are overseen by the Community Relations Department. The purpose is to be visible and maintain a positive presence in the community by increasing community activities / education. These efforts are focused on increasing public awareness of services offered by SCCCMHA, and reducing the stigma experienced by persons served who have a mental illness diagnosis, intellectual developmental disabilities, severe emotional disturbance or substance use disorder.
- 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, 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 and Development Committee is to develop an organizational environment which optimizes the potential of all staff through training, education and opportunities of growth.
- Safety – The primary purpose of the Safety Committee is to provide an effective safety management program for the Agency. It will be the Committee's objective to minimize the risk of injury to staff, clients, and the general public by ensuring that the work environment is safe and free of hazards, with a goal of continual improvement. The goal is that 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 Executive Director 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 Executive Director 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 indictors 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- A key role Facilities plays is to ensure secure, safe, and properly maintained building facilities (offices and group homes) for agency staff and consumers as well as transportation services for programs, including an agency vehicle fleet for staff to use in providing services. The method for doing this will be to implement best practices in facilities maintenance, and policies and procedures, as prescribed by 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.

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 SCCCMHA 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 demonstrable 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

SCCCMHA 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 SCCCMHA 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

Executive Director

- 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.

Executive Director

- 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

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
- Develops agency's annual "Strategic Plan"
- Reports on System Improvement Committee (SIC)

QUALITY IMPROVEMENT PLAN GOALS: FY 2022

Community Activities Adrienne Luckenbacher			
Reference	**PRIORITY GOALS/KEY TASKS**	**Start Date**	**End Date**
MDHHS Contract Attachment C.6.9.3.3,B3 and A4	1. ANTI-STIGMA Complete a variety of anti-stigma projects with the public each month. Examples: • Public awareness events during recognition "months" or "weeks" o Mental Illness Awareness Week o Intellectual/Developmental Disability Month o Mental Health Month o National Recovery Month • Paid advertising (television, print, radio) • Public information (television, print, radio, social media) • Other	10/1/21	9/30/22
MDHHS Contract Attachment C.6.9.3.3,B3	2. COMMUNITY EDUCATION Participate in public education and opportunities to share information and eligibility and access to CMH services (minimum 12 per year) and opportunities to enhance services through community feedback. Examples: 1. Public education programs 2. Speakers' Bureau 3. Health Fairs 4. Community Perception Survey and follow up 5. Miscellaneous	10/1/21	9/30/22
Good Community Collaboration	3. CRISIS INTERVENTION Provide crisis intervention through CISM program as needed.	10/1/21	9/30/22
MDHHS Contract Attachment C.6.9.3.3,B3	4. ONLINE PRESENCE Update information on website at least weekly. Facebook: make a new post minimum of 4 times per week. LinkedIn: make a new post minimum 2 times per week (HR & CR both post to this account) YouTube: add videos to account when available and share on Facebook.	10/1/21	9/30/22
MDHHS Contract Attachment C.6.9.3.3,B3	5. RELATIONSHIP BUILDING a. Build/maintain contacts and communicate CMH events/resources to local churches/faith leaders. b. Build/maintain contacts and communicate CMH events/resources to area physician offices, health care professionals and integrated health partners as it relates to CMH services, opportunities, and integrated healthcare advancements. c. Build/maintain contacts and communicate CMH events/resources with area educators, businesses and first responders.	10/1/21	9/30/22

Community Activities Adrienne Luckenbacher			
Reference	**PRIORITY GOALS/KEY TASKS**	**Start Date**	**End Date**
Good Community Collaboration	6. HEALTHCARE INTEGRATION OUTREACH a. Host at least two events promoting integrated healthcare. b. Provide ongoing physical/behavioral health and wellness resources and information to persons receiving CMH supports and their family members (i.e. Wellness Wednesdays, resource tables, marketing materials, health screening days, etc.) c. Promote healthcare messages through staff photos, post to Facebook for public awareness.	10/1/21	9/30/22
Good Community Collaboration	7. COMMUNITY COLLABORATIVE Promote community collaboration and community benefit through support and participation in CSCB efforts. a. Active CMH representation on the CSCB executive committee and workgroups. b. Staff support of the CSCB provided by CMH. c. Engage in networking, communication, and collaboration between CSCB and CMH.	10/1/21	9/30/22

Corporate Compliance Abbey Brown			
Reference	**PRIORITY GOALS/KEY TASKS**	**Start Date**	**End Date**
Medicaid Integrity Program, Corporate Compliance Plan	1. Report monthly on corporate compliance complaints; identify trends (St. Clair County CMH).	10/1/21	9/30/22
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.).	10/1/21	9/30/22
Corporate Compliance Plan	3. Report monthly on grievance and appeals activities.	10/1/21	9/30/22
Corporate Compliance Plan	4. St. Clair County CMH Corporate Compliance Committee to meet quarterly or more frequently as deemed necessary.	10/1/21	9/30/22
Good Administrative Practice	5. Monitor and report any legal/regulatory changes.	10/1/21	9/30/22
CFR Requirement 438.610	6. Monitor and report on debarred, suspended, or otherwise excluded (from participation in any federal healthcare program) providers.	10/1/21	9/30/22
CFR Requirement 438.608	7. Provide training and education on corporate compliance, including HIPPA.	10/1/21	9/30/22

Corporate Compliance Abbey Brown			
Corporate Compliance Plan	8. Monitor technology use and needs as they relate to PHI and HIPPA.	10/1/21	9/30/22
Corporate Compliance Plan	9. Monitor subnetwork providers' corporate compliance activities.	10/1/21	9/30/22
Corporate Compliance Plan	10. Conduct an annual evaluation of the Compliance Plan and report to the St. Clair County CMH Board.	10/1/21	9/30/22

Note: Claims verification and under/over utilization reported under Utilization Management, although part of Compliance Plan and quarterly Program Integrity Reports.

Finance Karen A. Farr			
Reference	**PRIORITY GOALS/KEY TASKS**	**Start Date**	**End Date**
Good Administrative Practice	1. Manage financial risks through establishment and maintenance of fund balances. Objectives: o Establish, review and update policies and procedures related to our CMHSP Local Fund Balance	10/1/21	9/30/22
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: o Identify fiscal concerns through monthly analysis of revenues and expenditures o Analyze trends and provide revenue forecasts o Prepare annual budget and provide comparison of budget to actual revenues and expenditures on a monthly basis o Prepare amended budget to reflect significant changes in revenues and expenditures of the agency, as needed o Make recommendations about how to best utilize agency resources o Interact with other managers to provide consultative support to planning initiatives through financial information analyses, reports, and recommendations	10/1/21	9/30/22
MDHHS	3. Ensure compliance with local, state, and federal budgetary reporting requirements. Objectives: o Coordinate and ensure completion of the annual Financial, Compliance and Single Audits. o Complete all required Federal, State and local financial reporting per the Medicaid and General Fund contracts. o Cost Allocation Methodology and the CCBHC Demonstration beginning 10/1/21.	10/1/21	9/30/22
ARR 7/3	4. Promote collaboration, efficiency and uniformity between PIHP members. Objectives: o Utilize the Region 10 Finance Officer's workgroup to share information and identify best practice strategies. o FY 2022 Regional CFO goals: o Independent Rate Model analysis	10/1/21	9/30/22

Finance Karen A. Farr			
Reference	**PRIORITY GOALS/KEY TASKS**	**Start Date**	**End Date**
Good Administrative Practice	5. Establish and maintain appropriate internal controls over record keeping and safeguarding of assets Objectives: o Establish, review and update policies and procedures for record keeping, handling of cash and tracking of assets o Ensure separation of duties to reduce the risk of fraudulent activity	10/1/21	9/30/22

Human Resources and Development Kim Prowse			
Reference	**PRIORITY GOALS/KEY TASKS**	**Start Date**	**End Date**
Good Business Practice	1. Review current Human Resource-related practice and software system including: a. Work with Sage implementation team to develop a bridge between Sage and Cybertrain to improve workflow efficiency. b. Work with Sage implementation team to introduce Sage Recruit (Applicant Tracking System) to replace Applitrack. c. Coordinate training/rollout of Sage People Human Capital Management (HCM) and Recruit to agency. d. Evaluate current recruitment and selection policy. Update to align with new Sage Recruit workflow process. e. Evaluate and establish best practice model of interview/selection process. f. Evaluate and develop agency-wide succession planning program to provide development opportunities for future agency leaders. g. Improve volunteer recruitment process h. Work towards movement to electronic personnel file	10/1/21	9/30/22
Good Business Practice CARF Requirements Sec.1.1.4 d,e Sec. 1.1.9 f b)Sec.10,Goal 2 d)Sec.10,Goal 1	2. Provide an opportunity for professional growth to enhance performance, skill development and cross training. a. Provide centralized training calendar identifying topic/date/location for all trainings. b. Continuously update/modify required training grid based on regulatory requirements, and ensure staff compliance. c. Offer/mandate supervisory courses to current/potential supervisors via MyLearningPoint as courses become available. d. Provide trainings on a variety of topics related to job development, mental health, physical health, etc., as directed by management, for all CMH staff. e. Evaluate / improve "New Employee Orientation" process. f. Collaborate with Regional HR staff, as appropriate, to offer/develop regional training options. g. Review Job Descriptions at least annually. h. Administer "Training Needs" survey at each CMH sponsored training. i. Work with identified employee groups to address improvement opportunities. j. Provide Compliance training on an annual basis. k. Provide Trauma Informed Care training for all new hires. l. Provide LOCUS training for all new and existing hires who will work with the Adult MI population.	10/1/21	9/30/22
Good Business Practice	3. Reward employees for performance that meets and exceeds defined expectations and recognize continued efforts. a. Continue to evaluate CMH "Staff of the Year" and "Team of the Year" recognition programs 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	10/1/21	9/30/22

Human Resources and Development Kim Prowse			
Reference	**PRIORITY GOALS/KEY TASKS**	**Start Date**	**End Date**
Good Business Practice	4. Utilize the Employee Wellness and Development Committee to evaluate needs in areas such as training, education, opportunities for growth, advancement, recognition, wellness, and personal enrichment.	10/1/21	9/30/22

Safety Latina Cates			
Reference	**PRIORITY GOALS/KEY TAKS**	**Start Date**	**End Date**
OSHA 08.450	1. Quarterly, report Employee Accidents within 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"	10/1/21	9/30/22
CARF Health and Safety	2. Ensure easy access to First Aid: a. Expertise b. Equipment c. Supplies	10/1/21	9/30/22
CARF Health & Safety	3. Quarterly, completed Building Inspection. a. Site Participation, (5) locations. Target compliance, 100%. b. Safety/Infection Control Checklist. Target compliance, 95%.	10/1/21	9/30/22
CARF Health & Safety	4. Quarterly completed Kitchen Inspection; via the Kitchen Safety Inspection Checklist. Target compliance, 95%.	10/1/21	9/30/22
CARF Health & Safety	5. Annually completed Emergency/Event Procedures (9 types) at all locations. Completion may be per "actual event" or drill. Target compliance 95%. *Conducted, monitored, recorded, and reported quarterly • Active Shooter • Chem./Biological • Fire • Natural Disaster • Utility Failure • Bomb Threat • Dangerous Person • Medical Emergency • Suspicious Mail/Parcel	10/1/21	9/30/22

CARF Health & Safety	6. Annually, all full time and part – time employees will *participate* as applicable in at least one (1) of the nine (9) types of Emergency 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. • Scheduled emergency drill participation will be electronically tracked via email voting responses or the "Emergency Event" form. • Actual emergency event participation is recorded via the "Emergency Event" form or email voting when applicable. b. Supervisors to receive notification, during third quarter 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 (09.001.000) or Emergency Procedures Handbook, with applicable staff.	10/1/21	9/30/22
CARF, Health and Safety, Emergency Procedures 1.H.5.c.5	7. Supervising staff to ensure for Staff Accountability during large evacuation drills and actual events (i.e. Fire, Bomb Threat, Chemical Biological, Tornado, etc.). Supervisors to ensure use of sign in/out binders, roll call, and/or text messaging when applicable.	10/1/21	9/30/22
CARF Health & Safety, Medication Use MHC R330.1719 R330.2813 R330.7158	8. Quarterly review "Medication Errors" reports. a. Error type b. Error location c. Trends d. Improvement opportunities Error type	10/1/21	9/30/22
MIOSHA R325.70001	9. Annually review the "Exposure Control Plan," update as needed. (Blood Borne Pathogens Exposure and Infection Control Plan)	10/1/21	9/30/22
CARF Health & Safety	10. Annually, complete (update/revise) Board Statement: "Health & Safety Work Plan".	10/1/21	9/30/22
CARF	11. Promote Safety by ensuring current Written Safety Procedures as applicable.	10/1/21	9/30/22
N/A	12. Promote implementation of Threat List individual's photos in OASIS.	10/1/21	9/30/22
CMH Policy	13. Address other safety-related items as needed.	10/1/21	9/30/22

Privileging and Credentialing Andrea Velez			
Reference	**PRIORITY GOALS/KEY TASKS**	**Start Date**	**End Date**
MDHHS/ PIHP contract	1. Maintain/update as applicable the Provider Enrollment and Credentialing Policy (01.003.0011), credentialing applications and forms.	10/1/21	9/30/22
State Licensing & MDHHS Requirement	2. Monitor the credentials for all staff requesting privileges to provide services to individuals in SCCCMHA presented to committee.	10/1/21	9/30/22
MDHHS Requirement	3. Review and privilege as appropriate organizational applications of Provider agencies.	10/1/21	9/30/22
MDHHS Requirement	4. Maintain the SCCCMHA list of credentialed positions and coordinate with Medicaid Medicare/MDHHS definitions. a. Monthly update Provider Registry Reports to ensure compliance with credentialing timeframes. b. Ensure list of practitioner and organizational providers are available upon request.	10/1/21	9/30/22
Good Clinical Practice	5. Monitor staff training requirements. Make recommendations for training and direction as needed.	10/1/21	9/30/22
Good Clinical Practice	6. Monitor delegated provider credentialing processes. a. Practitioner credentials – via monthly provider registry reports. b. Credentialing policy – via desk audits and site visits	10/1/21	9/30/22

Program Development Kathleen Gallagher			
Reference	**PRIORITY GOALS/KEY TASKS**	**Start Date**	**End Date**
Best Practice	1. Sustain current Evidence-Based Practices (EBP). a. Expand number of CMH staff trained in an applicable EBP. b. Continue to monitor current EBP for fidelity. c. Expand number of individuals receiving EBP throughout the CMH System through CCBHC funding.	10/1/21	9/30/22

Program Development Kathleen Gallagher			
Reference	**PRIORITY GOALS/KEY TASKS**	**Start Date**	**End Date**
Best Practice	2. Implement trauma informed system of care. a. Continue to provide TIC training to new staff at orientation and refreshers to existing staff. b. Expand TIC to contract system so all are Trauma Informed. c. Survey current perceptions from staff and those served regarding our current standing with regard to TIC	10/1/21	9/30/22
Grant FY20-21	3. 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. c. Utilize CCBHC to provide Veterans' access to care outside of their typical benefits.	10/1/21	9/30/22
Integrated Care/CCBHC	4. Implement Well Environment a. Implement a Healthy Environment for staff and individuals we support. b. Assist in facilitating Wellness Wednesdays. c. Continue to work with the People's Clinic on improving primary care service delivery to the community. d. Fully implement the wellness arm of CMH, supported through CCBHC funding (In Shape, Mediation, Yoga, etc.)	10/1/21	9/30/22
Best practice	5. Assess and explore EBP to provide SUD services. a. Train Staff identified EBP for SUD 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	10/1/21	9/30/22
Best Practice	6. To provide state -of -the art, evidence based assessment and treatment to individuals at risk for suicide. a. Train staff system wide in EBP for treatment for individuals at risk for suicide. b. Train staff system wide on use of Columbia and applicable clinical tools for treatment. c. Assess current EBP's for effectiveness. d. Research EBP's that may be implemented throughout the system.	10/1/21	9/30/22
Staff Recruitment Program Staff Training Expand Programs	7. Develop and Implement a plan to recruit and 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 area of people served. e. Work with supervisors to identify need areas and complete work plans to address those need areas. f. Next step to become operational.	10/1/21	9/30/22

Recipient Rights Telly Delor			
Reference	**PRIORITY GOALS/KEY TASKS**	**Start Date**	**End Date**
MI MHC MDHHS	1. Administrative Function a. Submit the MDHHS-ORR Annual Monitoring Form to the MDHHS-ORR by January 15th of each year. b. Submit the SCCCMHA Semi-Annual Report to the MDHHS-ORR by June 30th of each year. c. Submit the SCCCMHA Annual Report to the MDHHS-ORR by December 30th of each year.	10/1/21	9/30/22
MDHHS GF Contract	2. Complaint System a. Report the number of substantiated Recipient Rights violations in St. Clair County by classification and provider location (identified by month/quarter).	10/1/21	9/30/22
MI MHC MDHHS	3. Monitoring & Prevention a. On an annual basis, ensure a Recipient Rights site review is completed at each direct-operated service location and each contracted service location.	10/1/21	9/30/22
CARF MDHHS	4. Monitoring: Incident Report System a. Review Incident Reports within 10 business days of each reported incident. b. Identify and forward potential Critical Incidents to the Program Director/designee within three 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.	10/1/21	9/30/22
MI MHC	5. Prevention a. Review and update, as necessary, all SCCCMHA 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.	10/1/21	9/30/22
MI MHC MDHHS GF Contract	6. Education/Training a. Monitor training data to determine if staff members/volunteers (direct-operated & contract system) completed in-person Recipient Rights New-Hire training within 30 days of hire. i. Provide in-person 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 members/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 Recipient Rights Refresher training on an annual basis. i. Provide in-person Recipient Rights refresher training at least two times per month. ii. Report the number of staff trained. 1. Direct-Operated staff members/volunteers 2. Contract System staff members/volunteers	10/1/21	9/30/22

System Improvement Denise Choiniere			
Reference	**PRIORITY GOALS/KEY TASKS**	**Start Date**	**End Date**
CARF	1. Maintain agency accreditation.	10/1/21	9/30/22
Regulatory Requirement	2. Ensure compliance with applicable Corrective Action Plans (e.g. Region 10 PIHP, MDHHS, HSAG etc.)	10/1/21	9/30/22
MDHHS	3. Monitor performance of each location through program performance indicators.	10/1/21	9/30/22
MDHHS, CARF	4. Achieve overall satisfaction through the annual surveys. a. Customer Satisfaction Survey b. Accessibility / Barriers to Services Survey c. Provider Satisfaction Survey d. Post-Discharge Survey e. Prescriber Satisfaction Survey f. NCI Project	10/1/21	9/30/22
HHS P.6.5.1.1	5. Monitor performance on the following MDHHS performance indicators (MA/GF and MA only). PI 1. Access: Timeliness: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within 3 hours. PI 2. Access: Timeliness: The percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. (95% standard) PI 3. Access: Timeliness: Percentage of new persons during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional. PI 4a. Access: Continuity of Care: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up within 7 days. (Standard: 95%) PI 10. Quality of Life: Adverse Customer Outcomes: The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. (Standard: 15% or less)	10/1/21	9/30/22
Choosing Wisely	6. Choosing Wisely a. Implement Choosing Wisely Guidelines b. Implement PDSA Cycles (Plan, Do, Study, Act) c. Implement technology to improve patient access and quality of service.	10/1/21	9/30/22
Region 10 Contract Requirement	7. Enhance Dashboard Indicators and other data mining capabilities that facilities population management/analysis. a. Utilize CC360 or population management/analytics. b. Utilize Dashboard for Quality Improvement Projects. c. Enhance CEHR usage for e-signature collection, patient education and program improvement.	10/1/21	9/30/22

Information Technology Dann Hayes			
Reference	**PRIORIT GOALS/KEY TASKS**	**Start Date**	**End Date**
Good Administrative Practice	1. Continuous improvement of Customer Service. a. Disaster Recovery Preparedness (45 CFR 164.308.) 1. Review IT Department Written Plan to ensure it addresses on-going software/hardware solutions and process changes (7/31/2022). 2. Complete annual simulated disaster recovery test and implement corrective actions and/or compensating controls, where appropriate. • Electric Avenue – (7/31/2022) • Marine City – (7/31/2022) • Capac – (7/31/22) • ABA – (7/31/22) 3. Complete HIPAA Risk Assessment (1/31/22) and Develop/Implement Plan (45 CFR 164) (9/30/2022).	10/1/21	9/30/22
Good Administrative Practice	2. Promote the efficient use of existing technology. a. Replace/Upgrade hardware related to IT Equipment. Replacement schedule to remain current with technology and support agreements. • Upgrade network switches in IDF • Upgrade all servers to Windows Server 2019 platform	10/1/21	9/30/22
Good Administrative Practice	3. Improve technology to increase operational efficiency. a. e911 – Updating our phone system to give responders a better idea of where people are physically located within buildings. b. Password requirement changes for ALL PCs and other technology. c. Network Security Audit (7/31/22) and Remediation of any vulnerabilities found. (12/31/22) d. Review Internet bandwidth needs for the agency with the increase in mobility and video conferencing e. Implement new strategy for updating all agency devices, with special attention to update devices that are mobile (laptops).	10/1/21	9/30/22

Facilities Mike Klemmer			
Reference	**PRIORITY GOALS/KEY TASKS**	**Start Date**	**End Date**
Good Administrative Practice	1. Continuous improvement of Customer Service a. Disaster Recovery Preparedness (45 CFR 164.308.) 1. Review/Revise Department written procedures, as appropriate. (9/30/2022) 2. Complete Annual simulated DR test and implement corrective actions/compensating controls, where appropriate; perform periodic testing of generators and emergency lighting. Electric Avenue, Marine City, Children's & Capac (6/30/22)	10/1/21	9/30/22
Good Administrative Practice	2. Promote the efficient use of existing Facilities a. Complete comprehensive updates to the Facilities Operations Manual detailing responsibilities, functions, vendor contacts and maintenance/ replacement schedule of hardware and vehicles as well as all CMH facilities preventative maintenance. (9/30/2022) b. Develop and maintain a Facilities Procedures Manual identifying and documenting all "key" tasks in the department; use for staff training and reference. (9/30/2022)	10/1/21	9/30/22
Good Administrative Practice	3. Improvements to increase operational efficiency a. Maintain a "Vehicle Use Policy" including general usage guidelines, balancing mileage/age of vehicles by location and routine mileage reports to dictate ideal agency vehicle fleet size. b. Maintain a SDS manual, including pictures of products, and complete training with staff concerning use of products and appropriate storage. c. Monitor and maintain existing CMH properties d. Follow a fueling and maintenance schedule for all company vehicles to better track fueling and maintenance costs. e. Utilize Kace Systems to document and monitor maintenance requests. f. Utilize Fleet Commander software to optimize vehicle fleet efficiency, use reporting capabilities to analyze optimal fleet size. g. Search, evaluate, purchase residential property to expand bed capacity. h. Search, evaluate, purchase commercial property to replace existing Marine City office.	10/1/21	9/30/22
Good Administrative Practice CARF Health & Safety	4. 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: 1. Continue participation in MiHAN (Health Alert Network) 2. Implement CMH closed WINS group for staff notifications. 3. Update existing document to include the Pandemic Plan and also update to reflect any changes in process, advances in technology, etc. 4. Complete planning process documents for each program. Documents identify: • Possible alternative locations • Prioritization of essential functions • Order of succession • Vital information/records 5. Identify process for addressing internal disaster (small and large scale) 6. Identify process for addressing community disaster (working with EOC, Homeland Security, etc.) b. Disseminate updated DR/BRP c. Train staff on the DR/BRP d. Periodically conduct tabletop exercises/drills	10/1/21	9/30/22

Utilization Management Michelle Measel-Morris			
Reference	**PRIORITY GOALS/KEY TASKS**	**Start Date**	**End Date**
Region 10 Delegation Contract Requirement	1. Integrated Health Care: Staff will participate in joint care meeting with Medicaid Health Plans and Region 10 PIHP. a. Monitor and report on Care Connect 360 program implementation and usage. b. Random select cases will be reviewed for reduction in non-emergent emergency department use, linkage with primary health care access and applicable linkage with Veterans' services. c. Random select cases will be reviewed for follow up after hospitalization for mental illness within 30 days (Standards: 70% ages 6-20 and 58% ages 21 and older). d. Annual narrative is due to the PIHP summarizing improvements in joint care activities/metrics.	10/1/21	9/30/22
Good Clinical Practice/CARF Recommendation	1. Utilization Review: For both Contract Provider and Direct Care: 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 coordinate services. b. Conduct claims verification associated with clinical case record reviews. Report claims discrepancies. Identify and address over/under-utilization. c. Completed special UM reviews upon need or request. d. Produce and distribute quarterly reports.	10/1/21	9/30/22
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 of 2.5% of Medicaid individuals receiving services through Contract Agencies a. Complete non-primary case holder review concurrent with Contract Management site visits for Residential, CLS and other community providers. b. Complete annual Medicaid Claims Verification Methodology Report c. Implement Service Activity Log requirement for contract agency staff – tie to claims review (supporting documentation must be available in the electronic health record for a warning will show to not pay the claim).	10/1/21	9/30/22
Region 10 Delegation Contract Requirement	4. Utilization Management / Trend Analyses: Report on over / under-utilization of the following programs: ACT, Home Based and Supports Coordination/ Case Management to the PIHP monthly QMC.	10/1/21	9/30/22
Good Clinical Practice	5. BTPRC: Conduct quarterly oversight of Behavior Treatment Plan Review Committee (BTPRC) activities. a. Risk Events Analysis Report – quarterly 1.) HSW, SEDW and CW Emergency use of Physical Management tracking b. System Improvements identified at BTPRC to provide additional training opportunities for staff and/or opportunities to reduce risk factors for individuals served.	10/1/21	9/30/22

QAPIP Performance Improvement Projects Michelle Measel-Morris			
Reference	**PRIORITY GOALS/KEY TASKS**	**Start Date**	**End Date**
Good Clinical Practice	1. To participate in the Region 10 PIHP QAPIP Performance Improvement Projects a. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications b. Medical Assistance for Tobacco Use Cessation c. Follow up visit after Hospitalization of Mental Health Diagnosis	10/1/21	9/30/22
MDHHS Audit Requirement	2. To participate in the MDHHS Quality Improvement Project for HSW, CWP and SEDW a. Staff training compliance b. Service provision compliance	10/1/21	9/30/22