Community Mental Health Partnership of Southeast Michigan

FY21 Quality Assurance and Performance Improvement Program Evaluation

Evaluation Year 2021

Final Version Approved:

Reviewed by Clinical Performance Committee: 12/16/21
Approved by CMHPSM Board:
Submitted to MDHHS for Review:

Table of Contents

I. Introduction

The Michigan Department of Health and Human Services (MDHHS) requires that each specialty Prepaid Inpatient Health Plan (PIHP) has a Quality Assessment and Performance Improvement Program (QAPIP) that meets standards required by: the PIHP's contracts, including the PIHP contract with MDHHS (attachment P.7.9.1); the Balanced Budget Act of 1997 (BBA), Public Law 105-33; and 42 Code of Federal Regulations (CFR) 438.358.

The Community Mental Health Partnership of Southeast Michigan (CMHPSM) creates an annual plan that describes the QAPIP. The CMHPSM Board of Directors (the Board) annually reviews and approves the overall QAPIP plan. The Board also annually reviews a written report on the operation or effectiveness of this plan (the QAPIP Evaluation). This QAPIP Evaluation evaluates whether interventions resulted in improvements in health care outcomes and services. CMHPSM provides notice through its website that the report is available to network providers, persons served, and MDHHS upon request.

The Board also receives regular progress reports on components of the QAPIP during the year. Additional information related to the QAPIP standards can be found in CMHPSM policies and procedures, the Clinical Performance Team (CPT) Committee charge, and other regional plans.

II. Purpose and Scope

This QAPIP Evaluation is an overall assessment of the projects in the QAPIP workplan. The Plan's purpose is to describe:

1) an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP;
2) the components and activities of the QAPIP;
3) the role for recipients of service in the QAPIP; and
4) the mechanisms or procedures used for adopting and communicating process and outcome improvement.

The CMHPSM serves populations in the region who experience mental illness, intellectual developmental disabilities, and substance use disorders. The CMHPSM QAPIP encompasses access, quality, and cost of service delivery. This plan outlines the current relationships and structures that exist to promote performance improvement goals. Improvement activities target operational efficiencies, service delivery, and clinical care. This plan is based on contract and regulatory requirements; the previous year's quality assessment and performance improvement projects; and CMHPSM vision, mission, and values.

III. Core Values—Quality Assessment and Improvement

The CMHPSM's Vision, Mission, and Values guide our quality assurance and performance improvement activities:

A. Mission Vision and Values

Mission: Through effective partnerships, the CMHPSM ensures and supports the provision of high-quality integrated care that is cost effective and focuses on improving the health and wellness of people living in our region.

Vision: The CMHPSM shall strive to address the challenges confronting people living in our region by influencing public policy and participating in initiatives that reduce stigma and disparities in health care delivery while promoting recovery and wellness.

Values:

- Strength Based and Recovery Focused
- Trustworthiness and Transparency
- Accountable and Responsible
- Shared Governance
- Innovative and Data driven decision making
- Learning Organization

B. Guiding Principles:

Guiding Principle #1: CMHPSM uses quality assurance and performance improvement to make decisions and guide day-to-day operations.

Guiding Principle #2: The QAPIP helps to ensure that our organization, member providers, and CMHSPs improve quality of care for consumers.

Guiding Principle #3: The QAPIP incorporates feedback and contribution from employees, departments, providers, and consumers.

Guiding Principle #4: The QAPIP focuses on identifying defects in system processes, rather than individuals, and utilizes knowledge and efforts of the individuals involved in these processes.

Guiding Principle #5: CMHPSM uses qualitative and quantitative methods to collect and evaluate data about performance.

Guiding Principle #6: CMHPSM strives to meet and exceed standards established through regulation, contract with the State, or through local, statewide, or national databases.

Guiding Principle #7: CMHPSM strives to use statistically valid sampling, data collection, analysis, and interpretation methods in all its performance improvement activities.

Guiding Principle #8: CMHPSM creates a culture that encourages employees to identify deficiencies in processes and areas of improvement.

IV. Quality Improvement Authority and Structure

The Board annually reviews and approves the QAPIP Plan and receives periodic QAPIP reports. The CMHPSM Leadership Staff oversee the committees that implement the QAPIP and address specific issues in need of remediation.

A. CMHPSM Board

The CMHPSM Board is responsible for overseeing the QAPIP by performing the following functions:

- Review and approve the QAPIP Plan.
- Review and approve an annual report on the operation of the QAPIP.
- Receive periodic written reports of the activities of the QAPIP, including performance improvement projects (PIPs), actions taken, and the results of those actions.
- Following approval, the Board submits the written annual QAPIP Plan to MDHHS for approval. The submission includes a list of all the members of the Board.

B. Clinical Performance Team (CPT)

The QAPIP is managed by the CMHPSM Clinical Performance Team (CPT) Committee. Membership includes clinical staff, PIHP staff, and performance improvement staff from each of the CMHSPs within the region. A CMHSP Chief Executive Officer (CEO) from the Regional Operations Committee (ROC) also serves as a coach on the committee.

CPT Committee responsibilities include performing the following:

- systematically gather information from various stakeholders
- define performance standards
- evaluate performance and/or gaps
- complete root cause analyses
- compete priority ranking of barriers
- develop interventions
- implement interventions
- evaluate effectiveness of the interventions
- examine the capacity to support and sustain improved performance

For the FY18-21 Performance Improvement Projects (PIPs) cycle an Integrated Health Care workgroup (IHW) was created by CPT to carry out specific PIPs and report back to CPT on a regular basis. Performance improvement projects are based on the population health needs of the community. To assess population health needs, CMHPSM analyzes data from national indicators of healthcare/behavioral health needs that may reflect local needs, state databases, clinical records, and collaborates with providers and persons served to carry out initiatives such as the Consumer Satisfaction Survey project, and the Recovery Self-Assessment project. Most QAPIP tasks are carried out by staff from each CMHSP and by Electronic Health Record Operations Committee (EOC) Liaisons.

CMHPSM staff at CPT and EOC provide leadership and support for data collection, analysis and report writing, compliance needs, and training. The CPT Committee meets monthly to review

progress on PIPs, and to ensure clear and consistent communication to staff, persons served, and stakeholders. After meetings are held, CPT Liaisons communicate the progress of PIPs to their staff, local Boards, local committees, persons served, and community stakeholders. Communication efforts include posting PIP plans on local websites, newsletters, internal communications boards, staff meetings, and community meetings.

The CPT Committee reviews the annual QAPIP Plan and may make revision suggestions. The Regional Operations Committee (ROC) then reviews and approves the plan before it is brought to the regional Board. ROC is made up of the four CMHSP Executive Directors and the CMHPSM CEO.

C. Committees and Workgroups

The FY21 QAPIP was implemented using various groups and teams including but not limited to the following:

- Clinical Performance Team
  - Integration of Health Care Workgroup (IHW)
- Regional Consumer Advisory Committee
- Utilization Review Committee
- Electronic Health Record Operations (EOC) Committee
- Customer Services Committee
- Network Management Committee
- Compliance Committee

The CPT Committee is responsible for general oversight of the QAPIP. The CMHPSM Chief Operations Officer and the CMHPSM Compliance and Quality Manager are responsible for the oversight of QAPIP Implementation. (See Attachment A—CMHPSM Organizational Chart).

V. QAPIP Components Include Written Regional Policies

CMHPSM has created several regional policies, as required by contract and regulation, that incorporate components of the QAPIP. The policies are implemented by various regional committees, CMHPSM departments, contracted CMHSPs, and regional providers. This plan introduces several policies to provide a sense of how different components of the QAPIP fit together.

A. Utilization Review (*Utilization Management and Review Policy*)

Purpose. The Utilization Review Committee plays an important role in the QAPIP. The Committee's purpose is to ensure the most efficient and effective use of clinical care resources, to support the utilization management process, and to review service delivery patterns for high risk, high volume, and high-cost services.

Monitoring. The Utilization Review Committee develops and monitors coverage criteria for services provided to vulnerable populations. It continuously monitors and improves the utilization review process, identifies, and corrects over- and under- utilization and ensures appropriate and cost-efficient utilization of services, and the parity program required by

the state. The committee reviews and analyzes aggregated case record data to ensure medical necessity and appropriateness of care, including those with special health care needs and long-term service and supports.

Utilization Review Decisions. Utilization review of services can be prospective, concurrent, or retrospective. Utilization review decisions are made by qualified professionals and based on the necessary clinical information. The service authorization and utilization review system ensures the reasons for decisions are documented and available to persons served in a timely manner, along with a description of due process/appeals rights when services are denied or there is a disagreement or dissatisfaction with service provision.. The committee also reviews data on consumer and provider satisfaction to evaluate the effects of the utilization review program.

B. Safety and Risk Monitoring- Sentinel Event Reporting (*Critical Incident, Sentinel Event, and Risk Event Policy*)

Reviews. CMHPSM and the CMHSPs use both qualitative and quantitative methods to review Critical Incidents, Sentinel Events, and Risk events for both mental health and substance use disorder (SUD) services. The CMHPSM completes quarterly reviews of these events for performance improvement opportunities. A review includes analyses of provider and member trends, causal factors (performance improvement opportunities), and compliance with CMHPSM policy and procedures. CMHPSM also reviews biannual reports of critical incidents related to SUD providers and persons receiving SUD services. The CMHPSM provides to MDHHS, upon request, documentation of the review process for critical incidents, sentinel events, and risk events.

Reporting. Critical Incidents and Sentinel Events that occur in the region are reported to the state as they occur via the electronic health record system (EHR) in CRCT. CMHPSM also reports SUD Sentinel Event data to MDHHS in accordance with Schedule E Reporting Requirements of the MDHHS-PIHP contract. Data on Critical Incidents is reported to MDHHS monthly. High-risk events that have a critical impact are reported to the state directly and more immediately. If a person served dies within one year of discharge from a state-operated service, then CMHPSM immediately notifies MDHHS and submits a written report of its analysis of the death within 60 days after the month in which it occurred.

Addressing Quality of Care. CMHPSM or its delegate identifies whether a critical incident was a Sentinel Event within three business days after it occurred. If the critical incident is classified as a Sentinel Event, CMHPSM or its delegate/responsible entity commences a root cause analysis in two subsequent business days. Root cause analyses are used to determine what actions should be taken to prevent the occurrence of additional events. Sentinel Events are reviewed by staff with the appropriate credentials (e.g., a client death requires review by a physician or nurse) and in a timely manner (two subsequent business days). CMHPSM ensures compliance of delegated functions related to sentinel events, including meeting timeframes, utilization of root cause analyses, staff credentials,

and corrective actions through CMHPSM monitoring processes and reporting of data to the CPT Committee. Following review, CMHPSM recommends improvements, identifies educational needs for staff and providers, and monitors compliance related to critical incidents and sentinel events.

C. Behavior Treatment (*Behavior Treatment Committee Policy)*

Quarterly Review. Each local CMHSP conducts quarterly reviews of data on behavior treatment where intrusive or restrictive techniques or medications have been used to treat behavior, and when physical management or involvement of law enforcement were used in a behavioral emergency. Data includes numbers of interventions, length of time the intervention was used per person, less intrusive interventions attempted, time limits for periodic reviews to determine if the modification is still necessary or can be terminated, assurance that interventions and supports will cause no harm to the member, and the process for reviewing service plans related to any needed modification due to a person's physical need or due to restrictions of another individual residing in the home. The CMHSP's monitor whether the intrusive or restrictive techniques were approved, and consent given by the person served or guardian in the Person-Centered Plan and permitted by the MDHHS Technical Requirement for Behavior Treatment Plans.

For FY21 BTC data collection was expanded to include that in cases where an increase of 3 or more such techniques were used within a 30-day period, the BTC committee reviews the individual's case within 30 days for any potential modifications to the individual's plan of service that could reduce the use of such techniques.

D. Provider Monitoring (*Organizational Credentialing/Recredentialing and Monitoring, Employee Competency and Credentialing, and Credentialing for Licensed Independent Providers Policies)*

Monitoring Providers. CMHPSM uses a written contract to define its relationship with each CMHSP and providers that is also used by the CMHSPs in their sub contractual relationships with providers. The contract requires compliance with federal and state laws and the CMHPSM contract with MDHHS. CMHPSM and the CMHSPs regularly monitors its provider network through audits and screenings—in accordance with written policies and procedures, contractual requirements, and regulations. For example, CMHPSM verifies that service delivery is performed by qualified employees. When providers fail to meet the standards established by CMHPSM, federal and state laws, and/or the MDHHS contract, they are required to complete a Corrective Action Plan (CAP). CMHPSM approves and monitors progress on CAPs. Further, provider monitoring and CAPs are subject to review by MDHHS. Finally, if fraudulent services for billing, waste, and abuse are discovered, CMHPSM will take appropriate actions including conducting investigations, recouping overpayments where indicated, and/or notifying the Office of Inspector General.

Contracts and monitoring tools are updated to include regulatory or practice changes, areas of risk, or trends found with provider performance.

Credentialing. Organizational providers, Licensed Independent Practitioners, and non-licensed providers must meet the credentialing requirements set forth in the *Organizational Credentialing/Recredentialing and Monitoring Policy* and *Credentialing for Licensed Independent Practitioners Policy*. CMHPSM conducts regular audits to ensure compliance with these requirements (see Monitoring Providers).

Employee Competence. Additionally, competence and credentialing for all employees is assessed at the time of hire and annually. Employees must meet qualifications for education, work experience, cultural competence, and certification or licensure as required by law. CMHPSM also provides training and continuing education for staff development. Before assigning clinical responsibilities, the CMHSP/Core Provider verifies identity, applicable licensure, training, and other evidence of the ability to perform the assigned responsibilities. For more information, please see the *Employee Competency and Credentialing Policy*.

Network Adequacy Plan: In accordance the MDHHS PIHP contract and federal regulations 42 CFR §438.207 §438.68 and §438.206(c)(1), the PIHP conducts a network adequacy plan that assesses at minimum:

- Assurance of sufficient amount and scope of a provider network that meets the service array and needs of the populations served.
- Assurance the provider network meets Home and Community Based Service Waiver requirements around choice and access for persons served that provides integrated experiences in their community in areas of provider choice, choice in place and type of residence, choice in place and type of vocational or community opportunities, and freedom to direct their resources.
- Timely appointments, including MMBPIS and appointment standards for its SUD priority populations.
- Language, including an assessment of languages spoken by its membership and its provider network, and an analysis of the use of interpreter services.
- Cultural competency, including an assessment of the cultural and ethnic make-up of its membership and the capability of its provider network to meet the needs of its members.
- Physical accessibility, including an analysis of provider types who can or cannot provide physical accessibility to members with disabilities.

E. Clinical Practice (*Clinical Practice Guidelines Policy*)

Recommendations. CPT Committee reviews the Clinical Practice Guidelines annually and on an as needed basis. CPT recommends a clinical practice for use within the network only when such practices are evidence-based or represent the consensus of health care professionals. Additionally, recommended practices will be based on the needs of the persons served by our region.

Adopting Practices. A representative of the CPT Committee presents recommendations to the Regional Operations Committee (ROC). ROC then decides whether the recommended practices will be adopted, require regional implementation, or will be a local

option to implement. Once ROC adopts a practice, the affiliates develop and disseminate an implementation plan to affected providers and to members upon request. CPT Committee reevaluates adopted practices annually for effectiveness of implementation and maintenance of fidelity.

F. Medicaid Verification (Service Verification Policy; Services Suited to Condition Policy)

Policies and Procedures. CMHPSM implements policies and procedures to monitor and evaluate its provider network. This includes verifying delivery of services billed to Medicaid and Healthy Michigan Plan in accordance with federal regulations and the state technical requirement.

Verification Process. CMHPSM conducts reviews annually and on an as needed basis. The verification process includes:

- Desk Audits of policies, procedures, staff training requirements and other resource material.
- On-site Audits to review and validate process requirements.
- Claims/Encounters review of a random sample of Medicaid and Healthy Michigan Plan participants to verify
  - correct billing amounts, code, scope, and timing
  - eligibility of the participant,
  - qualifications of staff
  - services were appropriate (medically necessary and within scope of individual plan of service) and actually rendered.
- Data is aggregated, reviewed, and analyzed
- Following review, CMHPSM develops a Medicaid Event Verification report detailing the results of the review and any corrective action plans that are required.
- The service verification tools are reviewed on an annual basis for functional utility and updated to reflect changing regulations or new contract terms.

Submission for Approval. CMHPSM annually submits this verification process, its findings, and any follow up actions to MDHHS for approval.

G. Oversight of Vulnerable Populations (*Assessment and Reassessment, Person Centered Planning, Self-Determination, Compliance, and Coordination of Integrated Healthcare Policies, Recipient Rights Policies)*

Standards. CMHPSM oversees its vulnerable persons served by establishing standards and goals that meet and exceed MDHHS contract requirements relating to health and welfare and addressing the needs of persons receiving long term supports and services and/or persons with special or complex health needs. Additionally, each CMHSP and provider has processes in place to address and monitor the health, welfare, and safety of all individuals served.

Compliance. CMHPSM monitors providers for appropriate credentialing and health and welfare standards. When it identifies areas of non-compliance, CMHPSM will review and monitor a provider's corrective action plans.

Person Centered Planning. CMHPSM is committed to person centered planning that respects individual voice, choice, choice and identifies opportunities to improve quality and oversight of care. Clinicians perform regular biopsychosocial assessments using an integrated health approach in collaboration with persons served and identify needs for additional assessments. Clinicians and persons served then develop or update an Individual Plan of Service (IPOS) following person centered planning standards.

H. Cultural Competence (*Culturally and Linguistically Relevant Services Policy*)

Cultural Competence involves the ability to provide services tailored to the unique needs of a particular population. This can include language competence or knowledge of and sensitivity to specific issues related to cultural or group values and norms.

Achieving Cultural Competence. CMHPSM and its providers participate in efforts to achieve cultural competence that include but are not limited to the following:

- Providing assistance for persons served in need of Limited English Proficiency (LEP) or other language assistance supports to access and participate in services.
- Ensuring that cultural and language needs are discussed with persons served initially and as needed but at least annually.
- Authorize or make recommendations for specialty services for speech, language, hearing, and cultural service needs.
- Evaluate effectiveness of a referral and person's satisfaction with the services.
- Requiring the CMHPSM, CMHSPs and contract service providers to have practices and procedures in place for persons served s to identify and request the need for interpretive services, and services that meet cultural and linguistic needs as outlined in the person's plan of service.

I. External Reviews

Subject to Review. CMHPSM is subject to review by MDHHS and external auditors to ensure compliance with federal and state laws and the MDHHS contract. When external reviews identify deficiencies, CMHPSM implements a corrective action plan to improve processes and meet required standards.

VI. Systematic Analysis and Systemic Action

A. Choosing Performance Measures:

CMHPSM uses the QAPIP to achieve minimum performance levels on performance indicators and analyzes the causes of any statistical outliers. The QAPIP endeavors to use objective and systematic methods of measurement in the areas of access, efficiency, and outcome. If

regulations or the MDHHS contract does not already require a specific performance measure, then CMHPSM chooses them according to the following guidelines.

First, priorities for improvements are determined based on our performance during the previous year regarding existing standards, audits, and a community assessment (e.g. prevalence of conditions, demographic characteristics, health risks etc.). CMHPSM considers, among other things, the needs of the community, stakeholder feedback, efficient use of resources, and providing patient-centered and effective services.

Second, CMHPSM selects specific clinical and non-clinical performance measures, or indicators. Indicators are indirect measures used to assess and improve quality and can indicate certain areas that require more attention. These are based on compliance with regulations, contract requirements, chosen projects, and external audits. CMHPSM also chooses indicators based on:

- Relevance to the outcome or process that we want to assess and improve.
- Measurability, given finite resources.
- Accuracy: whether the performance measure is based on accepted guidelines.
- Feasibility: Can the performance rate for an indicator realistically be improved?

Additionally, various types of indicators may be used to assess performance. Indicator types include:

- Process measures: What a provider does to maintain or improve health. Assesses steps/activities in carrying out a service. For example,
    - The percentage of consumers with diabetes who received one blood test in the past year.
- Outcome measures: reflect the impact of health care services or intervention on the consumers health status. For example,
    - The rate of Hospital Acquired Conditions.
- Balancing measures: Making sure problems do not result from improvement steps implemented in another part of the system. For example,
    - As systems are modified to increase access to care and reduce disparities with access, does satisfaction also increase? stay the same? or decrease? are other service inadvertently created?
- Structural measures: Fixed characteristics of an organization. For example,
    - Whether an organization uses electronic health records; or
    - an organization's calculation of co-pays.

Clinical indicators derive from evidence-based clinical guidelines for measuring an outcome of care. Examples of sources for clinical measures are the Healthcare Effectiveness Data and Information Set (HEDIS), and MDHHS's CC360 data derived from Medicaid claims/encounters data in the state CHAMPS system. Clinical areas include high volume services, high-risk services, disparities, and coordination of care. Non-clinical indicators are used to assess operational aspects of an organization. Non-clinical areas include appeals, grievances, trends of Recipient Rights complaints, satisfaction surveys, National Core Indicators, and access to services. Indicators can be used to identify steps in a process that CMHPSM should adopt, adapt, or abandon.

B. Data Collection and Analysis

If CMHPSM uses samples, then it will use appropriate sampling techniques to achieve a statistically reliable confidence level. The default confidence level for CMHPSM performance measures is a 95% confidence level with a 5% margin of error.

Data is collected, aggregated, analyzed, and evaluated at regular intervals depending on the performance measure and the goal/standard. The aggregated data and relevant statistical analyses and interpretations are presented to CPT. Analysis and interpretation of performance data are used to assess whether it meets the set quality level, or whether there is a deficiency that needs to be remediated.

C. Framework for Performance Improvement Projects

MDHHS requires CMHPSM to implement at least two PIPs each year. MDHHS chooses one based on Michigan's Quality Improvement Council recommendations. MDHHS contracts with an external quality review (EQR) organization to monitor and review this PIP. CMHPSM chooses the second PIP based on population needs and analyses of the previous year's performance indicators, and by state-defined parameters where applicable.

The CMHPSM uses Plan-Do-Study-Act (PDSA) cycles to guide its performance improvement projects. This involves the following:

1. Develop a plan to test the change (*Plan*),
2. Carry out the test (*Do*),
3. Observe, analyze, interpret, and learn from the test (*Study*), and
4. Determine what modifications, if any, to make for the next cycle (*Act*).

** Italics signify examples of a diagram/tool that may be used to guide and document work.*
Systematic steps for performance improvement projects and CAPs are implemented according to the following framework/guide (also available as a process flowchart in Attachment B):

1. Deficiencies identified (i.e., through audits, grievances, appeals, complaints, over- or under-utilization, clinical quality, administrative quality)

- If CMHPSM's choice: Select issue for PI project based on population needs, impact, cost of care etc.
- If a performance measure fell below a certain standard required by regulation or contract—then must implement a CAP for that standard.

2. Select a new or pre-existing quality indicator to measure performance of identified deficiency. (**Plan**)

- Conduct root cause analyses
  - *Fishbone Diagram, 5 Whys, Key Driver Diagram*
- Narrow down Causes:
  - *Pareto chart and table*
- Define Indicator & data Collection Plan

- *Define Indicator*:
  - Includes numerator and denominator, exclusion criteria, standard and goal (if pre-existing standard, otherwise add standard in step 4).
- *Indicator collection & monitoring Plan*:
  - Data source, sample size, frequency of measurement, duration, display, person responsible

3. Collect data on quality indicator to establish Baseline. (**Plan**)

- Baseline is a snapshot of performance that is typical over a period of time.
- Use a historical baseline (preexisting indicator); or
- a new baseline averaged over one year.

4. Set targets for improvement (Aim/goal/standard) (**Plan**)

- Use the Pre-existing targets set by regulation or contract.
- SMART: **S**pecific, **M**easurable, **A**cceptable, **R**ealistic to Achieve, **T**ime-bound with a deadline

5. Develop a specific Work plan/intervention that will lead to improved performance/outcomes (**Plan**)

- *Project Planning Form*
  - Detail tasks to be performed, Persons responsible for tasks, timeline

6. Implement change; gather new data at regular intervals to assess the success of intervention (**Do**)

- Carry out the test
- Collect data and monitor performance periodically (*Monitoring Intervention*)

7. Analyze results and compare to baseline. (**Study**)

- Analyze results and compare to baseline
  - Appropriate statistical analyses
  - *Run chart*
- Interpret results and lessons learned

8. Based on analyses—decide next steps (**Act**)

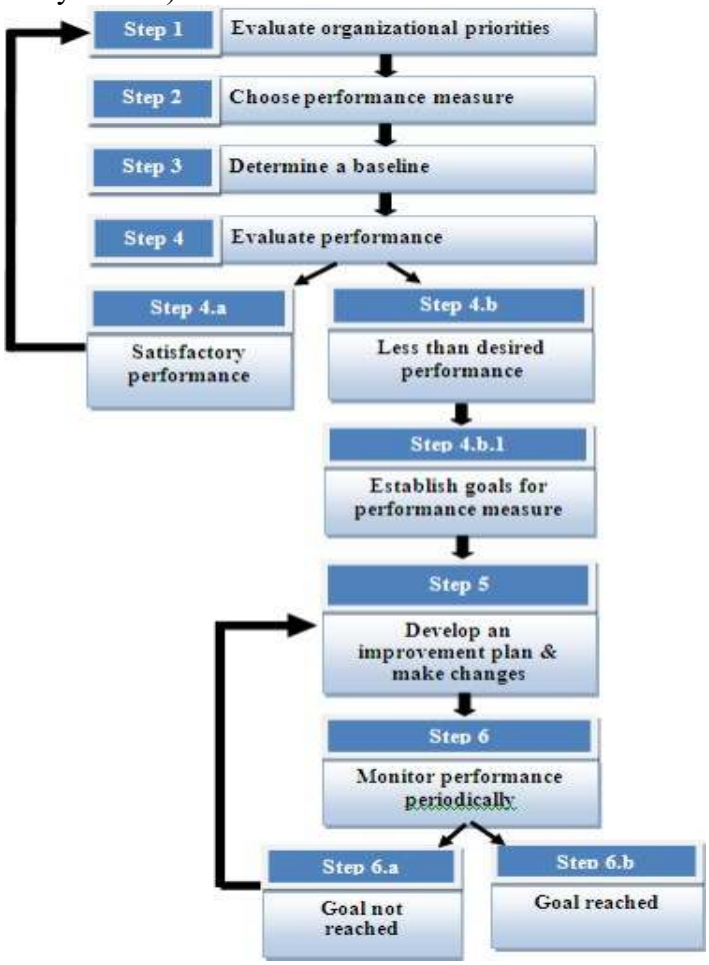
- A) Adopt: continue process as is with same indicators/data monitoring OR test on larger scale
- B) Adapt/ Modify Process (i.e. implement additional interventions to remove barriers and run another test)
  - Possibly add new monitors/quality indicators
  - Identified Barriers?
    - Complete *Root cause analyses diagram* (e.g. fishbone, 5whys, key driver)
    - Complete *Barrier ranking* (quantitative/qualitative)
    - Define new indicator for sub-intervention and *data collection plan*

- Complete *Project planning form*
- Implement change
- Analyze results to see if barrier is eliminated, compare against baseline (results with the barrier in place)

- C) Abandon: don't do another test on the change idea.

9. Work plan for sustainability of solution (*Sustaining Change*).

The above framework fits into the steps in the following overview Process Map for Performance Management (created by HRSA).



D. Oversight of PIPs

The Clinical Performance Team (CPT) Committee and PIHP staff are responsible for monitoring the implementation and effectiveness of performance improvement projects. As previously mentioned, for the FY18-21 PIP cycle CPT works with the Integrated Health Care Workgroup along with other staff, committees, and providers who implement PIPs.

The PIHP delivers this annual evaluation report on the QAPIP to the Board of Directors. The general public and other stakeholders may access CMHPSM performance reports through its

website or upon request. CMHPSM also reports to MDHHS and the HSAG EQR organization for review of PI projects and Corrective Action Plans.

VII. External Compliance and Quality Reviews

Summary. The Code of Federal Regulations (CFR), 42 CFR §438.358 requires the state conduct an external quality review organization (EQR) by a third party to determine PIHPs' compliance with Medicaid Managed Care Rules (42 CFR §438—Managed Care Subpart D and 42 CFR §438.330). To comply with the federal requirements, the Michigan Department of Health and Human Services (MDHHS), Behavioral Health and Developmental Disabilities Administration (BHDDA) contracted with Health Services Advisory Group, Inc. (HSAG), as its EQR organization to conduct compliance monitoring reviews of the PIHPs. HSAG completes an annual compliance review of the region, which includes three components: 1) Compliance Monitoring of Standards, 2) Validation of Performance Measures and 3) Validation of Performance Improvement Projects.

A. EQR Compliance Monitoring Review of Standards

The EQR Compliance review is a three-year cycle in which half the Medicaid Managed Care standards are reviewed year one, the second half of standards reviewed year two, and a corrective action plan review for all standards is conducted in year three. The FY21 review of CMHPSM was the start of a new cycle and completed remotely by Health Services Advisory Group (HSAG) mid-July of 2021. HSAG had positive feedback on the level of documentation our region provided for the review and thoroughness of responses. The summary of standards reviewed, and resultant scores is outlined below:

Summary of Standard Compliance Scores

Compliance Review Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Member Rights and Member Information	19	19	16	3	0	**84%**
II	Emergency and Poststabilization Services*	10	10	10	0	0	**100%**
III	Availability of Services	7	7	5	2	0	**71%**
IV	Assurances of Adequate Capacity and Services	4	4	1	3	0	**25%**
V	Coordination and Continuity of Care	14	14	11	3	0	**79%**
VI	Coverage and Authorization of Services	11	11	9	2	0	**82%**
Total		**65**	**65**	**52**	**13**	**0**	**80%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. (Denominator)

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Community Mental Health Partnership of Southeast Michigan demonstrated compliance in 52 of 65 elements, with an overall compliance score of 80 percent, indicating that some program areas had the necessary policies, procedures, and initiatives in place to carry out many required functions of the contract. Areas of correction included conducting and submitting a network adequacy plan annually, ensuring compliance with access for SUD priority populations is monitored consistently throughout the year, enhancing customer service information and available information in the provider directory, and ensuring compliance with adverse benefit determination notices.

B. EQR Validation of Performance Measures (Information Systems Capabilities Assessment Tool)

HSAG conducted the performance measure validation remotely for FY21, validating data collection and reporting processes used to calculate performance indicator rates. The review was completed June 2021. The final report September 2021 showed overall compliance. Strengths included partnerships that promote compliance, consistent processes used across all CMHSPs related to data collection and analysis, a robust repository of system-based reports to monitor performance indicator data quality and completeness, and estimated performance indicator results throughout each reporting period. The formalized committee structure was found to ensure data anomalies are readily identified and addressed and ensure the PIHP can monitor access and timeliness of care for its members and can take prompt action if necessary.
Areas of improvement were minimal discrepancies in BH-TEDS data and minimal data entry that was case specific for MMBPIS Indicator #1 Pre-Admission Screening within 3 hours, that had zero timeframes due to staff entry errors but still met the standard.

C. EQR Validation of Performance Improvement Projects (PIPs)

HSAG conducted a remote review of the CMHPSM's compliance and performance with the PIP project: Patient(s) with Schizophrenia and Diabetes who had an HbA1c and LDL-C Test in June 2021.While most standards were met, CMHPSM did meet statistically significant improvement over the baseline due to COVID-19 related barriers.

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Patient With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test	Resubmission	90%	90%	Not Met

D. State Review of 1915(c) Home and Community Based Services Waiver; HSW, CWP, SEDW, SUD

The Michigan Department of Health and Human Services (MDDHS) PIHP contract also requires state reviews of the PIHPs' compliance with 1915(c) Home and Community Based Services Waiver Rules, the Habilitation Supports Waiver (HSW), Children's Waiver (CWP), and Children's SED Waiver (SEDWP) programs.
In FY21 MDHHS discontinued the reviews of Autism/ABA services as this service array was transitioned from a waiver service to a state plan service, and cases where ABA services are being

provided often appear in enrollment waiver reviews therefore assurance of compliance with this service array would continue in waiver reviews.
Due to the COVID-19 pandemic state reviews were delayed to occur in October-November of FY22. As part of the last site review, the region was instructed is to complete quarterly credentialing audits which were completed.

VIII. Enhanced Compliance Monitoring

A strong compliance and program integrity system is a critical component of managed care systems. All PIHPs are required to comply with 42 CFR 438.608 Program Integrity Requirements. Designation of a PIHP Compliance Officer, development and implementation of region wide policies and procedures which comply with federal and state laws, training, clear lines of communication with the Compliance Officer, discipline and enforcement, internal monitoring and auditing and prompt responses to detected offenses are key elements of compliance and program integrity.

A. PIHP Compliance Review of the CMHSPs

The clinical case compliance review will incorporate a total of 33 cases per CMHSP, with a random sample of 28-30 active cases and 3-5 discharged cases from each population served. These populations were Adults with MI, Adults with CI/IDD, HSW, Children with CI/IDD (including autism and CWP), and Children with SED (including SEDW), and (within existing populations) individuals receiving behavior treatment through review of the local Behavior Treatment Committee.
Based on 100% performance of staff credentialing standards for all four CMHSPs in FY20, staff credentialing was be waived for this FY21 review.

Areas of focus incorporated trends and findings from state and federal EQR reviews and included:

- Access Standards
- Service Decisions
- Assessment of Need
- IPOS/Person Centered Planning Process
- Service Provision
- Coordination of Integrated Healthcare
- Information Provided to Consumers on Providers, Staff Contacts, and Customer Services
- Discharge Planning
- Performance Improvement (focus on accurate data with BHTEDS, critical events, FUH, and timeframes of prescreens/crisis contacts)

Results of CMHSPs reviews and corrective action plans are pending and will continue as part of FY22 monitoring.

B. PIHP Compliance Review of SUD Providers

CMHPSM resumed reviewing the implementation of compliance and contractual standards in practice for FY21. Due to the ongoing COVID-19 pandemic and increase in limited provider resources in the past year, a full administrative and policy review was waived to reduce undue resource/ administrative burden on SUD providers. Only specific areas of policy that were revised in FY21, such as service denial, appeals, and use of the state consent form, were incorporated in the review. Areas of focus included:

- Admission and Assessment Standards
- Treatment Standards
- Discharge Standards
- Provider Compliance with Performance Indicators
- Administrative Standards of SUD Rights, use of MDHHS 5515 Consent Form, and compliance with Due Process/Appeals processes
- Staff Training Standards – In FY 20, providers had evidence of staff credentials but not evidence of staff training. However, since FY21was also a re-credentialing year for SUD providers, outcomes of the SUD provider recredentialing process were incorporated into FY21 review findings to prevent duplication.

Results: Seventeen (17) SUD FFS providers were reviewed by PIHP staff. For providers based in other regions, CMHPSM requested the monitoring reports conducted by the PIHP of that region.

Findings needing corrective action were related to full evidence of staff trainings, performance with SUD access PI data, individualized treatment plans, updates to treatment plans when there was a change in service, and coordination of care.
SUD providers showed overall compliance with accurately documenting and billing for services, use of ASAM criteria, and an increased awareness of their role in the due process/appeals system. Provider support and education on when and how to complete ABD notices and the local appeals process will continue for FY22.

C. FY21 Substance Use Disorder (SUD) Prevention and Grant Funded Provider Monitoring

Monitoring was conducted remotely as a full compliance review of contractual requirements. For those areas that did not produce the results anticipated, a 'course correction' was required. The CMHPSM considers the ramifications of the pandemic and promotes the rectification of program implementation to enhance the opportunity for successful efforts within the respective targeted community. Thus, feedback and consultation were provided where necessary.
Trends included providers needing more support/improvement in contractual requirements and policies, and strengths in programming compliance and staff training.

IX. Modernization of the Regional Electronic Health Record

For over a decade, the region has been in a contractual relationship with Peter Chang Enterprises (PCE) as vendor for the electronic health record (EHR). The CMHPSM Chief Information Officer (CIO) and the Electronic Health Record Operations Committee (EOC) are the primary parties responsible for managing the electronic health record in conjunction with PCE. These groups

identify regional needs, prioritize those needs, and identifies system problems, with local solutions developed the EHR vendor.. Since the last significant modernization of the regional electronic record in FY18/19, goals have centered around system enhancements and optimization. For FY 21 the following system enhancements and optimizations have been identified:

- Regional sub-committees modified forms with review and approval by the Regional Implementation Team.
- During FY21 EOC was able to implement approximately 38 system enhancements into our regional EHR. System enhancements included updating clinical forms and documentation to align with clinical workflow and regulatory needs.
- Upgraded substantial system modules such as the Community Living Supports Module, Grievance and Appeals Module, Letters Module, and Performance Indicators Module.
- Substantial system upgrades for state required changes to CPT codes and modifiers for both MH and SUD services, including code and modifier replacements, new modifiers for staff credentials and for number served related to certain group-type service codes.
- Increased operational supports within the EHR through the addition of a supervisor dashboard.
- Reviewed all user role security and privacy groups with modifications as indicated.
- Implemented increased system validations to increase user documentation of required fields.
- Upgrades to BHTEDS reporting and compliance with state requirements in the system updates for reporting of behavioral health related data (similar to ADT data) in the health information exchange system.
- Implementation of system bi-directional interface and training for use of an Inner Rater Reliability (IRR) system for the state required Milliman Care Guidelines (MCG) and Indicia level of care documentation. The Milliman Care Guidelines (MCG) and Indicia level of care system was implemented in FY20 for authorization of urgent/emergent services such as psychiatric inpatient, partial hospitalization.
- Continued review and implementation of clinical, revenue, and operations local custom reports using clinical and revenue EHR data.

X. QAPIP Evaluation Performance Improvement Projects

A. Performance Improvement Projects

For these projects, unless otherwise specified, "quarterly" updates show a percentage that represents one year of data.

1. Admission Discharge, Transfer

Project Description: This project aims to help consumers transition in and out of inpatient settings, reduce avoidable re-admissions and improve overall consumer outcomes. To do this, CMHPSM will implement admission, discharge, and transfer (ADT) alerts and develop clinical protocols for staff to manage these alerts. This project was developed as part of a state requirement for a PI project. **The state began a new cycle of PIP projects for FY22 therefore this project sunset on 9/30/21.** FY21 aims were:

1. Increase alerts per consumer compared to prior quarters

2. Continue to develop and refine a formal protocol regarding how to respond to alerts that results in effective and efficient outcomes.
3. Continue to develop an indicator that measures the extent to which the protocol is followed.
4. A goal (threshold or significant improvement from baseline) and timeline will be developed for the new indicator.
5. Work through Health Information Exchange errors.
6. Work with the Health Information Exchange (Michigan Health Information Network) to address technology barriers.

Indicator/Performance Measure	Source	Goal/ Benchmark	Documentation/ Deliverable	Reporting
1. Percentage of ADT alerts the CMH responds to w/in 3 days (does not have to be face-to-face response) 2. Alerts per consumer= (Number of consumers for whom one or more ADT alerts were received during the data period) / (Number of consumers open to a CMH team during the data period)	CRCT Reporting Services	Improve over time. Work through technology barriers to obtain reliable data.	Meeting Minutes;	Monthly reports to CPT Report to State/HSAG

Status Update: Overall regional performance declined in the first two quarters of FY21 and began some improvements in the last two quarters.

ADT Project	QI	QII	QIII	QIV
Lenawee	100%	100%	93%	74%
Livingston	87%	44%	57%	47%
Monroe	43%	80%	75%	85%
Washtenaw	84%	66%	82%	85%
PIHP	**83%**	**69%**	**77%**	**73%**

Performance depended on hospitals' participation in the MI health information exchange as hospitals based in other states (with locations in Michigan) cannot provide ADT data for Michigan. Fluctuations in performance were also affected by service issues relates to the COVID19 pandemic. Ways to improve the number of ADT alerts to which CMH staff can respond was analyzed to include visit types less clearly identified instead of filtering them out of the data set. It was determined the number of discharges affected would not substantially impact outcome data. **The state began a new cycle of PIP projects for FY22 therefore this project sunset on 9/30/21.** ADT data will continue to be available as an option for local clinical practice.

2. Consumers with Schizophrenia and Diabetes who had an HbA1c and LDL-C test

Project Description: This project aimed to improve the health and quality of life for consumers 18-64 years old with Schizophrenia and Bipolar Disorder who are using antipsychotic medications (SSD). CMHPSM implemented interventions for consumers with schizophrenia and diabetes to increase the proportion of those patients receiving a HbA1c and LDL-C test (diabetes screening).

This project was developed as part of a state requirement for the PIP project overseen in federal reviews by HSAG.

Indicator/Performance Measure	Source	Goal/ Benchmark	Documentation/ Deliverable	Reporting
Consumers with a diagnosis of schizophrenia who had an HbA1c and LDL-C test during the reporting period (i.e. the previous 4 quarters).	CRCT Reporting Services	72.16%	Meeting Minutes; CMHPSM Documentation tool	Monthly Reports to CPT CMHPSM reports to HSAG/State

Status Update: The final PIP submission for remeasurement period 2 ended on 4/30/21 and was based on a comparison of the baseline measurement from 8/1/2017- 7/31/2018 and remeasurement period 2 (5/1/19– 4/30/20). During remeasurement period 2, CMHPSM addressed barriers and implemented new interventions developed by the Integrated Health Workgroup. While performance increased during the last remeasurement period, the COVID19 pandemic continued to be a significant barrier in returning to the 72.16% benchmark. As the last remeasurement period for this project ended 4/30/21 yet there is a lag in the data, the results up to QIII of FY21 (ending 6/30/21) are reported below.

The rate reached an overall high in March 2020 of almost 70%. From April 2020 into FY21 the number dropped due to the COVID-19 pandemic bringing multiple barriers to consumers' ability to get labs completed. While new interventions were implemented to address these barriers, and some CMHSPs met the goal, the overall regional rate declined, and the threshold was not met. The project ended in QII of this year at a 47% regional completion rate.

FY21 Results*

Lenawee CMHSP rates by quarter:	87% (QI), 75% (QII) 83% (QIII)
Livingston CMHSP rates by quarter:	63% (QI), 50% (QII) 57% (QIII)
Monroe CMHSP rates by quarter:	57% (QI), 46% (QII) 50% (QIII)
Washtenaw CMHSP rates by quarter:	49% (QI), 37% (QII) 45% (QIII)
Total PIHP performance:	**59% (QI),47% (QII) 54% (QIII)**

**Measurement ended on 6/30/21*

The state will begin a new cycle of PIP projects for FY22 therefore this project sunset on 9/30/21. The state plan for the FY22 PIP is to reduce racial and ethnic disparities in a state specified area of care.

B. Recent Additions to Performance Improvement Data Reported to MDHHS

1. Michigan Mission Based Performance Indicators

Project Description: MDHHS indicators are established in the MDHHS PIHP contract and reported by the CMHPSM, with the values of improving access to services and reducing inpatient recidivism. Data is cleaned monthly, aggregated, and reported quarterly to MDHHS.

Project Description	Indicator/Performance Measure	Source	Goal/ Bench mark	Documentation/ Deliverable	Reporting
Pre-Admission Screening within 3 hours	**1.** 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	CRCT Reporting	95%	CMHSPs complete a CAP within 30 days if they fall below the standard.	Quarterly reports to MDHHS and CPT
Access/1st Request Timeliness	**2a.** The percentage of new persons during the quarter receiving a completed bio-psycho-social assessment within 14 calendar days of a non-emergency request for service.	CRCT Reporting	Base-line period	CMHSPs complete a CAP within 30 days if they fall below the standard.	Quarterly reports to MDHHS and CPT
Access/1st Request Timeliness	**2b.** The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders.	CRCT Reporting	Base-line Period	CMHSPs complete a CAP within 30 days if they fall below the standard.	Quarterly reports to MDHHS and CPT
Access/1st Service Timelines for all CMH populations and SUD	**3.** Percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment.	CRCT Reporting	Base-line Period	CMHSPs complete a CAP within 30 days if they fall below the standard.	Quarterly reports to MDHHS and CPT
Hospital Discharges Follow-up-Psychiatric Inpatient	**4.a.** The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days (child and adult).	CRCT Reporting	95%	CMHSPs complete a CAP within 30 days if they fall below the standard.	Quarterly reports to MDHHS and CPT
Hospital Discharges Follow-up – SUD Detox	**4b** - The percentage of discharges from an SUD detox unit during the quarter that were seen for follow-up care within 7 days.	CRCT Reporting	95%	CMHSPs complete a CAP within 30 days if they fall below the standard.	Quarterly reports to MDHHS and CPT
Inpatient Recidivism	**10-** The percentage of readmissions of children	CRCT Reporting	15% or less	CMHSPs complete a CAP	Quarterly reports to

	and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.			within 30 days if they fall below the standard.	MDHHS and CPT

Status Update: The chart below specifies the indicators and region and local CMHSP(s) compliance. While indicator 2a, 2b and 3 were baseline data for FY21 and therefore not held to a goal, the region through the CPT Committee reviewed and discussed corrective action plans for these indicators using the usual state standard of 95% to prepare and plan for access needs. Indicators that did not meet required benchmarks required a corrective action plan for the respective indicator in that quarter.

Indicator (num/pop)	**Type**	**2021_Q1**		**2021_Q2**		**2021_Q3**		**2021_Q4**	
1Child	CMHSP	(143/145)	98.62%	(159/160)	99.38%	(138/138)	100.00%	(113/115)	98.26%
	PIHP	(139/141)	98.58%	(157/158)	99.37%	(137/137)	100.00%	(110/112)	98.21%
1Adult	CMHSP	(582/594)	97.98%	(652/661)	98.64%	(670/680)	98.53%	(598/603)	99.17%
	PIHP	(554/565)	98.05%	(623/631)	98.73%	(647/655)	98.78%	(571/576)	99.13%
2MIC	CMHSP	(143/225)	63.56%	(201/277)	72.56%	(159/246)	64.63%	(144/222)	64.86%
	PIHP	(142/208)	68.27%	(194/268)	72.39%	(153/231)	66.23%	(140/212)	66.04%
2MIA	CMHSP	(271/418)	64.83%	(264/403)	65.51%	(283/386)	73.32%	(291/424)	68.63%
	PIHP	(246/380)	64.74%	(251/378)	66.40%	(265/356)	74.44%	(275/395)	69.62%
2DDC	CMHSP	(52/64)	81.25%	(73/89)	82.02%	(52/72)	72.22%	(64/87)	73.56%
	PIHP	(50/62)	80.65%	(71/84)	84.52%	(51/69)	73.91%	(62/84)	73.81%
2DDA	CMHSP	(21/32)	65.63%	(30/36)	83.33%	(20/28)	71.43%	(32/48)	66.67%
	PIHP	(20/30)	66.67%	(30/35)	85.71%	(20/28)	71.43%	(28/43)	65.12%
2SUD	PIHP	(638/984)	64.84%	(644/952)	67.65%	(645/1029)	62.68%	(587/946)	62.05%
3MIC	CMHSP	(125/149)	83.89%	(150/191)	78.53%	(135/166)	81.33%	(127/164)	77.44%
	PIHP	(125/149)	83.89%	(145/186)	77.96%	(132/163)	80.98%	(123/160)	76.88%
3MIA	CMHSP	(203/257)	78.99%	(183/219)	83.56%	(227/257)	88.33%	(218/267)	81.65%
	PIHP	(185/238)	77.73%	(177/212)	83.49%	(216/246)	87.80%	(208/255)	81.57%
3DDC	CMHSP	(62/70)	88.57%	(61/71)	85.92%	(54/66)	81.82%	(58/71)	81.69%
	PIHP	(60/68)	88.24%	(60/69)	86.96%	(53/64)	82.81%	(57/69)	82.61%
3DDA	CMHSP	(21/26)	80.77%	(20/28)	71.43%	(20/27)	74.07%	(17/30)	56.67%
	PIHP	(20/25)	80.00%	(19/27)	70.37%	(20/27)	74.07%	(17/30)	56.67%
4Child	CMHSP	(36/37)	97.30%	(39/39)	100.00%	(39/39)	100.00%	(43/44)	97.73%
	PIHP	(36/36)	100.00%	(39/39)	100.00%	(39/39)	100.00%	(43/44)	97.73%
4Adult	CMHSP	(130/136)	95.59%	(162/174)	93.10%	(167/170)	98.24%	(139/144)	96.53%
	PIHP	(128/134)	95.52%	(160/172)	93.02%	(165/168)	98.21%	(137/142)	96.48%
4SUD	PIHP	(86/87)	98.85%	(86/88)	97.73%	(78/82)	95.12%	(84/86)	97.67%
10Child	CMHSP	(3/43)	6.98%	(4/44)	9.09%	(5/43)	11.63%	(4/51)	7.84%
	PIHP	(3/42)	7.14%	(4/44)	9.09%	(5/43)	11.63%	(4/51)	7.84%
10Adult	CMHSP	(18/177)	10.17%	(28/219)	12.79%	(30/230)	13.04%	(16/206)	7.77%
	PIHP	(18/175)	10.29%	(28/215)	13.02%	(30/226)	13.27%	(16/202)	7.92%
5All	CMHSP	(128/632)	20.25%	(136/657)	20.70%	(109/624)	17.47%	(100/631)	15.85%

C. Critical and Sentinel Events

Project Description: CPT reviews critical, sentinel, and risk event data to look for trends, appropriate use of root cause analyses, monitor CAPs, determine educational needs, and verify compliance with policy & procedures. Sentinel events and identified trends may require a root cause analysis and a CAP to prevent future occurrences. Critical and sentinel event reporting is an MDHHS contractual requirement. Critical incidents included in the data review include:

Suicide	Hospitalization due to Injury or Medication Error
Non-suicide Death (unexpected)	Hospitalization from a Physical Illness
Accident Requiring an ER Visit or hospitalization	Arrest of Consumer
Injury resulting from physical management	Serious Challenging Behaviors
Emergency Medical Treatment due to Injury or Medication Error	

Indicator/Performance Measure	Source	Goal/Benchmark	Documentation/ Deliverable	Reporting
Number, type, of critical and sentinel events Causal Factors Provider Trends Member Trends	CRCT Report	CMHSPs determine whether a critical incident was a Sentinel Event within 3 business days after it occurred. If the critical incident is classified as a Sentinel Event, staff with appropriate credentials commence a root cause analysis in two subsequent days. CAPs to prevent future occurrences.	Meeting Minutes; CAPs if Trends are Identified	CMHSPs: Quarterly report to CPT SUD Providers: Bi-annual report to CPT

Status Report: During FY21, it was discovered that some critical incidents were reported outside the required timeframe in FY20. As a result, CMHPSM implemented a CAP and revised its analysis of critical incidents to ensure compliance with reporting timeframes. Monitoring and revision of CAPs will continue as needed to ensure compliance. CMHPSM also revised its oversight of sentinel events to review compliance with timing and event review requirements.

D. Behavior Treatment Committee Data

Project Description: Each local CMHSP conducts quarterly reviews of data on behavior treatment where intrusive or restrictive techniques have been used and when physical management or 911 calls were used in a behavioral emergency. Data includes numbers of interventions, length of time the intervention was used per person, and whether emergency interventions were used three or more times in a 30-day period. The CMHSP's monitor whether the intrusive or restrictive techniques were approved by the beneficiary or guardian in the Person-Centered Plan and permitted by the Technical Requirement for Behavior Treatment Plans.

Status Report: CMHPSM revised its oversight of Behavior Treatment Committee data to enhance compliance with contract and regulatory requirements. Use of physical management or

involvement of law enforcement is also considered a critical incident, therefore this review also serves as an additional avenue to review those critical incidents. The revised oversight includes quarterly reports that examine the following:

1. If emergency interventions were used three or more times in a 30-day period, BTC has reviewed the IPOS for potential modifications to reduce recurrence.
2. Intrusive or restrictive techniques were approved by the beneficiary
3. Behavior treatment Plan is reviewed at least quarterly
4. Positive behavioral supports pursued prior to restrictive techniques
5. BTC has consent for restrictive/intrusive techniques in the behavior treatment plan

E. Special Quality Improvement Projects Chosen by the CMHPSM

1. Medication Labs Project

Project Description: CMPSM will implement interventions to increase the percent of Medicaid consumers prescribed antipsychotics who have all required labs entered as discreet values in our electronic health record. This project was intended to support the PIP.

Indicator/Performance Measure	Source	Goal/Benchmark	Documentation/ Deliverable	Reporting
Percent of Medicaid consumers prescribed antipsychotics who have all required labs entered as discreet values in our electronic health record during the data period.	CRCT Report	To increase medication labs entered into the Electronic Health Record for Medicaid and Non-Medicaid consumers prescribed psychotropic medications. Target= 44.8%	Meeting Minutes (CPT, IHC) CMHPSM Documentation tool	Monthly Report to CPT

FY21 QI and QII Results:

The target percentage to meet was 44.8%, which was achieved in FY20. Like the PIP Project, the rate continued to drop in Quarters I and II of FY21, with a rate of 33% and 32% respectively. Quarter III had a slight increase of 37% with Quarter IV ending at 36%. This project was created to support the PIP project and data monitoring continued through the end of the PIP's remeasurement 2 period. **As the state will begin a new cycle of PIP projects for FY22, this project will sunset on 9/30/21**. Med labs data will continue to be available for local use in standard clinical practice.

2. Regional Customer Services: Consumer Satisfaction Survey

Project Description: CMHPSM conducts periodic quantitative (surveys) and qualitative (focus groups) assessments of consumer experiences (including those receiving long-term supports). These assessments are representative of the consumers, and services offered. A random sample of consumers, families and/or guardians from all populations served will be asked to participate in customer satisfaction surveys. The committee collects and analyzes the data to address issues of

quality, availability, and accessibility of care. As a result of the analyses, PIPs and CAPs are implemented, and providers and consumers are notified of assessment results. The MDHHS-CMHPSM contract requires reporting of survey data.

Indicator/Performance Measure	Source	Goal/Benchmark	Documentation/ Deliverable	Reporting
Satisfaction data incorporates grievance data and appeals data, and the trends from the Adult In-Person Survey from the National Core Indicators (NCI). Satisfaction survey (phone; in-person)	Customer service Committee CRCT Assessments of survey results address issues of quality, availability, and accessibility of care.	Grievance, appeals, and NCI: informational only Identify Areas for improvement. The committee's goal is to set up a benchmark (for appeal/grievance/NCI) by the end of the year.	Meeting Minutes; CAPs/interventions goal to set up benchmark (appeal/grievance /NCI) by end of the year.	Customer Services Committee Reports to CPT Annually (February)

FY21 Results:

A. Satisfaction Survey

From FY20 into FY21, the COVID-19 pandemic created a shift in the provision of services, with the state allowing the expansion of telehealth services. There were also COVID-19 related limitations to conducting satisfaction surveys resulting in more remote survey practices. CMHPSM therefore decided to survey consumer experiences with telehealth services to better understand how consumers were adjusting to these service delivery changes, and plan for any limitations with telehealth expansion options.

FY21 results were similar to FY20 with a slight increase in positive feedback. Most responses preferred the option of both telehealth and face-to-face services. Feedback became more positive over time as the system worked out barriers and acclimated to technology needs, including it being easier to make appointments without transportation issues, convenience and flexibility of telehealth, and safety from potential COVID-19 exposure.

Negative feedback included preferring face-to-face, not having technology (Wi-Fi, cell phones, computers), or quality of care.

B. CMHPSM Grievance Data

Below analysis of grievances per county with trends reported by Regional Customer Services staff.

Grievances	Lenawee	Livingston	Monroe	Washtenaw	Grand Total
Access and Availability	11	2	21	9	43
Accommodations	1	0	0	1	2
Financial or Billing Matters	1	0	0	1	2
Provider Choice	18	13	0	8	39
Quality of Care	3	25	29	13	70
Service Environment	1	1	1	1	4
Other	0	2	1	0	3
Grand Total	**35**	**43**	**52**	**33**	**163**

The pandemic impacted many elements of care and barriers in receiving certain services, with most grievances related to the inability to attend vocational programming, have in-home services such as autism/ABA, and shortage of provider staff. Staff worked to ensure care was provided when it was safe to do so, and transition plans where made where needed. Provider stability is a focus as COVID-19 risks continue and providers experience staffing shortages.

C. CMHPSM Consumer Appeals Data:

Consumer appeals data is maintained and monitored by the Fair Hearings Officers and regional representatives of the CMHPSM Utilization Management/ Review Committee. In FY21 this committee partnered with Regional Customer Services and the Regional Consumer Advisory Committees to review what appeals data is collected quarterly, and what data would be meaningful for their analysis of consumer experiences. Based on that process data sets were identified, and a summary report developed.

County Number of Appeal Requests Number of Expedited Appeals requested Number of Expedited Appeals Denied Number of Cases Where Actions & Date of Notice within correct time frames Number of Notices Out of Compliance with Timeframes Service(s) Involved Number of Appeals Per the Service (Won't match # of appeals as 1 appeal can involve multiple services) Number of Denials	Number of Suspensions or Reductions Number of Terminations Medicaid/Non-Medicaid Specify if HSW, CWP, SEDW or ABA (autism) Number of Local Appeals Number of State Level Hearing/Appeals Number of Internal/Local Appeal Timeframes Met Number Upheld Number Reversed Number Withdrawn/ Dismissed Trends and Provider Specific Performance Issues

Type	Total	Upheld	Reversed	Withdrawn/ Dismissed	SUD Cases (within data)
Local Appeals	40	27	7	6	4
State Level Appeals	11	3	2	6	3

Appeal requests continued to decline as the COVID-19 pandemic continued, some of which was attributed to state directives that the pandemic was not a viable legal reason to change services.

In March 2021 SUD providers received a regional training, including the provision of resources and documents/templates, to ensure appeal requirements are being met in the SUD system of care, included in FY21 SUD provider monitoring, and SUD providers were given access to resources to assist them in complying with service denial and appeal processes. There was an increase in SUD appeal cases, which indicates some success with FY21 steps taken to ensure SUD providers understand their role in the due process system.

Trends included an increased need to delay or suspend services due to the provider staffing crisis that was further exacerbated by the pandemic, and the resultant need to find service/supports alternatives.

Also, for FY21, MDHHS initiated a reporting requirements and template for local appeals and service authorization denials, therefore the internal report developed by the regional UM Committee will sunset, and report reviews will transition to using the MDHHS required report.

The UM Committee and the PIHP will continue to monitor for trends (i.e. provider issues, cases that go to state level hearings), compliance issues, and potential PI projects.

D. National Core Indicators for Michigan:
The National Core Indicators (NCI) program is a voluntary effort by state developmental disability agencies to track their performance using a standardized set of consumer and family/guardian surveys with nationally validated measures. The NCI provides an in-Person Survey to be used with adults with IDD age 18 and older. Areas included in the survey are: Residential Designation, Choice and Decision-Making, Work, Self-Direction, Community Inclusion, Participation and Leisure, Relationships, Satisfaction, Service Coordination, Community Access, Health, Wellness, Safety, Rights and Respect. The data was reviewed for any trends that apply to our region for which recommendations could be made to improve consumer experience in those areas.

FY21 Analysis: As the data does not provide regional/local specifics, the Regional Customer Services Committee has been pursuing the following ways to improve the analysis of this data:

- Input from Consumer Advisory Councils for feedback and potential areas for performance improvement.
- Accessing the new FY21 MDHHS employment database for potential local data on work experiences and potential areas for performance improvement.

For FY22 the MDHHS Quality Improvement Council is incorporating the use of NCI to address potential improvements for PIHPs. CMHPSM was recognized as one of 3 PIHPs in the state that took proactive measures to incorporate this data in PI efforts in FY21.

3. Recovery Self-Assessment (RSA)

Project Description: The Recovery Self-Assessment-Revised survey (RSA-R) (O'Conell, Tondora, Croog, Evans, &Davidson, 2005) is delivered to providers that use the Recovery Oriented System of Care (ROSC) model. Data is collected from individuals who completed the survey online or on paper. During FY 21, the CMHPSM distributed the to the contracted providers in its four-county region that use the Recovery Oriented System of Care (ROSC) model. The counties that the survey was distributed to included: Lenawee, Livingston, Monroe, and Washtenaw. The CMHPSM wanted to accurately assess and measure the effectiveness of substance-use disorder (SUD) and community mental health (CMH) providers in the implementation of recovery focused services from the perspective of consumers, provider staff, and administrative staff.

Indicator/Performance Measure	Source	Goal/Benchmark	Documentation/ Deliverable	Reporting
5-point Likert Scale 3 versions: 1. Consumers, 2. Provider Staff 3. Administrator Each survey has five domains: 1. Life Goals	Survey Monkey Software	Identify areas for improvement in the 5 domains.	Meeting Minutes; CAPs	Annually: SUD Director reports to CPT and ROC

2. Involvement 3. Diversity of Treatment Options 4. Choice 5. Individually Tailored Services				

Status Update: This is the sixth year our region has used this survey. Comparisons were made to measure how effectively substance-use disorder (SUD) and community mental health (CMH) providers implement recovery focused services from the perspective of consumers, providers, and administrative staff. The FY20 survey was updated to better reflect validation to the national survey. The FY21 survey used the FY20 survey results as the baseline period for comparison. The survey was administered in September of FY21.

Results of Survey:

Participants

A total of 650 individuals participated in this analysis. Some individuals skipped answering some questions which accounts for the lower total amounts represented below:

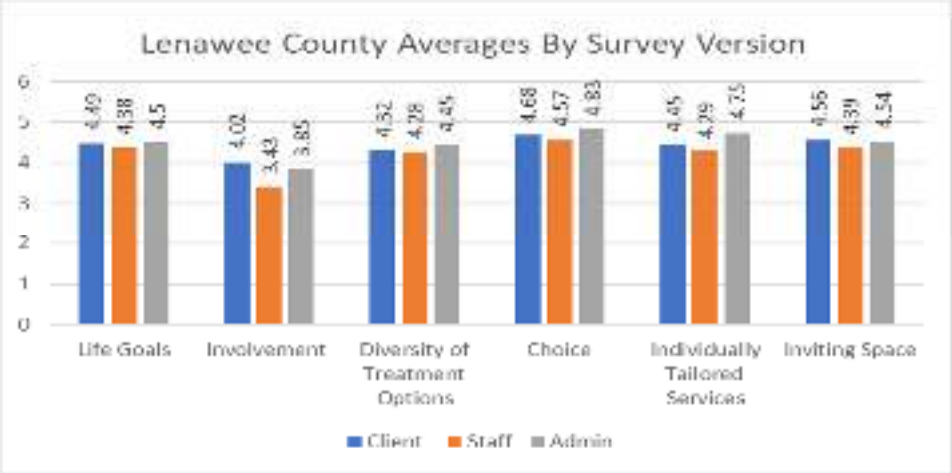
Participant	Total	Lenawee	Livingston	Monroe	Washtenaw
Clients	486	73	26	354	32
Provider Staff	124	14	31	31	28
Administrators	40	10	4	11	5

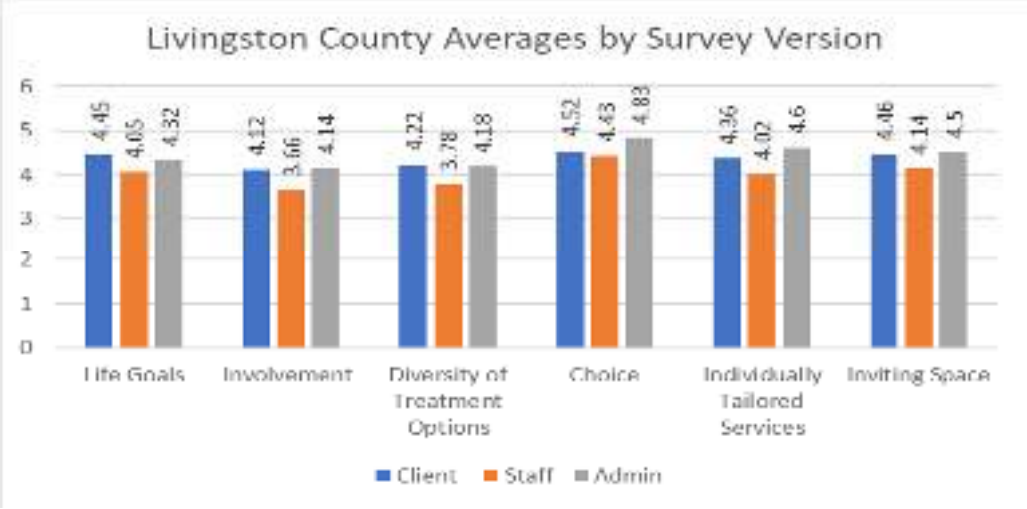
The COVID-19 public health crisis may have impacted the number of respondents and/or perception of services due to providers possibly not seeing as many individuals in person as in past years and a staffing crisis that also related to complications of the pandemic. The numbers of respondents were lower than the previous year.

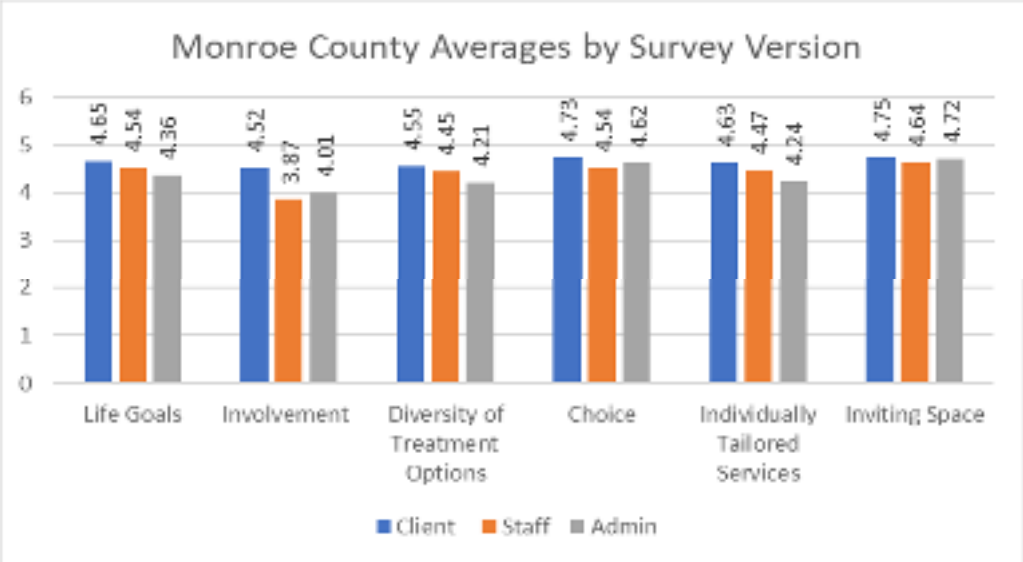
CLIENT COUNT BY AGENCY

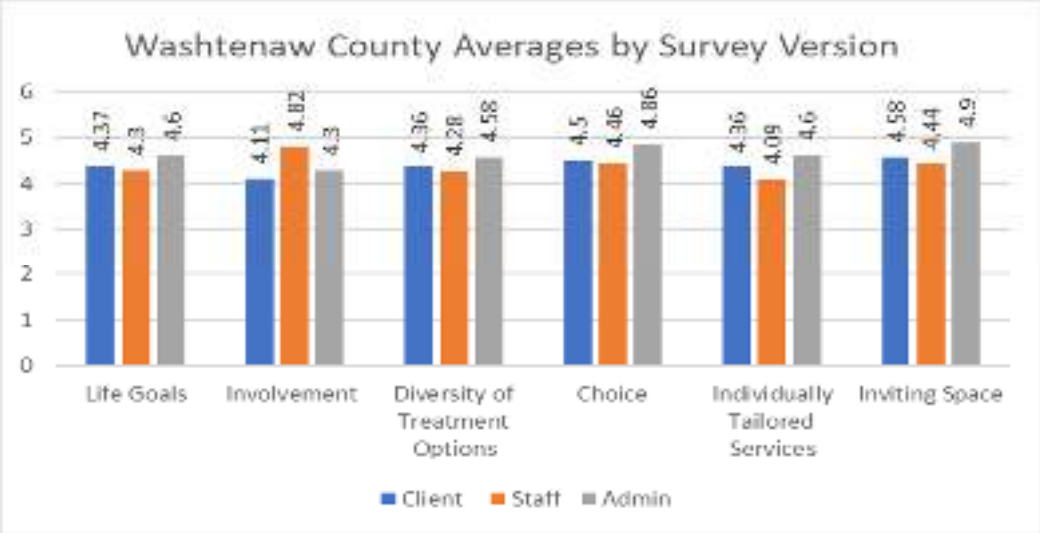
	client count
Ann Arbor Treatment Center (West Ann Arbor)	1
Catholic Charities (Lenawee)	32
Catholic Charities Monroe	4
Catholic Social Services (Washtenaw)	1
Home of New Vision (Washtenaw)	22
Lenawee County Community Mental Health Authority	29
Livingston County Catholic Charities	3
Livingston County Community Mental Health Authority	24
McCullough-Vargas (Lenawee)	5
Monroe County Community Mental Health Authority	24
Other (please specify)	25
Parkside for Families (Lenawee)	9

Passion of Mind (Monroe)	298
Therapeutics (Ann Arbor)	1
Therapeutics (Livingston)	2
Washtenaw County Community Mental Health	5
(blank)	1
Grand Total	**486**









Conclusion:
Across the region, consumer ratings remained comparable to recent years- relatively high, with averages of most questions wavering between agree and strongly agree on the 5-point Likert scale. The Involvement domain scored the lowest in all four counties on all three survey versions. For FY22 the Involvement domain will be further reviewed for potential PI projects or improvements.

F. Shared Metrics Projects Between the CMHPSM, CMHSPs and the Michigan Medicaid Health Plans

1. Care Coordination for High Consumer Utilizers Project

Project Description: CMHPSM, the Mental health Plans (MHP), and the CMHSPs meet monthly to review consumers with high risk or high utilization of services. Meetings discuss who to include in the project and potential interventions to better serve and stabilize them.

Indicator/Performance Measure	Source	Goal/Benchmark	Documentation/ Deliverable	Reporting
High utilization of services = Highest utilizers for each health plan. Based on the top 20 utilizers from on the past 6 months regarding: 1. # of ED visits or admissions; and 2. # of chronic conditions	Care coordination activities are in CRCT and the CC360 file	CMHPSM, the Medicaid Health Plans, and the CMHSPs identify consumers for a potential intervention to better serve and stabilize them.	Meeting Minutes; Data from meetings (used to analyze trends); High level narrative (whether the group met, incentive program)	Semi-annually CEO reports to CPT and/or ROC Data from meetings reported to state.

Status Update: For FY21 CMHPSM, the MHPs, and the CMHSPs continued to meet this indicator by meeting monthly to review consumers with high risk or high utilization of services, who to include in reviews, and potential interventions to better serve and stabilize those consumers. Areas of focus included ways interventions can be created to improve sustained outcomes for consumers and reduce the need for urgent/emergent services.

2. Follow-Up after Hospitalization for Mental Illness (30 days) (FUH)

Project Description: This project monitors follow up after hospitalization for individuals (aged 6 and older) with a mental illness or self-harm diagnosis. CPT and EOC takes the following actions to assess how performance may be improved:

1. Collect, review and evaluate the timeliness of outcome data.
2. Intervene on a local level to address any barriers to timely data.
3. Ensure adherence to project protocols.
4. Consult data exchange vendors such as PCE and/or Great Lakes Health Connect (health highway data exchange vendor) and Medicaid Health Plans

Indicator/Performance Measure	Source	Goal/ Benchmark	Documentation /Deliverable	Reporting
The percentage of discharges for individuals age six and older, who were hospitalized for mental illness or intentional self-harm diagnoses, and who had a follow-up visit with a mental health practitioner within 30 days of discharge.	MDHHS CC360 Medicaid Encounter	ages six (6) to 17= at least 70%. ages 18 and older = at least 58%.	Meeting Minutes (CPT, EOC); PIPs	Quarterly report to CPT

Status Update: While the CMHPSM performed above the benchmark in FY21, this is a joint metric shared with the Medicaid Health Plans (MHPs) and the PIHP only received partial incentive due to a lower percentage performance with one of the MHPs. As a result, the CMHPSM and MHPs started meeting to coordinate and improve the MHPs performance in this metric. The latest state FUH data shows the CMHPSM and MHPs above the benchmark.

Report: 3/31/21 (CY20)

- FUH-children
  - Region is above the 70% benchmark at 91.3 84.9%
  - Compared to 12/30 report: 84.9%
  - All MHPs exceeded the benchmark
- FUH Adults
  - Region is above the 58% benchmark at 66.22%
  - Compare to 12/30 report: 63.37%
  - One MHP was below the threshold 57.47%

3. Follow-Up after Emergency Department (ED) Visit for Alcohol and Other Drug Dependence—(FUA)

Project Description: This project monitors follow up after an emergency department visit for individuals (aged 13 and older) with an alcohol or other drug abuse diagnosis. CPT, EOC, and other Workgroups will Explore how performance may be improved. The age ranges for children will change to 6-17 and 18+ for adults for FY21 (previously adults were 21+).

Indicator/Performance Measure	Source	Goal/Bench mark	Documentation/ Deliverable	Reporting
The percentage of emergency department (ED) visits for individuals age 13 and older with a principle diagnosis of alcohol or other drug (AOD) abuse or dependence, who also had a follow up visit for AOD within 30 days of the ED visit.	MDHHS CC360 Medicaid Encounter	Baseline Data collected 2020 (standard to be determined)	Meeting Minutes (CPT, EOC);	Quarterly report to CPT

Status Report: The indicator measures consumers 13 years and older with an Emergency Department (ED) visit for alcohol/drug dependence that had a follow up visit within 30 days, as a metric the PIHPs share with Medicaid Health Plans (MHPs). FY21 will be the baseline year. For our FY22 QAPIP, the PIHPs and MHPs are held to a state-defined benchmark that includes a minimum overall percentage as well as an incentive to reduce racial/ethnic disparities.

Latest Report: FUA data is maintained by MDHHS and reported to PIHPs, with the last data set provided 3/31/21.

- Region 6 is **above** the *proposed* CY22 benchmark of 27% at **28.27%**

G. PIHP-only Performance Bonus/Pay for Performance Measure

1. Behavioral Health Treatment Episode Data Set (BHTEDS) and Veteran Services Navigator (VSN) Data Collection

Project Description: This project aims to use BHTEDS to:

1. Identify persons eligible for services through the Veterans' Administration by verifying elements required for military/veteran status.

2. Evaluate and review timeliness
3. Interventions on local level to address barriers to timely data
4. Examine data to ensure adherence to project protocols

Indicator/Performance Measure	Source	Goal/Benchmark	Documentation/Deliverable	Reporting
Must be an active BHTEDS associated with an encounter, within 15 months of that encounter. Identify people eligible for Veteran Services Navigator (within BHTEDS data)	CRCT Reporting	Make sure BHTEDS is 100% accurate	CPT Meeting Minutes; CPT and EOC monitor records showing "not collected". They compare the number of veterans reported on BHTEDS and the VSN. CPT and EOC submit a 1–2-page narrative report on regional findings and any actions taken to improve data quality on BH-TEDS military and veteran fields (July 1st).; Errors are discussed and addressed in the Regional Encounter Data Information (REDI) Workgroup	Quarterly Report to CPT

Status Report: The FY21 state report was submitted on time. Project analysis includes cross comparisons of veteran-related data to veteran navigator (VN) referrals. To improve performance, the IM/CRCT operations teams and veteran navigator program are working on identifiers in the CRCT record that support CMH's increasing referrals to the VN project, and for the VN project to provide education and outreach to CMH Access departments on making VN referrals.

For FY21 the VN had ongoing contact with 145 individuals (not unduplicated), including 80 new contacts, an increase from 69 last year. The VN provided care coordination services directly with the Veteran's Administration (14), with their Veterans Service Officer (41), as well as 12 referrals for legal services. Of these individuals, 19 had a new service connection (up from seven last year), and 15 had an increased service connection (up from eight last year). As a result of COVID, the CMHPSM Veteran's Navigator provided a larger amount of communication and services via phone and telehealth. Many others requested information and direct referral but did not wish/need to have ongoing support from the VN.
During 2021 the CMHPSM Veteran's Navigator continued working with the Walking with Warriors campaign, which will again continue into FY 2022.
Starting in FY22, this program will include a Veteran Peer Support Specialist to work alongside the VN, increasing capacity in numbers and in expertise, and the program will begin to work toward tracking referrals the CMH Access Departments provide to V/MF to the VN or the Veteran Peer Support Specialist, when individuals are seeking SUD treatment services.

2. IET-AD: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Project Description: This project monitors the percentage of beneficiaries ages 18 to 64 with a new episode of alcohol or other drug (AOD) abuse or dependence during the measurement period who ***Initiated*** and ***Engaged*** treatment. (HEDIS measures used). The CPT, SUD Committee and EOC will:

a) Collect, review, and evaluate the timeliness of outcome data.
b) Establish Interventions for barriers to timely data.
c) Examine data to ensure adherence to project protocols

This project was informational only for FY20 and FY21. The state will require the PIHP to participate in further data validation activities in CY22. The CMHPSM continues to track and trend overall percentages and statistically significant disparities in racial or ethnic groups. This data includes all SUD services (even those not funded by the PIHP), including those covered by Medicaid Health Plans. Accurate encounter reporting of this data has been a challenge to date based on allowable state parameters/services that count for this indicator.

Indicator/Performance Measure	Source	Goal/Benchmark	Documentation/Deliverable	Reporting
1. Initiation of AOD Treatment: Percentage of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis	MDHHS CC360 Medicaid Encounter	Baseline Data collected 2021 (standard to be determined) CMHPSM is working to improve during baseline year	Meeting Minutes (CPT, SUD Committee, EOC); PIPs	Quarterly Report to CPT
2. Engagement of AOD Treatment: Percentage of beneficiaries who initiated treatment *and* who had two or more additional AOD services or medication treatment within 34 days of the initiation visit	MDHHS CC360 Medicaid Encounter	Baseline Data collected 2021 (standard to be determined) CMHPSM is working to improve during baseline year	Meeting Minutes (CPT, SUD Committee, EOC); PIPs	Quarterly Report to CPT

Status Update: This project has two measures for individuals ages 18 to 64 related to access in the SUD service system:
1) Percentage who initiated treatment within 14 days of an SUD diagnosis (initial assessment): The state 3/31/21 report shows 41.5% compared to state Medicaid total of 41.39%
2) Percentage of beneficiaries who received services within 34 days of the initiation visit: The state 3/31/21 report shows 18.68% compared to state Medicaid total of 15.85%.

XI. Conclusion

The QAPIP establishes a framework to systematically evaluate the vital components of service delivery. It also clarifies the persons and systems responsible (leadership staff, committees, and the regional board) for the approval and ongoing monitoring of the plan. This QAPIP has a balance of operational and clinical project plans to promote excellent service delivery. This structure will drive and support the CMHPSM and CMHSPs to complete their designated functions better than previous years.

XII. Definitions

Confidential Record of Consumer Treatment (CRCT) refers to the CMHPSM electronic health record (EHR) co-created and shared by the region. This a primary resource for data entry by local CMHSP and contractual staff, data collection, and has been Meaningful Use Certified. This is an example of a standardized and centralized business process.

Critical Incident Reporting System captures information on five specific reportable events: suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and arrest of consumer. The population on which these events must be reported differs slightly by type of event.

External Quality Review (EQR) means the analysis and evaluation by an External Quality Review Organization of aggregated information on quality, timeliness and access to health care services that the CMHPSM furnish to consumers.

Medicaid Abuse refers to provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet the professionally recognized standards for health care (see 42 CFR 455.2)

Medicaid Fraud means the intentional deception or misinterpretation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or another person (see 42 CFR 455.2).

Outcomes means changes in consumer health, functional status, satisfaction, or goal achievement that result from health care of supportive services.

Quality Assessment refers to a systematic evaluation process for ensuring compliance with specifications, requirements or standards and identifying indicators for performance monitoring and compliance with standards.

Quality Assurance refers to a broad spectrum of evaluation activities aimed at ensuring compliance with minimum quality standards. The primary aim of quality assurance is to demonstrate that a service or product fulfills or meets a set of requirements or criteria. QA is identified as focusing on "outcomes," and CQI identified as focusing on "processes" as well as "outcomes."

Quality Improvement refers to ongoing activities aimed at improving performance as it relates to efficiency, effectiveness, quality, performance of services, processes, capacities, and outcomes. It is the continuous study and improvement of the processes of providing services to meet the needs of the individual and others.

Quality as it pertains to Managed Care Rules and External Quality Review (EQR) standards, means the degree to which the CMHPSM increases the likelihood of desired outcomes of its enrollees through 1) Its structural and operational characteristics. 2) The provision of

services that are consistent with current professional, evidenced based knowledge. 3) Interventions for performance improvement.

Risk Events: Critical incidents that put individuals (in the same population categories as critical incidents above) at risk of harm. These 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

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

Validation means the review of information, data and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

XIII. Resources

CENTERS FOR MEDICARE AND MEDICAID, *QAPI Process Tool Framework*. Last accessed September 2021 at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapitools.

HEALTH SERVICES ADVISORY GROUP, *Quality Assurance and Performance Improvement Workbook.* Last accessed September 2020 at *https://hsag.com/qapi.*

MDHHS—PIHP CONTRACT, DEFINITIONS/EXPLANATION OF TERMS, (FY21).

MDHHS—PIHP CONTRACT, ATTACHMENT P.1.9.1, *Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans* (FY21).

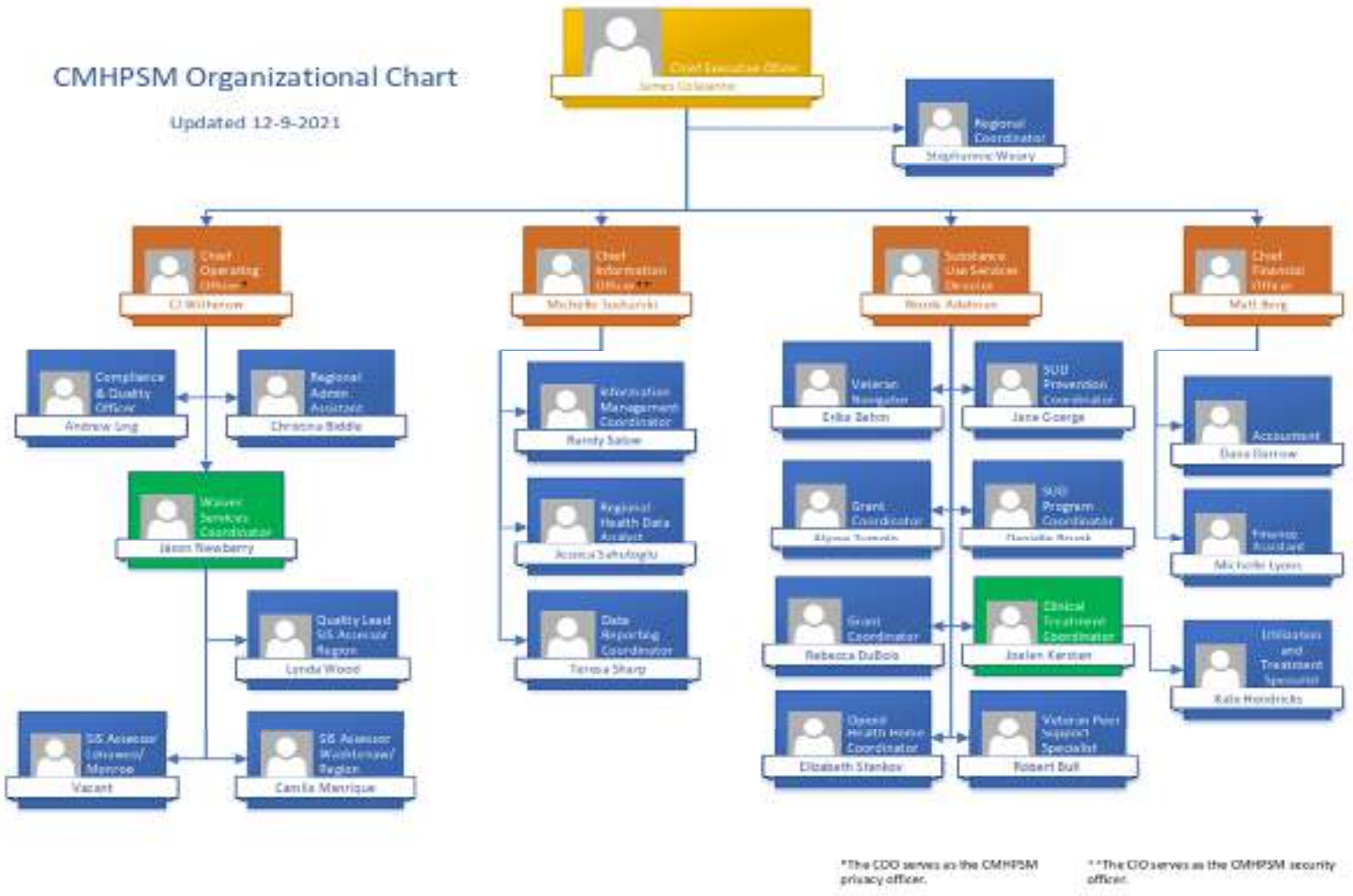
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN RESOURCES, HRSA. *Developing and Implementing a QI Plan*. Available at https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/developingqiplan.pdf.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN RESOURCES, HRSA. *Performance Management and Measurement*. *Available at* https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/performancemanagementandmeasurement.pdf.

INSTITUTE FOR HEALTHCARE IMPROVEMENT. *Quality Improvement Essentials Toolkit*. *Last accessed* September, 2020 at http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx

XIV. Attachments

A. Attachment A:



B. *Attachment B:*