Macomb County Community Mental Health

Quality Assessment and Performance Improvement Program (QAPIP) Description

Fiscal Year 2023-2025

Approval History:

Entity	Approval Date
Approved by MCCMH Board of Directors	02/28/2024

Quality Assessment and Performance Improvement Program Description

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I. INTRODUCTION

Macomb County Community Mental Health (MCCMH) is the Prepaid Inpatient Health Plan (PIHP) and Community Mental Health Services Program (CMHSP) for Macomb County. MCCMH is the third largest Community Mental Health Services Program in the State of Michigan. MCCMH holds a Standard Contract with the Michigan Department of Health and Human Services (MDHHS) for the Medicaid Managed Care Specialty Supports and Services Waiver Programs and Substance Use Disorder (SUD) Grant Programs and the MI Health Link Demonstration Program. In addition, MCCMH participated in the expanded Certified Community Behavioral Health Clinic (CCBHC) during its inception and has continued to participate as a CCBHC. MCCMH is also an Opioid Health Home. This places MCCMH in a unique position to offer a full array of services and supports to individuals seeking services.

This document outlines requirements for the Quality Assessment and Performance Improvement Program (QAPIP) Description as described in the MDHHS Behavioral and Physical Health and Aging Services Administration for Specialty Prepaid Inpatient Health Plans. It also describes how these functions are accomplished and the organizational structure and responsibilities related to these functions.

Mission

Macomb County Community Mental Health, guided by the values, strengths, and informed choices of the people we serve, provides quality services, which promote recovery, self-sufficiency, and independence.

Values

MCCMH has a phrase that drives its mission to serve its community. The phrase is "Putting People First." The way MCCMH ensures it is putting people first is by embracing the core values of being accountable, collaborative, and respectful in all interactions. MCCMH Core Values are incorporated into all team member functions. MCCMH's Core Values are best implemented into actions when the below statements are true in all interactions:

Collaborative: "I approach all situations with a teamwork and solution focused mindset."
Accountable: "I take ownership and empower others to do the same. "
Respectful: "I treat people with dignity while honoring individual differences."

Quality Improvement Authority and Scope

MCCMH's Quality Improvement (QI) Program aims to provide the structure and processes necessary to improve the clinical care and quality of services for persons served. MCCMH's QI Program includes multidirectional input from its Governing Body (MCCMH's Board of Directors), Executive Leadership, Quality Improvement Committee, persons served, and providers.

The Quality Improvement Program realizes success through data and measurable outcomes to determine progress toward regulatory and accreditation requirements. The QI Program is committed to continuous quality improvement and is evaluated annually for its overall effectiveness. Based on the annual evaluation findings, the QI Program is modified to ensure opportunities are acted upon to improve the quality-of-care members receive.

Objectives

To achieve the overarching goals of the Quality Improvement Program, MCCMH has identified the following program objectives to work towards, herein referenced as its Quadruple Aim:

Objective	Purpose
1) Obtain NCQA MBHO Accreditation at full accreditation (score of >84)	Demonstrate a high-level of adherence to industry best-practices, resulting in high-quality care, access and member protections, and outcomes. Quality goals focus on quality improvement, member rights and responsibilities, practitioner and facility credentialing, utilization management, and care coordination and collaboration with behavioral health and physical health providers.
2) Maintain CARF Accreditation	Demonstrate MCCMH's commitment to continually enhance the quality of services and programs with a focus on the satisfaction of persons served.
3) Achieve a score of >90% on Member Satisfaction Survey	Achieving a score of > 90% on the Member Satisfaction Survey demonstrates that members are accessing high-quality provider care and are generally satisfied with the services of MCCMH and its provider network.
4) Achieve a score of > 90% on Provider Satisfaction Survey	Achieving a consistently high level of provider satisfaction demonstrates that providers are successfully understanding and implementing MCCMH policies and guidelines. This level of satisfaction demonstrates that MCCMH is generally supporting providers in achieving goals necessary to provide quality care to persons served.

Approach to Quality

The Quality Improvement Program is developed and evaluated in alignment with the Quadruple Aim and other regulatory and accreditation requirements. MCCMH utilizes several strategies and approaches to ensure the Program is effective in improving the health and health outcomes of MCCMH's persons served.

Quality Improvement Governance

MCCMH's organizational structure enables clear and effective administration and evaluation of the QAPIP Description. MCCMH's Chief Executive Officer provides guidance and supervision to the Chief Quality Officer. The Chief Quality Officer is responsible for the development and implementation of the QAPIP and provides quarterly reports to the Quality Committee and the Governing Board (MCCMH Board of Directors) on activities related to the QAPIP as well as Key Performance Indicators (KPI) set by MDHHS standards and performance improvement projects. These reports describe current performance improvement plans, actions taken, and results of actions. Board minutes illustrate when progress reports are presented and reviewed.

MCCMH Governing Body - Board of Directors

1. Membership: MCCMH's Board currently includes: Twelve (12) members representing the people of Macomb County.

2. Role/Function: The Governing Board retains the responsibility for the review and approval of the QAPIP, administrative policies, and overall governance. The Board's approval of the QAPIP will be evidenced in the meeting minutes and the QI Workplan. The Board monitors, evaluates, and assists with the establishment of policies that support the provision of quality care in the region.

3. QAPIP Progress Reports: The Governing Board routinely reviews reports of current activities, actions taken, and the impact of those actions as presented by the Chief Quality Officer during scheduled Board Meetings. Such reviews are evidenced in meeting minutes.

4. Annual QAPIP Review: At least annually, the Governing Board formally reviews a written report on the QAPIP. The annual QAPIP review is evidenced in meeting minutes.

5. Reporting Accountability: The Governing Board reports to stakeholders via Committees and Board Meeting Minutes. Following the Board's review and approval of the QAPIP, the report is submitted to MDHHS. Each annual submission to MDHHS includes a list of the members of the Governing Body. This submission must occur by February 28 of each year. MCCMH's current QAPIP is on a three-year cycle.

    a. February 28, 2023: First Year – Finalize QAPIP FY 2023-2025
    b. February 28, 2024: Second Year – Review QAPIP FY 2023-2025
    c. February 28, 2025: Third Year – Final Review QAPIP FY 2023-2025
    d. February 28, 2026: First Year – Finalize QAPIP FY 2025-2027

Quality Improvement Monitoring and Reporting

The MCCMH Quality Improvement Program builds upon traditional quality assurance activities while simultaneously engaging in continuous quality improvement activities. The activities are directed at operationalizing the mission of MCCMH and assuring a provision of quality care to persons served.

Quality processes include measuring MCCMH against predefined standards, utilizing formal and informal assessment activities, utilizing data to measure performance against standards, and identifying strategies with which to improve areas.

Key Performance Indicators

MCCMH has adopted the Key Performance Indicators (KPI) for Behavioral Health. MCCMH is responsible for overseeing established performance measures based on Michigan's Mission-Based Performance Indicator System (MMBPIS) developed by MDHHS. Standards for performance measure compliance for FY23 were based on the MMBPIS Codebook. Indicator 1, 4a, and 4b have a standard of 95% or better and Indicator 10 has a standard of 15% of less. Revisions to the Reporting Codebook were made in preparation for FY24. Revisions included establishing PIHP specific benchmarks for Indicator 2, 2e, and 3. Standard percentiles were created based on the FY22 time period and reported on an annual basis.

KPIs include indicators in the domains of Access, Efficiency, and Outcomes. MMBPIS data (outlined in the PIHP Codebook) provides set standards for measures based on rational for use, population, and indicator specific selection and exception methodology. From these set standards, MCCMH has developed internal processes and validation activities to ensure data is valid and reliable. Strategies to ensure the systematic ongoing collection and analysis of valid and reliable data through MCCMH's EMR system (FOCUS) and interactive dashboard development is a collaborative effort among key departments within MCCMH. Departmental collaboration includes Quality, Information Systems, and Data Informatics. MCCMH has used a combination of validation activities including primary source verification, member-level detail file reviews, and also ensuring that source code is up to date to ensure reports are pulling information from the most up to date standards.

This data is reported to MDHHS according to established timelines and formats. MDHHS develops and distributes quarterly PIHP Performance Indicator Reports based on statewide performance measure data submission.

MCCMH also has internal reporting standards to monitor and analyze data collection. Data is reported to the Quality Committee and other internal committees for review and recommended actions to address any areas falling below the statewide threshold. When negative statistical outliers occur, MCCMH analyzes the causes and develops remediation and improvement strategies.

Performance Improvement Projects

MCCMH's Quality Department conducts at least two Performance Improvement Projects (PIPs) annually. PIPs address clinical and non-clinical aspects of care.

1. Clinical areas include, but are not limited to, high-volume services, service disparity, high-risk services, and continuity and coordination of care.

2. Non-Clinical areas include, but are not limited to, appeals, grievances, trends, and patterns of substantiated Recipient Rights complaints as well as access to and availability of services.

Current MCCMH Performance Improvement Projects include:

1. Increase percentage of adults receiving follow-up appointments and a reduction in racial disparity between Caucasian and African American persons served post inpatient psychiatric hospitalization.

2. Increase the number of MCCMH persons served enrolled in the MDHHS Habilitation Supports Waiver Program.

The purpose of PIPs is to improve the performance of existing services or develop new processes to meet identified needs. MCCMH's topic selection is based on statistical disparity measures, barriers related to access of care, improving service delivery, and increasing persons served satisfaction.

Oversight of the PIPs is achieved through collaborative interdepartmental efforts within MCCMH as well as partnerships with its provider network, advocates, and persons served. Improvement is tracked on an ongoing basis through the development of detailed workplans, data collection and analysis tools.

Corporate Compliance and Medicaid Services Monitoring

Activities related to the monitoring of Medicaid services delivery are reported to MCCMH's Executive Staff and Board, as required, through the Corporate Compliance Office. Corporate Compliance activities which impact quality of care issues for persons served may result in the development of additional performance indicators and/or monitoring activities.

In addition to the activities of the Corporate Compliance Office, MCCMH ensures that services to Medicaid beneficiaries, for which it has paid, have been delivered as claimed.

Annual audits will be conducted in accordance with MDHHS Guidelines for verification of Medicaid services and MCCMH Medicaid Verification Financial Audit Process guidelines. Audits will verify the existence of appropriate clinical records for each claim in the sample selection, evaluate the reasonableness of clinical records associated with each claim, verify that services specified in the claim were part of the consumer's Individual Plan of Service and that services provided were included in Chapter Ill, Mental Health/Substance Abuse Section, of the Michigan Medicaid Provider Manual. Final report for each vendor, detailing findings by claim and by provider, including the dollar amount of claims that were not supported by appropriate clinical record documentation will be shared with each provider. Overall Audit results will be summarized and analyzed in accordance with the following:

- Total number and dollar value of claims processed during the audit period.
- Total number and dollar value of the sample.
- Number of claims that were found to be deficient.
- Dollar value of claims that were found to be deficient.

An Executive Summary Report will be prepared to summarize, at the provider level, the number and dollar amount of claims not supported by appropriate clinical records and the number and dollar amount of claims for services that were not represented on the consumer's Individual Plan of Service. This report will be submitted to MDHHS at least annually but no later than December 31 of each year.

When a particular provider appears to have more serious documentation issues, immediate action is taken by the MCCMH to reduce the risk for overpayment of Medicaid dollars. Specific actions may include but are not limited to MCCMH Quality Department undertaking a more extensive audit of the provider. Depending on the result of the findings, referrals to the Attorney General may be made as well.

II. QUALITY IMPROVEMENT PROGRAM

Framework for Quality Improvement (QI)

The success of the QI Program is dependent on appropriate oversight and resources. This section outlines the framework and responsibilities of the QI Program.

1. Quality Improvement Committee Framework
   The QI Committee provides oversight of the QI Program. It focuses on performance indicator data, conducting and analyzing satisfaction surveys, overseeing performance improvement projects, monitoring quality activities to ensure quality of services, and evaluating member and provider experiences and provider performance.

   QI Committee responsibilities include, but are not limited to the following:

   a. Managing the coordination of quality improvement efforts across the organization
   b. Establishing QI priorities
   c. Approving the Annual QAPIP Description and Workplan
   d. Overseeing QI activities and ensuring appropriate follow-up
   e. Regularly evaluating QI projects
   f. Recommending and approving QI policies and procedures
   g. Conducting an annual evaluation of the QI Program

2. Designated Behavioral Health Care Practitioner
   The MCCMH Chief Clinical Officer is a doctoral-level clinical psychologist and serves as the lead behavioral healthcare practitioner for the QI Committee.

MCCMH's Chief Clinical Officer is involved in all aspects of the Quality Improvement Program, provides leadership to the QI Committee, advises on the development of new services and policies and procedures, and ensures that data analysis of quality improvement activities and appropriate follow-up occurs. MCCMH's Chief Clinical Officer attends QI Committee meetings at least quarterly.

4. Quality Sub-Committee Structure

   The QI Committee provides oversight and guidance to Quality sub-committees and is responsible for assigning quality improvement activities to the responsible sub-committee. Quality sub-committees focus on the areas of Quality Improvement, Quality Evaluation, and Quality Monitoring. QI sub-committees are responsible for bringing information to the QI Committee for reporting, monitoring, and decision-making purposes.

5. Partnered Committees

   The Utilization Management (UM) Committee is chaired by the Director of Managed Care Operations. This Committee conducts ongoing reviews of under and over utilization of services, reviews consistency of utilization management criteria application, reviews and approves the UM Program Description, and compiles an annual UM Evaluation report. The UM Committee reviews established data dashboards to assess timeliness of intake assessments, hospitalization rates, usage of services by service category, and other datasets to identify utilization rates and propose improvement strategies, as needed. As improvement strategies are operationalized, ongoing reports are presented to and discussed at the Quality Committee. Although the UM Committee is not an official sub-committee of the Quality Committee, their reviews and findings are incorporated into Quality activities and formal UM reports are presented to the Quality Committee at least annually.

   The Credentialing Committee is chaired by the Chief Medical Officer. Although the Credentialing Committee is not an official sub-committee of the Quality Committee, credentialing processes are highly influenced by Quality activities. The Credentialing Committee reports to the QI Committee on its processes, at least annually, to ensure ongoing collaboration between committees' scopes of work.

MCCMH's reporting structure for these committees is as follows:

6. Stakeholders and Persons Served

   The involvement of persons served and advocates in MCCMH's QI Program is actively sought through the two advisory bodies to the Board; The Citizens Advisory Council (CAC) and the Substance Abuse Advisory Council (SAAC). Input is sought from CAC and SAAC during the development of the QAPIP Description and throughout the year. Person served input is also sought through the Member Satisfaction Survey.

7. Committee Councils and Workgroup Structures

   MCCMH has additional committees that collaborate with the QI Program on various quality improvement activities and initiatives. These include:

   a. Behavior Treatment Plan Review Committee (BTPRC) – Reviews behavior treatment plans with restrictive or intrusive techniques and provides approval or denial of plans with these techniques.

   b. Clinical Risk Management Committee (CRMC) – Reviews areas of clinical risk within the MCCMH provider network. These include incident reports, findings of mortality reviews and root cause analyses. Key findings and recommendations are provided to the Quality Committee or Executive Staff for action, as necessary.

   c. Improving Practices Leadership Team (IPLT) – Develops and monitors clinical service areas such as clinical practice guidelines, evidence-based practices, care integration processes, home and community-based services, transition planning, safety of clinical care, quality of services and enhancement of member experience.

d. Certified Behavioral Health Clinic (CCBHC)– Ensures integration of medical and behavioral health, along with SUD.

e. Process Improvement Committee (PIC) – Engages in the development of new data warehouses, dashboards, and reports.

f. Citizens Advisory Council (CAC) - Comprised of primary and secondary persons served, service and advocacy representatives, and interested members of the community.

g. Substance Abuse Advisory Council (SAAC) – Comprised of primary and secondary persons served, service and advocacy representatives, and interested members of the community.

Clinical Practice Guidelines

MCCMH has adopted Clinical Practice Guidelines to help practitioners and members make decisions about appropriate healthcare for specific clinical circumstances. MCCMH's Clinical Practice Guidelines are updated at least every two years and are based on scientific evidence and/or professional standards from recognized sources and approved by the QI Committee. MCCMH distributes the guidelines in a bulletin and email to all providers and practitioners upon initial adoption and at least every two years. Practitioners and providers are notified of the availability of the guidelines on the MCCMH website and may request a copy of the Clinical Practice Guidelines to be mailed to them as needed. Annually, each guideline will be measured for effectiveness on two important aspects of the clinical process of care as outlined in the Clinical Practice Guideline and QI Workplan.

Clinical Practice Guidelines developed by MCCMH are presented to the Quality Committee as they are developed. MCCMH has expanded the development of clinical protocols to support the integration of physical and behavioral healthcare. The Substance Use Division continues to focus on expanding treatment services for Opioid use disorder using the Opioid Health Home model of care.

Credentialing and Re-Credentialing

MCCMH maintains written policies and procedures that delineate standards and processes to credential and re-credential its practitioners. MCCMH's policies adhere to MDHHS' Credentialing and Re-Credentialing requirements and federal guidelines. MCCMH, through its Credentialing Committee, reviews and credentials licensed behavioral healthcare practitioners/professionals employed directly by MCCMH and organizational providers under direct contract with MCCMH.

MCCMH contracted providers have the responsibility of credentialing the individual practitioners employed directly by the provider. All MCCMH network providers will have credentialing policies in place that are approved by MCCMH and cover all behavioral health care practitioners. During re-credentialing, MCCMH reviews any sanctions, complaints, and quality issues pertaining to the practitioner. This must include, at minimum, a review of Medicare/Medicaid sanctions; state sanctions or limitations on

licensure, registration, or certification; enrollment in the Community Health Automated Medicaid Processing System (CHAMPS); and specific internal quality concerns or issues including but not limited to grievances and appeals.

MDHHS standards and MCCMH contracts with providers require that providers provide training for all new staff and ongoing training and development activities for existing staff. MCCMH's Training Department ensures that staff possess the appropriate qualifications as outlined in their job descriptions, including qualifications for educational background, relevant work experience, cultural competence, and certification/registration/licensure as required by law. Team members participate in trainings required for their job responsibilities and MCCMH's policies and standard operating procedures.

The Macomb County Office of Substance Abuse (MCOSA) monitors the substance use provider network for compliance with state and national requirements. MCCMH continues to monitor the Medicaid sanctioned provider list, as published by Medical Services Administration (MSA).

Quality Improvement Scope and Strategies

MCCMH uses several strategies to ensure that Quality goals and objectives are strategically aligned with achieving the priorities of the Quadruple Aim. The QI Program's scope includes activities related to Member Safety, Member Satisfaction, Provider Satisfaction, and Quality Measurements.

Member Safety

MCCMH is committed to the safety of the members we serve. Member Safety activities work toward improving the Quadruple Aim of achieving quality care for our members. This is accomplished through several mechanisms including:

Coordination of Care:

The Chief Clinical Officer and Chief Quality Officer are responsible for coordinating and participating in quality activities to improve coordination of care among providers in the network. These activities include:

1. Ongoing coordination of care monitoring:
    a. Coordination of care between care settings among behavioral health practitioners and providers.
    b. Coordination of care between medical and behavioral health practitioners.
2. Partnerships with physical health managed care organizations in joint quality activities and initiatives related to best practices in clinical care.

Use of Appropriate Treatment Guidelines:

MCCMH has adopted Clinical Practice Guidelines for disorders that are commonly identified. MCCMH's goal for the Clinical Practice Guidelines is to provide both clinicians and the community with a reference to the standards of care used by MCCMH. Standards are based on the most current resources available in the field of behavioral

healthcare. MCCMH uses the 25th edition of the MCG Behavioral Health Care Guidelines, which houses thousands of research-supported standards for clinical care as the reference source for Clinical Practice Guidelines.

For Adults:
Clinical Practice Guideline – Major Depressive Disorder
Clinical Practice Guideline – Schizophrenia
Clinical Practice Guideline – Bipolar

For Children:
Clinical Practice Guideline – ADHD And Disruptive Behaviors
Clinical Practice Guideline – PTSD

Evidence-Based Practices:
Evidence-Based Practice List – Adults and Children

Practitioner/Facility Office Review:
Onsite office reviews may occur as part of the complaint investigation process, when a quality-of-care concern warrants a site review, when physical concerns have been identified, a need for chart review presents itself, and/or during provider meetings. Processes for complaints, grievances, critical incidents, and quality of care concerns to investigate and address member safety issues may also lead to the need for onsite review.

Chart Audits:
To ensure quality of care and member safety, provider medical records are reviewed through multiple mechanisms:

1. The facility site review process conducts chart reviews of different levels of care. This process is incorporated into the credentialing (initial and recredentialing) process.

2. Charts are also reviewed for compliance with billing rules for fraud, waste, and abuse.

3. Monitoring the effectiveness of behavioral health interventions for selected Quality metrics.

4. Concentrating efforts on effective discharge management planning and follow up care.

Critical Incidents/Patient Safety:
MCCMH Policy 8-003, "Reporting and Responding to Critical Incidents, Sentinel Events, and Risk Events," establishes definitions and guidelines, based on criteria specified by MDHHS' technical and reporting requirements, for reporting and reviewing potential sentinel events and critical incidents. MCCMH Policy 8-003 delineates standards requiring all MCCMH providers to report critical incidents and risk events within the required timeframes and according to MCCMH incident reporting requirements. Such reports are submitted by providers through the MCCMH incident report module in its EMR system.

MCCMH uses the Critical Incident Reporting System to report information on suicides, non-suicide deaths, emergency medical treatment due to injury or medication error: type of injury will include a subcategory for reporting injuries that resulted from the use of physical management; hospitalization due to injury or medication error: hospitalization due to injury related to the use of physical management; and arrest of the individual. MCCMH analyzes additional risk events that may include actions taken by persons served that cause harm to themselves or others; and 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 a person has a terminal illness) within a 12-month period.

MCCMH's Critical Risk Management Committee (CRMC) reviews sentinel events and other critical incidents and acts upon them as appropriate. CRMC is composed of individuals with the appropriate credentials to review the scope of care and includes individuals not involved in the treatment or care of the person served. The CRMC's review process results in the understanding of causes of the event and if necessary, a root cause analysis with subsequent corrective action plans is implemented to avoid similar events from occurring in the future. MCCMH continuously monitors critical incidents to evaluate the quality and performance of the provider network. CRMC reports sentinel event findings and documents follow-up and system improvements as required by MDHHS.

MCCMH creates quarterly summary reports on issues or trends pertaining to quality of care based on information received from the mortality review process, sentinel event investigations and action plans, critical incident reports, and risk event reports. MCCMH's Quality Division provides these quarterly summary reports to the CRMC for further review and discussion.

MCCMH's CRMC reviews sentinel events reported by network providers and annually submits to the Board of Directors a summary report for review. The Quality Department tracks and trends patterns related to critical incidents and risk events.

Behavioral Treatment Review:

MCCMH's Behavioral Treatment Plan Review Committee (BTPRC) standards and expectations are included in MCCMH Policy 8-008, "Behavior Treatment Reviews." MCCMH's quarterly QAPIP reviews analyze data from the BTPRC where intrusive or restrictive techniques have been approved for use with members and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis. The data tracks and analyzes the length of time interventions used per individual.

Quality Efforts:

Quality Improvement activities are implemented and monitored through a complex system of different groups and committees, network providers, members, advocates, and additional stakeholders working in collaboration with one another to ensure the delivery of quality supports and services.

This is not an exhaustive list and does not cite all daily and ongoing efforts made in collaboration with MCCMH's community partners. This list is specific to activities that are the responsibility of the MCCMH Quality Department. MCCMH's QI activities include efforts to:

1. Provide an outline of MCCMH's QI structure for its region.

2. Evaluate QI processes and outcomes on an ongoing basis to assure that they are effective and have a positive impact on the quality of care and services provided to MCCMH's stakeholders.

3. Evaluate MCCMH systems and processes on an ongoing basis related to clinical and non-clinical services that can be expected to impact the quality of life and satisfaction for persons served.

4. Review and identify, on an ongoing basis, opportunities for priority performance improvement based upon information obtained from data and stakeholders.

5. Assure that input from stakeholders is received and considered in the development of QI activities for the Quality Department.

6. Ensure the focus of QI activity development is on prevention instead of remediation. The ability to have a positive impact on the service delivery system by engaging in administrative simplification while simultaneously assuring a high-quality service delivery system decreases the strains placed upon all stakeholders.

7. Seek continuous feedback from stakeholders on the quality of services being provided and incorporate feedback into future QI initiatives.

8. Meet standards set forth within MCCMH's various regulatory agencies.

Member Satisfaction

MCCMH annually conducts quantitative and qualitative reviews of member satisfaction through member surveys, focus groups, and complaints and appeal analyses.

Member Experience Survey:

1. MCCMH conducts an annual member experience survey and identifies improvement opportunities and actions designed to improve member experience. Survey data is collected over a defined period of time to capture level of satisfaction based on experience from individuals actively receiving MCCMH services.

2. Surveys are distributed throughout the survey period via paper or electronically. Individuals can complete the survey electronically through scanning a QR code or navigating to MCCMH's website. Paper surveys are made available at each service site and once completed, are securely uploaded and aggregated with the survey responses collected electronically.

3. To collect quantitative data, MCCMH utilizes standardized assessment tools to conduct satisfaction surveys for its adult and children's populations. The MHSIP survey is used to assess the Adults and the YSS-F is used for Children/Caregivers to

collect data for customer satisfaction. To collect qualitative data, MCCMH provides space within the survey for narrative responses and encourages individuals who may want to share additional feedback to provide their contact information to receive direct communication and follow-up from an MCCMH representative.

4. The survey presents statements about services within eight domains. The eight domains include Access, Participation in Treatment Planning, Person-Centered Care Planning, Quality and Appropriateness (or Cultural Sensitivity), Social Connectedness, Functioning, Outcomes, and General Satisfaction.

5. The assessment addresses issues of quality, availability, and accessibility of care. The member experience survey includes questions about the experience members have with language services when communicating with MCCMH and during experiences with providers. Quality improvement opportunities are identified for areas not meeting the threshold of 90%.

6. As a result of the assessments, MCCMH:
    a. Takes specific action on cases as appropriate;
    b. Identifies and investigates sources of dissatisfaction;
    c. Outlines systemic action steps to follow-up on the findings;
    d. Informs practitioners, providers, recipients of service, and the governing body of assessment results.

7. MCCMH monitors and identifies opportunities for improvement, implements interventions, and measures the effectiveness of the interventions for the following categories of complaints:
    a. Quality of Care
    b. Access
    c. Availability
    d. Attitude and Service
    e. Billing and Financial Issues
    f. Quality of Practitioner Office Site

8. Input may be sought from persons served and the community using focus groups and ongoing community-wide forums. The Citizens' Advisory Council (CAC) may be asked to participate in the development of new questions for focus groups and locally developed surveys. The CAC is part of the MCCMH committee structure and is provided reports related to the QAPIP. MCCMH conducts annual person served satisfaction surveys for continuous identification of improvement opportunities. Happy or Not terminals are located at each clinic location and on the website to provide real time customer service feedback.

<u>Access to Services:</u>
MCCMH will ensure member access to services by reviewing the answer and abandonment rates of telephone calls to the MCCMH Customer Services line; monitoring the provision of interpretation and translation services; evaluating penetration rates; and other means.

On a quarterly basis, MCCMH monitors telephone access and responsive rates, including the rate of answering telephones and abandonment rates.

Cultural and Linguistic Diversity:
MCCMH is committed to serving a culturally and linguistically diverse membership in a manner to prioritize members accessibility to services and care and identify potential health care disparities. MCCMH requires that Cultural Competency trainings be completed by contracted providers and their workforce members as well as all MCCMH workforce members. Such trainings remind the network that cultural values affect behavior and provide the basics for team members to begin or continue their work toward cultural competency. Through continuous monitoring and evaluation of its network, MCCMH equips itself to identify and pursue opportunities to improve its service delivery system's cultural and linguistic diversity.

Member Needs Assessment:
The cultural and linguistic needs of MCCMH's members are assessed annually through the Member Needs Assessment in the following:

1. Conducting ongoing member needs assessment in service utilization through areas such as penetration rates and identifying service access rates by race/ethnic groups.
2. Annual analysis of primary language by service needs.
3. Conducting data analyses that focus on several variables including race, gender, age, eligibility category, and language to gain insight into the long-standing disparities in the health status of people of diverse backgrounds.
4. Monitoring the provision of interpretation and translation services to ensure effective communication with non-English-speaking populations.
5. Monitoring the provision of alternative communication for individuals who are deaf or hard of hearing including American Sign Language and providing alternative methods of phone communication including Text Telephone Typewriter (TTY).
6. Ensuring that member materials are culturally competent and available for members in a preferred language or communication method on MCCMH's website and mailed when requested.

Results of the Member Needs Assessment will be used to improve services offered to members and make provider network capacity changes.

Long-Term Services and Supports (LTSS):
CMS requires that states monitor the quality of LTSS provided through managed care as part of their state quality strategies, regular external quality reviews (EQR), and reporting of quality and performance measures. These activities are described in detail on Medicaid.gov7. There are few standardized measures of access and quality that are specific to LTSS. The Medicaid measures include standardized measures of access and quality, some of which may be relevant to assessing access to care for LTSS enrollees. MCCMH's

HCBS programs serve a variety of targeted population groups— such as older adults and people with intellectual or developmental disabilities, physical disabilities, or mental health and substance use disorders (MH/SUDs)— and provide opportunities for Medicaid beneficiaries to receive services in their own homes and communities rather than in institutions. These Medicaid benefits help enrollees manage their basic needs and live independently in the community.

MCCMH has mechanisms in place to assess the quality and appropriateness of care furnished to individuals using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the person's treatment/service plan. Mechanisms comprehensively assess each Medicaid person served identified as needing LTSS to identify any ongoing special conditions of the person that require treatment or regular care monitoring. Some of the activities conducted by the PIHP include but not limited to timely and appropriate service authorization, adequate provider network, encounter data verification, review of appeals and grievances.

Assessment mechanisms use appropriate providers or individuals meeting MDHHS' LTSS service coordination requirements. This may include, but is not limited to review, analysis, and monitoring of person-centered planning, IPOS reviews/amendments, and standardized assessment scores that support level of care such as the Level of Care Utilization System (LOCUS)

MCCMH ensures individuals receiving long-term supports or services (e.g., individuals receiving case management or supports coordination) are incorporated in the review and analysis of information obtained from both quantitative and qualitative methods. MCCMH continuously reviews care between settings and compares services and supports received based on the individual's plan of service.

LTSS members are included as survey participants and members of the Consumer Advisory Councils and LTSS cases are tracked and reported on the MDHHS OBRA dashboard.

Reducing Healthcare Disparities:
MCCMH assesses various performance measures for healthcare disparities related to language, cultural competence, and physical accessibility. Identified disparities are addressed with specific interventions to reduce healthcare disparities. MCCMH's network adequacy is assessed annually to ensure the network is culturally competent.

Education and Prevention Programs:
MCCMH annually monitors the promotion of educational information to persons served and identifies members monthly to participate in the screening program. Members are informed annually of self-management tools available on its website.

Provider Satisfaction

Provider Participation:

MCCMH regularly includes practitioner and provider representatives in decision-making committees to ensure provider input is incorporated into MCCMH practices and initiatives. Practitioner and provider representatives participate in at least the following committees:

- Quality Improvement Committee
- Utilization Management Committee
- Credentialing Committee

Access to Provider Network:
MCCMH will determine member access to its provider network by ensuring geographic accessibility of choice of providers via mapping of the provider network by level of care; identifying provider to member ratios; auditing samples of progress notes to ensure that a choice of providers is consistently offered; and observing penetration rates to determine possible barriers to access.

Quality Measurements

MCCMH annually reviews the demonstration of appropriate quality measurements to ensure it is providing high quality care and working toward achieving the Quadruple Aim.

Annual Evaluation:
MCCMH provides an annual report on required standards within timeframes specified to evaluate the impact and effectiveness of the QI program and includes an analysis of internal Quality processes and initiatives. As part of the annual evaluation, MCCMH conducts an annual written evaluation of the QI program that includes a description of completed and ongoing activities that address safety of clinical care and quality of service, trending of measures to assess performance of clinical care and quality of service, and an analysis and evaluation of the overall effectiveness of the QI program. MCCMH annually shares results of its current QI program evaluation with its members and provider network in the MCCMH Annual Report.

Provider Profiles:
MCCMH builds provider profiles based on the following Performance Measures:

1. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA): The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

2. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD): The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

3. Plan All-Cause Readmissions (PCR): For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

4. Initiation and Engagement of Substance Use Disorder Treatment (IET): The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement.

5. Follow-Up After Emergency Department Visit for Mental Illness (FUM): The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness.

6. Follow-Up After Hospitalization for Mental Illness (FUH): The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider.

7. Follow-Up After Emergency Department Visit for Substance Use (FUA): The percentage of emergency department (ED) visits among members aged 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up.

8. Antidepressant Medication Management (AMM): The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment.

9. Follow-Up Care for Children Prescribed ADHD Medication (ADD): The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.

III. QUALITY IMPROVEMENT STRUCTURE

The Quality Improvement Division consists of the following units: Complaints and Grievances, Quality Monitoring, Quality Evaluation, and Quality Improvement.

Complaints and Grievances Unit

The MCCMH Ombudsman assists persons served with informal concerns and filing grievances. When the Ombudsman receives a grievance, if the member requests someone else to represent them in the process, the Ombudsman will request that this be in writing. The Ombudsman sends a written acknowledgement of the grievance and ensures that those deciding and assisting in the grievance are appropriate individuals to do so. Once a grievance is resolved, the MCCMH Ombudsman sends written notice of the resolution containing the results of the grievance, the closing date of the grievance, and information how to access a State Fair Hearing.

MCCMH ensures members receive reasonable assistance in completing forms and taking other procedural steps related to a grievance. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

Quality Monitoring Unit

Provider Teaming:
A meeting of an interdisciplinary group of individuals representing MCCMH is convened when MCCMH becomes aware of a significant provider-related issue(s). Any MCCMH Officer or MCCMH staff person in consultation with the Chief Quality Officer can convene a Provider Teaming. Depending on the nature of the concern, staff representing Quality, Compliance, Chief Medical Office, Provider Network, Clinical, Customer Services, Information Technology (IT), and other division staff may be included in the Provider Teaming. It should be noted that although any MCCMH staff member can request a Provider Teaming, the staff member's direct supervisor must be consulted prior to the request being made.

Quality Concerns:
Typically generated by the Quality or Clinical Division and/or Chief Medical Office as a result of clinical and service request reviews or Network Operations or Customer Services regarding significant member incidents and member concerns when members do not want to file a formal complaint.

Quality Improvement Plan (QIP):
A written document that identifies areas of clinical quality concerns, an intervention plan to bring services to an acceptable standard of care, specification of the staff responsible for implementation, and the target dates to resolve concerns. The following domains are considered in a QIP:

- Severity (high versus low)
- Category (clinical versus non-clinical)
- Duration (chronic versus short lived)
- Frequency (multiple versus one)

Quality Evaluation Unit

The Quality Evaluation Unit leads provider performance evaluation activities that ensure MCCMH members receive services that are safe, effective, person-centered, timely, efficient, and equitable.

Provider Performance Evaluation:
Quality Evaluation works in conjunction with the Clinical Division to develop or select performance measures that reflect the treatment goals of MCCMH-funded programs. Performance Evaluation is also responsible for the evaluation of the MCCMH network for State-mandated performance measures, such as HEDIS measures.

Quality Evaluation works closely with the Quality Improvement Unit on planning, designing, implementing, and conducting provider service quality improvement activities based on evaluation results for State initiatives and NCQA accreditation.

Quality Evaluation team members also work closely with the MCCMH Network Operations Division in the development of program monitoring and evaluation plans included in requests for proposals for pilot and demonstration programs. As part of this

process, in addition to developing and implementing program evaluation and monitoring plans, Quality Evaluation team members provide technical support for continuous quality improvement at provider programs.

Quality Improvement Unit

The Quality Improvement (QI) Unit is responsible for developing, monitoring, and reporting of quality improvement efforts across MCCMH for State and National reporting requirements. The team leads the following initiatives:

Performance Improvement Projects:
The QI Team is responsible for developing the Performance Improvement Projects (PIPs) required by MDHHS, including the development, monitoring, and reporting of quality improvement activities and performance measures. PIPs are approved through the Quality Committee and Improving Practices Leadership Team (IPLT). The purpose of PIPs is to achieve through ongoing measurement, demonstratable and sustained improvement in clinical and non-clinical areas that benefit health outcomes and member satisfaction. MCCMH incorporates the following in its PIPs:

1. Measurement of performance using objective quality indicators.
2. Implementation of interventions to achieve improvement in the access to and quality of care.
3. Evaluation of the effectiveness of the interventions based on the performance of measures.
4. Planning and initiation of activities for increasing or sustaining improvement.

Integrated Care Planning:
The Quality Improvement Team is responsible for providing ongoing quality improvement support to Integrated Care Planning (ICP). Ongoing review and monitoring of performance measures and intervention effectiveness is conducted quarterly.

National Committee for Quality Assurance:
The National Committee for Quality Assurance (NCQA) is a private, non-profit organization dedicated to improving healthcare quality and offers accreditation to health care plans. The Chief Quality Officer is responsible for assessing MCCMH for compliance with NCQA accreditation standards in the areas of Quality Improvement, Utilization Management, Care Coordination, Members Rights, and Credentialing and Re-credentialing.

Quality Improvement Activities:
The QI team is responsible for process and performance improvement activities and utilizes a standardized QI framework to ensure that all process and performance improvement activities are conducted efficiently and effectively to achieve the best outcomes.

Staffing Structure/Support

1. Chief Quality Officer:
   The Chief Quality Officer has the overall responsibility for implementation of the

Quality Improvement Program. The Chief Quality Officer also oversees the Quality Sub-Committees and Units. The Chief Quality Officer provides daily technical oversight in quality incident screens, validity of system entries, severity ratings, category assignments, investigation, and determination of response levels. The Chief Quality Officer conducts root cause analyses for variance patterns and trends with incidents, serious complaints, and other quality measures. The Chief Quality Officer is responsible for the development, implementation, and reporting of performance measures and uses those performance measures to evaluate the effectiveness of provider performance and quality improvement activities across initiatives.

2. Chief Clinical Officer:
   The Chief Clinical Officer is a board-certified behavioral healthcare practitioner who is responsible for leadership to the Quality Committee. The Chief Clinical Officer is responsible for participating in the implementation of continuous quality improvement throughout the provider network, as well as within departments at MCCMH. The Chief Clinical Officer participates in the ongoing development and monitoring of clinical practice guidelines, key performance indicators, and performance standards. The Chief Clinical Officer provides doctoral-level clinical psychologist leadership for maintenance of National Committee for Quality Assurance (NCQA) standards.

3. Quality Administrators
   Quality Administrators are responsible for ongoing oversight and implementation of Quality initiatives, programs, policies, and procedures. Quality Administrators collaborate with the Quality Committee and other committees in developing and implementing special initiatives, projects, audits, and accreditations.

4. Quality Coordinators
   Quality Coordinators provide support to Quality initiatives, programs, and accreditation pursuits. Quality Coordinators are available to assist with required reporting for the agency and ensure quality and compliance of programs and duties.

5. Quality Case Managers
   Quality Case Managers maintain network monitoring lists, schedule monitoring visits with providers, and utilize monitoring and audit tools. They coordinate, consult, and provide liaison work with providers and other MCCMH divisions to ensure quality of services.

6. Ombudsman
   The MCCMH Ombudsman assists members voice their wishes and concerns so that they are heard and understood by MCCMH providers; facilitates resolution of Medicaid Grievances and Non-Medicaid Grievances; assists members with accessing the

MCCMH Office of Recipient Rights (ORR) to pursue formal processes when a Mental Health Code issue arises; and maintains documentation of Medicaid Grievances and Non-Medicaid Grievances.

7. MCO Physician Advisors:
   MCO Physician Advisors participate in quality reviews for member complaints, grievances, appeals, quality improvement plans, and practitioner chart reviews.

8. Director of Clinical Informatics:
   The Director of Clinical Informatics works with the Quality Improvement Division to review/develop and implement metrics for measuring the outcomes of the activities and goals described in the Quality Improvement Work Plan. They also provide information and guidance to the team of analysts responsible for evaluating the QI program activities.

9. Chief Network Officer:
   The Chief Network Officer is responsible for developing and maintaining high quality and satisfied provider networks within MCCMH's service area. This includes the functions of credentialing and recredentialing organizational providers. They are also responsible for contract quality overview and amendment processes, contract review for language update and revision, and establishment/ oversight of the contract library. The Chief Network Officer has oversight of the provider database and accuracy of provider listings in the Provider Directory.

10. Clinical Informatics Analysts:
    MCCMH has a team of analysts in the Clinical Informatics Department and Quality Department involved in evaluation processes. The team works to identify key stakeholders and do thorough quantitative and qualitative analyses on the different reports needed for the QI program.

IV. QUALITY PROGRAM DOCUMENTATION AND TOOLS

QAPIP Description

The QAPIP Description provides a guide to ensure that MCCMH quality assessment and performance improvement activities are assessed regularly and according to regulatory and accreditation standards. The QAPIP Description outlines the structure (functional areas and responsibilities, reporting relationships, resources, collaborative QI activities) and content of the QI program. The QAPIP Description is submitted to MDHHS by MCCMH's Governing Body. It defines the involvement of a designated behavioral healthcare practitioner, the function of QI Committee oversight, and provider representatives input

into the QI program through the QI Committee. It also outlines MCCMH's approach to address members cultural and linguistic needs.

Quality Workplan

The Quality Workplan is a dynamic document that outlines annual QI activities as required by MDHHS, CARF, NCQA, and other regulatory entities. Progress on the activities outlined in the Quality Workplan is assessed at regular intervals and reported on quarterly.

The format of the work plan includes the following elements:

- Target Objective
- SMART Goals
- Planned Activities
- Responsible Staff/Department
- Quarterly Updates
- Evaluation
- Barrier Analysis
- Next Steps

Goals on the Quality Workplan require ongoing review to ensure that performance is on target. Goals experiencing challenges or obstacles undergo a root cause/barrier analysis process to identify barriers to goal achievement.

Identifying Opportunities for Improvement

Traditional quality improvement tools such as brainstorming, affinity diagrams, driver diagrams, and priority matrices may be utilized, as deemed appropriate, to address encountered obstacles. Interventions will be developed and implemented using a continuous quality improvement framework.

MCCMH utilizes the Deming Cycle (Plan-Do-Study-Act) in its approach to ongoing quality improvement.

1) The Deming Cycle begins with the **Plan** step, which involves identifying a goal or purpose, formulating a theory, defining success metrics, and putting a plan into action.

2) These activities are followed by the **Do** step, in which the components of the plan are implemented.

3) Next is the **Study** step, where outcomes are monitored to test the validity of the plan for signs of progress and success, or problems and areas for improvement.

4) The **Act** step closes the cycle, integrating the learning generated by the entire process, which can be used to adjust the goal, change methods, or reformulate a theory.

These four steps are repeated as part of iterative cycle of continual improvement.

Analytic Resources

A variety of data sources are utilized to support the ongoing needs of measuring quality in the QI Program. These sources include:

- Medical Records
- Satisfaction Surveys
- Complaint and Appeal data
- Utilization Management Systems
- Claims Data
- Credentialing and Recredentialing data
- HEDIS measurements
- Enrollment data

Internally, the QI program receives support from the Clinical Informatics Division, which is responsible for identifying and collecting data to evaluate program performance and service use. This data is then used to drive the organization's quality management and continuous quality improvement decisions and activities. The Clinical Informatics Team works with Quality datasets to help design and produce reports and dashboards that accurately identify quality improvement opportunities, which are presented to the QI committee for review.

The following definitions describe some of the types of measures utilized by MCCMH:

1. Outcome measures:
   Achievement of goals and/or effectiveness of actions; requires baseline data collection and periodic updates to capture changes in status over time.

2. Fidelity measures:
   Verification that evidenced based practices have been implemented in a manner consistent with prescribed models.

3. Process Measures:
   Compliance with defined timelines, methodologies, and tools; includes administrative and clinical processes; generally, includes a desired level of performance.

4. Satisfaction:
   Degree of stakeholder approval of performance, including primary and secondary persons served, referral sources, providers, and employees.

Compliance with the Balanced Budget Act Of 1997

MCCMH continues to monitor and improve its compliance with the Balanced Budget Act (BBA) of 1997 as outlined in the contract with Michigan Department of Health and Human Services and the Federal Regulations. MCCMH continually reviews its compliance with the requirements of the BBA, as identified by MDHHS and the protocols developed by Centers for Medicaid and Medicare Services (CMS) and implemented by the External Quality Review Organization (EQRO).

V. EXHIBITS

A. MCCMH Governing Body Form