Macomb County Community Mental Health
Quality Improvement Annual Workplan

FY 2025

Approval History:

Entity	Approval Date
Approved by MCCMH Board of Directors	02/26/2025

MCCMH 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, community participation, self-sufficiency, and independence.

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
**Section 1: Quality Program Structure**
Annual Evaluation	MCCMH will submit its 2024 QI Program Evaluation to Quality Committee by Q2 of 2025.	• The Chief Quality Officer complete the Annual Evaluation by February 10, 2025. • The Annual Evaluation is presented to the Quality Committee by Q2 of 2025. The Quality Committee is responsible for providing feedback on the qualitative analysis, proposed interventions, and intervention plan. • The MCCMH Board of Directors reviews the Annual Evaluation and provides feedback. • The MCCMH Board of Directors approves the final version of the Annual Evaluation in February 2025.	Chief Quality Officer Quality Committee MCCMH Board	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
QAPIP Description	Submit QAPIP Description to Quality Committee by end of Q2 of 2025.	• Review the previous year's Quality Improvement Program Evaluation and enhance the current year's Program Description to include previously identified issues as well updated current standards and requirements. • Present QAPIP Description to the Quality committee by Q2 2025. • MCCMH Board of Directors approves QAPIP Description by February 28, 2025.	Chief Quality Officer Quality Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No
QAPIP Workplan	Finalize MCCMH's 2024 QAPIP Workplan by Q1 2025.	• Utilize the Annual Evaluation in the development of the QAPIP Workplan for the upcoming year. • Include measurable goals and objectives. • Develop a calendar of key activities and due dates along with names of responsible staff.	Chief Quality Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:**

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
		• Present formalized work plan to the Quality Committee in Q2 2025. • Present 2025 QAPIP Workplan to Board of Directors by Q2 2025.		N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No
Policies and Procedures	Submit updated policies and procedures to QI Committee as necessary but no less than annually.	• Review necessary policies and procedures, revise as needed to meet regulatory and contractual requirements. • Develop new policies and procedures for areas not currently covered or to meet new regulatory and contractual requirements. • Present updated policies and procedures to the Quality Committee for review and discussion. • Educate and disseminate new policies and procedures as necessary.	Chief Quality Officer Quality and Policy Administrator MCCMH Chiefs and Directors.	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No
Evaluation of network capacity and adequacy.	Evaluate network capacity and adequacy by completing a community needs assessment.	• Review the network and its infrastructure with key stakeholders across internal departments and network.	Chief Quality Officer Chief Network Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:**

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
		• Develop improvement strategies as necessary to improve infrastructure and availability.		**Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No

Evaluation of Quality Committee	• At least annually, assess if the QI Committee has completed the following:
	
	  o Recommends policy decisions.
	
	  o Analyzes and evaluates the results of QI activities.
	
	  o Ensures practitioner participation in the QI program through planning, design, implementation, or review.
	
	  o Identifies needed actions.
	
	  o Ensures follow-up, as appropriate.
		• Review meeting minutes with community stakeholders.
		
		• Evaluate the effectiveness of the committee by implementing a questionnaire where member will assess the committee as it relates to the committee charter and make recommendations.
			Chief Quality Officer	**Goal Met:** ☐ Yes ☐ No
				
				Quarterly Update:
				Q1:
				
				Q2:
				
				Q3:
				
				Q4:
				
				Evaluation:
				
				Barrier Analysis:
				
				Next Steps:
				
				Previously Identified Issue(s)?
				☐ Yes ☐ No

**Section 2: Clinical HEDIS Measures**			

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
Behavioral Health Quality Overhaul 3YR Rollout (HEDIS Performance)	Focus on new Behavioral Health Quality Overhaul 3YR Rollout identified by MDHHS for the 2025 Reporting Year.	• Establish benchmark for Year-1 rollout. • Develop training material to educate the network on the new measures, the baseline standard and how to meet this benchmark. • Track measures proactively and develop improvement plans to increase observed rates. • Provide actionable data to the network providers. • Identify areas for improvement and development of interventions including additional educational materials for providers and persons served. • Continue evaluating incentive programs for providers to improve outcomes.	Chief Quality Officer Quality Administrator	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** Lack of real-time data to implement real-time changes. **Next Steps:** Working on creative methods to obtain real-time data. **Previously Identified Issue(s)?** ☐ Yes ☐ No
Training	Review and update network wide training requirements grid and policy to comply with all internal and external requirements.	• Review current training course descriptions and training grid to ensure information is accurate and up to date.	Chief Clinical Officer Chief Quality Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:**

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
		• Complete any necessary revisions and update to the training requirements policy and exhibits. • Submit revisions to the Quality Committee for internal review and discussion. • Submit updated policy through the policy approval workflow. • Disseminate updated policy and supporting documentation to network.	Quality and Policy Administrator	**Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No
Section 3: Complaints and Potential Quality of Care Issues				
Grievance and Appeals	Establish and report quarterly grievance and appeals rate per 100 member per quarter for 2025.	• Track and trend member grievances and appeals on a quarterly basis. • Identify consistent patterns related to member grievances and appeals. • Develop interventions to address identified issues identified within MCCMH.	Chief Quality Officer Ombudsperson	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:**

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
				N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No
Potential Quality of Care Issues	Create a tracking system to track potential quality issues.	• Develop tracking system for potential Quality of Care Issues that are identified from incident reports received. • Request for corrective action plans from providers where there are systematic concerns with quality of care. • Generate reports and evaluate trends and implement corrective measures where necessary.	Chief Quality Officer CRMC	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** Q1: Q2: Q3: Q4: **Evaluation:** **Barrier Analysis:** No standardized way to effectively track cases. **Next Steps:** Potentially work with IT to implement a tracking system. **Previously Identified Issue(s)?** ☐ Yes ☐ No
Section 4: Provider Access and Availability				
Appointment Availability	Conduct ongoing reviews, at least quarterly, to assess network capacity.	• Educate providers on the requirements for appointment accessibility and availability	Chief Quality Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** Q1:

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
		(from MDHHS and HEDIS standards). • Improve coordination methods for providers to express concerns related to their appointment availability and accessibility of services by establishing and publicizing a direct point of contact. • Provide network quarterly reminders on necessary appointment availability. • MCCMH Leadership continues to meet with providers to understand challenges and identify ways to support providers through the challenges.	Chief Network Officer MCCMH Leadership	**Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** 1. Providers not using FOCUS system calendar as required. **Next Steps:** Working with Finance to incentivize providers to be more creative in offering more available appointments. **Previously Identified Issue(s)?** ☐ Yes ☐ No
**Section 5: Continuity and Coordination of Care**			

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
Continuity and Coordination of Care between Psychiatric Hospitals and Outpatient facilities.	Improve Communication between Psychiatric Hospitals and Outpatient facilities to Reduce Inpatient Readmissions	Interventions include, but are not limited to, the following: • Continue to educate and remind the provider network to proactively engage members served while they are in the hospital which will result in a smoother transition of care. • MCO continue to notify providers of any admissions and discharges in a timely manner; within 24 hours. • Formalize outreach and reminder processes to assist persons served in scheduling post-discharge appointments with their outpatient provider within 7 days of inpatient discharge. • Provide additional training and reminders to MCCMH team and providers on transition of care processes and standards.	Chief Quality Officer Chief Clinical Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** High staff turnover leads to information loss. **Next Steps:** Implement continuous reminders and training as necessary. **Previously Identified Issue(s)?** ☐ Yes ☐ No
Continuity and Coordination of Care between medical and behavioral/ment	Improve coordination between medical and behavioral health providers.	• Improve compliance in obtaining consent from persons served to authorize sharing of health information	Chief Quality Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:**

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
al health providers.		between primary care practitioners and behavioral health providers. • Implement an ongoing process to educate providers on effective care coordination and how they can improve current processes in accordance with policy 2-0424 Service Referrals/Recommendations, Coordination of Care, and Follow-up / Advance Directive.	Chief Clinical Officer	**Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** High staff turnover leads to information loss. **Next Steps:** Implement continuous reminders and training as necessary. **Previously Identified Issue(s)?** ☐ Yes ☐ No
Section 6: Member Satisfaction				
Member Satisfaction	Improve the collection method and data analysis of member satisfaction surveys to improve participation. Review/evaluate the impact of Limited English Proficiency on survey completion (i.e. improving access for completion of survey by providing services in alternate formats that will meet LEP needs).	• Develop interventions to address areas for improvement based on member satisfaction survey results from the 2024 survey. • Meet one on one with providers who have low scores in various areas to discuss ways to support them to improve their scores. • Develop and implement new initiatives to get members to be more engaged in	Chief Quality Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** N/A

Quality Assessment and Performance Improvement Program Workplan / Calendar Year 2025

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
		responding to these surveys.		**Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No
Section 7: Provider Satisfaction				
Provider Satisfaction	Implement the administration and data analysis of provider satisfaction surveys to improve the provider network.	• Complete provider satisfaction survey by Q3 2025. • Identify opportunities for improvement based on the survey findings. • Develop interventions to address areas for improvement based on provider satisfaction survey.	Chief Quality Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** Q1: Q2: Q3: Q4: **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No
Section 8: Key Performance Indicators				
Key Performance Indicators (MMBPIS and HEDIS)	MCCMH will continue to track and trend the following areas based on Michigan's Mission-Based Performance Indicator System (MMBPIS) developed by MDHHS: • Indicator #1 Percent of Medicaid children/adults receiving a pre-	• Collect and monitor data on performance measure activities on a quarterly basis throughout FY25. • Analyze provider specific data monthly.	Chief Quality Officer Director of SUD	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** Q1: Q2: Q3:

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
	admission screening for psychiatric inpatient care for whom the disposition was completed within three hours (Standard: 95%) • Indicator #2 Percent of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. (Standard 2: reach or exceed the 50th percentile <57%) (Standard 2e: maintain or exceed the 75th percentile <75.3%) • Indicator #3 Percent of new persons starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. (Standard: reach or exceed the 50th-75th percentile 72.9%-83.8%) • Indicator #4a (4b SUD) Percent of persons discharged from a psychiatric inpatient (Withdrawal Management/Detox) unit who are seen for follow-up care within 7 days (Standard: 95%)	• Conduct monthly Provider meetings to share and discuss statistical outliers. Conduct root cause analyses on negative statistical outliers, as they occur. • Perform primary source verification (PSV) on a quarterly basis for all Indicators to ensure continuous validation efforts. • Compile indicator data for templated reports on performance measures to submit quarterly to MDHHS. • Define MCCMH standards for timely access to specific services, formalize, standardize and distribute improvement initiatives to the network. • Develop process improvement plans for negative trends and patterns identified. Implement a	Chief Clinical Officer IT/IS Division Quality Administrators	**Q4:** **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
	• Indicator #10 Percent of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge. (Standard: 15% or less within 30 days) • For the new HEDIS indicators, the Quality Department will review current data and establish state and agency benchmarks.	tracking mechanism to ensure improvement plans are meeting the need based on the negative trends. • Provided status updates quarterly to the Quality committees. • Share data and educate the providers about these new HEDSI indicators. • Create quick reference tools for each new KPI to allow providers to better understand the KPI and how to meet the requirements.		
**Section 9: Performance Improvement Areas**			
Performance Improvement Project (PIP) # 1	Increase percentage of adults receiving follow-up appointments and reduce racial disparity between Caucasian and African American persons served post inpatient psychiatric hospitalization.	• Continue to reassess the number of available appointments at MCCMH North and East for individuals discharged from inpatient hospital settings and identify areas for further expansion. • Collaborate with providers monthly to assess and bridge barriers to follow-up care.	Chief Quality Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** Q1: Q2: Q3: Q4: **Evaluation:** **Barrier Analysis:**

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
		• Continue to provide continuous reminders to provider network on the required standard and detail expectations. • Have ongoing provider meetings to understand barriers and work through mitigation. • Pull data, broken down by provider, on providers' compliance rates for seeing persons served 7 days after being discharged from an inpatient unit. Follow up with certain providers to assess if additional support is needed by Q2, 2025.	Director of Clinical Informatics	N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No
Performance Improvement Project (PIP) # 2	Increase the number of MCCMH persons served enrolled in the MDHHS Habilitation Supports Waiver (HSW) Program.	• Review available data showing MCCMH population's enrollment in the HSW Program with provider network by Q2, 2025.	Chief Quality Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** Q1: Q2: Q3:

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
		• Coordinate to identify barriers to enrollment in the HSW Program by Q2 2025. • Run paid Claims reports to identify persons served currently utilizing HAB-like services at high volume (H2014, H2015, H2000, etc.) by Q2, 2025 • Complete case reviews of currently enrolled HSW beneficiaries to identify service trends by Q2, 2025 • Continue coordination and communication strategies with Provider Network to increase enrollment numbers by June 30, 2025. • Monitor effectiveness of interventions through data reporting and HSW enrollees.	Chief Network Officer	**Q4:** **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No
Critical Incidents, Sentinel Events, and Other Risk Events	Improve the continuous review and reporting of critical incidents, sentinel event, and other risk event to identify trends and patterns and develop tailored improvement strategies, as needed. Objectives:	• The Quality Department continues to review every incident report received and categorize them as either a sentinel event, critical incident, risk event or immediately reportable event.	Chief Medical Officer Chief Quality Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** Q1: Q2: Q3:

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
	• MCCMH's Critical Risk Management Committee (CRMC) will formalize its documented process for reviewing and disseminating quarterly reports on critical incident data collected by Q2 of 2024. • Documented meeting minutes will demonstrate the presentation and review of the quarterly reports at the CRMC and Quality Committee.	• CRMC continues to evaluate provider's root cause analyses for sentinel events and report findings and trends of data to the Quality Committee. • Track suicide deaths and attempts, evaluate this data, and address ways to counteract through policies, processes and best practices. • Using data from incident reporting, MCCMH will continue to implement Zero Suicide initiatives to reduce suicide deaths to zero.	Chief Clinical Officer	**Q4:** **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No
Behavior Treatment Review Committee (BTPRC)	Foster development of effective behavior treatment plans to decrease the use of emergency physical management interventions. Objective: MCCMH will identify a baseline and work to decrease the use of emergency physical management in all cases on restrictive and/or intrusive behavior treatment plans reviewed by the Behavior Treatment Plan Review Committee (BTPRC) to no more than between 5 to 10 % of total cases reviewed.	• Conduct quarterly training for new behaviorists on the BTPRC policy, process, and presentation to the BTPRC for all plans utilizing restrictive and/or intrusive interventions. • Review cases with excessive use of emergency physical management (3 or more times in a 30-day period) more frequently than quarterly to assure effectiveness of plan and interventions.	Chief Clinical Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** Q1: Q2: Q3: Q4: **Evaluation:** **Barrier Analysis:** N/A **Next Steps:**

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
		• Provide approval or disapproval for behavior treatment plans that pose to utilize restrictive of intrusive techniques. • Present quarterly reports to the Quality Committee. • Educate providers on the updated BTPRC policy.		**Previously Identified Issue(s)?** ☐ Yes ☐ No
Clinical Practice Guidelines	Continuing to review Clinical practice guidelines and identify areas for ongoing improvements.	• Utilize findings from the Community Needs Assessment to identify and address MCCMH's populations' needs by Q3 2025. • Update Clinical Practice Guidelines based on results of the Community Needs Assessment. • Present and discuss updated Clinical Practice Guidelines based on results of the Community Needs Assessment with the Quality Committee and other stakeholders.	Chief Clinical Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
		• Distribute updated Clinical Practice Guidelines to stakeholders as necessary.		
Credentialing and Re-Credentialing	Continue to review and finalize credentialing and re-credentialing process within MCCMH. This will include streamlining the process and the tracking mechanism.	• Review current credentialing and re-credentialing workflows and adjust as necessary.	Chief Quality Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** Q1: Q2: Q3: Q4: **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No
Verification of Services	• Improve quality and consistency of supporting documentation for submitted claims.	• Participate in ongoing reviews of audit reports and identify improvement areas. • Provide technical assistance and timely consultation to providers when documentation issues are identified.	Chief Quality Officer Finance Director	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** Q1: Q2: Q3: Q4: **Evaluation:**

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
		• Develop and provide training to network on record documentation, corporate compliance, and billing practices.		**Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No
Utilization of Services	• The UM Committee will analyze claims and encounter data to create and review utilization reports. • Reports and collected data sets will be referenced and utilized to update MCCMH's risk management strategies and other managed care functions.	• Appropriate utilization management data points will be identified in Q1 2025 and discussed at the UM committee. • Clinical Informatics Department in collaboration with the Finance Department to develop appropriate utilization reports to capture needed data by Q2 2025. • Risk management strategies will be outlined and updated to incorporate the report's findings by Q3 2025.	Managed Care Operations Division Clinical Informatics Division Finance Director	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** Q1: Q2: Q3: Q4: **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No
Integrated care plans for Vulnerable Individuals	MCCMH serves a population of vulnerable individuals considering most of the population is SMI or SED with co-occurring conditions such as physical health concerns or substance use disorder. To this respect MCCMH	• Train new staff and provide refresher training on plans of service and writing integrated care plans.	Chief Clinical Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** Q1: Q2:

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
	will assure individuals have integrated care plans. Objectives: Baseline data will be collected on individuals' access to integrated care plans. Data from each quarter should demonstrate increases in the percentage of integrated care plans written.	• Provide training on physical health concerns and substance use disorders to write more effective integrated care plans. • Improve easy access to persons served friendly fact sheets on chronic health conditions.		**Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No
Provider Network	Update provider contracts and improve the visibility and accessibility of MCCMH's provider network in FY 2025.	• Finalize interactive time and distance mapping software. • Develop formalized process for ongoing review and updates to published mapping software.	Chief Network Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** Q1: **Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
Long-Term Services and Supports (LTSS)	• Assess, through quantitative and qualitative methods, long-term services and supports settings and compare coordination of services and supports received based on documented plans of service.	• Quarterly review care coordination for LTSS persons served through Quality Record Reviews. • Compile aggregated findings and identify trends and patterns. Aggregated data will be presented to the QI Committee for review. • QI Committee determine improvement opportunities in LTSS care coordination. • QI Committee develop and implement interventions to improve care coordination in identified areas.	Chief Quality Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No

Section 10: External Monitoring				
Indicator	**Target and Objective**	• **Planned Activities**	**Responsible Staff/ Department**	**Status Update**
Audits (Hospital, Primary Providers and Residential)	Conduct annual quality audits of network hospitals for MDHHS' Inpatient Hospital Reciprocity Group and contracted providers.	• Prepare for and conduct quality audits using various audit tools. • Complete and distribute final reports for reviewed by providers. • Aggregate and trend findings from reviews. • Present findings to Quality Committee by Q4 2025 and discuss opportunities for improvement.	Chief Quality Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No

Indicator	**Target and Objective**	**Planned Activities**	**Responsible Staff/ Department**	**Status Update**

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
CARF Accreditation	Review current practices to ensure ongoing adherence to Commission on Accreditation of Rehabilitation Facilities (CARF) standards.	• Review current directly operated policies and procedures to ensure information is accurate and up to date. • Complete any necessary revisions and updates to formalized documentation. • Conduct ongoing self-audits to ensure current practices align with internal and external requirements.	Chief Quality Officer Director of Community and Behavioral Health Services	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
Customer Service Metric	Ensure compliance with all Customer Service metrics. Present data to QI Committee quarterly or as scheduled.	• Compile Customer Service Key Performance Indicator (KPI) data quarterly. • Develop and implement strategies to ensure compliance with the established Customer Service KPI benchmarks.	Customer Service Administrator	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:**

				Evaluation:
				Barrier Analysis: N/A
				Next Steps:
				Previously Identified Issue(s)? ☐ Yes ☐ No

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
NCQA Accreditation	Prepare and submit for initial managed behavioral health care organization (MBHO) accreditation through the National Committee for Quality Assurance (NCQA).	• Review all current policies, procedures, case files, and reports to ensure appropriate adherence to NCQA MBHO standards. • Continue to work with consultant group, The Mihalik Group (TMG), to assess any gaps in documentation or established process flows. • Submit initial application for NCQA MBHO accreditation.	Chief Operations Officer Quality and Policy Administrator	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No

Health Plan	Expand care coordination initiatives to include individuals with Bipolar/Major Depression/Schizophrenia, at-risk with their BMI, waist circumference, and vital signs indication of high blood pressure, and diagnosed with a chronic healthcare condition as identified collaboratively with the MHPs. Continue collaboration with the MHPs to improve racial disparity rates and to improve the overall FUH, FUA, SAA-AD, and IET performance rates as defined in the HEDIS measures.	• Review current data and ensure required datapoints can be pulled from the FOCUS system. • Work with IT/PCE to develop report for date pull. • Identify benchmark and educate provider network as necessary. .	Chief Quality Officer Quality Administrator	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** Q1: Q2: Q3: Q4: **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No
Indicator	**Target and Objective**	**Planned Activities**	**Responsible Staff/ Department**	**Status Update**
PIHP CCBHC Oversight	The PIPH will ensure that CCBHCs comply with the CCBHC handbook and the contract requirements.	• After determining system impact, the PIHP will revise the workflow process for enrolling and dis-enrolling CCDHC eligible individuals in the WSA by the end of Q2. • The PIHP will define and implement a process to retrospectively review CCBHC services to confirm	Chief Clinical Officer Director of Managed Care Operations.	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** Q1: Q2: Q3: Q4: **Evaluation:**

		that the care was medically necessary by Q3. • The PIHP will identify, review elements, develop review tools, define sample size and implement a schedule for retrospective reviews by Q3.	Chief Quality Officer	**Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No