Macomb County Community Mental Health
Quality Improvement Annual Work Plan

FY 2026

Approval History:

Entity	Approval Date
Approved by MCCMH Board of Directors	02/25/2026

MCCMH Mission

Macomb County Community Mental Health (MCCMH), 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 2025 QI Program Evaluation to the Quality Committee by Q2 of 2026.	• The Chief Quality Officer completes the Annual Evaluation by February 10, 2026. • The Annual Evaluation is presented to the Quality Committee by Q2 of 2026. 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 2026.	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
QAPIP Description	Submit QAPIP description to Quality Committee by the end of Q2 of 2026.	• Review the previous year's Quality Improvement Program Evaluation and enhance the current year's Program Description to include previously identified issues, as well as updated	Chief Quality Officer Quality Committee	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2:** **Q3:**

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
		current standards and requirements. • Present QAPIP Description to the Quality Committee by Q2 2026. • MCCMH Board of Directors approves QAPIP Description by February 28, 2026.		**Q4:** **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No
QAPIP Workplan	Finalize MCCMH's 2026 QAPIP Work Plan by Q1 2026.	• 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. • Present formalized work plan to the Quality Committee in Q2 2026. • Present the 2026 QAPIP Work Plan to Board of Directors by Q2 2026.	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
Policies and Procedures	Submit updated policies and procedures to the QI Committee as necessary, but no less than annually.	• Review necessary policies and procedures, and 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 Respective 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. • Develop improvement strategies as necessary to improve infrastructure and availability.	Chief Quality Officer Chief Network Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** Q1: Q2: Q3: Q4: **Evaluation:**

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
				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 members 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				
Behavioral Health Quality Overhaul Year 3 Rollout (HEDIS Performance)	Focus on the new Behavioral Health Quality Overhaul Year 3 Rollout identified by the Michigan Department of Health and Human Services (MDHHS) for the 2026 Reporting Year.	• Establish a benchmark for Year 2 rollout. • Develop training material to educate the network on Year 2 measures, the baseline	Chief Quality Officer Clinical Administrator	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** Q1: Q2: Q3:

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
		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.		**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 the network-wide training requirements grid and policy to comply with all internal and external requirements, including updates in the latest CCBHC handbook.	• Review current training course descriptions and the training grid to ensure information is accurate and up-to-date. • Complete any necessary revisions and updates to the training requirements policy and exhibits.	Chief Clinical Officer Chief Quality Officer Quality and Policy Administrator	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:**

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
		• 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 the network.		**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 the quarterly grievance and appeals rate per 100 members per quarter for 2026, and the quarterly grievance, appeals, and service denials report on Certified Community Behavioral Health (CCBHC) individuals served, both Medicaid and non-Medicaid members.	• 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 within MCCMH. • Review feedback from the member experience survey and implement solutions.	Chief Quality Officer Ombudsperson	**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
Potential Quality of Care Issues	Create a mechanism to track potential quality of care issues.	• Develop a tracking process in collaboration with other departments to track and address Quality of Care Issues that are identified from incident reports received (Critical Risk Management Committee [CRMC]) and other sources. • 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 Committees Departments	**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.	• Continue to educate providers on the requirements for appointment accessibility and availability (from MDHHS and HEDIS standards). • Improve coordination methods for providers to express concerns related to	Chief Quality Officer Chief Network Officer MCCMH Leadership	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** Q1: Q2: Q3: Q4:

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
		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.		**Evaluation:** **Barrier Analysis:** 1. Providers are 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				
Continuity and Coordination of Care between Psychiatric Hospitals and Outpatient Facilities	Improve communication between Psychiatric Hospitals and Outpatient facilities to reduce inpatient readmissions. This includes CCBHC and DCO outpatient facilities.	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. • Managed Care Operations (MCO) to continue to notify providers of any admissions	Chief Quality Officer Chief Clinical 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
		and discharges in a timely manner, within 24 hours. • Assess transition team initiatives and identify additional areas for improvement.		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/Mental Health Providers	• Improve coordination between medical and behavioral health providers. • Work with the Medical Director's Office to track coordination of care, including integrated care plans, signed consents for medical providers, and evidence of coordination of care among Direct and DCO CCBHC service providers. • Work with Network Operations to provide education and reminders when expectations are not met.	• Improve compliance in obtaining consent from persons served to authorize sharing of health information 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 Quality Officer Chief Medical 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

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
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 2025 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 responding to these surveys.	Chief Quality Officer Quality Coordinator	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** N/A **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 2026. • Identify opportunities for improvement based on the survey findings. • Develop interventions to address areas for improvement based on the provider satisfaction survey.	Chief Quality Officer Quality Coordinator	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:** **Evaluation:**

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
				Barrier Analysis: N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No
**Section 8: Key Performance Indicators**			
Key Performance Indicators (MMBPIS, HEDIS, and CCBHC)	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-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%)	• Collect and monitor data on performance measure activities on a quarterly basis throughout FY25. • Analyze provider-specific data monthly. • Conduct monthly provider meetings to share and discuss statistical outliers. Conduct root cause analyses (RCA) on negative statistical outliers as they occur. • Perform primary source verification (PSV) on a quarterly basis for all indicators to ensure continuous validation of efforts.	Chief Quality Officer Director of SUD Chief Clinical Officer IT/IS Division Quality Coordinator	**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 #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%) • 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. • CCBHC Measures:	• 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 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.	Quality Administrator	

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
	o I-SERV – three sub-measures: average number of days to initial evaluation; average number of days to initial clinical service; average number of hours to crisis service. o FUH-AD and FUH-CH – Follow-Up After Hospitalization for Mental Illness, adults and children 6-17. Two sub-measures: 30-day follow up; 7-day follow up. ▪ Goal: increase 30-day follow up for adults by 3% and children by 5% ▪ Goal: increase 7-day follow up for adults by 3% and for children by 3% o IET-AD: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – two sub-measures: SUD episodes resulting in treatment initiation within 14 days; SUD episodes with evidence of treatment engagement within 34 days.	• Continue creating quick reference tools for the new Key Performance Indicators (KPI) to allow providers to better understand the KPI and how to meet the requirements.		

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
	▪ Goal: increase percentage of initiation by 3%; increase engagement by 5%. ○ PCR-AD: Plan All Cause Readmission – reduce readmission rate by 2.5%			
		Section 9: Performance Improvement Areas		
Performance Improvement Project (PIP) #1 (Also Meets CCBHC Requirement)	Increase the 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. • Continue to provide continuous reminders to the Provider Network on the required standard and detail expectations. • Have ongoing provider meetings to understand	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
		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, 2026. • Evaluate the effectiveness of Quality Initiatives implemented and revise the plan as needed.	Quality Coordinator	
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, 2026. • Coordinate to identify barriers to enrollment in the HSW Program by Q2 2026. • Run paid claims reports to identify persons served currently utilizing HAB-like services at high volume	Chief Quality Officer Chief Network Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** Q1: Q2: Q3: Q4: **Evaluation:** **Barrier Analysis:** N/A

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
		(H2014, H2015, H2000, etc.) by Q2, 2026 • Continue coordination and communication strategies with the Provider Network to maintain enrollment numbers by Q2, 2026.		**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 events, and other risk event to identify trends and patterns and develop tailored improvement strategies, as needed. Objectives: • MCCMH's 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.	• 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. • CRMC continues to evaluate providers' RCA 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. • Track fatal and non-fatal overdoses, evaluate this data, and address ways to counteract them through	Chief Medical Officer Chief Quality Officer Quality Administrator Clinical Administrator Quality Case Manager	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2: Designated CRMC task Force compete project around further supporting coordination of care efficiency Enforcing the changes made to the medication error reporting policy.** **Q3: Tracking of medication error IRs continued.** **Q4: first medication error trends report for year 2025** **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **CRMC task force will be designated in 2026 to work on recommendations that may**

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
		policies, processes, and best practices. • Track and review all-cause mortality among CCBHC recipients and develop strategies to mitigate risk. • Using data from incident reporting, MCCMH will continue to implement Zero Suicide Initiative to reduce suicide deaths to zero.		**address the most significant trends noted in 2025.** **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. <u>Objective:</u> MCCMH will 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 5 and 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. • Conduct quarterly reviews on cases with restrictive and/or intrusive behavior treatment plan interventions AEB meeting minutes and BTPRC Action forms documenting approval or disapproval of interventions. • Provide approval or disapproval for behavior treatment plans that are	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
		proposed to utilize restrictive intrusive techniques. • Present quarterly reports to the Quality Committee.		
Clinical Practice Guidelines	Continuing to review Clinical Practice Guidelines and identify areas for ongoing improvements.	• Review and update the clinical practice guidelines as the need arises. • Present and discuss updated Clinical Practice Guidelines with the Quality Committee and other stakeholders. • Distribute updated Clinical Practice Guidelines to stakeholders as necessary.	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
Credentialing and Re-Credentialing	Continue to review and finalize the credentialing and re-credentialing process within MCCMH. This will include streamlining the process and the tracking mechanism.	• Review and update current credentialing and re-credentialing workflows to fully align with the new state system. • When processes don't align between state requirements and NCQA, reach out to the state to make the necessary adjustments. • Continue to review and update the credentialing process to align with NCQA accreditation requirements.	Chief Quality Officer Quality Office Administrator	**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. • Develop and provide training to the network on record documentation, corporate	Chief Quality Officer Finance Director Chief Network Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** Q1: Q2: Q3: Q4: **Evaluation:** **Barrier Analysis:** N/A

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
		compliance, and billing practices. • Work with the Provider Network to address identified deficiencies.		**Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No
Utilization of Services (UM)	• 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 Q2 2026 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 2026. • Risk management strategies will be outlined and updated to incorporate the report's findings by Q3 2026.	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. In this respect, MCCMH will assure individuals have integrated care plans.	• Train new staff and provide refresher training on plans of service and writing integrated care plans. • Provide training on physical health concerns and substance use disorders to write more	Chief Clinical Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2:** **Q3:**

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
	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.	effective integrated care plans. • Improve easy access for persons served to friendly fact sheets on chronic health conditions.		**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 2026.	• Develop a formalized process for ongoing review and updates to published mapping software.	Chief Network Officer SUD Director	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No
Long-Term Services and	• Assess, through quantitative and qualitative methods, long-term services and supports settings, and	• Review care coordination for LTSS persons served through Quality audits.	Chief Quality Officer	**Goal Met:** ☐ Yes ☐ No **Quarterly Update:**

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
Supports (LTSS)	compare coordination of services and supports received based on documented plans of service.	• Compile aggregated findings and identify trends and patterns. Aggregated data will be presented to the Quality Committee for review. • Quality Committee determine improvement opportunities in LTSS care coordination. • Quality Committee develops and implements interventions to improve care coordination in identified areas.		**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 updated audit tools. • Complete and distribute final reports for review by providers. • Aggregate and trend findings from reviews. • Present findings to the Quality Committee by Q4 2026 and discuss opportunities for improvement.	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

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 formalize documentation. • Apply for reaccreditation by completing the application package by Q1, 2026. • Conduct mock audits to ensure current practices align with CARF requirements.	Chief Quality Officer Director of Community and Behavioral Health Services 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
Customer Service Metric	Ensure compliance with all Customer Service metrics. Present data to the QI Committee quarterly or as scheduled.	• Compile Customer Service (KPI data quarterly. • Develop and implement strategies to ensure compliance with the established Customer Service KPI benchmarks.	Customer Service Administrator	**Goal Met:** ☐ Yes ☐ **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:**

Indicator	Target and Objective	Planned Activities	Responsible Staff/ Department	Status Update
				Evaluation: **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?** ☐ Yes ☐ No
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 2026 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 Quality Officer Chief Operations Officer	**Goal Met:** ☐ Yes ☐ **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** N/A **Next Steps:** **Previously Identified Issue(s)?**

| Health Plan | Expand care coordination initiatives to include individuals with Bipolar/Major Depression/Schizophrenia, at risk with their BMI, waist circumference, and vital signs indicating 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 data points can be pulled from the FOCUS system.

• Work with IT/PCE to develop report for the data pull.

• Identify benchmarks and educate the Provider Network as necessary. | Chief Quality Officer

Quality Administrator | **Goal Met:** ☐ Yes ☐

Quarterly Update:
Q1:

Q2:

Q3:

Q4:

Evaluation:

Barrier Analysis:
N/A

Next Steps:

Previously Identified Issue(s)?
☐ Yes ☐
No |

(Top of page, continued cell:) ☐ Yes ☐ No

Section 11: MI Coordinated Health (MICH) Program and Coordination Agreements with HIDE-SNPs				
Indicator	**Target and Objective**	• **Planned Activities**	**Responsible Staff/ Department**	**Status Update**
MI Coordinated Health (MICH) Program and Coordinating Agreements with Highly Integrated Dual Eligible-Special Needs Population (HIDE-SNP)	MI Health Link (MHL) enrollees will benefit from the enrollment transition from the Integrated Care Organizations (ICO) to a HIDE-SNP plan with their respective health plan provider. Any beneficiaries engaged in behavioral health services with Macomb, during the program transition, will continue to be served at Macomb without interruption or change in their care. Macomb will also provide services to any newly enrolled MICH members who wish to engage in and prefer to	• Monthly exchange of enrollment and eligibility files • Ongoing Care Coordination efforts with the Community Mental Health Service Programs (CMSHP) Case Holders and HIDE-SNP Care Coordinators • Participation in Integrated Care Team (ICT) Meetings	Chief Quality Officer Quality Administrator	**Goal Met:** Yes No **Quarterly Update:** **Q1:** **Q2:** **Q3:** **Q4:** **Evaluation:** **Barrier Analysis:** N/A **Next Steps:**

	receive Behavioral Health Services with a Macomb Provider.		**Previously Identified Issue(s)?** Yes No