WEST MICHIGAN COMMUNITY MENTAL HEALTH

Quality Assurance / Performance Improvement Plan

Introduction

It is the mission of West Michigan Community Mental Health (WMCMH) to partner in coordinating and providing high quality care for children, adults and families experiencing mental illness, intellectual/ developmental disabilities, and substance use disorders. The role of the Department of Service Enhancement (the structural "home" of Performance Improvement / Quality Assurance at WMCMH) is to partner and coordinate with staff throughout the organization to support WMCMH efforts to constantly improve the quality of services we provide in our three-county region. Part of the foundation for a strong quality improvement program is a performance improvement plan that provides a written description of the structural and evaluative components of the performance improvement (PI) / quality assurance (QA) process at WMCMH. A Performance Improvement Plan also explains the interaction between organizational level QA/PI functions and quality oversight at the prepaid inpatient health plan (PIHP) level. The foundation of a strong quality improvement plan at any level is a planned, systematic, organization-wide approach to the monitoring, analysis and coordination of performance improvement activities designed to improve the quality of care and services provided.

Philosophical Orientation

WMCMH Strategic plan indicates that providing quality services, improving clinical outcomes, and maintaining an outcome focus is the responsibility of everyone in the organization. Additionally, structures such as the Performance Improvement Oversight Committee and the WMCMH Executive Team facilitate and provide structure and oversight to this at the organizational level to ensure that the expected quality of care is achieved consistently. The affiliation-level Regional Quality Advisory Team and Lakeshore Regional Entity Chief Operating Officer advance this quality mandate across the 7-county region of the PIHP. Each of these structures interacts to support adherence to organizational and contractual standards of care.

As a specific structure, the WMCMH Performance Improvement Oversight Committee (PIOC) is responsible for facilitating the successful implementation of a strong Quality Assurance and Performance Improvement Process throughout the organization. When committee members are working together as a PIOC, they function as a team committed to organization-wide improvement and act in support of the best interests of the organization and those the organization serves. The role of each member on PIOC is to represent the organization in fulfilling its mission of ongoing improvement in customer care. Each member of PIOC brings subject matter expertise to discussions. *Although membership on other organizational teams is part of this expertise, PIOC members are asked to think more globally of the organizational team while at the PIOC table.* We are one team of diverse experts with a set of common goals. Our committee is a dynamic, evolving, working committee.

Authority

A strong quality assurance and performance improvement process requires consistent accountability across the organization. This means that the PIOC has the ability to recommend to the WMCMH Executive Team that opportunities for improvement are prioritized and specific actions to address these improvement opportunities are taken. Ultimate authority for Quality Assurance / Performance Improvement at WMCMH rests with the WMCMH Board of Directors, who vests responsibility for all operations of the organization with the WMCMH Executive Director. The WMCMH Executive Director places responsibility for the leadership, implementation, and overall organizational coordination of Performance Improvement / Quality Assurance Activities with the Deputy Director of Service Enhancement.

PIOC Membership

PIOC is chaired by the Quality Assurance and Public Relations Coordinator with the Service Enhancement Administrative Assistant acting as the Recorder. The committee is comprised of:

- Deputy Director of Service Enhancement;
- Quality Assurance and Network Coordinator;
- Support Services Coordinator;
- Clinical Services Team Leaders for Service Entry, Adults with a Mental Illness, Children and Adults with a Developmental Disability, Children with a Mental Illness, and Health Services Team; and
- Representative from the WMCMH Consumer Advisory Panel.

Ad hoc members include all members of the Executive Team, the Medical Director, Regulations and Rights Officer, Human Resources Coordinator, Information Services Coordinator, contract providers and/or other stakeholders, and any member of the WMCMH staff.

Responsibilities and Accountability

1. The **Lakeshore Regional Entity (LRE) Board of Directors** is accountable for quality assessment and performance improvement activities across the 7-county affiliation / PIHP. The LRE Board will annually review and evaluate the written Regional Quality Assessment and Performance Improvement Plan. The Board will regularly receive specific reports of affiliation-wide performance indicators, quality oversight activities, and corrective actions as requested. They vest authority for management of Quality Oversight to the Chief Operating Officer (COO) for the LRE. The LRE COO is responsible for implementation of Quality Oversight at the PIHP Level and is responsible for facilitation of the affiliation-wide Quality Oversight Committee.

   Members of the WMCMH PIOC sit as members of the LRE Regional Quality Advisory Team and support affiliation-wide Quality Oversight Functions.

   As part of the contractual arrangement between the LRE and WMCMH, Quality Assurance / Performance Improvement is a delegated function, whereby the affiliation ensures compliance with federal and state requirements for a functioning quality improvement system but WMCMH is responsible for implementation. All Community Mental Health Service Programs, as part of this arrangement, will develop, implement and maintain quality improvement programs and will report results of monitoring and improvement activities to the Regional Quality Advisory Team as requested.

2. The **WMCMH Board of Directors** is accountable for QA and PI activities across the 3-county region. The Board will review and evaluate the Quality Assurance and Performance Improvement Plan annually. They will receive reports on the performance of WMCMH on State, Accrediting Body, and PIHP site visits (annually), contractual performance improvement indicators (quarterly), and day-to-day QA / PI activities (monthly).

3. The **WMCMH Executive Director** is ultimately responsible for QA / PI activities of the organization. The Executive Director has the authority to require providers, departments, and teams within the organization to comply with all contractual and organizational requirements.

4. The **WMCMH Executive Team** includes the Executive Director and all Deputy Directors. All members of this team are ad hoc members of the PIOC. Deputy Director of Service Enhancement is responsible for sharing all recommendations of the committee with the Executive Team for review. The Executive Team is responsible for evaluating recommendations, evaluating plans of correction, and prioritizing critical

organizational activities. Recommendations regarding QA / PI issues may come from PIOC as well as from individual departments, teams, and staff throughout the organization.

5. The **WMCMH Medical Director** actively participates as an ad hoc member of the PIOC and provides medical and clinical expertise relative to the QA / PI activities of the organization when needed.

6. The **PIOC** is the primary body responsible for reviewing the quality and performance of services across the organization and making recommendations for prioritization of improvement opportunities. The PIOC also is responsible for evaluating the effectiveness of WMCMH's QAPIP on an annual basis.

7. **Individuals served by the organization** are standing members of the PIOC, with the same responsibilities as all members of the committee.

Ongoing Expectations

Consistent with strong models of quality improvement and quality oversight, the unifying focus of the WMCMH QA / PI program is on the ongoing performance measurement, analysis of information, and data-based decision making at all levels of the organization. The performance measures employed will be based upon the following priorities:

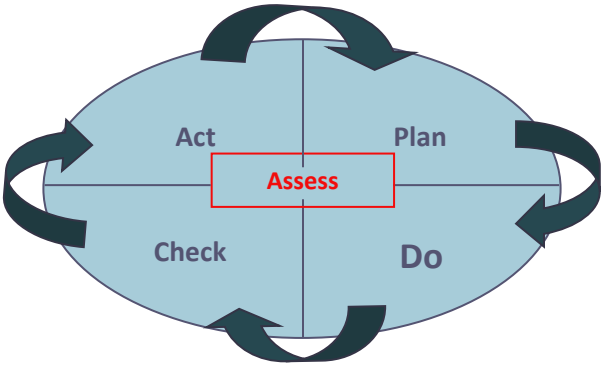
1. Federal requirements for prepaid health plans (as this is a delegated function in our affiliation);
2. DHHS/PHIP, DHHS/CMHSP and PIHP/CMHSP contractual requirements;
3. Accrediting Body standards;
4. Stakeholder surveys, and;
5. Additional items indicated through analysis of performance measures and other data.

Purpose of the WMCMH Performance Improvement Oversight Committee (Committee Charge)

WMCMH has identified 5 main purposes for the PIOC.

1. Link, monitor, and coordinate activities around organizational performance improvement priorities;
2. Provide support to organizational efforts to integrate a performance improvement philosophy into the everyday work of the organization;
3. Make recommendations to Executive Team for specific improvement actions / changes;
4. Communicate improvements and challenges within and outside the organization; and
5. Weigh risks and opportunities associated with identified organizational performance improvement opportunities.

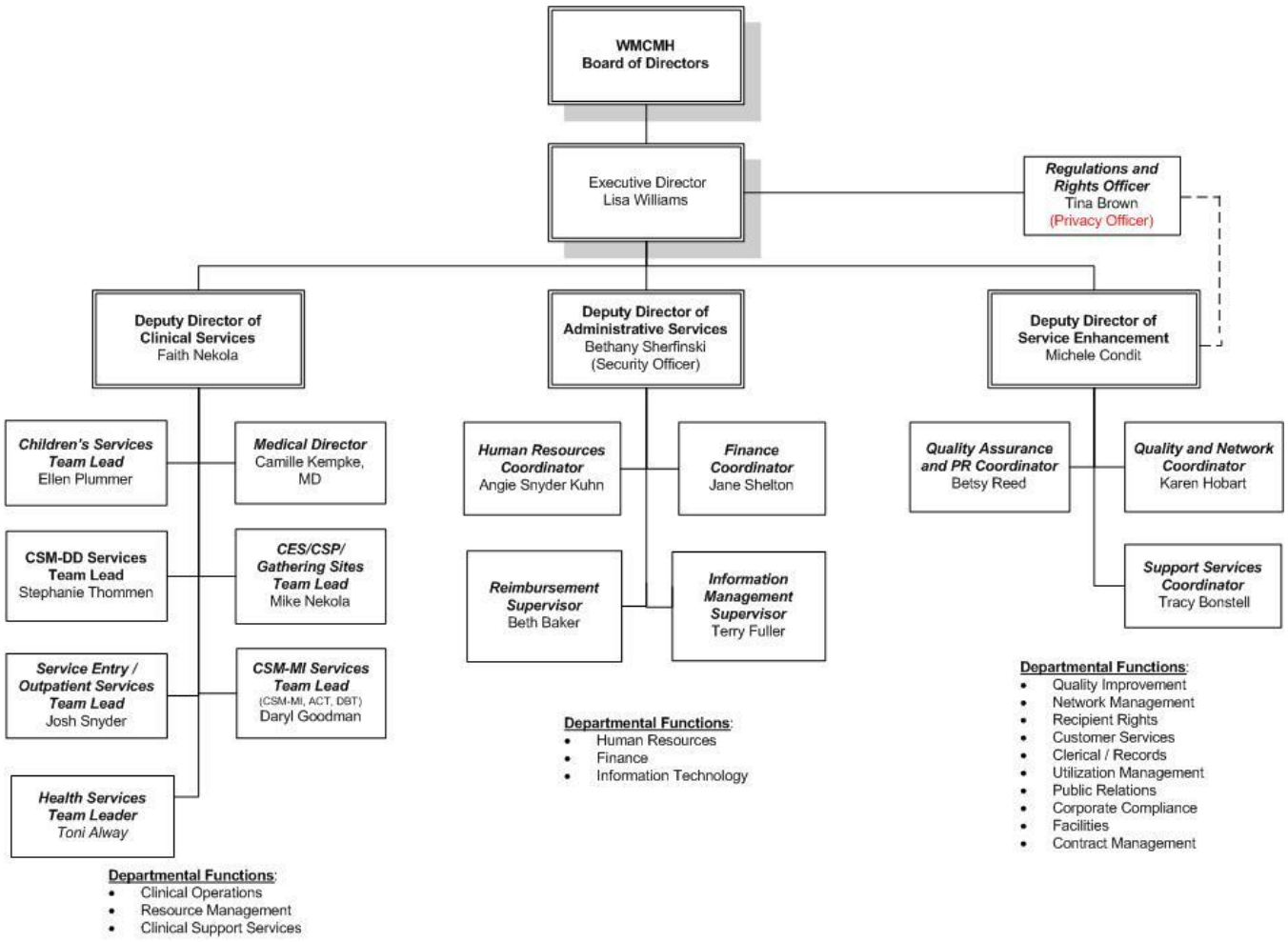
Throughout all quality assessment performance improvement activities whether occurring at the Regional Quality Assurance Advisory level or PIOC level, the Shewhart Cycle of continuous improvement is used to facilitate activities. The Shewhart Cycle is illustrated below:



As the Shewhart Model suggests, Plan, Do, Check, Act (PDCA) is a continuous process, meaning that at times the agency loops back to previous phases to adjust or revise what the agency has implemented to enhance the desired outcome. Additionally, assessment is a critical core, meaning the agency ALWAYS continuously assesses performance relative to the desired outcome throughout the PDCA process.

WMCMH Organizational Structure

Below is the WMCMH Organizational Structure.



Sentinel Events

Sentinel events are identified as part of the Critical Incident Review Process at WMCMH. WMCMH requires the use of Root Cause Analyses (RCA) in response to Sentinel Events, ensuring that those involved in the root cause analysis process have appropriate credentials to address the scope of the issues involved. Summary Reports and corrective actions relative to these reports are reviewed and monitored by the Clinical Oversight Committee at WMCMH. If system-wide issues are identified as part of the RCA process, these are referred to PIOC for review and action. Sentinel Events are tracked at WMCMH via a Sentinel Event Database. Notification of the occurrence of a Sentinel Event is shared with the LRE COO. For additional information see the WMCMH Policy on Sentinel Events.

Standards in the DHHS Contract also require a PIHP level submission and review of Critical Incidents and Risk Events. The PIHP has an established process for real time submission of the Critical Events and Risk Events and monitors via the LRE Regional Quality Advisory Team in accordance with contractual standards.

Credentialing and Privileging
Credentialing and privileging at WMCMH occurs via the performance appraisal process and in conjunction with the Executive Committee of the Clinical Oversight Committee.

Performance Improvement Projects
As required by the Department of Health and Human Services (DHHS), performance improvement projects will be developed, implemented and monitored through PIOC under the direction of the Executive Team. Performance Improvement Projects are designed such that they achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and satisfaction of the individuals served. Performance improvement projects must address clinical and non-clinical aspects of care. Clinical areas include, but are not limited to, high-volume services, high-risk service, and continuity and coordination of care. Non-clinical areas include, but are not limited to, appeals, grievances and complaints; and access to, and availability of services. Project topics will be selected in a manner which takes into account the potential impact on the individuals the organization serves, and the particular demographic characteristics and health risks of individuals served.

In addition, WMCMH also participates in an ongoing basis in the Quality Assurance Performance Improvement Projects identified by DHHS at the PIHP Level and in other Performance Improvement Projects identified and approved at that level.

Priorities for Performance Improvement
Performance Improvement opportunities occur at various times throughout the life of a system. On occasion, the improvement opportunity identified conflicts with other existing organizational priorities. The PIOC thus engages in an ongoing process of identifying and prioritizing Performance Improvement Opportunities that it identifies over the course of the year. Recommendations regarding prioritization of these issues are sent to the Executive Team for prioritization within the context of other Organizational Goals and Improvement Projects. The prioritization schema utilized at WMCMH at both the PIOC and Executive Team level asks individuals to prioritize activities based upon the impact of the issue on:

- Mission, Vision, Values (M, V, V critical)
- Level of Risk (contractual, person served, accreditation, other)
- Number of individuals served by the organization who would be affected
- Process complexity
- Impact on other well-functioning processes
- Drain on organizational resources

Standing Performance Measures
The following list of performance measures will be analyzed and reported to the PIOC at least annually. Where appropriate, analysis will include performance compared to established benchmarks or targets, tracking of performance over time, actions to improve performance, outcomes of the actions to improve performance, and ongoing plans for each measure. Detailed reports are made to PIOC at appropriate intervals, and performance on all the listed measures will be summarized annually as part of the PIOC's annual program evaluation.

Measure	Source	Suggested Reporting Frequency
Satisfaction: West Michigan MHSIP and YSS	MHSIP and YSS survey	Annual
CAFAS and PECFAS	Annual CAFAS and PECFAS reports	Annual
Suicide deaths and suicide attempts	*CIR / RE*	*Semi-Annual*
Access, efficiency, and outcomes as reported via the Michigan Mission-Based Performance Indicator System	MMBPIS	Quarterly
Care Coordination data (releases to PCPs, documents sent to PCPs)	Data draw	Annual
LRE Site Review	LRE	Annual
CARF Accreditation Summary	CARF	Triennial
Medicaid Verification Results	LRE	Semiannual
Provider Network Quality Oversight – Site Reviews (Pending LRE Action)	Network Coordinator / LRE	Annual
Physical Management and Behavior Treatment Review Committee Data	BTC report	Quarterly
Post-Discharge Monitoring	Customer Service	Semiannual
PIOC Self-Evaluation	PIOC	Annual
Walk-In Monitoring	PIOC	annual
DD Proxy Completeness	SETeam	Annual
Accessibility Reporting	ACCC	Annual
UMUR Summaries	UMUR	Monthly

Confidentiality
WMCMH is absolutely committed to maintaining the confidentiality of individuals served in our organization. The following statements below reflect specific tenets of this commitment. Specific details are reflected in WMCMH Policy and Procedure.

1. The contents of clinical records and provider credentialing files are confidential.
2. Although usually accomplished via aggregate non-individual-identifying reports, at times PIOC may review specific individually-identifiable confidential information.
3. Access to confidential quality improvement or quality oversight information (i.e. clinical information, medical history, credentialing information) shall be restricted to those individuals and/or committees charged with the responsibility/accountability for the various aspects of the program.
4. Individual provider information may be utilized and/or evaluated at the time of re-credentialing or contracting.
5. All information about individuals served and/or provider-specific information will be kept in a confidential manner in accordance with applicable federal and state laws and will be used solely for the purposes of quality oversight and/or directly related activities. Disclosing confidential information about individuals served and/or provider information internally or externally may be grounds for immediate dismissal from the committee.

Establishing Practice Guidelines
WMCMH recognizes the state of the art in clinical practice is rapidly changing as our knowledge base on disability and treatment evolve. National research provides a foundation for direction for treatments specific to diagnostic categories, however, this research usually does not provide for clear guidance for persons with multiple disabilities or severe and persistent mental illness. The WMCMH Clinical Oversight Committee is responsible for reviewing the literature for guidelines with research supporting evidence or expert consensus, assessing the validity of the method, based on the strength of the evidence and expert judgment, assessing the reliability and reproducibility of the practice, and examining clinical applicability including attention to multidisciplinary strengths that benefit the people we serve.

WMCMH is also responsible for implementing all contractually mandated Practice Guidelines. These include but are not limited to Person Centered Planning / Family-Centered Planning, Self-Determination Policy and Practice Guideline, Inclusion, Housing, Consumerism, Co-occurring Treatment, Jail Diversion, and School to Community Transition.

Utilization Management
The WMCMH Utilization Management Plan provides a written program description that includes procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical, clinical and support services. Utilization management includes mechanisms for regular and ongoing review of individual needs of the persons served, circumstances and services being delivered. Utilization management includes processes to detect and correct under-utilization and over-utilization as well as procedures to conduct prospective, concurrent and retrospective reviews that ultimately improve quality of service. Data and recommendations for system-related Performance Improvement opportunities are directed to PIOC for their review and action and/or recommendation.

Corrective Action Initiatives
Corrective Action or Plan of Correction may be requested by the PIOC at any point in time regarding an identified performance challenge where the organization, a provider, a department, or a team does not meet the established thresholds or standards (as set by the organization, via contract, or accrediting body). Problems requiring corrective action may be identified through routine performance indicator monitoring, results of a monitoring study, results of a special study, results of a site visit, results of a Utilization Management/Utilization Review study, and/or results of a root cause analysis. Minimum elements of an acceptable plan of correction (POC) or corrective action include, summary of the assessment of the nature of the problem, plan to address the problem with timeframes, identified leads, action steps, proofs, timeline for next monitoring, and a statement regarding how to know a plan of correction is completed (for all required elements see ***Attachment 1***). POCs may be accepted or rejected by PIOC and consultative recommendations may be added at the discretion of the committee. Problems with implementing a POC should be shared with the PIOC and primary supervisor in advance of the deadline for completion. Repeated failure to submit timely plans of correction or corrective action plans will be addressed first through the behavioral contract and then through the attention of the primary supervisor.

Reporting
Reports and corrective action plans developed at the request of the committee are submitted to the Quality Assurance and PR Coordinator or Deputy Director for Service Enhancement for distribution to the committee as part of the monthly meeting packet. The findings of monitoring and evaluation activities and/or POCs are presented to PIOC by the individual responsible for the study and/or POC.

Minutes of all PIOC meetings will be kept in a standard format sufficient to document the topics discussed, analysis and resulting action items. The minutes will be approved by the PIOC and will include original

attachments. Meeting packets and accompanying minutes from the previous meetings will be maintained by the Quality Assurance and PR Coordinator and are available for audit and/or review as requested. All records, audit materials and communications / correspondence will be retained according to regulatory record keeping requirements. Such records are not available as part of "Discovery" or other proceedings associated with litigation and may not be copied or distributed in any manner. Such records are not part of the medical record.

Medicaid Verification

The LRE policy on Medicaid Verification defines the specific processes used for ongoing record review, including the verification of documentation for services provided, timeliness of documentation and quality of service provided and documented. The Lakeshore Regional Entity PIHP performs regular record reviews and results are provided to PIOC, Executive Team, and the WMCMH Corporate Compliance Officer. If WMCMH's performance is below accepted PIHP thresholds, the WMCMH Corporate Compliance officer will share findings with the WMCMH Corporate Compliance Committee with this Committee determining actions necessary to improve performance. WMCMH Corporate Compliance Officer also shares individual level data/findings with appropriate WMCMH staff.

Annual Self-Assessment

In order to ensure the ongoing effectiveness of the committee and to support a strong QA / PI process within the organization, PIOC will conduct an annual self-assessment of the workings of the committee. Annually, all members will be advanced a series of questions designed to assess the workings of the committee (see ***Attachment 2***). The group allocates time on the agenda for a thoughtful discussion of the strengths and challenges of the committee. Recommendations regarding improving performance are then drafted and reviewed by the committee to determine if they will achieve the desired impact. Results of the Annual Self-Assessment are incorporated into the Annual Program Evaluation described below.

Annual Program Evaluation

The PIOC completes an annual QAPIP evaluation that includes:

1. A review of QAPIP Goals of the previous year;
2. A review of the Committee annual Self-Evaluation results;
3. A review of all quality oversight activities (see ***Attachment 3*** for review template);
4. A review of the appropriateness and relevance of current measures (contained throughout this report).
5. Identify QAPIP Goals for the coming year (see ***Attachment 4*** for new goals for FY1718 and ***Attachment 5*** for FY1617 goals with year-end updates).
6. An overall performance summary including Improvements to Quality of Service Delivery, Trends in Service Delivery and Health Outcomes over Time, and Progress on Goals and Objectives (see ***Attachment 3***).
7. Recommendations and next steps.

Documentation of the QAPIP annual review, its findings and recommendations are forwarded to the Executive Team, the Board, the provider network, the Consumer Advisory Panel, and any person served upon request. The annual review may lead to:

1. Identification of educational/training needs;
2. Establishment and revision of policies and procedures related to quality initiatives;
3. Recommendations regarding credentialing of practitioners;
4. Changes in operations to minimize risks in the delivery of quality services, and;
5. Development of objectives for the coming year.

Attachment 1

POC Monitoring Template

Instructions: Each POCs monitoring plan submitted should include all of the following elements. See below for an example of a POC that contains all the necessary elements.

Standard Number: Usually an acronym (DHHS, CWP, etc.) and letters and number to identify the standard.
Citation: Brief description of the standard that was not met; should explain the reason a POC was required.
Plan of Correction: A description of the tasks to be completed to correct the identified opportunity for improvement and achieve the desired outcome.
Proofs: What evidence will you bring forward to show evidence that the outcome has been achieved.
Responsible Person(s): Name of the person(s) responsible for completing the tasks identified in POC. These are also the individuals who will be contacted for monitoring updates and proofs.
How will we know when POC is completed? This is a brief statement of when the POC will be considered "done" and taken off the POC monitoring list.
Status or Monitoring: Is this a status update or a full monitoring proof? A status proof requires a discreet change that needs to be made and reported while a monitoring proof requires a change that requires ongoing monitoring or measurement to substantiate that the change has been made.
Completion Time Frame: When will the tasks identified in the POC be completely implemented?
Monitoring Frequency: How frequently will the status of this POC be reviewed and where? All POCs will be reviewed at PIOC for completion at least quarterly, but you may identify more frequent intervals at additional locations if it's helpful to you for getting the POC completed and the outcome achieved.

<table>
<tr><td colspan="2">Standard:
MMBPIS #2</td><td>Mark when Complete: ☐</td></tr>
<tr><td colspan="3">CITATION (OK to summarize; also include reason for POC)
Timeliness—95% of assessments occur within 14 calendar days of the person's first request for services.
Out on MIC in 2nd Quarter FY1415 (PIHP).</td></tr>
<tr><td colspan="3">PLAN OF CORRECTION
The Service Entry Team Leader will re-train Service Entry staff on the 14 day standard and proper documentation when the person being served chooses to have their assessment appointment more than 14 days after they requested services. Clinician must document on the SE Screening at least one assessment appointment date that was offered to the person within 14 calendar days of their request for services.</td></tr>
<tr><td colspan="2">PROOFS
At least two consecutive quarters of performance within the 95% standard.</td><td>RESPONSIBLE PERSON(S):
Service Entry Team Leader</td></tr>
<tr><td>HOW DO WE KNOW WHEN IT'S DONE?
WMCMH meets the 95% standard for this indicator for 2 consecutive quarters</td><td>Check one:
☐Status
☒Monitoring</td><td>COMPLETION TIMEFRAME:
October 1, 2015</td></tr>
<tr><td colspan="3">Monitoring Frequency: Monthly at PIOC</td></tr>
</table>

Attachment 2

Performance Improvement Oversight Committee
Committee and Self-Evaluation

There are three basic reasons for committees in healthcare organizations to perform periodic self-evaluations. The first is that today's unforgiving health care environment demands nothing less than excellence in healthcare. The second is that a well-constructed self-evaluation process can help a committee improve its performance and achieve and maintain excellence in quality oversight. The third is that regulatory groups (BBA, DHHS, CARF, etc.) specifically require that committees evaluate their own performance.

Self-evaluation provides a committee with a structured opportunity to look at its past performance and to plan ahead. The process allows the committee to ask itself such questions as: What are we doing well? What could we be doing better? What are our objectives? How well did we achieve our objectives, or, why did we not achieve our objectives? The committee may then use the answers to develop an action plan to improve its performance and establish new goals.

The aggregated responses from the Performance Improvement Oversight Committee self-evaluation questionnaires will be used to facilitate discussion at the next committee meeting. It is this discussion that provides the real value of the self-evaluation process.

Instructions: Please read each item in the left column and indicate in 1 of the 4 right columns your rating for our committee's performance in this area (Note: in the last section, please rate only your own personal performance).

	Very Good	Good	Fair	Poor
Section 1: Mission and Planning Oversight				
A. Each committee member has received a copy of our committee charge.				
B. Proposals brought before our committee are evaluated to ensure that they are consistent with our committee's charge.				
C. The committee periodically reviews, discusses, and if necessary recommends changes to the committee's charge to ensure that it remains current and relevant.				
D. The committee periodically reviews, discusses, and if necessary recommends changes to the Quality Assurance Performance Improvement Plan (QAPIP) and supportive policy statements.				
E. The committee provides support to organizational efforts to integrate a performance improvement philosophy into the everyday work of the organization.				
F. Committee members are active and effective in representing WMCMH's quality oversight interests.				
G. Our committee supports and assists the WMCMH Executive Director in achieving the WMCMH mission.				
Section 2: Quality Oversight				
A. The committee reviews and discusses performance reports that provide comparative statistical data about WMCMH services.				
B. The committee reviews feedback from community partners including residential homes, the LRP, DHS, referral sources, community agencies, and others, regarding WMCMH's overall performance as a service provider.				
C. The committee effectively communicates performance data to WMCMH staff and other stakeholders (communicates improvements and challenges within and outside the organization).				
Section 3: Committee Effectiveness				
A. The committee evaluates its own performance and the individual performance of each committee member.				
B. Committee members work for the overall good of the organization and those we serve.				
C. The frequency and duration of committee meetings are appropriate.				
D. The committee chair ensures that members have equal opportunity to participate, meeting time is used appropriately, and agenda items are addressed with adequate discussion.				
E. Committee members receive the agenda and back-up materials well in advance of meetings.				
F. Committee members come to meetings well prepared.				

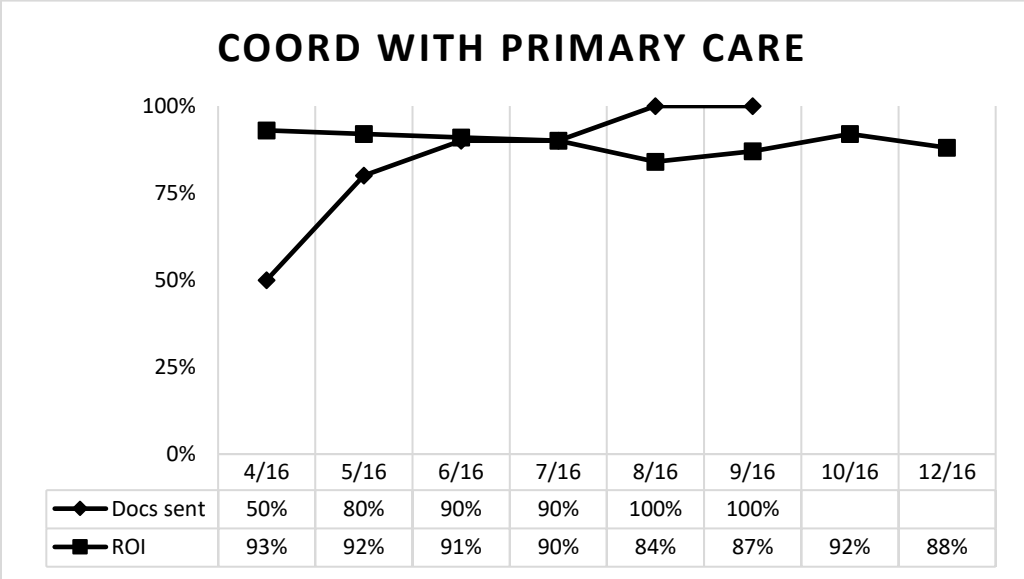
	Very Good	Good	Fair	Poor
Section 4: Individual Self-Assessment				
A. I prepare for meetings, attend meetings, participate in committee discussions and assume a fair workload when applicable.				
B. I deal fairly and appropriately with other committee members.				
C. I support the committee chair in fulfilling the committee charge.				
D. I maintain privacy regarding information discussed in committee meetings.				
E. I am satisfied that no conflict of interest exists in my service as a committee member.				
F. As a committee member, I act as a liaison between WMCMH and the community, representing the interests of both.				

Attachment 3

Sample format for Performance Measure Reporting

Indicator C. Care Coordination data (releases to PCPs, documents sent to PCPs)

Reported Semi-Annually



	4/16	5/16	6/16	7/16	8/16	9/16	10/16	12/16
Docs sent	50%	80%	90%	90%	100%	100%		
ROI	93%	92%	91%	90%	84%	87%	92%	88%

Analysis

This measure was implemented in a response to an LRE plan of correction from the December 2015 site visit. Documents sent to PCPs reached 100% for two consecutive reviews, and so monitoring was discontinued for the remainder of the year. Releases to primary care physicians has approached the 95% standard but has not yet met it. If this standard is cited by the LRE from the December 2016 site visit, the plan of correction will be revisited, with possible practice changes implemented, and intensive monitoring will continue. If it is not cited, PIOC will evaluate the ongoing reporting frequency of this standard.

Methods to improve performance have included:

- Team Leaders are provided a monthly list of persons served whose releases have expired.
- It was noted that performance at our December 2016 LRE site visit appeared better than our monitoring shows. This may be because of problems with the monitoring data set. In the next monthly monitoring cycle, we will pull a smaller random sample and drilldown as needed to ensure data is accurate.

Appropriateness of this Measure

Coordination with Primary Care is a requirement of the LRE. Monitoring was implemented as part of a FY16 Plan of Correction to the LRE. It remains appropriate and relevant. Monitoring will be continued, with frequency to be determined.

See Attachment C for full FY1516 report on Care Coordination Data

Attachment 4

West Michigan Community Mental Health
Quality Improvement and Performance Improvement Program
Annual Goals FY 1718

Committee Goal #1	**Enhance current organizational satisfaction monitoring.**
Key Deliverables	• Evaluate the LRE satisfaction results by program for customer satisfaction to be strongly agree to agree for 90% of individuals surveyed. • Report provided to PIOC per the Customer Satisfaction Survey Calendar • PIOC will determine next steps for indicators that fall below 90% satisfaction
Desired Outcome	Continued access to valuable feedback from individuals served.
Start Date	10/1/2017 – Ongoing
Completion Date	9/30/2018
Who	• Tracy Bonstell PIOC
Goal #1 Update	
Committee Goal #2	**Engage WM staff from all departments at all levels in the organizations QAPIP.**
Key Deliverables	• Written procedures for staff involvement • Buy in from Leadership Team • Qualitative feedback from staff on their experience
Desired Outcome	Input from staff is used to make performance improvement decisions and to guide performance improvement activities.
Start Date	2/1/2018
Completion Date	9/30/18
Who	• Quality Assurance Coordinator • Leadership Team • All staff
Goal #2 Update	
Committee Goal #3	**Revise Current Program-level monitoring (e.g., Access, Efficiency, Effectiveness and Satisfaction) to ensure measures are relevant and meaningful.**
Key Deliverables	• Revise current program-level monitoring to ensure monitoring is relevant and meaningful, meets organizational needs, aligns with WMCMH risk assessment, and also meets CARF requirements. • Develop a process for collection and analysis of the data. Develop a mechanism for performance improvement in the event the organization does not meet established performance targets.
Desired Outcome	• Useful data for WMCMH operations – both clinical and business side of our business. Meet CARF requirements.
Start Date	12/1/17
Completion Date	Risk Assessment completion – February 2018 Indicator and Process Development– March 2018 Implementation – April 2018 Monitoring - Ongoing

Who	• Leadership Staff • SET team • PIOC
Goal #3 Update	
Committee Goal #4	**Ensuring stakeholder/provider feedback and involvement in organizational QI efforts**.
Key Deliverables	• Develop a process for valuable and meaningful stakeholder/provider feedback and involvement in organizational QI efforts.
Desired Outcome	Increased involvement and feedback from stakeholders/providers in organizational QI efforts.
Start Date	May 1, 2017
Completion Date	Process Development and Implementation - July 2017 PIOC Involvement and Feedback will be ongoing
Who	• Karen Hobart • Betsy Reed • ET • PIOC

Attachment 5

West Michigan Community Mental Health
Quality Improvement and Performance Improvement Program
Annual Goals
FY 1617
With Year-End Updates

Committee Goal #1	**Enhance current organizational satisfaction monitoring.**
Key Deliverables	• Identify organizational performance targets for satisfaction monitoring. • Develop a mechanism for performance improvement in the event the organization does not meet established performance targets. • Develop a mechanism to collect the population and/or program served from each survey respondent in order to allow data aggregation at the population and program level. • Develop a mechanism to meet all LRE requirements relative to satisfaction monitoring.
Desired Outcome	Continued access to valuable feedback from individuals served.
Start Date	1/1/2017 – Ongoing
Completion Date	May 2017 PIOC
Who	• Tracy Bonstell • PIOC
UPDATE October 2017 from Tracy	*This goal is being carried forward into FY1718*
Committee Goal #2	**Establish a process for sharing performance data, in a meaningful manner, with staff.**
Key Deliverables	Develop and implement a process for sharing performance data with staff.
Desired Outcome	Staff have ready access to current, meaningful, and relevant performance data.
Start Date	3/1/17 - Ongoing
Completion Date	Process Development and Implementation - June 2017 PIOC Data sharing will be ongoing
Who	• Betsy Reed • IT Staff • PIOC
Update October 2017 from Betsy	Performance reports have been placed on Infohub with an agency-wide email notifying staff.
Committee Goal #3	**Revise Current Program-level monitoring (e.g., Access, Efficiency, Effectiveness and Satisfaction) to ensure measures are relevant and meaningful.**
Key Deliverables	• Revise current program-level monitoring to ensure monitoring is relevant and meaningful, meets organizational needs and also meets CARF requirements. • Develop a process for collection and analysis of the data. • Develop a mechanism for performance improvement in the event the organization does not meet established performance targets.
Desired Outcome	• Useful data for CTLs to use to manage their programs. • Meet CARF requirements.
Start Date	3/1/17
Completion Date	Process Development and Implementation – June 2017 PIOC Monitoring is ongoing
Who	• CTLs • Megan Teall and Michele Condit • PIOC

UPDATE October 2017 from Michele and Megan	October 2017 Update - The organization is in the process of performing a Risk Assessment and developing a Risk Assessment document. Once this work is completed, work will continue on the development and implementation of program-level access, effectiveness, efficiency and satisfaction measures (clinical and business). It will be important that these clinical and business measures align with the WMCMH Risk Assessment.
Committee Goal #4	**Ensuring stakeholder/provider feedback and involvement in organizational QI efforts**.
Key Deliverables	• Develop a process for valuable and meaningful stakeholder/provider feedback and involvement in organizational QI efforts.
Desired Outcome	Increased involvement and feedback from stakeholders/providers in organizational QI efforts.
Start Date	May 1, 2017
Completion Date	Process Development and Implementation - July 2017 PIOC Involvement and Feedback will be ongoing
Who	• Karen Hobart • Betsy Reed • ET • PIOC
UPDATE October 2017 from Karen and Betsy	Betsy will attend the October Stakeholders meeting to present some sample reports and lead a discussion about what kind of information will be helpful, interesting, and meaningful to the group. Betsy and other PIOC members will continue attending Stakeholders meetings to facilitate quality-based discussion and brainstorming.