
	General Policy			
	Chapter:	Board Services and Program Administration	Policy #	2-4-1
	Section:	Performance Improvement Plan	Revision #	5

- I. **PURPOSE:** To establish policy and procedures for a Performance Improvement program for all services provided by the West Michigan Community Mental Health.
- II. **APPLICATION:** All programs and services operated by the West Michigan Community Mental Health Governing Body.
- III. **REQUIRED BY:** Michigan Standard for Community Mental Health Services, 1976, Sections 7.5 and 9.12; Accrediting Bodies; Mental Health Manual; Department of Health and Human Services, Administrative Rules 330.7199 (4) (0) Act 258, Public Act of 1974, and as amended being MCL 330.1717; Lakeshore Regional Entity.
- IV. **DEFINITIONS:** Not applicable.
- V. **POLICY:** It is the policy of the West Michigan Community Mental Health to develop and implement a Performance Improvement Plan in accordance with guidelines and standards established by the Department of Health and Human Services Master Contract and accrediting bodies.
- VI. **PROCEDURES:**
 1. The Chief Operating Officer and/or the Director of Network, Quality, and Compliance will be responsible for developing the Performance Improvement Plan, under the direction of the Chief Executive Officer.
 2. The Quality Assurance / Performance Improvement Plan (QAPIP) is a standing document that outlines the structure, scope, activities, and functions of the overall plan to align resources around positive program outcomes and improved quality of life for persons served.
 3. The QAPIP will be assessed for ongoing relevance and annually reviewed for approval by the Quality Improvement Steering Committee (QISC), the Senior Management Team, and the Board.
 4. The implementation of the QAPIP and its goals will be overseen by the Network, Quality, and Compliance Team. The responsibility for performance improvement/quality assurance activities, however, lies with all WMCMH employees.
- VII. **SUPPORTING DOCUMENTS:**

Appendix 2-4-1A: WMCMH Quality Assurance / Performance Improvement Plan

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VIII. **POLICY/PROCEDURE REVIEW:**

REV#	APPROVED BY	Policy/Procedure	DATE
1			08/2007
1			10/2010
1			01/2015
1			12/2016
1		Procedure	01/2020
2	PIOC	Title Changes	01/2021
2	QISC	Annual Review/QAPIP Plan Updated	01/2022
3	QISC/Board	Procedures/QAPIP Plan Updated	12/20/22
3	QISC/Board	Annual Review	10/2023
4	QISC/Board	Appendix	11/2023
5	QISC/Board	Procedure/Appendix	10/2024
Board Approval Date: 04/16/1996			

IX. **CHIEF EXECUTIVE OFFICER ENDORSEMENT:**

I have reviewed and approved of policy # 2-4-1 Revision# 5.

CEO: Lisa Williams Approval Signature: _____



Quality Assurance and Performance Improvement Program

2025

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Attachment: “Plan, Do, Check, Act”

I. Foundations of the QAPIP

A. Purpose

The Quality Assurance and Performance Improvement Plan (QAPIP) describes the functions and structures of WMCMH's quality improvement activities, how these functions are accomplished at WMCMH, and responsibilities related to those functions.

The purpose of quality improvement activities at WMCMH includes meeting contractual and accreditation requirements, providing data and information on performance, and establishing structures and processes to improve performance. QAPIP activities inform strategic planning and the setting of organizational priorities. In turn, strategic planning and organizational priorities inform and shape the QAPIP, with the ultimate goal of supporting WMCMH's achievement of its goals.

B. Scope

The scope of the QAPIP includes WMCMH business functions and programs and services operated by WMCMH and contract service providers. The QAPIP incorporates, by reference, any and all policies and procedures necessary to operate as a Community Mental Health Services (CMHSP) program and a Certified Community Behavioral Health Clinic (CCBHC). WMCMH's QAPIP meets applicable Federal and state laws, contractual requirements, and regulatory standards.

C. Philosophy

The QAPIP is guided by the following beliefs and core values:

- Personal and organizational accountability.
- Data-driven decision making.
- Continuous Quality Improvement (see Attachment "Plan, Do, Check, Act")
- A commitment to organizational excellence in all areas.
- Input from stakeholders, including persons served, contract providers, payors, and the community (see section III. Input of Staff, Stakeholders, and Persons Served).
- A focus on positive outcomes for persons served.
- Active and meaningful engagement of all stakeholders.
- A workforce that is knowledgeable about and engaged in performance measurement and performance improvement activities.
- [Staff at all levels of the organization participate in Quality Improvement.](#)
- An investment of resources to implement a successful QAPIP.

D. Statement of Confidentiality

WMCMH is committed to maintaining the confidentiality of persons served. Although the utmost efforts are made to prevent the use or sharing of personal health information/personally-identifiable information (PHI/PII), there may be times when PHI/PII, or other confidential information, is used in the assessment of performance and when carrying out oversight activities. All information will be kept strictly confidential in accordance with federal and state laws and consistent with organizational policy, and used solely for the purposes of oversight and/or directly related activities.

II. Structures and Responsibilities

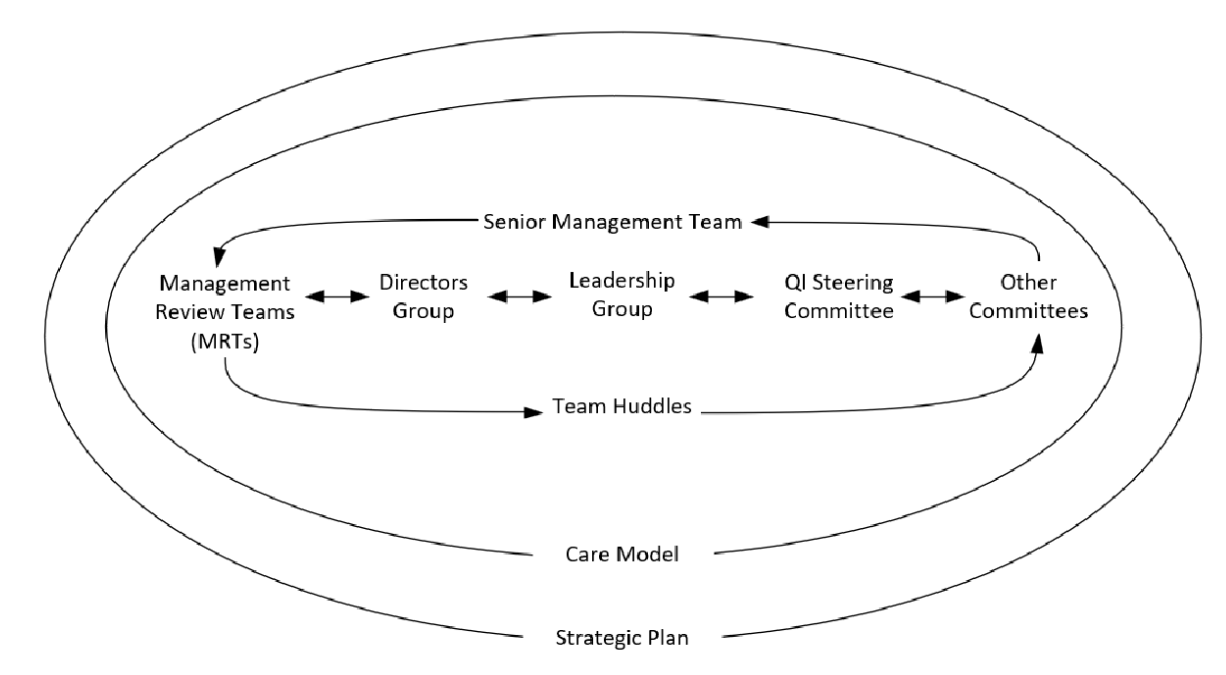
A. Authority and Accountability

Ultimate authority for performance measurement and management rests with the WMCMH Board of Directors, who vests operational responsibility to the Chief Executive Officer. Facilitation of the organization's performance improvement activities falls to the Operations Team, most specifically within the Network, Quality Improvement, and Compliance Department.

WMCMH's QAPIP aligns with the broader regional approach to quality improvement, as directed by the Lakeshore Regional Entity (LRE)/PIHP. WMCMH partners with LRE and Community Mental Health Services Programs (CMHSPs) across the seven-county regional affiliation. WMCMH participates in regional quality meetings and is contractually delegated to adhere to regional QI/QA efforts, including the broader regional QAPIP. As part of this arrangement, all CMHSPs develop, implement, and maintain quality improvement programs and report results of monitoring and improvement activities to the Quality Improvement Regional Operations Advisory Team (QIROAT) as requested.

B. QAPIP Organizational Structures

Every WMCMH staff person and every contract service provider staff has a role in the implementation of the QAPIP. While there are teams, committees, and individual staff who are specifically dedicated to Quality Improvement work, QI is everyone's job. Staff at all levels review and analyze performance data and actively engage in quality improvement activities. Performance information flows from one accountability body to another as needed. One group can refer the responsibility to drive action to another group(s), as appropriate. The figure below demonstrates some of the information flow.



1. Care Model and Strategic Plan

The QAPIP operates within the context of the Strategic Plan and the Care Model. The **Strategic Plan** sets forth organizational direction for the next one to five years, and is grounded in WCMCMH's Core Values, Purpose, and Promise. WCMCMH's **Care Model** is the organizational structure that supports individualized, customized services and supports for each person served.

2. Senior Management Team (SMT)

Senior Management Team (SMT) monitors MRT metrics and ensures that ongoing quality improvement activities uphold WCMCMH's values, purpose, and promise.

3. Management Review Teams (MRTs)

Monitoring and accountability of team huddles will occur through **Management Review Teams (MRTs)**, which meet weekly to provide broad team oversight of departments within the larger team. Team leaders will report on metrics and provide project updates, as well as discuss cross-departmental issues that arise.

4. Directors Group and Leadership Group

Directors Group includes all Directors. **Leadership Group** includes all leadership team members. Quality improvement responsibilities of these groups include identifying potential opportunities for quality improvement, and referring these to Quality Improvement Steering Committee, SMT, or Directors as appropriate for investigation, action planning, and driving improvement.

5. Network, Quality Improvement, and Compliance Team

The **Network, Quality Improvement and Compliance (NQC) Team** has primary responsibility for facilitating the QAPIP. Housed in the Operations Team, NQC is under direction of the **Chief Operations Officer (COO)**. The COO is responsible for establishing the strategic direction of NQC efforts and ensuring that quality assurance and performance improvement activities align to the broader organizational objectives. Together with the **Director of Network, Quality, and Compliance**, the COO is responsible for setting departmental objectives and the successful implementation of the QAPIP, coaching team members on Continuous Quality Improvement (CQI) principles, and ensuring inter-departmental collaboration on quality improvement initiatives. The Director of Network, Quality, and Compliance (NQC Director) oversees the day-to-day facilitation of the QAPIP, ensuring effective monitoring and reporting structures to promote achievement of identified objectives, as well as serves chair for QI Steering Committee and acts as a champion for quality improvement initiatives throughout the organization. The NQC Team acts in partnership with stakeholders, recipients, advocates, contracted providers, organizational leadership, and WCMCMH staff.

6. Huddles and KPMs/KPIs

WCMCMH's strategic direction and organizational priorities are used to inform and guide **key performance metrics/indicators (KPMs/KPIs)** for clinical services and business functions. KPMs and KPIs are measured and monitored at all levels in the organization to drive improvement.

Daily **Team Huddles** are the venue for monitoring and oversight of team-level KPMs/KPIs. At huddles, teams will implement and carry out performance improvement projects that address performance issues identified through internal or external monitoring. This structure embeds CQI in each organizational

team, supporting that performance improvement is the responsibility of every team and every team member.

7. Quality Improvement Steering Committee

In addition to the Team Huddle, MRT, SMT structure, the Quality Improvement Steering Committee (QISC) provides monitoring, accountability, and oversight for selected organization-wide KPMs and KPIs and provides leadership to quality improvement processes and activities. Leadership Group, Directors, SMT, or any other group or committee can refer quality concerns to QISC for investigation, monitoring, or driving action. In turn, QISC can refer quality concerns to other WMCMH bodies as appropriate.

The QISC Committee Charge is:

- Oversee, implement, and revise WMCMH QAPIP as needed.
- Review performance information, prioritize areas for improvement, drive improvement, and recommend action to meet goals.
- Provide oversight and accountability for performance improvement activities.
- Communicate critical and relevant performance data timely to inform strategic decision-making.
- Perform an annual QAPIP Evaluation (see section VIII of this document).

QISC Membership: QISC membership includes leadership staff and non-leadership staff from the Healthcare Integration, Service Delivery, Operations, and the Compliance/Information Systems/Administration departments, and a representative from the Consumer Advisory Panel. The Director of Network, Quality, and Compliance acts as the QISC chair. Any member of the organizational team may serve as an ad hoc member.

Role of QISC Chair: The NQC Director accepts general responsibility for ensuring the committee achieves desired outcomes. The committee chair is the liaison between the committee and team-based QI initiatives. Responsibilities include:

- Preparing the meeting agenda and facilitating meetings.
- Assisting with identifying, prioritizing, and planning for performance improvement projects.
- Leading problem-solving initiatives.
- Documenting, organizing, monitoring, and coordinating performance improvement activities and ensuring timely and accurate required reporting.
- Assuring coordination with other WMCMH committees and groups, and the Lakeshore Regional Entity.

8. Other WMCMH Committees and Groups with QI Responsibilities

Clinical Oversight Committee (COC): COC is responsible for ensuring quality care is provided in all settings. This includes services provided directly and those provided through contract. COC structure and procedures are detailed in policy 2-1-1. In summary, COC's quality improvement responsibilities include:

- Clinical Case review of all deaths and suicide attempts, including but not limited to Sentinel Events, to determine if any aspect of care may have contributed to the occurrence, and to inform future treatment approaches to reduce recurrence.
- Review and approve changes to clinical processes or procedures.

- Review and address network provider quality concerns.
- Address corrective actions related to performance improvement activities, whether focused on internal processes or external provider expectations.
- Establish practice guidelines and review and approve evidence-based practices or treatment philosophies.
- Credentialing and recredentialing of providers by the Credentialing and Privileging Subcommittee (reference policy 2-1-2).

Behavior Treatment Review Committee (BTC): Structures and procedures of the BTC are detailed in policy 2-9-1. In summary, BTC's quality improvement responsibilities include reviewing patterns and trends related to use of physical management, law enforcement intervention, and restrictive and intrusive techniques, and identifying areas for improvement and training needs. Data is reported to the Lakeshore Regional Entity as required in policy and procedure.

Recipient Rights Advisory Committee (RRAC): RRAC provides input on Recipient Rights policies and procedures, reviews and monitors data reports to identify trends and areas for improvement, and provides general oversight to activities related to the protection of the rights of persons served. See policy 5-1-1 for more detail.

Safety Committee: The Safety Committee's goal is to reduce or eliminate workplace injuries, illnesses, and critical incidents by identifying hazards and implementing plans to prevent them. Safety Committee responsibilities include reviewing critical incidents, ensuring timely debriefing of critical incidents, and recommending remedial action. Procedures related to critical incidents are detailed in Policy 2-12-8. See Safety Committee records for more detail.

Accessibility Committee: The Accessibility Committee assesses WCMCMH's accessibility on a regular basis and recommends performance improvement plans to reduce barriers to access. See policy 1-13-1 for more detail.

Diversity, Equity, and Inclusion Committee (DEI): the DEI Committee performs a regular assessment of clinical service and business practices, workforce and board composition, demographics of the community and persons served, and recommends improvement plans to meet objectives. See policy 1-13-1 for more detail.

CCBHC Core Team and Implementation Work Group (IWG): WCMCMH establishes committees and work groups as needed for change management and program evaluation, for example Core Team and the CCBHC IWG. Quality improvement responsibilities include reviewing performance information, developing recommendations for improvement, and driving improvement.

Provider Stakeholders Group: WCMCMH hosts a quarterly meeting with contract service providers to share performance information and obtain input on areas for improvement. For more detail, see section III. B. Contract Service Provider Network Input, below.

Consumer Advisory Panel: The Consumer Advisory Panel provides consumer perspective to aid in WCMCMH's organizational performance improvement efforts, to provide input on the design, implementation, and review of practices and procedures that impact WCMCMH consumers, and to add

value to consumer experiences at WMCMH. For more detail, see policy 2-20-1, the Consumer Advisory Panel Bylaws, and section III.A. Input of Persons Served, below.

III. Input of Staff, Stakeholders, and Persons Served

WMCMH recognizes that a vital aspect of any performance program includes successfully obtaining and meaningfully using stakeholder input and information. For the purposes of this plan, *stakeholder* is defined as any person or organization that partners with, relies upon, or directly or indirectly supports WMCMH's efforts in fulfilling its obligation as Community Mental Health Services Program (CMHSP). This includes the state of Michigan, Lakeshore Regional Entity, contractual providers, WMCMH staff, persons served and their families or other natural supports, advocates, community partners and the community-at-large.

Input is obtained through various methods, including directly through committee participation and involvement, surveys, and as part of ongoing person-centered planning, as well as indirectly through review of critical incident reports, complaints, and grievances. Collectively, this information helps WMCMH better understand its performance as it relates to stakeholder perception. Input also informs how WMCMH operates. Information obtained is analyzed and integrated into processes and practices.

A. Input of Persons Served

WMCMH seeks input from persons served in a variety of ways to create, define, change, monitor, and evaluate all aspects of the WMCMH system, including but not limited to access, care, services, programs, facilities, and processes. Persons served are selected to serve on the Consumer Advisory Panel, on WMCMH Committees, and the WMCMH governing board. Data gathered from customer experience of care surveys, customer grievances, and customer suggestions are used to guide program decisions, to identify areas for improvement, and set organizational priorities. See policy 2-20-1 for detail.

B. Contract Service Provider Network Input

The NQC Team is the main point of contact for contract service providers. WMCMH hosts quarterly meetings with contract service providers for the purpose of communicating about requirements, reporting, and procedures, sharing performance information, and obtaining input on areas for improvement. Additionally, input is solicited regularly via surveys and informal inquiries.

C. Input of Staff

WMCMH Staff at all levels are provided performance information in writing via published reports, staff newsletters, and presentations at all-staff meetings. Staff are encouraged to suggest areas for improvement via the Suggestion System, at Team Huddles, and by participating in staff focus groups or other opportunities to provide input.

IV. Event Notification and Event Reporting

WMCMH uses event reporting to monitor for quality care concerns, to identify improvement opportunities, and to plan remedial interventions to reduce the likelihood of recurrence. Events are analyzed individually as they occur and at least quarterly in aggregate.

Critical Incident Reports (CIRs) are retained in an electronic database. CIRs and CIR data are reported to the Safety Committee monthly and to QI Steering Committee at least quarterly. This data is available to other oversight groups as necessary to promote CQI efforts.

Definitions, reporting requirements, and reporting procedures for Critical Incidents, Risk Events, and Sentinel Events Reference are detailed in policies 2-12-8 and 2-6-6. WMCMH reports and responds to Critical Incidents, Risk Events, and Sentinel Events in accordance with LRE and MDHHS contractual requirements.

V. Performance Measurement and Management

WMCMH's performance measurement and management system includes data collection, reporting, and analysis on standardized and customized performance indicators (metrics) covering clinical services and business functions. WMCMH follows processes to ensure that performance data is valid and reliable. In order to identify gaps and opportunities and set plans for performance measurement and management, WMCMH considers historical performance information, contractual requirements, strategic goals and organizational priorities, data about persons served, and input from persons served, staff, and other stakeholders.

Groups or committees such as Huddles, MRTs, Quality Improvement Steering Committee, and other Committees review metrics compared to performance targets, analyze performance data to identify trends and areas for improvement, implement actions to improve performance, document results of actions taken, and adjust action plans to meet targets. For more detail on metrics, see section VI.M. Workbooks, below.

WMCMH uses its performance measurement and management system to guide key decision-making related to:

- Strategic Planning
- Resource allocation
- Clinical services
- Administrative process changes
- Staff training
- Support and monitoring of network providers
- Other activities identified by stakeholders.

A. Clinical Service Objectives and Metrics

For services delivered, WMCMH identifies performance objectives and sets performance indicators (metrics) including, at minimum, measures of effectiveness, consumer satisfaction and feedback, stakeholder satisfaction and feedback, efficiency, and effectiveness. Contract service providers are accountable for quality care through monitoring of key performance indicators described in Provider Service Agreement Attachment F (Performance Indicators) and through at least annual program monitoring.

B. Business Function Objectives and Metrics

WMCMH identifies performance objectives in priority areas for business functions. For each objective, WMCMH identifies a performance indicator (metric) and performance targets.

C. Required Metrics

In addition to performance measurement and management priorities that are identified via the above processes, WMCMH includes the following required metrics in its QAPIP: Recipient Rights data reports, a review of the effectiveness of WMCMH's Behavior Treatment Committee, data on the use of physical management, law enforcement intervention, and restrictive or intrusive techniques, data from the Michigan Mission-Based Performance Indicator System, timeliness data on Access System Standards, incident report data, sentinel event and mortality data, billing error reports, and CCBHC Quality Measures.

VI. Quality Improvement Strategies and Responsibilities

In addition to the structures and processes described above, WMCMH utilizes and upholds the following strategies and responsibilities to guide and perform quality assurance and performance improvement.

A. External reviews

External quality reviews and audits are contractual requirements and also provide valuable feedback on quality of services and business functions. Results of audits and reviews are used to identify areas for corrective action, programmatic changes, performance improvement, and to set organizational priorities. The NQC Team facilitates the annual LRE Audit, MDHHS Waiver audits, and other audits as needed.

B. Internal Quality Reviews

Internal Quality Records Reviews are conducted at quarterly intervals to identify areas of strength and opportunities for improvement. Audits include monitoring for fidelity to evidence-based practices. The NQC Team facilitates the Quality Records Review process and holds WMCMH accountable to driving action on areas of deficiency as needed. See NQC Team records for Quality Records Review processes.

C. Accreditation

WMCMH maintains CARF Accreditation. Triennial surveys, ongoing consultation provided by CARF, and maintaining conformance to CARF standards helps identify programmatic changes for quality improvement. Maintaining conformance to CARF standards is the role of assigned leadership team members based on their areas of responsibility. The NQC team facilitates accreditation and supports WMCMH's conformance to standards.

D. Provider Network Monitoring

WMCMH regularly monitors contracted providers to ensure health and safety, and contractual, legal, and program compliance. Monitoring considers performance requirements, including, but not limited to:

- Compliance with all elements of Provider Service Agreement.
- Procedures to ensure health and safety of recipients and staff.
- Completion of clinical documentation.

WMCMH's NQC Team monitors quality of services provided by contract service providers via a variety of methods, including provider site visits, monitoring of clinical documentation, monitoring of performance on timeliness standards, and monitoring staff training and staff qualification records. Some site visit and credentialing responsibilities are shared with the Lakeshore Regional Entity. In addition, WMCMH's clinical staff provide ongoing informal monitoring of quality of care at service provider locations while visiting persons served. Plans of correction are required when standards and requirements are not met.

E. Provider Credentialing and Qualification

A strong network of qualified providers is vital to WMCMH's service array. This includes internal staff and contracted providers. WMCMH procedures ensure service providers meet all credentialing and qualification standards prior to the beginning of service provision. Qualifications of professional staff hired directly by WMCMH or under contract are reviewed according to the WMCMH Credentialing and Privileging policies, with final approval granted by the Credentialing and Privileging Subcommittee of the Clinical Oversight Committee. Ongoing and regular monitoring of credentials occurs consistent with established policies and practices (see policy 2-1-2). WMCMH delegates credentialing to the provider when a service is provided through a contract. Oversight of compliance is managed through the annual site visit. WMCMH retains the right to request, at its discretion, a sampling of credentialing at any time.

In partnership with the Lakeshore Regional Entity, the NQC Team is responsible for paneling network providers consistent with established policies and procedures. Final approval for adding contracted providers rests with the Clinical Oversight Committee. The Lakeshore Regional Entity retains the right to approve or disapprove any provider from the network.

F. Protection of Rights

WMCMH is committed to protecting the health and safety and upholding the rights of all persons. This is accomplished through a variety of mechanisms, including timely reporting and analysis of incidents, ongoing clinical and administrative monitoring of programs and services, and responsiveness when systemic failures occur. Clinical Oversight Committee, in partnership with the NQC Team and Office of Recipient Rights (ORR), is responsible for ensuring care is provided in accordance with practice guidelines and for driving improvements in care and systems when clinical outcomes are not met.

The WMCMH ORR is responsible for the protection of the rights of recipients receiving mental health services. ORR provides broad oversight into clinical practices and guidance on matters relating to Michigan Mental Health Code protected rights, including investigating any suspected or reported violations. The Recipient Rights Officer is an ex-officio member of the Behavior Treatment Review Committee. The ORR performs site visits of service provider locations, both those directly operated by WMCMH and those operated by contract service providers, to ensure promotion and protection of recipient rights. The ORR also uses reciprocity agreements with other Community Mental Health Service Provider ORRs to assist in accomplishing some of its oversight responsibilities.

G. Medicaid Verification

To ensure that financial resources are used appropriately, WMCMH's Corporate Compliance team conducts quarterly Medicaid Verification Audits. WMCMH participates in the LRE's quarterly Medicaid Verification Audits. Findings from Medicaid Verification Audits guide process improvement activities around utilization review, documentation, and reporting of service provision.

H. Utilization Management

WMCMH is committed to using resources effectively, efficiently, and in accordance with medical necessity criteria. WMCMH uses its oversight authority to manage care from the point of entry, through treatment, and discharge. UM policies and procedures establish a framework for oversight of Medicaid-funded programs to assure consistency in applying program/service eligibility criteria and the decision-making regarding requests for initial or continued authorization for services. UM processes and procedures are also meant to support successful management of resources by identifying gaps in delivery of clinical services and resolution for under- or over-utilization of services.

WMCMH is structured to maximize conflict-free principles, with the UM department operating and managed separately from service provision. This ensures clinical decisions are free from potential influence of service providers. Many functions of this department overlap or rely on coordination with quality improvement, integrated care, and other clinical teams. Successful interface is accomplished by data-sharing, reporting, joint participation on organizational committees, and collaboration across teams on policies and practices to address UM-related concerns. For more details, see WMCMH's Utilization Management Plan.

I. Plans of Correction

WMCMH uses a plan of correction system to address areas of deficiency identified during external and internal reviews, audits, and accreditation surveys. Plans of correction include systemic remediations and individual remediations as appropriate, identify a lead person responsible for implementation, and include a timeline for completion. While any WMCMH staff can initiate and complete a plan of correction, the NQC team generally facilitates the process and holds WMCMH accountable for completion.

J. Root Cause Analysis

The purpose of Root Cause Analysis (RCA) is to reduce the likelihood of recurrence of an adverse event by understanding and addressing systemic factors that caused the event. RCA is required for any identified Sentinel Event. Procedures and requirements are detailed in policy 2-6-6. RCA may also be conducted upon request, when the cause of an event is not known, when recurrence presents a significant risk to health or safety, or if multiple attempts to address a problem have failed to initiate change.

WMCMH policy 2-6-6 requires that RCA participants have the appropriate credentials and experience to address the scope of issues involved.

A member of the NQC Team will be responsible for facilitating an RCA, including monitoring and reporting follow-up on corrective action measures. The Clinical Oversight Committee is the accountable body for any RCA related to service provision. Reports on activities, progress, and remediation efforts will be made to this committee upon completion. If activities are expected to be ongoing, a defined reporting schedule will be determined when developing corrective action steps. RCAs conducted on non-clinical events will be accountable to the body of Directors.

RCA will, at minimum, involve:

- Use of Fishbone Diagram, 5 Whys, or other approved analysis tools.
- A final statement, or cause, that led to a process breakdown.

- The action step(s) to be taken to remediate the concern or prevent recurrence.
- If remedial actions are expected to be ongoing, a schedule for reporting results and the anticipated time frame until the process can be closed.
- Clear responsibilities, roles, and expectations of all participants, including those responsible for implementation of new processes and monitoring of progress.

K. Organizational Projects

WMCMH's standardized Organizational Project process is a quality improvement activity. WMCMH defines a project as a non-routine, temporary, organized effort by a group of people within or outside of the organization to achieve a goal or create a service/product. Projects have a definitive start and end date and produce an observable and measurable result. Projects can be implemented to address identified gaps or priority areas for improvement. The Development Director oversees the Organizational Project process.

L. Suggestion System

WMCMH uses a suggestion system to encourage all staff to make suggestions for quality improvement. A suggestion is an idea that pertains to a current defined process that supports improvement. A suggestion may also be an idea for a new process. The Directors group reviews all suggestions and determines which ones will be implemented, incorporated into existing efforts, or otherwise addressed.

M. Workbooks

WMCMH teams, MRTs, and committees use Workbooks to document and retain data reports on metrics, data analysis, documentation of actions taken to improve performance, and results of actions taken. Among other data analysis methods, teams use Pareto charts to identify the most frequent causes for not meeting targets. Pareto data guides Teams in prioritizing which problems to address, in order to have the greatest impact on performance. Workbooks also document key information about metrics including performance objectives, to whom the indicators are applied, who is responsible for collecting data, data sources, timeframes for data collection and reporting, and performance targets. Workbooks are reviewed and updated at regular intervals by teams including staff at all levels in the organization.

N. Value Stream Mapping and Process Mapping

WMCMH uses Value Stream Mapping and other process mapping tools to identify waste in processes, reduce cycle times, and implement process improvement.

O. Methodical Problem Solving

Methodical Problem Solving (MPS) is used to address problems that are persistent, critical, or of a foundational nature. Cases for MPS are assigned as needed. Each MPS project follows a formal structure and format to define the problem(s), identify causes, implement solutions, and prevent recurrence.

VII. Quality Improvement Prioritization

Performance improvement opportunities can occur at any point during an organization's operations. Regardless of when an opportunity presents itself, and whether it arises following a specific event or as the result of ongoing monitoring, corrective action must be taken to address all performance concerns. However, there may be times when improvement opportunities appear to conflict with other existing organizational priorities due to the limitations in time, resources, and staff capacity. Nevertheless, it is

important that improvement projects and priorities align with the overall strategic direction and priorities of the agency. Leadership groups including QI Steering Committee engage in an ongoing process of identifying performance improvement opportunities and working with the Senior Management Team to prioritize improvement projects within the context of the agency's overall strategic plan goals and existing improvement projects. The prioritization framework seeks to balance consistency with context; as a result, improvement opportunities are assessed based on their impact on the following:

- Safety of persons served and staff (at WCMCH as well as provider agencies)
- Quality of care and services provided
- Potential to improve performance
- Relevance to WCMCH Mission, Vision, and Values
- Level of risk (contractual, person served, accreditation, other)
- Number of persons served that would be affected
- Complexity of the processes involved
- Scope of the proposed change
- Impact on other processes and systems
- Availability of organizational resources (funding, staff time, expertise, etc.)

VIII. Annual QAPIP Review and Evaluation

In the spirit of continuous quality improvement, and to ensure the ongoing effectiveness of the organization's quality improvement efforts, the QI Steering Committee conducts an annual QAPIP evaluation or Annual Effectiveness Review (AER). The AER addresses clinical service indicators of effectiveness, consumer satisfaction and feedback, stakeholder satisfaction and feedback, efficiency, and effectiveness. It includes priority business function indicators. It incorporates characteristics of persons served and extenuating or influencing factors that affected or may have affected results. It includes comparative analysis, identifies trends, and identifies causes. The AER includes:

- A self-evaluation of the committee's effectiveness;
- A review of all quality oversight activities and their effectiveness;
- A review of the appropriateness and relevance of current measures;
- An overall performance summary including improvements to quality of clinical services, trends in delivery of services, and health outcomes over time;
- Recommendations and next steps.

The QAPIP annual review, its findings, and recommendations are presented to the Senior Management Team. A summary is provided to WCMCH staff, the Board, the Consumer Advisory Panel, contracted service providers, and any person served upon request. The annual review is used to:

- Identify educational/training needs;
- Establish and revise policies and procedures related to quality initiatives;
- Make recommendations regarding credentialing of practitioners;
- Recommend changes in operations to minimize risks in the delivery of quality services;
- Improve quality of programs;
- Facilitate organizational decision making regarding clinical services and business functions;

- Guide changes to the QAPIP and Strategic Planning; and
- Develop objectives for the coming year.

IX. Sources

CARF Behavioral Health Standards Manual 2024

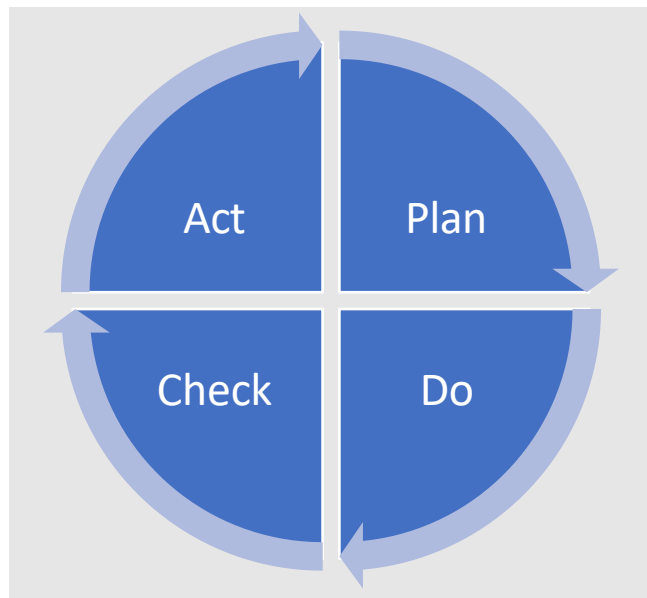
MDHHS FY25 GF/CMHSP Contract, Part II, Section 6.8 and Attachment C6.8.1.1

LRE Desk Audit Standards, Standard XIII Quality Assessment and Performance Improvement Program

Plan, Do, Check, Act

WMCMH's performance improvement activities are guided by the Shewhart Cycle of Continuous Improvement, more commonly referred to as Plan, Do, Check, Act (PDCA). Once an issue has been identified, WMCMH incorporates the following process for improvement:

1. Develop a **PLAN** to change.
2. **DO** something to test that plan.
3. Review results to **CHECK** what was learned.
4. **ACT** on what was discovered to determine the next course of action.



As the model suggests, PDCA is a continuous process. Planning and adjustment occur as part of ongoing assessment (“check”) of processes and outcomes. It is recognized that even actions that achieve the desired outcome may benefit from further refinement. The “check” process also identifies unintended consequences that need to be addressed.

Adapted from the U.S Department of Health and Human Services Health Resources and Services Administration (HRSA).