SAGINAW COUNTY
COMMUNITY MENTAL
HEALTH AUTHORITY

Quality Assurance and Performance Improvement Program (QAPIP)

June 4, 2019

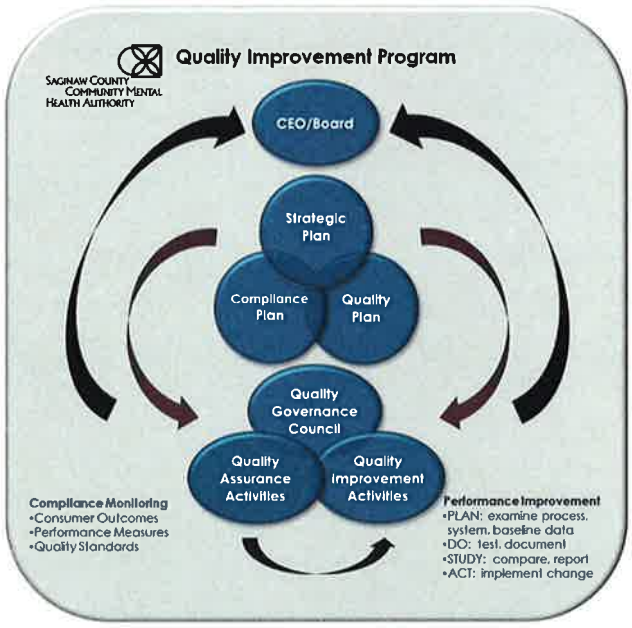
FY 2018 Quality Report

FY 2019 Quality Improvement Plan

Quality Report FY2018 and Plan for FY2019

Introduction and Overview

As a way of introducing the reader to the Saginaw Quality Program we thought that an explanation of the graphic presentation of our program paradigm would be helpful. First, a bit of history is needed to understand the dynamic intention of this design. From 2002-2016 SCCMHA was both a PIHP and a CMHSP and our Quality Program model reflected that duality with two tracks of quality governance; the managed care obligations which we held as a PIHP were addressed under a group called the Quality Team and the provider obligations which we held as a CMHSP were addressed under a group called the Quality Improvement Committee. When SCCMHA joined the Mid-State Health Network PIHP in FY 2015; we decided to re-consider our quality paradigm, after several months of program review and discussion the management team concluded that it would be more efficient and unifying to integrate our delegated managed care function and our CMH functions into a model that addressed both ***quality assurance***, through compliance monitoring and ***quality improvement***, through performance monitoring and through the implementation of quality improvement projects using the principles of rapid cycle quality improvement.



The ribbon arrows in the diagram to the right emphasize the importance which we have attributed to the continuous flow of information in the quality program. Corporate level plans inform the direction of quality activities and quality activities are continuously informing the organization leadership and governance on the compliance and outcomes of the organization. This dynamic environment is the *first principle* of our program paradigm. We believe that information must be accessible, predictable, continuous, and must meet the needs of all levels of the organization. You will see this demonstrated in "metric reports" which are a signature feature of our program.

The *second principle* of our program is the duality of Quality *Assurance* and Quality *Improvement*. Quality *assurance* activities are typically monitoring key areas of compliance or required performance. Quality *improvement* activities are interventions with the specific intent of resolving a problem or variance from performance or implementation of a new initiative. Our objective is to ensure that all dimensions of operations and service delivery are involved in quality activities and that those activities are visible throughout the organization.

The *third principle* of our Saginaw paradigm is the construct of organizational planning. Three global plans underpin and drive the quality program, the first of which is the Strategic Plan. This plan is

reviewed and updated annually. The strategic plan report is published for stakeholders and presented at the annual public hearing concurrent with the annual cycle of budgeting and community needs assessment. The Compliance Plan and the Quality Plan are subordinate to the Strategic Plan and all three are reviewed and approved by the SCCMHA Board of Directors.

This year the Saginaw County Community Mental Health Authority has reviewed its Quality Program performance under two sets of contractual standards in addition to two sets of accreditation standards. Our CARF three-year re-accreditation is scheduled for the Fall of 2019 and this year, for the first time, we are also considering our readiness to meet the NCQA Managed Behavioral Health Organization standards. While no formal decision has been made to pursue MBHO status with NCQA, as a Michigan 298 Pilot CMH, we want to understand the performance measures that might be expected of us through the Managed Health Plans as we prepare to interface with them as payors. While attempting to meet four different sets of standards might seem ill-advised, we find that there is a great deal of overlap with many of the general principles emanating from federally promulgated standards. There are five themes to these standards which we describe below. The SCCMHA Quality Program has met all contractual standards from the MDHHS and Mid-State Health Network payor contracts in FY 2018 and is scheduled for a MSHN program compliance audit in July of 2019. At our last CARF evaluation a recommendation was made to address the quality cycle in our program, using a PDSA model and increasing our use of data throughout the program. We have addressed that CARF recommendation both in our plan, in projects implemented and the ongoing development of quality metrics.

Organizational Commitment: The requirement for a Quality Program description or plan is universal across payor contracts and accrediting organizations and includes specific expectations for a system of program governance and program evaluation. The Saginaw Quality Plan is documented in both policy and in our annual plan which is published with the report in this document. The policy details how the program will operate (process) and the plan details what topics of work will be addressed (content).

Consumer and Provider Involvement: The requirements for consumer and provider involvement are also uniform expectations. Inclusion of consumers/members in evaluating and improving the experience of the service delivery system in areas such as access, authorizations, network adequacy is detailed in the Quality Policy. There are similar expectations for business operations which shape the provider experience.

Public Information: The expectation for the publication of the results of program performance evaluation is also universal. Whether satisfaction surveys, key-performance measure, continuous quality improvement measures or overall program performance the agency is expected to provide stakeholders with the information that they need to evaluate the quality of care.

Data Driven Performance Monitoring: In this era of Electronic Health Records there is virtually no aspect of care that can't be quantified for the purpose of monitoring and improvement. SCCMHA has dedicated the past ten years to the maturing of our data infrastructure and this is evident in our use of data throughout the quality program.

Plan, Do, Study, Act (PDSA) Performance Cycle: SCCMHA is a rather pragmatic organization and as such we chose a quality curriculum that was basic, easily taught and communicated and amenable to the circumstances of quality improvement as we experience it this fast-paced healthcare environment.

Embracing Quality in Public Health: A Practitioners Quality Improvement Guidebook, Michigan Public Health Institute, 2012, was funded by a Robert Woods Johnson Foundation grant and is in use in a number of collaborative population health workgroups throughout Saginaw County. The MPHI guidebook uses basic quality improvement concepts, is readily applicable to CMH operations and as such was chosen to support our core curriculum.

QAPIP and QIP Compliance Summary

This 2018 Quality Program Report marks the end of the third full year of conversion and implementation of the SCCMHA Rapid Cycle Quality Improvement Program. With this report we will resume an annual planning cycle as opposed to a multi-year plan with annual reports, knowing that many tasks in our work-plan will extend beyond a twelve-month horizon as we engage in a program of continuous quality improvement.

In the July 2017 Mid-State Health Network Delegated Function site visit, SCCMHA was found in full compliance with 168 delegated functions under the PIHP contract and in partial compliance with 3 of the 171 standards.

In 2018, the Interim year for MSHN Site visit, SCCMHA was found in full compliance for newly issued requirements and implementation of corrective action plan for the three elements that had been in partial compliance in 2017. The Mid-State site review also covers the CMHSP Quality Assurance contract requirements which are a sub-set of the delegated functions.

The Mid-State Site Review report is received and responded with approval of corrective action plans by the Quality Governance Council. This site review along with a review of CARF accrediting performance standards comprise the assessment of the SCCMHA quality program performance. This report is available to the public on the SCCMHA website.

The following table shows the Quality Program standards from the CMHSP and PIHP payor contracts which are reviewed by Mid-State Health Network.

FY 2018 CMHSP Standards C.6.8.1.1		Status	FY 2018 PHIP Delegated Standards P.7.9.1		Status
I	Quality Improvement Program	Met	I	Written program description	Met
II	Systematic Process	Met	II	Accountable to Governing Body	Met
III	Accountable to Governing Body	Met	III	Senior official	Met
IV	QIP Supervision	Met	IV	Active participation by providers and consumers	Met
V	Provider Qualification	Met	V	Standardized indicators	Met
VI	Enrollee rights and responsibilities	Met	VI	Assurance of minimum performance	Met
VII	(number skipped in CMHSP contract)		VII	Performance Improvement Projects	Met
VIII	Utilization Management	Met	VIII	Sentinel Events	Met
			IX	Behavior Treatment Review	Met
			X	Member experience	Met
			XI	Practice Guidelines	Met
			XII	Provider Qualification	Met*
			XIII	Event Verification	Met
			XIV	Utilization Management	Met
			XV	Delegation Monitoring	Met
			XVI	Vulnerable population monitoring	Met
				*3 items found partially met in 2017 were met in 2018	

Chartered Workgroups and Associated Quality Metrics

In FY 2018 twenty-six chartered workgroups were formed, some were newly formed and others were existing groups which were incorporated into the new model of Quality Governance. This model of Quality Governance ensures that resources are used efficiently and the workgroups are given defined scopes of work. Our goal in work group deployment is to achieve as broad a reach as possible throughout the operation with a high level of integration across departments reducing the silo effect of department level operations.

- Access and Identity Management (AIM) Team: The AIM Team will monitor the risk of privacy breach of the Sentri II electronic health record in regular sessions. The objective of the cross division workgroup is to ensure that a standard of operation is met in each of the security sectors of the Sentri II set up including staff security level, staff program assignment, log on frequency, approval and termination, consumer program assignment, and break-the-glass (BTG) utilization. The group will also continue to examine all system functions which pose possible access to records beyond the HIPAA allowed Treatment, Payment and Operations (TPO) or reasonable Incidental Exposure. The *AIM Metric Report* developed by this team includes "Break the Glass" uses, staff (user) records and program enrollment This Metric Report is reviewed by Compliance and Policy Team.
- Access Management Group (AMG): Reporting to the Service Management Team, the AMG is a utilization management group responsible for monitoring the penetration and engagement

rates with a focus on the patient experience. The newly developed Metric Report from the AMG groups performance measures into four stages of Access including: Outreach, Access, Engagement, and Activation activities. The *AMG Metric Report* is reported to the Services Management Team.

- Adult Case Management (ACM) Team Leaders: The ACM Team Leaders, from both direct and contracted programs, meet regularly to address critical issues relative to service delivery compliance and needs. Team Leaders are asked to give input on training needs, to discuss implementation of compliance corrective action plans or remedies, and to get updates from SCCMHA on key areas pertaining to their work. The venue often provides an opportunity for mini-training sessions to orient the supervisors to key system changes, including EMR updates. Data relative to consumer population assessments and outcomes is shared.

- Behavior Treatment Committee (BTC): The Behavior Treatment Committee is a contractually required committee that reviews behavioral plans which contain restrictive or intrusive interventions and approves or denies the use of that intervention. The BTC has also taken on the coordinating role of improving the quality of positive support plans through training and the implementation of the Behavioral Champions program. The *BTC Metric Report* includes quarterly emergency intervention data that is submitted to MSHN and it is monitored by the BTC and the Service Management Team.

- Board Operated Billing Integrity (BOBI) Workgroup: The objective of BOBI is to prevent errors from occurring at any point in the documentation of services provided through the construction of a billing file for board operated services, whether paper or electronic, to any payer and to establish a routine monitoring and self-audit procedure to ensure that such errors or fraudulent charges do not occur through any SCCMHA billing. A revenue cycle critical path analysis is done to be sure that, as the system evolves, any set up changes which could be problematic are identified and monitored.

- Care Management Conference (CMC): Care Management Conference is charged with monitoring all dimensions of managed care authorization processes. Their objective is to demonstrate optimal functioning of the system of controls for authorization. The *Care Management Metric Report* includes aggregate authorization status and timeliness data and it is reviewed by the Services Management Team on a monthly basis.

- Children's Case Management (CCM) Team Leaders: The CCM Team Leaders, from both direct and contracted programs, meets regularly to address critical issues relative to service delivery compliance and needs. Team Leaders are asked to give input on training needs, to discuss implementation of compliance corrective action plans or remedies, and to get updates from SCCMHA on key areas pertaining to their work. The venue often provides an opportunity for mini-training sessions to orient the supervisors to key system changes, including EMR updates. Data relative to consumer assessments and outcomes is shared.

- Claims/Contracts/Care Management/Coding (CCCC): The CCCC workgroup consists of Coding, Care Management, Claims, Contracts departments working together in efforts to ensure State service code/modifier/credential compliance, rate setting integrity, and various departmental functions such as authorizations and claims entry/processing on behalf of the external SCCMHA service provider network. Workgroup goal is to streamline processes

between departments to ensure timely service delivery to SCCMHA consumers, troubleshoot problems, and standardizing systems to support provider relations.

- Clinical Risk Committee (CRC): The CRC monitors clinical issues related to the safe and appropriate treatment of consumers through an interdisciplinary review. The committee addresses and recommends treatment approaches for consumer's whose conditions are at high risk, complicated, or unusual. They review cases brought forth with concerns regarding diagnosis and treatment, and may review and recommend modifications to agency policy and/or practices that negatively affect the treatment of consumers and/or the safety of consumers, staff and/or visitors.
- Continuing Education Committee (CEC): It is the expectation that SCCMHA will ensure a competent network of service providers. SCCMHA specifies required instruction in specific areas for service delivery providers of mental health and substance use disorder services. When on-site audits and other compliance reviews of SCCMHA operations are conducted, proof of those required education standards for employees, staff and providers must be provided. In addition, the provision of ongoing education and competency testing ensures at a minimum, compliance with the State and Federal standards, and also the provision of appropriate and quality services that maintain and promote the health, safety and goal achievement of persons served by the SCCMHA network.
- Credentialing Committee (CC): The Credentialing Committee provides oversight for needed credentialing activities across the network, assuring compliance and appropriate processes and policies in keeping with any federal, state or regional requirements and changes. Maintains summary reference documents and may consult with specific persons as needed to conduct work.
- Critical Incident Review Committee (CIRC): The purpose of CIRC is to monitor and review all consumer-related critical incidents, risk events, and sentinel events to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. CIRC includes the participation of the SCCMHA Medical Director. The CIRC also analyzes aggregate incident report data, seeking both common cause and special cause variances which indicate the need for quality improvement interventions. Critical Incidents are submitted to MSHN monthly and the work of the CIRC is trended on the *CIRC Metric Report* also monitored by the Service Management Team.
- Employee Wellness Committee: To keep energy around the focus of wellness, the Employee Wellness Committee generates ideas to encourage employees to participate and engage in wellness initiatives to improve overall health and wellness. The Committee develops goals and activities, such as a personal health assessment, as a means to provide feedback to an individual to assist employee decision making regarding personal wellness and health decisions. Information, such as a personal health assessment, will be developed and shared in an effort to engage employees in determining if a personal call to action is warranted. The Committee's goals and activities focus upon a personalized service approach with a special emphasis upon face to face communication as the primary vehicle for communication of wellness education. The Annual Wellness Plan guides and informs development of goals and activities. These goals and activities are generated at the committee level for the purpose of

developing individual and group interventions. Success is be measured by tracking the number of employees who engage in education related activities as well as the number and level of contact of each engagement.

- Environment of Care Committee (EOC): The Environment of Care Program was designed to provide a functional and safe environment for SCCMHA employees, consumers of service, and visitors to provide an environment that is safe from recognized and potential physical hazards. The EOC Program also provides guidelines for managing staff activities with the goal of reducing the risk of accidents and mishaps. The EOC Program provides guidance consistent with the SCCMHA mission and vision and ensures compliance with applicable local, state and federal codes and regulations as well as other legal and regulatory guidelines including CARF, OSHA and the National Fire Protection Agency. The EOC Program consists of five Environment of Care Plans that are maintained by SCCMHA Supervisors and Directors including: Fire Safety; Health Management; Safety Management; Security Management; and Emergency Management. The *EOC Metric Report* uses a risk factors and protective factors paradigm for consideration of program scope and effectiveness.

- Evidence-Based Practice (EBP) Leadership Team: The Evidence-Based Practice (EBP) Leadership Team was formed shortly after the Evidence-Based Practice Coordinator position was created. The team was created to provide oversight and consultation to the Evidence-Based Practice Coordinator. The EBP Leadership Team also provides consultation to the EBP Coordinator on such things as privileging, fidelity reviews, and vetting of new Evidence-Based Practices. The EBP Leadership Team is also the group that researches new practices and identifies practice needs within the network. The *EBP Metric Report* is used to track the rate of utilization across the network. The team will oversee the implementation of new EBPs and the vetting of all new practices being implemented in the agency and network.

- HCBS Rule Implementation Workgroup: Statewide HCBS Rule Implementation as required by recent federal Medicaid regulation changes necessitate improvements in applicable mental health service settings for covered beneficiaries/consumers to ensure funded system compliance by the March 2022 federal deadline. Through direction of the PIHPs, for SCCMHA via Mid-State Health Network, SCCMHA as a CMHSP will work with residential, skill build, other CLS and supported employment providers to ensure consumer freedom, privacy, choice and all other conditions of the federal statue(s) are met in order to continue to use Medicaid funds for such services. Although the Michigan transition plan is not yet officially approved by the federal government, it is assumed that this will apply to all State Plan, B and B(3), Medicaid Waiver setting based services as well, not just habilitation waiver, including specialized residential sites, and community living supports, skill build and supported employment services for all such consumers. Change parameters include but are not limited to the following protections: selection of provider, choice of roommate, ability to lock bedrooms and bathrooms, ability to furnish and decorate private spaces, freedom of movement in the community, open access to food and visitors, access to funds and existence of a lease or otherwise compliant legal agreement and various person-centered planning and accessibility requirements. In keeping with adjustments being made in state licensing standards to accommodate elements of the rule, SCCMHA will offer guidance and oversee local compliance for these needed changes across its provider network.

- Health Care Integration Committee (HCIC): The Health Care Integration Committee focuses upon agency-wide transformation to health care integration and Meaningful Use capacity, implementation and certification. The committee focus upon establishing, identifying and/or reviewing existing key performance indicators that impact consumer health outcomes across the life span of the consumers we serve. This committee also provides another context, in addition to CIRC, for practitioner leadership in the Quality Program through the ongoing participation of the SCCMHA Medical Director and a Physician Assistant.

- Peer Support Specialists (PSS) Workgroup: The purpose of this workgroup is to provide a venue for education, information, news and issues dialog as well as an opportunity to discuss their unique roles with the services they provide to the populations served by SCCMHA. Additionally, this meeting provides an opportunity for Peer Support Specialist to network and receive support from their colleagues in their roles within the SCCMHA system. It is also a venue for direct communication between Peer Support Specialists throughout the SCCMHA system and the SCCMHA administration. The goal of this meeting is to provide the Peer Support Specialists within the SCCMHA system the support and information they need to feel confident and successful in their roles.

- Quality of Life (QOF) Workgroup: The mission of the QOL Workgroup is to improve the quality of life for adults who reside in licensed settings in Saginaw County. The QOL work group is concerned with health and safety, living arrangements, community involvement, positive relationships and staff supports, income resources, home conditions, rights, freedoms and choice as well as transportation needs for these persons served. Some of the past accomplishments of the QOL workgroup include home manager training curriculum development, First Choice of Saginaw creation, development of the quality of life workbook - "A World of Choices," recognition of direct care staff, development of uniform house rules and approval process for all homes, publication of Licensed Residential Homes Directory (which assists consumers and others in selection of home settings and promotion of independent living skills) and implementation of Memorandum of Understanding (MOU) agreement with general (non-contract) AFC providers.

- Residential Provider Watch Committee (RPWC): This committee was started in order to preempt closures of residential facilities and to offer support for residential providers that might be struggling. Prior to the inception of this committee, the clinical staff were having to deal with residential closures especially around holidays when there were minimal staff available to assist with finding placement options for consumers. We have identified areas of risk of displacement from consumer residential living arrangements and work with the providers to prevent, when possible, this potential risk. This is also a venue to bring concerns noted by others in the community, staff at SCCMHA, or other interested parties for discussion and possible solutions for providers under contract as well as providers that may not be under contract but may need some additional education or monitoring by support staff. At times it has been necessary to have key members of the committee meet with providers to discuss the issues and come up with a workable solution agreeable by the committee and the provider. The objective of the workgroup is to minimize the necessity to move consumers out of a residential facility due to loss of licensure or poor quality of care for consumers by offering additional monitoring, supports in way of trainings, additional quality reviews such as

quality of life reviews or audits, property inspections and additional visits by clinical staff already involved with consumers at the facilities.

- Security Management Committee (SMC): Information security is a set of strategies for managing the processes, tools and policies necessary to prevent, detect, document and counter threats to digital and non-digital information. The purpose of the Security Management Committee is to establish and oversee business processes that will protect information assets. (Delayed start of this chartered workgroup until completion of role-based security conversion.)
- Sentri II: This group meets to review decisions on how Sentri II should be configured as a whole. Representatives from various users and management combine to establish consensus. Information is distributed as to upcoming changes. The meeting agenda is set by requests as well as discussions from the Sentri Planning Team.
- State Reporting Workgroup (SRW): This workgroup is charged with ensuring SCCMHA compliance with MDHHS and MSHN contractually defined reporting requirements; documenting the data collection processes on which those reports are based and monitoring the completeness of the submitted data. This workgroup is responsible for monitoring sources of state reporting policy communications such as EDIT, CIO Forum and MSHN QIC and UM. Encounter, BH-TEDS and Performance Indicator counts are trended on the *State Reporting Workgroup Metric Report* which is submitted to the Operation Committee each month.
- Supports Coordination Team Leaders: The Supports Coordination Team Leaders, from both direct and contracted programs, meet regularly to address critical issues relative to service delivery compliance and needs. Team Leaders are asked to give input on training needs, to discuss implementation of compliance corrective action plans or remedies, and to get updates from SCCMHA on key areas pertaining to their work. The venue often uses mini-training sessions or to orient the supervisors to key system changes, including EMR updates. Data relative to consumer assessments and outcomes is shared.
- Trauma Informed Care (TIC) Core Implementation Team: SCCMHA has been accepted in the National Council for Behavioral Health TIC Learning Community, for 2017 - 2018. Kick off was in April 2017, with required representation at Nat Con conferences in 2017 and 2018. Historically, SCCMHA has maintained a training program and work plan related to the promotion of trauma informed services, including hosting a community event in May 2008, development of a policy in 2012, implementation of various evidence-based practices recognizing trauma, hosting a community webinar in 2015, some trauma informed assessment of the SCCMHA environment, and continued emphasis on trauma and building resiliency in the support of persons being served. SCCMHA's trauma work has been part of the Saginaw Community Health Improvement Plan, Behavioral Health Action Group plan. In 2016 SCCMHA initiated the provision of routine Trauma 101 training, now a mandated training for the service network but also available to community partners in Saginaw. Including through SCCMHA's support of the Saginaw MAX System of Care, SCCMHA has also actively recognized the effect of various forms of trauma on adults, children and families, and recently has focused on secondary or vicarious trauma of the workforce. SCCMHA sought

participation in this learning community to continue to be more effective in all aspects of trauma informed care across the local service network.

- Waiver Management Teams: The purpose of this group is to ensure that SCCMHA is in compliance with operational waiver regulations; that system interfaces are synchronized; and that waiver specific revenue payments are optimized. This group meets as three teams in back to back work sessions with the relevant staff attending the waiver session they are associated with. At the time of this charter there are three teams: HSW, Autism and DHS SED/SOC (this last group also address SOC grant revenue in the same manner.) Waiver activity is trended on the *WMT Metric Report* and monitored monthly by the Operations Committee.

In addition to these chartered workgroups there are five executive/management group venues which receive and review quality metric reports. These Teams along with the Chartered workgroups create a matrix of quality assurance and improvement venues which address all populations, demographic groups, services and service locations.

Management Team: Under the leadership of the CEO this group meets monthly, typically with an open work agenda moving the larger scope of corporate decision making. This group writes and reviews the SCCMHA strategic plan and prepares presentation for the annual public hearing. The Strategic Plan was reviewed and updated in September 2018 and presented at October 4, 2018 Public Hearing.

Service Management Team: Under the leadership of CEO, the Service Management Team is a subset of the management team and focuses on clinical service delivery. Metric reports reviewed by this group include: *Access Management Group metric report*, *Behavior Treatment Review metric report*, *Care Management Conference metric report*, *and the Primary Team Capacity metric report*.

Operations Team: Under the leadership of the Finance Director, this team is comprised of the management team with an agenda which includes the working discussion of all matters related to finance and operations. The group reviews several quality metric reports including the *Medicaid Penetration Rate metric report*, the *State Reporting metric report*, and the Waiver Management Team Metric Report.

Compliance and Policy Team: Under the leadership of the SCCMHA Compliance Officer, the Compliance and Policy Team monitors the implementation of the Compliance Plan and is the venue for review of all matters related to regulatory and payor requirements. The Compliance and Policy Team serves as a venue for the intake and distribution of regulatory, policy and laws which impact the agency's strategic plan and corporate obligations. The agenda is twofold with the Compliance Officer presenting newly published content gathered from public sources and members of the team surveying their respective scopes of policy information from Michigan Department of Health and Human Services or Mid-State Health Network committees. This workgroup also monitors the Quality Assurance Metrics of relevant chartered workgroups working in the area of compliance, the *Access and Identity Management Metric Report* is reviewed here.

Quality Governance Council: Under the leadership of the Director of Care Management and Quality Systems, the management team assembles to provide oversight of the quality process, approve new charters and guide the overall implementation of activities under the plan. The *Mid-State Health Network Key Performance Indicator Metric* Report along with the *Clinical Quality Measures Metric Report are reviewed by Quality Governance.*

Quality Program Progress on 2018 Workplan

The FY 2018 QAPIP Workplan was originally approved as a three-year plan with the following planned activities.

Task	Results	Status
1. Recruit and hire at least one more Quality Project Specialist.	One additional staff member was hired	Complete
2. Develop and publish metric reports for Environment of Care, Credentialing, Health Integration, Zenith and Board Operated Billing Integrity.	Three of the five are complete: Environment of Care, Health Integration and Zenith which has been retitled Utilization Risk Analysis Two are incomplete: Credentialing and Board Operated Billing	Partially complete and carry forward to FY 2019.
3. Implement the Access Management Group and Outcomes Measurement Group metric reports which are in development.	AMG Metric Report is complete	Complete
4. Link the revised Care Management Plan to the Quality Plan with concurrent review metric reports.	The Care Management metric report is complete but the Care Management Plan revision has been delayed awaiting the MSHN decision on a Level of Care model and MSHN Parity Plan implementation of MCG for acute care medical necessity review.	Partially complete and carry forward to FY 2019
5. Implement and report on MIPS (Merit-based Incentive Program) Quality Measures.	The Clinical Quality Measures metric report is complete	Complete
6. Fully implement Meaningful Use measures and report on performance.	The Meaningful use measures, now referred to a Promoting Interoperability was met in FY 17 but not in FY 18. The measures related to implementation of the portal with successful messaging and the electronic messaging through HIE were not completed.	Partially complete and carry forward to FY 2019
7. Consider Charter for Customer Service Customer Satisfaction workgroup.	The Director of Customer Service and Recipient Rights has started drafting a charter,	Not started, carry forward to FY 2019.

8. Create stakeholder membership lists and create events for stakeholder input.	The Director of Customer Service and Recipient Rights plans to include this in the scope of work for the CSCS Charter (Task #7above.) Several consumer stakeholder events were held in addition to the Consumer Leadership Group.	Not started.
9. Finish the revision of the Enterprise Risk Management Plan.	The idea of a broad risk management plan was withdrawn and a focused document Compliance Plan was approved by Compliance and Policy Team in February 2019 and is scheduled for presentation to the Board in March.	Complete
10. Create and implement Quality Curriculum with Continuing Education Unit.	The quality curriculum work has moved to the Outcomes Measurement Group and the new Manager of Network Services and Continuing Education has joined the membership of OMG. Work on the PDSA Quality Procedure and training was initiated in February 2019. The Outcomes Measure Group revised its charter and name in June 2019 and will serve as the Performance Measure Group with task of teaching PDSA cycle in all projects and tracking and monitoring all chartered projects.	Started and carry forward to FY 2019
11. Identify Quality Consultants/Faculty for ongoing training and consultation.	The Apprecots SCCMHA consultant group continues to advise on use of CAFAS, ANSA and related clinical outcomes measures. The MiCETA organization provides consultation on Promoting Interoperability and MIPS. The CMH Association in Michigan will be conducting Rapid Cycle quality training in FY 2019 which SCCMHA will take advantage of.	Partially complete and carry forward for FY 2019.
12. Complete a communication plan for distribution of reports outward through the organization to consumers and the public.	Metric report distribution plan complete, external communication plan not yet started.	Partially complete and carry forward to FY 2019.
13. Initiate project reports at least annually summarizing work of Chartered Workgroups.	Not started	Not started, carry forward to FY 2019
14. Discuss and draft a Data Governance policy.	Not started.	Not started, carry forward to FY 2019.

Quality Plan FY 2019

1. Carry Forward Tasks: The tasks numbered 2, 4, 6, 10 from the table above are partially complete with work in progress. Tasks numbered 7, 8, 13 and 14 will be initiated in FY 2019.
2. New Quality Director: In FY 2019 a new Director of Quality will be hired to replace the retiring director. The organization will have the opportunity to recruit a new member of the

management team who will advance the analytics work accomplished to date and who will further implement the integration of quality metrics and projects in partnership with the Medicaid Managed Health Plans.

3. Ends Committee: Create a new Metric Report to inform the Ends Committee of the SCCMHA Board using the 19 CMHSP contract attachment topic areas: Access Standards, Person Centered Planning, Self Determination, Recovery, Special Populations, PASARR, SED Waiver, Mental Health Court, Local Dispute Resolution, Behavior Treatment, IST/NGRI, Housing, Inclusion, Consumerism, Jail Diversion, School to Community Transition, Family Drive/Youth Guided, Employment Works!, and Trauma.
4. Provider Experience Survey: SCCMHA will implement a survey soliciting the experience of the broader SCCMHA provider network. We will include NCQA required topics such as experience with prior authorization, claims adjudication, provider appeals, provider access for questions and resolution of claims and authorization concerns, and methods of referral.
5. Succession Training and Program Development: In 2019 the ranks of the SCCMHA management team will be nearly completely changed with new members joining who are replacing four retiring directors along with the addition several new members who have been added to deepen the management capacity of the organization. This new group of leaders will require training in the Saginaw Quality Improvement Program Model.