QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

FY23 ANNUAL PLAN

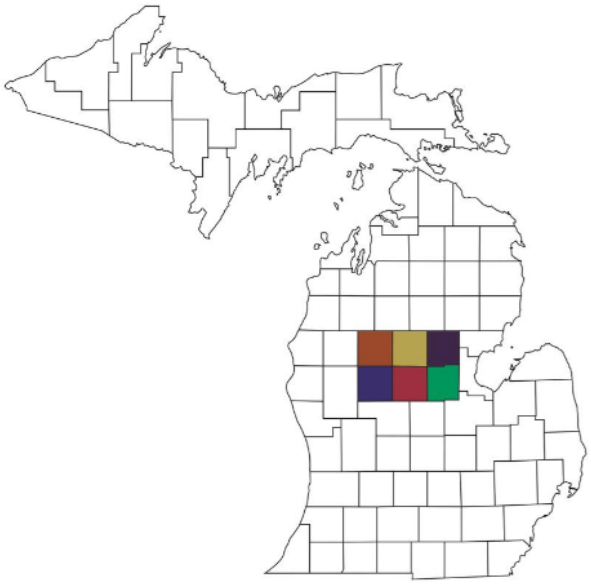
Community Mental Health
FOR CENTRAL MICHIGAN

PREPARED BY CHIEF QUALITY & COMPLIANCE OFFICER - 7/15/2022
REVIEWED AND APPROVED BY MANAGEMENT TEAM- 8/3/2022
REVIEWED AND APPROVED BY PIC - 8/24/2022
REVIEWED AND APPROVED BY SERVICES COMMITTEE - 9/8/2022
REVIEWED AND APPROVED BY CMHCM BOARD - 9/27/2022

Introduction

Community Mental Health for Central Michigan (CMHCM) provides an array of behavioral health and co-occurring substance use disorder services and supports to individuals in the Michigan counties of Clare, Gladwin, Isabella, Mecosta, Midland, and Osceola through a network of directly operated programs and contracted service providers. CMHCM is a Michigan Department of Health and Human Services (MDHHS) certified Community Mental Health Service Program (CMHSP) and is accredited by The Joint Commission.

CMHCM places quality care for consumers at the core of its mission utilizing the Quality Assessment and Performance Improvement Program (QAPIP) Plan and Strategic Plan to advance its following agency mission, vision, and values:



MISSION

To promote community inclusion and whole-person wellness through comprehensive and quality integrated services to individuals with a Serious Emotional Disturbance, Intellectual/Developmental Disability, Serious Mental Illness, or Co-Occurring Substance Use Disorder

VISION

Communities where all individuals experience fulfilled lives

VALUES

CMHCM Values:

- The dignity and worth of each individual
- Consumer involvement and empowerment
- Person-Centered Planning and Self-Determination
- Trauma Informed Care
- Behavioral and physical health integration
- Early intervention, prevention, and wellness
- Diversity and community inclusion
- Advocacy and public education
- Responsiveness to local community needs
- High quality services that are affordable and accessible
- Creativity, Innovation, and Evidence-Based Practices (EBPs)
- Competent staff and providers
- Continuous quality improvement
- Participative management
- Ethical practices
- Fiscal integrity and efficient utilization of resources

Purpose and Background

PURPOSE
The QAPIP and CMHCM Quality Assessment and Performance Improvement Program Policy (5.300.004) both support the mission, vision, and values of the agency through various quality improvement initiatives along with meeting the standards in the following documents:

1. MDHHS/CMHSP Managed Health Supports and Services Contract - Attachment C6.8.1.1
2. Mid-State Health Network (MSHN) Quality Management Policy
3. The Joint Commission Comprehensive Accreditation Manual

The CMHCM QAPIP objectively and systematically monitors and evaluates the quality and appropriateness of care and services to its consumers through quality assessment and performance improvement projects in conjunction with related QI activities. In addition, the agency collects, compiles, and analyzes data through the QAPIP program to improve organizational and service performance.

SCOPE
The QAPIP defines how processes, systems, functions, and outcomes related to all consumers, staff, and service delivery provided by the agency directly or by contract through the CMHCM Provider Network are monitored and evaluated. The CMHCM QAPIP includes delegated functions of the Pre-Paid Inpatient Health Plan (PIHP), MSHN, in support of the MSHN QAPIP.

ORGANIZATIONAL ELEMENTS AND ACTIVITIES
The agency encourages active involvement in the quality improvement process from all levels within the agency in addition to the involvement of consumers, families, advocacy groups, the community, the CMHCM Provider Network, and coordinated efforts through MSHN. The Board of Directors are responsible for approving the QAPIP Plan and the QAPIP Policy; the Executive Director carries out the annual QAPIP Plan; the Deputy Director for Administration is responsible for the QAPIP implementation; the Medical Director advises on the QAPIP Plan regarding clinical standards/practice guidelines; the Management Team implements performance improvement principles in all programs; direct service staff provide first-hand perspectives on improvement effectiveness and make suggestions for improvement; and subcontracting agencies offer suggestions for improvement. Subcontracting agencies carry out quality improvement efforts and performance activities within their own organizations.

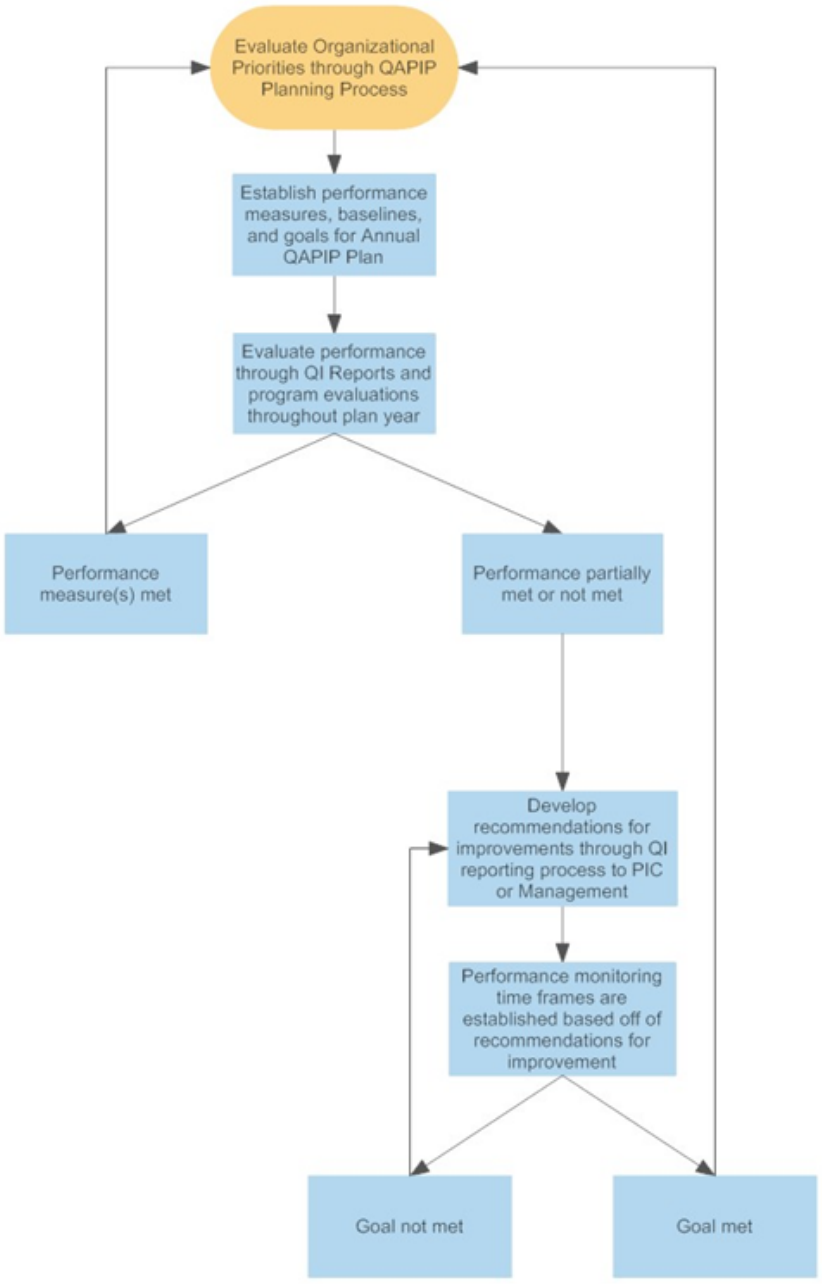
The Performance Improvement Committee (PIC) and agency's Management Team provide oversight to the QAPIP. Agency standing committees and performance improvement teams provide reports on a regular basis to the assigned oversight committee.

Agency standing committees are responsible for performance improvement in their area of responsibility. Standing committees are listed in Appendix A along with their charges. Each committee publishes minutes documenting its activities, quality improvement suggestions, findings, recommendations, and actions. Process improvements and recommendations are reviewed and adopted through the PIC and Management Team. Changes made within these teams are then communicated to the agency through published minutes as well as agency communications. The flow of quality information throughout the agency is outlined in the Quality Improvement Process located in Appendix B.

CMHCM's Performance Improvement System
Performance Improvement (PI) teams are initiated and operated under the direction of an agency standing committee and the Executive Leadership Team (ELT). Teams meet on an ad-hoc basis to address an assigned issue, agency process, or to design a new process, and may form workgroups to address specific components of more complex processes.

The process and outcome improvements implemented by the PI teams are communicated at staff meetings, provider network updates, the agency website, the agency intranet, through online/in-person trainings, and/or all staff email, as appropriate. The improvement process is monitored, as designed, under the direction of an agency committee or team and reported to the applicable oversight committee.

Identified initiatives follow the various stages of the PI process through ongoing measurement and intervention based on a problem-solving model. The CMHCM QAPIP Policy (5.300.004) describes the model of design, measure, assess, and improve and is depicted in Appendix A. This model is incorporated in scheduled progress reports for quality initiatives identified within the QAPIP Plan. The overarching QAPIP process can be found below:



PI initiatives are identified through various means such as by contract with MDHHS or MSHN; external review entities; QI suggestions from consumers, providers, and staff; QAPIP goal progress report recommendations; or CMHCM Strategic Plan initiatives. All demographic groups, care settings, and types of service are included in PI initiatives. These opportunities for improvement are prioritized by the ELT, Management Team, and/or PIC according to the severity of the issue, as well as the impact on services and supports for consumers and agency operations.

Quality assessment and PI initiatives involve data analysis, as applicable, to support problem identification. Appropriate follow-up as related to either an individual case or systemic action includes communication with those involved, staff, Provider Network, and/or MSHN. The Quality Improvement Department tracks the progress of PI initiatives and suggestions. Additionally, performance indicators are monitored and compared to available benchmark statistics to identify additional opportunities for internal agency improvements.

In reviewing regional performance measurements, if progress on a measure falls below regulatory standards and/or identified established targets by CMHCM, additional quality improvement plans are required to be submitted to MSHN with corrective action plan interventions outlined. These improvement plans are monitored and followed by MSHN for corrective action and follow-up to ensure that regulatory standards are met upon establishment of interventions for improvement.

Data is used throughout the agency for decision making as well as performance monitoring of treatment outcomes, programs, and processes. Performance improvement utilizing data is dynamic, system-wide, and integrated into most processes. CMHCM tracks multiple key performance indicators to manage risk, ensure consumer outcomes, and track achievement of organizational strategies and priorities. The measures established within this QAPIP Plan reflect the agency's priorities for FY2023 and are designed to ensure accountability of the responsible parties identified for oversight and monitoring of the agency's objectives. These QAPIP priorities have been established in consideration and alignment with CMHCM's key strategic priority areas outlined for FY2021-2023.

Recipient Rights

CMHCM is committed to ensuring that all consumers are treated with respect, dignity, and consideration that acknowledges all of a consumer's rights and responsibilities. The CMHCM Recipient Rights, General Administration, General Rights Policy (7.100.006) monitors and ensures that recipients of mental health services have all of the rights guaranteed by state and federal law in addition to those guaranteed by the Mental Health Code. Procedures have been established to address complaints and appeals through the CMHCM Recipient Rights office. The Recipient Rights Department will monitor and evaluate substantiated Recipient Rights complaints to identify trends or patterns that occur to ensure that additional staff training is completed as necessary. Recipient Rights data will be submitted to MDHHS bi-annually.

Adverse Event Management

Critical events, sentinel events, and other events that put people at risk of harm will be identified, reported, analyzed, and managed in an effort to understand root causes and identify opportunities for risk reduction.

The Sentinel Event Review Committee will review critical incidents, sentinel events, and develop action plans that minimize future occurrences on a quarterly basis. As necessary, root cause analyses are completed and risk reduction strategies are recommended to reduce the likelihood of recurrence. Event data will be submitted to MSHN for benchmark analysis and to MDHHS in fulfillment of critical incident reporting requirements. Timeframes for reporting are identified within the CMHCM Sentinel Event Policy (5.300.001).

FY23 Clinical Service Priorities

The following QAPIP priorities shall guide quality efforts for FY23. The below QAPIP activities are aligned with the CMHCM Strategic Plan and Priority Areas of Provision of Clinical Services, Whole-Person Behavioral/Physical Health Integration, Outreach and Education, and Operational Sustainability.

CMHCM promotes community inclusion and whole-person wellness through the provision of comprehensive and quality integrated services to children and adults with an intellectual/developmental disability (I/DD), children with Serious and Emotional Disturbance (SED), and adults with a Serious and Persistent Mental Illness (SPMI) and co-occurring substance use disorder.

CMHCM assures the health and welfare of its consumers by assuring that services are consistently provided in a manner that considers the health, safety, and welfare of consumers, family, providers, and other stakeholders. CMHCM reviews service provision data regularly to monitor adequacy of treatment approach for consumers based on medical necessity.

Objectives/Activities	FY22 Baseline (Q1-Q3)	FY23 Performance Goal	Assigned Team/Position	Frequency of Review	Review Committee(s)
A.1. 100% of Psychosocial assessments are completed within 365 days of the previous psychosocial assessment date	56%	100%	COC/Deputy Director for Services	Semi-Annual	Management
A.2. 100% of Person-Centered Plans are completed within 365 days of the previous PCP effective date (or prior to expiration date of the PCP)	67%	100%	COC/Deputy Director for Services	Semi-Annual	Management
A.3. 100% of Person-Centered Plans will be provided to consumers/guardians within 14 days of the PCP Meeting	72%	100%	COC/Deputy Director for Services	Semi-Annual	Management
A.4. Service Activity Log (SAL) Timeliness will be reduced to an average of 24 hours agency-wide	5 days	24 hours	COC/Deputy Director for Services	Semi-Annual	Management
A.5. 100% of youth and family therapists will be trained in at least one evidence-based practice in FY23		100%	COC/Deputy Director for Services	Semi-Annual	Management
A.6. The number of consumers served with an I/DD primary diagnosis in the Supported Employment program will increase to 35 consumers in FY23	11	35	COC/Deputy Director for Services	Semi-Annual	Management
A.7. Baseline data will be collected in FY23 on the completion rates of the DLA-20 outcome measurement tool for targeted improvement efforts in FY24		Baseline Collection Year	COC/Deputy Director	Semi-Annual	Management
A.8. Eighty-five (85) percent of consumers will utilize at least the minimum authorized amount of internally provided services	35%	85%	COC/Deputy Director	Semi-Annual	Management
A.9. Baseline data will be collected in FY23 on the number of services provided through iPad screenings within the law enforcement crisis pilot for targeted improvement efforts in FY24		Baseline Collection Year	COC/Deputy Director	Semi-Annual	Management

FY23 Clinical Oversight Priorities

Behavior Treatment

The CMHCM Behavior Treatment Policy (2.200.001) guides the administration of the Behavior Treatment Committee (BTC). The BTC submits quarterly reports to the PIC on data for intrusive or restrictive techniques that have been approved for use with consumers and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis. The BTC also tracks patterns of incidents or interventions that suggest opportunities for improvement, planning, or training, and arrange for follow-up. This includes review of children on psychotropic medications who are not currently participating in an evidence-based practice (EBP) treatment or who have a positive support plan in place. The data will be submitted to MSHN on a quarterly basis for benchmark analysis. The objectives identified below will help the effectiveness of behavior treatment plans implemented for individuals receiving CMHCM services.

Objectives/Activities	FY22 Baseline	FY23 Performance Goal	Assigned Committee/Team, Assigned Person	Frequency of Review	Review Committee(s)
B.1.1. Behavior Treatment Team will work with CMCHM Provider Network Department and CMHCM Rights Department to implement a targeted BTC-related training calendar to include both the understanding of when BTC review is required and information around development of positive support interventions for direct care staff over FY23			BTC/Waiver Services Manager	Quarterly	PIC
B.1.2. The Behavior Treatment Team will increase multi-disciplinary treatment team meetings with AFC homes by 25 percent over FY22 totals to address ongoing behavioral support needs	19	24	BTC/Waiver Services Manager	Quarterly	PIC

Integrated Health

CMHCM continues its efforts to integrate physical and mental health services with the goal of improving overall consumer health. The focus will be on the following to impact whole-person wellness and to increase partnerships with community health and primary care systems to improve consumers' physical health outcomes.

Objectives/Activities	FY22 Baseline (Q1-Q3)	FY23 Performance Goal	Assigned Committee/Team, Assigned Person	Frequency of Review	Review Committee(s)
B.2.1. The Abnormal Involuntary Movement Scale (AIMS) will be performed as indicated in at least 80% of consumers within Health Services	44%	80%	Medical Director/Nurse Administrator	Semi-Annual	Management
B.2.2. Nursing Health Assessments will be completed as indicated in at least 60% of consumers	23%	60%	Medical Director/Nurse Administrator	Semi-Annual	Management
B.2.3. Memorandums of Understanding (MOUs) will be developed and signed by at least 5 adult health provider clinics and 5 child health provider clinics in Isabella County	0	10	Medical Director/Nurse Administrator	Semi-Annual	Management
B.2.4. Nursing use of the care coordination modifier will increase by at least 50%	351	527	Medical Director/Nurse Administrator	Semi-Annual	Management
B.2.5. 100% of nursing staff will be re-trained in the Integrated Health dashboard and population health concepts		100%	Medical Director/Nurse Administrator	Semi-Annual	Management

FY23 Administrative Oversight Priorities

Utilization Management

Utilization Management (UM) practices are guided by the CMHCM Utilization Management Policy (2.400.001) that assures medically necessary services are delivered and provided in an appropriate amount, scope, and duration to provide individuals with the least restrictive, equitable, and most cost-effective service(s). The UM Department completes prospective, concurrent, and retrospective reviews of service utilization to monitor authorization decisions and congruencies regarding level of care determinations that are consistent with MSHN and MDHHS policies, standards, and protocols. Centralization of high cost, high risk service authorizations utilizes a Utilization Review Specialist (URS) review tool which was developed as part of this centralization process to review these requested authorizations and to ensure that all documentation was in the chart to make a utilization determination of medical necessity for services requested.

Objectives/Activities	FY22 Baseline (Q1-Q3)	FY23 Performance Goal	Assigned Committee/Team, Assigned Person	Frequency of Review	Review Committee(s)
C.1.1. Utilization Review Specialist (URS) tool achieve or exceed 70% compliance for the review element, "Does the IPOS include amount, scope and duration for all authorized/requested services?"	53%	70%	Utilization Management/Utilization Manager	Semi-Annual	PIC
C.1.2. Utilization Manager will work with the Quality Department to set up a process to be able to complete quarterly tracking of outliers that will involve developing a new data report looking at LOC (with a focus on the top 5 outliers per LOC and UM high risk/high cost services) to determine if there are outliers within specific counties, programs, or with staff			Utilization Management/Utilization Manager	Semi-Annual	PIC

Provider Network Management

The CMHCM Provider Network Department is responsible for maintaining the Provider Network to assure it is adequate and meets the needs of the consumers. The CMHCM Provider Network Development General Guidelines Policy (3.100.001) guides the department in its work with the provider network. CMHCM holds regular provider meetings and sends frequent email communication to contracted service providers to discuss system issues, regulatory changes, process changes, and to garner feedback from providers on quality improvements. CMHCM assures appropriate access and choice of provider in concert with MSHN Provider Network adequacy efforts. The Provider Network is responsible for assuring that federal, state, and local regulations and requirements are met. When a deficiency is identified, providers complete a corrective action plan. Provider scores are aggregated to identify opportunities for systemic improvement. The Provider Network is guided by the CMHCM Event Verification Policy (3.500.003) for event verification. CMHCM performs event verification on a sampling of all services provided according to this policy. MSHN performs a Medicaid Event Verification (MEV) review to verify that Medicaid services claimed by providers were authorized by CMHCM, delivered as described in the Individual Plan of Service (IPOS), and billed at the correct rate. CMHCM provides data and support as requested by MSHN to verify internal/external Medicaid claims/events.

Objectives/Activities	FY22 Baseline (Q1-Q3)	FY23 Performance Goal	Assigned Committee/Team, Assigned Person	Frequency of Review	Review Committee(s)
C.2.1. Achieve 95% documentation compliance with service documentation requirements for CMHCM contracted providers	84%	95%	Provider Network/Provider Network Manager	Semi-Annual	Management
C.2.2. Achieve 95% provider compliance with staff training requirements for CMHCM contracted providers	83%	95%	Provider Network/Provider Network Manager	Semi-Annual	Management
C.2.3. Develop a provider lunch and learn training schedule with a minimum of one training to be offered to CMHCM contracted provider staff per month. Provider Network team to collaborate with providers to determine topics of interest/need; CMHCM admin/clinical staff collaboration to deliver trainings as needed, review, and monitor provider attendance		12	Provider Network/Provider Network Manager	Semi-Annual	Management

FY23 Quality Management Priorities

Customer Service

Customer Service practices are guided by the CMHCM Customer Services Policy (5.300.002). Customer Service handles all calls where a consumer expresses dissatisfaction and helps individuals understand their options when requesting to file a grievance, appeal, or second opinion. Customer service data is submitted to MSHN on a quarterly basis for grievance, appeals, and denials for benchmark analysis and aggregation to MDHHS.

Objectives/Activities	FY22 Baseline (Q1-Q2)	FY23 Performance Goal	Assigned Team/Position	Frequency of Review	Review Committee(s)
D.1.1. The number of days to resolve a grievance is lower than the MDHHS standard of 90 days	11.5	<90 days	Customer Service Coordinator	Semi- Annual	PIC
D.1.2. The number of days to resolve a local appeal is lower than the MDHHS standard of 30 days	11.8	<30 days	Customer Service Coordinator	Semi- Annual	PIC
D.1.3. The number of days to resolve a second opinion is lower than the MDHHS standard of five days for service access requests	4	<5 days	Customer Service Coordinator	Semi- Annual	PIC
D.1.4. The number of days to resolve a second opinion is lower than the MDHHS standard of three days for hospitalization requests	1	<3 days	Customer Service Coordinator	Semi- Annual	PIC

Quality Performance Improvement Projects (PIPs)

CMHCM will support the two PIPs selected by MSHN with data submission and intervention implementation as requested and determined by the MSHN Quality Improvement (QI) Council.

Objectives/Activities	FY22 Baseline	FY23 Performance Goal	Assigned Team/Position	Frequency of Review	Review Committee(s)
D.2.1. PIP #1: Reducing or eliminating the racial or ethnic disparities between the rate of new persons who are black/African American and the rate of new persons who are white and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment (HSAG Submission)		Baseline Collection Year	Chief Quality and Compliance Officer	Semi- Annual	PIC
D.2.2. PIP #2: Penetration rates by race: Reducing or eliminating the racial or ethnic disparities between the black/African American Medicaid recipients and the white Medicaid recipients penetration rate (Internal MSHN Submission)		Baseline Collection Year	Chief Quality and Compliance Officer	Semi- Annual	PIC

Quality Performance Measurement

Five MDHHS performance measures addressing access to services and outcome metrics are submitted quarterly to MDHHS and MSHN and are reviewed and reported to the PIC. Each measure is reported for adults with a mental illness, children with a serious emotional disturbance, and individuals with an intellectual/developmental disability. MDHHS updated data collection and methodology for two of the performance indicators in FY20; this update no longer allows for exceptions to be documented for outliers. Because of this update along with the COVID pandemic impacting baseline collection, FY23 continues to be seen as a baseline year with no target values set for Indicators #2a and #3.

Objectives/Activities	FY22 Baseline (Q1-Q2)	FY23 Performance Goal	Assigned Team/Position	Frequency of Review	Review Committee(s)
D.3.1 Indicator #1: Achieve or exceed the 95% standard for adults and children receiving pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours	99.62%	>95%	Quality Advisor	Quarterly	PIC

Objectives/Activities	FY22 Baseline (Q1-Q2)	FY23 Performance Goal	Assigned Team/Position	Frequency of Review	Review Committee(s)
D.3.2. Indicator #2a: Collect baseline data for consumers who meet with a professional for an intake assessment within 14 days of request for service	72.93%		Quality Advisor	Quarterly	PIC
D.3.3. Indicator #3: Collect baseline data for consumers who have a first service within 14 days of their intake assessment	74.91%		Quality Advisor	Quarterly	PIC
D.3.4. Indicator #4a: Achieve or exceed the 95% standard for consumers discharged from a psychiatric inpatient unit who are seen for follow-up care within seven days	98.59%	>95%	Quality Advisor	Quarterly	PIC
D.3.5. Indicator #10: Compliance equal to or less than 15% for consumers readmitted to an inpatient psychiatric unit within 30 days of discharge	8.1%	<15%	Quality Advisor	Quarterly	PIC

Quality Program Evaluations

Program evaluation principles are employed by CMHCM to assure the ongoing assessment of the quality of clinical services that are provided to consumers. Program evaluation procedures can be found in the Program Evaluation Policy (5.300.005). The program evaluation process is a systematic method for collecting, analyzing, and using qualitative and quantitative data to review clinical service programs including their effectiveness, efficiency, consumer access, and consumer satisfaction with the service.

Objectives/Activities	FY22 Baseline	FY23 Performance Goal	Assigned Team/Position	Frequency of Review	Review Committee(s)
D.4.1. A clinical program evaluation dashboard will be utilized to provide analysis and comparison between FY21 and FY22 outcome metrics on key performance indicators to COC, Management Team, and the Board Services Committee within each service program identified for program evaluation			Quality Manager	Monthly	Clinical Oversight Committee, Board Services Committee

Quality Record Review

The CMHCM record review process involves a stratified random selection for review of staff's clinical consumer charts by the Quality Department. In FY21, a focus was placed on new staff entering the CMHCM system and additional training was completed for current case holders in the summer to ensure compliance standards are being met. Upon discussion with clinical teams, the current record review process was viewed as ineffective for identification and resolution of compliance targets for staff. An improved record review process was implemented in FY22 and focused on the overall team with the implementation of the team-based care model. Benchmarks were established utilizing this new record review process for additional quality improvement activity.

Objectives/Activities	FY22 Baseline (Q1-Q3)	FY23 Performance Goal	Assigned Team/Position	Frequency of Review	Review Committee(s)
D.5.1. Achieve or exceed 70% compliance for the record review element, "Is IPOS training documentation attached to the IPOS for external providers and was it completed prior to delivery of the service?"	40%	70%	Quality Analyst	Quarterly	Management, PIC
D.5.2. Achieve or exceed 90% compliance for the record review element, "Is there evidence of care coordination with other relevant providers?"	73%	90%	Quality Analyst	Quarterly	Management, PIC

Quality Consumer Satisfaction Measurement

CMHCM assesses quantitative and qualitative consumer satisfaction through an annual survey process, as well as from feedback obtained by the clinician during the course of a consumer's treatment. In addition, a post-service survey is sent to all discharged consumers to evaluate their satisfaction with the services and supports received. CMHCM, in conjunction with MDHHS, also participates in the National Core Indicators survey on an annual basis to provide additional satisfaction information for individuals receiving services for intellectual/developmental disabilities.

For the annual consumer satisfaction survey, adults with a mental illness, families of youth receiving services, and consumers or guardians of consumers with an intellectual/developmental disability are offered a survey which assesses satisfaction with CMHCM staff and services, as well as how services have impacted the consumer. As part of the survey process, consumers receiving Assertive Community Treatment (ACT) are surveyed using the Mental Health Statistical Improvement Program (MHSIP) survey and families of youth receiving home-based services are surveyed using the Youth Services Survey for Families (YSS-F). CMHCM will analyze the data from all survey results for trends and to identify opportunities for improvement.

Objectives/Activities	FY22 Baseline	FY23 Performance Goal	Assigned Team/Position	Frequency of Review	Review Committee(s)
D.6.1. Meet or exceed 95% satisfaction during the annual survey as measured by consumer response to the question, "Overall, I am satisfied with the services I receive"	98%	>95%	Quality Manager	Annually	Management, PIC, Board Services Committee

Quality Assessment and Performance Improvement Plan

The Quality Department will identify performance improvement projects for the coming year with input from PIC, ELT, Management Team, and MSHN initiatives to develop the FY24 QAPIP Annual Plan. The annual plan will be submitted to the Board of Directors for final approval.

Objectives/Activities	FY22 Baseline	FY23 Performance Goal	Assigned Team/Position	Frequency of Review	Review Committee(s)
D.7.1. Prepare and review the FY24 QAPIP Plan in August 2023 for Board approval in September 2023			Chief Quality and Compliance Officer	Annually	Management, PIC, Board Services Committee

Quality External Compliance Requirements

Three external entity reviews will occur in FY23 with CMHCM providing required documentation to meet required compliance requirements. Of note, CMHCM becomes eligible for a full Joint Commission review in FY23; however, it is uncertain when this activity will occur and is not reflected in the objectives below.

Objectives/Activities	FY22 Baseline	FY23 Performance Goal	Assigned Team/Position	Frequency of Review	Review Committee(s)
D.8.1. CMCHM will complete the annual Intracycle Monitoring self-assessment tool using The Joint Commission online process to verify ongoing compliance with existing and newly revised accreditation standards			Quality Advisor	Annually	Management
D.8.2. CMCHM will achieve MSHN compliance during the full Delegated Function site review in May of 2023			Quality Team	Bi-Annually	Management
D.8.3. CMCHM will achieve MDHHS compliance during follow-up site review for the Waiver Program audit required as a result of the FY22 MDHHS full Waiver review			Quality Team	Bi-Annually	Management
D.8.4. CMCHM will support all MSHN QAPIP goals identified for FY23.			Quality Team	Annually	Management

FY23 Mental Health Awareness Plan Priorities

Mental Health Awareness Plan

CMHCM undertakes outreach activities to educate the community regarding its mission and to publicize the array of available mental health services to the overall community through the annual Mental Health Awareness (MHA) Plan. Each county location conducts community education and outreach activities as directed by their local Program Directors in accordance with the annual MHA Plan. Outreach and education activity is guided by the Outreach and Education Policy (5.100.018).

Objectives/Activities	FY22 Baseline (Q1-Q3)	FY23 Performance Goal	Assigned Committee/Team, Assigned Person	Frequency of Review	Review Committee(s)
D.9.1. A minimum of 14 Mental Health First Aid trainings (Youth/Adult) will take place in FY23	12	14	MHFA Trainers	Semi-Annual	Management
D.9.2. Suicide prevention presentations will be conducted with at least two community partners (schools, libraries, etc.) during FY23	0	2	Outreach and Education Coordinator	Semi-Annual	Management
D.9.3. The number of active users with MoodFit will increase by 10 percent in FY23 as compared to FY22	89	98	Outreach and Education Coordinator	Semi-Annual	Management
D.9.4. CMHCM will participate in a minimum of six outreach and mental health awareness events within FY23	4	6	Outreach and Education Coordinator	Semi-Annual	Management
D.9.5. CMHCM will expand to 500 followers on Instagram in FY23	0	500	Outreach and Education Coordinator	Semi-Annual	Management
D.9.6. An education and promotional packet will be developed and distributed across community partners and stakeholders to increase community reach and resources across the six counties			Outreach and Education Coordinator	Semi-Annual	Management
D.9.7. Increased promotion and activity relating to Walk-a-Mile activites will occur for both staff and consumers in FY23 to increase attendance and participation at this event			Outreach and Education Coordinator	Semi-Annual	Management
D.9.8. CMHCM will plan and promote the Walk-and-Roll event in partnership with MMI for FY23			Outreach and Education Coordinator	Semi-Annual	Management

Appendix A- Agency Standing Committees

Behavior Treatment Committee

Charge: The Behavior Treatment Committee oversees the provision of behavior services at CMHCM and provides a forum for: 1) review and approval or disapproval of behavior treatment plans which include intrusive or restrictive behavioral interventions, 2) review of behavior treatment progress reports, including behavior and intervention data, to determine whether an approved plan should be continued, discontinued, or revised, and 3) review of all incident reports describing emergency use of physical management, PRN medication, and involvement of law enforcement. The purpose of the oversight activities of the Behavior Treatment Committee is to assure that recipients receive high quality services within a culture of gentleness, utilizing best practices in the field of behavior treatment, that applicable regulatory requirements and agency policies are consistently applied, and that recipients are afforded due process and protection of their rights as specified in the Michigan Mental Health Code.

Meeting Times: Monthly, fourth Thursday, 1:30 p.m.

Children's Services Committee

Charge: To guide agency practices of services and supports for children and families that embodies the principles of a family-driven/youth-guided philosophy.

Meeting Times: Monthly, Fourth Wednesday, 1:00 p.m.

CIGMMO Committee

Charge: To oversee the ongoing updates and maintenance of the Electronic Medical Record (EMR) to fulfill contract and accreditation requirements and facilitate clinically and fiscally sound practice.

Meeting Times: Monthly, second Tuesday, 8:30 a.m.

Clinical Oversight Committee

Charge: To evaluate current clinical practice for efficacy and sustainability agency-wide and to provide oversight and guidance on quality of service delivery to improve outcomes.

Meeting Times: Monthly, first Thursday, 1:00 p.m.

Consumer Action Committee

Charge: The Consumer Action Committee will serve as a forum for consumers to exercise leadership and support advocacy endeavors on mental health issues.

Meeting Times: Monthly, second Wednesday, 1:30 p.m.

Credentialing Committee

Charge: To provide for the development, implementation, and ongoing review of the CMHCM credentialing and privileging process and to make recommendations regarding provider applications for clinical privileges.

Meeting Times: As needed.

Executive Leadership Team

Charge: To establish policy direction and strategic outcomes.

Meeting Times: Semi-monthly, Thursdays, 8:30 a.m.

Management Team

Charge: To provide leadership, direction, and management of resources to enable staff to achieve the mission of the agency while adhering to the values established by the Board.

Meeting Times: Semi-monthly, first and third Wednesdays, 9:30 a.m.

Office Managers Committee

Charge: To share information and to review and coordinate implementation of agency policies and procedures to assure efficient and consistent office operations in the six county offices of the agency.

Meeting Times: Monthly, second Tuesday, 1 p.m.

Appendix A- Agency Standing Committees Continued

Performance Improvement Committee

Charge: To advance and improve services for consumers through the philosophy and process of Quality Improvement.
Meeting Times: The Committee meets on the fourth Wednesday at 9:30 a.m. in November, February, May, August, September, and October

Residential Review Committee

Charge: The Residential Review Committee is a resource and support for staff by reviewing existing resources, monitoring utilization, anticipating needs and demands for future placements, and educating staff when needed on compliance standards for state laws, licensing rules and regulations, foster care practices, as well as, industry best practice standards.
Meeting Times: Monthly, fourth Friday, 8:30 a.m.

Safety Committee

Charge: To promote consumer safety, safe employee work practices and a healthful environment in support of MDHHS, the Joint Commission, and other regulatory standards.
Meeting Times: Quarterly, second Tuesday, 10 a.m.

Sentinel Event Review Committee

Charge: To identify and respond appropriately to all sentinel events occurring in the organization or associated with services that the organization provides or provides for.
Meeting Times: As needed.

Standards Compliance Committee

Charge: To identify, interpret, and ensure compliance of external regulations, rules, and standards.
Meeting Times: Bi-monthly, first Wednesday, 9 a.m.

Super Management Team

Charge: To provide leadership, direction, and management of resources to enable staff to achieve the mission of the agency while adhering to the values established by the Board.
Meeting Times: Quarterly, third Wednesday, 9:00 a.m.

Appendix B- Quality Improvement Process