Community • Independence • Empowerment

QUALITY IMPROVEMENT PROGRAM & PLAN

Fiscal Year 2021/22

INTRODUCTION

The Michigan Department of Health and Human Services (MDHHS) requires that each specialty Prepaid Inpatient Health Plan (PIHP) have a quality assessment and performance improvement program (QAPIP) which meets the specified standards in the contract with MDHHS. In addition to the QAPIP, MDHHS requires each Community Mental Health Services Program (CMHSP) to have a Quality Improvement Program (QIP). The description that follows provides the QIP for the Integrated Services of Kalamazoo (ISK) for fiscal year 2021/22. Aside from this QIP, ISK participates in and contributes to the QAPIP of our PIHP – Southwest Michigan Behavioral Health.

PURPOSE

The purpose and assurances of the QIP for ISK is as follows:

1. Continually evaluate and enhance organizational processes that most influence organizational effectiveness and efficiency. Each Continuous Quality Improvement (CQI) project implemented will include documentation of the reason for the project and measurable progress achieved. All improvement activities will be evaluated for effectiveness.

2. Monitor and evaluate the systems and processes related to the quality of clinical care and non-clinical services that can be expected to affect the health status, quality of life and satisfaction of persons served by each affiliate member. All improvement activities will be evaluated for effectiveness.

3. Focuses on indicators related to improved behavioral and physical health outcomes and takes action to demonstrate improved performance.

4. Identify and assign priority to identified opportunities for performance improvement. Addresses priorities for improved quality of care and individuals served safety.

5. Create a culture that has a focus on the individuals we serve and includes their input and participation in problem solving.

MISSION, VISION, VALUES

This Quality Improvement Program and Plan is tailored to help achieve the agency mission and vision. Our activities will be guided by those organizational values we believe to be critical to our success.

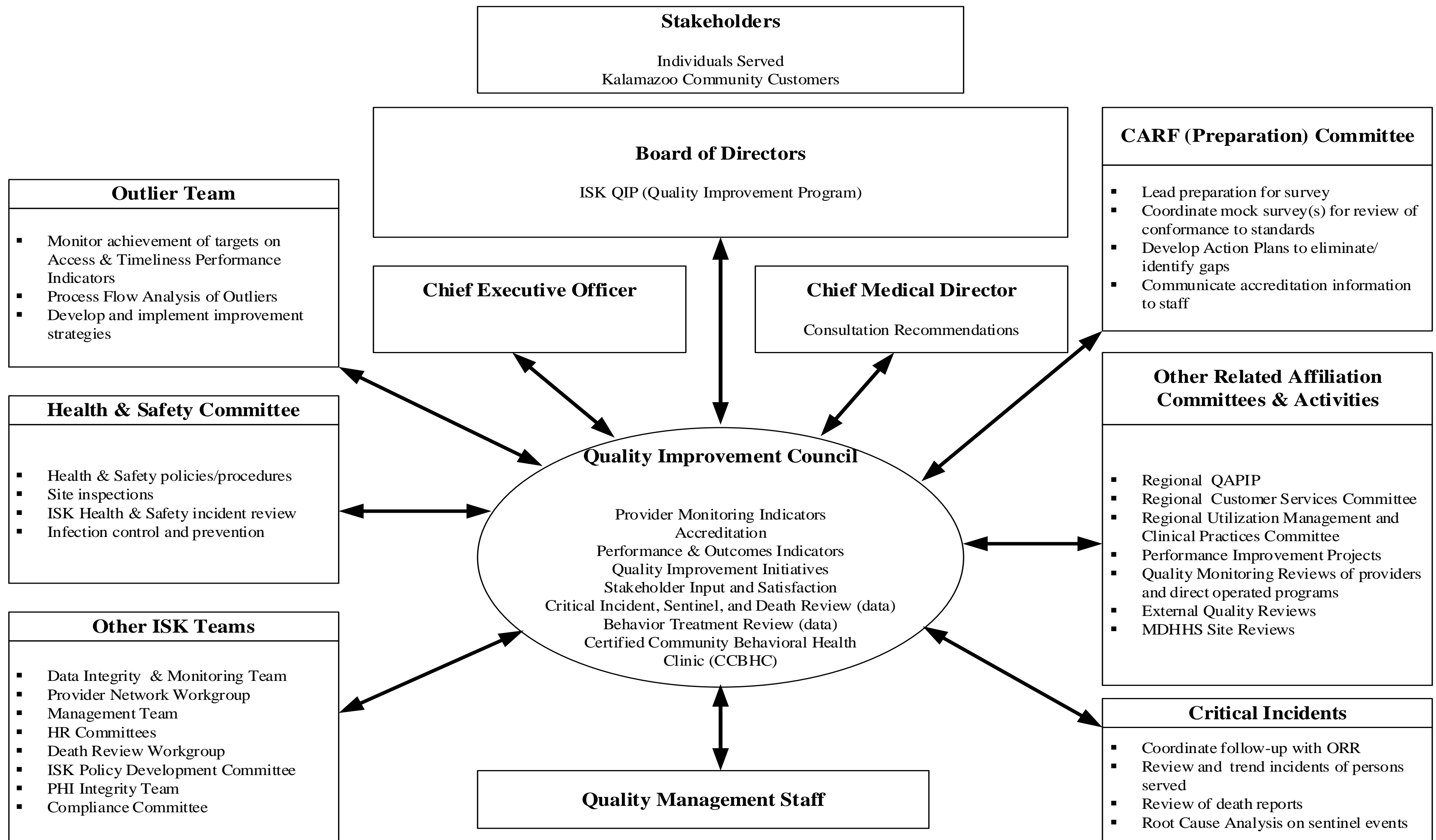
Mission	We promote and provide mental health, intellectual and developmental disability and substance use disorder supports and services that empower people to succeed
Vision	We provide a welcoming and diverse community partnership which collaborates and shares effective resources that support individuals and families to be successful through all phases of life

Values

- Community
- Competence
- Diversity
- Effectiveness
- Integrity
- Leadership
- Recovery and Self-Determination
- Respect
- Responsibility
- Teamwork
- Trust

QUALITY IMPROVEMENT STRUCTURE

The Quality Improvement Structure for Integrated Services of Kalamazoo is outlined through a graphic presentation on the next page followed by a narrative description of key elements of the structure.


ISK QUALITY MANAGEMENT STRUCTURE
Stakeholders
Individuals Served
Kalamazoo Community Customers
Board of Directors
ISK QIP (Quality Improvement Program)
CARF (Preparation) Committee
Lead preparation for survey
Coordinate mock survey(s) for review of conformance to standards
Develop Action Plans to eliminate/ identify gaps
Communicate accreditation information to staff
Outlier Team
Monitor achievement of targets on Access & Timeliness Performance Indicators
Process Flow Analysis of Outliers
Develop and implement improvement strategies
Chief Executive Officer
Chief Medical Director
Consultation Recommendations
Other Related Affiliation Committees & Activities
Regional QAPIP
Regional Customer Services Committee
Regional Utilization Management and Clinical Practices Committee
Performance Improvement Projects
Quality Monitoring Reviews of providers and direct operated programs
External Quality Reviews
MDHHS Site Reviews
Health & Safety Committee
Health & Safety policies/procedures
Site inspections
ISK Health & Safety incident review
Infection control and prevention
Quality Improvement Council
Provider Monitoring Indicators
Accreditation
Performance & Outcomes Indicators
Quality Improvement Initiatives
Stakeholder Input and Satisfaction
Critical Incident, Sentinel, and Death Review (data)
Behavior Treatment Review (data)
Certified Community Behavioral Health Clinic (CCBHC)
Other ISK Teams
Data Integrity & Monitoring Team
Provider Network Workgroup
Management Team
HR Committees
Death Review Workgroup
ISK Policy Development Committee
PHI Integrity Team
Compliance Committee
Quality Management Staff
Critical Incidents
Coordinate follow-up with ORR
Review and trend incidents of persons served
Review of death reports
Root Cause Analysis on sentinel events

ACCOUNTABILITY TO GOVERNANCE

The ultimate responsibility for the quality of organizational services is retained by the Governing Board. The role of the Board is to support and promote ongoing improvement in organizational processes and outcomes. The Board responsibilities for the QIP include:

- Oversight of the QIP, including documentation that the Board has approved the overall QIP and annual QI plan.
- Review of QIP reports, including actions taken, progress in meeting Quality Improvement objectives and improvements made.
- Assures that action has been taken where indicated and directs the operational QIP be modified to accommodate review findings and issues of concern within ISK.

KEY CONTRIBUTORS IN QUALITY ACTIVITIES

THE QUALITY IMPROVEMENT COUNCIL

The role of the Integrated Services of Kalamazoo Quality Improvement Council (IQIC) includes the function of the organization's Quality Improvement Plan as established by the Board, including setting priorities for improvement efforts throughout the agency. The Quality Improvement Council (IQIC) is responsible to monitor and report progress toward established goals to the Senior Executive team. Additional IQIC activities are outlined above in the Quality Management Structure diagram.

INDIVIDUALS SERVED

The satisfaction of persons receiving services with our agency will be greatly enhanced when we involve those individuals in the identification and prioritization of improvement opportunities. Likewise, we must continually measure trends in satisfaction levels of individuals served. In addition to input received from individuals served, many standing committees throughout the organization include the voice of individuals served through Peer Support Specialist representation. Peer Support Specialists play a key role on the relevant committees related to review of performance information and status, policy/procedure development, and strategic planning for the organization.

COMMUNITY STAKEHOLDERS

In addition to Individuals served, stakeholders are those individuals or organizations that have a valid interest in the agency's processes and outcomes. Some of our most important stakeholders are staff members, funding sources, regulatory bodies and human service agencies in our community. Funding sources usually outline performance standards in written documents such as contracts and standards manuals. Input from staff and other community partners will be collected via surveys, focused groups, etc. Staff and stakeholders' input and satisfaction must be monitored on an ongoing basis.

ISK STAFF

Within the structure of this QIP, staff will be key participants through participation in committees, providing feedback when presented with information, identifying process improvement opportunities and submitting ideas to the IQIC, while continuing to provide medically necessary services to individuals served. Staff will promote Recovery concepts in their everyday work.

COMMUNICATION

This QIP will ensure that all groups described above receive information about prioritized agency needs, improvement projects and changes in performance in order to reinforce commitment to meaningful quality improvement. Feedback will be provided by means of Board reports, results of regulatory audits, interoffice communications, etc.

UTILIZATION MANAGEMENT

ISK's Utilization Management plan is a standalone document that is reviewed and updated as needed on an annual basis. ISK policies and procedures also outline utilization management activities and expectations for the organization and its provider network. This includes the evaluation of medical necessity, eligibility criteria used, information sources, and the process used to approve the provision of medically necessary services and supports. The Utilization Management Plan addresses components related to practices of retrospective and concurrent review of clinical and financial resource utilization, clinical and programmatic outcomes, other aspects of utilization management deemed appropriate by administration. The ISK Utilization Management Plan is also aligned with the PIHP Utilization Management Plan as reviewed and adopted by the region. In accordance with this plan, data is used to identify and address underutilization and overutilization throughout the network. Policy, procedure, and practices are in place the ensure that 1) review decisions are supervised by qualified medical professionals; 2) efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate; 3) reasons for decisions are clearly documented and available to consumers; 4) there are well-publicized and readily available appeal mechanisms for both providers and individuals served; notification of a denial includes a description of how to file an appeal; denials are made by appropriately qualified staff; decisions and appeals are made in a timely manner as required; and there are mechanisms to evaluate the effects of the program using data on customer satisfaction, provider satisfaction, or other appropriate measures.

PERFORMANCE IMPROVEMENT

Quality improvement activities are person serve focused and committed to improving the quality of clinical care and outcomes of individuals served. Ongoing input must be collected from both individuals receiving services as well as other stakeholders using a variety of methods. Methods to collect input include surveys, monitoring of progress individuals served, tracking of rights violations and incident reports, community forums, and performance reports generated by stakeholders such as the MDHHS.

Data is used to determine performance levels and must be accurate, valid and reliable to produce meaningful performance information. This assures that our conclusions are accurate, and resources are properly allocated to improvement opportunities that are most important to the individuals served and other stakeholders.

Quality indicators are those measures that reflect performance in areas that are most important to individuals we serve and other ISK stakeholders. Quality indicators include the areas of effectiveness of care, efficiency of operations, accessibility to services and satisfaction among individuals served and other stakeholders. These indicators are more meaningful when compared to established standards, trends over time and/or comparison with performance of similar organizations.

Quality and performance indicators reports are used to determine significant trends and to plan, design, measure, assess and improve services, processes, and systems. Quality improvement activities monitor the quality of care against established standards and guidelines. Improvement strategies are used to eliminate undesired outliers, ensure the proper use of practice guidelines, and optimize the desired outcomes of

individuals served. Remedial action is taken whenever inappropriate or substandard services are furnished as determined by substantiated recipient rights complaints, clinical indicators, or other quality indicators.

Sources of quality and performance indicators include:

- MDHHS Performance Indicator System Reports (also referenced as the Michigan Mission-Based Performance Indicator System [MMBPIS])
- MDHHS Boilerplate Reports
- CCBHC Quality Indicators
- Behavioral Health Treatment Data and Reports
- Health & Safety Reports
- Utilization Management Reports, including under-utilization and overutilization based on medical necessity and other established criteria and the mechanisms to correct under-utilization and overutilization
- Accreditation Survey Report
- Quality Improvement Reports
- Incident and Event Reports
- Performance Indicator and Outcomes Reports, such as CAFAS (Child and Adolescent Functional Assessment Scale) and other implemented functional assessment tools
- MDHHS Contract Compliance Reports (e.g., MDHHS Site Review, Rights System Assessment, Compliance Examination)
- Stakeholder Survey Reports, such as, Customer Satisfaction Survey, Employee Survey, and Community Needs Assessment Survey
- Quality Monitoring Reviews (including clinical records review, claims verification, and the verification of provider and individual qualifications and credentials)
- Compliance and Risk Management activities
- Demographic, Encounter, and Claims Reports on Persons Served (SWMBH Tableau, Care Connect 360, Behavioral Health [BH] TEDS, ISK EHR reports, etc.)
- Reports focusing on Enrollee (Customer) Rights and Protections. Such data may be provided by the Office of Recipient Rights or the Customer Services Office and be related to the number and type of complaints/grievances/appeals and investigations completed along with summary of the outcomes of complaint activities.

RIGHTS AND RESPONSIBILITIES

The following are assessment activities conducted by or in conjunction with the Office of Recipient Rights:

- Monitor and assure that individuals served have all the rights established in Federal and State law.

- Investigate and follow-up on rights complaints;
- Review incident, accidents and sentinel events and investigate as needed;
- Look for trends and making suggestions to prevent reoccurrence;
- Review death reports of persons served and investigating any unexpected death to identify potential system improvements; and
- Share trends and process improvements made with stakeholders.

The Quality Improvement Council will determine any quality and performance indicators in addition to those established by the PIHP that will be monitored. The performance indicators may depend on each department's specific consumer group, service delivery activities, and requirements of the State Department of Health and Human Services and CARF standards.

ANNUAL REVIEW OF PLAN

The Integrated Services of Kalamazoo Quality Improvement Plan will be evaluated and revised on an annual basis and reviewed and approved by the ISK Board. At least annually, the status of goals and objectives will be evaluated and goals for the next fiscal year will be created based on status of previous goals and current agency priorities.

QUALITY IMPROVEMENT GOALS FOR FY 2021/22

The QIP is completed within the framework of the current overall ISK Strategic Plan. Goals within the QIP will help support the direction and priorities of the agency. The broad quality improvement goals include:

1. Everyone shares responsibility for the continuous quality improvement of processes to be more efficient and/or effective.
2. We prioritize the processes that have the most impact on outcomes persons served desire.
3. We work together as a team.
4. We aspire to meet or exceed all performance standards established by funding sources.
5. We maintain clear and ongoing communication, so internal staff are aware of improvements in performance and outcomes.
6. We share performance and outcome information with our individuals served and other stakeholders on an ongoing basis.
7. We actively engage in PIHP standing committees and ad hoc workgroups.

The following pages outline the specific quality improvement goals/objectives for 2021/22:

#	GOALS	OBJECTIVES / ACTION STEPS	MEASURES
1.	Learn from reported incident/event data and improve the quality of the organization and services provided	1. Implement consistent processes to review and trend incident and event data, through submitted ISK Incident and Accident reports, with reporting to the IQIC at a 6-month frequency.	1. Number of reports reviewed in IQIC. 2. Number of quality improvement efforts identified as a result of reviewing incident and event reporting data
2.	Remain informed and compliant with all performance indicators expected and maintain compliance with Accreditation and regulatory standards	1. Review at least one performance report per IQIC meeting, including but not limited to: a. MMBPIS b. Encounters status c. BH TEDS d. SWMBH Board Metrics 2. Ensure knowledge of current accreditation standards and changes within the CARF manual.	1. Number of performance reports reviewed through the committee. 2. Number of improvement efforts and/or projects related to performance measure data review 3. Number of improvement efforts resulting from audit results and outcomes
3.	Ensure effective implementation of Certified Community Behavioral Health Clinic (CCBHC) state demonstration	1. Meet MDHHS incentive thresholds for all Quality Bonus Payment (QBP) metrics (IET, SRA, FUH, SAA) 2. Ensure that CCBHC implementation, outreach and engagement efforts are effectively expanding access to services	1. Report and review QBP metrics during IQIC committee meeting. Trending and analysis of QBP metrics completed within CCBHC subgroups. 2. Trending and analysis of (1) number of CCBHC individuals served, (2) CCBHC recipients' ongoing engagement in services as completed by CCBBH subgroups.
4.	Further promote cultural competency, equity, inclusion and trauma informed approaches to respond to the needs of persons served, workforce and the community.	As facilitated, monitored, and implemented through JETT: 1. Enhance training for staff to include concepts of historical/racial trauma and resilience-oriented principles 2. Increase and enhance organization's ability to prevent, identify and appropriately respond to workforce concerns/ stressors 3. Educate ourselves on equity principles and apply those principles on the activities of training, hiring and self-care	1. JETT committee will report to IQIC trainings completed and other areas for improvement identified by the committee 2. JETT will report projects and improvement efforts launched and implemented quarterly 3. IQIC will provide feedback and improvement ideas to JETT as needed
5.	Improve access to care and ensure future financial sustainability.	1. Monitor and support quality improvement initiatives within ISK, focusing on increasing number of individuals served and effective processes for access to care. 2. Define and develop plan for organizational financial sustainability, including but not limited to: a. Diversification of funding	1. ISK access to services tracking data will be reported and analyzed by IQIC quarterly for system trends and improvement. 2. IQIC to review measured outcomes of initiatives to assess effects on service delivery and financial impact at a 6-month frequency. (Ongoing)

#	GOALS	OBJECTIVES / ACTION STEPS	MEASURES
		b. Department and staff level tracking of billable service	
7.	Effectively apply the strategies that were prioritized in the 2021 Community Health Needs Assessment to better meet community needs	1. Effectively apply the CHNA's top prioritized strategy, Workforce development and hiring, to better meet community needs 2. Effectively apply the CHNA's second prioritized strategy, Internal process improvement, to better meet community needs	1. Review of data and suggestions compiled from the CHNA and development of a targeted workplan to implement a Workforce Development and Hiring strategy 2. Review of data and internal process improvement suggestions compiled from the CHNA; implementation of specific suggested process improvements and/or development of a targeted workplan as appropriate