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DETROIT WAYNE COUNTY MENTAL HEALTH AUTHORITY

QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

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**Quality Improvement Plan
Detroit Wayne Mental Health Authority (DWMHA)
October 1, 2014- September 30, 2016**

SECTION 1: Overview

PURPOSE

The DWMHA is the Pre-paid Inpatient Health Plan (PIHP) and Community Mental Health Service Provider (CMHSP) for Detroit and Wayne County. It is the largest community mental health services provider in the State of Michigan. The Quality Assessment and Performance Improvement Program (QAPIP) provides assurance that the DWMHA achieves alignment with healthcare reform and demonstrates to consumers, advocates, community organizations, health care providers and State policy makers that it has a distinct competency as a high-performing, customer-focused, quality-focused and evidence-based efficient provider of mental health and substance use disorder services and is an essential partner in helping healthcare reform to succeed. The QAPIP is the vehicle for improving the quality of care to consumers and improving methods of service delivery to ensure desired consumer health status, quality of life and consumer satisfaction.

INTRODUCTION

The DWMHA's QAPIP details the structure, scope, activities and functions of the DWMHA's overall Quality Improvement Plan (QIP). The QAPIP description contains core activities as well as functions that are conducted by the DWMHA and its network of contracted service providers, including the Managers of Comprehensive Provider Networks (MCPNs), Direct Contractors, and subcontractors. It is the responsibility of the DWMHA to ensure that the QAPIP meets applicable Federal and State laws, contractual requirements and regulatory standards. The term of the QAPIP begins October 1, 2014 and ends September 30, 2016. Upon expiration of the term, the QAPIP shall remain in effect until the DWMHA's Board of Directors approves a new QAPIP.

The QAPIP incorporates by reference any and all policies and procedures necessary to operate as a Community Mental Health Services Program and a Prepaid Inpatient Health Plan. The DWMHA's Board of Directors hereby approves all current and subsequent policies and procedures through the approval of the QAPIP.

MISSION, VISION AND VALUES

Mission

To lead and support a community system that provides and manages an array of supports, services, care and treatments that honors choice and advances the quality of community life for adults with mental illness, individuals with developmental disabilities, autism, persons with substance use disorders, children with serious emotional disturbance, individuals with co-occurring disorders, their families and the community.

Vision

To be a culturally proficient leader in the community that is supportive and embraces individuals with disabilities in community life in a manner that reflects the values, roles and responsibilities of full and

meaningful citizenship. The values of this organization are intended to advance and support recovery, self-determination and integrated healthcare principles to help benefit the community.

Values

To advance, reflect and embrace:

- Social justice and equity
- Public accountability
- Efficacy
- Reciprocal community partnerships and collaboration
- The efficient use of fiscal, human, technical and physical property resources
- The principles of self-determination, a recovery orientation and perspective of the resiliency of individuals, families, and the community
- The achievement of real life choices and desired outcomes through a person-centered process
- Intended beneficiary systems ownership, influence and participation
- Efforts and actions as bound by law, knowledge ethnics, resources and obligations.

SCOPE OF THE QAPIP

The scope of the quality improvement activity includes the DWMHA, Managers of Comprehensive Provider Networks (MCPNs), Subcontractors, Direct Contractors, and Substance Abuse Providers. It identifies the important processes and aspects of care, both clinical and non-clinical, required to ensure quality supports and services for persons in the system. The DWMHA requires all contractors to have a mental health and substance use disorder quality improvement plan relevant to the services they provide. The DWMHA assures that all demographic groups, care settings and types of services are included in the scope of the QAPIP by including consumers, advocates, MCPNs, Substance Abuse Providers, Direct Contractors, sub-contractors consumers and community groups in the quality improvement process using a continuous quality improvement perspective.

QUALITY IMPROVEMENT PROGRAM DWMHA

The Centers for Medicare and Medicaid Services (CMS) Medicaid Bureau mandates that Quality Improvement programs be a part of Pre-paid Inpatient Health Plans (PIHP). The DWMHA has several contracts with the Michigan Department of Community Health (MDCH) for the provision of Managed Specialty Supports and Services (Medicaid), General Fund and waiver services for mental health and substance abuse and must comply with Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 15 – Attachment P7.9.1 and CMHSP Managed Mental Health Supports and Services Contract FY15: Attachment C6.8.1.1 “QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAMS FOR SPECIALTY PRE-PAID INPATIENT HEALTH PLANS” and the “Department of Community Health Michigan Mission Based Performance Indicators”, and the Application for Renewal and Recommitment.

DESCRIPTION OF THE QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

The following Quality Improvement Plan serves as the foundation of the commitment of the DWMHA to continuously improve the quality of the treatment, supports and services it provides. Quality services are

services that are provided in a safe, effective, person-centered, timely, equitable, and recovery-oriented fashion.

The DWMHA is committed to the ongoing improvement of the quality of care its consumers receive, as evidenced by the outcomes of that care. The organization continuously strives to ensure that:

- The treatment provided incorporates evidence based, effective practices;
- The treatment and services are appropriate to each consumer's needs, and available when needed;
- Risk to consumers, providers and others is minimized, and errors in the delivery of services are prevented;
- Consumers' individual needs and expectations are respected; consumers – or those whom they designate – have the opportunity to participate in decisions regarding their treatment; and services are provided with sensitivity and caring;
- Procedures, treatments and services are provided in a timely and efficient manner, with appropriate coordination and continuity across all phases of care and all providers of care.

Quality Improvement Principles: Quality improvement is a systematic approach to assessing services and improving them on a priority basis. The DWMHA's approach to quality improvement is based on the following principles:

- Client Focused: Services should be designed to meet the needs and expectations of consumers. An important measure of quality is the extent to which customer needs and expectations are met.
- Understanding work and system processes: Providers need to understand the service system and its key processes in order to improve them. Using process-engineering tools provides simple visual images of these processes and systems.
- Teamwork: Because work is accomplished through processes and systems in which different people fulfill different functions, it is essential to involve stakeholders and process owners in the improvement process. This brings their insights to the understanding of changes that need to be made and to the effective implementation of the appropriate process. It also ensures ownership of the improvement processes and systems.
- Data Driven: Data is needed to analyze processes, identify problems and measure performance. Changes can then be tested and the resulting data analyzed to verify that the changes have actually led to improvements.

QAPIP methodology: includes the use of quality improvement methodology and process management/ improvement tools and techniques. Quality Improvement methodology consistently includes four steps:

- Identify - Determine what to improve
- Analyze - Understand the problem
- Develop - Hypothesize what changes will improve the problem
- Test/Improvement - Test the hypothesized solution to see if it yields improvement. Based on the results, decide whether to abandon, modify, or implement the solution.

The framework for the DWMHA QAPIP quality improvement process is to:

- Find a Process to Improve
- Organize to Improve
- Clarify Current Knowledge of the Process

- Uncover Causes of Process Variation or Poor Quality
- State Plan Do Check Act (PDCA)
 - ✓ Plan the Improvement Process
 - ✓ Do the Improvement, Data Collection, and Analysis
 - ✓ Check the Results and Lessons Learned
 - ✓ Act by Adopting, Adjusting, or Abandoning the Change

Key cultural components also ensure the success of improvement efforts including: leadership involvement, data informed practice, use of statistical tools, prevention over correction, and continuous improvement. Strong leadership, direction and support of quality improvement activities by the governing body and CEO are key to performance improvement. This involvement of organizational leadership assures that quality improvement initiatives are consistent with the DWMHA mission and/or strategic plan.

Successful QI processes create feedback loops, using data to inform practice and measure results. Fact-based decisions are likely to be correct decisions, for continuous improvement of care, tools and methods needed to foster knowledge and understanding. CQI organizations use a defined set of analytic tools such as run charts, cause and effect diagrams, flowcharts, Pareto charts, histograms, and control charts to turn data into information. Continuous Quality Improvement entities seek to design good processes to achieve excellent outcomes rather than fix processes after the fact. Processes must be continually reviewed and improved. Small incremental changes do make an impact, and providers can almost always find an opportunity to make things better.

Continuous Quality Improvement Activities. Quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by the leadership, is understood, accepted and utilized throughout the system, as a result of continuous education and involvement of staff at all levels in performance improvement. Quality Improvement involves two primary activities:

- Measuring and assessing the performance of processes and services through the collection and analysis of data.
- Conducting quality improvement initiatives and taking action where indicated, including the redesign of processes, design of new services, and/or improvement of existing services.

MDCH requires that DWMHA provide a written description of the QAPIP plan for approval by the Board of Directors. At a minimum, the plan must specify the following elements below:

- A. An adequate organizational structure that allows for clear and appropriate administration and evaluation of the QAPIP.
- B. Responsibilities of the governing body for monitoring, evaluation and making improvements to care.
- C. Objectives and timelines for implementation and achievement.
- D. Role of recipients of services and other stakeholders in the QAPIP plan.
- E. Role of MCPNs and directors in the QAPIP plan.
- F. Mechanisms or procedures used for adopting and communicating process and outcome improvements.

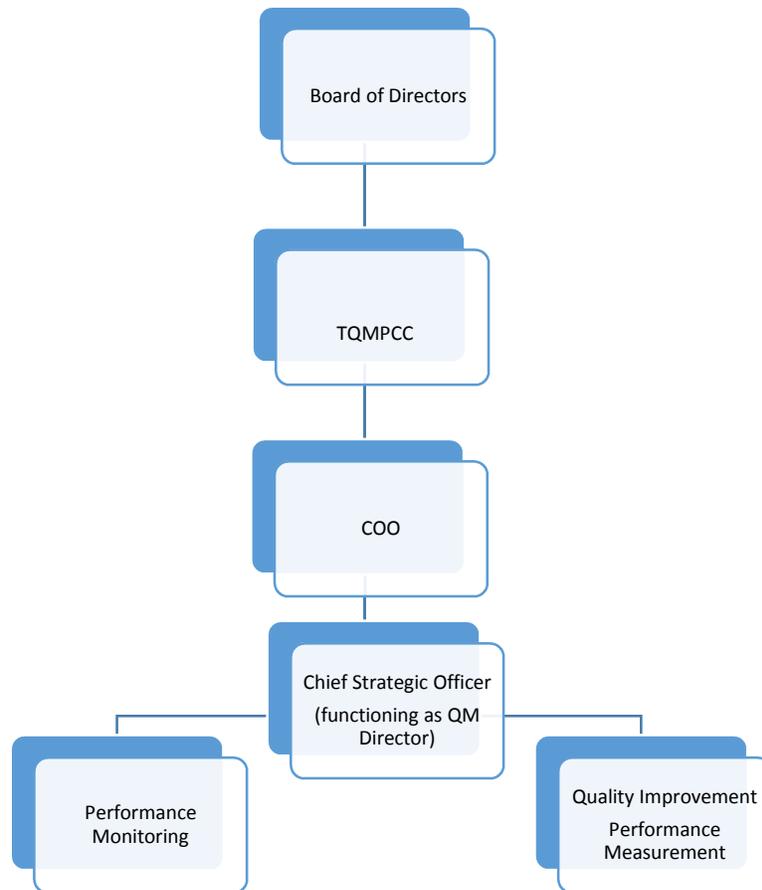
- G. Description of a designated senior official responsible for QAPIP implementation.
- H. Performance measures to address access, availability, quality, efficiency and outcome of services, using standardized indicators based upon the systematic, on-going collection and analysis of valid and reliable data.
- I. Performance improvement projects that address clinical and non-clinical aspects of care that are directed as the state and the DWMHA established aspects of care. Clinical areas include high volume services, high-risk services and continuity and coordination of care. Non-clinical areas include grievances and appeals, complaints and access to and availability of services.
- J. Process from the review and follow-up of Critical/ Sentinel Events and events that place consumers at risk of harm.
- K. Periodic quantitative (i.e., survey) and qualitative (i.e., focus group) assessments of member experiences with services. These assessments must address issues of quality, availability and accessibility of care.
- L. Process for the incorporation of consumers receiving services into the review and analysis of the information obtained from quantitative and qualitative reviews.
- M. Written procedures to determine whether physicians and other licensed health care professionals are qualified to perform their services.
- N. Written procedures to ensure non-licensed providers of care or support are qualified to perform their jobs.
- O. The organization's process for the initial credentialing and re-credentialing of providers.
- P. Identification of staff training needs and provision of in-service training, continuing education and staff development activities.
- Q. The DWMHA's process to verify whether services reimbursed by Medicaid were actually provided to enrollees by affiliates, providers and subcontractors.

The written plan is reviewed for the effectiveness of the methods used to implement, monitor and evaluate the quality improvement processes and for any necessary revisions and adjustments on at least an annual basis. The review of the written plan includes consumers, providers, Quality Improvement Steering Committee, Total Quality Management Program Compliance Committee (TQMPCC) of the DWMHA's Board of Directors, and other stakeholders.

The Quality Management Unit reviews the response received regarding the effectiveness of the methods proposed or used to implement, monitor and evaluate the quality improvement processes. The results and recommendations are incorporated in the QAPIP for the next fiscal year cycle.

SECTION 2: Leadership and Structure

Leadership. The key to the success of the Continuous Quality Improvement process is leadership. The following describes how the leaders of the DWMHA provide support to quality improvement activities. Consistent with a total quality management philosophy, the following is the structure of the organization in which the Quality Management Unit resides.



Descriptive Elements of the QAPIP

GOVERNING BODY

The QAPIP must be accountable to the Governing Body. Responsibilities of the Governing Body for monitoring, evaluating and making improvements to care include the following:

1. The Governing Body formally reviews on a periodic basis, but no less than annually, a written report on the operation of the QAPIP, including studies undertaken, results, unit and committee activities, subsequent actions and aggregate data on utilization and quality of services rendered to assess the QAPIP's effectiveness.
2. Documentation in board meeting minutes that there is approval of the overall QAPIP and review of periodic reports.
3. Approval of policies and procedures has been delegated to the Chief Operating Officer; however, approval of the QAPIP is retained by the DWMHA Board of Directors.

DESIGNATED OFFICIAL CHIEF STRATEGIC OFFICER FUNCTIONING AS THE DIRECTOR OF QUALITY MANAGEMENT

The Chief Strategic Officer is functioning as the Quality Management (QM) unit director as an administrator with experience in managed care quality improvement. The Chief Strategic Officer (QM Director) has overall responsibility for implementation of the QAPIP. Under the Chief Strategic Officer's (QM Director's) leadership, an integrated interdivisional approach to improving DWMHA services and systems is undertaken. The Chief Strategic Officer (QM director) is also responsible for the following:

1. Assisting staff in understanding and participating in the Total Management Quality (TQM) process.
2. Establishing regular communication throughout the DWMHA network about Total Quality Management issues, problems, status and progress.
3. Assisting the TQMPC Committee and the Board of Director's understanding of the Total Quality Management process.
4. Developing and implementing a data collection system that yields real-time meaningful data for needs assessment, program planning, outcome evaluations and operationalizing quality improvement opportunities.
5. Pursuing opportunities for partnership between the DWMHA and other public and private entities involved in quality improvement efforts.
6. Participating on quality improvement teams and work groups at DWMHA and state levels.
7. Strategic Planning

QUALITY MANAGEMENT (QM) UNIT

The Quality Management Unit is the department responsible for performing quality improvement functions and assuring that program improvements are occurring within the Pre-paid Inpatient Health Program (PIHP) and the Community Mental Health Services Program (CMHSP). The QM Unit puts the QAPIP into practice and has direct and/or oversight responsibility for monitoring the DWMHA's quality improvement program.

QM operates in partnership with stakeholders including consumers, advocates, MCPNs, Substance Abuse Providers, Direct Contractors, direct care providers, DWMHA staff and other stakeholders.

The QM Unit achieves the scope of continuous quality improvement through two functions: performance monitoring and quality improvement.

Performance Monitoring

The DWMHA continuously monitors the provider network, including any affiliates or sub-contractors to which it has delegated managed care functions. The standards used to assess contractors are the applicable sections of the Social Security Act, the Code of Federal Regulations (CFR), the Center for Medicare and Medicaid (CMS) Medicaid & State Operations Manuals, Michigan's Medicaid State Plan, and the Michigan Medicaid Provider Manual: Mental Health-Substance Abuse Section, as well as show a process that demonstrates continuous quality improvement.

In an ever-changing economy, quality services and supports that result in positive outcomes for persons that receive services in a cost-effective manner are crucial. DWMHA continues to move toward a system that ensures accountability and transparency relative to service quality and cost. Utilizing a standardized system to measure performance and outcomes will ensure accountability and transparency relative to service quality and cost. The DWMHA's self-monitoring/self-regulating plan is a component of the Continuous Quality Improvement (CQI) process designed to provide an organized documented process for assuring that eligible Detroit and Wayne County residents are receiving services for mental health and/or substance disorders and intellectual developmental disabilities that are medically necessary and appropriate, conform to accepted standards of care, and achieve the consumer's desired outcomes.

The DWMHA has adopted a performance monitoring process to support a CQI process in an on-going effort to improve services through consistent evaluation, resulting in process/procedure/program refinements by on-going monitoring improvements as seen in **Figure 1**.

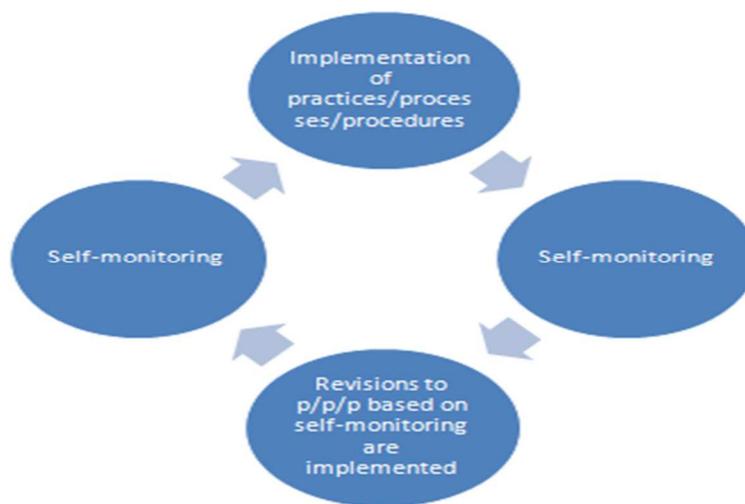


Figure 1

The Monitoring Plan is geared to improve quality and measure our performance in the delivery of service and compliance with required standards. This plan requires the involvement, skills, expertise and input from service providers, MCPNs and DWMHA staff and requires self-regulation and monitoring by all partners (DWMHA, MCPN's, providers, professionals and consumers).

As part of the monitoring process, DWMHA developed multiple levels using a self-monitoring/self-regulating approach. This multilevel monitoring approach begins at the service provider level and cascades up to the DWMHA's Quality Improvement Team. The "Monitoring Process" document sets forth the roles and responsibilities of each party within this multilevel approach.

Standardized tools have been developed to ensure that:

- Actions and/or process requirements are not open to different interpretations;
- The process is made easier to understand;
- Non-value added steps are eliminated;
- Effectiveness and efficiency is increased;

- The process can be benchmarked to determine if it is excellent or to set new performance goals;
- The DWMHA and MCPN staff can collect evidence relying on process conformity to increase validity and reliability in findings.

- Step 1:** The beginning of the process occurs at the provider level with the clinician delivering the service and documenting it in the clinical record. Staff are expected to self-regulate their clinical activities under the direction of the supervisor.
- Step 2:** The service provider's Quality Improvement staff is responsible for evaluating their programs using self-monitoring fidelity and outcome assessment tools.
- Step 3:** The MCPN will ensure 100% of their contracted service providers including the AFC residential homes are reviewed during the fiscal year. The MCPN will monitor self-monitoring results as part of the continuing quality process.
- Step 4:** The DWMHA Performance Monitoring staff will be responsible for analyzing the self-monitoring review tools and quarterly data information submitted by the MCPNs and service providers. This data information will be reviewed and analyzed by the following units: Quality Management, Contract Management, Customer Service, and Office of Recipient Rights

The scope of the performance monitoring activity includes the MCPNs, their contractors, and direct contract providers. It includes all supports and services provided within our system of care. The system is reviewed against pre-determined standards, protocols, and guideline. Additionally, the system is reviewed against contractual obligations and DWMHA policies to ensure compliance with regulatory requirements and expectations.

Quality Improvement

Quality improvement is a formal approach to analysis of performance and systematic effort to prevent, reduce or eliminate waste, rework, problems that will lead to improvement in service quality. This approach is system-wide, and addresses the DWMHA and its provider network. It includes State mandated performance improvement activity as well as, activities identified by the Quality Steering Committee.

As stewards of the system, the Quality Improvement component ensures guidance is provided to the system through the provisions of policy directives. All service providers are required to have certain policies in place which mirror our policies. The policies address those areas that are contractually mandated in our contract with MDCH, and describe the process for ensuring compliance with those policies. They are disseminated to our providers and are located on our website.

The DWMHA must have at least two affiliation-wide Performance Improvement Projects (PIPs) during the waiver renewal period. These are conducted to promote continuous quality improvement through on-going measurement, intervention as well as verifiable and sustained improvement in significant aspects of clinical care and/or non-clinical services. These projects are expected to have a beneficial effect on health outcomes and consumer satisfaction.

The MDCH Quality Improvement Council identifies the project topic on at least one of the PIPs and the DWMHA identifies at least one project topic. The DWMHA PIP topic is to address performance issues that have been identified through the External Quality Review, the Medicaid site reviews, the Needs Assessment, the performance indicator system, the performance monitoring and measurement system.

Once the performance of a selected process has been measured, assessed and analyzed, the information gathered by the above performance indicator(s) is used to identify the DWMHA defined continuous quality improvement initiative to be undertaken. The decision to undertake the initiative is based upon DWMHA priorities. The purpose of an initiative is to improve the performance of existing services or to design new ones. The model utilized by the DWMHA is called Focus-Plan-Do-Check-Act (PDCA).

The MCPN/Substance Abuse Providers/Direct Contractors are expected to participate in the DWMHA PIPs related to their programs and services. They are also expected to conduct PIPs based on their own self-assessment of need, risk, frequency, performance, etc.

Oversight of the quality improvement infrastructure is achieved through collaboration with consumers, advocates, providers, the DWMHA Medical Director, the Quality Improvement infrastructure and other stakeholders. Planned, systematic activities are implemented so that quality requirements for community mental health services are fulfilled by the DWMHA, MCPNs, Direct Contractors and sub-contractors.

In partnership with stakeholders Quality Improvement activities include:

- Assessment of needs, quality of services, accessibility of care, availability of care, outcomes of services provided and beneficiary experiences with services
- Evaluation of systems, programs and services
- Collect performance data utilizing effective quantitative metrics that are specific, measurable, actionable, relevant and timely for Michigan Mission Based Performance Indicator System Version 6.0, MDCH and DWMHA Performance Improvement Projects, QAPIP Status/Outcomes, Satisfaction Surveys (Consumer and Provider), HCPCS Code Utilization, Medicaid and Other Claim Verification, MDCH and DWMHA Needs Assessments, and Network Policies
- Identification of positive and negative process trends
- Analysis of causes of positive and negative statistical variation and outliers
- Identification of opportunities for improvement
- Determination of goals and objectives
- Decision making and planning
- Stakeholder education/information sharing
- information and technical assistance regarding the quality improvement issues, trends, techniques and proposed outcomes
- Implementation of performance improvement activities
- Measure and monitor progress toward goal achievement
- Evaluate outcomes and modify performance improvement process as needed
- Implementation of standardized performance improvement activities
- Strategic and annual planning

Some of the tools and techniques used in the continuous quality improvement process include Problem Solving Methodology, Process Mapping, Force Field Analysis, Cause and Effect Diagrams, Brainstorming, Pareto Analysis, Control Charts, Check Sheets, Bar Charts, Scatter Diagrams, Matrix Analysis and Tally Charts.

Quality Assurance and Improvement functions include informing practitioners, providers, beneficiaries and the Governing body of assessment results, facilitates a process of evaluating the effectiveness of the assessments and outlining systematic action steps to follow-up on findings.

The Leaders support QI activities through the planned coordination and communication of the results of measurement activities related to QI initiatives and overall efforts to continually improve the quality of care provided. This sharing of QI data and information is an important leadership function. Leaders, through a planned and shared communication approach, ensure the Board of Directors, staff, recipients and family members have knowledge of and input into ongoing QI initiatives as a means of continually improving performance.

This planned communication may take place through the following methods:

- Story boards and/or posters displayed in common areas
- Recipients participating in QI Committee reporting back to recipient groups
- Sharing of the annual QI Plan evaluation
- Newsletters and or handouts
- Dashboards

Performance Measurement

Performance Measurement is the process of regularly assessing the results produced by a program. It involves identifying processes, systems and outcomes that are integral to the performance of the service delivery system, selecting indicators of these processes, systems and outcomes, and analyzing information related to these indicators on a regular basis. Continuous Quality Improvement involves taking action as needed based on the results of the data analysis and the opportunities for performance they identify.

The **purpose** of measurement and assessment is to:

- Assess the stability of processes or outcomes to determine whether there is an undesirable degree of variation or a failure to perform at an expected level.
- Identify problems and opportunities to improve the performance of processes.
- Assess the outcome of the care provided.
- Assess whether a new or improved process meets performance expectations.

Measurement and assessment **involves**:

- Selection of a process or outcome to be measured, on a priority basis.
- Identification and/or development of performance indicators for the selected process or outcome to be measured.
- Aggregating data so that it is summarized and quantified to measure a process or outcome.
- Assessment of performance with regard to these indicators at planned and regular intervals.
- Taking action to address performance discrepancies when indicators indicate that a process is not stable, is not performing at an expected level or represents an opportunity for quality improvement.
- Reporting within the organization on findings, conclusions and actions taken as a result of performance assessment.

Selection of a Performance Indicator. A performance **indicator** is a quantitative tool that provides information about the performance of a process, service, function or outcome. The DWMHA utilizes the Michigan Mission Based Performance Indicator required by MDCH as well as, identification of indicators relevant to our operation. Selection of a Performance Indicator is based on the following considerations:

- Relevance to mission - does the indicator addresses the population served
- Clinical importance - does it addresses a clinically important process that is:
 - high volume or
 - problem prone or
 - high risk.

Characteristics of a Performance Indicator. Factors to consider in determining which indicator to use include:

- Scientific Foundation: the relationship between the indicator and the process, system or clinical outcome being measured
- Validity: whether the indicator assesses what it purports to assess
- Resource Availability: the relationship of the results of the indicator to the cost involved and the staffing resources that are available
- Consumer Preferences: the extent to which the indicator takes into account individual or group (e.g., racial, ethnic, or cultural) preferences
- Meaningfulness: whether the results of the indicator can be easily understood, the indicator measures a variable over which the program has some control, and the variable is likely to be changed by reasonable quality improvement efforts.

The Performance Indicator Selected for the DWMHA’s Quality Improvement Plan. For purposes of this plan, an indicator(s) comprises five key elements: name, definition, data to be collected, the frequency of analysis or assessment, and preliminary ideas for improvement. The following Table presents each performance indicator currently in use by the DWMHA, along with the corresponding descriptors.

Measure of Service Quality	
Name	<i>Michigan Mission Base Performance Indicators (MMBPI)</i>
Definition	<i>This includes the indicators found in the MDCH Code Book.</i>
Data Collection	<i>Most of the data is collected through WH-WIN, and the remainder is submitted to Quality by the MCPNs.</i>
Assessment Frequency	<i>The Quality Improvement Committee will assess information associated with the indicator on a Quarterly basis.</i>

Measure of Service Quality	
Name	Utilization Management
Definition	<i>Evaluation of medical necessity, appropriateness, and efficiency of the use of healthcare services, procedures and facilities under the provision of the DWMHA Benefit Plan.</i>
Data Collection	<i>MHWIN</i>
Assessment Frequency	<i>The Quality Improvement Committee will assess information associated with the indicator on a Quarterly basis.</i>

Measure of Service Quality	
Name	Service Denials
Definition	<i>Any service denial made the Access Center (Pioneer), the MCPN or the service provider.</i>
Data Collection	<i>Primarily collected through MHWIN</i>
Assessment Frequency	<i>The Quality Improvement Committee will assess information associated with the indicator on a Quarterly basis.</i>

Measure of Service Quality	
Name	Satisfaction
Definition	<i>Measure of how services meet or exceed consumer expectation.</i>
Data Collection	<i>MHWIN, Survey, Consumer Questionnaire</i>
Assessment Frequency	<i>The Quality Improvement Committee will assess information associated with the indicator on a Quarterly basis.</i>

Measure of Service Quality	
Name	<i>Practice Improvement</i>
Definition	<i>Measure of Model Fidelity or Measure of outcomes of persons served within various Best Practices.</i>
Data Collection	<i>Through Provider Data, MHWIN Data</i>
Assessment Frequency	<i>The Quality Improvement Committee will assess information associated with the indicator on a Quarterly basis.</i>

Measure of Service Quality	
Name	<i>Finance</i>
Definition	<i>Definition. Compare budget to actual expenditure by MCPNs/Providers</i>
Data Collection	<i>Audits, Financial Reports</i>
Assessment Frequency	<i>The Quality Improvement Committee will assess information associated with the indicator on a Quarterly basis.</i>

Assessment. Assessment is accomplished by comparing actual performance on an indicator with:

- Self over time
- Pre-established standards, goals or expected levels of performance;
- Information concerning evidence based practices;
- Other systems or similar service providers

Specific, measurable, actionable, relevant and timely data is a critical element of Quality Improvement operations. Quality Management unit staff is engaged in on-going processes for identification of data process deficiencies and opportunities to improve accuracy and completeness of the DWMHA's datasets in MH-WIN and in the state's data warehouse.

The Quality Management Unit has responsibility for oversight of the Michigan Mission Based Performance Indicator System data. Standardized indicators, based on the systematic, on-going collection and analysis of valid and reliable data are utilized. Performance measures utilized have been established by MDCH in the areas of access, efficiency and outcome. This data is reported to MDCH according to established timelines and formats. Data is also reported quarterly to various factions of the quality management infrastructure (i.e., Total Management Quality Program Compliance Committee, Quality Operations Technical Assistance Workgroup, etc.).

The quality improvement activities are achieved through a complex infra-structure which includes key stakeholders and process owners, and cross-functional units and committees. The structure is depicted below:

TOTAL QUALITY MANAGEMENT PROGRAM COMPLIANCE COMMITTEE (TQMPCC) COMMITTEE:

Purpose of the TQMPCC:

The Total Quality Management Program Compliance Committee (TQMPCC) is a committee of the **Board of Directors**, and provides leadership for the Quality Improvement process through supporting and guiding implementation of quality improvement activities at the DWMHA; and reviewing for changes, evaluating, need for Board Actions and approving the Quality Improvement Plan annually.

Membership:

The DWMHA's TQMPCC Committee consists of members of the Board of Directors. The Chief Operating Officer is the DWMHA liaison to the committee. Meeting notices are posted in public places and meetings are open to the public.

The function of the TQMPCC:

The committee monitors the effectiveness of the QAPIP and makes recommendations for:

- Annual evaluation of the effectiveness of the QAPIP and recommends approval of reports to the Board
- System-wide trends and patterns of key indicators;
- Opportunities for improvement;
- Studies in areas identified from data review as having the potential for affecting the outcomes of care and related quality concerns;
- Policy or procedure;
- System-wide attainment of goal(s) and objective(s).

The responsibilities of the Committee include:

- Developing and approving the Quality Improvement Plan
- As part of the Plan, establishing measurable objectives based upon priorities identified through the use of established criteria for improving the quality and safety of clinic services
- Developing indicators of quality on a priority basis
- Periodically assessing information based on the indicators, taking action as evidenced through quality improvement initiatives to solve problems and pursue opportunities to improve quality
- Establishing and supporting specific quality improvement initiatives
- Reporting to the Board of Directors on quality improvement activities of the clinic on a regular basis
- Review of program operations
- Recommend Board Actions to the Full Board relative programs

QUALITY IMPROVEMENT STEERING COMMITTEE (QISC):

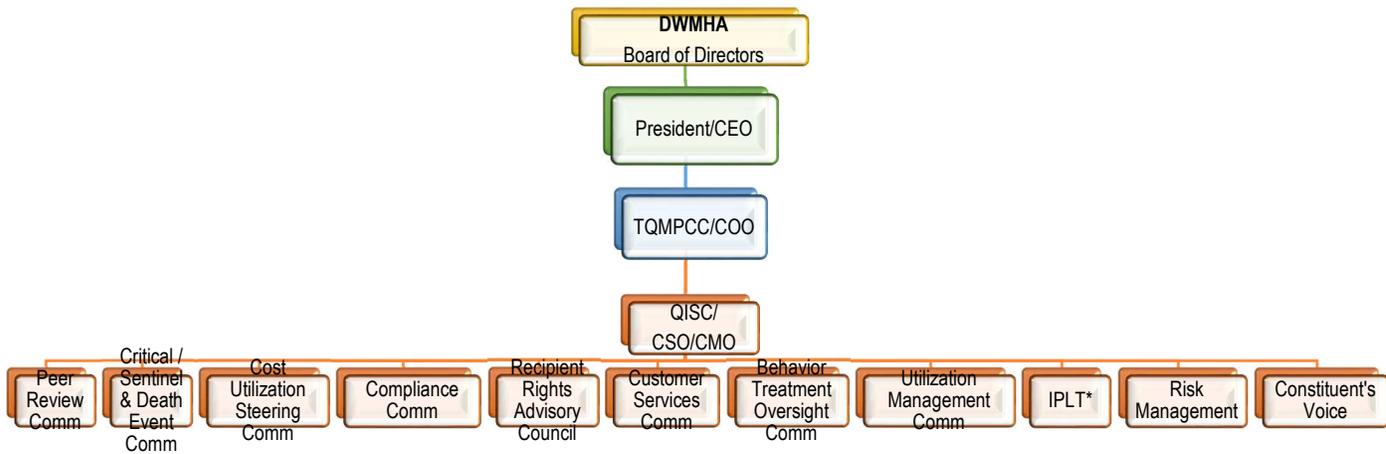
Purpose of the Quality Improvement Steering Committee:

The DWMHA's Quality Improvement Steering Committee (QISC) is an advisory group with responsibility for ensuring system-wide representation in the planning, implementation, support and evaluation of the DWMHA's continuous quality improvement program. The QISC provides ongoing operational leadership of continuous quality improvement activities for the DWMHA. It

meets at least monthly or not less than ten (10) times per year. The QISC provides leadership in practice improvement projects and serves as a vehicle to communicate and coordinate quality improvement efforts throughout the quality management program structure.

Membership:

Membership must include the Medical Director and is also composed of directors of the DWMHA’s units or designee, chairpersons of the committees within the Quality Management structure or designee, consumers, advocates and MCPN, /Direct Contractor providers of services to consumers with Serious Mental Illness, Severe Emotional Disturbance, Substance Use Disorders, Developmental Disabilities and Co-Occurring Disorders.



Functions of the Quality Improvement Steering Committee:

- Establish and annually review committee operational guidelines, such as confidentiality, meeting frequency, management of information requests, number of members required for a quorum, membership, etc.
- Establish committee goals and timelines for progress and achievement
- Participate in the development and review of quarterly/annual reports to the Total Quality Management Program Compliance Committee and the Board of Directors regarding the Quality Management System
- Annually review and evaluate the effectiveness of the Quality Assessment Performance Improvement Program
- Oversee a circular communication process in order to ensure that all involved constituencies, including the Board of Directors, DWMHA staff, and consumers, MCPNs, providers and other stakeholders are a part of the Quality Management Process
- Provide recommendations and feedback on process improvement, program implementation, program results and program continuation or termination
- Examine quantitative and qualitative aggregate data at predetermined and critical decision making points and recommend courses of action
- Review reports from regulatory DWMHA reviews
- Review of DWMHA improvement plans and make recommendations based on these reviews
- Monitor progress and completion of plans of correction in response to recommended remedial actions identified for the DWMHA or by regulatory organizations
- Review quality management operating procedures and propose changes in procedures as needed
- Oversee a process for establishing, continuing or terminating subcommittees, standing committees, improvement teams, task groups and work groups
- Identify training needs and opportunities for staff development in the quality management process
- Identify future trends and make recommendations for next steps
- Develop standardized forms required for the work of the Steering Committee
- Initiate and participate in recognition and acknowledgement of successes in quality management for the DWMHA and the community mental health system
- Leadership in practice improvement projects

STANDING COMMITTEES:

The DWMHA's quality management system consists of standing committees that oversee on-going monitoring, peer evaluation, and improvement functions, including receipt and review of data related to their identified areas of responsibility. This structure is designed to improve quality of care to consumers, improve operations of providers and promote efficient and effective internal operations. Standing Committees may be assigned quality indicators to use in monitoring aspects of care and service or may establish indicators for which data will be collected and monitored.

The standing committees consist of qualified representatives of DWMHA units, MCPNs, other contractors or providers and in some cases, stakeholders and consumers. The committees define aspects of services and supports to be monitored for opportunities to improve, based on priorities established in the MDCH contract and on the needs of high-risk consumers and high volume/problem-prone programs. Results from the DWMHA's Performance Indicators System,

which is an extension of the MDCH data collection program, are a key source for identification of aspects to be monitored. The committees develop plans by which data for their scope of responsibility will be reviewed and opportunities for improvement identified. QM staff work with the committees and assure that the principles of data based continuous quality improvement are followed. The standing committees monitor improvements that are implemented for effectiveness and improved outcomes.

Standing committees identify and recommend needs for quality improvement teams, as appropriate, and may bring in outside resources, if needed, to facilitate the work of teams and to facilitate involvement of internal staff, MCPNs, providers, consumers, stakeholders and various outside groups, as needed. The standing committees are:

UTILIZATION MANAGEMENT COMMITTEE (UM):

Purpose of the Utilization Management Committee:

The mission of the UM committee is to ensure delegated UM functions meet required state and federal standards. The goal is to ensure that delegated Utilization Management processes effectively and efficiently promote quality and cost-effective care for all consumers.

Membership:

Members of the committee include consumer and DWMHA representation.

The function of the Utilization Management Committee:

The activities of the UM Committee include development, implementation, review and analysis of the following processes as defined in the written UM plan:

- Centralized and standardized access to community mental health services
- Consumer selection of an appropriate network provider that is close to the consumer's home
- Determination of emergent and non-emergent care according to established clinical guidelines
- New enrollee access to care within MDCH established timelines
- Medical necessity is determined according to established clinical criteria
- Utilization review processes to support the need for continued treatment follow are in accordance with established clinical criteria
- Determination of denial of services follows established clinical guidelines
- Expedited appeal processes for review of emergency care follows established clinical guidelines
- Review of information about patterns of care and services related to over and under utilization
- Monitoring of the utilization of resources, cost of services incurred and utilization information with aggregated cost data
- Monitoring the high-user population, identification of contributing factors and remedial strategies
- Coordination and authorization functions for those levels of care identified as high cost or high risk
- Information sharing with the DWMHA and provider staff about the role of UM
- Management of special populations
- Identification of unmet service needs

- Monitoring of Medicaid eligibility data and control of unnecessary costs;
- Identify, implement and evaluate mental health-relevant and evidence-based practices, sharing information at the University/College and community levels;
- Support/Coordinate implementation of best-practice models;
- Assess fidelity with best-practice models;
- Facilitate implementation of new science-based practices;
- Evaluate outcomes and performance indicators in partnership with practitioners;
- Disseminate results at a state/national level, including the funding community (i.e. state and federal foundations);
- Work toward informing curriculum development at the University/College level to aid in the preparation of a qualified workforce;
- Establish website with best-practice materials;
- Link the VCE website to other informational web-based centers;
- Research, develop and disseminate core competencies and training thresholds;
- Monitor fidelity in support of a continuous learning environment;
- Confirm quality improvement through on-going monitoring, evaluation and feedback.

CRITICAL/SENTINEL EVENTS COMMITTEE (CSEC):

Purpose of the Critical/Sentinel Event Committee:

The Critical/Sentinel Event process involves the reporting of all unexpected incidents involving the health and safety of the consumers within the DWMHA's service delivery area. Incidents include consumer deaths, medication errors, behavioral episodes, arrests, convictions, physical illness and injuries. The CSEC retains the right to make the final decision whether an incident is a Critical/ Sentinel Event.

Membership:

Membership consists of core group members:

- Medical Director
- Designated Psychiatrist
- UM/Clinical Services
- Managed Care Operations
- Quality Management
- Substance Use Disorders Initiatives

As applicable, when necessary to respond to questions/concerns of the CSEC others will be requested to attend.

The function of the Critical/Sentinel Event Committee:

The mission of the CSEC is to ensure the MCPN–Substance Abuse Providers/Direct Contractor and/or clinically responsible service provider conducts a thorough review of incidents with an action plan to ensure the incident does not reoccur or the risk of the incident reoccurring is minimized.

The goal of the CSEC is to ensure the MCPN/Substance Abuse Providers /Direct Contractor and/or clinically responsible service provider is compliant with the DWMHA's Critical and Sentinel Event Policy and Procedures for conducting a thorough investigation of the incident.

The CSEC uses a four-tiered system of peer review activity. In the first tier, the Critical Events are reviewed by the QM Critical/Sentinel Event Liaison for data collection, review for quality of

care issues, request for additional documents, completeness of the information and notification of high risk critical incidents to the DWMHA's QM Unit Director and the DWMHA's Administration.

In the second tier, the Critical/Sentinel Events are reviewed by the UM/Clinical Services, designated psychiatrist and QM Critical/Sentinel Event Liaison for clinical issues, standards of care and potential Critical/Sentinel Events.

In the third tier, the Critical/Sentinel Events are reviewed by the DWMHA's Peer Review Committee, if needed, as a peer review activity.

In the fourth tier, the data collection is reviewed by the DWMHA's Critical/Sentinel Event Committee for policy review and implementation, patterns, trends, compliance, education and improvement and presentation to the DWMHA TQMPC.

The activities of the CSEC include:

- Review of the criteria established by MDCH for implementation of established criteria throughout the DWMHA service area
- Development and revision, as needed, of the DWMHA's Critical and Sentinel Event policy and procedures to be in compliance with MDCH criteria for the reporting of critical and sentinel event activity
- Development and implementation of the DWMHA's internal review process for utilization and collection of the Critical and Sentinel Event documentation received from the provider networks
- Review and aggregation of data for patterns and trends of Critical/Sentinel Event incidents reported throughout the DWMHA's service delivery area
- Education and training on the Critical and Sentinel Event process
- Monitoring contractor/subcontractors performance in the area of reporting of critical/sentinel events, data submission, quality and outcome
- Reporting and implementation of a Critical/Sentinel Event processes as defined in the DWMHA, MDCH criteria and Medicaid standards
 - ✓ Evidence of clinical review
 - ✓ Evidence of quality of care review
 - ✓ Reporting results of findings from data collection and on-site reviews are issued to contractors, MCPN administrators and the MCPNs

Findings can include requests for corrective action plans, if needed. Repeated deficits or failures to correct identified deficits may result in recommendations for performance sanctions as defined by DWMHA policy, procedures and contracts.

PEER REVIEW COMMITTEE (PRC):

Purpose of the Peer Review Committee

The PRC Committee is a peer review activity responsible for the clinical peer review of critical incidents involving consumer deaths, Critical/ Sentinel Events, incidents involving the media or special requests from the DWMHA's Medical Director or DWMHA administration. All peer review activities are privileged, confidential and are in accordance with the state and federal laws and regulations that govern peer review activities.

Membership:

The membership is comprised of DWMHA staff from the following units/areas:

Core group: Medical Director
 Designated psychiatrist
 Clinical Services
 Managed Care Operations
 Quality Management

As applicable, when necessary to respond to questions/concerns of the PRC Committee other persons will be requested to attend.

Function of the Peer Review Committee:

The mission of the PRC Committee is to ensure the MCPN/Substance Abuse Providers/Direct Contractor and/or clinically responsible service provider conduct a thorough review of incidents and provide an action plan that will ensure similar incidents do not reoccur and that the risk of reoccurring is minimized. The goal of the PRC Committee is to review the processes at the MCPN/CA/Direct Contractor and/or the clinically responsible service provider when conducting a thorough clinical review of the incident in accordance with the DWMHA's Peer Review Policy and Procedures.

Activities of the PRC Committee include:

- The review, revisions (as applicable) and training of the DWMHA's Peer Review Policy and procedures
- The review of selected clinical cases identified, through referral by the DWMHA's Medical Director and/or designated psychiatrist or DWMHA administration
- Conducting, at the request of the DWMHA's Medical Director or DWMHA's administration, a peer review as part of an external peer review or during credentialing, privileging, and performance improvement activities
- The discussion and review of cases referred for a peer review submitted to the DWMHA by the MCPN/CA/Direct Contractor and/or clinically responsible service provider
- Notification or recommendation or referral for additional action (i.e., monitoring, clinical case conference) to be taken by DWMHA administration and/or other DWMHA Units because of the action involving the MCPN and/or clinically responsible service provider(s)
- The review of aggregate data from the Critical/Sentinel Events Committee and Death Review Committee for patterns, trends and improvement within the DWMHA's service delivery area

DEATH REVIEW COMMITTEE (DRC):

Purpose of the Death Review Committee:

All unexpected* deaths of consumers who at the time of their deaths were receiving specialty supports and services must be reviewed and must include:

- Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
- Involvement of medical personnel in the mortality reviews
- Documentation of the mortality review process, findings, and recommendations
- Use of mortality information to address quality of care

- Aggregation of mortality data over time to identify possible trends.

*Unexpected deaths” include those that resulted from suicide, homicide, an undiagnosed condition, accidental, or suspicious for possible abuse or neglect.

Membership:

Membership is comprised of DWMHA staff from the following areas:

- | | |
|-------------|---|
| Core group: | <ul style="list-style-type: none"> Medical Director Designated Psychiatrist Clinical Services Managed Care Operations Quality Management Recipient Rights |
|-------------|---|

As applicable, when necessary to respond to questions/concerns of the DRC other persons will be requested to attend.

All Peer Review activities are privileged, confidential and are in accordance with state and federal laws and regulations that govern Peer Review activities.

Function and Goal of the Death Review Committee

The mission of the DRC is to ensure a thorough review of the consumer’s death has been conducted by the consumer’s respective MCPN/Substance Abuse Providers/Direct Contractor and/or clinically responsible service provider, the DWMHA’s Recipient Rights Unit and the DWMHA’s Clinical Services Unit in accordance with the DWMHA’s Death Reporting Policy and procedures

The goal of the DRC Committee is to ensure the MCPN/Substance Abuse Providers Direct Contractor and/or clinically responsible service provider, the DWMHA’s Recipient Rights Unit and the DWMHA’s Clinical Services Unit are compliant in the review and investigation of all consumer deaths reported to Michigan Department of Community Health (MDCH).

The activities of the DRC Committee include:

- Review of the criteria established by the MDCH for implementation throughout the DWMHA’s service delivery area
- Development and revision as needed of the DWMHA’s Death Report Policy to be in compliance with MDCH criteria for the reporting of consumer deaths that occur throughout the DWMHA’s service delivery area
- Development and revision as needed of the DWMHA’s internal review process for utilization and collection of the death reporting documentation received from the network contractors
- Review and monitoring of the internal and external processes for improvement through the utilization of aggregate data
- Review of aggregate data for patterns and trends of consumer deaths reported throughout the DWMHA’s service delivery area
- Information sharing with the DWMHA and provider staff about the role of the DRC Committee
- Education and training on the death reporting process

IMPROVING PRACTICES LEADERSHIP TEAM (IPLT):

Purpose of the Improving Practice Leadership Team

The Detroit Wayne Mental Health Authority (DWMHA) endeavors to implement and support Evidence-Based Practices (EBP), Promising and Emerging Practices. The Michigan Department of Community Health (MDCH) defined the elements of the Improving Practices Leadership Team (IPLT), whose purpose is to oversee and monitor these practices. These teams were charged with developing work plans, coordinating the regional training and technical assistance plan, working to integrate data collection, developing financing strategies and mechanisms, assuring program fidelity, evaluating the impact of the practices, and monitoring clinical outcomes.

DWMHA will gather a number of previously operating committees and work groups into one coordinated IPLT which will serve as liaison between the DWMHA Quality Improvement Steering Committee (QISC) and the groups developing and monitoring the clinical practice standards. It will envelop and reorganize the following groups:

- Developmentally Disabled Systems of Care Work Group
- Children's Cross-Systems Management Committee
- Standards of Care-Adult Committee,
- Substance Use Disorder Services Group
- Integrated Health Work Group
- Peer and Consumer Group (previously three groups: Consumer Empowerment and Engagement, Peer Promotion and Utilization, and Prevention and Education).

Membership:

The IPLT committee membership includes:

Improving Practice Leader

Specialists in the following areas

Individuals with Serious Mental Illness (SMI)

Children with Serious Emotional Disturbance (SED)

Individuals with Intellectual and/or Developmental Disabilities (I/DD)

Individuals with Substance Use Disorders (SUD)

Quality Management

Finance

Data

Evaluation

Consumer employed by the system

Family member of a child receiving PIHP services

Peer support specialist

An identified program leader for each practice being implemented

Identified program leader for peer-directed or peer-operated services

The function of the IPLT:

The IPLT is expected to:

- Expand the use of clinical guidelines based on relevant evidence of clinical and cost-effectiveness, associated clinical audit methodologies and information on good practices
- Dissemination of standardized monitoring tools based on a set of predetermined and established criteria
- Adopt a vision for a transformed system of care for adults and children
- Establish leadership capabilities and organizational capacity to communicate the vision and lead the transformation
- Create an environment or climate of working that is receptive and amenable to the transformation
- Develop and communicate a strategy that is tailored to the context and the roles, capabilities, and interests of the stakeholder groups involved in the public mental health system
- Identify and mobilize program leaders or change agents within the organization to implement the activities required to achieve the desired outcomes
- Develop an on-going process to maximize opportunities and overcome obstacles
- Monitor outcomes and adjust processes based on learning from experience
- Align relevant persons, organizations, and systems to participate in the transformation process
- Support membership of a consumer/Certified Peer Support to represent the PIHP/CMHSP on the Recovery Council of Michigan
- Assess parties' experience with change
- Establish effective communication systems
- Ensure effective leadership capabilities
- Enable structures and process capabilities
- Improve cultural capacity
- Demonstrate their progress in system transformation by implementing evidence based, promising and new and emerging practices

TECHNICAL ADVISORY BEHAVIOR TREATMENT COMMITTEE ON BEHAVIOR TREATMENT PLAN REVIEW REQUIREMENTS:

Purpose of the Technical Advisory Behavior Treatment Committee:

The DWMHA's Technical Advisory Behavior Treatment Committee on Behavior Treatment Plan provides oversight, direction and monitoring of the function of the Behavior Management Committee at the MCPN and providers sites. Additionally, the committee review requirements, performs analysis of the MCPN/Direct Contractor data from their respective Behavior Treatment Review Committees where intrusive or restrictive techniques have been approved for use and where physical management has been used in an emergency or non-emergency situation.

Membership:

The committee consists of a psychiatrist, licensed psychologist, consumers, DWMHA staff, MCPN, provider representatives and ORR. A representative of the DWMHA's Office of Recipient Rights (ORR) is required to attend each Technical Advisory Behavior Treatment Committee on Behavior Treatment Plan Review Requirements meeting in the MCPN network.

Each of the provider Behavior Treatment Review Committees consists of a licensed psychologist, a licensed physician/psychiatrist and the DWMHA's Office of Recipient Rights who assigns a representative. Each committee sends representative(s) to the monthly DWMHA's Behavior Treatment Technical Advisory.

Function of the Behavior Management Committee:

The DWMHA's Committee is charged with monitoring the use of the intrusive and/or restrictive interventions throughout the network. The committee oversees the MCPNs Behavior Treatment Review Committees that are responsible for reviewing, approving and/or disapproving individual plans that propose to use restrictive or intrusive interventions for persons who exhibit seriously aggressive, self-injurious or other behavior that place the person or others at risk. The community based Behavior Treatment Committee provide a status report on the implementation of the technical requirement standards, problems with implementation; training needs, etc. Additionally, the DWMHA's Committee collects data and information on implementation issues including:

- Percent of provider Behavior Management committees with active Recipient Rights representation;
- Types of challenging behaviors resulting in intrusive and/or restrictive interventions;
- Percent of consumers exhibiting challenging behaviors per the client record with behavior treatment plans;
- Types of interventions used;
- Frequency and duration of interventions used;
- Frequency of review of behavior management plans;
- Percent of interventions matching behavior management plans;
- Percent of charts labeled appropriately;
- Number of Critical/Sentinel Events involving challenging behaviors;
- Percent of care staff at all levels trained in behavior management (i.e., positive behavior management, the culture of gentle teaching, management of challenging behaviors, etc.);
- Percent of care staff at all levels who demonstrate the required behavior management competencies;
- Number of behavior management related Office of Recipient Rights complaints.

QUALITY IMPROVEMENT TEAMS, AD HOC COMMITTEES AND WORKGROUPS:

The DWMHA may identify opportunities for improvement that do not fit into the existing standing committee structure. Ad hoc teams, workgroups and quality circles are appointed for a limited period of time for a specific task by the Quality Improvement Steering Committee, Quality Management or a Standing Committee based on organizational need. Reports from the various Committee(s), Ad hoc team(s), DWMHA Unit(s) and workgroup(s) will include outcome measures and are forwarded to the Quality Improvement Steering Committee.

SECTION 3: Evaluation

An evaluation is completed at the end of each calendar year. The annual evaluation is conducted by the DWMHA and submitted to MDCH and kept on file at the DWMHA, along with the Quality Improvement Plan. These documents will be reviewed by Health Services Advisory Group and MDCH as part of the certification process.

The evaluation summarizes the goals and objectives of the DWMHA's Quality Improvement Plan, the quality improvement activities conducted during the past year, including the targeted process, systems and outcomes, the performance indicators utilized, the findings of the measurement, data aggregation, assessment and analysis processes, and the quality improvement initiatives taken in response to the findings.

- Summarize the progress towards meeting the Annual Goals/Objectives.
- For each of the goals, include a brief summary of progress including progress in relation to training goal(s).
- Provide a brief summary of the findings for each of the indicators used during the year. These summaries should include both the outcomes of the measurement process and the conclusions and actions taken in response to these outcomes. Summarize progress in relation to Quality Initiative(s). For each initiative, provide a brief description of what activities took place including the results on indicators. What are the next steps? How will we "hold the gains?" Describe any implications of the quality improvement process for actions to be taken regarding outcomes, systems or outcomes in the coming year.
- Recommendations: Based upon the evaluation, state the actions necessary to improve the effectiveness of DWMHA and the QI Plan.