



Quality Management Program Description & Improvement Plan For Fiscal Year 2010 – 2011

[October 1, 2010 through September 30, 2011]

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LifeWays
Quality Management Program Description

I. INTRODUCTION AND PURPOSE

The purpose of this Quality Management Program Plan is to describe and direct the organization’s Quality Assessment and Performance Improvement Program (QAPIP), while satisfying the expectations and standards of the Michigan Department of Community Health (MDCH), the Balanced Budget Act (BBA), and the Commission on Accreditation of Rehabilitation Facilities (CARF), to effectively implement the organization’s commitment to the provision of quality services and meaningful outcomes.

The LifeWays QAPIP, also referred to herein as the Quality Management Program, encompasses many quality management activities, all of which are driven and governed by the LifeWays Board of Directors and are intended to support the agency’s mission, vision, values and strategic plan.

Mission	Dedicated to the community we serve; LifeWays’ mission is to help individuals achieve personal growth and recovery, focusing <u>first</u> on individuals in greatest need.	
Vision	LifeWays is an innovative public leader and the community’s choice for assistance, services, and referral	
Values	<i>Customer Driven:</i>	Customers feel empowered through person-directed, community-based services.
	<i>Strategic Partnerships:</i>	The success of all stakeholders (LifeWays’ staff, consumers, providers, suppliers, etc.) is dependent upon collaborative efforts that embrace diverse perspectives and a wide range of inputs.
		<i>Exceptional Service:</i> All customer interactions result in a positive experience and fostered relationships.
	<i>Innovative:</i>	Improvement opportunities are maximized through a dedication to learning, leading, and teaching for today and tomorrow.
	<i>Integrity:</i>	Through personal accountability and adherence to professional ethics, LifeWays is a steward of the public trust
	<i>Intergenerational Equity:</i>	Current and future generations of stakeholders will benefit from LifeWays’ resources.
	<i>Recovery:</i>	Consumer-defined recovery is promoted using natural and community supports.

The Quality Management Program incorporates quality assurance, quality planning, and continuous quality improvement activities with the intended purpose of:

- A. Ensuring compliance with state and federal law, regulatory expectations, and accreditation standards;
- B. Systematically measuring, assessing and improving organizational performance;
- C. Facilitating good process design;
- D. Ensuring the effective and efficient use of resources; and
- E. Achieving quality outcomes

II. SCOPE AND PRINCIPLES

The scope of the Quality Management Program includes all LifeWays managed care functions, behavioral healthcare settings, and internal and external customers. Quality improvement is a core function of the Quality Management Council (QMC), LifeWays Teams, Leadership Council, Governing Board of Directors, and the LifeWays Provider Network. The Quality Management Program model is based on industry theory, principles, and standards that include the following fundamental concepts.

Process Planning and Design: Organizational planning and development is conducted in a systematic manner. The planned approach to design and improvement involves a collaborative effort between customers and suppliers.

Consideration is given to expected outcomes from improvement efforts, implementation, training and communication. Process improvement and development design is based on the organization's mission, vision, and values identified by the Board of Directors through strategic planning. Attention is given to the needs and expectations identified by consumers, staff, providers and other stakeholders. Changes to processes are based on objective monitoring of performance and up-to-date sources of information on process design.

Monitoring and Evaluation: Measures included in the monitoring and evaluation process are identified through an assessment of important organizational functions that are high volume, high risk, problem prone, and/or critical to customer satisfaction. Through the monitoring and evaluation function, LifeWays ensures compliance with applicable state and federal laws. These functions are coordinated by the QMC or one of its designated standing committees and include participation of primary and/or secondary consumers when appropriate and are conducted through clinical reviews, monitoring of trends in service and resource utilization, facility and provider site reviews, provider program outcomes reporting, and/or customer satisfaction surveys and focus groups.

Continuous Improvement: Each LifeWays team reports to the QMC and manages quality improvement activities within their scope. Opportunities for improvement are identified through monitoring of internal and external systems and/or stakeholder input. A recommendation for process improvement can be made through the QMC, LifeWays Board of Director, Leadership Council, a LifeWays Team, a standing committee, feedback from a consumer or other community stakeholder, or an employee recommendation to the QMC. Recommendations for improvement relating exclusively to LifeWays functions or the provider network are referred to the QMC. The QMC may determine the scope of a process improvement project and schedule a routine project review.

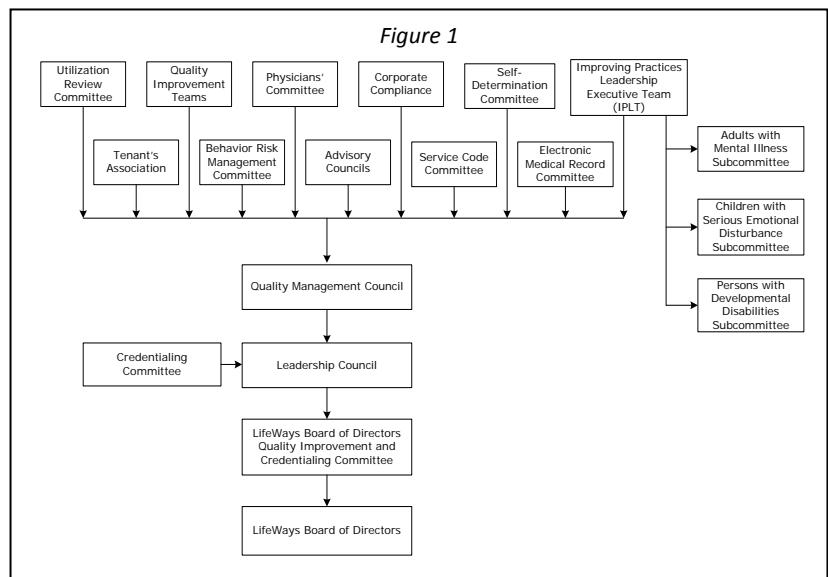
Outcomes and Results: It is the focus of the QMC to continuously monitor and assess the organizational and provider network performance to provide continuous quality improvement and achieve the desired results of the Quality Management Program Plan. This is completed through regularly scheduled monitoring reports that are dynamic and encompass a broad range of critical functions and performance indicators. The QMC agenda items are reviewed annually to ensure continued compliance with requirements and to incorporate new elements that are of interest for continued support of the plan.

III. PROGRAM STRUCTURE

Leadership: The Executive Director of Network Performance & Consumer Services is the senior official responsible for the Quality Management Program implementation and is a participating member of the QMC, the primary liaison between the QMC, the Leadership Council and the Board of Directors, and provides chief oversight and leadership for the Quality Management Program. The position requires an advanced degree and/or minimum of five (5) years experience in behavioral healthcare administration. The Quality Management Team supports the senior official's role through facilitation of the QMC, dissemination of reports and other duties as needed.

Structure: The Quality Management Council (QMC) is the organized body that holds primary responsibility for the development and implementation of the Annual Quality Management Program Plan under direction of the LifeWays Board of Directors. The QMC recommends and oversees many quality improvement activities to provide an effective Quality Management Program. The QMC facilitates and monitors all quality improvement activities and routinely reports the results of such activities to the Leadership Council and the LifeWays Board of Directors for review, recommendation and/or approval.

Standing Committees: Figure 1 depicts the reporting structure for the Quality Management Program, which is centralized by the QMC but with ultimate authority held by the LifeWays Board of



Directors. The standing committees serve to focus attention on specific organizational and network functions, to complete preliminary review and develop initial recommendations to the next level of authority¹. The standing committee and reporting structure is reviewed annually and modified as necessary to support the goals of the Quality Management Program Plan. Standing committee meets at least quarterly or more frequently as needed and are required to maintain meeting minutes of activities and routinely report to the QMC to support the intended goals.

Quality Management Council Description:

1. QMC Membership: The council is composed of the Executive Director of Network Performance & Consumer Services, the LifeWays Quality Management Team, and at least one (1) representative from each LifeWays Team. The council shall be diverse in both team representation and with staff from various levels of authority within the agency to provide unique perspectives and thoroughly disseminate the quality improvement initiatives and other pertinent QMC information within their respective teams and scope; membership is reviewed annually through the QMP Evaluation to ensure this expectation is met and changes are made as needed.
2. Operating Guidelines: The QMC meets with sufficient frequency to conduct business and effectively monitor the Quality Management Program. The QMC establishes guidelines for meeting operation and membership such as membership appointment, decision making process, attendance, participation, preparation, and discussion. These guidelines are maintained in Quality Management Operating procedures. The Quality Management Team reviews the procedures at least annually and makes revisions as needed.
3. Record Keeping: The QMC maintains meeting minutes and records of all meetings including reports and supporting documentation for three years or pursuant to record retention requirements. Meeting minutes are distributed to all members of the committee post-meeting and reviewed and approved at the subsequent meeting. Proceedings of the QMC are reported to the LifeWays Leadership Council, the Quality Improvement & Credentialing Board Committee, and the Board of Directors through the *Quality Improvement & Credentialing Board Report*.
4. Council Functions and Responsibilities: A primary function of the QMC is to review monitoring reports monthly and provide conclusions and recommendations to the Leadership Council and the Board of Directors Quality Improvement & Credentialing Board Committee. Additional Council responsibilities include:
 - Develop, implement and evaluate the Quality Management Program Plan;
 - Establish Quality Management Program Goals and Objectives;
 - Continually review consumer demographics and epidemiological trends;
 - Ensure that quality improvement activities are relevant for the populations served;
 - Identify opportunities for improvement;
 - Implement the Quality Improvement process;
 - Approve all Quality Improvement process activities;
 - Establish priorities and timeframes for improvement activities;
 - Assign responsibility for action;
 - Review audit findings and recommend improvement;
 - Monitor achievement toward standards or accreditation; and
 - Identify training needs related to process improvements and other Quality Improvement related topics.

At least annually the QMC completes an evaluation of the Quality Management Program Plan. The evaluation considers the effectiveness of the Quality Management Program, demonstrates improvements in the quality of clinical care and services provided, and makes recommendations for continuous quality improvement. The written evaluation includes:

- A summary of complete or current improvement activity;
- An evaluation of the efficacy of the performance measurement system;
- An analysis of demonstrated improvements;
- An evaluation of the overall effectiveness of the QM program; and
- Recommended changes to plan for the forthcoming year.

Refer to Page 7 for the Annual Evaluation of the FY 2010 Quality Management Program and the improvement plan for

¹ Refer to Attachment 1 for a brief description of each standing committee.

FY 2011.

IV. PROGRAM COMPONENTS

As previously depicted in *Figure 1*, the Quality Management Program encompasses a large infrastructure of standing committees, workgroups and direct reports that are centralized and monitored by the Quality Management Council. Various quality improvement activities are addressed and implemented through these workgroups with the goal of supporting the recommendations of the Quality Management Program Plan to achieve continuous quality improvement. The components and activities are categorized by four (4) main Domains – Access, Process, Outcomes, and Structure & Resources. The Quality Management Team has established the following components and activities within each domain to support the Quality Management Program Plan.

Domain 1: Access

Getting into Services

QMP Goal #1: Through the Quality Management Program, Access will be improved for consumers.

Components/Activities Monitored:

- Accessibility
- Grievance & Appeals
- Network Capacity Evaluation
- Performance Indicator Dashboard Monitoring
- Waiting List

Domain 2: Process

What Happens in Service

QMP Goal #2: Through the Quality Management Program, network-wide processes will be targeted for improvement.

Components/Activities Monitored:

- Care Coordination
- Critical Incidents
- Consumer Deaths
- Medicaid Fair Hearings
- Recipient Rights Activity
- Sentinel Events and Root Cause Analysis
- Standing Committee and Quality Improvement Team Recommendations

Domain 3: Outcomes

Results of Service

QMP Goal #3: Through the Quality Management Program, the quality of service and care received by consumers will be monitored and improved.

Components/Activities Monitored:

- Corporate Compliance Activity
- Customer Satisfaction Assessments
- Evidence-Based and Promising Practices
- Improving Practices Leadership Team Initiatives
- Performance Indicator Dashboard Monitoring
- Program Outcomes & Fidelity Assessments
- Provider Credentialing
- Recovery Initiatives

Domain 4: Structure & Resource

Efficacy of Resources

QMP Goal #4: Through the Quality Management Program, resources will be monitored and tracked to ensure appropriate use.

Components/Activities Monitored:

- Cost per Case by Provider and Service Type

- External Audit Improvement Plan
- Over-Under Service Utilization
- Performance Indicator Dashboard Monitoring
- Safety Management Program
- Standing Committee and Quality Improvement Team Recommendations

V. ROLES OF RECIPIENTS OF SERVICE

Consumers and families have a significant role in the Quality Management Program including monitoring improvement and evaluation activities. Consumers, family members and/or guardians serve on the LifeWays Board of Directors, Improving Practices Leadership Teams and Subcommittees, the Consumer Advisory Council, and the Recipient Rights Advisory Council. Additionally, focus groups and surveys are routinely utilized as part of the process to afford recipients of service with the opportunity to provide input into various aspects of the organization's Quality Management Program and operations.

VI. ADOPTING, EFFECTING & COMMUNICATING CHANGE

There are several mechanisms for adopting, effecting and communicating change within LifeWays and its Provider Network. Quality improvement initiatives are reported to the LifeWays Quality Management Council for approval and recommendations are made to the LifeWays Leadership Council, the LifeWays Board of Directors and/or the Consumer Advisory Council. The Improving Practices Leadership Team, which is a cross-functional workgroup involving various stakeholder types, is responsible for improving service delivery within the provider network to achieve the desired outcomes; recommendations are made to the LifeWays Quality Management Council, Leadership Council and/or the Board of Directors for continuous quality improvement within the network.

Provider and LifeWays staff receive ongoing training and technical assistance at various levels as needs arise and processes are improved. Provider communication occurs primarily through the monthly Provider Meeting, monthly MCO Process Alert, newsletters, memorandums, emails, letters, trainings and conferences, and the LifeWays Provider Manual. LifeWays staff may receive additional training and communication, provided internally and externally, through various means, such as all-staff meetings, team meetings, individual coaching, internal written correspondence (email, memos, etc.), new hire and annual staff trainings, and other modes as identified to effectively communicate process improvement and maintain an effective workforce.

References: The LifeWays Quality Management Program may include, but is not limited to, the activities and program components described in the following LifeWays Operating Procedures:

- 02.04.01 Death Reporting
- 04.02.01 Clinical Case Reviews
- 04.03.01 Utilization Management Criteria
- 05.01.01 Best Practice Guideline Development
- 06.03.01 Grievance & Appeal
- 06.05.01 General Customer Satisfaction
- 08.01.01 Data Collection Analysis
- 10.02.01 Auditing Certification and Accreditation
- 02.04.02 Incident Report Process
- 05.02.02 Behavior Risk Management Committee
- 05.08.02 Waiting List Procedure
- 08.01.02 Service Fidelity & Outcomes Monitoring
- 10.01.03 Network Development and Capacity Evaluation
- 10.02.04 Delegated Functions
- 10.03.04 Credentialing Appointment and Credentialing Committee
- 02.04.05 Investigation of Recipient Rights Complaints
- 08.01.04 Quality Management Annual Plan and Program Evaluation
- 08.01.05 Quality Improvement Process Facilitation
- 08.01.06 Quality Management Council
- 08.07.07 Quality Performance Measure Development
- 08.01.09 Sentinel Event and Root Cause Analysis Process
- 08.01.10 Mission Based Performance Improvement System (MIMBPIS) Reporting
- 08.01.12 Purpose, Scope, Performance Dimensions, Roles and Responsibilities

LifeWays
Quality Management Program Annual Evaluation & Improvement Plan for Fiscal Year 2010 – 2011

I. EVALUATION OF CURRENT COMMITTEE STRUCTURE

Membership: The LifeWays Quality Management Council (QMC) is the organized body responsible for the development and implementation of the annual Quality Improvement Plan. The Quality Management Council meets and conducts business at least monthly. The QMC is cross-functional team with at least one (1) representative from each MCO team and from each staffing level within the organization. Representatives from provider organizations and other LifeWays staff attend the QMC meetings upon request.

In reviewing the FY 2010 membership, a few changes were made in preparation for FY 2011, which includes the addition of a representative from the Governance Team (added November 2010), and the rescheduling of the standing meeting date and time to accommodate regular attendance from the Information Systems Team (changed meeting to accommodate in January 2011). The QMC maintains a total of eleven (11) council members.

The council is facilitated and coordination by a member of the Quality Management Team. Oversight is provided by the Executive Director of Network Performance & Consumer Services Division/Corporate Compliance Officer, who is responsible for supervision of the Quality Management Team and all quality improvement initiatives. The LifeWays Leadership Council is represented by four (4) members on the QMC (Executive Director of Network Performance & Consumer Services Division, Director of Finance, Director of Consumer Relations, CEO & Board Liaison), who assist in reporting at the monthly Leadership Council meetings. The attendance has remained consistent on the QMC which has been value-added. Meetings continue at a monthly frequency. All LifeWays teams are currently represented and the diversity of staff levels (leadership, professional, and specialist) has brought meaningful discussions to the council versus when membership was composed of all leadership level staff (prior to 2006). The council members are invested in their role on the QMC and report back to their teams with celebrations and problem solving for improvement opportunities, as well as bring team new issues to the QMC for discussion.

Meeting Structure: As the QMC agenda items continue to increase with new requirements and enhanced focus on quality improvement and demonstrated outcomes, the council needs to continue to evolve the agenda format for effective time management. The council has expanded the meeting time from 1 to 1.5 hours for FY 2011 to accommodate the increase in committee responsibility. In addition, the council will be moving towards a two-part agenda, which will include a “Concession” section with items that are reviewed prior to the meeting with no planned discussion, and a “Discussion” section with items that need the council’s discussion at the meeting. The agenda items will continue to have a specified frequency and assigned staff person responsible for presentation at the meeting. Throughout discussion of agenda items, the council members actively discuss areas that could improve efficiency, effectiveness, and stakeholder satisfaction. In FY 2011, the QMC will strive to send out the meeting agenda packet to members at least 4 business days before the meeting to facilitate a successful preparation and review of the Concession items and increase efficiency during the scheduled meeting time.

The procedure used for follow-up on items needing action has proven effective, which is done through a recap at the end of the meeting, written documentation within the minutes, a reminder email, and recap at the beginning of the next meeting for a status report with a goal of closing out the task.

In FY 2010, to improve communication of quality improvement initiatives at all levels of the organization, the QMC began to include the Leadership Council through the review of a monthly QMC summary report titled *Quality Improvement & Credentialing Committee Board Report*. This change has improved communication of process improvements within all levels of the organization.

II. EVALUATION OF FISCAL YEAR 2010 GOAL ACHIEVEMENT

The QMC has identified the following four (4) Domains and Goals for the Quality Management Program. Below is a list of quality improvement activities performed in FY 2010 to achieve the goal.

A. Access

QMP Goal #1: Through the Quality Management Program, Access will be improved for consumers.

Quality Improvement Activities:

- The QMC defined and implemented indicators for monitoring the Waiting List activity at the Access Center. The Waiting List criteria were revised to meet the needs of the organization. Consumers were moved into services when General Fund dollars became available.
- Interventions were implemented to increase access for Medicaid eligible children.
- The Self-Determination QIT continued to address improving access for participants under the Self-Determination Program.
- An effective performance measurement system was monitored by the QMC through the dashboards in the area of access.
- The Accessibility Plan was effectively utilized to remove barriers to accessing services.
- The Network Capacity Evaluation was effectively monitored by the QMC for achievement of goals.
- The LifeWays Continuous Comprehensive Integrated System of Care (CCISC) Committee effectively addressed improving access and service delivery for persons with co-occurring mental health and substance abuse disorders.
- Through a successful environmental scan and strategic planning process, the organization made the decision to direct operate the Access Center in FY 2011 and has implemented a project plan which includes many service improvements to streamline access to care. Focus groups were held with various stakeholders to seek input on improving access.

B. Process

QMP Goal #2: Through the Quality Management Program, network-wide processes will be targeted for improvement.

Quality Improvement Activities:

- The Waiting List QIT effectively implemented eligibility criteria for persons with no insurance presenting for services.
- The Care Coordination QIT identified improvement opportunities for the provider network and LifeWays.
- The Self-Determination QIT continued to address improving processes for participants under the Self-Determination Program.
- The Maximizing Medicaid Enrollment QIT was formed and identified objectives to be achieved in FY 2011.
- The Residential QIT was formed and identified objectives to be achieved in FY 2011.
- The Behavior Treatment Plan Workgroup was formed and implemented process changes to meet the Behavior Treatment Plan Technical Requirement and collect the necessary data elements for monitoring.
- The Electronic Medical Record Committee finalized a set of Business Rules that will be implemented and monitored in FY 2011 to increase reliability and integrity of the information provided within the consumer information system.
- Training was provided by the Corporate Compliance Committee to improve processes within the provider network.
- The 2010 MDCH Site Visit resulted in many opportunities improvement related to network-wide processes, which will be monitored by the QMC and the involved providers for continuous quality improvement.
- An effective performance measurement system was monitored through the dashboards by the QMC in the area of provider network performance.

C. Outcomes

QMP Goal #3: Through the Quality Management Program #3, the quality of service and care received by consumers will be monitored and improved.

Quality Improvement Activities:

- LifeWays continued efforts to improve the culture of the system of care by implementing the goals of the Application for Renewal and Recommitment (ARR) Quality Improvement Plan.
- The Evidence Based Program Outcomes were effectively monitored by the QMC.
- The Annual Evaluation of LifeWays Integrated Evidence Based and Promising Practices Report was prepared and identified the current practices, areas for improvement and outcome measure achievement.
- Fidelity assessments were completed to monitor adherence to the intended fidelity model for the best

practices and promising practices provided within the network.

- The Improving Practices Leadership Team and Subcommittees reviewed the system of care for all service populations and made changes as necessary to best serve our consumers.
- The DD Outcomes Tool is currently being considered for network-wide implementation to provide outcomes information for the developmentally disabled consumer population.
- The Recovery Enhancing Environment (REE) survey was administered within the network to provide the system with information to move towards a recovery-focused environment.
- The customer satisfaction surveys were revised and the content was standardized to provide the ability to aggregate the results of the network. The provider satisfaction survey was revised to provide meaningful content and action-orientated questions to improve LifeWays services.
- Training was provided to the physicians to educate on the importance of care coordination with the consumer's primary care physician through the utilization of the Health Care Coordination form.
- Under-utilization of specific services was addressed through targeted case reviews and monitoring of the provider's plan of correction.
- The QMC added the ability to monitor and trend critical incidents, recipient rights, and consumer deaths.
- LifeWays partnered with Allegiance Health and Consumer Services, Inc. to form a monthly Diversion Committee to review high utilization of inpatient services and recommend appropriate treatment to provide the necessary outcomes.
- The Provider Network Fingerprint Report was revised with a new focus on the network-wide performance and published for stakeholders.
- An effective performance measurement system was monitored through the dashboards by the QMC in the areas of service utilization (URC), satisfaction (Advisory Council) and physician services (PSU).

D. Structure & Resource

QMP Goal #4: Through the Quality Management Program, resources will be monitored and tracked to ensure appropriate use.

Quality Improvement Activities:

- The Incident Report procedure was revised to create efficiencies and critical incidents are trended and reported to the QMC.
- The Rates and Service Code Committee revised the procedure to designate the Leadership Council as having final authority in reimbursement rate changes. The Rate and Service Code Sheet was improved.
- The QM Team prepared quarterly provider-specific MIMBPIS reports to identify each provider's performance in comparison to the network.
- The QM Team prepared quarterly Exception Reports to assist in improving the completeness of data in the consumer information system.
- LifeWays is currently establishing an arrangement for consumers that have large assets to have access to a Pooled Trust Fund to assist them in becoming Medicaid eligible.
- In comparison to past years, a high number of QITs were formed in FY 2010 to assist the agency in streamlining business functions and maximizing resources.
- An ongoing and annual review of the QMC monitoring items is conducted by the council to provide for continuous quality improvement while ensuring best use of resources.

III. EVALUATION OF FY 2010 RECOMMENDATIONS

An assessment of the LifeWays Quality Management Program was conducted in December 2009 and the following recommendations were made to address in FY 2010. A report on the action taken is included below each recommendation. Additionally, the action taken has been evaluated to determine if further work is needed or if the concern has been fully address. Items that are not fully addressed will continue as a recommendation for FY 2011.

1. Continue the Self Determination Quality Improvement Team and make formal recommendations to the QMC by September 30, 2010.

Actions Taken: The Self Determination QIT was formed in September 2008 with 3 objectives, all of which

have been achieved and the QIT continues to work on new issues as they arise.

Evaluation of Actions: A final report should have been sent to the QMC when the objectives were complete. Once the final report is sent to QMC and approved, the QIT will transition to a standing committee, as the QMC believes there will always be a need for a workgroup dedicated to Self Determination. (Update: Completed 12/14/10)

Status: Complete.

2. Evaluate the effectiveness of the Rates and Service Code QIT through the QMC by April 2010.

Actions Taken: The Rates and Service Code QIT was finalized in April 2009 and thereafter transitioned to the Service Code Committee, which is a cross-functional standing committee that meets monthly to address service code related issues.

Evaluation of Actions: The Service Code Committee continuously evaluates its effectiveness, which was evident through a procedure revision in April 2010 that clearly outlines the process for changing or adding a service code. Most recently, a subgroup was formed to define the authority and process for establishing or revising a rate, as previously there was no clear process. This procedure is currently being finalized and will be reviewed by Leadership, who will maintain the final authority for approving a rate change.

Status: Complete.

3. Review the current Physicians Unit performance indicators for appropriateness and continuation for FY 2010.

Actions Taken: The dashboard was reviewed with the Physicians Unit management staff and revised at the beginning of FY 2010.

Evaluation of Actions: In planning for FY 2011, Quality Management has identified the need to strengthen the report from the Physicians Committee to the QMC and will meet with management staff to review needs and implement a meaningful report to QMC.

Status: Continue recommendation for FY 2011.

4. Improve the completeness of the consumer demographics reported to the MDCH within the Quality Improvement (QI) File submission, specifically the employment and minimum wage status fields.

Actions Taken: The QMC has monitored the completeness of the QI file over the FY 2010 and the quality improvement actions taken by the Quality Management and Information Systems Teams. Exception Reports were sent to primary providers each quarter, which improved the number of null records from 1,500 to 240 by year's end. The year-end QI File indicates a completeness rate of 55%, significantly below the target of 95%.

Evaluation of Actions: It has been discovered that the largest contributor to the null fields are the consumers that are only seen at the access center and are not referred into services, but a crisis encounter is submitted to MDCH, thus requiring a complete QI File. This "crisis only" population attributes for over 22% of the total population base reported in the QI File. As LifeWays develops the implementation plan for direct operation of the access center in April 2011, Quality Management will work with the Access management staff to develop a plan for collecting the required demographic elements.

Status: Continue recommendation for FY 2011.

5. Identify new approaches to marketing services to those that are eligible in order to increase the penetration rate of Medicaid eligible children in the catchment area.

Actions Taken: The Developmental Disability (DD) Improving Practices Leadership Team Subcommittee is working with the local Intermediate School Districts (ISD) in order to review the transition process for students that are "aging out" of the ISD system and into the CMH system. The subcommittee plans to review the referral process with the ISD staff and work through the barriers that are present.

Evaluation of Actions: The subcommittee plans to review the referral process with the ISD staff and work through the barriers that are present to improve the process for transitioning a consumer from ISD to CMH services.

Status: Complete.

6. Continue the Waiting List QIT to address the additional standards that have been issued by TSG and achieve full compliance with the requirements.

Actions Taken: A workgroup was formed in 2010 to implement the Waiting List requirements.
Evaluation of Actions: The workgroup successfully implemented the Waiting List requirements that are included in LifeWays CMHSP and PIHP contracts with the MDCH.
Status: Complete.

7. Evaluate the results of the DD Outcomes Tool pilot for consideration of network-wide implementation by September 30, 2010.

Actions Taken: The DD IPLT Subcommittee had originally planned to implement the DD Outcomes Tool network-wide in FY 2010. However, a network-wide initiative to improve coordination of care halted the outcomes tool project as these two initiatives will be implemented in tandem.
Evaluation of Actions: An in-depth training has been developed and will be used with any of the planned coordination of care trainings that are developed in FY 2011.
Status: Complete.

IV. QUALITY IMPROVEMENT TEAMS (QIT) REPORT

The LifeWays Quality Improvement Team process has proven to be very effective over the course of the last fiscal year and it has been used to target critical areas needing process improvement. The following is a summary of the FY 2010 QITs and a status report to date:

A. Self Determination QIT

Team Mission/Purpose: To review the current Self Determination process and increase the efficiency of monitoring.

Concern: In June 2008, the LifeWays Quality Management Council recommended a Quality Improvement Team (QIT) to address concerns with the LifeWays Self-Determination Program. At that time, a need was specifically identified to: 1) review monitoring practices, 2) create internal efficiencies, and 3) collect program outcomes for enrolled participants.

Actions Taken: The Self Determination QIT commenced in July 2008 and has since addressed a multitude of concerns resulting in significant improvement for this program. It is expected that continuation of this QIT will be required well into the future as LifeWays works to improve the service provided in accordance with current Medicaid regulations and in consideration of the Self Determination program clarifications that have been issued by the Michigan Department of Community Health. In FY 2009, the QIT completed a thorough revision of the LifeWays Self Determination Practice Guideline, which is published in the LifeWays FY 2010 Provider Manual and will be the basis for training and education provided in the future. The following describes the barriers that were identified during the course of the last year and the action that was taken to remove the barrier:

1. Barrier: LifeWays paid the Fiscal Intermediary provider from an invoice, resulting in service claims not being available in the consumer information system to ensure a clean claim and no ability to reconcile expenses.
Actions Taken to Remove Barrier: The new FI is paid fee for service through import of an 837 file, which is processed against the clean claims policies and reviewed by the Claims Specialist for accuracy in payment. Since the FI is paid fee for service, reconciliation is done with each claim.
2. Barrier: Monthly budgets were not provided to consumers to support budget monitoring and control over how funds are spent.
Actions Taken to Remove Barrier: LifeWays issued a new requirement beginning October 1, 2008 for the FI providers to prepare monthly consumer budget reports, which are sent to LifeWays, the consumer/guardian, and the primary clinician. During FY 2010, it was discovered that one of the FI providers refused to comply with this requirement and this was one of the factors in termination. The new FI provider that started in FY 2011 has a very consistent and clean monthly budget reporting process.
3. Barrier: Flexibility and consumer control was not supported by the current structure, as services under Self Determination were required to adhere to the LifeWays service grids in regards to the number of units allowed per day, month, etc, regardless if the consumer had the funds available.
Actions Taken to Remove Barrier: LifeWays made the decision that having money available in the individual budget took precedence over units available and that the consumer would have the flexibility with the

amount and duration of service provided – as long as the total amount spent remained within the total service budget amount, the consumer adhered to labor laws, the service was provided as authorized within the individual plan of service, and that money was not shifted between services (receive less of one service to receive more of another).

4. **Barrier:** Funds were being used for non-service related expenses.
Actions Taken to Remove Barrier: LifeWays issued the requirement that all expenses within the consumer's individual budget must be actual service provided in accordance with plan of service, with the exception of employment related costs that must be built within the established budget.
5. **Barrier:** Rates paid exceeded the LifeWays published Medicaid rate.
Actions Taken to Remove Barrier: LifeWays issued the requirement that all service claims must be at or below the LifeWays published Medicaid rate and any overage would be denied. Consumers continue to have control over rate setting, but must stay within these guidelines.
6. **Barrier:** Review the employment process to ensure consumers are provided the support needed to hire qualified staff.
Actions Taken to Remove Barrier: LifeWays contracted with a new FI provider who excels in this area and has face to face enrollment meetings with the consumer and their supports to assist in employing qualified staff. Additionally, LifeWays issued clear guidelines on the definition of a qualified and competent staff.
7. **Barrier:** Develop a sound budget monitoring process between the FI, the consumer/guardian, and the primary clinician.
Actions Taken to Remove Barrier: LifeWays contracted with a new FI provider who excels in this area and is currently providing clear and consistent monthly budgets reports to all necessary parties involved. Additionally, LifeWays has trained the case management staff on their role in assisting the consumer to manage their budget.
8. **Barrier:** Ensure the consumer's individual budget is integrated with the plan of service and flexible use of funds is provided in accordance with the plan.
Actions Taken to Remove Barrier: LifeWays issued the requirement that the budget is filed with the treatment plan and is reflective of such services. LifeWays also changed policy to monitoring the total amount spent per service type instead of the units per day, to allow for flexible use of each service.
9. **Barrier:** Conduct a satisfaction survey with self determination participants to support continuous quality improvement.
Actions Taken to Remove Barrier: LifeWays conducted a satisfaction survey in May 2010 with a response rate of 27%, which adequately represents the population base. The results are considered a baseline, as they surveyed the work of the 2 FI providers who are not longer on the panel. LifeWays will resurvey in May 2011 to obtain a remeasurement and identify improvement opportunities.
10. **Barrier:** Conduct training to educate all participants on the Self Determination practice guideline/procedure.
Actions Taken to Remove Barrier: LifeWays developed training for Primary Clinicians (case managers and supports coordinators) that work with Self Determination participants. This training covered a wide array of topics and LifeWays has received positive feedback. The training will continue to be provided to all new staff at time of hire. Consumers/guardians are trained by the FI on their roles and responsibilities during the initial enrollment meeting.
11. **Barrier:** Review the FI's understanding and compliance with their roles and responsibilities to ensure consumers are receiving the necessary support to be successful in Self Determination.
Actions Taken to Remove Barrier: LifeWays terminated the 2 FIs that were on panel prior to FY 2011 due to performance and risk issues. LifeWays contracted with a new FI provider for FY 2011 forward and has conducted several meetings and telephone conferences to train on LifeWays expectations and support the FI provider in their role. LifeWays plans to conduct a Readiness Review in FY 2011 on the FI provider to review for evidence of compliance.

Evaluation of Actions: The Self Determination QIT has made significant accomplishments in the last 2 years and is now addressing new issues as they arise through a monthly meeting. A final report should be reviewed by the QMC as all objective are now complete and the QIT can transition to a standing workgroup.

Current Status: Complete.

B. Waiting List QIT

Team Mission/Purpose: Develop a procedure for consumers that are requesting new services and do not meet service

eligibility criteria to be placed on a waiting list and create the ability to monitor the movement of persons once on the waiting list.

Concern: LifeWays is required to implement a waiting list for the uninsured that are not eligible for services per the requirements of our contract with the Michigan Department of Community Health.

Actions Taken: The Waiting List QIT commenced in June 2009 and developed a Waiting List for Community Mental Health Services procedure, which was piloted in September 2009. Under the new procedure, the access center utilizes objective assessments to identify the consumer's preliminary diagnosis and severity of illness, which the evaluators use to determine if the consumer meets the criteria to receive LifeWays services. If a consumer is not eligible for LifeWays services, they are placed on the waiting list and receive routine follow up contacts from the access center. The QIT evaluated the pilot, identified improvement opportunities and made revisions for full implementation in October 2009.

Evaluation of Actions: The evaluation of the pilot identified areas that needed improvement, such as the need for the access center provider to consistently place eligible persons into service or ineligible persons onto the waiting list. LifeWays has also experienced resistance from the access center provider in fully implementing this new procedure and continues to provide the necessary education and supports to make this change successful. In October 2009, LifeWays received revised The Standards Group (TSG) Waiting List Guidelines that identify new areas that will need to be addressed by the QIT in order to achieve compliance. It is recommended that the Waiting List QIT continue into FY 2010 to address the additional standards that have been issued by TSG and achieve full compliance with the requirements.

Current Status: Complete. Recognizing the TSG Waiting List Guideline was not a contractual requirement by the Department of Community Health, the QIT decided to not implement any changes to the established processes in fear of DCH making significant revisions to the Guideline prior to placing it in the contract. To date, the Guideline has not been enforced, and the Waiting List process continues as developed in FY 2009. The QIT has not met formally, but continues to stay apprised of DCH communications relative to the Waiting List. It is anticipated that more direction will be coming from DCH within fiscal year 2011.

C. Coordination of Care QIT

Team Mission/Purpose: Develop recommendations to LifeWays Leadership regarding efforts to employ to improve the coordination of care between providers within the network.

Concern: Identified through the Department of Community Health audit, interagency coordination lacked resulting in adverse outcomes or unmet consumer needs. As required, LifeWays submitted a plan of correction to address the concern throughout fiscal year 2010.

Actions Taken: The QIT members represented provider administrators and staff and LifeWays administrators and staff. The group identified 9 barriers that prevent effective coordination of care. Recommendations were developed for each barrier. Many recommendations were not feasible as the current electronic record system is not conducive to coordinating care between separate entity providers. Other recommendations will be addressed in the access procedures as LifeWays moves forward in direct operating the Access Department. The remaining barriers will be presented to Leadership for discussion and implementation.

Evaluation of Actions: An evaluation has not been completed as the recommendations have not yet been implemented. Once the recommendations are approved and implemented, an evaluation will be conducted to determine effectiveness of addressing the concerns identified by the Department of Community Health.

Current Status: Complete.

D. Child Caring Institute (CCI) and Institute for Mental Disease (IMD) QIT

Team Mission/Purpose: Define process for allocating expenses in a CCI and IMD setting in compliance with the Medicaid standards.

Concern: LifeWays is not allocating funding in accordance with the Medicaid standards.

Actions Taken: IMDs are free-standing psychiatric hospitals – Havenwyck, Harbor Oaks, Forest View, and Stonecrest. Referral sources have been notified that General Fund dollars must be used for consumers between ages 22-64 even if they are a Medicaid beneficiary, so minimal use of IMDs is desired. A quarterly report has been developed to pull

services in period and allocate costs based on Medicaid standards.

LifeWays now requires the CCIs to sign a letter of attestation to not use seclusion and restraint with LifeWays consumers. If the CCI refuses to sign, we will not approve placements at that facility. For example, we decided to no longer use The Manor due to concern with seclusion and restraint practices. Medicaid funds can only be used for DD consumers in a CCI that will not use seclusion and restraint. CCI providers must have a DD exclusive component. A quarterly report has been developed to pull services in period and allocate costs based on MI/DD diagnosis and if the CCI has a signed attestation (The Manor, NO; The Lighthouse, YES; DART, YES). A procedure has been developed and finalized by the QIT to outline how compliance is achievement with standards and how to allocate costs. LifeWays has sought another CCI provider, Hope Network's DART program, which is Medicaid reimbursable. The QIT commenced in January 2010 and ended in June 2010.

Evaluation of Actions: A quarterly report has been developed to pull services in period and allocate costs based on Medicaid standards; this has proved to be a successful tool in monitoring utilization and cost. A procedure was created to outline the Medicaid standards and identify the elements needed for routine reports and monitoring.

Current Status: Complete.

E. Maximizing Medicaid Enrollment QIT

Team Mission/Purpose: To review the current process of Medicaid enrollment to maximize the number of individuals obtaining and maintaining Medicaid benefits.

Concern: LifeWays has a high number of uninsured individuals in ongoing services, many are losing Medicaid. The Provider Network does not have a process for monitoring enrollment and taking action to increase or maintain consumers on Medicaid, and LifeWays lacks current resources dedicated to monitoring Medicaid enrollment activity.

Actions Taken: The QIT began in July 2010 and identified 3 main goals with objectives to accomplish: 1) Verifying Medicaid and creating access to accurate insurance information, 2) Improving the spend-down (deductible) process, and 3) Creating the resources within LifeWays to monitor status, collaborate with DHS, and educate the Provider Network and consumers. The committee is currently addressing many barriers to achieving the objectives.

Evaluation of Actions: Not available at this time, goal is to complete the QIT by fiscal year end.

Current Status: The Maximizing Medicaid Enrollment QIT is in progress with a goal of completing by September 30, 2011.

F. Residential Setting/Supported Independent Living Program (SILP) QIT

Team Mission/Purpose: To review the current arrangements of consumers living in unlicensed setting, determine changes needed to comply with requirements, minimize risk, and provide for adequate reimbursement to providers.

Concern: LifeWays has a high number of individuals living in unlicensed (SILP) settings that may be more appropriately served in licensed settings. Currently have high behavior consumers living in SILP settings, which are intended for more independent consumers and not to serve as an alternative to a licensed setting. Need to develop a continuum of care for the different settings, identify eligibility in each setting and services LifeWays will authorize, and encourage providers to work with consumers to become more independent and move along the continuum. LifeWays shall also review the reimbursement structure as licensed and unlicensed settings receive the same reimbursement, some providers are reporting financial struggles, and there is evidence that providers are also inflating the level of care to receive a higher rate.

Actions Taken: The QIT began in March 2010 and identified 2 main goals to accomplish: 1) Review and address uninsured consumers living in specialized residential setting, 2) review all residential settings to ensure consumers are in the correct placement, and 3) encourage transitional planning and further community integration. The committee is currently addressing many barriers to achieving the objectives. To date, the committee has created a Service Eligibility Criteria Guideline, reviewed and addressed the eligibility status of uninsured individuals living in specialized residential, and educated the Provider Network on the importance of all providers verifying Medicaid status to ensure reimbursement, as specialized residential services are only a Medicaid benefit. The committee is currently drafting a position paper to educate providers on the importance of transition planning and outline the eligibility criteria for services authorized in various residential settings. The committee is also discussing the reimbursement model and the need to move away from unit based payments.

Evaluation of Actions: Not available at this time, goal is to complete the QIT by fiscal year end.

Current Status: The Residential Setting/SILP QIT is in progress with a goal of completing by September 30, 2011.

V. PERFORMANCE IMPROVEMENT PROJECT (PIP) REPORT

Overview: As part of the federal waiver granted to the State of Michigan by the Centers for Medicare and Medicaid Services (CMS), the Michigan Department of Community Health (MDCH) required that each Community Mental Health Services Program (CMHSP) in the state conduct two (2) Performance Improvement Projects (PIP) during the 2 years of the waiver. For FY 2010, MDCH mandated all CMHSPs to focus the first study on improving the penetration rate of Medicaid children served. The CMHSPs were allowed to choose the subject of their second project and LifeWays chose to focus on the implementation of an Outcomes Tool for persons with Developmental Disabilities. Both projects are expected to be three (3) years in duration as recommended by the Health Services Advisory Group (HSAG).

A. Study #1: Increasing Penetration Rates of Medicaid Children Served

Description of Project: This is a contract requirement with the Michigan Department of Community Health that access for Medicaid eligible children is increased, thereby increasing the penetration rate of persons in the LifeWays catchment area.

Goal of Project: Increase the total number of Medicaid eligible children served from 658 (2006 baseline) to 723 persons through the implementation of targeted interventions to increase assess and penetration of those residing in the LifeWays catchment area.

Actions Taken:

In the first 2 years of the project, LifeWays provided the following interventions:

- 1) Conduct a network-wide autistic training by the LifeWays Medical Director to increase awareness the disorder and service eligibility through LifeWays Provider Network.
- 2) Evaluate the Wraparound program model through a fidelity assessment to ensure alignment with the intended model.
- 3) Implement the new evidence-based program Cognitive Behavioral Therapy -Trauma Focused Treatment within the current home based program.
- 4) Contract with 1 DHS worker to be on-site at LifeWays and educate on service eligibility criteria to improve referrals from DHS.
- 5) Add Multi-Systemic Therapy (MST) services to the LifeWays Provider Network.
- 6) Add 1 FTE to the home based provider to increase capacity to serve priority population.
- 7) Implement the new evidence-based program Parenting Wisely in the provider network.
- 8) Educate the local school counselors on the services eligibility criteria for CMH services for children.
- 9) Expand Multi-Systemic Therapy services to Hillsdale County.
- 10) Complete the Continuum of Care document for children services through the LifeWays Provider Network.
- 11) Add Hillsdale Probate Court to the LifeWays Provider Network for Juvenile Diversion Screening services to increase referrals from the court.

Interventions that remain and are to be implemented in FY 2011 (Year 3):

- 12) Train the access center provider on the service eligibility criteria for children.
- 13) Review the roles of the CMH and the local ISD to identify improvement opportunities and increase referrals.
- 14) Inform referral sources (i.e. access center, schools, ISD) in Hillsdale County of the availability of respite services for children.
- 15) Add Neuropsychology testing to the LifeWays Provider Network service array.

Evaluation of Actions: In reviewing preliminary encounter data, LifeWays met the overall goal for FY 2010 by increasing to a total of 916 Medicaid children served. In reviewing each population subgroup, LifeWays met the target for children with SED and DD but did not meet the target for the dual population (SED/DD). Most of the targeted interventions have been completed to date, but those remaining have been referred to the appropriate committees for implementation. The intervention that is believed to have the most impact in the future is the plan to collaborate with the local ISDs to clarify roles and improve the referral process. The PIP will be closed at this time and the Children's IPLT Subcommittee will begin to work on the remaining interventions to continue to increase the penetration rate for Medicaid Children.

B. Study #2: Measuring Outcomes for Adults with Developmental Disabilities

Description of Project: LifeWays selected to develop a study on the implementation of an outcomes measurement tool for persons with developmental disabilities. The DD Outcomes Tool that will be utilized focuses on two major domains: Health and Welfare (i.e. Safety, Wellness) and Self-Determination (i.e., Work, Choice & Decision Making). The DD Outcomes Tool was developed by Washtenaw County Community Support and Treatment Services of the Washtenaw County Community Mental Health Authority. Washtenaw provided consultation and training for implementation and assessment. This project is expected to be three (3) years in length, with specific activities occurring each year. Year 1 will focus on pilot program implementation of the tool and evaluation of its effectiveness. Year 2 will focus on the network-wide implementation if recommended by pilot participants. Year 3 will focus on measuring positive or negative consumer movement on the tool through data collection, in addition to identifying system issues (i.e. lacking opportunities for employment). FY 2010 is Year 2.

Goal of Project: To implement an outcomes measurement tool for persons with developmental disabilities.

Actions Taken: During FY 2009, LifeWays and the IPLT DD Subcommittee piloted the tool in three (3) residential homes with adults with developmental disabilities who have Hope Network Southeast as their primary provider. Hope Network Southeast applied the tool during the month of May 2009 to gather baseline data. The provider applied the tool again the month of October 2009 to assess change. The provider's recommendations are to be reviewed by the IPLT DD Subcommittee for consideration of a network-wide implementation in FY 2010.

During FY 2010, a thorough evaluation of the pilot was conducted by the IPLT DD Subcommittee. The Supports Coordinator shared her thoughts regarding the tool. She felt the tool was a voice for the consumer. It stated where the consumer was in each domain, an objective format that other providers, the guardian, and the consumer could not deny. It also assisted the consumer in tangibly seeing areas they can focus on for the next treatment plan year; encouraging them to look beyond their current status. It sparked discussion regarding consumer choice and decision making that the Supports Coordinator felt was invaluable. The following reveals the culmination of changes made for the 19 consumers who completed the tool at least twice

- 8 saw an increase in stages (one consumer had both a decrease and an increase in stage)
- 2 saw a decrease in stages (one consumer had both a decrease and an increase in stage)
- 11 did not experience a change in stage.

The supports coordinator was concerned with the best way to utilize the tool. The authors of the tool recommend completing the tool with insight from all providers during the preplanning meeting. However, this would not work for LifeWays as all providers are not present at the pre planning meeting. The supports coordinator found completing the tool with the consumer using information gathered through monitoring and discussions with ancillary providers and guardians was more conducive to the treatment planning timeline. The supports coordination was also concerned with inter-rater reliability. Overall, the IPLT DD Subcommittee recommends the full implementation of the DD Outcomes tool for all DD consumers receiving Supports Coordination services. However, during the same time, a Coordination of Care QIT was developed and identified improvement opportunities in the treatment planning process. Due to having similar objectives, it was recommended that the DD Outcomes PIP be merged with the Coordination of Care QIT objectives, one of which includes training of the Case Management and Residential staff. At that training, the DD Outcomes Tool would be introduced and implemented. This is expected to be completed in FY 2011.

Evaluation of Actions: The DD Outcomes Tool pilot is considered successful with some implementation modifications made to accommodate the LifeWays Provider Network. A recommendation was made to the Coordination of Care QIT to implement the DD Outcomes Tool network-wide by incorporating into upcoming provider training, which is scheduled to occur in FY 2011. The PIP will be closed at this time as the project objectives are complete and the workgroup and has made the necessary recommendations to LifeWays for implementation.

VI. EVALUATION OF DASHBOARD PERFORMANCE MEASUREMENT SYSTEM

Six (6) key areas are monitored through a "dashboard" performance measurement system. In FY 2010, LifeWays added a new dashboard to streamline the monitoring of the Coordination Agency (CA), Mid-South Substance Abuse Commission. Each dashboard is maintained by a QMC member and their respective MCO team who are responsible for reporting at least quarterly to the council. The QMC reviews progress and action plans and makes

recommendations for continuous quality improvement. The QMC conducts an annual review of each dashboard for revisions, which may include new performance indicators, revising current indicators for added value, or discontinuing indicators that have sustained performance or are determined to be no longer value-added. The QM Team ensures areas removed from the dashboards still have a method to be monitored on an ad hoc basis if future needs arise. To review the final dashboards for FY 2011, refer to Attachment 2.

For each dashboard the following section describes: 1) the revisions made during FY 2010 or in preparation for FY 2011, 2) the performance indicators that maintained positive outcomes throughout the FY 2010 and the year's average/result, 3) the performance indicators that improved during FY 2010 after interventions were implemented, and 4) the performance indicators that did not realize improvement and are priority to address in FY 2011.

A. ACCESS SERVICES DASHBOARD

1. Revisions Made to Dashboard: The QMC changed the target from 2 to 3 for the number of calendar days between the date of triage and the date it is entered in the consumer information system. The call monitoring indicators were revised to align with the Access System Standards issued by the MDCH, which included changing the average speed of answer to monitor only the Access Center (previously monitored 2-1-1 Program and Customer Services, but these programs have a queue) and changing the time on hold to monitor the 2-1-1 Program and Customer Services (this is an optional monitoring element that was of added value to the QMC, not required by the state).

In planning for FY 2011, the QMC plans to add 2 new indicators to monitor the rate of consumers that engage in services after receiving an in-network referral and the timeliness between an authorized referral and first ongoing service.

2. Indicators Maintaining Positive Outcomes:

Indicator	Purpose	Target	Year's Average
Rate of consumers referred in-network that are denied services by UM	To monitor appropriate referrals from the access center	<5%	2.7%
Average number of days between the date of the triage assessment and the date of data entry	To monitor timeliness of referral	<3 days	2.38 days
Rate of crisis interventions with decision made within 3 hours of request	To monitor timeliness of crisis services	>95%	99%
Rate of walk-ins at Community Connections assisted within 30 minutes of arrival	To monitor timeliness of access center services	>90%	96%

3. Indicators Improved from Interventions:

Indicator	Purpose	Target	Year's Average
Rate of new consumers with no insurance triaged and referred into services	To monitor General Fund expenditures	Not set	49%
<i>Actions Taken:</i> In FY 2010, LifeWays implemented many new strategies to address the GF budget cuts, which included a waiting list at point of access, limited eligibility criteria for CMH services, and provider education. In FY 2009, LifeWays averaged 61% of uninsured individuals being referred into the provider network, which decreased to 49% in FY 2010.			

4. Indicators Not Improved from Interventions:

Indicator	Purpose	Target	Year's Average
Rate of triage call backs	To ensure access services at provided at the time of first request whenever possible	<7%	8.9%
<i>Actions Taken:</i> In FY 2008, CSI was performing well with the rate of triage call backs and they remained at a low level. However, in FY 2009, the rate of call backs increased due to understaffing and an increase in service requests. CSI addressed this through a plan of correction and dedicated one full time evaluator to fielding and following up with telephone requests. Since the interventions, the yearly average rate decreased from 13% to 8.9%. The QMC will continue to monitor and identify interventions as necessary to improve performance.			
Rate of triage call backs occurring within 24 hours of first request	To monitor timeliness of access services	>95%	86%

Actions Taken: In 2008, the timeframe for the triage call backs was changed from within 3 hours to within 24 hours of first request, which aligns with the state's Access System Standards. CSI performed well in FY 2008 and achieved a year average of 97% within 24 hours. However, in FY 2009 performance declined and resulted in a year average of 90% and FY 2010 yearly average was 86.3%. It is believed that the increase in the number of triage call backs requests at the access center is contributing to decline in timeliness performance. CSI continues to implement an internal plan of correction to address the issue. The QMC will continue to monitor and identify interventions as necessary to improve performance.

Rate of intakes occurring within 14 days of triage	To monitor timeliness of access to services	>95%	85%
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Actions Taken: In FY 2009 the yearly average was 97% of intakes being completed within 14 days, but this has since decreased to 85% for FY 2010. The QMC has discussed and identified the barriers, which will be addressed and removed in the new access structure that is planned for implementation April 1, 2011 and includes part of the intake being completed at the access center and also providing the consumer with an actual appointment date and time for their first ongoing appointment (currently process is to not schedule until services are authorized by UM). The QMC will continue to monitor and identify interventions as necessary to improve performance.

Rate of triaged consumers offered choice of provider	To ensure choice is provided to consumers accessing services	>95%	47%
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Actions Taken: LifeWays and CSI met in FY 2009 to review the consumer choice indicator and requirement. CSI developed a thorough procedure, which was reviewed and approved by LifeWays and ensures that consumers accessing services through Community Connections are offered a choice of provider when referred to in-network services. However, in FY 2010, performance became very unstable per provider report and the year average declined significantly to 47% (from 84% in FY 2009). The QMC has discussed and identified the barriers, which will be addressed and removed in the new access structure that is planned for implementation April 1, 2011 which include a revised data collection system for documenting consumer choice. The QMC will continue to monitor and identify interventions as necessary to improve performance.

B. ADVISORY COUNCIL DASHBOARD

1. Revisions Made to Dashboard: No indicators were revised, removed or added throughout the course of FY 2010.

In planning for FY 2011, the QMC will discontinue the Dashboard format and replace with a quarterly narrative report on the Advisory Council's recent meeting activities to improve communication between the two groups. The narrative report will also include the grievance and appeal data and their analysis of the information.

2. Indicators Maintaining Positive Outcomes:

Indicator	Purpose	Target	Year's Average
Rate of consumer satisfaction	To ensure customers are satisfied with services	>90%	93%
Timeliness of processing grievances	To monitor grievances are processed within 15 days	>85%	100%

3. Indicators Improved from Interventions: None to report, all indicators maintained positive outcomes throughout the fiscal year.
4. Indicators Not Improved from Interventions: None to report, all indicators maintained positive outcomes throughout the fiscal year.

C. PHYSICIANS COMMITTEE DASHBOARD

1. Revisions Made to Dashboard: No indicators were revised, removed or added throughout the course of FY 2010.

In planning for FY 2011, the QMC will review the Dashboard format with the Physicians Unit management staff to determine what elements are of added value and strengthen the report to QMC. This may include continuation of the dashboard format or replacing it with a narrative report depending on the needs of the Physicians Unit.

2. Indicators Maintaining Positive Outcomes: None to report, all indicators did not maintain positive outcomes throughout the fiscal year.
3. Indicators Improved from Interventions: None to report, all indicators did not maintain positive outcomes throughout the fiscal year.
4. Indicators Not Improved from Interventions:

Indicator	Purpose	Target	Year's Average
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Peer Record Review overall score	To monitor the physician compliance with best practices for treatment	>90%	86%
<u>Actions Taken:</u> The Peer Record Review tool was revised in FY 2010 at the direction of the new Medical Director and all practitioners were trained to increase inter-rater reliability and understanding of the importance. This slightly decreased the yearly average from 93% in FY 2009 to 86% in FY 2010. The QMC will continue to monitor and identify interventions as necessary to improve performance.			
Administrative Record Review overall score	To monitor the physician compliance with medical record documentation requirements	>90%	87%
<u>Actions Taken:</u> The Administrative Record Review tool was revised in FY 2010 at the direction of the new Medical Director and management staff were trained to increase understanding. This slightly decreased the yearly average from 91% in FY 2009 to 87% in FY 2010. The QMC will continue to monitor and identify interventions as necessary to improve performance.			
Rate of record reviews with evidence of utilization of the Health Care Coordination form	To monitor compliance with coordination of care requirements	>75%	63%
<u>Actions Taken:</u> The PSU administrative staff trained the physicians through the Physicians Committee meeting on the purpose and intended outcomes of using the Health Care Coordination form. Compliance improved over the course of the year but declined in the last quarter of FY 2010. Management staff will train the practitioners on appropriate use of the communicate tool and the QMC will continue to monitor and identify interventions as necessary to improve performance.			

D. NETWORK PERFORMANCE DASHBOARD

1. Revisions Made to Dashboard: In FY 2010, the QMC moved the Mid-South performance indicators to a separate dashboard to streamline the monitoring of the coordinating agency. The Provider Satisfaction performance indicator was moved from the Advisory Council dashboard to the Network Performance dashboard. All other performance indicators remain unchanged.
2. Indicators Maintaining Positive Outcomes:

Indicator	Purpose	Target	Year's Average
Rate of compliance with Residential Reviews for LifeWays providers	To monitor compliance with residential service requirements	>90%	98%

3. Indicators Improved from Interventions: None to report.

4. Indicators Not Improved from Interventions:

Indicator	Purpose	Target	Year's Average
Overall compliance score average for the provider network's billing verification reviews	To monitor the network's performance as a whole in compliance with clean claims processes	>95%	90.5%
<u>Actions Taken:</u> In FY 2010, this performance indicator was added to the dashboard to gauge the performance on billing reviews as a network. During the year, LifeWays placed providers on Limited credentialing status when performance issues were identified; some providers were also terminated after unresolved performance concerns. LifeWays will continue to use the credentialing process to address provider performance on critical areas. The QMC will continue to monitor and identify interventions as necessary to improve performance.			
Overall compliance score average for the provider network's certification reviews	To monitor the network's performance as a whole in compliance with LifeWays standards and best practice guidelines	>95%	88%
<u>Actions Taken:</u> In FY 2010, this performance indicator was added to the dashboard to gauge the performance on certification reviews as a network. During the year, LifeWays placed providers on Limited credentialing status when performance issues were identified; some providers were also terminated after unresolved performance concerns. LifeWays will continue to use the credentialing process to address provider performance on critical areas. The QMC will continue to monitor and identify interventions as necessary to improve performance.			
Rate of provider satisfaction	To ensure customers are satisfied with MCO services	>90%	70%
<u>Actions Taken:</u> The QM Team significantly revised the provider survey tool in FY 2010 to increase the usefulness of the results. This resulted in a significant decline in overall satisfaction with LifeWays as reported by providers. The results have been sent to LifeWays Leadership Council to address. In the next measurement, the QM Team will add a Not Applicable rating to each question and present the results to Leadership for action. The QMC will continue to monitor and identify interventions as necessary to improve performance.			
Rate of consumer records within QI File with demographic elements complete (not blank)	To monitor compliance with the MDCH reporting requirements regarding consumer demographics	>95%	55%

Actions Taken: Although performance did not improve by year's end, many interventions were implemented throughout the fiscal year. In preparation for the start of the new fiscal year 2010, LifeWays developed new membership events in eCura to streamline the demographic information and accurately gather the necessary elements for reporting to the MDCH. Instructions were created and published in the 2010 LifeWays Provider Manual, which requires primary service providers to enter a new Demographic event each year for each member. QM and IS are currently developing a method of monitoring the input of this information. The IS Team also rebuilt the QI File to ensure accuracy in the data that was being pulled into the file and create new links to the new events. The QM Team sent out quarterly Exception Reports to providers alerting them of consumer records that did not have the required demographic information. In future investigation, it was identified that a large population (22%) of consumers are seen at the access center but are never served by the provider network, where the demographic information is gathered. To address this concern, the QM Team will work with the Access Team to revise the current demographic data collection process to shift some of the elements to be collected at the point of access. The QMC will continue to monitor and identify interventions as necessary to improve performance.

E. UTILIZATION REVIEW COMMITTEE DASHBOARD

1. Revisions Made to Dashboard: The Target for the average number of inpatient admissions per quarter has been decreased from less than 88 to less than 72 for FY 2011 to provide for a 10% reduction. The Target has been removed from the state hospital occupancy rate indicator as this is more of a gauge to monitor without a defined target. All other performance indicators remained unchanged.
2. Indicators Maintaining Positive Outcomes:

Indicator	Purpose	Target	Year's Average
Average number of community inpatient admissions per quarter	To monitor community hospital utilization	<88	75
Rate of community inpatient admissions for the uninsured	To monitor expenditures for the uninsured receiving community hospitalization services	<30%	24%
Total community inpatient service spending	To monitor inpatient service activity is within allowed budget	25% per quarter or <\$2.85 M per year	75% of budget spent or \$2.25 M
Rate of adult consumers readmitted to inpatient within 30 days of previous admission	To monitor compliance with the required service outcome performance indicators	<15%	11.5%
Average number of consumers in state hospital per quarter	To monitor state hospital utilization	<=7	6
Rate of underutilization of authorized services for Supports Coordination cases	To ensure consumers are provided with adequate service	<25%	27%

3. Indicators Improved from Interventions:

Indicator	Purpose	Target	Year's Average
Rate of underutilization of authorized services for ACT cases	To ensure consumers are provided with adequate service	<25%	41%
Actions Taken: The UM Team conducted targeted case reviews in 2009 and 2010 on the cases that were reported as under-served. The providers submitted a plan of correction to address concerns, which are monitored by the UM Team through follow up record reviews. The ACT program is closely monitored by the UM Team. Although the Target was not met for 2010, LifeWays did decrease from 47% in FY 2009 to 41% in FY 2010. The QMC will continue to monitor and identify interventions as necessary to improve performance.			
Rate of underutilization of authorized services for Case Management cases	To ensure consumers are provided with adequate service	<25%	Adult: 25% Child: 18%
Actions Taken: The UM Team conducted targeted case reviews in 2009 and 2010 on the cases that were reported as under-served. The providers submitted a plan of correction to address concerns, which are monitored by the UM Team through follow up record reviews. The CSM program is closely monitored by the UM Team. Although the Target was not met for 2010, LifeWays did decrease from 47% in Quarter 1 to 13% in Quarter 4 for Adults and from 34% in Quarter 1 to 8.5% in Quarter 4 for Children. The QMC will continue to monitor and identify interventions as necessary to improve performance.			
Rate of underutilization of authorized services for Supported Employment cases	To ensure consumers are provided with adequate service	<25%	39%
Actions Taken: Although the Target was not met for 2010, LifeWays has implemented many interventions to increase understanding of the program, achieve compliance with the fidelity model, and increase the number of consumers in the program. The QMC will continue to monitor and identify interventions as necessary to improve performance.			
Rate of underutilization of authorized services for Home Based cases	To ensure consumers are provided with adequate service	<25%	24%
Actions Taken: The UM Team conducted targeted case reviews in 2009 and 2010 on the cases that were reported as under-served. The providers			

submitted a plan of correction to address concerns, which are monitored by the UM Team through follow up record reviews. It is noted that performance has significantly improved from 82% in Quarter 4 of FY 2009 to 27% in Quarter 4 of FY 2010. The QMC will continue to monitor and identify interventions as necessary to improve performance.

4. Indicators Not Improved from Interventions:

Indicator	Purpose	Target	Year's Average
Rate of underutilization of authorized services for Skill Building cases	To ensure consumers are provided with adequate service	<25%	50%
<u>Actions Taken:</u> The QM Team will bring this service type to URC to address the rate of under utilization in FY 2011.			

F. QUALITY MANAGEMENT COUNCIL MONITORING DASHBOARD

The QMC conducts a direct review of select items to provide for continuous quality improvement and efficiency within the organization and the LifeWays Provider Network (refer to Attachment 2 for complete listing). Additionally, at the end of FY 2010 the QMC reviewed areas that can be removed from the agenda to create efficiency or new areas of interest that should be reported through the QMC. The QMC was not able to remove any reports in preparation for FY 2011, but the following new reports were added:

- Strategic Plan Status Report
- Critical Incident Report
- Quality Improvement Teams Status Reports
- Advisory Council Report

For specific action taken within each monitoring report, please refer to the QMC FY 2010 meeting minutes.

VII. RECOMMENDATIONS FOR FISCAL YEAR 2011

The changes to the quality management program at LifeWays in the last year have brought great awareness and interest to quality improvement. The changes made within the Quality Management Council, both to membership and to the agenda format, have expanded the QMC role to more than monitoring measure performance. The council has a fully expanded role of identifying broad quality improvement opportunities and recommending the best intervention for successful change. The dashboard format that is used for performance measures/indicators and the quality improvement team guidelines have brought effective structure to the quality management program. The high utilization of quality improvement teams is an indication that this process is effective in implementing meaningful change. Overall, the improvements made over the last year have been successful and value-added for the quality management program. The following recommendations have been identified during the evaluation to address next fiscal year:

1. Review the Dashboard format with the Physicians Unit management staff to determine what elements are of added value and strengthen the report to QMC.
2. Work with the Access Team to revise the current demographic data collection process to shift some of the elements to be collected at the point of access to improve the rate of completeness of demographic elements reported to MDCH.
3. Continue the Maximizing Medicaid Enrollment QIT and make formal recommendations to the QMC by September 30, 2011.
4. Continue the Residential Setting/SILP QIT and make formal recommendations to the QMC by September 30, 2011.
5. Review the Access Dashboard performance measures that are below target and need to be strategically addressed within the new access center model scheduled for implementation April 1, 2011.
6. Review the network's overall rate of compliance with billing verification and certification reviews and determine appropriate strategies to increase the network's overall score.
7. Conduct a remeasurement of the Provider Satisfaction Survey and seek action from the Leadership Council to improve service to LifeWays customers.
8. Review the Skill Building under-utilization rate with the Utilization Review Committee and determine appropriate strategies to decrease the rate in FY 2011.

9. Develop a means to monitor over-utilization of services through the Utilization Review Committee.
10. Consider incorporating Peers into the LifeWays auditing process to provide a peer-to-peer interview.
11. Develop an Information Systems & Finance Team report to the Quality Management Council.
12. Increase the availability of outcomes data by developing new outcomes metrics for monitoring by the Quality Management Council.

ATTACHMENT 1

Standing Committee Description²

Behavior Risk Management Committee (BRMC): The BRMC is composed of the appropriate clinical personnel as required by MDCH Behavior Risk Management Technical Requirement. The Committee convenes semi-monthly to review consumer cases involving behavior management techniques or medication. The Committee also reviews and analyzes aggregate data relative to the number of intrusive or restrictive techniques that have been used.

Consumer Advisory Council: The Consumer MI and DD Advisory Council are composed of consumers, consumer family members, and/or provider agency representatives. The Advisory Council is provided with regular updates from LifeWays staff regarding the efficiency, effectiveness and customer satisfaction with LifeWays management and the LifeWays Provider Network. The council members represent consumers with a mental illness and/or developmental disability, and are responsible for advising the LifeWays Board of Directors in the best interest of the community and consumer population.

Corporate Compliance Committee: The Corporate Compliance Committee role is to prevent fraud and abuse throughout the network, monitor and reduce the risk within the organization, ensure compliance with federal and state regulations, and conduct investigations of corporate compliance allegations including verifying whether services reimbursed by Medicaid were actually furnished to enrollees by providers. Committee membership includes representatives of all critical functions and the Corporate Compliance Officer.

Credentialing Committee: The committee is composed of the LifeWays Directors, Medical Director, and the Chief Executive Officer and provides oversight to the credentialing and recredentialing processes. Activities of the Credentialing Committee are reported to the Quality Improvement & Credentialing Board Committee. Functions include:

- Development and approval of credentialing procedures;
- Approval of credentialing/recredentialing applications;
- Peer review (Recredentialing only);
- Review of credentialing decision appeals, and;
- Identification of network provider training needs or deficiencies.

Executive Improving Practices Leadership Team (IPLT): The Executive Improving Practices Leadership Team is composed of various network providers and LifeWays representatives from critical areas of the agency. The charge of the IPLT is to lead the network and organization as a whole to a system of care for all consumers that is receptive and amenable to transformation as evidenced by implementation and improvement of provided evidence-based/promising practices.

- Adults with Mental Illness IPLT Subcommittee: The Subcommittee is composed of any provider of adult MI services and LifeWays representatives. The Subcommittee's responsible for developing a gap free continuum of care for this population, obtaining and reviewing outcomes of evidence-based practices and identifying barriers to success and recovery of consumers.
- Children with Serious Emotional Disturbance IPLT Subcommittee: The Subcommittee is composed of any provider of child SED services and LifeWays representatives. The Subcommittee's responsible for developing a gap free continuum of care for this population, obtaining and reviewing outcomes of evidence-based/promising practices and identifying barriers to success and recovery of consumers.
- Persons with Developmental Disabilities IPLT Subcommittee: The Subcommittee is composed of any provider of DD services and LifeWays representatives. The Subcommittee's responsible for developing a gap free continuum of care, obtaining and reviewing outcomes of services and identifying barriers to success and recovery of consumers.

Leadership Council: The committee serves the CEO in an advisory and problem solving capacity. The committee meets weekly to review organizational development and planning issues. The committee provides oversight and monitoring

² For a detailed description of the committee, please refer to the appropriate LifeWays policy and procedure.

of quality improvement and strategic planning activities. A monthly report is submitted to the Leadership Council and reporting progress of QMC activities including Performance Improvement Projects, actions taken, and results of the actions taken.

LifeWays Quality Improvement & Credentialing Board Committee and LifeWays Board of Directors: The Board of Directors is ultimately accountable for the progress of the Quality Management Program. The Board has delegated the monitoring, evaluating, and making improvements to care to the Quality Management Council with monthly progress reporting progress of QMC activities including Performance Improvement Projects, actions taken, and results of the actions taken. The Board of Directors reviews progress and recommendations of the Council monthly and has the authority to redirect the Council to further progress of the Organizations goals and objectives. The Board of Directors has final approval of the Annual Quality Management Program Plan and Evaluation.

Physicians Committee: The Physicians Committee makes policy and procedure recommendations regarding service delivery to LifeWays' Chief Executive Officer. Additionally, the committee monitors trends in adverse occurrences and noncompliance to standards and protocols. Quality Management Reports are reviewed in aggregate and by individual practitioner. The CEO/COO may request special psychiatric service case reviews if data suggests a significant pattern of deviation. Special reviews may be conducted for the following: unexpected consumer death, suicide, significant medication change, diagnostic change, adverse medication reaction, and/or medical records noncompliance.

Quality Improvement Teams (QIT): Quality Improvement Teams are composed of appropriate representatives for the project objectives. The QMC representative from each team provides an update of activity to the QMC.

Tenants Association: The Tenants Association is composed of tenant representatives that identify concerns and make recommendations regarding the operation and security of both the Jackson and Hillsdale buildings to the Facilities Manager. The association is a forum to field and discuss building concerns and resolutions.

Utilization Review Committee (URC): The Utilization Review Committee evaluates the utilization of services with the goal of ensuring that each consumer receives the right services, in the right amount, in the most appropriate time frames to achieve the best outcomes. This is a collaborative process by which specific questions are asked by Utilization Managers about populations for which they are managing services so that over or under utilization of services can be detected, monitored and corrected. The role of utilization review is a Utilization Management Team job function. The committee serves as a vehicle to communicate and coordinate quality improvement efforts to and with the QMC.

ATTACHMENT 2
QM Dashboard Performance Measurement System

QUALITY MANAGEMENT COUNCIL DASHBOARD					
Frequency Q=Quarterly, A=Annually, SA=Semi-Annual	Month of Review:	Report No.	Report		
Q, A	Q: Feb, May, Aug, Nov A: Oct	1A	Corporate Compliance Report		
Q, A	Q: Feb, May, Aug, Nov A: Oct	new	Strategic Plan Status Report		
Q	Q: Feb, May, Aug, Nov	5A	Behavior Risk Management Committee		
Q	Q: Feb, May, Aug, Nov	5A	Recipient Rights Activity Report		
SA, A	SA: Feb, Aug A: Oct	6A	Network Capacity Evaluation Status		
SA, A	SA: Feb, Aug A: Oct	7A	Performance Improvement Project (QAPIP) Report		
SA, A	Q: Feb, Aug A: Oct	2A	Customer Satisfaction Surveys		
SA	SA: Feb, Aug	8A	Improving Practices Leadership Team Report		
SA	SA: Feb, Aug	9A	Accessibility Plan		
SA	SA: Feb, Aug	10A	Sentinel Events Report		
SA	SA: Feb, Aug	new	Critical Incidents Report		
SA	SA: Feb, Aug	new	Quality Improvement Team Status Report		
SA	SA: Feb, Aug	3A	QI Plan and Evaluation		
SA	SA: Feb, Aug	19B	External Audit Status Report		
Q	Q: Mar, Jun, Sep, Dec	11B	Crisis Residential Services		
Q	Q: Mar, Jun, Sep, Dec	12B	MIMBPIS Quarterly Report		
Q	Q: Mar, Jun, Sep, Dec	13B	Quarterly Grant Summary		
Q	Q: Mar, Jun, Sep, Dec	14B	Program Outcomes Report		
Q	Q: Mar, Jun, Sep, Dec	15B	Fair Hearings Report		
Q	Q: Mar, Jun, Sep, Dec	18B	Waiting List Activity		
Q	Q: Mar, Jun, Sep, Dec	new	Advisory Council Activity Report		
A	A: Oct	20	Safety Management Program		
A	A: Oct	21	Evidence Based Practices Annual Report		
A	A: Feb	22	Annual Death Report		
ACCESS DASHBOARD					
Report No.	Report	Purpose	Definition	Key Performance Indicator	Target
1A	Rate of New Consumers with No Insurance (GF)	Added Value Indicator Developed Internally	# of triages with no insurance /total # triaged	% of triaged consumers with no insurance (GF)	N/A
1B	Rate of New Consumers with No Insurance (GF) Referred In-Network	Added Value Indicator Developed Internally	# of triages with no insurance referred in-network/total # triaged with no insurance	% of triaged consumers with no insurance (GF) are referred in-network	N/A
2	Rate of Denials (Appropriate Referrals)	Added Value Indicator Developed Internally	# of denials/# of in-network referrals	<5% of consumers referred in-network denied services by UM	<5%

3	Timeliness of Triage	Added Value Indicator Developed Internally	# days between date of triage and 'create' date in eCura	Average # of days to enter triage in eCura is less than 3 business days	<3 days
4	Timeliness of Intake Appt (MIMBPIS)	Required by DCH	# of days between triage date and date of intake appointment	95% of intakes will occur within 14 days of triage	95%
5	Timeliness of Disposition for Crisis Intervention (MIMBPIS)	Required by DCH	Total time spent for crisis intervention (start time=time of request; end time=time of disposition)	95% of crisis interventions will have disposition completed within 3 hours of request	95%
6	Consumer Choice of Provider at Triage	Required by DCH to Offer Consumer Choice	# of provider choice forms completed/# of triages in period	95% of triaged consumers are offered choice of provider	95%
7	Rate of Triage Call Backs	Added Value Indicator Developed Internally	# of triage call backs performed/# of triages performed in period	<7% triage call backs completed in period	<7%
8	Timeliness of Triage Call Backs	Added Value Indicator Developed Internally	# of triage call backs performed within 24* hours/# of triage call backs performed in period	95% of Triage Call Backs completed within 24* hours of first request	95%
9	Timeliness of Walk-Ins Served at Community Connections	Added Value Indicator Developed Internally	# of walk-ins served within 30 minutes of arrival/# of walk-ins in period	90% of Consumers seen within 30 minutes of walk-in	90%
10	2-1-1 Dropped Call Rate (Call Abandonment)	Critical Indicator Developed Internally	# of dropped calls/# of total calls in period	<10% of dropped calls per quarter at 2-1-1	<10%
11	Access Center Dropped Call Rate (Call Abandonment)	Added Value Indicator Developed Internally	Number of calls abandoned/total # of agency calls	% of dropped calls per quarter	TBD
12	2-1-1 Average Speed of Answer	Added Value Indicator Developed Internally	Average speed of answer by seconds	Average speed of answer by seconds	TBD
13	Access Center Average Speed of Answer	Added Value Indicator Developed Internally	Average speed of answer by seconds	Average speed of answer by seconds	TBD
New	Rate of New Consumers Engaging in Services	Added Value Indicator Developed Internally	# triaged in-network with a paid claim for services (not intake)/# triaged in-network	% of new consumers that engage in ongoing services	TBD
New	Timeliness Between Authorized Referral and First Ongoing Appt (additional service, not new)	Added Value Indicator Developed Internally	# of days between the Provider Referral Event and the first Paid Claim for that service	Avg # of days between service referral and delivery	TBD

NETWORK PERFORMANCE DASHBOARD

Report No.	Report	Purpose	Definition	Key Performance Indicator	Target
40	Provider Satisfaction	Required to monitor customer satisfaction per CARF	Overall satisfaction score (%) from semi-annual provider survey	90% provider satisfaction	90%
41	Billing Verification Reviews	Added Value Indicator Developed Internally	Overall score (%) from BVRs completed in period	95% Provider Network compliance score for BVRs completed in period	95%

42	Certification Reviews	Added Value Indicator Developed Internally	Overall score (%) from Cert Revs completed in period	95% Provider Network compliance score for Certification Reviews completed in period	95%
47	Residential Reviews	Added Value Indicator Developed Internally	Source: Residential Review Quarterly Report	90% Provider Network Compliance Score for Residential Reviews	90%
48	Data Integrity Report - Completeness of Provider Reported Fields in QI File	Required by DCH	# of files with Demo fields complete in QI File/# of consumers in QI File	95% of Demo field in QI File is complete	95%

PHYSICIANS COMMITTEE DASHBOARD

Report No.	Report	Purpose	Definition	Key Performance Indicator	Target
20	Peer Record Reviews	Added Value Indicator Developed Internally	Overall score (%) from Peer Reviews in period	Average overall score of 90% each quarter	90%
21	Administrative Record Reviews	Added Value Indicator Developed Internally	Overall score (%) from Admin Reviews in period	Average overall score of 90% each quarter	90%
22	Administrative Record Reviews	Added Value Indicator Developed Internally	Compliance score (%) for utilization of Health Care Coordination form from Admin Reviews in period	75% of record reviews with evidence of appropriate utilization of Health Care Coordination form	75%

UTILIZATION REVIEW COMMITTEE DASHBOARD

Report No.	Report	Purpose	Definition	Key Performance Indicator	Target
27	Community Inpatient Admission Rate	Required by CARF to monitor service utilization; Benchmarking Initiative	total # of inpatient admissions each month in quarter, divided by 3 months to calculate average <i>Source: Dan F.</i>	average # of inpatient admissions per quarter is less than 72	10% decrease or <72
28	Community Inpatient Admissions GF Payor	Critical Indicator Developed Internally	# of inpatient admissions with no insurance at time of admission/# of total inpatient admissions in period <i>Source: Dan F.</i>	<30% of total admissions are paid from GF	<30%
29	Community Inpatient Expenditures	Critical Indicator Developed Internally	FY 2009 Community Inpatient Budget: \$2,850,000 <i>Source: Monthly Financial Report</i>	Total \$ and percent spent on inpatient per quarter. (report cumulative % spent)	25% per quarter
30	Community Inpatient Recidivism Rate (MIMBPIS)	Required by DCH	% of inpatient readmission <i>Source: MIMBPIS Quarterly Report</i>	<15% of adults are readmitted to inpatient services within 30 days of discharge	<15%
31	State Hospital Inpatient Admission Rate	Benchmarking Initiative	# of state hospital admissions (excluding NRGi) <i>Source: Dan F.</i>	Average # of consumers in state hospital per quarter is less than 7	<=7
32	State Hospital Occupancy Rate	Required by CARF to monitor service utilization	# of billable days per month <i>Source: Dan F.</i>	Average Occupancy in State Hospital is less than 70 Days	N/A
33	Intensive Crisis Stabilization Utilization	Internal	# of persons served <i>Source: Nikki/CSI billing specialist</i>	# of persons served per quarter	N/A
34	Intensive Crisis Stabilization Utilization	Internal	Average length of stay <i>Source: Nikki</i>	Average length of stay (units per case, unit=hour)	N/A
36	Hab Waiver	Required by DCH	# of HSW consumers that	95% of consumers receive a service	95%

	Services (MIMBPIS)		received a service other than SC/# of HSW consumers served in period <i>Source: Shannan/Sally</i>	other than supports coordination in period	
37	Over/Under Utilization Report - ACT	Required by CARF to monitor service utilization	# of consumers that are considered over/under and not found appropriate/# of consumers that are considered over/under <i>Source: Over-Under Report Under Def: <35 units/month</i>	% of consumers reported as having under utilization of authorized services	<25%
38	Over/Under Utilization Report - Home Based	Required by CARF to monitor service utilization	# of consumers that are considered over/under and not found appropriate/# of consumers that are considered over/under <i>Source: Over-Under Report. Under Def. < 53 units/month</i>	% of consumers reported as having under utilization of authorized services	<25%
39	Over/Under Utilization Report - Supported Employment	Required by CARF to monitor service utilization	# of consumers that are considered over/under and not found appropriate/# of consumers that are considered over/under <i>Source: Over-Under Report. Under Def. < 25 units/month</i>	% of consumers reported as having under utilization of authorized services	<25%
40	Over/Under Utilization Report - Case Management	Required by CARF to monitor service utilization	# of consumers that are considered over/under and not found appropriate/# of consumers that are considered over/under <i>Source: Over-Under Report. Under Def. < 4 units/month</i>	% of consumers reported as having under utilization of authorized services	<25%
41	Over/Under Utilization Report - Supports Coordination	Required by CARF to monitor service utilization	# of consumers that are considered over/under and not found appropriate/# of consumers that are considered over/under <i>Source: Over-Under Report. Under Def. < 4 units/month.</i>	% of consumers reported as having under utilization of authorized services	<25%
42	Over/Under Utilization Report - Skill Building	Required by CARF to monitor service utilization	# of consumers that are considered over/under and not found appropriate/# of consumers that are considered over/under <i>Source: Over-Under Report. Under Def. < 50 units/month.</i>	% of consumers reported as having under utilization of authorized services	<25%

COORDINATION AGENCY (MID-SOUTH) DASHBOARD

Report No.	Report	Purpose	Definition	Key Performance Indicator	Target
50	Mid-South Substance Abuse Report	Required to monitor CA activity	Source: Mid South Quarterly Report	95% compliance with Administrative Audits for Mid South providers	95%
51	Mid-South Substance Abuse Report	Required to monitor CA activity	Source: Mid South Quarterly Report	95% compliance with Clinical Audits for Mid South providers	95%
52	Mid-South Substance Abuse Report	Required to monitor CA activity	Source: Mid South Quarterly Report	95% compliance with Financial Audits for Mid South providers	95%
53	Mid-South Substance Abuse Report	Required to monitor CA activity	Source: MIMBPIS Quarterly Report	95% compliance with MIMBPIS Performance Indicator - 14 days from triage to intake	95%

54	Mid-South Substance Abuse Report	Required to monitor CA activity	Source: MIMBPIS Quarterly Report	95% compliance with MIMBPIS Performance Indicator - 14 days from intake to first service	95%
55	Mid-South Substance Abuse Report	Required to monitor CA activity	Source: MIMBPIS Quarterly Report	95% compliance with MIMBPIS Performance Indicator - served within 7 days of detox discharge	95%
56	Mid-South Substance Abuse Report	Required to monitor CA activity	Source: Mid South Quarterly Report	75% customer satisfaction reported by Mid South providers	75%
57	Mid-South Substance Abuse Report	Required to monitor CA activity	Source: Mid South Quarterly Report	# of grievances or appeals in period	N/A
