

Quality Assurance and Performance Improvement Plan

FY2026

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Overview

This document presents the comprehensive and systematic plan for the operation of the quality assurance program of Northern Lakes Community Mental Health Authority. The Quality Assurance and Performance Improvement Plan shall be the standard that guides business functions and service delivery and applies to all programming and services at the agency. NLCMHA is a publicly-funded behavioral health care treatment provider offering mental health, co-occurring and intellectual and developmental disability supports and services for children, adolescents, and adults. The agency's Board of Directors has adopted the philosophy of continuous quality improvement to ensure organization-wide ongoing quality assurance. NLCMHA understands the need to strategically monitor and assess its performance as defined by the agency, state Performance Indicators, and CARF accreditation.

Acronyms

- NLCMHA** – Northern Lakes Community Mental Health Authority
- QAPIP** – Quality Assurance and Performance Improvement Plan
- CEO** – Chief Executive Officer
- CCO** – Chief Clinical Officer
- COO** – Chief Operations Officer
- CIO** – Chief Information Officer
- CFO** – Chief Financial Officer
- DCR** – Director of Customer Relations
- DCAS** – Director of Crisis and Access Services
- DSS** – Director of Specialty Services
- CARF** – Commission on Accreditation of Rehabilitation Facilities

Goals

1. Identify problem trends and gaps related to service delivery.
2. Provide information about service needs to people in the organization responsible for planning.
3. Develop corrective action plans that address problems at the appropriate level of the organization.
4. Promote opportunities to improve service delivery through a process of case review, consumer satisfaction, performance indicator analysis, and internal audits.
5. Ensure that consumers served, employees, and the Board of Directors have the opportunity for feedback in the development of the Quality Improvement Plan as

well as the components of Quality Assurance planning and evaluation through annual stakeholder meetings and customer satisfaction.

Work Plan

Business Function Objectives

Performance Indicator	Type	Measure/Data Source	Implementation
1. Monitor monthly cash flow and reverse negative trend by 10%	Efficiency	Monthly reports will be generated from the EHR and bank statements	CFO and Reimbursement Manager will review monthly reports and complete an annual analysis to present to Leadership Team and the Board Finance Committee
2. Annual workforce turnover rate will not exceed 30%	Efficiency	Monthly retention, daily headcount, hired and terminated reports will be generated from PayChex	HR Coordinator and CHRO will review monthly reports and complete an annual analysis to be presented to Leadership Team and the Board
3. A. Increase organizational awareness and accountability for cybersecurity B. Decrease the total number of staff who consistently fail security awareness simulations to below 10% of the total workforce	Effectiveness Effectiveness	Provide four in-person trainings per fiscal year to 95% of workforce members identified as "high risk." Quarterly reports will be generated from Arctic Wolf Security Awareness	CIO will oversee provision of remedial training evidenced by attendance and competency evaluation quarterly. Reports will be shared with Leadership Team CIO and IT staff will monitor trends and compare to national data for similar organizations. Reports will be shared with Leadership Team and the Board
4. Increase timeliness of contract completion for Medicaid specialized services to within 60 days	Efficiency	Bi-Annual reports will be pulled from PowerBi	CCO and Director of Specialty Services will monitor trends. Reports will be shared with Leadership and the Board.

5. Decrease the number of consumers living in specialized settings outside the catchment area by five percent.	Satisfaction	Bi-Annual reports will be pulled from PowerBi	CCO and DSS will monitor trends. Reports will be shared with Leadership and the Board.
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Outpatient Treatment Objectives

Performance Indicator	Type	Measure/Data Source	Implementation
1. 60% of outpatient consumers will receive a first service appointment within 14 days of the initial assessments	Efficiency	Quarterly reports will be generated from our EHR system.	The CCO will review quarterly reports and complete an analysis to be presented to Leadership Team.
2. 80% of outpatient consumers will show improvement (decrease) in LOCUS score within 12 months	Effectiveness	At admission and at least annually, a LOCUS assessment will be completed.	The CCO will review quarterly reports and complete an analysis to be presented to Leadership Team.
<p>3. A. Less than 10% of outpatient consumers will express dissatisfaction with their provider by filing a grievance.</p> <p>B. Outpatient staffing levels will be sufficient to accommodate 80% change of provider requests.</p>	<p>Satisfaction and Accessibility</p> <p>Satisfaction and Accessibility</p>	<p>Customer service staff will enter and track all grievances including changes in provider request.</p> <p>Customer service staff will enter and track all change of provider requests for outpatient staff</p>	<p>The DCR and COO will review quarterly reports and complete an analysis to be presented to Leadership Team.</p> <p>The DCR and COO will review quarterly reports and trends to be presented to Leadership Team.</p>

Access Program Objectives

Performance Indicator	Type	Measure/Data Source	Implementation
1. 60% of eligible new consumers will receive an initial assessment within 14 days of request.	Access	Quarterly reports will be generated from our EHR system.	The DCAS and CCO will review quarterly reports and complete an analysis to be presented to Leadership Team.

2. 70% of all eligible consumers will attend their scheduled appointment for their initial clinical assessment (ICA).	Effectiveness	Quarterly reports will be generated from our EHR system	The CCO will review quarterly reports and complete an analysis to be presented to Leadership Team.
3. 100% of interpreter requests by new consumers will be accommodated.	Accessibility	Customer service staff will enter and track all interpreter requests	The DCR and COO will review quarterly reports and trends to be presented to Leadership Team and the NMRE.

Case Management Program Objectives

Performance Indicator	Type	Measure/Data Source	Implementation
1. 60% of Case management consumers will receive a first service appointment within 14 days of the initial assessment	Efficiency	Quarterly reports will be generated from our EHR system.	The CCO will review quarterly reports and complete an analysis to be presented to Leadership Team.
2. 80% of Case management consumers will report quality of life improvement.	Effectiveness	Reports will be generated quarterly from data collected during the annual IPOS meeting.	The CCO will review quarterly reports and trends to be presented to Leadership Team.
3. 80% of Case management consumers will report satisfaction services.	Satisfaction	Reports will be generated quarterly from data collected during the annual IPOS meeting.	The CCO will review quarterly reports and trends to be presented to Leadership Team.
4. 100% of consumer accommodation requests will be addressed.	Accessibility	Customer Service tracks all reported consumer accommodation requests.	The DCR will review quarterly reports and trends to be submitted to Leadership Team and the NMRE.

Crisis Services Program Objectives

Performance Indicator	Type	Measure/Data Source	Implementation
1. 95% of requests for inpatient screening will have disposition within 3 hours of request.	Efficiency	Quarterly reports will be generated from our EHR system.	The DCAS and CCO will collaborate on a quarterly analysis presented to the Leadership Team.
2. 30% of inpatient screens will result in diversion from hospitalization	Effectiveness	Quarterly reports will be generated from our EHR system.	The DCAS and CCO will collaborate on a quarterly analysis presented to the Leadership Team.
3. 100% interpreter request by new consumers will be accommodated.	Accessibility	Customer Service will enter and track all reported consumer accommodation requests.	The DCR and COO will review quarterly reports and trends to be submitted to Leadership and the NMRE.

ACT Program Objectives

Performance Indicator	Type	Measure/Data Source	Implementation
1. 100% of ACT consumers will have their IPOS reviewed on a quarterly basis.	Efficiency	Quarterly reports will be generated from our PowerBi system	The CCO will review quarterly reports and complete an analysis to be presented to Leadership Team.
2. 80% of ACT consumers will show improvement (decrease) in LOCUS score within 12 months	Effectiveness	At admission and at least annually, a LOCUS assessment will be completed.	The CCO will review quarterly reports and complete an analysis to be presented to Leadership Team.
3. 80% of ACT consumers will report satisfaction services.	Satisfaction	Reports will be generated quarterly from data collected during the annual IPOS meeting.	The CCO will review quarterly reports and complete an analysis to be presented to Leadership Team.
4. 80% of ACT services will take place in the community.	Accessibility	Quarterly reports will be generated from our EHR system.	The CCO will review quarterly reports and complete an analysis to be presented to Leadership Team.

Intensive Child and Family Services (ICFS) Program Objectives

Performance Indicator	Type	Measure/Data Source	Implementation
1. Staffing levels will be maintained to meet ratio requirements of program model.	Efficiency	Quarterly reports will be generated from our EHR system.	The CCO will review quarterly reports and trends to be presented to Leadership Team.
2. All families discharged from home-based services will receive a satisfaction survey within 90 days of their discharge	Effectiveness	Customer Service will survey families discharged from home-based service within 90 days.	The DCR and COO will review quarterly reports and trends to be presented to Leadership Team.
3. 80% of children/families will report satisfaction with services.	Satisfaction	Reports will be generated quarterly from data collected during the annual IPOS meeting.	The CCO will review quarterly reports and trends to be presented to Leadership Team.
4. 100% of consumer accommodation requests will be addressed.	Accessibility	Customer Service tracks all reported consumer accommodation requests.	The DCR and COO will review quarterly reports and trends to be submitted to Leadership and the NMRE.

Prevention Program Objectives

Performance Indicator	Type	Measure/Data Source	Implementation
1. Increase understanding of NLCMHA role in community with one event per month	Effectiveness	Quarterly updates from CPR committee, evaluation of community programs	The DCR will track brochures, press releases, Digital TV campaigns, Email blasts, Website, and presentations in the community
2. Increase role among public, consumers, families with partnership roles with one event per month	Effectiveness	Quarterly updates on minutes and attendance from collaboratives, survey results, resource fair attendance	The DCR will track monthly meetings with collaboratives, participation in events, and welcome packets to consumers

<p>3. Reduce stigma, promote wellness and prevention for consumers, staff, and community with one event held quarterly</p>	<p>Satisfaction</p>	<p>Quarterly updates on attendance, evaluation, and tests from MHFA classes, recognition for consumers at Recovery Conference, monthly wellness for staff</p>	<p>The DCR will keep a record of Walk a Mile attendance in Lansing, Building Community Resilience for consumers, MHFA classes, Resource Fairs, and Recovery Art Shows</p>
<p>4. Develop and update written marketing procedures annually</p>	<p>Accessibility</p>	<p>Monthly CPR meeting minutes, update printing of brochures, distribution</p>	<p>The DCR will complete an annual review of materials and establish point people for distribution</p>

Quality Assurance and Improvement Model

Quality assurance and improvement is a systematic, ongoing process that is designed to assess and evaluate the quality and appropriateness of services, to resolve identified problems, to identify gaps in service, to promote opportunities to improve business practices and service delivery and overall organizational performance.

Scope of Service

NLCMHA is a comprehensive provider of mental health and co-occurring services to a six (6) county service area that includes Grand Traverse, Leelanau, Wexford, Missaukee, Roscommon, and Crawford. Services provided (internal and contracted) include case management, outpatient, psychiatric, crisis intervention, crisis residential, community living supports, respite, assertive community treatment, residential care, clubhouse, peer-delivered & peer specialist services, infant mental health, intensive home-based for children, autism services, support groups, consultation, prevention, and community education.

The agency’s structure is based on a decentralized model and operates offices in 4 counties of the service area (Grand Traverse, Wexford, Crawford, and Roscommon). These four (4) sites provide a full range of mental health and co-occurring disorders services and are incorporated as consumer demographics in the clinical performance indicators. The services below are CARF accredited programs. CARF is an international accrediting body that seeks to promote strong values and quality care to organizations that provide services to consumers, which further demonstrates NLCMHA’s commitment to providing the highest quality of service.

- 1. Assessment and referral
- 2. Assertive Community Treatment (ACT)
- 3. Crisis Intervention (Specifically Pre-Hospitalization Screening)

4. Outpatient Treatment
5. Intensive Family-Based Services
6. Case management and Supports
7. Prevention, Education, Consultation

Important Organizational Functions and Dimensions of Quality

Assurance

The framework and process of the QAPIP complies with applicable standards of the Michigan Department of Health and Human Services (MDHHS), the Northern Michigan Regional Entity Prepaid Inpatient Health Plan (NMRE-PIHP), and the Centers for Medicare and Medicaid Services (CMS). NLCMHA's focus is on improvements in functions and processes in the areas of direct consumer care, governance, business, management operations, and support functions

Quality Assurance and Improvement Roles and Responsibilities

Monitoring and evaluating activities are performed through committee structure, designed to ensure appropriate representation of all functional areas of the agency.

1. **Board of Directors:** The Board of Directors maintains ultimate responsibility for agency quality standards. The CEO, COO and the Quality Improvement Committee (QI), assume quality assurance and improvement responsibilities for the Agency.
2. **Quality Improvement Committee:** This committee is chaired by the COO and convenes on a quarterly basis to meet with clinical and other program leaders across the agency. The committee is responsible for implementing, revising, and monitoring adherence to agency quality performance goals and delineating these findings to the Board of Directors, leadership, and staff.
3. **Leadership:** The Executive Leadership plays a vital role in ensuring that their staff work toward the stated performance goals in the QAPIP. This is accomplished through guidance, supervision, relaying information in meetings, and upholding agency standards for ongoing quality assurance and improvement.
4. **Agency Staff:** Quality is the collective responsibility of every employee and is maintained by adherence to this plan and by ensuring that all work is done in an ethical and proper manner.

NLCMHA Data System

Specific data management processes support the use of high-quality data to develop information about the quality of care or services being provided, the performance of various

organizational processes and the overall performance of the organization. In individual quality improvement studies, the reliability, validity, and completeness of data is described, and specific data collection and aggregation techniques designed to quantify quality of the data are used. In addition, data accuracy is estimated quantitatively and reported by our Business Intelligence Analyst.

The management information system, which also fuels quality improvement activities with data, utilizes forced-choice mechanisms to ensure the completion of required fields within data entry screens. In addition, regular auditing is used to report the integrity of data and that information is used to further target and prioritize data improvement efforts.

Dissemination of Performance Information

Performance and quality information is shared in format(s) that are useful to the persons served, personnel and other stakeholders. Specifically, the quality improvement process frequently transforms raw or complex data into meaningful information designed to be useful in the education of key stakeholders and further, establishes or increases motivation and designs incentives to influence improved performance. The Northern Lakes CMHA Chief Operations Officer individually and the QI committee collectively, will develop information that is produced in ways that encourage and engage people in its use.

Sentinel Events

Processes designed to identify sentinel events and in response, conduct thorough and credible root cause analysis are specified in NLCMHA policy and procedure. The Leadership Team will regularly review the findings of root cause analysis with specific attention to opportunities to systematically improve performance, reduce risk and ensure safety as a result of review of the findings. These events are reported to the NMRE-PIHP according to contract requirements.

Utilization Management

The NLCMHA Utilization Management Plan specifies the goal, scope, authority, responsibility, objectives, organizational structure, and specific activities of the utilization management program. The plan also describes how the agency makes uniform service authorization and reduction decisions. The QI committee embraces a goal of ensuring the provision of high-quality services. As such, in the course of data collection, analysis and monitoring, the committee may determine an issue could best be addressed by a subcommittee that will investigate and report back. In these cases, the collaborative, consultative relationship between QI and subcommittees

is used to ensure the most appropriate organizational component is addressing important issues in improving the quality of care.

Credentialing and Privileging Processes

NLCMHA conducts credentialing and privileging according to established policies and procedures. The credentialing and privileging committee is represented on the QI committee by the chairperson. Clinical staff are credentialed at the time of hire and when required, privileged to perform specific duties for which they are qualified. Re-credentialing occurs at least every two years or may occur more often under special circumstances. The credentialing committee establishes standards for credentialing and re-credentialing, and provides orientation to the affiliate providers regarding standards, and monitors for implementation.

Staff Training and Development

The NLCMHA training and staff development plan specifies that all clinical staff members, both internal and external practitioners are required to receive initial and continuing education and staff development which includes minimum annual training requirements. The quality improvement process will identify issues which require additional training or revisions in currently provided training. These will be referred to the staff development and training committee for action and implementation through the QI committee participant.

Quality Improvement Performance Goals and Work Plan

The NLCMHA Leadership Team establishes broad performance goals for the organization. The QI committee establishes specific measures and ongoing monitoring to ensure continuous pursuit of those goals. Performance goals are based on contractual performance requirements, industry benchmarks, historical performance trends of the organization, and new performance targets established internally or externally to the organization. Annually, the QI committee establishes performance goals and incorporates the content of those goals into a specific work plan to be accomplished during the year.

Interaction with the NMRE Quality Oversight Committee

This quality improvement plan is written with the expressed intention to be complimentary to the NMRE Quality Assessment Performance Improvement Plan. Of note is that the QAPIP references the affiliation process for identifying, reporting, and processing sentinel events, the process for adopting practice guidelines and how the affiliation will ensure the verification of Medicaid reimbursed services. The NLCMHA quality improvement process will utilize and fully

participate in the affiliation system of quality and performance improvement oversight. In addition, NLCMHA will participate in coordinated studies of service satisfaction, specific quality improvement initiatives, and Quality Assessment Performance Improvement Projects with the NMRE.

Annual Quality Review

On an annual basis the COO will draft a report summarizing all efforts by the QI committee and present the results for review and approval by the NLCMH Authority Board of Directors.