Performance Improvement Plan

July 2023-June 2024

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Contents

Mission Statement

Community Mental Health of Ottawa County partners with people with mental illness, developmental disabilities and substance use disorders and the broader community to improve lives and be a premier mental health agency in Michigan.

Performance Improvement

An efficient approach for improving employee and organizational performance that achieves results through a process that describes preferred performance, identifies causes, selects, designs, and implements interventions to fix the cause and determines changes in performance.

The Goal of Performance Improvement

To solve performance issues and/or recognize opportunities for enhancement in performance at the organizational, system, process, and employee levels in order to achieve desired organizational results of high quality, sustainable behavioral health services that increase positive outcomes for consumers.

I. PURPOSE

The function of the Performance Improvement Plan is to perfect the quality of services provided and performance of the agency by performance and quality improvement.

The purpose of the Community Mental Health of Ottawa County (CMHOC) Performance Improvement Plan is to follow a process of assessment, strategy development, stakeholder input, plan implementation, results review, and change using the cycle of continuous quality improvement (CQI). CMHOC will seek to improve outcomes for those receiving services.

Continuous quality improvement is based on the following assumptions:

1. Persons working on behalf of the organization seek to provide high quality services.
2. In nearly all situations, improvement can be made by analyzing processes and systems for completing work.
3. Persons served will be involved in defining the quality of services.
4. Decisions are based on reliable data.

The Performance Improvement Plan addresses the requirements of the Michigan Department of Health and Human Services (MDHHS), CARF standards, Lakeshore Regional Entity, and other federal requirements through the implementation of organization-wide, systematic, and performance-based activities.

II. GOALS

1. Target improvements at all levels including management, administration, and programs. Dimensions of care such as access, efficient assessments, coordination of services, timeliness, safety, respect, effectiveness, appropriateness, and continuity will be included.
2. Involves people served and those who care for them in assessing and improving satisfaction with outcomes and services.
3. Develops performance indicators to assure that services are effective, safe, respectful, and appropriate.
4. Tracks key performance indicators, comparing performance to statewide and/or nationwide data, when available.
5. Assures that providers of service fulfill their contractual or employment obligations in accordance with applicable regulatory and accreditation standards.
6. Assures that providers of service are competent and capable of providing services through a system of competency evaluation and credentialing.
7. Assures that providers of service are culturally competent and can accommodate individual needs of people served by the organization.
8. Assures that performance indicators and QI activities impact all populations served by the agency, including but not limited to populations such as persons served over a long period of time, older adults, children, non-English speakers, and those served with developmental disabilities.

III. PLAN REQUIREMENTS

The Performance Improvement Plan will meet the following requirements:

1. Meet the minimum performance standards as set by the Michigan Department of Health and Human Services (MDHHS) and our awarded grant requirements. Failure to meet the standards for one quarter will result in an initiation of a performance improvement project and in-depth analysis.
2. Develop internal standards for performance when these standards are not set by MDHHS, CARF, the Lakeshore Regional Entity, federal standards, and/or awarded grant requirements.
3. Performance improvement projects will sustain improvement in significant aspects of clinical and non-clinical services.
4. Carry out monitoring and review activities to assure that systematic problems are identified and corrected.
5. Meet all MDHHS and awarded grand requirements for grievances and appeals and maintain an active member services function.
6. Maintain a record of all performance improvement projects and provide follow-up data to assure improvements are demonstrated and maintained.
7. Performance improvement activities in the clinical area will strive to improve prevention, acute, chronic, high-volume, high-risk services, providing a whole person approach to health care services as well as any process that may be relevant to service improvement.
8. Performance improvement activities in non-clinical processes may include such areas as availability, accessibility, cultural competency, quality of providers, processes regarding billing and authorizations, appeals, grievances, and complaints.
9. Identify performance improvement initiatives through a regular process of data gathering, analysis, and prioritization which considers prevalence, need, risks, and the interest of persons served in pursuing the project.
10. Assure that whole person wellness promotion occurs for persons served who are eligible for services.
11. Review all sentinel events and implement action items based on these reviews.
12. Implement a utilization management function that clearly identifies criteria for services with the agency, publicizes these to those individuals currently and potentially receiving services, and reviews trends in access and service utilization.
13. Carry out performance projects as required by State, Federal and awarded grant guidelines.

IV. PLAN REVIEW

The QI system and Performance Improvement Plan will be reviewed on an annual basis. The Deputy Director will assure that an annual report of the QI system is presented to Leadership Group, which will review the plan and submit it for approval to the CMHOC Board. The Executive Director will assure that the plan, with or without changes, is presented to the CMHOC Board.

V. RESPONSIBILITIES

A. The CMHOC Board will annually approve the Performance Improvement Plan. The Board will also periodically review QI data and information.

B. The Executive Director will assure that a QI system is in place. The director will review recommendations from the Leadership Group and authorize any subsequent action plans.

C. The Medical Director or designee shall provide consultation to any committee that requires medical consultation. The Medical Director or designee will serve as an ad hoc member of the Leadership Group and will assure that psychiatric representation is available for the Pharmacology & Therapeutics/Medication Committee, Utilization Management Committee, and the Behavioral Treatment Review Committee, as needed.

D. The Deputy Director will be responsible for the implementation and ongoing functions of the QI system. The Deputy Director will serve as a member of the Leadership Group and will provide facilitation and data analysis within the QI system. This includes the ongoing development of the QI Plan and evaluation of the QI system.

E. The Leadership Group will serve as the organization's QI Committee, reviewing data and setting implementation steps based on recommendations and data from the various QI standing committees.

F. Managers and Staff will participate on QI standing committees and performance improvement groups. Managers will authorize appropriate staff to perform these functions prior to staff participating in a committee or improvement group.

G. CMHOC staff may make recommendations for change using the employee suggestion process. Staff may also bring quality issues to their direct supervisor for evaluation. Quality and performance initiatives may also start based on findings in process and data quality monitoring such as Medicaid Verification. Staff will serve on QI standing committees and performance improvement groups if approved by their direct supervisor.

H. Contractual agencies will be evaluated based on the performance standards stated in their contracts. They will be provided a regular means of communicating issues to CMHOC such as the Provider Network Council (PNC) which meets quarterly or by submitting issues via a help desk portal system.

VI. STRUCTURE

The CMHOC Board meets monthly and receives quarterly reports regarding the agency's performance on indicators in the Michigan Mission Based Performance Indicator System (MMBPIS). Additional performance indicators and data, as well as consumer satisfaction data, may be presented to the CMHOC Board or its subcommittees by the Executive Director on a regular basis. The structure of the QI system is graphically depicted in Appendix A, "Management/Performance Improvement Structure."

Leadership Group serves as the agency's quality improvement committee. QI standing committees will regularly report to Leadership Group with findings and recommendations. The duties and responsibilities of Leadership Group include:

1. Receive regular reports from the committees and act on recommendations and findings.
2. Review reports generated by performance improvement groups (ad hoc work groups).
3. Review and evaluate all employee generated suggestions for QI.
4. Annually review and approve the Quality Improvement Plan and structure.
5. Annually review the committee structure to assure comprehensive QI process.
6. Analyze the root cause analysis of those sentinel events warranting such analysis.
7. Assure that plans for improving systems are in place and effectively implemented, monitored, and communicated.
8. Identify training needs of the organization related to QI.
9. Recommend priorities for action based on data and recommendations.
10. Maintain a log that tracks status on all actions taken.
11. Maintain guidelines on communication and conflict resolution within the organization and model these expectations.
12. Assure that any work groups assigned by the Leadership Group understands its role and function clearly.

The Quality Improvement Unit is responsible for the following:

1. Presents a Performance Improvement Plan to the Leadership Group and the CMH Board on an annual basis.
2. Provides consultation and support to QI standing committees and to the Leadership Group in their role as the Performance Improvement Committee.
3. Assures that QI data is regularly presented to the Leadership Group.
4. Provides an updated QI Plan to the Leadership Group for approval.
5. Completes all state required performance indicator reports.
6. Completes all state required consumer satisfaction surveys and reports data.
7. Assures that a credentialing process is implemented.

VII. QI STANDING COMMITTEES

QI standing committees include CMHOC staff and may include persons served by the organization or persons who care about them such as family members, guardians, and advocates. The QI standing committees are established to evaluate and monitor the quality of important aspects of care. See appendix B: "PI Committee Responsibility Matrix," "PI Matrix" tab, for a detailed review of committee responsibility for plan development, policy, CARF standards, and performance indicators.

Behavior Treatment Review Committee – The committee reviews restrictive, intrusive, or aversive behavior plans, whether developed by CMHOC operated or contracted programs, and psychotropic medications prescribed for behavioral control purposes. The committee also educates staff regarding behavior issues, as specified in the Behavior Treatment Review Committee Operating Manual; See appendix J: "Behavior Treatment Review Committee Manual" for full details. The committee provides

recommendations for staff seeking interventions for challenging cases. The committee meets monthly and reports quarterly to the Leadership Group.

Clinical Case Review Committee – This committee serves as a review body and determines dispositions within the mental health and developmental disability systems related to requests from treatment teams to transfer consumers to a higher level of care; transfers between treatment teams at the same or lower level of care, should third-party involvement be required; and team assignment for new consumers when the initial disposition is unclear.

Pharmacology & Therapeutics/Medication Committee – The committee monitors the utilization of medications in CMHOC operated and contractual programs. The committee reviews significant medication errors, assures compliance with internal and external standards and policies, provides assistance to programs for the purpose of developing procedures, and revises CMHOC policies and procedures regarding medication. Record reviews are completed monthly by prescribers, pharmacists and nurses, independent of the monthly committee meeting. The committee meets monthly and reports to the Leadership Group semi-annually. Please see appendix K: "Medication Committee Manual" for full details and requirements.

Utilization Management Committee – The committee monitors the utilization of resources to assure that services are clinically necessary, effective, and provided in the most cost-effective manner. Regular data reports will be reviewed, and adjustments will be made in the organization based on the data. The committee meets monthly and reports to Leadership Group quarterly. Please see appendix L: "UM Plan" for further details and requirements.

Improving Practices Leadership Team (IPLT)/Clinical Oversight Committee: This team reviews the implementation of evidence-based practices in the organization and recommends strategic direction to the leadership group. This committee identifies, develops, evaluates, reviews, and implements clinical practice guidelines used in the organization. This committee interacts with other IPLT in the affiliation or region such as the LRE Clinical Region Operations Advisory Team (Clinical ROAT), and monitors CMHOC's fidelity to best practice models. The team meets monthly and reports quarterly to the leadership team.

Compliance Committee – This committee provides oversight of the compliance functions of the organization, reviews compliance incidents and data, and oversees policy and procedure development in privacy, security, and compliance. The committee develops a Corporate Compliance Plan, and an annual Risk Management Plan which covers a variety of risk factors such as programmatic, financial, or health and safety; see appendix M: "Risk Management Plan" and appendix N: "Corporate Compliance Plan: for further details. The committee meets monthly and reports to the Leadership Group quarterly.

Consumer Advisory Committee – This committee is comprised of CMHOC staff and current CMHOC consumers or guardians. The committee reviews satisfaction surveys, consumer experiences, and other information to make recommendations to the agency. The committee meets monthly and will report to the Leadership Group on a quarterly basis.

Health and Safety Committee – The committee oversees efforts across the organization, assuring that effective safety, emergency preparedness, and security issues are addressed. The committee meets quarterly and reports to the Leadership Group semi-annually. Please see appendix O: "Health and Safety Plan" for further details and requirements.

Information Technology Committee – The committee addresses data system implementation issues, clinical and IT workflows, reviews performance indicators, and identifies data and reporting needs. This committee meets monthly and reports to the Leadership Group quarterly. Please see the appendix P: "Technology Plan" for further details.

Health Information Management Committee – This committee develops and implements CMHOC's move to an electronic medical record (EMR), identifies trends and needs related to clinical documentation, and monitors compliance with documentation standards. This committee meets monthly and reports to the Leadership Group semi-annually.

Human Resources/Credentialing Committee – The committee develops an annual staff training plan, accessibility plan, and a cultural competency plan. The committee will monitor credentialing requirement process. Meetings will be held on a quarterly basis and the plans will be presented to the Leadership Group for approval on an annual basis. Please see appendix Q: "Staff Development and Training Plan," appendix R: "Accessibility Plan", and appendix S: "Cultural Competency Plan" for further information and details.

Recipient Rights Committee – This committee, mandated by the Mental Health Code, helps to ensure that every individual receiving CMHOC services has certain protected rights. The committee will meet quarterly, and it is the responsibility of the Rights Office for reports and data presentation.

Provider Network Council – This committee will address any CMHOC provider network issues that may be related to contractual changes, CMHOC Provider Portal issues, Provider Performance and Compliance issues, as well as any other CMHOC provider concerns such as billing changes. This committee will meet regularly and is recently working with the LRE to update the Network Adequacy Plan, which was originally Beacon's responsibility; see appendix T: "Network Adequacy Plan" for more details and information on CMHOC's current version. This committee will also hold quarterly or semi-annual meetings with the CMHOC provider network to provide CMHOC updates and communicate changes.

Fiscal Services Team (CMHOC) – This department will address and provide any accounting and budgeting services for CMHOC. This department will monitor financial management, centralized procurement, budget administration, billing, fixed asset accounting, and debt management. This committee will meet monthly or semi-annually with CMHOC QI to provide updates and changes. Note: This is not a formal committee, but the PI Plan needed to capture the team's initiatives toward improvement as well.

Access Center Team– This department connects callers with the most appropriate services and resources as quickly and efficiently as possible and ensure that all eligible consumers receive timely, appropriate, and high-quality services while preventing unnecessary, inappropriate, and ineffective

utilization of resources. This department assists individuals seeking assistance for mental health and substance use disorders to obtain needed information, services, and resources in a manner that is customer friendly, timely, and accurate. Access Center staff members welcome all individuals by demonstrating empathy and providing opportunity for the person presenting to describe their situation, problems, and functioning difficulties. This department will meet to update as needed. Note: This is not a formal committee, but the PI Plan needed to capture the team's initiatives toward improvement as well.

VIII. CRITICAL INCIDENTS

A. Critical incidents will be reported consistent with MDHHS contract requirements.
B. Critical incidents that meet criteria as sentinel events will result in a full review, analysis, and semiannual report by CMHOC to MDHHS and the Lakeshore Regional Entity compliance point-person. The review will meet requirements as defined by MDHHS and specified in CMHOC Policy 1.03, Sentinel Events (see appendix D for the full policy.) The results of root cause analysis, with recommendations for change, will be presented to Leadership Group for information and further action if necessary.
C. The Quality Improvement Unit will provide support and facilitation to the review process.
D. The Compliance Committee will maintain a log of all recommendations, assuring that actions are taken to complete all plans.
E. Persons involved in the review will have the proper expertise and credentials for the specific event being reviewed. The Medical Director, or other assigned medical professional, will participate in the process and review all results when appropriate.
F. CMHOC will report all applicable deaths to the State per C 6.5.1.1 and will assure that all deaths subsequent to leaving a state facility within a 6-month period will be properly reported.

IX. INVOLVEMENT OF PERSONS SERVED

CMHOC will assure that persons served will be offered input and involvement into the performance improvement system through the following mechanisms:

1. Primary consumers of mental health services serve on the CMH Board.
2. CMHOC consumers serve as full members on the Consumer Advisory Committee.
3. CMHOC consumers will be recruited to serve on various quality improvement committees.
4. Satisfaction surveys are completed according to the following frequency:
    a. Persons served with mental illness or emotional disturbance – annually.
    b. Persons served with developmental disabilities (includes parents and guardians) – annually.
    c. Post discharge satisfaction surveys – monthly.
    d. Satisfaction with contractual provider services – completed during contract review and pre-planning and treatment planning process.
    e. ACT and Home-Based satisfaction as mandated by MDHHS.

   f. Progress note completion or quarterly outcome measures in the electronic medical record as required.
5. Persons served will always be given the opportunity to directly contact a representative of CMHOC as part of the satisfaction process.
6. When specific issues are discovered, special efforts may be utilized such as targeted consumer interviews or focus groups.
7. Involvement of persons served will be solicited to address issues relating to quality, availability, and accessibility of services.
8. CMHOC will seek to improve representation of people served in quality improvement participation, policy setting, as well as employment and volunteer opportunities.
9. CMHOC will communicate information on satisfaction, performance indicators, and needs assessment to consumers and stakeholders.
   a. The Consumer Advisory Committee will receive this information for discussion and be given the opportunity to make recommendations to the CMHOC Executive Director and CMHOC Leadership Group.
   b. Data will be provided to the CMH Board on a regular basis. Performance Indicator data will be presented at least quarterly.
   c. Findings and analysis will be made available on the CMHOC website through the Ottawa County website. Periodically, information will be made available in agency lobbies and offices.

X. PROBLEM SOLVING TECHNIQUES/REMEDIAL ACTIONS

The Leadership Group will identify issues that require additional effort to resolve and improve. A "Work Group"/Committee Charge Form" (see Appendix C) will be completed that specifies the scope of expectation for any group sanctioned by Leadership Group.

CMHOC will use ASPIRE to Excellence, a system put in place by the accreditation body CARF for their 2008 standards, as its problem-solving model. This will be used for performance improvement groups, which are time-limited groups designed to address areas needing improvement. All staff will be encouraged to identify quality issues.

Problem Solving Process:

1. **A**ssess the environment
2. **S**et strategy
3. **P**ersons served (provide input into design and delivery of quality services)
4. **I**mplement the plan
5. **R**eview Results
6. **E**ffect change

QI staff provides support to the QI system by serving as facilitators to the committees and performance improvement groups. This includes using QI tools and methods to assist groups in problem identification and plan development.

KATA. In addition to the ASPIRE method of problem solving, CMHOC will also use another process improvement tool called Improvement KATA. Improvement KATA accomplishes improvements through a scientific process with a goal-oriented method to meet objectives. KATA allows for practitioners of the tool to evaluate existing conditions, define a work goal or objective and work towards these goals using a Plan, Do, Check, Act (PDCA) process. KATA also works on the foundations of LEAN thinking which aims to remove waste in processes and increase value to the consumer through an efficient and timely process. (https://www.lean.org/lexicon/kata)

XI. CREDENTIALING, PRIVILEGING, AND COMPETENCY OF STAFF

CMHOC maintains a complete system for credentialing and competency that includes CMHOC staff and contractual staff. Practices relating to these functions are explained in detail in CMHOC policies 9.02, Credentialing (appendix G) and 9.14, Competency and Performance Evaluation (appendix E.)

CMHOC adheres to the following procedures for the selection and ongoing management of staff. For more detail, refer to the aforementioned policies.

1. Selection: CMHOC follows Ottawa County guidelines for staff selection. Prior to hiring the following actions are taken:
    a. Ottawa County Human Resources completes the criminal background check on all prospective employees.
    b. Ottawa County Human Resources verifies from the source, the educational status of the applicant.
    c. Ottawa County Human Resources completes reference checks of the applicant prior to hire.
    d. CMHOC verifies from the source licensing status of professional staff and assures that no adverse actions have been taken against the professional.
2. Maintenance: CMHOC has the following procedures in place for review of staff competency:
    a. Ottawa County Human Resources maintains job descriptions for every county employee.
    b. CMHOC has a more detailed function and ability description specifying expectations for each position.
    c. CMHOC maintains a list of licenses with expiration dates and assures licensing is up to date and no adverse actions have been taken against the individual's license.
    d. Annually, all supervisory staff is required to complete an evaluation of staff as specified in CMHOC Policy 9.14, Competency and Performance Evaluation.
    e. Annually, Leadership Group identifies core priorities for the organization that specifies the expectations for agency staff.
    f. CMHOC will assure that all credentialing and re-credentialing requirements within the Lakeshore Regional Entity are met.

In addition to the above requirements, CMHOC will assure that all Licensed Independent Practitioners (LIPs) are approved by the Medical Director or designee, and the Executive Director or designee, prior to starting services at CMHOC. This will include a review of experience and references, in addition to compliance and licensure verification included in CMHOC Policy 9.02, Credentialing (appendix G.) Supervisors will maintain documentation of all training and supervision of non-licensed staff.

CMHOC's Human Resources/Credentialing Committee will monitor compliance with credentialing requirements by reviewing summary information on both LIP and non-LIP positions consistent with CMHOC Policy 9.02, Credentialing (appendix G.)

CMHOC will assure that staff are properly oriented and trained to complete their job functions. Completion of all necessary and required training will be tracked by the Training Center, and documentation of compliance will be maintained by assigned administrative staff. Initial and ongoing training requirements will be documented in an annual Training Plan (appendix Q.) The Human Resources/Credentialing Committee will assure that the Training Plan is up to date on an annual basis.

XII. CULTURAL COMPETENCE

CMHOC will annually evaluate their program for access and treatment trends of ethnic/minority groups. The evaluation will analyze all current activities designed to assure equitable access and effective treatment to persons with cultural barriers to receiving services. An annual Cultural Competency Plan (appendix S) will be developed and periodic training to CMHOC staff will be provided based on the organizational assessment.

XIII. UTILIZATION MANAGEMENT SYSTEM

A. All persons requesting services will be evaluated by the agency's Access Center using standardized, approved admission criteria. The Access Center will maintain an Access Manual.
B. Practice guidelines for admission and ongoing services will be reviewed and approved by the Leadership Group prior to being implemented.
C. The agency will maintain a Utilization Management Committee which reviews trends in service utilization, outcomes, and costs on a regular basis. The Utilization Management Committee will also review organization Key Performance Indicators which may include financial, organizational, and/or clinical indicators.
D. CMHOC will develop and regularly update a Utilization Management Plan (appendix L.)

XIV. PERFORMANCE IMPROVEMENT COMMUNICATION/TRAINING

CMHOC will develop and maintain an orientation process for all new staff on agency policy and procedural requirements. CMHOC will assure that decisions and actions are communicated to all appropriate staff. When a decision is made by the Leadership Group, an implementation plan will identify the responsible individual to inform staff and carry out the decision. Implementation of decisions can occur at the team level, QI Committee level and/or even agency-wide level. CMHOC will leverage Leadership members and their staff to communicate and provide information on agency updates, initiatives, and performance on indicators within the agency. Training in QI for all staff is completed during the orientation process.

XV. CLAIMS VERIFICATION OF MEDICAID SERVICES

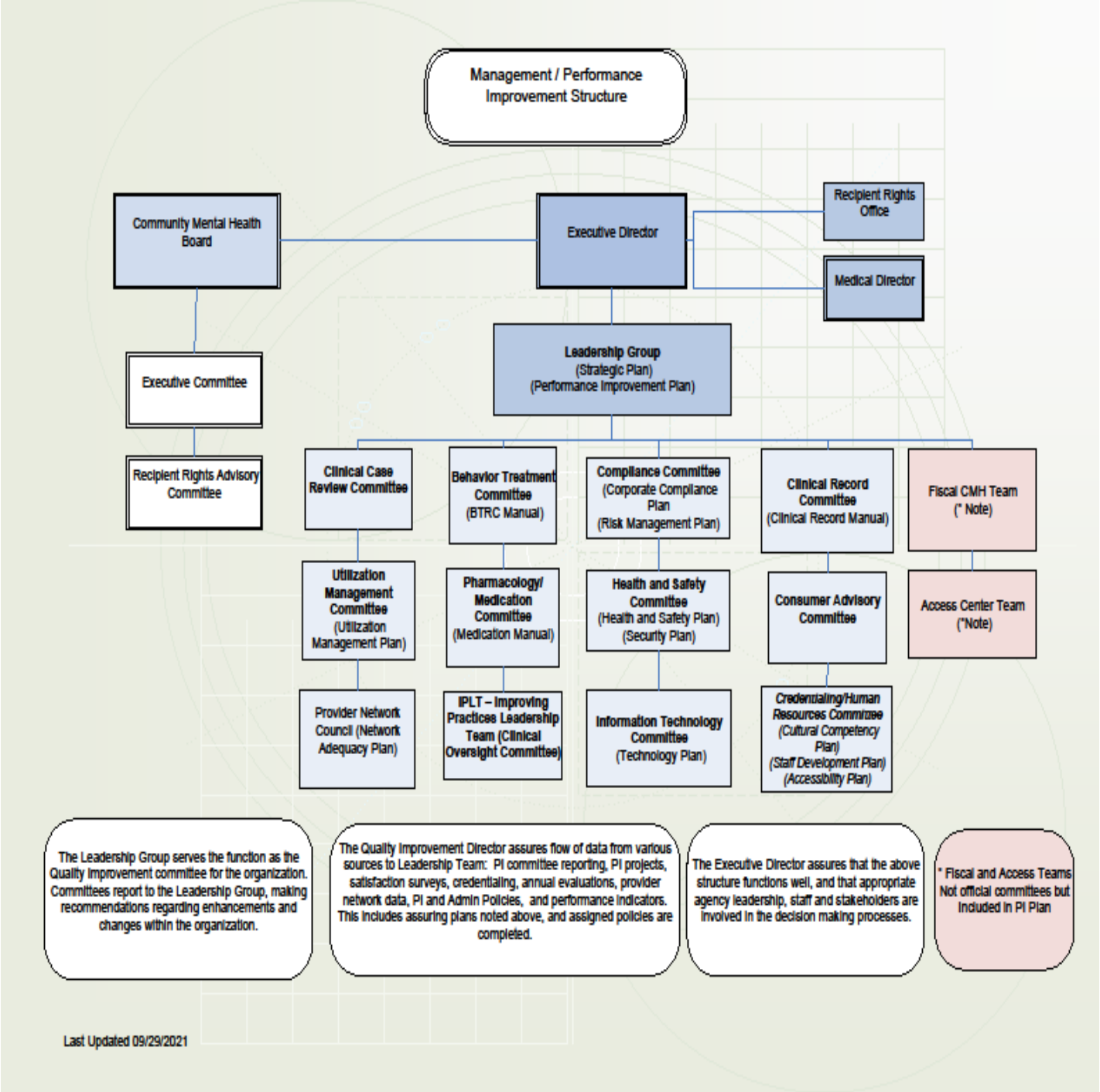
CMHOC and the PIHP will conduct an audit of all internal and external programs to assure that claims billed under Medicaid have met standards as identified by the Lakeshore Regional Entity, MDHHS, and federal standards. Data will be provided to the Lakeshore Regional Entity as requested. Findings will be presented to CMHOC's Compliance Committee. Immediate recommendations may be made to the agency's Leadership Group. Claims found to be deficient will result in a required plan of correction. Restitution will be sought for those claims when necessary.

XVI. APPENDICES

Appendix A: Management/Performance Improvement Structure
Appendix B: PI Committee Responsibility Matrix
Appendix C: Work Group/Committee Charge Form
Appendix D: CMHOC Policy 1.03, Sentinel Events
Appendix E: CMHOC Policy 9.14, Competency and Performance Evaluation
Appendix F: CMHOC Policy 9.14(a), Competency Matrix – Specialized Function
Appendix G: CMHOC Policy 9.02, Credentialing
Appendix H: QAPIP Assessment and Goals
Appendix I: Practice Guideline
Appendix J: Behavior Treatment Review Committee Manual
Appendix K: Medication Manual
Appendix L: Utilization Management Plan
Appendix M: Risk Management Plan
Appendix N: Corporate Compliance Plan
Appendix O: Health and Safety Plan
Appendix P: Technology Plan
Appendix Q: Staff Development and Training Plan
Appendix R: Accessibility Plan
Appendix S: Cultural Competency Plan
Appendix T: Network Adequacy Plan

Appendix A: Management/Performance Improvement Structure

(Double-click image below to view the full document)



Appendix B: PI Committee Responsibility Matrix

(Double-click image below to view the full document)

Committee Name	Committee Chair/Lead
Quality Improvement Committee	Anna Bednarek
UM - Utilization Management	Anna Luellen
Health and Safety	Kristen Henninges
Compliance	Kristen Henninges
CMH IT - Information Technology	Kristi Chittenden
BTRC	Lynne Doyle
Recipient Rights (Board)	Briana Fowler
Finance (Board)	Lynne Doyle
HR/Credentialing (Training)	William Phelps
Provider Network Council	William Phelps
CAC -Customer Advisory Committee	Chelsea Eisenlohr
IPLT - Family Services	Katie Clausing
IPLT - MI Adult	Michele VanderSchel
Clinical Case Review	Michele VanderSchel
IPLT - DD Services	Beth Durkee
P/T Medication	Dr. Joseph Drumm
CRC - Clinical Record Committee	Kristen Henninges
Sub Committees	
Data Mapping	Kristi Chittenden
Access	Cal Taylor
Finance (internal committee, not board)	Amy Bodbyl-Mast

Appendix C: Work Group/ Committee Charge Form

(Double-click image below to view the full document)

Ottawa County
Community Mental Health
Organizational Management Tools

Work Group / Committee Charge Form

A. Name of Committee:	
B. Sponsor:	
C. Advisor to the workgroup:	
D. Date charge was given to the workgroup	
E. Expected Date of Completion	
F. Issue being addressed by Committee; Description of the end-product expected of the Committee:	Committee will provide specific feedback related to CMHOC organizational and programmatic functioning. Committee functions include but are not limited to the following: 1. Provide feedback and recommendations related to CMHOC strategic planning. 2. Provide feedback and recommendations related to CMHOC budget development. 3. Provide feedback and recommendations related to CMHOC program development. 4. Provide feedback and recommendations related to State wide policy initiatives and directives 5. Review CMHOC performance improvement initiatives 6. Other functions as identified by the committee and Executive Director
G. Role of group (can be any one or a combination of them)	[ ] Make recommendations to sponsor relative to changes to be made [ ] Implement changes as determined by the group (subject to reporting and approval requirements set by sponsor [ ] Monitor implementation
H. Format of end product (i.e., written plan, report, redesigned process, etc.)	Formal Committee minutes

Appendix D - CMHOC Policy 1.03, Sentinel Events

(Double-click image below to view the full document)

COMMUNITY MENTAL HEALTH OF OTTAWA COUNTY
RECIPIENT RIGHTS

CHAPTER: **4**	SECTION: **47**	SUBJECT: **INDIVIDUAL CARE TO CONSUMERS**
TITLE: **SENTINEL EVENTS & CRITICAL INCIDENTS**		
EFFECTIVE DATE: **02/15/99**		REVISED DATE: **1/26/01, 1/25/02, 1/3/05, 6/20/05, 4/03/07, 6/13/08, 3/01/10, 2/18/11, 12/16/13, 9/22/14, 9/28/15, 12/19/16, 7/24/17, 9/24/18, 9/23/19, 10/20/20; 1/25/2022**
ISSUED AND APPROVED BY: EXECUTIVE DIRECTOR		

I. PURPOSE:
To establish and maintain consistent procedures for sentinel event reporting to the Lakeshore Regional Entity (LRE) and/or Michigan Department of Health and Human Services (MDHHS) and to ensure that appropriately credentialed staff are conducting the investigations. CMHOC will analyze the sentinel events and critical incidents at least quarterly to determine what action needs to be taken to remediate the problem or situation and to prevent reoccurrence.

II. APPLICATION:
To all Community Mental Health of Ottawa County (CMHOC) operated and contractual programs (as specified by contract).

III. DEFINITIONS:
Critical Incident (CI): Specific consumer related events, or incidents, that include suicide, non-suicide death, hospitalization due to injury or medication error, emergency medical treatment due to injury or medication error, and arrest of a consumer.

Risk Event (RE): Specific consumer related events, or incidents, that include harm to self or others which requires emergency medical treatment or hospitalization, police calls for emergency assistance when staff are unable to handle a situation, use of physical management, and two or more unplanned hospitalizations within a twelve month period.

Root Cause Analysis: Processes for identifying the most basic or causal factors that underlie variation in performance, including the occurrence of an adverse Sentinel Event. Root cause analyses focus primarily on systems and processes, not individual performance; progresses from special causes in clinical processes to common causes in organizational processes; and identifies potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or determines, after analysis that no such improvement opportunities exist.

Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury (or risk thereof) not related to the natural course of the consumers' illness or underlying condition. Such events are called "sentinel" because they signal the need for immediate investigation and response. Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

Appendix E - CMHOC Policy 9.14, Competency and Performance Evaluation

(Double-click image below to view the full document)

COMMUNITY MENTAL HEALTH OF OTTAWA COUNTY
HUMAN RESOURCES **Page 1 of 3**

CHAPTER: 9	SECTION: 14	SUBJECT: HUMAN RESOURCES
TITLE: **Competency and Performance Evaluation**		
EFFECTIVE DATE: **1-8-99**	REVISED DATE: **5/7/02, 3/15/05, 3/7/06, 5/10/07, 6/2/08, 10/05/10, 8/1/13, 6/10/15, 5/13/16, 5/9/17, 11/01/18, 2/25/19, 4/16/2, 5/14/21, 11/07/22**	
ISSUED AND APPROVED BY:  EXECUTIVE DIRECTOR		

I. PURPOSE: The purpose of this policy is to define the process for evaluation competency and conducting annual performance evaluations, to develop an objective performance appraisal based on current position descriptions and competency evaluation, to link individual accountability to office and Agency-wide goals, to link competency evaluation with individualized development plans, to link the competency evaluation to the Community Mental Health of Ottawa County (CMHOC) Board's Strategic Plan, and quality improvement efforts, and to ensure clinical staff are competent to provide services to the specified ages and populations identified in the position description.

II. APPLICATION:
All CMHOC staff.

III. DEFINITIONS:
The Application of Knowledge: completes job responsibilities, makes effective use of training, follows defined work formats, uses assigned equipment, etc.

Initiative: does not require constant supervision, takes on new tasks when appropriate, demonstrates self-directed behavior, attempts to anticipate job-related demands, demonstrates flexibility, and attempts to generate better ideas.

***Work Habits*:** Takes good care of assigned equipment, makes effective use of time, meets defined work schedule, and does not let personal interests interfere with work requirements.

Interaction with Others: Demonstrates courtesy in contacts with consumer, the public and co-workers, attempts to provide co-workers with information that will be helpful, is receptive to direction, is receptive to and considers the needs of others, demonstrates good listening skills.

Organization and Planning: Prioritizes tasks, sets time standards, defines objectives, follow through on assignments, communications plans to others, and considers departmental work flow.

Appendix F: CMHOC Policy 9.14 (a) Competency Matrix – Specialized Function

(Double-click image below to view the full document)

Position Title	Initial Competencies	Competencies at 6 Months	Annual Competencies
Building Designee	• Appointment by Health & Safety Officer • Demonstrates familiarity with emergency procedures and policies specific to the designated site including but not limited to the following: fire safety, tornado safety, security breaches, and medical emergencies	• Successful orientation with the Health & Safety Officer • CPR Certification • First Aid Certification • Comprehensive and timely reports to Health & Safety Officer • Compliance with emergency procedures	• CPR Certification • First Aid Certification • Safety training • Blood borne pathogen training • Compliance with emergency procedures • Completes monthly checklist(s)
Building Manager	• Appointment by Program Director or CEO	• Orientation with Health & Safety Officer • Compliance with emergency procedures including fire, tornado, security, and medical emergencies • Addressing safety and other building concerns	• Knowledge of procedure and policy relating to fire, tornado, security, and medical emergency • Blood borne pathogen training • Addressing safety and other building concerns, as evaluated by their Supervisor • Attempts to remedy identified building problems by placing work orders or contacting the landlord, building manager, and any other means necessary
Privacy Officer	• Current CMHOC supervisory employee • Knowledge and experience in the protection of privacy and access to patient health information in compliance with federal and state laws and Ottawa County policies and practices • Appointment by CEO	• Orientation/training with the County's Corporation Counsel • Compliance with agency's policies and procedures covering privacy of and access to patient health information • Maintain a process for receiving, documenting, tracking, investigating, and	• Oversee all ongoing activities related to the development, implementation, maintenance of, and adherence to the organization's policies and procedures covering privacy of and access to patient health information.

January 2022

Appendix G - CMHOC Policy 9.02, Credentialing

(Double-click image below to view the full document)

COMMUNITY MENTAL HEALTH OF OTTAWA COUNTY
HUMAN RESOURCES **Page 1 of 10**

CHAPTER: 9	SECTION: 2	SUBJECT: **HUMAN RESOURCES**
TITLE: **CREDENTIALING**		
EFFECTIVE DATE: **8/3/95**		REVISED/REVIEWED DATE: **3/14/97, 7/6/01, 8/6/04, 5/3/05,4/21/08, 10/25/10, 01/07/11, 1/25/12, 5/2/13, 7/9/13, 6/24/14, 6/10/15, 1/29/16, 4/20/17, 11/14/17, 8/9/18, 12/31/19; 09/25/2020; 10/25/2021; 1/20/2022; 05/25/2023**
ISSUED AND APPROVED BY:  EXECUTIVE DIRECTOR		

I. **PURPOSE:** The purpose of this policy is to assure that all Service Providers of Community Mental Health of Ottawa County comply with all applicable, Federal, State, and local laws, and the Michigan Department of Community Health rules and regulations for credentialing and re-credentialing.

II. **APPLICATION:** All Service Providers of Community Mental Health of Ottawa County (CMHOC).

III. **DEFINITIONS:**

A. **Service Provider:** Persons providing services for Community Mental Health of Ottawa County who are employees, agency contract providers or individual contract providers.
B. **Credentialed Positions:** Positions that require certain specified credentials.
C. **Credentialing:** Process by which CMH assures that Providers meet and maintain required criteria in order to be accepted as a Network Provider.
D. **Re-credentialing:** Process by which CMH assures that Providers meet and maintain required criteria in order to continue as a Network Provider.
E. **Credentials:** Documented evidence of licensure/registration, education, training, experience or other qualifications, as required by the position/service to be provided.
F. **Employees:** Persons who are employees of the County of Ottawa.
G. **Primary Source:** The original source of a specific credential that can verify the accuracy of a qualification reported by an individual health care practitioner. Examples include medical school, graduate medical education programs and state medical board

IV. **POLICY:**

A. It is the policy of Community Mental Health of Ottawa County to verify all employees and contracted Service Providers to be in compliance with all applicable Federal, State, and local laws, the Michigan Department of Health and Human

Appendix H: Ottawa QAPIP Goals 2023 Assessment, 2024 Goals

Utilization Management (UM):

Name	Committee Chair	Status	Status Update 07/2023	Status Update 12/2022	Status Update 01/2022
Enhance BHTeds Reporting	Anna Luellen	Ongoing	•Working on BHTeds SUD completeness reports. •BHTeds Crisis report has been completed. •BHTeds Caseload widget has been added to Avatar.	•Emphasis on increasing BHTeds completeness with MI adults •Add caseload BHTeds widget to Avatar •BHTeds Crisis report will be created	
Improve reporting mechanism/automation		Ongoing	• Have converted 14 of 23 reports to PowerBI	•Configured the SQL server and converted 10 reports of 24 to PowerBI •Payroll integration is completed	•Configuring SQL server •Working towards setting up Power BI reporting server
KPI Dashboards/ AaaS—Measures reporting (Netsmart)		Ongoing	•Presented to UM •Create new KPI Dashboards for UM for feedback.	•Present KPI Dashboards to UM and get feedback from members on what would be good clinical measures.	•Waiting for the Netsmart project to kick off to implement reporting capability.
LRE UM ROAT monitoring		Ongoing	•Presented LRE KPI Dashboard •Present LRE KPI Dashboard to the UM Committee. •UM Committee decides how to impact the LRE KPI Dashboards	•LRE ROAT is responsible for UM Dashboards •UM specific metrics in the LRE KPI Dashboard •Present LRE KPI Dashboard to UM Committee quarterly •UM Committee decides how to impact the LRE KPI Dashboards	•LRE has taken over many Beacon functions •UM functions are still transitioning back to LRE •Review CMHOC UM Data to old Beacon UM Data reports for CSR
Outcome reporting		Ongoing	•DD ANSA report is presented quarterly. •Evaluated NCQA measures. •Evaluate MICHICANS outcomes. •Create MMBPIS Dashboards.	•NOMS evaluation and review NOMS data •DD ANSA presented to UM ROAT. DD supervisor to determine outcome metrics.	•ANSA and CAFAS complete •CCBHC/NOMs waiting on data to start evaluation •Still determining how to best evaluate the DD outcomes oSpeak with Beth for input
Review UM Plan		Ongoing	•Review to see if we need to add CCBHC language based on the Demonstration Site requirements. •Review the CSR reports from the LRE and present to the UM	•Review UM Plan for CCBHC language and include CCBHC outcome metrics. •Review UM Plan for CSR language and process to align with LRE •Needs to be reviewed annually	•Add language for CCBHC outcome and integration to UM Plan oWaiting on what outcomes and criteria are decided on
SUD Monitoring		Ongoing	•Work with the SUD supervisor to identify potential SUD reports. •Review NCQA measures	•Ongoing reviewing internal CMHOC SUD data •UM Committee decides on SUD metrics. Example, ASAM data and BHTeds data.	•Reviewing SUD data reports continues oWaiting on UM committee's feedback •Look at implementing IET Reports
CSR Reporting		New	•Review the CSR reports from the LRE and present to the UM		

Health Information Management Committee (HIMCO)

Committee Chair	Status	Status Update 07/2023	Status Update 12/2022	Status Update 01/2022
Kristen Henninges	Ongoing	•Regional training developed for SMART goals and objectives was obtained in March 2023. Was uploaded in the spring to MyLearningPointe. • Determined what staff needed it, was assigned to 119 staff, only 6 didn't take it. • Want to have it as part of the new employee orientation training, possibly make it an annual requirement. Will be discussed at August HIMCO meeting.	•LRE provided trainings to those that request it following the LRE's annual site review •Provided teams with the new PCP technical guidance. •Updated PCP policy •Still in process to put training in MyLearningPointe •PowerBI is completed for qualitative and quantitative.	•Continue to get training in for SMART Goals •Review SMART goals at each CRC meeting; continues to be an area of concern •Training Reciprocity Group is trying to implement a region-wide SMART training •Goal to put this training on MyLearningPoint to be able to reassign to staff when training needs are identified and oGoal to be able to reassign as a part of our plan of correction •Power BI continues to be used for CCR, but only CMHIT can present the data oNow have a reporting server that everyone will have access to. Plan to implement in future
	Ongoing	•No recommendations from CARF currently. •Continue to monitor through monthly clinical reviews reported to HIMCO.	•Risk Assessment was added to the qualitative assessment clinical chart reviews. The results are reviewed quarterly at the CRC meetings.	•Process is ongoing, continue to monitor •Most recent findings from CARF were sent out, resulting in an addition to the qualitative assessment form re: risk assessment
	Ongoing	•Still need to be updated. •FS, MI, and DD have been updated with new staff. •Still need to do Crisis and Access.	• Still need to schedule BCP meetings with Access and Crisis •BCP will be documented	•Working with program supervisors to implement plans •Currently have plans for MI, DD, Family Services oStart reviewing and gathering forms needed in case of system failure •Goal to complete plan for Crisis and Access

Health and Safety:

Name	Committee Chair	Status	Status Update 07/2023	Status Update 12/2022	Status Update 01/2022
Testing new panic alarm procedure utilizing computer notification and 911 call notification procedure	Kristen Henninges	Ongoing	•Looking for an alternative for PERSA, want an app based solution. Kristi is testing different ones. •Kristen receives 911 emergency notifications which she followups on. Most have been accidental. •Still using the Little Green Button. Send quarterly emails to staff to check that it's active and has their location.	• Receives notifications from all locations, Kristen followups •Little button is still active •Still testing for PERSA	•911 Call notification list by building implemented •Little green button is still in place active •PERSA system for staff safety devices in the community—look into potential and positives for use for consumers in residential settings
Increase committee participation and attendance at Health Care Coalition meetings		Ongoing	•Continue to cancel the meetings in the last six months. •Will attend if they are held.	•Haven't had a meeting for Region 6 Healthcare, continues to be cancelled. •There was a draft agreement that Lynne signed that was sent to the Region 6 Health Care Coalition.	•Meeting with Region 6 Health Care Coalition continues to be cancelled, used to meet twice a week during the height of COVID-19 •Waiting on agreement for what CMHOC's responsibility would be in the case of a disaster or emergency
Complete County Site Emergency Plan		Ongoing	•No communication from Leah Delano. •Will continue to reach out to Leah.	•Haven't heard back from Leah Delano. •Will continue to reach out to Leah.	•Still waiting for information from Leah Delano for the County Site Emergency Plan
Active shooter training for all staff		Ongoing	•Is on the new employee orientation to sign up for the training on Topyx. •Investigating live active shooter drills, if they're a requirement.	•New hires take CPTED on Topyx, included on New Hire Employee training document. •Will approach leadership about a live active shooter drill.	• County is now offering training for active shooter training •CMHOC is still not ready to have the live active drill •In process of getting recording of training so CMHOC can give the training to newly hired staff

Compliance:

Name	Committee Chair	Status	Status Update 07/2023	Status Update 12/2022	Status Update 01/2022
MDHHS Credentialing Guideline	Kristen Henninges	Ongoing	•Updated Credentailing policy to align with the MDHHS Guidance. •Continue to meet with the LRE on updated credentialing for Universal Credentialing.	•Review updated Credentialing Guideline •Find out more about universal credentialing initiative at MDHHS •Align CMHOC with new state guidelines	
MDHHS OIG Program Integrity Report		Ongoing	•Quarterly submission is in place. •Streamlined process flow with CMH IT and Fiscal to identify and resolve reporting issues. •Ongoing	•Work with CMH Fiscal to review and resolve findings on the OIG report	
Medicaid Verification as a tool to better monitor and support internal provider network		Ongoing	•New process implemented FY 2023 Q2 •FY 2023 Q2 completed June 2023 •Working on creating a report with the findings to analyze the data and implement	•Revisit process on Medicaid Verification for internal •LRE has increased sample size on Medicaid Verification	•Continues to be the same as noted in July 2021
Develop and implement 2023 Compliance and Risk Management Plans		Ongoing	•Risk Management completed for 2023 •Corporate Compliance Plan has been revamped to align with the LRE Corporate Compliance Plan. Made a few additions	•Ongoing, continue reviewing plans for updates	•Continue to update these plans annually •Reached out to staff supervisors for input on Compliance and Risk identification/input
Committee will work to align policies, procedures, and objectives with LRE		Ongoing	•Have a established monthly Compliance ROAT led by new Compliance Officer •LRE Compliance policies are still in review, CMH policies will be aligned once that is completed.	•Have a established monthly Compliance ROAT led by new Compliance Officer •LRE Compliance policies are still in review, CMH policies will be aligned once that is completed.	•No compliance meeting since July 2021 •New Compliance Officer hired at LRE, waiting for him to get up and running to help align policies procedures and objectives and have regular meetings
CHAMPS		Ongoing	•Not expanded for nonprofessional enrollments	•Not expanded for nonprofessional enrollments	•Ongoing •Process in place, continue to monitor for updates
County IT checks on AD User Accounts and comparing passwords to known, breeched passwords used in cyber attacks		Ongoing	•Continue to get results from County IT on breeched passwords and AD account recommendations •County IT is testing different Password Managers and Generators.	•Continue to get results from County IT on breeched passwords and AD account recommendations	•County IT will be running checks frequently •If any staff is ID'd on these reports, are asked to reset their passwords immediately

CMH IT:

Name	Committee Chair	Status	Status Update 07/2023	Status Update 12/2022	Status 01/2022
Review Technology Plan in relation to EVV and Parity integration	Kristi Chittenden	Ongoing	• Reviewing state guidance and implementing by 10/01/2023. (EVV) • Parity Integration is completed.	• Waiting for direction from the state • MCG, going to update to 26 edition of web version, update Avatar Criris form. • Will not pursue EMR integration	• EVV continues to be on hold at state level • Looking at state level implementation FY 2023 • Parity (MCG)—LRE decided to continue with the web dynamic content w/ EMR integration continues to be on hold
LRE IT Requirements		Ongoing	• Access to LRE PowerBI Reports (Completed) • FUH Data requirements have been changed and implemented. (Completed) • New ABA monthly report is needed. Still in development, testing. • CIRE (Critical Incident Risk Events) monthly submission to LIDS (Completed)	• Access to PowerBI Reports • Waiting FUH data requirement changes	• Waiting for PowerBI Reports from LRE
Work with Team programs to complete various projects related to the EHR, convert forms, develop new forms		Ongoing	• Psychosocial Changes completed. • Two new COSSAP and two DDR (Deflection Diversion and Re-Entry) forms in development • Mobile Crisis note is being developed. • Provider Referral information in development. • Internal referral form and Med Clinic request form on hold pending approval. • CCBHC dashboards in development.	• Completed NOMS and the NOMS in Avatar • Completed ACT Progress Note • Electronic Consent Form was completed • Med Review Psych Eval rework was completed Forms that are progress are referral database for Access • Internal referral form is in progress • Med Clinic request form is in progress	• Completed COSSAP program forms • Reviewing Netsmart's NOMs forms • Create Navigator/CCBHC Assessment • Working on new progress note forms for ACT and contract OP agencies • Create MIA/CLS checklist • Reviewing IMH diagnostic checklist for finalization • Child NOMs was created but determined unnecessary
SRA		Ongoing	• Completed Security Risk Assessment for 2023 • Will complete annually • Continue to work with County IT with security assessments.	• Continue M-CEITA for SRA • Work with County IT on getting results from their security assessments, example vulnerability testing and penetration testing.	• Getting audited about meaningful use • Look at cost of having M-CEITA come out to complete SRA
Avatar		Ongoing	• CMH IT offers monthly training on Avatar. • Continue to part tips and tricks in the CMH Technology group on Microsoft Teams.	• New hires to join CMH Technology group • Developed CCBHC widgets and reports	• Continue to part "tips and tricks" at least once a month, and encourage new hires to join the Teams group • Continue to develop useful widgets and reports to improve user experience, and for CCBHC
SCA		Ongoing	• MSO changes started end of June. • PM changes on September 1st. • Executime implementation, staff tracking and training. • Must be completed by 10/01/2023	• Setup Avatar to meet new SCA requirements (completed by 10/01/2023)	
Other Initiatives—SQL Server, UPDOX/eFAX, MiHIN(VIPR), MiCAL CRM, AVATAR NX and ProviderConnect NX, PERSA		Ongoing	• Updox implementation is complete • MiHIN VIPR is on hold. • MiCAL is now BHCRM (Behavioral Health Customer Relationship Manager) and is complete. • Avatar NX is completed • NIAM went live in May, completed. • Reviewing LONE worker apps. • My HealthPointe 2.0 implementation, hoping for August. • MICHICANS state implementation.	• SQL server is setup and configured • Updox is live for faxing and texting (GH and A Building Clinic in process) • MiHIN VIPR is on hold • MiCAL is complete • ProviderConnect NX is complete Avatar NX is scheduled for January 2023 • NIAM is kicking off in January • PERSA is complete • CIRE changes is complete	• SQL server, new server is set up • UPDOX-transitioned 4 teams/departments • MiHIN(VIPR)—continues to be available, and will transition when it goes away to MiGATEWAY • MiCAL—is set up, staff should have access to live environment • Roll out in conjunction the 988 national suicide hotline • Customer service, facility certifications and Compliance are currently set up in MiCAL • Signed agreement for AVATAR NX and Provider Connect NX, waiting projects to start • PERSA—working on program implementation (Community staff safety devices)
Update CMH IT Plan		Ongoing	• Completed for 2023	• Update plan for 2023	

BTRC:

Name	Committee Chair	Status	Status Update 07/2023	Status Update 12/2022	Status Update 01/2022
Improve data reporting on plans and follow up on BTRC recommendations - Contractual providers should provide this data timely and accurately	Lynne Doyle	Ongoing	•Data collecting has improved. •Continue to monitor and follow up with Clinicians.	•Ongoing goal to get completed consumer documentation needed from Clinicians. •Work on using FTP site as an option for providers to upload documents.	•Discussion with Beacon about who completes consumer documentation, needed Clinician not supports coordinator •Continue to work with providers and monitor progress for process improvement oConcern about data collection at Beacon •Amber to Reach out to providers to see if they would like to use FTP site to upload documents
Align current BTRC practices and procedures with anticipated HCBS impacts and requirements		Ongoing	•Met with LRE for HCBS training. •Look at new BTRC requirements and make sure we align.	•Will reach out to Beth (DD Program Supervisor) on where we're at with this. •Monitor regularly	•Heightened scrutiny reviews still ongoing, but HCBS state workgroup hasn't meet in regard to BTRC recently.

Recipient Rights:

Name	Committee Chair	Status	Status Update 08/2023	Status Update 12/2022	Status Update 01/2022
Continue to provide RR training to new hires and update training to current employees and board members	Briana Fowler	Ongoing	•Continue to complete through Network 180. No longer recommending Improving MI Practices since it's more generic where N180's is more specific. Will accept RR trainings from other counties. •Briana will do in-person training if requested.	•Continue to complete trainings through Network 180 virutally or Improving MI practices (https://www.improvingmipractices.org/) •Briana continues to offer to assist with trainings with Network 180. •Still on hold with implementing face to face trainings in Ottawa County.	•Continue to complete trainings through Network 180 virtually offered every week and one evening a month oBriana offered to assist with the trainings, but Network has not taken her up on that yet •Considering implementing face to face trainings again in Ottawa County depending on the status of the pandemic in the spring oWill also look at the numbers of those completing the training into consideration too
Site review		Ongoing	•We're doing Recipient Rights reviews collectively in the region with regional rights department. •Developed a Site review tool and correspondence that was approved by MDHHS ORR.	•LRE has taken over site visits but will no longer be doing recipient rights site reviews. •Briana is working with RR Directors in our region to implement site reviews reciprocity to avoid duplication. Utilizing Teams to share documents.	•Beacon currently completes the site reviews for the LRE region •Briana completes site reviews for out of county/out of region •LRE looking to change site review process—pulling a sample of providers instead of completing for all providers annually (current ORR requirement) oIf this change does go into effect, this will impact CMHOC ORR oJeff Rozema at LRE in charge of LRE site reviews and this decision, Briana to follow up with him •State level ORR doesn't like having non-Recipient Rights staff completing Rights reviews, but unsure if this will change anything d/t lack of County staff to cover the needed 175 site reviews (15 site reviews a month) •Consider possibility of hiring new staff member for Rights or pulling internal QI staff hours depending on the LRE's decision of how site reviews will be completed oRich to discuss with Lynne oBriana to complete job analysis for staffing hour need per site review
Training Customer Service Specialist to provide Recipient Rights Backup as Needed		New	•Train to take over RR background checks received internally and from providers.		

HR and Credentialing (Training):

Name	Committee Chair	Status	Status Update 07/2023	Status Update 12/2022	Action Plan 01/2022
Update the new Accessibility Plan, Cultural Competency Plan, and Training plan for 2023	William Phelps	Ongoing	•Setup meeting to complete Cultural Competency Plan and Accessibility Plan. •Training Plan for 2023 is in process, researching requirements. Splitting trainings to be done quarterly. Hope to be completed by the end of August. •Continue to update plans to align with the Network Adequacy.	•Training Plan for 2023 is in process. Months are complete, adding more detail. •Bringing to HR meeting •Setup meeting to complete Cultural Competency Plan and Accessibility Plan •Update plans to align with the Network Adequacy	•Updating Training plan for 2021 •Cultural Competency Plan and Accessibility Plan has been updated and are complete
CMHOC Customize Trainings in MyLearningPointe		Ongoing	• SMART training is assigned to the correct staff, be done annually. •Working on having all the trainings in a grid by the end of August based on staff's role.	•SMART Training is complete, will be uploading. •Medicaid Eligibility Training is no longer needed. •No word on a new training platform for MyLearningPointe	•Have been working with Mercy at Network 180 to improve our SMART goal training oGoal launch date of February 2022 •Working with Compliance Manager to include the new additional required training that came from the LRE for their annual site review •Medicaid Eligibility Training no longer needed •MyLearningPointe platform may be changing. Wait to hear/learn more
Create common folder for CMHOC Training & HR Documentation in one location		Ongoing	•Continue to working on merging folders to create a common location for Training and Contracts.	•Working on merging folders to create a common location for Training and Contracts	•Create common location for all completed training documents: plan, staff training requirements, etc •Connect with teams to ensure not getting rid of documents other staff use •Rich recommended putting it under the QI folder to limit staff access
HR Meetings		Ongoing	•Will meet with Anna Bednarek to figure out next steps with the HR Committee. •Plan on an August meeting. •Will figure out if we should continue every other month, how often.	•Conducted monthly, thinking of doing every other month. •If needed, will schedule special meetings.	
Improving Orientation Process		New	• Creating a grid of trainings each staff needs to complete based on role at the orientation.		

Provider Network Council (PNC):

Name	Committee Chair	Status	Status Update 07/2023	Status Update 12/2022	Status Update 01/2022
Prioritize provider identified issues	Bill Phelps and Gina Kim	Ongoing	•Bill will review providers and will determine if we want to make a survey to look at areas of improvement.	•Working on a survey through Qualtrics to providers to get input on areas that need improvement.	•Will continue to monitor needs as they come up oNothing new at this time oWill continue to engage our provider network for meeting topics, but the ones they routinely bring up, are the topics we currently cover •Are receiving a lot of positive feedback from providers after each PNC meeting
Review Annual Needs Assessment and align Accessibility Plan with it		Ongoing	•Make sure Accessibility Plan has all the elements. •Align plan with Annual Needs Assessment. •Review findings and how we can adjust.	•Make sure Accessibility Plan has all the elements. •Align plan with Annual Needs Assessment. •Review findings and how we can adjust.	•LRE is taking Network Adequacy Plan over in 2022 •Will take as much information as possible from the LRE's finalized plan to include in CMHOC's own Adequacy Plan •Will need to form internal workgroup between Contracts Manager, Fiscal manager, Deputy Director and Training/Contracts Program Coordinator to include new requirements from ANA, CCBHC, satisfaction survey, providers, other CMH's plans, etc. to come up with Network Adequacy initiation plan oForm group by end of January 2022
Scorecard KATA		Ongoing	•Working on clinical indicators, trying to figure out who would implement it. •Looking to see if we have the capacity to do it. •Looking into if we could use MMBPIS for performance indicators. •Put on hold until after October.	•Phase two is in process to finding measurable outcomes for services provided. •Have a Provider Scorecard.	•Was put on temporary hold with 10/01 updates, DCW changes, and Contract Manager maternity leave •Look at how can use QI CCBHC staff to assist with data entry and reaching out to the providers for their Scorecard information •Will be looking at accumulated data and working with CMHIT to see how we can auto populate information--a dashboard report for provider performance/scorecard •Providers have been very receptive/responsive in getting us the documents needed •
Revamping internal and external policies and procedures related to contracts and training		New	•Want to complete by December. •Have a draft updated for RFS. •Improve/update operational guideline for contracts.		

Consumer Advisory Council (CAC):

Name	Committee Chair	Status	Status Update 07/2023	Status Update 12/2022	Status Update 01/2022
Increase the participation of consumers attending the committee meetings	Chelsea Eisenlohr	Ongoing	•Holding the meetings bi-monthly. They are at various locations, going where the providers are. •Have a representative on the LRE CAP, looking to get one more. •No round tables are scheduled but might be scheduling one in the late fall/winter.	•Holding consumer advisory meetings. Had a couple in 2022, will have more in 2023. •Going out to providers to get input. •Have one person on the LRE Consumer Advisory Panel. •Holding round table meetings with parents, guardians, and consumers to get input. Lynne attends these meetings. These are held periodiocally.	•Anna and Lynne are still in Planning phase for improving accommodation of CAC meetings •Lynne attending monthly meetings of parents and guardians to answer questions about CMHOC services as well as provide more information about our services •No CAC meetings this past FY and no plans to have any scheduled this FY •Lynne and other CMHOC staff attend and participates in virtual meetings with parents •Anna is attending and awaiting to hear how new members can attend the state CAC meetings
Improve the agency's use of the consumer input from CAC; integration of consumer input into strategic planning		Ongoing	•Lynne attends all the meetings. •Anna and Amy continue to participate in the Customer Satisfaction Survey meetings with the LRE. •Had a good response rate with the mailed out surveys, looking for prepay postage for future mailings. •Looking for ways to increase response rates with the Qualtrics surveys for the Customer Satisfaction Survey.	•Lynne attends all the CAC meetings, uses the information from these meetings for the strategic planning and goals. •Anna and Rich attend the LRE Customer Satisfaction Survey meetings, in process of making a new survey. Amy will be joining the group. •Try to publicize the survey, make it more available (Qualtrics as an example). Think of ways to increase our outcomes.	•Goal to include a separate section on satisfaction survey that addresses CAC meetings and gathers consumer input oAmber and Rich to complete this in January 2022 and goal to publish results for FY 2023, and include additional attachment to PI plan oKeep Anna in the loop for when the satisfaction surveys are going out •LRE to present at the CAC council the aggregated regional data from satisfaction surveys; good opportunity to voice customer service concerns regarding the LRE survey

IPLT – Family Services:

Name	Committee Chair	Status	Status Update 07/2023	Status Update 12/2022	Status Update 01/2022
Increase ABA Capacity	Katie Clausing	Ongoing	•Still an ongoing issue, hoping to add two more ABA agencies.	•Long waitlist, agencies don't have technicians	
Address capacity issues and the capacity for Supports Coordination for Autism Benefit.		Ongoing	•Hired a new Supports Coordinator, have 8 Supports Coordinators currently. •Have a new report in Avatar to help with paperwork. Teresa has been sending reminders and keeping track. •Working on getting caseloads down, hoping to get down to 50.	•Family Services is going to hire one more Supports Coordinator early next year if approved by Commissioners in January 2023. •Look at how to get paperwork for autism caseload done in a timely manner.	•Expanding capacity for Autism supports--2 MH specialists positions posted for Autism and other for respite and self-determination •Will continue to monitor as Autism benefit need expands; will continue to attempt to meet needs
Address capacity issues for outpatient		Ongoing	• Holding steady currently. •Second Story and Samaritas have expanded their capacity and Bethany is working on expanding.	•Lost a couple agencies, Catholic Charities, Winning at Home, and Arbor Circle stopped taking children •Continue to have capacity issues for children with Medicaid. •Capacity is an issue with those with Commercial insurance (Have to be served by a fully licensed	•Have one contractual agency interested in providing these services but location is not as accessible for Ottawa County consumers as other providers oCurrent concentration of need is Holland/Zeeland area, not Jenison •Have therapist positions posted. Will revamp and repost after the first of 2022
Capacity for initial Autism testing--ADOS		Ongoing	• Average wait time is 2 months •Pending state decision on ADOS being a requirement.	•Hope Network isn't taking in anyone. •Developmental Enhancement and Centria are the only ones taking in children •CARD is no longer contracting with us. •Need more capacity.	•Let all providers know the need for ADOS testing •Developmental Enhancement hired another TLLP to increase capacity but they cover more than just Ottawa County •Continue to wait for the ADOS requirement change from annually to every 3 years to reduce the waitlist •LRE still negotiating using LMSW's with appropriate ADOS training, but
Expand Schools Network collaborative project between CMHOC/ISD		Ongoing	•OCSN has taken over their own projects. Ann and Lynne are just consultants. •A new collaborative project was started in April with the ISD, it's on hold for the summer. •Beth and Ann are working on a transition project with the ISD program.	•Still having regular meetings •Still is millage funded •They have expanded, have 15 school coordinators. They are in 7 school districts. We're reorganizing the structure to accomodate the demands on the OCSN.	•Regular meetings with OCSN continue monthly •CMHOC/ISD collaborative is millage funded •Now 13 school coordinators, 1 director and 1 assistant director still in 6 school districts
SAMHSA Grant		Ongoing	•Hope to start on-call mobile crisis in August. •Continue to exceed the numbers for data points. •Anti-Stigma campaign is in full swing. •Concluded the second cohort of TFCBT. •Discontinued the neurosequential training •Going to apply for another 4 years in August.	•Mobile crisis, have on call positions posted. Will be reorganizing and hoping to launch in the next couple months. •Change in supervision, Bethany left and Jen has taken her position. •Revamping what the government team will look like. •Started second cohort of TFCBT •Exceeded numbers in data points. •Submitted annual reporting in November. •Did a project with TBD, using information to project further development of system of care.	•Latino Outreach services have transitioned to Bethany Christian Services •Mobile crisis has been put on hold, looking at how to address the state-wide mandate for these services •2 SAMHSA staff being moved from part time to full time oWaiting for SAMHSA approval community trainings •Continue to monitor and improve, including community trainings •Complete with NOMS data reporting requirements
MHJJ/ PACC Grant (MDHHS)		Ongoing	•Cori left. •Exploring next steps with MDHHS. •Submitted quarterly reports.	•Matt left, hired Cori. •Revamped our relationship with Juvenile Court. •Lot of referrals coming in from West Ottawa Schools, Juvenile Court, and Help me Grow •New pilot project with OAISD	•MHJJ—CMHOC Staff continues to provide services. Catholic Charity's staff quit, and are holding off on replacing that staff until referral need increases •PACC-CMHOC Staff continues to provide services •Continue to monitor need and capacity
MI Kids Now Settlement		Ongoing	•Pushed to do therapeutic foster care •Mobile crisis in 2024 to be 24 hour care and the provision of crisis stabilization services. •Implementing CANS and the opening of the front door (CMH). •24/7 mobile crisis is being pushed •MDHHS push for workforce development. •BCCHPS is the new bureau at the state level for children. •Continue to monitor and give feedback	•Implementing CANS and the opening of the front door (CMH). •24/7 mobile crisis is being pushed •MDHHS push for workforce development. •BCCHPS is the new bureau at the state level for children. •Continue to monitor and give feedback	•MDHHS was supposed to provide update in December 2021 but did not. Are pushing update out to February 1st, 2022 •Based on the outcome of this settlement/lawsuit may result in increasing crisis services to 24 hours, 7 days a week

Substance Use Disorders (SUD):

Name	Committee Chair	Status	Status Update 07/2023	Status Update 01/2023	Status Update 12/2021
ASAM Tool Troubleshooting	Joel Ebbers	Ongoing	•The ASAM Continuum has been rolled out. •Internal staff are being trained on it. •Contract agencies haven't been having any problems with the tool. •Continue to train new staff on ASAM Continuum.	•Touch back with Joel about ASAM if there are any issues.	•ASAM is rolled out •Still some issues with ASAM tool itself: not populating levels of care oRegion is looking at this issue and discussing how to fix
SUD Authorization Process & Program Improvement		Ongoing	•In January, had a peer leave then hired a peer. •Currently have a peer leaving. Having trouble keeping staff for this role. •Rates Group have decreased the frequency of meetings, still trying to standardize to one rate change a year.	•Hired two new staff •SUD Clinician transferred to Access •Added Peer Support Staff. •SUD ROAT/Rates Group hopefully to standarize increases to one time a year. Continue to bring this to the ROAT group.	•UM modifier codes were updated •In process of hiring new staff to help address capacity needs with authorization process oThe frequent changes in authorized services causes the capacity issue oChange having Program Coordinator to complete these oSUD clinician will be transferring from Access to SUD services 75% of her time •Peer support staff added to help with level of care transitions increasing better outcomes for consumers
Develop and Monitor the transition of SUD to a separate program internally		Ongoing	•Since January, hired a Program Supervisor. •Did budget planning for FY 2024, which included a Program Coordinator and a SUD MH Specialist. •Beginning to develop a code list for internal SUD codes, which will include SBIRT codes.	•Ensure one resource that is appropriate for SUD team •	
Transportation for SUD Services		Ongoing	•Looking to apply for a MDHHS transportation grant. •Coordinating with Kaizen Health to help with transportation.	•Looking into transportation options for consumers to get to services internally. Look at what other CMHs are doing.	
Medication Assisted Treatment in the Jail		New	•Established Suboxone treatment and are looking to expand into Methadone.		

IPLT – MI Adult Services:

Name	Committee Chair	Status	Status Update 07/2023	Status Update 01/2023	Status Update 12/2021
Manual for MI Adult processes	Michele VanderSchel	New	• Placement and general procedures. •Know the different guardianships. •Referring to a level higher of care •Update Crisis Manual		
MI Program Capacity Needs Evaluation, including CCBHC Needs		Ongoing	• Added two CCBHC positions to GH Team. One was filled, the other is being interviewed. •Added a new prescriber and a CIT person. •Will be looking at capacity and reviewing what is needed.	•Added two CCBHC staff, requesting to add two more staff to GH Team. •Looking at other capacity impacts to the team. Lots of unknown factors, will review.	•Looking at MI program structure, gathering input from program coordinators to address the increase need of overall services capacity and consumer service demands •Also considering CCBHC expansion requirements

Clinical Case Review – MI:

Name	Committee Chair	Status	Status Update 07/2023	Status Update 01/2023	Status Update 12/2021
Use data to monitor costs of committee decisions and impact on agency, keeping costs in line with budget	Michele VanderSchel	Ongoing	•Continue to monitor •Create procedures for referring to different levels of care. Have residential as the last option (medically necessary).	•Continue to monitor	•Ongoing, always monitoring costs at UM to ensure the most efficient use of funds •Hired internal CLS staff, and they are up and running
Lower the unit cost of service for ACT		Ongoing	• Have not been able to do yet. Have a MIFAST review coming up on September 19 and will be addressing the issues that have driven up the cost. •Losing another prescriber in September. •Position is posted for a new prescriber.	•Continue to monitor •Down one staff, RN •Review UM report •Moved one ACT staff to master's level, hired one MHA.	•Continue to monitor •Have almost a full ACT team oJust hired a medical assistant and mental health aide to ACT •Risk of COVID-19 continues to pose barrier to length/duration of services provided per visit •Have 51 consumer served, clinical staff ratio ideally 10 per staff; ACT Team is at capacity

Pharmacy and Therapeutics Medication (P/T Medication):

Name	Committee Chair	Status	Status Update 08/2023	Status Update 12/2022	Status Update 01/2022
Med-Note, Order Connect and EHR Improvements for Users	Dr. Joseph Drumm	Ongoing	•EMR requires many clicks, is there a way to reduce and make it more efficient? It's very time consuming. Reaching out to vendor. • Look into possibly getting a badge sign in for the EMR. •Progress Notes now circulate correctly.	•No longer using Med-Note •Problems with having prescriptions going through to pharmacies, happening frequently. Need to look into with IT. •EMR requires many clicks, is there a way to reduce and make it more efficient? It's very time consuming. Reaching out to vendor. • Look into possibly getting a badge sign in for the EMR.	•CMHIT Got rid of Med-Note module because it wasn't being used. •Reached out to creators of the programs for assistance to improve program and yet they have not addressed efficiency concerns that are brought up •Continue to advocate for needed changes to improve efficiency within in the Electronic Health Record and Order Connect oConcerns for compliance and legality
Medication Review Process		Ongoing	•Continue to look into a new Pharmacist for reviews.	•Look into getting a contractual Psychiatrist for peer to peer reviews. •Looking into a new Pharmacist for reviews.	•Review process of who is completing the medication audits to improve efficiency and requirements oFelt it should be only peers: i.e. prescribers to prescriber not nursing staff nor pharmacists reviewing prescriber documentation because they are not trained to know the medication guidelines oLook at auditing and manual (Medicaid and Medication) requirements and possibility of implementing change
Hiring of two new Prescribers		New	•Looking to hire a new Psychiatrist/Medical Director •Looking to hire a Nurse Practitioner		

IPLT – DD Services:

Name	Committee Chair	Status	Status Update 07/2023	Status Update 12/2022	Status Update 01/2022
New Model for Supportive Employment	Beth Durkee	Ongoing	•New Model is starting August 1st •Want to get unified training •Coaching and how to fade coaching •How to find employment, get providers trained •Change mindset on how to get everyone employed regardless of ability.	•People in employment, average hours worked for Supportive Employment •Rolling out new model that consists of a tier system looking at number of hours worked. •Meeting with Kelly for costs and drafting a contract •Align encounter reporting with units and a tier model	
DD COFR Kata		Ongoing	•Working on implementing tracking monthly documentation for COFR/Out of County consumers. •IT created a report to track documentation from providers. •Operational guideline created of what documentation is required from the providers. •Create a workflow for monitoring	•Creating a flowchart for the process •Roles review for coordination and placement •Documentation requirements such as IPOS for authorization and evaluation •Monitoring for progress	
Improve monitoring of contractual providers		Ongoing	•Getting documentation from contractual providers monthly. •Case managers and Stacie have been reviewing. •Working with Social Rec providers to get more people involved with the community than just residential. Have a meeting in September with residential providers. •Working with DD Staff to improve implementation of Person Center Planning. •Improve reviewing of PCPs with providers.	•What are staff doing to monitor •Realign with organizational mission, value statement.	
Begin developing outcomes incorporating ANSA		Ongoing	•We have put ANSA metrics as benchmarks for UM.	•Looking at DD ANSA for specific metrics	•Look at how to track their quality of life using internal reports and measures/benchmarks oUnsure if ANSA and SIS reports will meet this goal, start looking at other methods oInclude looking at cost of services per person in these measures to see if it actually improves quality of life oMeet with UM team to see how to best collect these measures
Residential Rates Evaluation		Ongoing	•Have a meeting set up in August with Fiscal and Contracts to discuss. •Will be reviewing contract requirements for staffing and budget for shift staff homes. •Making sure FTEs are providing the services that they're required to provide. •Providers are doing well with using SSI instead of Medicaid dollars to cover housing costs. •Review admin costs, have 10% to 35% with various providers. The ones with higher admin costs have been seen to request more money.	•Did acquire the budgets from the shift staff homes. Review adding FTE data to the contract (To speak to capacity issues). •Bring in Amy from Fiscal and Kelly from Contracts to continue discussions •Consider an outcome model for SIL, staff rates and transitioning.	•Completed tier level for AFC standardized rates (only 3 tiers) •For shift staff homes, look at having them submit budgets to see how to best standardize rate and ensure they're not covering housing costs with Medicaid dollars instead of SSI supplement oBring in Keith from Fiscal and Kelly from contracts to continue this discussion •Requested to have scanners for homes in addition to FTP site to get documentation in timely
Increase utilization of Supported Living Arrangements and getting more people back in county		New	•Look to trying to increase options. •Try to get away from residential homes as the only option.		

Agency:

Name	Committee Chair	Status	Status Update 07/2023	Status Update 12/2022	Status Updat 01/2022
Millage initiatives: Variety of projects identified related to the millage (Project tracking on separate form) Strategic Plan	Anna Bednarek	Ongoing	•Continue to update strategic plan, Lynne and Anna work on annual strategic plan. •Continue to review monitoring of the millage spending and projects	•Continue to update strategic plan, Lynne and Anna work on annual strategic plan. •Continue to monitor millage spending and projects	•New grants continue to spur new staff hiring •Strategic plan will be updated and presented to the board •Monitor and update changes to the millage as agency leverage dollars
Committee will work to align policies, procedures, and objectives with LRE		Ongoing	•Continue to change CMH policies to align with the LRE. •Based on regional audit findings, CMHSP will align with any plan of corrections.	•Per Last audit, LRE changed the process for auditing •Policies continue to change at the LRE and CMH will align. •Based on regional audit findings, CMHSP will align with any plan of corrections.	•LRE still has not finalized the contract with MDHHS and continues to be on a monthly contract with them •Goal to get on annual contract with MDHHS oOngoing meetings related to this are happening between MDHHS and LRE
CCBHC		Ongoing	•Fine tuning our coordination of care as we move to becoming a demonstration site. •Next report is due in November. •Need to find out how PPS is going to affect our funding model. •Need to implement zero suicide by 09/30/2024.	•At second year of CCBHC, outcomes reporting has been completed to the feds. •Programmatic changes have been made to CMH to prepare for CCBHC services including information system changes, hiring of new staff, to perform CCBHC goals and objectives. •CCBHC will integrate into all CMH teams. •10/01/2023, possibility will becoming a demonstration.	•IT System updates to meet CCBHC requirements are complete oWorking on implementing IT infrastructure to support CCBHC as reflected in CMHIT goal section •Hired staff for CCBHC positions •Working on CCBHC programmatic workflow for the CCBHC use cases •Developing CCBHC policies and procedures to support CCBHC roll out •Working on third party agreement flow related to providing treatment CMHOC does not oCan come in the form of Memos of understanding or contracts with providers oNeed a Designated Collaborating Organization (DCO) template agreement in place
Since restructuring of LRE and taking back Beacon functions, Ottawa will align with new requirements		Ongoing	•Continue to credential based on MDHHS's guidelines. Pending implementation and training of Universal credentialing. •Continue to attend various ROATS and align with their guidelines.	•LRE facility level credentialing process •Align with various ROATs (Finance ROAT, Compliance, UM) •LRE audit process, site review process	
Per LRE Site Review Audit, CMHs are supposed to conduct Health Screenings which will be added to the FY24 Contract with PIHP and MDHHS. CMHSPs will align with this requirement.		Ongoing	•Will review contracts and make a plan on implementation with leadership.	• Currently health screenings are not conducted on everyone but the CCBHC team will integrate health screenings beyond I/DD and Waiver services.D13	

Finance:

Name	Committee Chair	Status	Status Update 07/2023	Status Update 12/2022	Status Update 01/2022
Internal Staff duties	Amy Bodbyl-Mast	Ongoing	• Continue to determine needs for billing and reporting requirements for CCBHC. • Updating procedural documents. •Cross training for all staff on procedures.	*Amy's new initiatives •Evaluating standard procedures, updating for current staff •Completed split billing and claims functions into two different teams and have new supervisor. •Continue to determine what is needed to meet CCBHC billing requirements.	•Approval for new supervisor •Split billing and claims functions into two different teams •Determine what is needed to meet CCBHC billing requirements
Fee Reallocation/ EQI/SCA		Ongoing	•SCA is on schedule for 10/01/2023 requirements. •New chart of accounts was implemented in Munis on June 29th and was updated in Avatar. •Internal rates were updated on March 1st.	•New payroll was rolled out in January •Extension for SCA to 10/01/2023 •Chart of accounts reconstruction •Complete EQI in a timely manner as requested by the LRE. •Align and update internal rates based on EQI	•Rolling out new payroll system in January 2022 •Extension for SCA to 4/1/2022 oAsking for it to be extended to 10/01/2022 •Break out clinical charged time by direct supervision and administrative
Monthly Encounter Reports		Ongoing	•Monthly meeting with IT to review •Continue to address encounter corrections as needed.	•Continue to address errors, processes, and documentation. •Continue to monitor claims and encounter reporting reports reviews	•Continue to meet each month, and make adjustments as new data and information comes in from these meetings •Claims monitoring and encounter reporting reports reviews—threshold reports, OIG reports, etc.
CMH Purchasing Card		Ongoing	• Added four new P-Cards. •Continue to evaluate if we need more.	•Evaluate who should have one •Evaluating CMH guidelines for travel, reviewing new guidelines.	
Quarterly Audit on Billing		New	• Based on the CARF recommendation, implementing internal audits in FY 2024. First one will be done in January 2024.		

Access:

Name	Committee Chair	Status	Status Update 07/2023	Status Update 01/2023	Status Update 12/2021
Community Navigator Program—CCBHC Integration	Cal Taylor	Ongoing	•Fully operational •Fully staffed since January •Clarifying the CCBHC Demonstration Site requirements and how they apply to the navigator service activities. •Update navigator service data collection to show compliance with the Demonstration project.	•Going well •Staffing issues. Just refilled Navigator position. Crisis implementation for staffing and follow-up. •Integrated navigator and aide position to help answer phones •Need to further develop procedures for coordination. Upgrade training for aide for crisis follow-up. •Improve activity tracking in way that it's not so burdensome.	•Continuing to work on CCBHC grant requirements for the Community Navigator Program oAdding 2 new FT positions to team oUpdating program description oPart of responsibilities will include more urgent care/Crisis follow up services •Expanding Community Navigator program to accommodate for CCBHC support •Program will require staff to complete more phone screens; need to reallocate more staff time to these screens oEvaluating how to include Navigator time to accomplish this
Upgrade the referral resource platform		Ongoing	•Work in progress •Working with IT to create a report. As soon as this is completed, will start to implement. •Still going to use Avatar as the platform.	•Use Avatar as a platform for Access referral •Staff have added capability to UAT. Cal will be testing it.	
Improving Access Center Data Collection		New	•Want to focus on phone data, working with IT to create a more accurate report. •This would include all of Access Center's activities: Phone screening, eligibility assessment, and navigator activity.		

Appendix I: Operational Guideline: Practice Guidelines

(Double-click the image below to view full document)

COMMUNITY MENTAL HEALTH OF OTTAWA COUNTY
OPERATIONAL GUIDELINE

ADMINISTRATION	**CHAPTER: 1**	**SECTION: 3**
TITLE:	Practice Guidelines	
ISSUED BY:	Jane Longstreet, LMSW, CAADC; Ann Heerde, LMSW; Katie Clausing, MA	
EFFECTIVE DATE: May 31, 2011	**REVISED DATE: March 10, 2015**	

I. PURPOSE: To ensure consistent development, implementation, continuous monitoring, and evaluation of practice guidelines for Community Mental Health of Ottawa County (CMHOC)

II. APPLICATION: All CMHOC programs

III. DEFINITIONS: "Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances." (Institute of Medicine, 1990). They define the role of specific diagnostic and treatment modalities in the diagnosis and treatment of consumers.

IV. PROCEDURE:

A. CMHOC Program Supervisors will regularly identify, develop, implement, and review practice guidelines for their respective programs. As a guiding principle, validated practice guidelines will be utilized whenever possible.

B. CMHOC's Clinical Leadership will review practice guidelines, evidence-based practices, and potential clinical tools on a regular basis.

C. CMHOC's Access Center Manual will be updated as required, using evidence and best practices.

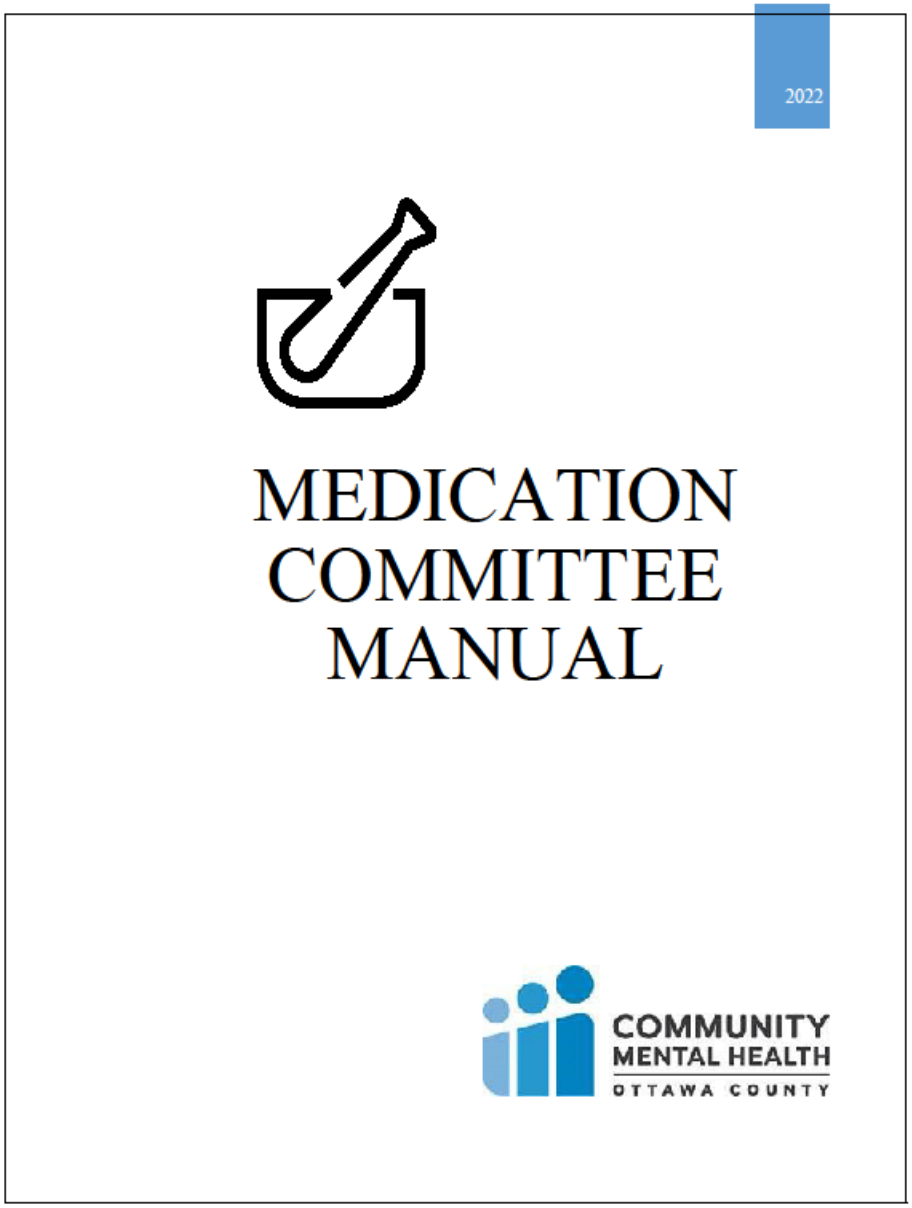
D. CMHOC Program Supervisors will provide periodic reports to the Leadership Group regarding identification, adoption, implementation, and monitoring of practice guidelines. Any recommendation for change in practice guidelines, standardized clinical tools, evidence based practices, or access criteria is presented to the Leadership Group for review and approval. Leadership has opportunity to review impact to each department. The Executive Director will approve all changes to any of the above systems or practices.

Appendix J: Behavior Treatment Review Committee Manual

(Double-click the image below to view full document)

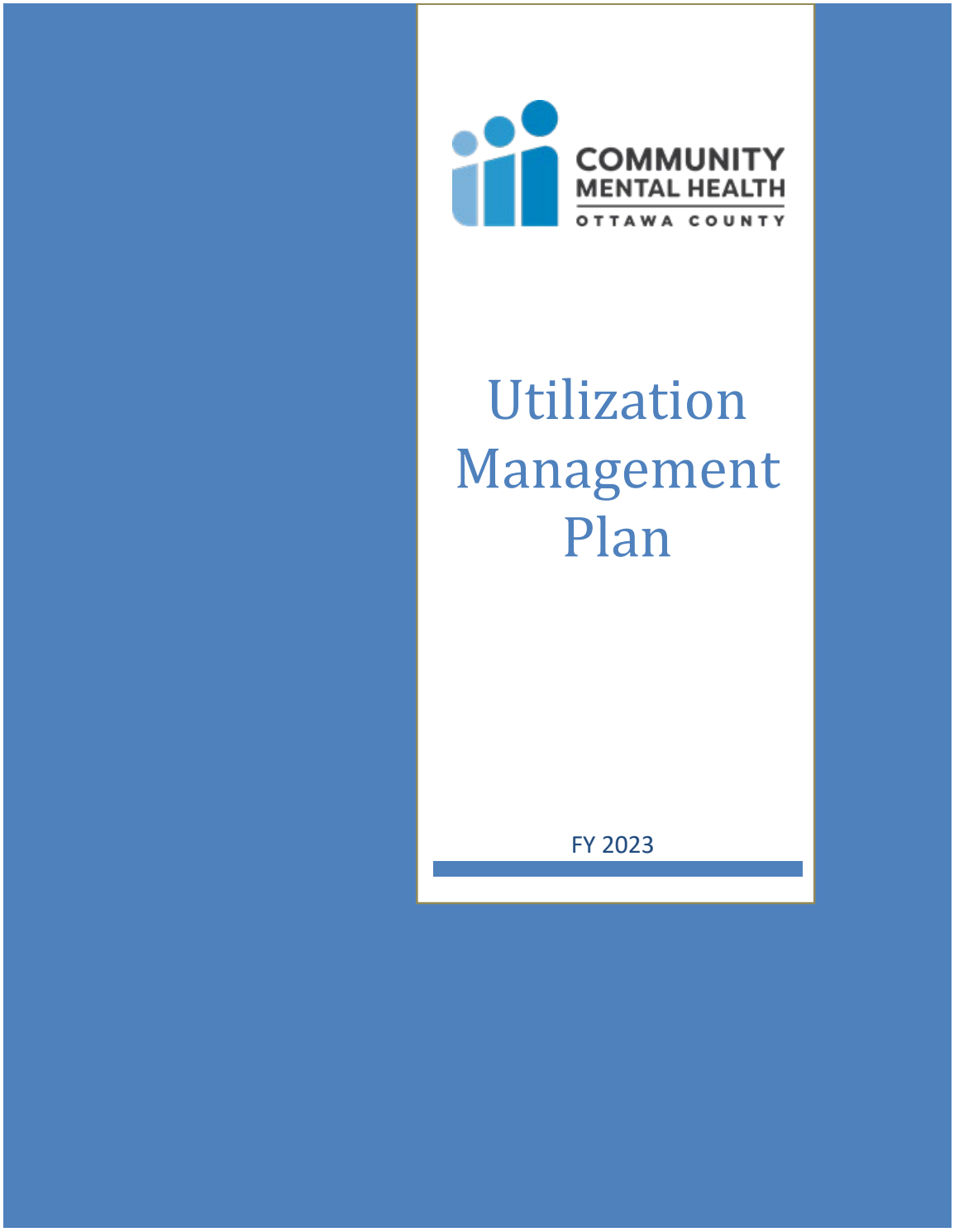
Appendix K: Medication Manual

(Double-click the image below to view full document)



Appendix L: Utilization Management Plan

(Double-click the image below to view full document)



Appendix M: Risk Management Plan

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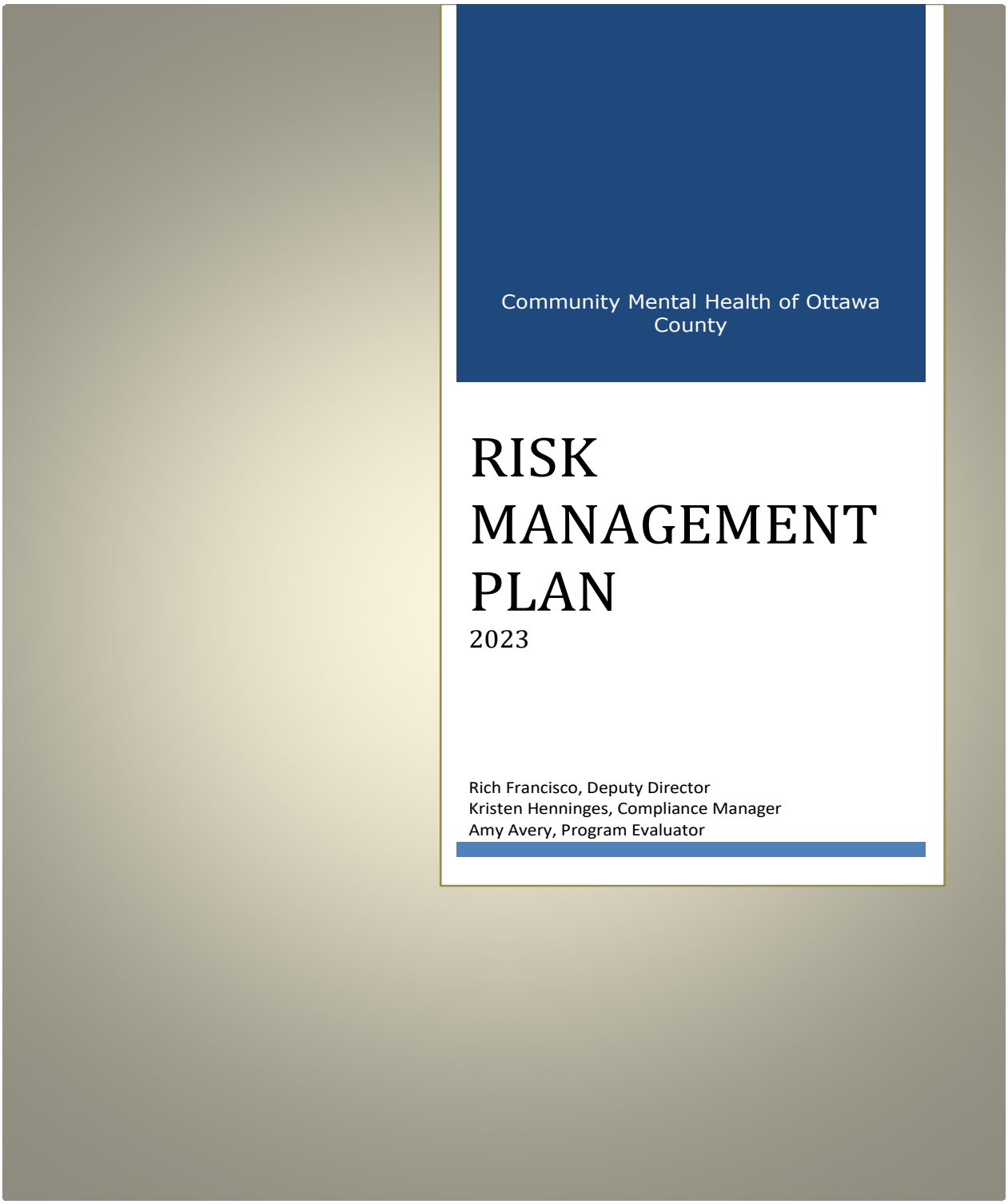

Appendix N: Corporate Compliance Plan

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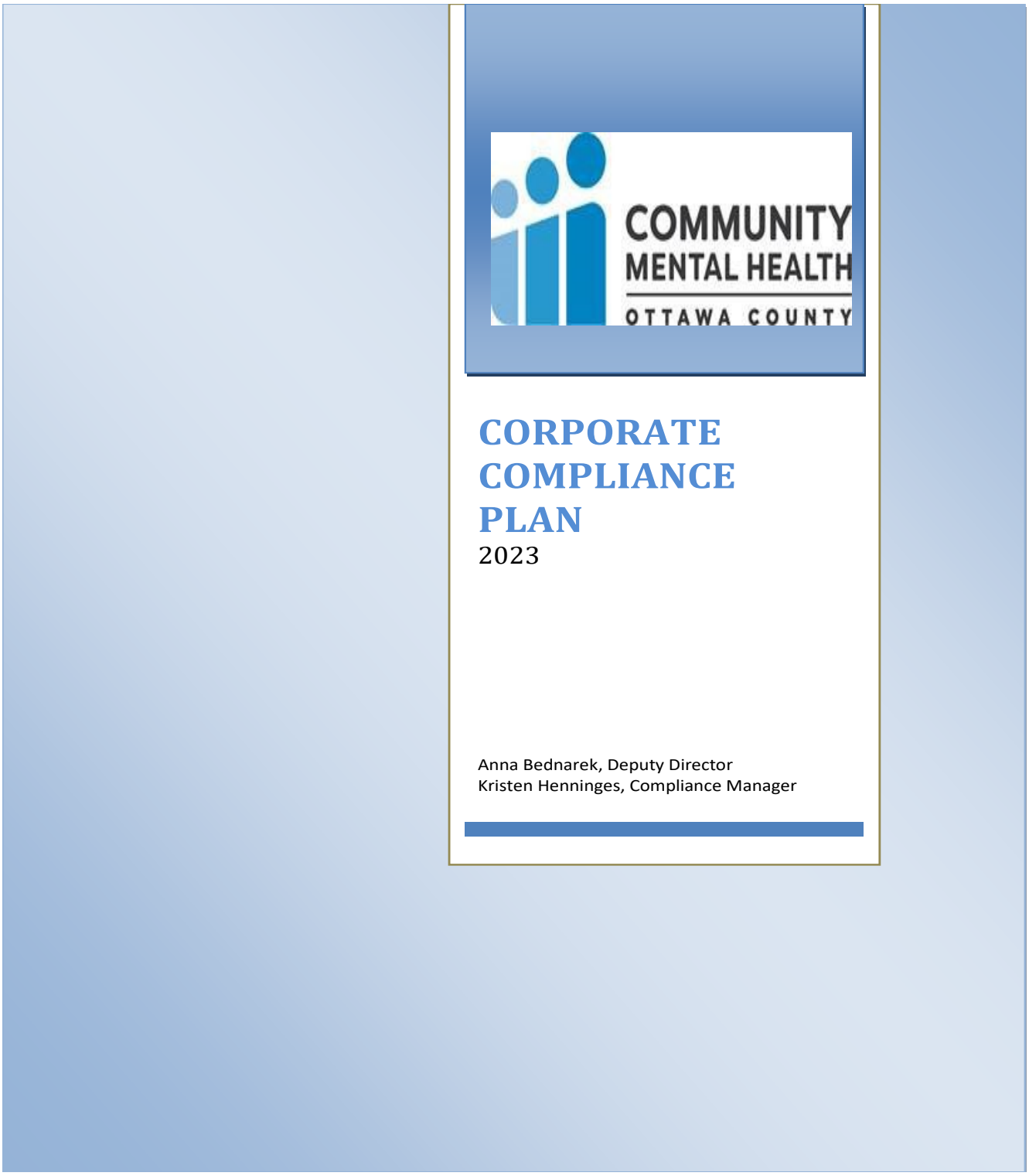

Appendix O: Health and Safety Plan

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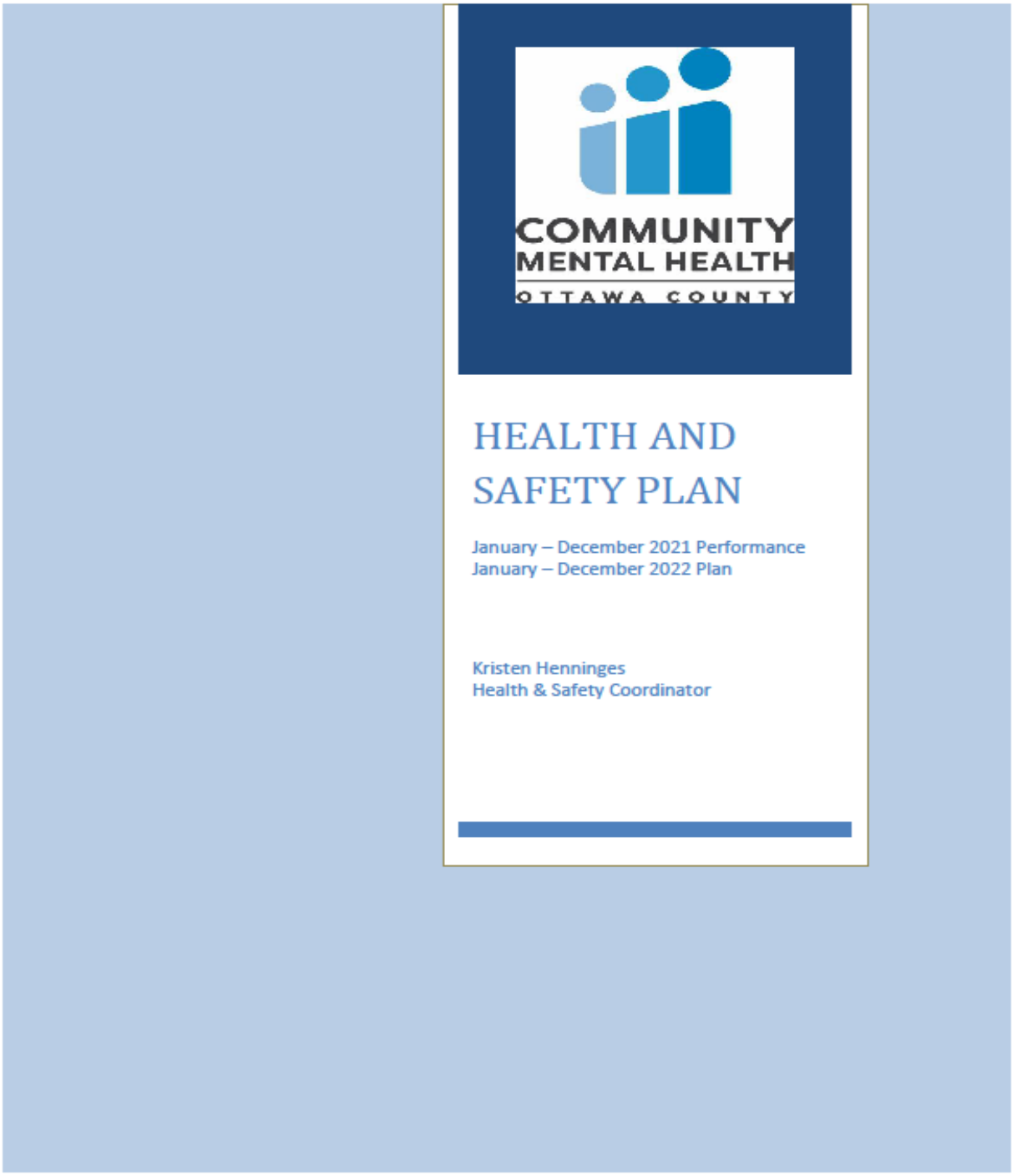

Appendix P: Technology Plan

(Double-click the image below to view full document)

CMHOC IT TECHNOLOGY PLAN

This document presents the IT Strategic Plan for CMHOC for the next 3 years (2021-2023).

Appendix Q: Staff Development and Training Plan

(Double-click the image below to view full document)


COMMUNITY
MENTAL HEALTH
OTTAWA COUNTY
2023 Staff
Training Plan
Kelly Goetzinger, Human Resources Committtee

Appendix R: Accessibility Plan

(Double-click the image below to view full document)

Appendix S: Cultural Competency Plan

(Double-click the image below to view full document)

COMMUNITY MENTAL HEALTH

Cultural Competency Plan

2023

Amy Avery, Program Evaluator & Bill Phelps , Program Coordinator—Contractual and Training Services

Appendix T: Network Adequacy Report
(Double-click the image below to view full document)

Provider Network Adequacy Report

September 2022

Approved by LRE Board of Directors: October 20, 2022