FY 2024

NorthCare Network

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN (QAPIP)

Quality Management Department
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Introduction

NorthCare Network is a regional entity under Section 1204(b) of the Michigan Mental Health Code and is governed by a board of directors with representation from the five-member Community Mental Health Authorities. NorthCare Network holds a Standard Contract with the Michigan Department of Health and Human Services (MDHHS) for the Medicaid Managed Specialty Supports and Services 1115 Demonstration Waiver, 1915 (c)/(i) Waiver Programs, the Healthy Michigan Program, the Flint 1115 Waiver and SUD Community Grant Programs and the MI Health Link Demonstration Program. NorthCare Network is also a contractor for the Upper Peninsula Health Plan L.L.C, identified by MDHHS as the Integrated Care Organization (ICO), for the provision of Covered Services to Enrollees in the MI Health Link Program.

NorthCare Network is the prepaid inpatient health plan (PIHP) for the five community mental health agencies serving the Upper Peninsula. The five consist of Copper Country Community Mental Health, Gogebic County Community Mental Health, Hiawatha Behavioral Health, Northpointe Behavioral Health System, and Pathways Community Mental Health. The counties in which each serve are detailed below.

- Copper Country: Baraga, Houghton, Keweenaw, Ontonagon
- Gogebic: Gogebic
- Hiawatha: Chippewa, Mackinac, Schoolcraft
- Northpointe: Dickinson, Iron, Menominee
- Pathways: Alger, Delta, Luce, Marquette

This document outlines requirements for the annual QAPIP (Quality Assessment and Performance Improvement Program) as set forth in the PIHP/MDHHS Medicaid Managed Specialty Supports and Services Program Contract Attachment. It also describes how these functions are accomplished and the organizational structure and responsibilities relative to these functions.

This QAPIP aids in supporting NorthCare's mission, which is "NorthCare Network ensures that every eligible recipient receives quality specialty mental health and substance use disorder services and supports through the responsible management of regional resources." This mission guides the activities of NorthCare Network. It supports our vision to ensure a full range of accessible, efficient, effective, and integrated quality behavioral health services and community-based supports for residents of Michigan's Upper Peninsula.

We achieve this by staying true to our values.

- We believe in respect, consumer empowerment, person centered care, self-determination, full community participation, recovery, and a culture of gentleness.
- We endorse effective, efficient community-based systems of care based on the ready availability of a competent workforce and evidence-based practices.
- We believe in services that are accessible, accountable, value based, and trauma informed.
- We support full compliance with state, federal and contract requirements, and responsible stewardship.
- The right care, and the right time, for the right cost, and with the right outcome.

Purpose

The QAPIP is intended to outline requirements and provide guidance for carrying out several functions, including but not limited to:

- Outlining the quality improvement structure for the managed care activities of the NorthCare Network.

- Evaluating and updating, as appropriate, NorthCare Network's QI processes and outcomes.
- Monitoring and evaluating the systems and processes related to the quality of clinical care and non-clinical services that can be expected to affect the health status, quality of life, and satisfaction of persons served by Network Providers.
- Identifying and assigning priority to opportunities for performance improvement.
- Creating a culture that encourages stakeholder input and participation in improvement initiatives and problem solving.
- Stressing the value of employees; cooperation between employees; team building; and a partner relationship between the PIHP, Member CMHSPs, Network Providers, advocacy groups and other human service agencies within a continuous quality improvement environment.
- Promoting the basic quality management principle of prevention over remediation. It is less expensive in the long run to build quality into an organization's services than it is to expend additional resources on rework and dissatisfied customers.
- Providing guidance for the PIHP Performance Improvement Projects.
- Ensuring verification that services reimbursed by Medicaid were provided to enrollees by Network Providers according to the plan of service and adequately documented.
- Working with the Regional Clinical Practices/Quality Improvement Committee to assure implementation of evidence-based practices throughout the region.
- Meeting standards specified in the NorthCare Network Medicaid Managed Specialty Supports and Services Contract and QAPIP attachment, the ICO/PIHP Contract for the MI Health Link Project, quality assurance provisions of the Balanced Budget Act of 1997, as amended, Medicaid Managed Care Rules, and Accreditation Standards, as applicable.

We do this to achieve the following desired outcomes:

- Meet, or exceed, state performance metrics as well as improving performance for identified projects.
- Improved data analysis of critical incidents to reduce adverse effects on consumers and behavior treatment committee data to reduce the need for physical intervention.
- Ensure satisfaction of services and HCBS rules and quality clinical practice guidelines that are accessible to consumers and staff.
- Verify staff are qualified to complete their duties and there is network adequacy to provide necessary services.
- Ensure services meet Medicaid standards. Ensure appeal and grievance information is provided to members.
- Increase consistency in Utilization Management decisions across the region and assess the appropriateness of individuals' level of care and the services they are providing.

Quality Improvement Authority and Structure

The QAPIP is reviewed and approved on an annual basis by the NorthCare Network Governing Board. Through this process, the governing body gives authority for the implementation of this plan and all components.

NorthCare Network's Chief Executive Officer provides day-to-day guidance and authority to the Quality Improvement Coordinator who is responsible for implementation of the QAPIP. The Performance Management Committee and Governing Board also receive routine reports on the progress of the QAPIP including performance indicators, quality improvement projects, progress and actions taken, and the results of those actions. The committee structure is designed to encourage contributions from a variety of sources, facilitate accountability, and ensure follow through on improvement efforts. NorthCare Network's Medical Director is involved in QI, UM, and credentialing activities and is available for

consultation to any of the regional committees as requested, including review and consultation regarding sentinel and critical events.

The Customer Services Committee and NorthCare Network's Governing Board provide significant opportunity for involvement by primary and secondary consumers. Additionally, focus groups and surveys may be utilized to elicit consumer feedback.

Accountability and Responsibility

NorthCare Network Governing Board

- *Membership:* NorthCare Network's 15-member Governing Board includes three representatives from each of the five Member CMHSP Boards of Directors.
- *Role/Function:* The NorthCare Network Governing Board retains the ultimate responsibility for review and approval of the QAPIP, policy approval and governance. Functions include, but are not limited to:
- *Oversight of the QAPIP:* This includes documented evidence that the Board has approved the overall QAPIP and QI Plan. The Board's role is to monitor, evaluate and establish policy that supports improvements to care.
- *QAPIP Progress Reports:* The NorthCare Network Governing Board routinely receives written reports from the Chief Executive Officer describing performance improvement initiatives undertaken, the actions taken, and the results of those actions.
- *Annual QAPIP Review:* The NorthCare Network Governing Board formally reviews a written report on the operation of the QAPIP, at least annually.
- *Reporting Accountability:* The NorthCare Network Governing Board reports to stakeholders via committee and Board meeting minutes. The Governing Body submits a written annual report to MDHHS following its review, due February 28th, which includes a list of members.
- *Reporting Frequency:* Quarterly

Designated Senior Official

NorthCare's Quality Improvement Coordinator is responsible for coordinating activities related to the design, implementation, management and evaluation of the quality improvement and compliance programs. Quality management works collaboratively with many different functional areas. Although each position identified below is not directly assigned to the quality management function, they maintain an active role in quality related activities. The following grid provides a representation of what percentage of total time is spent by NorthCare staff on quality related activities. Much of NorthCare's quality management work is implemented through the various committees listed below.

Title	Department	Average percent per quarter devoted to QM
Senior Clinical Director	Clinical/Access	15%
SUD Clinical Director	Clinical/ SUD Access	15%
Clinical Floater/Social Worker	Clinical/Access	10%
Clinical Practices Coordinator	Clinical	15%
Customer Service Specialist	Customer Service	10%
Data Analyst	Information Management	5%
Population Health Specialist	Integrated Care/Population Health	20%
Medical Director (Part-time)	Clinical	75%
Provider Network Specialist	Network Management	10%
QI/UM Specialist	QI	50%
Systems Analyst	Information Management	25%
Compliance-Privacy Officer	Compliance	25%

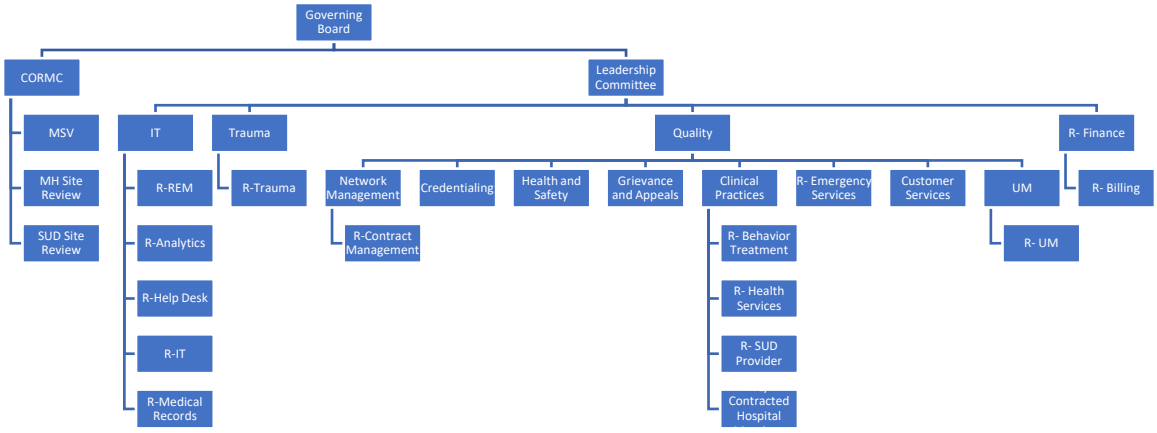
QAPIP Committee/Teams

NorthCare Network's QAPIP is implemented through various PIHP and regional committees/teams as listed below. All are ultimately accountable to NorthCare Governing Board and/or NorthCare Leadership. Regional committees are denoted with an "R" on the chart.

NorthCare Governing Board of Directors

A. NorthCare Compliance Oversight and Risk Management Committee (CORMC)
    1. NorthCare Medicaid Service Verification Team (MSV)
    2. NC Site Review Team (MH)
    3. NC Site Review Team (SUD)

B. NorthCare Leadership Committee
    1. NorthCare Information/Technology Management Committee
        a) Regional Elmer Management Committee (REM)
        b) Regional Analytics Committee
        c) Regional Help Desk Committee
        d) Regional Information Technology and Security Committee
        e) Regional Medical Records Committee
    2. NorthCare Trauma Informed Committee
        a) Regional Trauma Informed Committee
    3. NorthCare Quality Management Committee
        a) NorthCare Network Management Committee
            - Regional Contract Management Committee
        b) NorthCare Credentialing Committee
        d) NorthCare Health and Safety Review Committee
        e) Regional Grievance & Appeal Committee
        f) Regional Clinical Practices/QI Committee
            - Regional Behavioral Treatment Committee
            - Regional Health Services Committee
            - SUD Provider Clinical Meeting
            - NC/UPHS-Marquette QI Committee
            - NC/War Memorial QI Committee
            - NC/Willow Creek QI Committee
            - NC/Aspirus QI Committee
        g) Regional Emergency Services Committee
        h) NorthCare Utilization Management Committee
            - Regional Utilization Management Committee
        i) Regional Customer Services Committee
    4. Regional Finance Committee
        a) Regional Billing Committee



Each committee has an approved "Fact Sheet" which documents the committee charge, reporting requirement(s), membership, deliverables, and meeting frequency. Project specific or time specific workgroups are established as appropriate.

Additionally, each CMHSP has a quality improvement process to address quality issues within its operations. Each CMHSP also has a customer services meeting for increased consumer involvement and voice. Regional satisfaction results are shared and reviewed by NorthCare Network. NorthCare reviews the CMHSP websites and publications annually.

Substance Use Disorder (SUD) services are delivered through a network of contracted provider organizations. No managed care functions are delegated to SUD providers. To ensure representation, SUD providers are involved in the Regional SUD Provider Clinical Meetings and concerns are brought to leadership.

Quality Management System

NorthCare Network's Quality Management System combines the traditional aspects of quality assurance and adds the elements of continuous quality improvement. The Quality Management System helps NorthCare Network achieve its mission, realize its vision, and live its values. It protects against adverse events, and it provides mechanisms to bring about positive change while ensuring quality services. Continuous quality improvement efforts assure a proactive and systematic approach that promotes innovation, adaptability across the Network, and a passion for achieving best practices.

The *Quality Management System* includes:

- Predefined standards
- Formal and informal assessment activities
- Measurement of performance in comparison to standards
- Strategies to improve performance that is below standard

The various aspects of the system are not mutually exclusive. However, for descriptive purposes, the following table separates the components.

QUALITY MANAGEMENT SYSTEM			
Quality Standards	Assessment Activities	Performance Measurements	Improvement Strategies
▪ Federal & State Rules/Regulations ▪ Stakeholder Expectations ▪ MDHHS Contract ▪ Provider Contracts ▪ Practice Guidelines and Evidence Based Practices ▪ Network Standards ▪ Accreditation Standards ▪ Network Policies and Procedures ▪ Delegation Agreement ▪ Clinical Documentation Standards ▪ AFP/ARR	▪ Quality Monitoring Reviews ▪ Accreditation Surveys ▪ Credentialing ▪ Risk Assessment/ Management ▪ Utilization Reviews ▪ External Quality Reviews ▪ Stakeholder Input ▪ Sentinel Events ▪ Critical Incident Reports ▪ Documentation Reviews ▪ Medicaid Verification of Service Reviews ▪ Performance Improvement Projects ▪ Critical Event Reporting	▪ MDHHS MMBPIS ▪ Audit Reports ▪ External Quality Reviews (HSAG) ▪ MDHHS Site Reviews ▪ Outcome Reports ▪ Benchmarking ▪ Grievance & Appeals	▪ Corrective Action/Improvement Plans ▪ Improvement Projects ▪ Improvement Teams ▪ Strategic Planning ▪ Practice Guidelines ▪ Organizational Learning ▪ Administrative and Clinical Staff Training ▪ Cross Functional Work Teams ▪ Reducing Process Variation

Quality Standards

Quality Standards provide the specifications, practices, and principles by which a process may be judged or rated. NorthCare Network identifies and sets standards by reviewing, analyzing, and integrating such areas as:

- Performance expectations of network providers for both clinical services and administrative functions
- Government regulations/rules
- Practice Guidelines
- Accreditation and/or Network Standards
- External review findings
- Utilization Management and Authorizations

Quality Assessment Activities

Quality assessment consists of various strategically planned activities that help to identify the actual practices, attitudes, performance, and conformance to standards that are enhancing or inhibiting the achievement of quality. Obtaining stakeholder input is critical to quality assessment activities.

Stakeholder Input

NorthCare Network recognizes that a vital aspect of any continuous improvement system is a means to obtain stakeholder input and satisfaction information. Stakeholders identified to provide input to NorthCare Network may include individuals who are or have received services, staff, contract service providers, families/advocates, and the local communities, representing both internal and external customers.

Input is collected to better understand how NorthCare Network is performing from the perspective of its stakeholders. The input is continually analyzed and integrated into the practices of the PIHP, as feasible. NorthCare Network's Customer Services Committee and Governing Board both provide opportunity for stakeholder input. NorthCare Network encourages stakeholder participation on other committees as appropriate. Each Member CMHSP will ensure that there is adequate input from stakeholders for local

decision-making. Surveys are sent to staff periodically, as determined necessary, to identify training needs.

SUD providers are invited to provide input in the regional SUD clinical meeting. Grievance and appeals are also a valuable source of stakeholder input, as well as consumer satisfaction surveys and targeted surveys based on program (e.g., the BTC bi-annual survey).

The table below summarizes methods and sources for obtaining stakeholder input.

STAKEHOLDER INPUT METHODS AND SOURCES						
Type of Input	Consumer	Staff	Providers	Family/ Advocates	Community	MDHHS/EQRO
Interviews	MDHHS Site Reviews, Accreditation, NorthCare Network Site Reviews, Satisfaction Surveys, PCP process	Performance Evaluations, Termination/Exit Interviews	ORR Site Visit, Contract Provider Quality Review	MDHHS Site Reviews Fidelity Reviews of Evidence Based Practices	Open Door Policy of the NorthCare Network CEO	MDHHS Site Reviews, External Quality Review Organization (EQRO)– under contract w/MDHHS, Accreditation
Suggestions	Ongoing opportunity through PCP process	Supervision, Suggestion for Improvement process	Quality reviews	Ongoing opportunity through PCP process per consumer choice	Focus Groups or Public Forums	MDHHS, EQRO, Accreditation
Forums	Consumer advisory committees, Board meetings	Team/Dept Meetings, All staff meetings	MDHHS Review, Contract negotiations, meetings	MDHHS Review, Advisory committees	MDHHS /EQR/ Accreditation Reviews, Annual PRR forum, Public comments at Board meetings	MDHHS, EQRO, Accreditation
Surveys	Consumer surveys Health Plan Survey per Accreditation	Staff surveys	Provider surveys, Accreditation surveys	Satisfaction surveys	Stakeholder Surveys	MDHHS, EQRO, Accreditation
Assessment of experience with services/ organization	Ongoing through PCP process, progress notes, d/c summary, Various regional committee membership	Performance evaluations	Quality review of provider, AFC licensing reports	Regional committee membership	Community Needs Assessment	MDHHS, EQRO, Accreditation
Grievance & Appeals	Recipient Rights, Grievance & Appeals Process	Staff Grievance	Provider Grievance	Grievance systems	Comments via NorthCare Network Website	MDHHS, EQRO, Accreditation

Complaints	RR Complaint, Complaints discussed w/customer services, Compliance complaint process	Employee complaint, Compliance complaint process	RR Complaint, Compliance complaint process	RR Complaint, Compliance complaint process, Customer Service compliant process	RR Complaint, Compliance complaint process	MDHHS, EQRO, Accreditation

Ongoing Assessments of Consumer Experiences with Services and the PIHP

NorthCare Network conducts ongoing quantitative (e.g., surveys) and qualitative (e.g., focus groups, interviews) assessments of member experiences with its services. These assessments must be representative of the individuals served, including individuals receiving long-term supports or services, and the services and supports offered. Members of services are encouraged to complete the satisfaction survey. Surveys are mailed to a sample of individuals monthly, but the survey is always available online at https://forms.office.com/r/FAbuLXDuFh. To increase consumer input, CMHSPs have provided this survey link on appointment reminder cards, posted it in waiting room lobbies, and it has been advertised in the annual consumer newsletter. Survey results are shared in the annual newsletter and other reports as necessary.

A survey is completed annually to assess member experience with the Access and Intake process. This survey is competed on a sample of individuals who were approved for services as well as those who weren't.

Assessment results will be used to improve services, processes, communication, etc. Processes found to be effective and positive will be continued, while those with questionable efficacy or low consumer satisfaction will be revised by:

- Taking specific action on individual cases as appropriate.
- Identifying and investigating sources of dissatisfaction.
- Outlining systemic action steps to follow-up on the findings.
- Informing practitioners, providers, recipients of service, and the NorthCare Network Governing Board of assessment results.

Just as the original processes must be evaluated, the interventions used to increase quality, availability, satisfaction, and accessibility to care and services must also be assessed. Therefore, all actions taken as a result of assessments will be evaluated periodically. Quality improvement is never static, and it is an expectation that all evaluation efforts will be examined on an ongoing basis.

Provider Network Monitoring

NorthCare Network conducts annual site reviews of organizational providers with whom we directly contract to ensure compliance with delegated functions as well as regional, state, and federal mandates. NorthCare Network delegates and monitors annual review of Member CMHSP sub-contractors.

NorthCare Network's process is a systematic and comprehensive approach to monitor, benchmark, and make improvements in the provision of mental health and substance use services. NorthCare Network conducts annual (at minimum) site reviews to evaluate:

- Compliance with regional, state, federal and accreditation standards through annual site visits
- Compliance with delegated functions
- Clinical documentation reviews
- Verification of Medicaid services

- Clinical Implementation of effective treatments

The Provider Network Monitoring process provides NorthCare Network the ability to:

- Establish clinical and non-clinical priority areas for improvement
- Use a number of measures to analyze the delivery of services and quality of care
- Establish performance goals and compares findings and ratings with past performance
- Provides performance feedback through written report
- Requires an improvement/corrective action plan from providers in areas not achieving targets or in non-compliance with accepted standards
- Ensures implementation of the improvement plan by providers

Utilization Management and Authorizations

NorthCare Network implements a Utilization Management Plan within the provisions of its Standard Contract with Michigan Department of Health and Human Services (MDHHS). NorthCare Network has oversight authority and performs utilization management functions sufficient to control costs and minimize risk while assuring quality care. The UM Plan establishes a framework for oversight and guidance of the Medicaid and MHL Programs by assuring consistent application of program/service eligibility criteria, and in decisions involving the processing of requests for initial and continued authorization of services.

Utilization Management is committed to not only reviewing practices related to resource utilization, but also to taking action to modify inappropriate, inefficient or ineffective utilization. Many of the NorthCare Network Utilization Management functions overlap or are reliant on coordination with Quality Assessment & Performance Improvement, Provider Relations, Regional Quality Improvement and Clinical Practices Committee, Claims/Reimbursement, Management of Information Services and other managed care functions. Successful interface among the various functions of the PIHP is essential for effective and efficient management of resources, identification of gaps in service delivery and resolution of over- and under-utilization of services and resources. Interface between Utilization Management and other PIHP functions occurs through exchange of data, information and reports, joint participation in a variety of committees and collaboration in planning, projects, and operational initiatives.

Compensation to individuals or entities that conduct utilization management activities cannot be structured to provide incentives to the individual or entity to deny, limit, or discontinue medically necessary services to any recipient.

Some UM activities overlap with other areas and may be led by various committees but be pertinent to UM, such as recidivism for inpatient psychiatric admissions. UM areas of focus include over and under utilization, appropriate level of care, eligibility criteria, and medical necessity for specific services.

Credentialing and Qualification for Scope of Practice

The NorthCare Network Credentialing Committee is responsible to apply legal, professional and ethical scrutiny to applicants seeking to be credentialed as a provider in the network and to approve the re-credentialing of existing providers. NorthCare Network retains final authority for the credentialing of individual and organizational providers as a member of the provider panel employed or under contract. The qualifications of physicians and other licensed behavioral healthcare practitioners/professionals employed by or under contract to the PIHP are reviewed according to the NorthCare Network Credentialing and Privileging Policies to ensure they are qualified to perform their services. Continuous monitoring of the credentialing program occurs across the network to ensure compliance and identify quality or network issues. Organizations are responsible for ensuring that individual practitioners/providers, employed or under contract, and organizational providers meet all applicable

licensing, scope of practice, contractual, and payor requirements. The oversight and monitoring of the credentialing of sub-contract provider staff is delegated to direct contractors.

NorthCare Network requires professional staff in the network to have a documented review and approval of their clinical privileges as needed to assure services provided to the network members are delivered by qualified and competent staff. Minimally, this is done as part of the initial credentialing/re-credentialing process and when duties/responsibilities change in terms of primary eligibility group a person is working with and/or scope of work. MI Health Link (MHL) Community Providers are privileged per the MHL Standard Operating Procedures as codes are identified by professional discipline.

NorthCare Network and network providers shall train new personnel regarding their responsibilities, program policy, and operating procedures and identify staff training needs and provide in-service training, continuing education and staff development activities according to NorthCare Network's Training – Personnel Policy and the Training-Network Provider Policy.

Oversight of Vulnerable Individuals

NorthCare Network utilizes the appropriate clinical staff and various reporting mechanisms and data sets to identify vulnerable individuals and events that put them at risk of harm, including required health measures and health assessments. Such events and data, that are not a product of a protected peer review process, will be used to determine opportunities for improving care and outcomes and reported to the Compliance Oversight and Risk Management Committee as appropriate. However, if an issue that places an individual at imminent risk to health or welfare is identified, NorthCare will take immediate action to ensure their safety. NorthCare will invoke an immediate review and require a response by the Provider, within seven (7) calendar days.

We also complete metabolic monitoring for individuals receiving services with the CMHSPs. NorthCare Network works with designated representatives from each CMHSP to implement practices for the monitoring, prevention, and treatment of metabolic syndrome. In FY2023, NorthCare will implement system updates to ELMER to capture hip circumference and measure that against waist circumference. This will enable early monitoring and intervention with diet/exercise to address the metabolic impacts of psychotropic medications.

Behavior Treatment Review

NorthCare Network's Clinical Practices Improvement Coordinator will review analyses of data from Member CMHSP behavior treatment review committee(s) on a quarterly basis where intrusive or restrictive techniques have been approved for the use with beneficiaries and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis. Patterns and trends will be evaluated for possible system and/or process improvement initiatives and will be reported to NorthCare Network's Quality Management and Oversight Committee. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plan Review Committees and that have been approved during person-centered planning by the beneficiary or his/her guardian may be used with beneficiaries. Data includes numbers of interventions and length of time the interventions were used with the individual.

Event Reporting and Notification

Each Network Provider will record, assess, and report critical incidents according to NorthCare Network policy. They will analyze at least quarterly the cumulative critical incidents, sentinel events, and risk events to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents and report the outcome of this analysis to NorthCare Network. NorthCare Network's Health and Safety Review Team will analyze aggregate data to identify any trends or patterns and may follow-up on individual events as warranted. The Health and Safety Review Team will report aggregate high-risk areas and concerns to NorthCare Network's

Compliance Oversight and Risk Management Committee as appropriate. Member CMHSPs utilize NorthCare Network's Incident Report Module to report all events defined below. Specialty residential providers will report incidents to the CMHSP, either via electronic or paper process. Other Network Providers, including residential SUD treatment providers, may continue to report on paper. Incidents will be reviewed during the NorthCare Health and Safety meeting. Analysis and trend lines will be reviewed frequently.

- Critical Events: Critical Event Reporting will be uploaded, monthly at minimum, to MDHHS's PIHP Event Reporting Data Warehouse by PCE (NorthCare Network's software vendor) automatically. This automatic reporting will move from the Event Reporting Data Warehouse to the MDHHS CRM as of 10/1/22. This Critical Incident Reporting System captures information on five specific reportable events based on varying populations as mandated by MDHHS. Detailed requirements can be found in NorthCare Network's Incident, Event & Death Reporting & Monitoring Policy and the PIHP/ MDHHS Reporting Requirements Policy.
- Event Notification: The PIHP is also required to immediately notify MDHHS of specific events as outlined in the MDHHS Reporting Requirement Policy and NorthCare Incident, Event & Death Reporting & Monitoring Policy.
- Sentinel Events, as defined in the MDHHS Reporting Requirement Policy must be reviewed and acted upon as appropriate and in accordance with NorthCare Network's Incident, Event & Death Reporting & Monitoring Policy.
- Risk Events are additional events that put individuals at risk of harm, including at minimum: actions taken by individuals that cause harm to themselves or others; two or more unscheduled admissions to a hospital within a 12-month period; emergency use of physical management by staff in response to a behavioral crisis, and police calls by staff under certain circumstances. For detailed information refer to PIHP/ MDHHS QAPIP Guideline. NorthCare Network's Health and Safety Review Team and CMHSP staff review trends and follow up as indicated.
- All unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed. Unexpected deaths include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect. Unexpected deaths are marked as either critical, sentinel, or both. Specifics for reporting are included in NorthCare's Incident, Event & Death Reporting & Monitoring Policy.

Critical Incidents are automatically uploaded into the CRM as of 10.1.22. Immediately reportable events and SUD sentinel events are manually uploaded into the CRM within the specified timeframes identified in the MDHHS guidelines. Remediation details for events, as necessary, are also submitted via the CRM.

LTSS (Long Term Supports and Services)

The following services are noted as LTSS services per the 1115 Pathway to Integration Waiver:

- Respite,
- CLS (Community Living Supports),
- PDN (Private Duty Nursing),
- Supported/Integrated Employment,
- Out of Home Non-Vocational Habilitation,
- Good and Services,
- Environmental Modifications,
- Supports Coordination,
- Enhanced Pharmacy,
- PERS (Personal Emergency Response System),
- Community Transition Services,
- Enhanced Medical Equipment and Supplies,

- Family Training, Specialty Therapies (Music, Art, Message),
- Children Therapeutic Foster Care,
- Therapeutic Overnight Camping,
- Transitional Services,
- Fiscal Intermediary Services, and
- Prevocational Services.

The PIHP must have mechanisms in place to assess the quality and appropriateness of care furnished to beneficiaries using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment/service plan. Mechanisms are in place to comprehensively assess each Medicaid beneficiary identified as needing LTSS to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the State or the Contractor as appropriate. This is achieved by, but not limited to review, analysis, and monitoring of person-centered planning, IPOS reviews/amendments, and standardized assessment scores that support level of care such as the Level of Care Utilization System (LOCUS). For individuals on a waiver, or attempting to be on a waiver, there is additional paperwork and approval process for waiver covered services identified above. The new iSPA waiver also has additional process and scrutiny for identification of individuals receiving the services that are considered LTSS and qualifying for iSPA.

External Quality Reviews

1) MDHHS *Site Reviews*
   Follow up activities for site reviews conducted by MDHHS are carried out and/or monitored by NorthCare Network's Network Management and/or Quality Management and Oversight Committees. To best address local concerns, each Member CMHSP may be asked to draft a remedial action plan for all citations for which the Member CMHSP has been identified as being out of compliance. NorthCare Network will consider each response for inclusion in the Plan of Correction submitted to MDHHS. NorthCare Network also provides consultation for Member CMHSPs and monitors the implementation of improvement activities.

2) *External Quality Review Organization*
   The Michigan Department of Health and Human Services (MDHHS) will arrange for an annual, external independent review of the quality and outcomes, timeliness of, and access to covered services provided by the PIHP. The External Quality Review (EQR) includes an on-site review of the implementation of the QAPIP. The EQR also validates methodologies used in conducting the required performance improvement projects (PIP) as well as validates performance measure data collection and reporting to MDHHS. The PIHP addresses the findings of the external review through its QAPIP. The PIHP develops and implements performance improvement goals, objectives and activities in response to the external review findings as part of this QAPIP. A description of the performance improvement goals, objectives and activities developed and implemented in response to the external review findings will be included in the PIHP's Quality Improvement Plan and provided to the MDHHS upon request. The MDHHS may also require separate submission of an improvement plan specific to the findings of the external review.

3) *Accreditation*
   NorthCare Network's URAC accreditation will expire on March 1, 2023. Policy and processes established to ensure compliance with accreditation standards will continue. NorthCare's commitment to quality services will continue to provide the framework to improve business processes through benchmarking against nationally recognized standards.

Performance Measurement

NorthCare Network measures its performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data. Through monitoring and evaluation, the efforts and resources of the Network can be redirected to obtain the desired outcomes.

By using performance indicators, the variation between the target desired and the performance being measured can be identified. Indicators are used to alert NorthCare Network and the Network Providers of issues that need to be addressed immediately, to monitor trends and contractual compliance, and to provide information to consumers and the public. Performance indicators are the foundation to control and improve processes.

Performance indicator results are used to guide management decision-making related to:

- Strategic planning
- Resource allocation
- Modification of service delivery
- Administrative process changes
- Staff training, credentialing and privileging
- Other activities identified by our various stakeholders

Performance Indicators [Measures]

NorthCare Network's Quality Oversight Committee monitors performance indicators for individual Member CMHSPs and collectively for the region. The QAPIP is utilized to assure that at least the minimum performance level on each indicator is achieved. A plan of correction that includes a review of possible causes for outliers is required from any Member CMHSP for each Performance Indicator out of compliance for two consecutive quarters. NorthCare Network's Quality Oversight Committee and/or Quality Improvement Coordinator will monitor any plans of correction. Performance data is reviewed and discussed with the various QAPIP committees.

- Michigan Mission Based Performance Indicator System (MMBPIS)
  NorthCare Network utilizes performance measure established by the MDHHS that address areas of access, efficiency, and outcomes and report to the State as established in the contract. NorthCare Network and Member CMHSP staff will ensure the reliability and validity of the data on these indicators across the Network and that these conform to the "Validation of the Performance Measures" of the BBA protocols. The Quality Oversight Committee will review MMBPIS results. Member CMHSPs and SUD Providers who are out of compliance with MDHHS and/or NorthCare standards will work with NorthCare Network QI Coordinator and the Quality Oversight Committee to ensure the implementation of effective improvement plans.
- Regional Measures
  NorthCare Network may establish and monitor additional performance indicators specific to an individual program for the purpose of identifying process improvement projects. Performance indicators employed should be objective, measurable, and based on *current* knowledge and experience to monitor and evaluate key aspects of care and service. Performance goals and/or a benchmarking process are utilized for the development of each indicator.
- NorthCare Network will ensure compliance with and sustainability to meet performance measures as outlined in the contract between the State of Michigan - Michigan Department of Health and Human Services with NorthCare Network and the Quality Assessment and Performance Improvement Programs for Specialty Prepaid Inpatient Health Plans.
- NorthCare Network will participate and collaborate with the ICO/Medicaid Health Plan (MHP) in regular and ongoing initiatives that address methods of improved clinical management of chronic health conditions and methods for achieving improved health outcomes for Members enrolled in any Medicaid program with the ICO/MHP.

Outcomes Management

NorthCare Network's Clinical Practices Quality Committee will establish outcome measures and conduct quality improvement efforts to assure effective clinical practices based on a recovery and trauma informed system of care.

Practice Guidelines

NorthCare Network's Clinical Practices Coordinator is charged with the task of overseeing the adoption, development, implementation and continuous monitoring and evaluation of Practice Guidelines when there are nationally accepted, or mutually agreed upon (by MDHHS and the PIHPs) clinical standards, evidence-based practices, practice-based evidence, best practices, and promising practices that are relevant to the individuals served. Working with the regional Clinical Practices/Quality Improvement Committee, NorthCare's Quality Management and Oversight Committee, and the regional UM Committee newly implemented treatment practices required by MDHHS are monitored and measured for effectiveness for all populations. The NorthCare Network Practices Guideline Manual provides information regarding the process for the adoption, development, implementation, monitoring, and evaluation of the guidelines. This manual can be found at NorthCare Network Clinical Practices Guideline Manual

NorthCare must disseminate all practice guidelines it uses to all affected providers and, upon request, to beneficiaries. Beneficiaries are informed of the guidelines annually in the newsletter. CMHSP staff attest to having access to the guidelines annually. SUD provider staff attest to having access to the guidelines and, more importantly, the SUD operations manual- which is an SUD focused guide. NorthCare must ensure decisions for utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. NorthCare must ensure services are planned and delivered in a manner that reflects the values and expectations contained in practice guidelines adopted.

Additionally, for emergency services, NorthCare Network member CMHSPs use the MCG Indicia tool embedded into the regional preadmission screening form to assist in determining medical necessity for inpatient psychiatric admission.

To ensure fidelity to practice, NorthCare and the affiliate CMHSPs will participate in Michigan Fidelity Assistance Support Team (MiFAST) reviews, as required by MDHHS. MIFAST is required prior to implementation or use of specific Medicaid codes or modifiers and is available ongoing.

Verification of the Delivery of Medicaid Services

Verification of Medicaid services is conducted in accordance with NorthCare Network's Medicaid Service Verification Policy. This process is to ensure Medicaid services were furnished to enrollees by member CMHSPs, providers, and subcontractors with corrective action taken as warranted.

Improvement Strategies

Establishing and successfully carrying out strategies to eliminate outliers, incorporate best practices, and optimize consumer outcomes is key to continuous quality improvement. The particular strategy or sets of strategies used vary according to the situation and the kind of improvement that is desired. The following provides a brief description of some of the improvement strategies utilized.

Performance Improvement Projects (PIP)

Standards published by the Centers for Medicare and Medicaid Services (CMS) require that the PIHP (Prepaid Inpatient Health Plan) conduct, "performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and consumer satisfaction."

NorthCare Network must engage in at least two affiliation-wide projects during each waiver period, which must address clinical and non-clinical aspects of care. Project topics are either mandated by MDHHS or selected by the PIHP in a manner that takes into account the prevalence of a condition among, or need for a specific service by, the organizations' consumers, consumer demographic characteristics and health risks, and the interest of consumers in the aspect of service to be addressed. Clinical areas would include, but not be limited to, high-volume services, high-risk services, and continuity and coordination of care; while non-clinical areas would include, but not be limited to, appeals, grievances, trends and patterns of incident reports as well as access to, and availability of, services.

Projects selected may fulfill both MDHHS/HSAG and applicable accreditation requirements. The Performance improvement projects must be included in the QAPIP and must include the following elements:

1. Measurement of performance using objective quality indicators.
2. Implementation of interventions to achieve improvement in the access to and quality of care.
3. Evaluation of the effectiveness of the interventions based on the performance of measures in F(i).
4. Planning and initiation of activities for increasing or sustaining improvement.

PIP's are selected based on requirements of the PIP structure when possible. The most recent co-occurring PIP was selected and modified as there is not enough ethnic variation in the UP to create a PIP centered around racial disparity. Data that was gathered indicated that Native American's were receiving SUD treatment at a higher rate than their white counterparts. Therefore, MDHHS allowed for the PIP to be related to age rather than race.

When determining a PIP, NorthCare meets with the region via regional committee to discuss possible PIP topics. A topic is picked if it has the most regional support and the initial data review supports the need for a PIP that meets any of the criteria of the PIP structure. NorthCare then continues PIPs until improvement is shown that allows for sunsetting of the PIP. At times, a PIP will need to be modified based on additional discovery found in the data or review of literature.

Oversight of the PIPs is achieved through collaboration with regional committees and workgroups. Improvement is tracked on an ongoing basis through reviewing and updating the workplan, data collection reports, and analysis of the data. Results are communicated to appropriate committees and stakeholders.

FY23 PIPs include:

1. PIP #1 (modified): To increase the percentage of discharged enrollees ages six (6) and older, who were hospitalized for treatment of selected mental illness diagnoses, and who had a follow-up visit with a mental health practitioner within seven (7) days of discharge.
    a. NorthCare measured this goal by two populations: ages six to twenty years old and for enrollees ages twenty-one and older. The numerator and denominator are calculated based on claims data provided by the Michigan Department of Health and Human Services (MDHHS). This PIP project is validated by the External Quality Review Organization under contract with MDHHS, HSAG (Health Services Advisory Group).
    b. The enrollment requirement is the "Date of discharge through 30 days after discharge" under Continuous Enrollment for the eligible population, as specified in the HEDIS 2018 Volume 2 Technical Specifications for Health Plans Follow-up After Hospitalizations for Mental Illness (FUH) specification. However, recently this was modified to include T1017, case management, as this is provided face to face in Michigan and often an appropriate appointment to have post hospital discharge. A new baseline was determined.

    c. NorthCare is sunsetting this previously HSAG validated clinical PIP. Follow up to hospitalization data is already tracked via MMBPIS performance indicators as well as via HEDIS for the Performance Based Incentive Pool.
2. PIP #2: To Increase the Percentage of Individuals Ages 12 and Older Who Are Diagnosed With a Co-Occurring Disorder That Are Receiving Co-Occurring Treatment.
    a. NorthCare has begun a co-occurring PIP with the goal of increasing the percentage of individuals who are diagnosed with a Co-occurring disorder (COD) for children ages twelve to twenty-five and adults ages twenty-six and older who are receiving integrated COD treatment. Co-occurring is defined as having both a mental health and substance use diagnosis. The hope is that both populations will improve in their respective percentages of individuals with co-occurring needs being treated co-occurring treatment.
    b. This is a HSAG validated clinical PIP.
3. PIP #3: To improve documentation of skill building (H2014) and supported employment (H2023) services.
    a. As a result of various auditing and monitoring processes across NorthCare's provider network, the need for consistent documentation tools and training across the region has been identified. Improving the documentation of these services will provide accurate and timely information to ensure most appropriate level of service and information to support movement to more independence as most appropriate for everyone.
    b. It is agreed that the ability to have an adult life characterized by financial wellbeing, self-direction, self-determination, and richness of experiences is highly dependent on an individual's ability to utilize his/her skills and talents to engage in a successful career path. Simply put, finding, and maintaining successful employment is central in reaching these goals. The experiences of young people during their teenage years and transition from school to adulthood, will heavily influence and impact their success as adults in terms of employment, and in turn many other aspects of their lives. Working affects financial security, personal relationships, community engagement, and numerous other aspects of personal well-being.
    c. Findings have been positive overall, although there have been dips in certain areas.
4. PIP #4: To increase the number of individuals who receive services for at least 90 days after initial assessment indicates eligibility for specialty mental health services.
    a. This PIP has evolved over time. All Medicaid individuals discharged within 90 days of initial assessment where it is determined the individual meets medical necessity criteria for specialty mental health services and supports are included in the numerator. All individuals approved for ongoing specialty mental health services and supports are included in the denominator.
    b. This study has the potential to improve the health, functional status or satisfaction of individuals meeting criteria for specialty mental health services and supports because of the of the importance of engaging this population in care. If these individuals do not participate in needed treatment for their severe mental illness, intellectual/developmental disability or severe emotional disturbance, there is an increased likelihood of ineffective treatment and a decreased quality of life. The National Alliance on Mental Illness (NAMI) reports that 70% of persons seeking mental health services drop out within the first or second visit. NorthCare is responsible to ensure services are available to individuals who meet criteria for specialty mental health services. If the consumers can be engaged into services, they should receive needed mental health services and have a better quality of life.

c. For this PIP, data reviews the total admissions to those still in services 90 days later. In late 2023 or early 2024 the PIP will be adjusted to also review the number of services obtained in that time period, as cases may be open for 90 days while CMHSP attempts to engage individuals, but the treatment is lacking due to issues with engagement by the individual.
d. NorthCare is sunsetting this PIP.

Utilization Management (UM)/Authorization strategies

NorthCare Network UM activities are specifically designed to ensure only eligible beneficiaries receive plan benefits; that services received meet medical necessity criteria and are linked to other services when needed. To achieve these goals, various methods are used that focus on eliminating outliers, incorporate best practices, and optimize consumer outcomes. For example, NorthCare Network directly operates a centralized access system which assures more uniform access to non-emergent services and reduces variability in eligibility determinations in access to the public mental health system. To improve overall quality of consumer outcomes and consistency in the amount, scope, and duration of services, clinicians use the NorthCare Network level of care placement protocols to guide level of care determinations. This is being updated late FY23 to come into alignment with LOCUS for SMI adults and better match the parity initiative. This clinical decision-support tool allows for greater consistency in level of care assignments and aimed at reducing variances in service delivery. Finally, utilization review activities are employed which include monitoring of individual consumer records, specific provider practices and system trends. Review and monitoring activities are used to determine appropriate application of guidelines and criteria for decision involving level of care assignments, service selection, authorization, and best practices. Tracking consumer outcomes, detecting over utilization/under utilization and reviews of outliers are also the subject of utilization review efforts.

Quality Measures

NorthCare reviews the following quality measures to ensure quality care.

- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD): The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
- Plan All-Cause Readmissions (PCR): For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.
- Initiation and Engagement of Substance Use Disorder Treatment (IET): The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement.
- Follow-Up After Emergency Department Visit for Mental Illness (FUM): The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness.
- Follow-Up After Hospitalization for Mental Illness (FUH): The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider.
- Follow-Up After Emergency Department Visit for Substance Use (FUA): The percentage of emergency department (ED) visits among members aged 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up.

- Antidepressant Medication Management (AMM): The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment.
- Spirometry Testing for Newly Diagnosed COPD (SPR): Percentage of adults with newly diagnosed COPD who receive spirometry testing within 6 months of diagnosis.
- Preventative Dental Examination: presence of a dental exam every two years for all individuals with Medicaid Dental Coverage.

Procedures for Adopting and Communicating Process & Outcome Improvements

NorthCare Network will incorporate the Home and Community-Based Services (HCBS) Quality Framework developed for the Centers for Medicare and Medicaid (CMS) into its Quality Management Program. This Quality Framework is intended to serve as a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of services and supports provided by NorthCare Network's provider network. The Framework focuses attention on critical dimensions of service delivery and the desired outcomes of the four functions of quality management: design, discovery, remedy and improvement. Further, definitions of the functions of quality are:

- Design: Designing quality assurance and improvement strategies for a program at the initiation of the program.
- Discovery: Engaging in a process of discovery to collect data and direct participant experiences to assess the ongoing implementation of the program, identifying both concerns as well as other opportunities for improvement.
- Remedy: Taking actions to remedy specific problems or concerns that arise.
- Continuous Improvement: Utilizing data and quality information to engage in actions that assure continuous improvement in the program.

Focus will be on the following seven broad categories as outlined by CMS:

1. Participant access
2. Person-centered planning and service delivery
3. Provider capacity and capabilities
4. Participant safeguard
5. Participant rights and responsibilities
6. Participant outcomes and satisfaction
7. System performance

Suggestions for improvement can come from a variety of sources. Feedback from consumers, advocates, stakeholders, network providers, MDHHS, and NorthCare Network Personnel is incorporated into the QI Plan's components and activities. NorthCare Network's QI Work Plan will identify measurable objectives, as well as the individuals and/or departments responsible for each objective. Also included will be a timeline for completion of tasks and schedule for ongoing monitoring as appropriate. This document details the specific actions NorthCare is completing related to quality improvement and is a working document. The document will be reviewed and updated at the quarterly Quality Management meetings.

Evaluation and Monitoring

A meeting is convened if NorthCare becomes aware of any significant provider-related issues of quality concern. Issues would be added to the Quality Improvement Workplan. The Quality Improvement Workplan is a document that summarizes areas of quality concern, the intervention plan in place for improvement, and the staff responsible for the implementation and target resolution dates. The Quality Improvement Workplan considers severity, duration, frequency, and if the concern is clinical or not.

Items in the workplan will be monitored quarterly unless otherwise specified. The workplan is a living document, updated throughout the year.

NorthCare Network's QAPIP is reviewed and updated at least annually with input from various stakeholders and approved by the Governing Board. The NorthCare Network Governing Board and NorthCare Network Quality Management and Oversight Committee are responsible for the evaluation of the effectiveness of the QAPIP. This Annual Effectiveness Review includes analysis of whether there have been improvements in the quality of health care and services for recipients as a result of quality assessment and improvement activities and interventions carried out by the PIHP. The analysis considers trends in service delivery and health outcomes over time and includes monitoring of progress on performance goals and objectives. Information on the effectiveness of the QAPIP must be provided annually to network providers and to recipients upon request. This annual analysis will be provided to the MDHHS annually and no later than February 28.

NorthCare Network publishes an Annual Performance Management Report that provides a summary of accomplishments and highlights from the previous Fiscal Year as well as key information that will identify whether current systems and processes are providing desired outcomes. This report will be posted at www.northcarenetwork.org, posted at NorthCare Network's main office, a copy sent to all Network Providers and members of NorthCare Network Governing Board and copies provided to stakeholders as requested.

Additionally, the Network Adequacy standards are also completed annually, and this information is provided to MDHHS by February 28th each year and is available on the NorthCare website. Network Adequacy is reported using the MDHHS template once available, however Network Adequacy will be reviewed every 6 months and deficiencies and concerns brought to the attention of leadership, provider network management, and contract committees.

References

- The Balanced Budget Act of 1997 (BBA)
- MDHHS /PIHP Master Contract and pertinent Attachments
- MDHHS Michigan Mission Based Performance Indicator System V6.0 Codebook
- ICO/PIHP Contract for the MI Health Link Demonstration Program
- NorthCare Network Credentialing Program Policy
- NorthCare Network Incident, Event & Death Reporting & Monitoring Policy
- NorthCare Network Methodology – Michigan Mission Based Performance Indicator System V6.0
- NorthCare Network Annual Performance Management Report
- NorthCare Network QI Work Plan
- NorthCare Network Training-Personnel Policy
- NorthCare Network Utilization Management (UM) Plan
- NorthCare Network Training-Network Provider Policy
- NorthCare Network/CMHSP Delegation Agreement
- NorthCare Network Cultural Sensitivity Policy

All NorthCare Network policies can be found at www.northcarenetwork.org.

Attachments

A - Acronyms Used in this Document
B – Work Plan

Approvals

Reviewed/Revised Date: 8/15/23
Quality Management and Oversight Committee Approval: 9/14/23
Policy Committee/CEO Approval: 9/5/23
Board of Directors Approval: 9/13/23

Attachment A- Acronyms used in this document

BBA – Balanced Budget Act
CEO – Chief Executive Officer
CMHSP – Community Mental Health Service Provider
CMS – Centers for Medicare and Medicaid Services
EBP – Evidence Based Practices
EQR/EQRO – External Quality Review / External Quality Review Organization
HSAG – Health Services Advisory Group (External Quality Review Organization contracted by MDHHS to conduct annual reviews of each PIHP.)
HCBS – Home and Community-Based Services
HIPAA – Health Insurance Portability and Accountability Act
HMP – Healthy Michigan Plan
ICO – Integrated Care Organization
I/DD – Intellectual/Developmental Disability
MDHHS – Michigan Department of Health and Human Services
MI – Mental Illness
MHL – MI Health Link Demonstration Program
MHP – Medicaid Health Plan
PIHP – Prepaid Inpatient Health Plan
PIP – Performance Improvement Project
PMC – Performance Management Committee (A NorthCare Network Committee represented by Directors of each Member CMHSP and NorthCare Network's CEO)
QAPIP – Quality Assessment and Performance Improvement Plan
QC – Quality Council
QI – Quality Improvement
QIP – QI (Quality Improvement) Plan
UM – Utilization Management