Community MENTAL HEALTH CLINTON • EATON • INGHAM

PROGRAM & PLANNING COMMITTEE AGENDA

Monday, April 8th, 2024
5:30 p.m.
812 E. Jolly Rd, Atrium
Lansing, MI 48910

Join Zoom Meeting
https://zoom.us/j/94026869514
Meeting ID: 940 2686 9514

***Action Items**

1. Call to Order

2. Previous Meeting Minutes – March 11th, 2024

3. Adoption of Agenda

4. Public Comment on Agenda Items

PROGRAM AND PLANNING COMMITTEE BUSINESS ITEMS

***5. New Expense Contract: Big Five, LLC – Shana Badgley**

***6. New Expense Contract: Finni Health – SenseSational Learning Group – Karla Block**

***7. New Expense Contract: Golden Hearts LLC (Formerly Jennifer Burgess) – Karla Block**

***8. 2024 Mid-State Health Network Quality Assessment and Performance Improvement Program and the 2023 Annual Effectiveness and Evaluation Report 2024 CMHA-CEI Quality Improvement Program Plan and the 2023 Quality Improvement Program Plan Effectiveness Report – Elise Magen**

If you need accommodations in order to fully participate in this meeting, please call 517-346-8238. If, however, you are deaf/hard of hearing or deaf/blind, please call Michigan Relay Center, TTY/Voice by dialing 711 or 844-578-6563 *and ask them to forward your message to the above number. Requests must be made no later than 48 hours prior to the meeting. This meeting is open to all members of the public under Michigan's Open Meetings Act.*

***9. CMHA-CEI Consumer Advisory Council Recommended Appointees – Sara Lurie**

10. Unfinished Business

11. New Business

12. Public Comment

13. Adjournment

PROGRAM AND PLANNING COMMITTEE
Meeting Minutes
Monday, March 11th, 2024
5:30 p.m.
812 E. Jolly Rd, Atrium
Lansing, MI 48910

Join Zoom Meeting
https://zoom.us/j/94026869514
Meeting ID: 940 2686 9514

Committee Members Present:
Raul Gonzales
Tim Hanna
Dianne Holman
Joe Brehler
Paul Palmer via Zoom – South Lansing, MI

Committee Members Excused:
Al Platt

Staff Present
Darby Vermeulen, Sara Lurie, Stephanie Stevens, Marie Carrell, Jana Baylis

Other Board Members Present:
None

Public Present:
None

Others Present
None

Call to Order:
The meeting was called to order by Chairperson Raul Gonzales at 5:30 p.m.

Previous Meeting Minutes:
MOVED by Paul Palmer and SUPPORTED by Dianne Holman to approve the Program and Planning Committee meeting minutes of February 12th, 2024.

MOTION CARRIED unanimously.

Adoption of Agenda:
MOVED by Tim Hanna and SUPPORTED by Paul Palmer to adopt the agenda of March 11th, 2024.

Joe Brehler left the meeting at 5:31 pm.

MOTION CARRIED unanimously.

Public Comment on Agenda Items:
None

BUSINESS ITEMS:
New Expense Contract: Advance ABA Care
Marie Carrell presented this contract for an ABA provider. ABA stands for Applied Behavioral Analysis. We have some capacity issues and families waiting for ABA care, so this contract will hopefully alleviate some of that. Marie clarified that this provider is going to be in-home in the Lansing area. They are hoping to add other locations in the future, but will be solely in-home at this point.

Joe Brehler returned to the meeting at 5:35 pm.

Paul asked how many ABA contracts we have at this point? Marie guessed about 15-20, but she would have to confirm that number. Sara said she remembers when the benefit came in, we only had four to five providers. Marie said we are hoping to get more centered-based activities and options in the Lansing area, but there is benefit to the in-home care, as well. On the other hand, sometimes, especially with busy families, treatment in a center can be more beneficial because there are fewer distractions.

Dianne asked if any of the ABA services provided are in conjunction with services provided at public schools? Marie said the providers coordinate with other treatment professionals at school or in other places, but the care can't supplant the services being provided at school.

ACTION:

MOVED by Paul Palmer and SUPPORTED by Tim Hanna that the Program and Planning Committee of the CMHA-CEI Board of Directors authorize CMHA-CEI to enter into a contract with Advance ABA Care to provide the services at the rates listed below, for the period of April 1, 2024 through September 30, 2024.

ABA Service Rates									
Code	**Modifier**	**Service Description**	**Reporting Units**	**Provider Type**	**BCBA**	**BCaBA**	**QBHP**	**LP/LLP**	**BT**
97151	AH, HN, HO, HP, U5	ABA Behavior Identification Assessment	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$30.00	$21.25	$30.00	$30.00	
0362T	AF, AG, AH, HN, HO, HP, SA	ABA Behavioral Follow-up Assessment	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$30.00	$21.25	$30.00	$30.00	
97153	AF, AG, AH, HM, HN, HO, HP, SA, TD, U7	ABA Adaptive Behavior	Per 15 minutes	BCBA, BCaBA, QBHP,	$15.90	$15.90	$15.90	$15.90	$14.03

		Treatment, individual		LP/LLP, or BT					
97154	AF, AG, AH, HM, HN, HO, HP, TD, SA, UN, UP, UQ, UR, US, U7	ABA Group Adaptive Behavior Treatment	Per 15 minutes	BCBA, BCaBA, QBHP, LP/LLP, or BT	$5.19	$5.19	$5.19	$5.19	$4.83
97155	AH, HN, HO, HP, AF, AG, SA	ABA Clinical Observation and Direction of Adaptive Behavior Treatment	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$30.00	$21.25	$30.00	$30.00	
97156	AH, HN, HO, HP, AF,AG, SA	ABA Family Behavior Treatment Guidance	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$30.00	$21.25	$30.00	$30.00	
97157	AH, HN, HO, HP, AF, AG, SA, UN, UP, UQ, UR, US	ABA Multiple Family Behavior Treatment Guidance	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$12.00	$8.50	$12.00	$12.00	
97158	AH, HN, HO, HP, AF, AG, SA, UN, UP, UQ, UR, US	ABA Adaptive Behavior Treatment Social Skills Group	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$8.57	$6.07	$8.57	$8.57	
0373T	AF, AG, AH, HM, HN, HO, HP, SA	ABA Exposure Adaptive Behavior Treatment	Per 15 minutes	BCBA, BCaBA, QBHP, LP/LLP, or BT	$30.90	$22.25	$30.90	$30.90	$28.40

MOTION CARRIED unanimously.

New CAC Member Recommendations

Sara said one initiative the CAC has been focused on is recruitment of new members. The committee has had some turnover as of late. Recruitment efforts include a presentation at Manager meetings, staff meetings, and at Charter House. These efforts have resulted in a few interested folks. Daniel Arnold interviewed for a spot on the CAC. Daniel has been on the MSHN Regional Advisory Board, Recipient Rights Committee, and is active in other groups in the community. The CAC voted to move him forward to the P&P Committee and then full Board for a vote. Sara said there two more interviews scheduled – the bylaws allow up to 18 members, and we were down to seven members prior to this new rounds of interviewees.

ACTION:

MOVED by Tim Hanna and SUPPORTED by Paul Palmer that the Program and Planning Committee of the CMHA-CEI Board of Directors appoint the following individual named to serve as a member of the Consumer Advisory Council.

- **Daniel Arnold, for a 2-year term, to expire on 4/31/2026.**

MOTION CARRIED unanimously

Raul noted that John Peiffer appreciated the feedback provided at the CAC meeting on the new CSU. Sara said the council talked for 45-minutes regarding trauma informed care and sensory-safe settings and what would be best for the new center. Raul said their feedback had a lot of value.

Sara wanted to ask the group their thoughts about trying to reorganize the Greenlawn tour, either before the March Board meeting or before the April P&P meeting? Paul and Raul said they are open any time. Sara will ask John if the space is ready for a tour. She said a good time would be around 4pm prior to next week's Board meeting. The P&P Committee agreed this would work. Sara will check with John at Director's Group tomorrow.

Paul wanted Sara to share that prior to the MSHN Board meeting last week, folks were invited to visit the Crisis Res unit that the region will be opening in Alma. It's being operated by MI Mind Michigan. There will be six beds in the unit. Sara will be

hosting a visit for the MI Mind Michigan folks to Bridges so we can share information on crisis residential units.

Raul noted that we recently celebrated International Women's Day, and he wanted to thank the mostly female social work team at CEI. He went on to say that Paul's wife, Sharon Palmer, shared her story for the Connections publication. The piece will be out this month. Raul wanted to thank Sharon for sharing her story, because this the way we connect to the community and is a form of outreach for CEI. Paul said Sharon wanted to get her story out to help other consumers.

<u>Unfinished Business</u>

a. **Strategic Plan – Next Steps Discussion**

Sara wanted to thank the Program and Planning Committee for moving the Strategic Plan to the full Board last month. Currently, a summary document is being completed to share with staff and the community. In April, the items that are currently in the works will be discussed, and action planning will commence for the next year. Any input needed from committees will be added to corresponding committee agendas.

Sara said the Board pictures in the Annual Report look stellar!

<u>New Business</u>

Raul wanted to say that he is happy to see the CMHA-CEI stories shared on Channels 6 and 10. Sara said we sponsored the Not Alone series that they aired – as the channels get to know us, they call us for more things.

<u>Public Comment</u>:

None

The meeting was adjourned at 6:03 p.m. The next regularly scheduled Program and Planning Committee meeting is Monday, April 8th, 2024 at 5:30pm, 812 E. Jolly Rd, Atrium.

Minutes Submitted by:

Darby Vermeulen
Finance Administrative Assistant

Agenda Item: Program and Planning Committee
Agenda Item #P-5

Month, Year: April, 2024

Major Program: Adult Mental Health Services (AMHS), Community Services for the Developmentally Disabled (CSDD)

Component Program: Residential

Agenda Item Title: New Expense Contract: Big Five, LLC

SUMMARY OF CONTRACT/PROPOSAL:
Under this new contract, Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI) will purchase specialized residential services for AMHS and CSDD consumers from the adult foster care provider listed below for the period of April 1, 2024 through September 30, 2024.

Keyonie James – Big Five, LLC: 1718 Elmwood Rd., Lansing, MI 48917
License #: AS230416057

The expense of this contract is reflected in CMHA-CEI's FY 2024 budget. The revenue sources that support the contract are Medicaid, Healthy Michigan Plan (HMP), Habilitative Supports Waiver (HSW), Medicaid Spend-down/Deductible, State General fund dollars and other Community Mental Health Services Programs (CMHSP) through County of Financial Responsibility (COFR) agreements, and Local funding. The expense of the contract is reflected in the various contract residential line items of the AMHS and CSDD residential budgets. The contract will not affect CMHA-CEI's fund balance.

SUMMARY OF GOODS OR SERVICES REFERENCED IN THE CONTRACT/PROPOSAL:
Services provided under this contract include a range of residential care to MI and DD adults defined by one of three levels of service intensity. Overall, the provider is reimbursed at the same rate for each level of care. Occasionally, rates are supplemented to reflect additional costs such as day treatment transportation or an exceptional level of

care based on consumer needs. The provider listed is appropriately licensed and fully-qualified under Michigan Department of Health and Human Services and Licensing and Regulatory Affairs requirements.

STAFF RECOMMENDATION:
Staff recommends that the Program and Planning Committee of the Board of Directors of Community Mental Health Authority of Clinton, Eaton, and Ingham Counties approve the following resolution:

The Program and Planning Committee recommends that the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties Board of Directors authorize CMHA-CEI to enter into a new contract with Keyonie James of Big Five, LLC, including the provider's licensed Adult Foster Care facilities as requested and approved by management to meet consumer need, to purchase residential services at the rates below independent of any amount paid to the home for room and board as calculated in the consumer's ability to pay for the period of April 1, 2024 through September 30, 2024.

Facility(ies)		
Name	**Address**	**License Number**
Elmwood Acres	1718 Elmwood Rd. Lansing, MI 48917	AS230416057

Fee Schedule				
Service Level	**Service Description**	**Billing Code**	**Unit**	**Rate**
Level II A	Community Living Supports and Personal Care in Licensed Specialized Residential Setting	H2016/T1020	Per Diem	$132.08
Level II AA	Community Living Supports and Personal Care in Licensed Specialized Residential Setting	H2016/T1020	Per Diem	$155.39
Level II AAA	Community Living Supports and Personal Care in Licensed Specialized Residential Setting	H2016/T1020	Per Diem	$178.70

Agenda Item: Program and Planning Committee
Agenda Item #P-6

Month, Year: April, 2024

Major Program: Community Services for Developmentally Disabled (CSDD)

Component Program: Clinical Services

Agenda Item Title: New Expense Contract: Finni Health – SenseSational Learning Group

SUMMARY OF CONTRACT/PROPOSAL:
Under this new contract, Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI) will purchase ABA services from:

Company	Address
Finni Health – SenseSational Learning Group Main Contact: Sheila Hartley (Owner/Clinical Director (517)295-3175 Samantha Wu (Credentialing) (646)673-2983 finnienrollment@plyhealth.com	Main Address: Local Address: None (in-home services only)

CMHA-CEI will pay the rates as outlined in the chart below for assessments, direct therapy, required supervision, and family guidance by a Board Certified Behavior Analyst (BCBA) or other appropriately credentialed individual for the period June 1, 2024 through September 30, 2024.

ABA Service Rates									
Code	**Modifier**	**Service Description**	**Reporting Units**	**Provider Type**	**BCBA**	**BCaBA**	**QBHP**	**LP/LLP**	**BT**
97151	AH, HN, HO, HP, U5	ABA Behavior Identification Assessment	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$30.00	$21.25	$30.00	$30.00	
0362T	AF, AG, AH, HN, HO, HP, SA	ABA Behavioral Follow-up Assessment	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$30.00	$21.25	$30.00	$30.00	
97153	AF, AG, AH, HM, HN, HO, HP, SA, TD, U7	ABA Adaptive Behavior Treatment, individual	Per 15 minutes	BCBA, BCaBA, QBHP, LP/LLP, or BT	$15.90	$15.90	$15.90	$15.90	$14.03
97154	AF, AG, AH, HM, HN, HO, HP, TD, SA, UN, UP, UQ, UR, US, U7	ABA Group Adaptive Behavior Treatment	Per 15 minutes	BCBA, BCaBA, QBHP, LP/LLP, or BT	$5.19	$5.19	$5.19	$5.19	$4.83
97155	AH, HN, HO, HP, AF, AG, SA	ABA Clinical Observation and Direction of Adaptive Behavior Treatment	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$30.00	$21.25	$30.00	$30.00	
97156	AH, HN, HO, HP, AF,AG, SA	ABA Family Behavior Treatment Guidance	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$30.00	$21.25	$30.00	$30.00	
97157	AH, HN, HO, HP, AF, AG, SA, UN, UP, UQ, UR, US	ABA Multiple Family Behavior Treatment Guidance	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$12.00	$8.50	$12.00	$12.00	
97158	AH, HN, HO, HP, AF, AG, SA, UN, UP, UQ, UR, US	ABA Adaptive Behavior Treatment Social Skills Group	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$8.57	$6.07	$8.57	$8.57	

0373T	AF, AG, AH, HM, HN, HO, HP, SA	ABA Exposure Adaptive Behavior Treatment	Per 15 minutes	BCBA, BCaBA, QBHP, LP/LLP, or BT	$30.90	$22.15	$30.90	$30.90	$28.40

The CMHA-CEI FY24 budget contains approximately $9M for contracted autism services. The Autism benefit is an entitlement benefit, requiring CMHA-CEI to serve those that meet the criteria for the service. The administration of this program will be included in the costs to be reimbursed by the Michigan Department of Health and Human Services (MDHHS). This contract will not affect CMHA-CEI's fund balance.

DESCRIPTION OF GOODS OR SERVICES REFERENCED IN CONTRACT/PROPOSAL:

ABA is an intensive face to face therapy designed to assist the child to develop age appropriate skills and to address the key symptoms of ASD. While symptoms vary in severity, common symptoms of ASD include deficits in the area of communication and interactional skills. In addition, some children may exhibit repetitive, disruptive and/or intrusive, behavior. ABA is typically provided several hours a week in a clinical setting, community, and/or in the child's home. Hours authorized per week are dependent on the needs of the child. The Medicaid policy requires that supervision of the therapy occurs by a Board Certified Behavior Analyst, (or other appropriately credentialed individual supervised by a BCBA) one hour for every 10 hours of therapy provided. Family training and involvement in the therapy is a key component of the intervention. A CMHA-CEI psychologist will designate the level of service for which the child is eligible. MDHHS will verify the eligibility for each child.

STAFF RECOMMENDATION:

Staff recommends that the Program and Planning Committee of the Board of Directors of Community Mental Health Authority of Clinton, Eaton, and Ingham Counties approve the following resolution:

The Program and Planning Committee recommends that the Community Mental Health Authority of Clinton, Eaton, Ingham Counties Board of Directors authorize CMHA-CEI to enter into a contract with Finni Health to provide the services at the rates listed below, for the period of June 1, 2023 through September 30, 2024.

ABA Service Rates									
Code	**Modifier**	**Service Description**	**Reporting Units**	**Provider Type**	**BCBA**	**BCaBA**	**QBHP**	**LP/LLP**	**BT**
97151	AH, HN, HO, HP, U5	ABA Behavior Identification Assessment	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$30.00	$21.25	$30.00	$30.00	
0362T	AF, AG, AH, HN,	ABA Behavioral	Per 15 minutes	BCBA, BCaBA,	$30.00	$21.25	$30.00	$30.00	

	HO, HP, SA	Follow-up Assessment		QBHP, or LP/LLP					
97153	AF, AG, AH, HM, HN, HO, HP, SA, TD, U7	ABA Adaptive Behavior Treatment, individual	Per 15 minutes	BCBA, BCaBA, QBHP, LP/LLP, or BT	$15.90	$15.90	$15.90	$15.90	$14.03
97154	AF, AG, AH, HM, HN, HO, HP, TD, SA, UN, UP, UQ, UR, US, U7	ABA Group Adaptive Behavior Treatment	Per 15 minutes	BCBA, BCaBA, QBHP, LP/LLP, or BT	$5.19	$5.19	$5.19	$5.19	$4.83
97155	AH, HN, HO, HP, AF, AG, SA	ABA Clinical Observation and Direction of Adaptive Behavior Treatment	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$30.00	$21.25	$30.00	$30.00	
97156	AH, HN, HO, HP, AF,AG, SA	ABA Family Behavior Treatment Guidance	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$30.00	$21.25	$30.00	$30.00	
97157	AH, HN, HO, HP, AF, AG, SA, UN, UP, UQ, UR, US	ABA Multiple Family Behavior Treatment Guidance	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$12.00	$8.50	$12.00	$12.00	
97158	AH, HN, HO, HP, AF, AG, SA, UN, UP, UQ, UR, US	ABA Adaptive Behavior Treatment Social Skills Group	Per 15 minutes	BCBA, BCaBA, QBHP, or LP/LLP	$8.57	$6.07	$8.57	$8.57	
0373T	AF, AG, AH, HM, HN, HO, HP, SA	ABA Exposure Adaptive Behavior Treatment	Per 15 minutes	BCBA, BCaBA, QBHP, LP/LLP, or BT	$30.90	$22.15	$30.90	$30.90	$28.40

Agenda Item: Program and Planning Committee
Agenda Item #P-7

Month, Year: April, 2024

Major Program: Adult Mental Health Services (AMHS), Community Services for the Developmentally Disabled (CSDD)

Component Program: Residential

Agenda Item Title: New Expense Contract: Golden Hearts LLC (Formerly Jennifer Burgess)

SUMMARY OF CONTRACT/PROPOSAL:
Under this new contract, Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI) will purchase specialized residential services from the adult foster care provider listed below for the retroactive period of March 1, 2024 through September 30, 2024. The contract start date will be contingent on the effective date of the new AFC license.

- Golden Hearts LLC: 3329 Westwood Avenue, Lansing MI, 48906
  License Number: AS330418221

The expenses of this contract are reflected in CMHA-CEI's FY24 budget. The revenue sources that support the contract are Medicaid, Healthy Michigan Plan (HMP), Habilitative Supports Waiver (HSW), Medicaid Spend-down/Deductible, State General fund dollars and other Community Mental Health Services Programs (CMHSP) through County of Financial Responsibility (COFR) agreements, and local funding. The expenses of the contracts are reflected in the various contract residential line items of the AMHS and CSDD residential budgets. The contracts will not affect CMHA-CEI's fund balance.

SUMMARY OF GOODS OR SERVICES REFERENCED IN THE CONTRACT/PROPOSAL:
Services provided under this contract include a range of residential care, Personal Care (T1020) and Community Living Supports (H2016), for MI and DD Adults.

Personal Care Services include assisting the beneficiary to perform the following:

Assistance with food preparation, clothing and laundry, and housekeeping beyond the level required by facility licensure, (e.g., a beneficiary requires special dietary needs such as pureed food), eating/feeding, toileting, bathing, grooming, dressing, transferring (between bed, chair, wheelchair, and/or stretcher), ambulation, and assistance with self-administered medications.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential Settings. Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity.

STAFF RECOMMENDATION:

Staff recommends that the Program and Planning Committee of the Board of Directors of Community Mental Health Authority of Clinton, Eaton, and Ingham Counties approve the following resolution:

The Program and Planning Committee recommends that the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties Board of Directors authorize CMHA-CEI to enter into a new contract with Golden Hearts LLC (formerly operated under Jennifer Burgess), in addition to the provider's other licensed Adult Foster Care facilities as requested and approved by management to meet consumer need, to purchase specialized residential services at the rates below independent of any amount paid to the home for room and board as calculated in the consumer's ability to pay, for the retroactive period of March 1, 2024 through September 30, 2024. The contract start date will be contingent on the effective date of the new AFC license.

Facility(ies)		
Name	**Address**	**License Number**
Golden Hearts	3329 Westwood Ave. Lansing, MI 48906	AS330418221

Fee Schedule				
Service Level	**Service Description**	**Billing Code**	**Unit**	**Rate**
Level II A	Community Living Supports and Personal Care in Licensed Specialized Residential Setting	H2016/T1020	Per Diem	$132.08
Level II AA	Community Living Supports and Personal Care in Licensed Specialized Residential Setting	H2016/T1020	Per Diem	$155.39
Level II AAA	Community Living Supports and Personal Care in Licensed Specialized Residential Setting	H2016/T1020	Per Diem	$178.70

Agenda Item: Program and Planning Committee
Agenda Item #P-8

Month, Year: April, 2024

Major Program: All Programs

Component Program: All CMH Programs

Agenda Item Title: 2024 Mid-State Health Network Quality Assessment and Performance Improvement Program and the 2023 Annual Effectiveness and Evaluation Report
2024 CMHA-CEI Quality Improvement Program Plan and the 2023 Quality Improvement Program Plan Effectiveness Report

SUMMARY OF CONTRACT/PROPOSAL:
Mid-State Health Network (MSHN) monitors the overall quality and improvement of the PIHP. Responsibilities of the Quality Management Program are outlined in the Quality Assessment and Performance Improvement Plan (QAPIP). The scope of MSHN's QAPIP program is inclusive of all CMHSP participants. Performance monitoring covers all important organization functions and aspects of care and service delivery systems.

The structure of the QAPIP allows each contracted behavioral health provider to establish and maintain its own unique arrangement for monitoring, evaluating, and improving quality.

Additionally, as required by contract with MDHHS, CMHA-CEI develops an internal Quality Improvement Program. CMHA-CEI's QIP aligns with quality standards and expectations of The Michigan Department of Health and Human Services (MDHHS), Mid-State Health Network (MSHN), Certified Community Behavioral Health Clinics (CCBHC), the Balanced Budget Act (BBA), and the Commission on Accreditation of Rehabilitation Facilities (CARF). The QIP plan details the structure, scope, activities and functions of CMHA-CEI's overall Quality Improvement Program. The QIP plan describes core activities and functions that are conducted by CMHA-CEI and its network of contracted service providers.

An evaluation of the QAPIP and QIP plan is completed at the end of each fiscal year.

The evaluation summarizes activity that occurred around the goals and objectives of the plans and progress made toward achieving the goals and objectives. The evaluation describes the quality improvement activities conducted during the past year related to the goals/objectives, including a description of targeted processes and systems implemented, outcomes of those processes and systems, any performance indicators utilized, the findings of the measurement, data aggregation, assessment and analysis processes implemented, and the quality improvement initiatives taken in response to the findings. Annual evaluation of PIHP and CMHSP Quality Plans is required by contract with MDHHS.

STAFF RECOMMENDATION:
Staff recommend that the Program and Planning Committee of the CMHA-CEI Board of Directors approve the following resolution:

The Program and Planning Committee recommends that the Board of Directors of the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties approve the adoption of the 2024 Quality Improvement Program Plan and the 2024 Quality Assessment and Performance Improvement Program as CMHA-CEI's Quality Plans. Additionally, the Program and Planning Committee recommends that the Board of Directors of the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties approve the adoption 2023 Annual Effectiveness and Evaluation Report, and the 2023 Quality Improvement Program Plan Effectiveness Report as CMHA-CEI's annual effectiveness review of the Quality Plans.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

Annual Plan FY2024

Prepared By: MSHN Quality Manager –11/2023

Reviewed and Approved By: Quality Improvement Council – 12/2023

Reviewed By: MSHN Leadership – 12/20/2023

Reviewed By: MSHN Operations Council – 121/18/2023

Reviewed and Approved By: MSHN Board – 1/30/2024

Contents

I. OVERVIEW/MISSION STATEMENT

Mid-State Health Network (MSHN) is a regional entity, which was formed pursuant to 1974 P.A. 258, as amended, MCL §330.1204b, as a public governmental entity separate from the CMHSP Participants that established it. The CMHSP Participants formed Mid-State Health Network to serve as the prepaid inpatient health plan ("PIHP") for the twenty-one counties designated by the Michigan Department of Health and Human Services as Region 5.

Effective January 2014, MSHN entered into its first contract with the State of Michigan for Medicaid funding, and entered into subcontracts with the CMHSPs in its region for the provision of Mental Health, Substance Use Disorder, and Developmental Disabilities services. The contract was expanded in 2014 to include an expanded Medicaid benefit, the Healthy Michigan Plan. The CMHSP Participants include Bay-Arenac Behavioral Health Authority, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network, Huron Behavioral Health, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health Authority, Saginaw County Community Mental Health Authority, Shiawassee Health and Wellness, The Right Door and Tuscola Behavioral Health Systems. Effective October 1, 2015, MSHN took over the direct administration of all public funding for substance use disorder (SUD) prevention, treatment and intervention within the region and expanded the provider network to include SUD providers.

The mission of Mid State Health Network (MSHN) is to ensure access to high-quality, locally delivered, effective and accountable public behavioral health and substance use disorder services provided by its participating members. The vision of MSHN is to continually improve the health of our communities through the provision of premiere behavioral healthcare and leadership.

The Midstate Health Network utilizes the National Healthcare Reform Framework the "Quintuple Aim". For MSHN, the quintuple aim includes five strategic priorities: "Better Health", "Better Care", "Better Value", "Better Provider Systems", and "Better Equity". MSHN organizes and empowers a network of publicly funded community partnerships essential to ensure quality of life while efficiently and effectively addressing the complex needs of the most vulnerable citizens in our region.

The MSHN Quality Assessment and Performance Improvement Program (QAPIP) provides a structure for quality improvement in alignment with the MSHN Strategic Plan through performance monitoring. Additionally, the MSHN QAPIP aligns with the quality assessment and performance improvement program interventions as identified in the Michigan Department of Health and Human Services (MDHHS) Comprehensive Quality Strategy (CQS). Responsibilities of the quality management program are outlined in the QAPIP Plan.

II. SCOPE OF PLAN

The scope of MSHN's QAPIP includes services and programs provided by the CMHSP participants, substance use disorder providers and their respective provider networks including Certified Community Behavioral Health Clinics, Behavioral Health Home, and Opioid Health Home.

The performance monitoring through the QAPIP, covers all important organizational functions, aspects of care, and service delivery systems. Performance monitoring is accomplished through a combination

of well-organized and documented retained, contracted, and delegated activities. Where performance monitoring activities are contracted or delegated, MSHN assures monitoring of reliability and compliance.

III. DEFINITIONS/ACRONYMS

BTPRC: Behavior Treatment Plan Review Committee reviews, approves, or disapproves any plans that propose to use restrictive or intrusive intervention, with as defined in the Technical Requirement for Behavior Treatment Plans.

Behavioral Health: An individual with a mental illness, intellectual developmental disability and/or substance use disorder or children with a serious emotional disturbance.

BHH: Behavioral Health Home

CCBHC: Certified Community Behavioral Health Clinic

CMHSP: Community Mental Health Services Program is a program operating under Chapter 2 of the Michigan Mental Health Code - Act 258 of 1974 as amended.

CMHSP Participant refers to one of the twelve-member Community Mental Health Services Program (CMHSP) participant in the Mid-State Health Network.

Contractual Provider: refers to an individual or organization under contract with the MSHN Pre-Paid Inpatient Health Plan (PIHP) to provide administrative type services including CMHSP participants who hold retained functions contracts.

CIRS: Critical Incident Reporting System includes events required to be monitored and reported to MDHHS and the process in which this is completed. The current critical incidents categories include suicide death; non-suicide death; arrest of consumer; emergency medical treatment due to injury or medication error; and type of injury. Subcategories include injuries that resulted from the use of physical management; hospitalization or emergency treatment due to injury or medication error; emergency medical treatment of hospitalization due to injury related to the use of physical management.

Customer: For MSHN purposes customer includes all Medicaid eligible individuals (or their families) located in the defined service area who are receiving or may potentially receive covered services and supports. The following terms may be used within this definition: clients, recipients, enrollees, beneficiaries, consumers, primary consumer, secondary consumer, individuals, persons served, Medicaid Eligible.

EQR: External Quality Review is conducted quarterly by CMS and MDHHS.

LTSS: Long Term Supports and Services are provided to older adults and people with disabilities who need support because of age; physical, cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves, and who receive care in home-community based settings, or facilities such as nursing homes.(42 CFR §438.208(c)(1)(2)) MDHHS identify the Home and Community Based Services Waiver. MI-Choice as recipients of LTSS.

CQS: Comprehensive Quality Strategy provides a summary of work done to assess and improve the quality of care and services provided and reimbursed by Michigan's Medicaid programs, in accordance with State and Federal laws and regulations. The CQS provides a framework to accomplish its

overarching goals of designing and implementing a coordinated and comprehensive system to proactively drive quality across Michigan Medicaid managed care programs.

MEV: Medicaid Event Verification is a process which verifies services reimbursed by Medicaid.

MMBPIS: Michigan Mission Based Performance Indicator System includes domains for access to care, adequacy and appropriateness of services provide, efficiency (administrative cost vs. service costs), and outcomes (employment, housing inpatient readmission).

MDHHS CQS: Michigan Department of Health and Human Services Comprehensive Quality Strategy

MDHHS: Michigan Department of Health and Services

OHH-Opioid Health Home

PIP: Performance Improvement Projects must be conducted to address clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes.

PIHP: Prepaid Inpatient Health Plan is a managed care organization responsible for administering specialty services for the treatment of mental health, intellectual and developmental disabilities and substance use disorders in accordance with the 42 CFR part 401 et al June 14, 2002, regarding Medicaid managed care, Medicaid regulations, Part 438, MHC 330.1204b.

Provider Network: Refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP subcontractors.

QAPI: Quality Assessment Performance Improvement

QM/QA/QI: Quality Manager/Assurance/Improvement

QAPIP: Quality Assessment and Performance Improvement Program includes standards in accordance with the Guidelines for Internal Quality Assurance Programs as distributed by the Health Care Financing Administration Medicaid Bureau guide to states in July of 1993, the Balanced Budget Act of 1997, Public Law 105-33, and 42 Code of Federal Regulations (CFR)438.358 of 2002.

Research: (as defined by 45 CFR, Part 46.102) means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.

Root Cause Analysis (RCA): A root cause analysis (JCAHO) or investigation (per CMS approval and MDHHS contractual requirement) is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance." (JCAHO, 1998)

Sentinel Event (SE): A sentinel event is an “unexpected occurrence” involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase “or risk thereof” includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome

(JCAHO, 1998). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event

Stakeholder: A person, group, or organization that has an interest in an organization, including consumer, family members, guardians, staff, community members, and advocates.

Subcontractors: Refers to an individual or organization that is directly under contract with CMHSP and/or SRE to provide services and/or supports.

SUD Providers: Refers to substance use disorder (SUD) providers directly contracted with MSHN to provide SUD treatment and prevention services.

Veteran Navigator (VN): The role of the Veteran Navigator is to listen, support, offer guidance, and help connect Veterans to services they need.

Vulnerable Person: An individual with a functional, mental, physical inability to care for themselves.

IV. PHILOSOPHICAL FRAMEWORK

MSHN utilizes the Continuous Quality Improvement (CQI) model of Shewhart, Deming and Juran. The key principles of the CQI model, as recently updated by Richard C. Hermann ("Developing a Quality Management System for Behavioral Health Care: The Cambridge Health Alliance Experience", November 2002), are:

- Health care is a series of processes in a system leading to outcomes.
- Quality problems can be seen as the result of defects in processes.
- Quality improvement efforts should draw on the knowledge and efforts of individuals involved in these processes, working in teams.
- Quality improvement work is grounded in measurement, statistical analysis, and scientific methods.
- The focus of improvement efforts should be on the needs of the customer; and
- Improvement should concentrate on the highest priority problems.

Performance improvement is more narrowly defined as, “the continuous study and adaptation of health care organization’s functions and processes to increase the probability of achieving desired outcomes, and to better meet the needs of clients and other users of services” (The Joint Commission, 2004-2005). MSHN employs the Plan-Do- Study-Act (PDSA) cycle, attributed to Walter Shewhart and promulgated by Dr. W. Edwards Deming, to guide its performance improvement tasks (Scholtes P. R., 1991).

Performance measurement is a critical component of the PDSA cycle. Measures widely used by MSHN for the ongoing evaluation of processes, and to identify how the region can improve the safety and quality of its operations, are as follows:

- A variety of qualitative and quantitative methods are used to collect data about performance.
- Well-established measures supported by national or statewide databases are used where feasible and appropriate to benchmark desired performance levels; if external data is not available, then local benchmarks are established.
- Statistically reliable and valid sampling, data collection and data analysis principles are followed as much as possible; and

- If the nature of the data being collected for a measure limits the organization's ability to control variability or subjectivity, the conclusions drawn based upon the data are likewise limited.

Data is used for decision making throughout the PIHP and its provider network through monitoring treatment outcomes, ensuring timeliness of processes, optimizing efficiency, maximizing productivity, and utilizing key measures to manage risk, ensure safety, and track achievement of organizational strategies. MSHN's overall philosophy governing its local and regional quality management and performance improvement can be summarized as follows:

- Performance improvement is dynamic, system-wide and integrated.
- The input of a wide-range of stakeholders – board members, advisory councils, consumers, providers, employees, community agencies and other external entities, such as the Michigan Department of Health and Human Services, are critical to success.
- An organizational culture that supports reporting errors and system failures, as the means to improvement, and is important and encouraged.
- Improvements resulting from performance improvement must be communicated throughout the organization and sustained; and
- Leadership must establish priorities, be knowledgeable regarding system risk points, and act based upon sound data.

V. ORGANIZATIONAL STRUCTURE AND LEADERSHIP

a) Structure

The structure of the QAPIP allows each contracted behavioral health provider to establish and maintain its own unique arrangement for monitoring, evaluating, and improving quality. The MSHN Quality Improvement Council, under the direction of the Operations Council, is responsible for ensuring the effectiveness of the QAPIP. Process improvements will be assigned under the auspices of MSHN to an active PIHP council, committee, workgroup, or task specific Process Improvement Team.

b) Governance

Board of Directors

The MSHN's Board of Directors employs the Chief Executive Officer (CEO), sets policy related to quality management, and approves the PIHP's QAPIP, including quality management priorities as identified in this plan. The QAPIP Plan is evaluated and updated annually, or as needed, by the MSHN Quality Improvement Council.

Through the Operations Council, Substance Use Disorder Oversight Policy Board and MSHN CEO, the MSHN's Board of Directors receives quarterly progress reports through the Balanced Score Card and MSHN Department Reports. Additionally, the Board of Directors receives an Annual Quality Assessment and Performance Improvement Program Report evaluating the effectiveness of the quality management program and recommending priorities for improvement initiatives for the next year. The report describes quality management activities, performance improvement projects, and actions taken to improve performance. After review and approval of the Annual Quality Assessment and Performance Improvement Program, inclusive of a list of the Board of Directors', the QAPIP Plan

and Report is submitted to the Michigan Department of Health and Human Services (MDHHS) as required by February 28 of the respective year.

Chief Executive Officer

MSHN's CEO is hired/appointed by the PIHP Board and is the designated senior official with responsibility for ensuring implementation of the regional QAPIP. The MSHN CEO has designated the Quality Manager as the chair of the MSHN Quality Improvement Council, and a member of the MDHHS Quality Improvement Council. In this capacity, the Quality Manager under the direction of the Chief Compliance and Quality Officer, is responsible for the development, review, and evaluation of the Quality Assessment and Performance Improvement Plan in collaboration with the MSHN Quality Improvement Council.

The MSHN CEO allocates adequate resources for the quality management program and is responsible for linking the strategic planning and operational functions of the organization with the quality management functions. The CEO assures coordination occurs among members of the Operations Council to maintain quality and consumer safety. Additionally, the CEO is committed to the goals of the quality improvement plan and to creating an environment that is conducive to the success of quality improvement efforts, ensuring affiliation involvement, removing barriers to positive outcomes, and monitoring results of the quality improvement program across the PIHP. The CEO reports to the PIHP Board of Directors recommending policies and/or procedures for action and approval. The CEO is responsible for managing contractual relationships with the CMHSP Participants and Substance Use Disorder Providers and for issuing formal communications to the CMHSP Participants/SUD Providers regarding performance that does not meet contractual requirements or thresholds. Similarly, the CEO is responsible for ensuring ongoing monitoring and compliance with its MDHHS contract including provision of quality improvement plans as required.

Medical Director

The MSHN Medical Director and MSHN Addictions Treatment Medical Director consults with MSHN staff regarding service utilization, eligibility decisions, performance improvement projects and is available to provide additional input as required for the regional QAPIP.

The MSHN Medical Director leads the Regional Medicaid Directors Committee, is an ad hoc member of the MSHN Quality Improvement Council, demonstrating an ongoing commitment to quality improvement; participating on committees and work teams as needed, reviewing quality improvement reports, sentinel events, and critical incidents; and assisting in establishing clinical outcomes for the PIHP.

c) Components

Recipients

MSHN continues the legacy of its founding CMHSP Participants by promoting and encouraging active consumer involvement and participation within the PIHP, the respective CMHSPs and their local communities. Recipients of services participate in the QAPIP through involvement on workgroups, process improvement teams, advisory boards, and Quality Improvement (QI) Councils at the local and regional level. Recipients provide input into policy and program development, performance indicator monitoring, affiliation activities/direction, self- determination efforts, QI projects, satisfaction findings, consumer advocacy, local access and service delivery, and consumer/family education, etc. In addition to the participation of recipients of services in quality improvement activities, MSHN and the CMHSP Participants/ SUD Providers strive to involve other stakeholders

including but not limited to providers, family members, community members, and other service agencies whenever possible and appropriate. Opportunities for stakeholder participation include the PIHP governing body membership; PIHP Quality Improvement Council; PIHP Customer Services Committee; Consumer Advisory activities at the local, regional, and state levels; completion of satisfaction surveys; participation on quality improvement work teams or monitoring committees; and focus group participation. Stakeholder input will be utilized in the planning, program development, and evaluation of services, policy development, and improvement in service delivery processes.

MSHN will provide oversight and monitoring of all members of its contracted behavioral health network in compliance with applicable regulatory guidance. For the purposes of the Quality Management functions germane to successful PIHP operations, the following core elements shall be delegated to the Community Mental Health Services Programs and SUD Providers within the region:

- Implementation of Compliance Monitoring activities as outlined in the MSHN Corporate Compliance Plan
- Develop and Implementation of Quality Improvement Program in accordance with PIHP Quality Assessment and Performance Improvement Plan
- Staff Oversight and Education
- Conducting Research (if applicable)

MSHN will provide guidance on standards, requirements, and regulations from the MDHHS, the External Quality Review, the Balanced Budget Act, and/or other authority that directly or indirectly affects MSHN PIHP operations. Communication related to standards and requirements will occur through policy and procedure development, constant contact, training, committees/councils, and the MSHN website.

MSHN will retain responsibility for developing, maintaining, and evaluating an annual QAPIP plan and report in collaboration with its CMHSP Participants and Substance Use Disorder Providers. MSHN will comply with 42 CFR Program Integrity Requirements, including designating a PIHP Compliance Officer. Assurances for uniformity and reciprocity are as established in MSHN provider network policies and procedures.

Communication of Process and Outcomes

A quality structure identifies clear linkages and reporting structures. The MSHN Quality Improvement Council (QIC), in coordination with the CMHSP Participants and SUD Providers through regional committees and councils, is responsible for monitoring and reviewing performance measurement activities including identification and monitoring of opportunities for process and outcome improvements. Consumers and stakeholders receive reports on key performance indicators, consumer satisfaction survey results, and performance improvement (PI) projects through the Operations Council, Consumer Advisory Council meetings. Final performance and quality reports are available to the stakeholders and the general public through the MSHN website, and as requested. The Board of Directors receives periodic and an annual report on the status of organizational performance.

d) MSHN Provider Network

MSHN Councils and Committees are responsible for providing recommendations and reviewing regional policy regarding related managed care operational decisions. Each council/committee develops and annually reviews and approves a charter that identifies the following: Purpose, Decision

Making Context and Scope, Defined Goals, Monitoring, Reporting and Accountability, Membership, Roles and Responsibilities Meeting Frequency, Member Conduct and Rules, and Upcoming Goals supporting the MSHN Strategic Plan. The Operations Council approves all council/committee charters. Each council/committee guides the Operations Council, who advises the MSHN CEO. These recommendations are considered by the Operations Council on the basis of obtaining a consensus or simple majority vote of the twelve CMHSPs. Any issues remaining unresolved after Operations Council consideration will be subject to a vote with the minority position being communicated to the MSHN Board. The MSHN CEO retains authority for final decisions or for recommending action to the MSHN Board.
Among other duties, these councils/committees identify, receive, and respond on a regular basis to opportunities and recommendations for system improvements arising from the MSHN Quality Assessment and Performance Improvement Program and reports annually on the progress of accomplishments and goals.

CMHSP Participant/SUD Provider staff have the opportunity to participate in and to support the QAPIP through the following activities:

- Participating in valid and reliable data collection related to performance measures/indicators at the organizational or provider level.
- Identifying organization-wide opportunities for improvement.
- Providing stakeholder feedback through surveys.
- Participation on organization-wide standing councils, committees, work groups.
- Reporting clinical care errors, informing consumers of risks, and making suggestions to improve the safety of consumers.
- Communication between the PIHP QIC and their local organization.

Quality Improvement Council
A quality representative from each CMHSP is appointed by the CMHSP CEO to participate in the MSHN Quality Improvement Council. Primary and/or secondary consumer representatives are appointed through an application process. Substance Use Disorder (SUD) Treatment Providers are represented on the Council by MSHN SUD Staff on an as needed basis.

Regional Medical Directors
The Regional Medical Directors Committee, which includes membership of the MSHN Medical Director and the CMHSP participant Medical Directors, provide leadership related to clinical service quality and service utilization standards and trends. The RMDC was established to advise the MSHN Chief Medical Officer (CMO), the MSHN Chief Executive Officer (or designee), the MSHN Chief Behavioral Health Officer (CBHO), and the OC concerning the behavioral health operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CMO, CEO (or designee), CBHO, and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

SUD Oversight Policy Board
Pursuant to section 287 95) of Public Act 500 of 2012, MSHN established a Substance Use Disorder Oversight Policy Board (OPB) through a contractual agreement with and membership appointed by each of the twenty-one counties served. The SUD-OPB is responsible to approve an annual budget inclusive of local funds for treatment and prevention of substance use disorders; and serves to advise

the MSHN Board on other areas of SUD strategic priority, local community needs, and performance improvement opportunities.

SUD-Advisory Councils

The MSHN SUD provider network utilizes work groups to serve in an advisory capacity to MSHN to represent SUD providers and to offer input regarding SUD policies, procedures, strategic planning, quality improvement initiatives, monitoring and oversight processes, and to support MSHN's focus on evidence-based, best practice service and delivery to persons served. Each SUD provider work group is specific to a Level of Care (LOC) and functional area including, Women's Specialty Services, Medication Assisted Treatment, Residential, Recovery Housing, and Outpatient work groups.

Regional Consumer Advisory Council (RCAC)

The RCAC is charged with serving as the primary source of consumer input to the MSHN Board of Directors related to the development and implementation of Medicaid specialty services and supports requirements in the region.

Operations Council (OC)

The OC was established to advise the Pre-paid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) concerning the operations of the Entity. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the MSHN CEO to bring local perspectives, local needs, and greater vision to the operations of the Entity so that effective and efficient service delivery systems are in place that are accountable to the entity board, funders and the citizens who make our work possible.

Finance Council (FC)

The FC will make recommendations to the Mid-State Health Network (MSHN) Chief Finance Officer (CFO), Chief Executive Officer (CEO) and the Operations Council (OC) to establish all funding formulas not otherwise determined by law, allocation methods, and the Entity's budgets. The FC may advise and make recommendations on contracts for personnel, facility leases, audit services, retained functions, and software. The Finance Council may advise and make recommendations on policy, procedure, and provider network performance. The Council will also regularly study the practices of the Entity to determine economic efficiencies to be considered.

Information Technology Council (ITC)

The ITC was established to advise the Operations Council (OC) and the Chief Executive Officer (CEO) and will be comprised of the Chief Information Officer (CIO) and the CMHSP Participants information technology staff appointed by the respective CMHSP CEO/Executive Director. The IT Council will be chaired by the MSHN CIO.

Clinical Leadership Committee (CLC)

The CLC was established to advise the Prepaid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) and the OC concerning the clinical operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CEO and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

Utilization Management Committee (UMC)

The UMC was established to assure effective implementation of the Mid-State Health Network's UM Plan and to support compliance with requirements for MSHN policy, the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract and related Federal & State laws and regulations.

Compliance Committee (CC)

The CC was established to ensure compliance with requirements identified within MSHN policies, procedures, and compliance plan; the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract; and all related Federal and State laws and regulations, inclusive of the Office of Inspector General guidelines and the 42 CFR 438.608.

Customer Services Committee (CSC)

The CSC was established to draft the Consumer Handbook and to develop policies related to the handbook, the Regional Consumer Advisory Council (RCAC), and Customer Services (CS). The Customer Services Committee (CSC) will continue as a standing committee to assure the handbook is maintained in a compliant format, and to support the development and implementation of monitoring strategies to assure regional compliance with CS standards. This committee will be supported by the Director of Quality, Compliance, and Customer Service and will report through the Quality Improvement Council (QIC).

Provider Network Management Committee (PNMC)

PNMC was established to provide counsel and input to Mid-State Health Network (MSHN) staff and the Operations Council (OC) with respect to regional policy development and strategic direction. Counsel and input will typically include: 1) network development and procurement, 2) provider contract management (including oversight), 3) provider qualifications, credentialing, privileging and primary source verification of professional staff, 4) periodic assessment of network capacity, 5) developing inter- and intra-regional reciprocity systems, and 6) regional minimum training requirements for administrative, direct operated, and contracted provider staff. In fulfilling its charge, the PNMC understands that provider network management is a Prepaid Inpatient Health Plan function delegated to Community Mental Health Service Programs (CMHSP) Participants. Provider network management activities pertain to the CMHSP direct operated and contract functions.

Regional Equity Advisory Committee for Health (REACH)

To address MSHN's strategic priority of better equity, MSHN has established a Regional Equity Advisory Committee for Health (REACH), an advisory body comprised of Region 5 stakeholders and community partners from historically marginalized populations with lived experience. REACH goals are 1) to ensure attention to issues of equity, including reducing health disparities in access and delivery of quality behavioral health and substance use disorder (SUD) prevention, treatment and recovery programs; 2) to inform development and review of MSHN policies, procedures and practices through the lens of diversity, equity and inclusion (DEI); 3) to incorporate a trauma-informed perspective that accounts for historical and racialized trauma; 4) to address stigma and bias that may impact health outcomes.

VI. PERFORMANCE MANAGEMENT

Performance Management is defined as "a forward-looking process used to set goals and regularly check progress toward achieving those goals. In practice, an organization sets goals, looks at the actual data from its performance measures, and acts on results to improve the performance toward its goals."[1] MSHN utilizes a Dashboard and Balanced Score Card (BSC) to provide a comprehensive view of the organizational performance.

a) Establishing Performance Measures

MSHN encourages the use of objective and systematic forms of measurement. MSHN utilizes performance measurement to monitor system performance, promote improved performance, identify opportunities for improvement and best practices, and to ensure compliance with PIHP contract requirements and State and Federal processes and requirements.

Performance measures are developed through the regional committees/councils and align with the MSHN strategic priorities of Better Health, Better Care, Better Value, Better Provider System, and Better Equity.

The measures established can be clinical and non-clinical, use objective quality indicators, have clear expectations, promote transparency, and are accountable through ongoing monitoring. Information is a critical product of performance measurement that facilitates performance improvement, and priorities for risk reduction. Data must be systematically aggregated and analyzed to become actionable information. Data is used for clinical decision-making, and organizational decision-making (e.g., strategic planning and day-to-day operations).

The PIHP quality management program uses but is not limited to the following means for identification of system issues and opportunities for improvement through performance measurement:

- growth areas identified from performance summaries and reports.
- stakeholder feedback from providers and member experiences.
- oversight and monitoring reviews from external and internal processes.

Once an opportunity is identified a quality improvement process may be initiated.

b) Prioritizing Measures

Measures are chosen by MSHN leadership in collaboration with MSHN committees, councils, and work groups based on the needs of the organization, with consideration given to the following three factors:

Focus Area: Clinical, high volume or high-risk services; continuity and coordination of care, or Non-Clinical include but are not limited to appeals, grievance, trends, and patterns of substantiated member rights complaints as well as access to, and availability of services that can be expected to have a beneficial effect on health outcomes and individual satisfaction. Qualitative and quantitative assessment; internal performance.

[1] (U.S. Department of Health & Human Services, Health Resources & Services Administration. Performance Measurment and Management, 2011)

Impact: The effect on a significant portion of consumers served with potentially significant effect on quality of care, services, or satisfaction.

Compliance: Adherence to law, regulatory, accreditation requirement and/or clinical standards of cares.

c) Data Collection, Analysis, and Reporting

The purpose of data collection is to monitor performance, identify growth areas, and monitor the effectiveness of interventions. A description of the measure is written and may include, but is not limited to the following:

- Baseline
- Standard/Target/Goal
- Data collection timeframe, and remeasurement periods
- Frequency of data analysis
- Population/sample
- Data source
- Consistent data collection techniques.
- Strategies to minimize inter-rater reliability concerns and maximize data validity.
- Measure Steward

Additionally, if a sampling method is used, the population from which a sample is pulled, and appropriate sampling techniques to achieve a statistically reliable confidence level are included in the project/study description. The default confidence level for MSHN performance measurement activity is a 95% confidence level with a 5% margin of error.

Data is aggregated at a frequency appropriate to the process or activity being studied. Statistical testing and analysis are used as appropriate to analyze and display the aggregated data. PIHP data is analyzed over time to identify patterns and trends and are compared to established performance targets and/or externally derived benchmarks when available. Performance targets are set through established contract requirements and/or externally derived benchmarks. If there is no set performance target, baseline data should be considered prior to setting a target.

Baseline data is data that is collected for a period of time, typically up to one year, prior to establishing a performance target. Historical data, when available may be used for baseline. When collecting baseline data, it is important to establish a well- documented, standardized, and accurate method of collecting the data and set ongoing frequencies to review the data (monthly, quarterly, etc.).

Once the baseline has been collected for a measure, it can be determined if a performance target should be established or not. If the baseline data is at or above the state and national benchmarks when available, and deemed to be within acceptable standards, it is up to the monitoring committee or team to determine if a performance measure should be established or if the measure should continue to be monitored for variances in the baseline data. If the baseline data is below the state and national benchmarks when available, a performance target should be established that is at, or greater than, the state and national average.

Targets may be defined by a set percentage for achievement to meet the outcome being measured or a percentage increase/decrease change to be achieved. When establishing performance targets, the

following should be considered (as defined in the Health Resources and Service Administration (HRSA) Quality Tool Kit):

- *Minimum or Acceptable Level:* Performance standards can be considered "minimum" or "acceptable" levels of success.
- *Challenge Level*: This level defines a goal toward which efforts are aimed. Performance results below this level are acceptable because the level is a challenge that is not expected to be achieved right away.
- *Better Than Before:* The performance measurement process is comparative from measurement period to measurement period. Success is defined as performance better than the last period of measurement. This definition comes out of the continuous quality improvement (CQI) perspective.

The data is reviewed at the established intervals by the appropriate council, committee, or workgroup, in collaboration with QIC. The data is analyzed for undesirable patterns, trends, or variations in performance. In some instances, it may be necessary to complete further data collection and analysis to isolate the causes of poor performance or excessive variability, proceeding with performance improvement action steps until the performance target is met.

d) Performance Improvement Action Steps

Process improvements are achieved by taking action based on data collected and analyzed through performance measurement activities. Actions taken are implemented systematically to ensure any improvements achieved are truly associated with the action. Adhering to the following steps promotes process integrity:

- Plan-Develop a step-by-step action plan, limiting the number of variables impacted.
- Do-Implement the action plan, preferably on a small or pilot scale initially, and
- Study-Analyze the data to check for expected results.
- Act-Modify or develop interventions to obtain expected result.

The PDSA cycle is repeated until the desired level of performance/improvement is achieved. Sustained improvement is sought for a reasonable period (such as one year) before the measure is discontinued. When sustained improvement is achieved, measures move into a maintenance modality, with a periodic (1 year) reassessment of performance to ensure the desired level of quality is being maintained, as appropriate, unless the measure(s) mandated by external entities such as the MDHHS require further measurement and analysis.

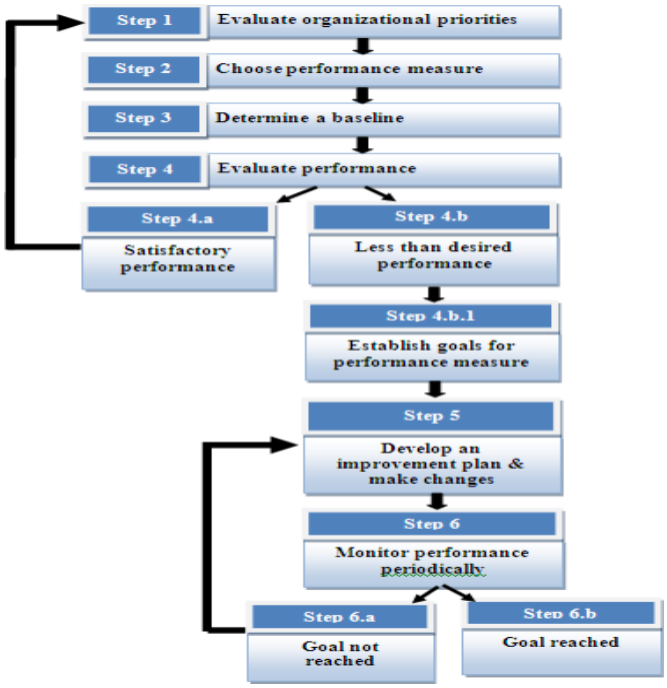
When the established minimum performance targets or requirements are not met, CMHSP Participants/SUD Providers may need to submit a quality improvement plan that includes the following:

- Causal factors that caused the variance (directly and/or indirectly)
- Interventions that will be implemented to correct the variance
- Timelines for when the action will be fully implemented
- How the interventions will be monitored
- Any other actions that will be taken to correct undesirable variation

The appropriate MSHN staff, council, committee, workgroup, etc. will monitor the implementation and effectiveness of the quality improvement plan (QIP). The effectiveness of the QIP will be monitored based on the re-measurement period identified.

In some instances, region wide quality improvement efforts may be developed based on the patterns and trends identified through data analysis, in lieu of provider level improvement plans. Region wide efforts will be reviewed for effectiveness at established intervals within the appropriate MSHN council, committees, workgroups.

Process Map of Performance Management Pathway (defined by HRSA)



e) Performance Indicators[2]

The Michigan Department of Health and Human Services (MDHHS), in compliance with Federal mandates, establishes measures in access, efficiency, and outcomes. Pursuant to its contract with MDHHS, MSHN is responsible for ensuring that it's CMHSP Participants and Substance Use Disorder Providers are measuring performance using standardized performance indicators and participate in the Michigan Mission Based Performance Improvement System (MMBPIS).

When minimum performance targets or requirements are not met, CMHSP participants/SUD providers develop a quality improvement plan documenting causal factors, interventions, implementation timelines, and any other actions taken to correct undesirable variation. The plan will be reviewed by the designated MSHN content expert to ensure sufficient action planning. Regional trends are identified and discussed at the QIC or relevant committee/council for regional planning efforts and coordination. The effectiveness of the action plan will be monitored based on the re-measurement period identified.

[2] Quality-Michigan Mission Based Performance Indicator System

f) Performance Improvement Projects[3]

MDHHS requires the PIHP to complete a minimum of two performance improvement projects (PIP) per waiver renewal period. The QIC chooses performance improvement projects based on the methodology described in Section VI Performance Management of this document which includes but is not limited to the analysis of data, analysis of process, satisfaction, and/or outcome trends that may have an impact on the quality of service provided. Once chosen, a recommendation is made to the MSHN Operations Council for approval. The PIP is presented to relevant committees and councils for collaboration during the duration of the PIP. One of the two is chosen by the department based on Michigan's Quality Improvement Council recommendations. This project is approved by MDHHS and subject to validation by the external quality review (EQR) organization, requiring the use of the EQR's form. In alignment with the MDHHS Comprehensive Quality Strategy, MDHHS has elected the focus of the PIP topic for FY22-FY25 to include the reduction of existing racial or ethnic disparities in access to healthcare or health outcomes. MSHN has approved the following Non-clinical Performance Improvement Project to address access to services for the historically marginalized groups within the MSHN region:

Study Topic - Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population.

Study Question - Do the targeted interventions reduce or eliminate the racial or ethnic disparities between the black/African American population and the white population who have received a medically necessary ongoing service within 14 days of completing a biopsychosocial assessment?

The second or additional PI project(s) is chosen by the PIHP. MSHN QIC has recommended and MSHN Operations Council has approved the following Non-clinical Performance Improvement Project to ensure time access to treatment:

Study Topic - The racial or ethnic disparities between the black/African American penetration rate and the index (white) penetration rate will be reduced or eliminated.

Study Questions - Do the targeted interventions reduce or eliminate the racial or ethnic disparities in the penetration rate between the black/African American penetration rate and the index (white) penetration rate?

Performance is reviewed as outlined in the performance improvement project description to ensure significant improvement is sustained over time. The summary is submitted to the external quality review organization for a validation review, and to MDHHS through the QAPIP Annual Report and upon request.

VII. STAKEHOLDER EXPERIENCE/ENGAGEMENT [4]

MSHN values the opinions of consumers, their families, and other stakeholders as essential to identify ways to improve processes and outcomes. Surveys and focus groups are an effective means to obtain input on both qualitative and quantitative experiences. Consumers receiving services funded by the PIHP, and organizations providing services to consumers are surveyed by MSHN at least annually using a standardized survey or assessment tool. The tools vary in accordance with service population needs,

[3] Quality-Performance Improvement

[4] Quality-Consumer Satisfaction Survey Policy

address quality, availability, and accessibility of care. Focus groups are conducted as needed to obtain input on specific issues. Consumers may also be queried by the CMHSP participants/SUD providers regarding the degree of satisfaction via periodic reviews of the status of their person-centered plans, as well as during discharge planning for the cessation or transition of services.

Surveys used to assess stakeholder and member experiences include but are not limited to the following:

- Mental Health Statistics Improvement Program (MHSIP)-Adults with a Mental Health illness
- Youth Satisfaction Survey (YSS) Youth with a Severe Emotional Disturbance
- Substance Use Disorder Satisfaction Survey-Individuals with a substance use disorder
- Home and Community Based Services Survey-Individuals receiving Long Term Supports and Services
- Provider Network Survey-Organizations who contract with MSHN
- Committee/Council Survey-Provider representatives on MSHN committees/ councils
- National Core Indicator Survey-Individuals receiving LTSS
- Appeals and Grievance Data, and customer complaints

The aggregated results of the surveys and/or assessments are collected, analyzed, and reported by MSHN to the QI Council, Regional Consumer Advisory Council, and other relevant committees/councils, who identify strengths, areas for improvement and make recommendations for action and follow up as appropriate. Regional benchmarks and/or national benchmarks are used for comparison when available. The data is used to identify best practices, demonstrate improvements, or identify growth areas. The QI Council determines action for improvements. The findings are incorporated into program improvement action plans as appropriate. The CMHSP participant/SUD providers take action on individual cases, as appropriate, to identify and investigate sources of dissatisfaction and determine appropriate follow-up.

Survey or assessment results are included in the annual PIHP QAPIP Report and presented to the MSHN governing body, the Operations Council, Regional Consumer Advisory Council, CMHSP Participants, SUD Providers and is accessible on the MSHN website. Findings are also shared with stakeholders on a local level through such means as advisory councils, staff/provider meetings and printed materials.

VIII. ADVERSE EVENTS

Adverse Events include any event that is inconsistent with or contrary to the expected outcomes of the organization's functions that warrant a PIHP review. A subset of the adverse events will qualify as "reportable events" according to the MDHHS Critical Event Reporting System. These include MDHHS defined sentinel events, critical incidents, and risk events. MSHN also ensures that each CMHSP participant/SUD provider has a system in place to monitor these events, utilizing staff with appropriate credentials for the scope of care, and reporting or follow up within the required timeframes.

MSHN submits and/or reports required events to MDHHS including events requiring immediate notification as specified in the MDHHS PIHP contract and the Critical Incident Reporting and Event Notification Policy.

MSHN delegates the responsibility of the review and follow-up of sentinel events, critical incidents, and other risk events that put people at risk of harm to the CMHSP participants and SUD providers.

Risk events are monitored by the providers and include actions taken by individuals receiving services as defined by MDHHS, that may cause harm to self or others, and have had two or more unscheduled admissions to a medical hospital within 12 months. CMHSP Participants report suicide deaths, non-suicide deaths, arrests, emergency medical treatment and/or hospitalization for injuries and medication errors for required populations as defined by MDHHS.[5] Additionally, subcategories reported for deaths include accidental/unexpected and homicide. Subcategories for emergency medical treatment and hospitalizations include those injuries from the use of physical management. SUD Providers, including but not limited to residential providers, review and report deaths, injuries requiring emergency medical treatment and/or hospitalization, serious behavioral issues, medication errors, physical illness requiring hospitalization, and arrests and/or convictions as defined by MDHHS.[6] All MSHN providers are responsible to review critical incidents to determine if the incident is sentinel within three days of the occurrence. Once appropriately qualified and credentialed staff identify an incident as sentinel, a root cause analysis/investigation is to commence within 2 business days of the identification of the sentinel event. Following completion of a root cause analysis, or investigation, the CMHSP will develop and implement either a plan of action to address immediate safety issues, an intervention to prevent further occurrence or recurrence of the adverse event, or documentation of the rationale for not pursuing an intervention. The plan shall address the staff and/or program/committee responsible for implementation and oversight, timelines, and strategies for measuring the effectiveness of the action. [7]MSHN providers are responsible to report any death that occurs as a result of staff action or inaction, subject to recipient rights, licensing, or police investigation within 48 hours of the death or receipt of the notification of the death and/or investigation. A written report of the review and analysis of the death will be completed and submitted to MDHHS for any individuals whose death has occurred within 12 months of a discharge from a state operated facility

MSHN provides oversight and monitoring of the CMHSP participant/SUD provider processes for reporting sentinel events, critical events, events requiring immediate notification to MDHHS, and monitoring of risk events. In addition, a quarterly analysis of the events, identified patterns or trends, the completion of identified actions, and recommended prevention strategies for future risk reduction is reviewed with the relevant committees and councils. The goal of reviewing these events is to focus the attention of the CMHSP participant/SUD providers on potential underlying causes of events so that changes can be made in systems or processes in order to reduce the probability of such events in the future.

IX. CLINICAL QUALITY STANDARDS

a) Utilization Management [8] -

MSHN ensures access to publicly funded behavioral health services in accordance with the Michigan Department of Health and Human Services contracts and relevant Medicaid Provider Manual and Mental Health Code requirements.

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[5] Quality-Critical Incidents

[6] Quality-Critical Incident Review for SUD Providers

[7] Quality-Sentinel Events

[8] Utilization Management Plan

MSHN directly or through delegation of function to the CMHSP Participants/SUD Providers acting on its behalf, is responsible for the overall network's utilization management (UM) system. Each CMHSP Participant/SUD Provider is accountable for carrying out delegated UM functions and/or activity relative to the people they serve through directly operated or contracted services.

Initial approval or denial of requested services is delegated to CMHSP Participants/SUD Providers, including the initial screening and authorization of psychiatric inpatient services, partial hospitalization, and initial and ongoing authorization of services for individuals receiving community services. All service authorizations are based on medical necessity decisions that establish the appropriate eligibility relative to the identified services to be delivered.

Communication with individuals regarding UM decisions, including adverse benefit determination notice, right to second opinion, and grievance and appeals will be included in this delegated function.

Utilization review functions are delegated to CMHSP Participants in accordance with MSHN policies, protocols, and standards. This includes local-level prospective, concurrent and retrospective reviews of authorization and utilization decisions and/or activities regarding level of need and level and/or amount of services, consistent with PIHP policy, standards, and protocols. A Regional Utilization Management Committee comprised of each CMHSP Participant assists in the development of standards and reviews/analyzes region-wide utilization activity and trends.

MSHN retains utilization review functions for substance use disorder (SUD) services in accordance with MSHN policies, protocols, and standards. This includes local-level prospective, concurrent, and retrospective reviews of authorization and utilization decisions and/or activities regarding level of need and level and/or amount of services, consistent with PIHP policy, standards, and protocols. Initial service eligibility decisions for SUD services are delegated to SUD providers through the use of screening and assessment tools.

MSHN ensures that screening tools and admission criteria are based on eligibility criteria established in contract and policy and are reliably and uniformly administered. MSHN policies are designed to integrate system review components that include PIHP contract requirements and the CMHSP Participant's/SUD Provider roles and responsibilities concerning utilization management, quality assurance, and improvement issues.

MSHN has established criteria for determining medical necessity, and the information sources and processes that are used to review and approve provision of services. MSHN and its CMHSP Participants/SUD Providers use standardized population-specific assessments or level of care determination tools as required by MDHHS. Assessment and level of care tools guide decision making regarding medical necessity, level of care, and amount, scope, and duration of services. No one assessment shall be used to determine the care an individual receives, rather it is part of a set of assessments, clinical judgment, and individual input that determine level of care relative to the needs of the person served.

MSHN has mechanisms to identify and correct under-and over-utilization of services as well as procedures for conducting prospective, concurrent, and retrospective reviews. MSHN ensures through policy and monitoring of the CMHSP Participants/SUD Providers that qualified health professionals supervise review decisions and any decisions to deny or reduce services are made by health care professionals who have appropriate clinical licensure and expertise in treating the beneficiary's condition. Through policy and monitoring of CMHSP Participants/SUD Providers, MSHN shall ensure that reasons for treatment decisions are clearly documented and available to persons

served; information regarding all available appeals processes and assistance through customer services is communicated to the consumer; and notification requirements are adhered to in accordance with the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Health and Human Services.

b) Integrated Care

MSHN has developed a population health and integrated care plan to establish regional guidance and best practices related to population health and integrated care strategies. Integrated care initiatives are used to improve the health of individuals within the MSHN region. The integrated care initiatives are monitored through population health analysis and a core set of performance measures designed to measure the health outcomes of individuals and the effectiveness of services requirements within various models of care. Currently MSHN participates in the following initiatives:

- Certified Behavioral Health Clinics (CCBHC)
- Behavioral Health Homes (BHH)
- Opioid Health Homes (OHH)
- Complex Care Management

c) Practice Guidelines[9]

MSHN supports and requires the use of nationally accepted and mutually agreed upon clinical practice guidelines including Evidenced Based Practices (EBP) to ensure the use of research -validated methods for the best possible outcomes for service recipients as well as best value in the purchase of services and supports. Practice guidelines include clinical standards, evidenced-based practices, practice-based evidence, and promising practices that are relevant to the individuals served.

The process for adoption, development, and implementation is based on key concepts of recovery, and resilience, wellness, person centered planning/individual treatment planning and choice, self-determination, and cultural competency. Practices will appropriately match the presenting clinical and/or community needs as well as demographic and diagnostic characteristics of individuals served. Practice guidelines utilized are a locally driven process in collaboration with the MSHN Councils and Committees. Practice guidelines are chosen to meet the needs of persons served in the local community and to ensure that everyone receives the most efficacious services. Clinical programs will ensure the presence of documented practice skills including motivation interviewing, trauma informed care and positive behavioral supports.

Practice guidelines will be monitored and evaluated through data analysis and MSHN's site review process to ensure CMHSP participants and SUD providers, at a minimum, are incorporating mutually agreed upon practice guidelines within the organization. Additionally, information regarding evidenced based practices is reported through the annual assessment of network adequacy. Fidelity reviews shall be conducted and reviewed as part of the local quality improvement program or as required by MDHHS.

[9] Service Delivery-Clinical Practice Guidelines and Evidence Based Practices

The use of practice guidelines and the expectation of use are included in provider contracts. Practice guidelines are reviewed and updated annually or as needed and are disseminated to appropriate providers through relevant committees/councils/workgroups. All practice guidelines adopted for use are available on the MSHN website.

d) Long Term Supports and Services

MSHN ensures that individuals needs are assessed, and long term supports, and services are included in the individuals plan of service and provided in a manner that considers the health, safety, and welfare of consumers, family, providers, and other stakeholders. When health and safety, and/or welfare concerns are identified, those concerns will be acknowledged, and actions taken as appropriate. As indicated in the 1115 Waiver, LTSS include the following services: 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, Non-Family training, Specialty Therapies (Music, Art, Message), Children Therapeutic Foster Care, Therapeutic Overnight Camping, Transitional Services, Fiscal Intermediary Services, and Prevocational Services. MSHN assesses the quality and appropriateness of care furnished, assessment of care during the transition between care settings, and community integration through individual feedback on member experiences (satisfaction surveys, appeals and grievance data), adverse events (sentinel, critical, and risk), and clinical chart reviews to ensure opportunities for community integration are occurring, and services are being provided as indicated in the individual plan of service.. MSHN monitors systemic patterns through population health using data analytics software to identify adverse utilization patterns and to reduce health disparities.

e) Cultural Competence

MSHN and its Provider Network shall demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area. Such commitment includes acceptance and respect for the cultural values, beliefs, and practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services.

Competence includes a general awareness of the cultural diversity of the service area including race, culture, religious beliefs, regional influences in addition to the more typical social factors such as gender, gender identification, sexual orientation, marital status, education, employment, and economic factors, etc.

With MSHN's added strategic priority of "better equity," MSHN is seeking to expand its scope of activity beyond cultural competence with an added focus on actively seeking to address implicit bias and to reduce health disparities.

f) Behavior Treatment[10]

MSHN delegates the responsibility for the collection and evaluation of data, and the evaluation of the effectiveness of the Behavior Treatment Committee by stakeholders to each local CMHSP

[10] Quality-Behavior Treatment Plan Review Committee

Behavior Treatment Review Committee. Behavior treatment data is reviewed as part of the each CMHSP Quality Program. Only those (restrictive and/or intrusive) techniques that are included in the individual's plan of service and contained in a Behavior Treatment plan that addresses all standards will be reviewed and approved by the BTPRC prior to plan implementation. Data is collected, reviewed, and reported to MSHN quarterly by the CMHSP where intrusive and restrictive techniques have been approved for use with individuals, and where physical management or 911 calls to law enforcement have been used in an emergency behavioral situation. Data shall include numbers of interventions and the length of time the interventions were used per person. By asking the behavior treatment committees to track this data, it provides important oversight to the protection and safeguard of vulnerable individuals including those receiving long term supports and services.

MSHN provides oversight through analysis of the data on a quarterly basis to address any trends and/or opportunities for quality improvements. MSHN also uses this data during the delegated managed care site reviews to ensure accurate reporting and adherence to the Behavioral Treatment Standards[11] by each CMHSP. MSHN also conducts clinical chart reviews for those with recommended restrictive and/or intrusive interventions, in addition to the annual review of BTPRC policy and procedures. The clinical chart reviews address each of the behavior treatment standards and overall compliance is determined based on implementation of those standards. This data is available to MDHHS upon request.

g) Trauma Informed Care

MSHN and its Provider Network shall adopt a trauma informed culture including the following: values, principles, and development of a trauma informed system of care ensuring safety and preventing re-traumatization. In compliance with the MDHHS Trauma Policy MSHN has delegated the responsibility to the network providers to ensure development of a process for screening and assessing each population for trauma. Providers shall adopt approaches to address secondary trauma for staff and utilize evidenced based practices or evidence informed practice to support a trauma informed culture. An organizational assessment shall be completed to evaluate the extent to which the organizations policies are trauma informed. Organizational strengths and barriers, including an environmental scale to ensure the building and environment does not re-traumatize will be identified and utilized for improvement efforts. The assessment should occur every three years.

Consistent with MSHN's broader agenda to address racial disparities and cultural competence, efforts around being trauma-informed will necessarily be expanded to incorporate competency and awareness around racialized and historical trauma for certain demographics that have historically faced discrimination, marginalization, and violence.

X. PROVIDER STANDARDS

a) Provider Qualifications [12][13]

MSHN has established written policy and procedures, in accordance with MDHHS's Credentialing and Re-Credentialing Processes, for ensuring appropriate credentialing and re-credentialing of the

[12] Provider Network-Provider Network Credentialing/Re-Credentialing

[13] Provider Network-Non-licensed Provider Qualifications

provider network. Whether directly implemented, delegated, or contracted, MSHN shall ensure that credentialing activities occur upon employment/contract initiation, and minimally every two (2) years thereafter. MSHN written policies and procedures also ensure that non-licensed providers of care or support are qualified to perform their jobs, in accordance with the Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes chart.

Credentialing, privileging, primary source verification and qualification of staff who are employees of MSHN, or under contract to the PIHP, are the responsibility of MSHN. Credentialing, privileging, primary source verification and qualification of CMHSP Participant/SUD Provider staff and their contractors is delegated to the CMHSP Participants/SUD Providers. MSHN monitors the CMHSP Participant and SUD Provider compliance with federal, state, and local regulations and requirements annually through an established process including desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies.

MSHN policies and procedures are established to address the selection, orientation, and training of directly employed or contracted staff. PIHP employees receive annual reviews of performance and competency. Individual competency issues are addressed through staff development plans. MSHN is responsible for ensuring that each provider, employed and contracted, meets all applicable licensing, scope of practice, contractual, and Medicaid Provider Manual requirements, including relevant work experience and education, and cultural competence. The CMHSP Participants/SUD Providers are likewise responsible for the selection, orientation, training and evaluation of the performance and competency of their own staff and subcontractors.

b) Medicaid Event Verification [14]

MSHN has established a written policy and procedure for conducting site reviews to provide monitoring and oversight of the Medicaid and Healthy Michigan funded claims/encounters submitted within the Provider Network. MSHN verifies the delivery of services billed to Medicaid and Healthy Michigan in accordance with federal regulations and the state technical requirement.

Medicaid Event Verification for Medicaid and Healthy Michigan Plan includes testing of data elements from the individual claims/encounters to ensure the proper code is used for billing; the code is approved under the contract; the eligibility of the beneficiary on the date of service; that the service provided is part of the beneficiary's individualized plan of service (and provided in the authorized amount, scope and duration); the service date and time; services were provided by a qualified individual and falls within the scope of the code billed/paid; the amount billed does not exceed the contract amount; the amount paid does not exceed the contract amount; and appropriate modifiers were used following the HCPCS/MDHHS guidelines.

Data collected through the Medicaid Event Verification process is aggregated, analyzed, and reported for review at the QI Council and Regional Compliance Committee meetings, and opportunities for improvements at the local or regional level are identified. The findings from this process, and any follow up needed, are reported annually to MDHHS through the Medicaid Event Verification Service Methodology Report.

[14] Quality-Medicaid Event Verification

c) Financial Oversight

MSHN has established written policies and procedures to ensure appropriate financial management. MSHN will conduct a financial oversight review of the SUD provider network. The review will be based on eight standards used to assure regulatory compliance by reviewing the following: Certified Public Accountant (CPA) Audit, compliance with previous corrective action; financial management policies and procedures; documents to ensure proper segregation of duties; evidence to support the Financial Status Report (FSR) billing; verification of board approved sample financial reports; and evaluation of Risk Management Plan. Information obtained from the review will be used to identify focus areas for improvement efforts, in accordance with the oversight monitoring corrective action process.

All CMHSP Participants and MSHN have implemented the generation of a summary of Explanations of Benefits in accordance with the MDHHS Specialty Mental Health Services Program contract. This will provide an additional step to ensure that consumers are aware of service activity billed to their insurance.

d) Value Based Purchasing

MSHN utilizes a value-based purchasing model in coordination with the CMHSP participants and SUD Providers to provide cost effective, and high-quality care. This is completed through incentivizing positive clinical outcomes utilizing the most effective service model.

e) Provider Monitoring and Follow-Up[15][16]

MSHN uses a standard written contract to define its relationship with CMHSP Participants/SUD Providers that stipulates required compliance with all federal and state requirements, including those defined in the Balance Budget Act (BBA), the Medicaid Provider Manual, and the master contract between the PIHP and MDHHS. Each CMHSP Participant/SUD Provider is contractually required to ensure that all eligible recipients have access to all services required by the master contract between the PIHP and MDHHS, by either direct service provision or the management of a qualified and competent provider panel. Each CMHSP Participant/SUD Provider is also contractually required to maintain written subcontracts with all organizations or practitioners on its provider panel. SUD Providers, however, must first obtain written authorization from MSHN in order to subcontract any portion of their agreement with MSHN. These subcontracts shall require compliance with all standards contained in the BBA, the Medicaid Provider Manual, and the Master Contract between the PIHP and the MDHHS.

Each CMHSP Participant/SUD Provider is required to document annual monitoring of each provider subcontractor as required by the BBA and MDHHS. The monitoring structure shall include provisions for requiring corrective action or imposing sanctions, up to and including contract termination if the contractor's performance is inadequate. MSHN continually works to assure that the CMHSP Participants support reciprocity by developing regionally standardized contracts, provider performance protocols, maintain common policies, and evaluate common outcomes to avoid duplication of efforts and reduce the burden on shared contractors. MSHN monitors compliance with federal and state regulations annually through a process that includes any combination of desk review, site review verification activities, and/or other appropriate oversight and compliance enforcement strategies. CMHSPs Participants/SUD Providers that are unable to demonstrate acceptable

[15] Quality-CMHSP Participant Monitoring & Oversight

[16] Quality-Monitoring & Oversight of SUD Service Providers

performance may be required to provide corrective action, may be subject to additional PIHP oversight and interventions, and may be subject to sanctions imposed by MSHN, up to and including contract termination.

f) External Reviews[17]

The PIHP is subject to external reviews through MDHHS and/or an external quality reviewer contracted by MDHHS to ensure quality and compliance with all regulatory requirements. MSHN collaborates with MDHHS and the external quality reviewer to provide relevant evidence to support compliance. In accordance the MDHHS-PIHP, all findings that require improvement based on the results of the external reviews are incorporated into the QAPIP Priorities for the following year. An action plan will be completed that includes the following elements: improvement goals, objectives, activities, timelines, and measures of effectiveness in response to the findings. The improvement plan will be available to MDHHS upon request.

(2020) What are Long-Term Supports and Services (LTSS) (https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/ltss-overview)

(2021). Medicaid Managed Specialty Supports and Services Contract

(2021). Medicaid Managed Specialty Supports and Services Contract Quality Assessment and Performance Improvement Technical Requirement

(2004-2005). The Joint Commission. Comprehensive Accreditation Manual for Behavioral Health Care.

(May 13, 2011). Michigan Department of Community Health (MDCH)/Prepaid Inpatient Health Plan (PIHP) Event Reporting v1.1, Data Exchange Workgroup-CIO-Forum.

(November 2002). "Developing a Quality Management System for Behavioral Health Care: The Cambridge Health Alliance Experience". Harvard Review of Psychiatry.

(1991). Scholtes, P. R. In The Team Handbook (pp. 5-31). Madison, WI: Joiner Associates, Inc.

[17] Quality-External Quality Review

XI. Quality Assessment and Performance Improvement Program Priorities (QAPIP) FY2024

The QAPIP priorities shall guide quality efforts for FY24. Figure 1 provides the QAPIP Priorities and Quality Work Plan for FY24. The FY23 QAPIP Priorities include completion of required elements of the QAPIP, and improvement areas based on QAPIP review of effectiveness and external quality and/or compliance reviews. QAPIP activities are aligned with the MSHN Strategic Plan contributing to Better Health, Better Care, Better Provider Systems, and Better Equity for the individuals we serve.

Figure 1. QAPIP Priorities and Work Plan

Organizational Structure and Leadership	Objectives/Activities	Lead	Frequency/ Due Date
MSHN will complete and submit a Board approved QAPIP Plan, Evaluation and Workplan with list of members of the Governing Body. *42 CFR §438.330(a)(1) Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section I*	• Collaborate with other committees/councils to complete an annual effectiveness review with recommendations to be incorporated into the MSHN QAPIP Evaluation. • Collaborate with committees/councils to develop regional QAPIP workplan. • Review/revise QAPIP Plan to include new regulations. • Submit to MDHHS via FTP site.	Quality Manager	10/31/2024 10/31/2024 9/30/2024 2/28/2024
MSHN Board of Directors will review QAPIP Progress Reports describing performance improvement projects, actions, and results of actions.	• Establish an organizational process to monitor the status of the quality workplan and key performance indicators used to monitor clinical outcomes and process implementation. • Development of standard templates for use in organizational performance improvement projects and QI plan. • Include standard agenda items specific to the organizational performance and improvement activity (QAPIP). (Balanced Scorecard Review, Quarterly Department Reports)	Quality Manager Quality Manager Deputy Director	6/30/2024 6/30/2024 6/30/2024
MSHN will have an adequate organizational structure with clear administration and evaluation of the QAPIP *Contract Schedule A—1(K)(2)(a). QAPIPs for Specialty PIHPs, Section I*	• Evaluate the committee/structure to ensure responsibilities align with the strategic priorities. • Review committee charters to ensure effectiveness in carrying out the defined responsibilities. • Complete committee/council survey of effectiveness	Quality Manager	9/30/2024 10/30/2024 8/30/2024
MSHN will include the role of recipients of service in the QAPIP. *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section I*	• Recipients will provide feedback and have membership in select regional committees for the purpose of advocacy, project/policy planning and development, project implementation and evaluation.	Customer Services Manager Quality Manager	9/30/2024

	• Recipients will complete an assessment/survey of services and experiences of care. • Document member feedback in meeting minutes or other documents to ensure follow up. (QAPIP Description, Organizational Chart, Charter Membership).	Customer Services Manager	8/30/2024
MSHN will have mechanisms or procedures for adopting and communicating process and outcome improvement. *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section I*	• Utilize the regional committee structure for communication and distribute policies/procedures, reports through. o Committee/councils, o MSHN Constant Contact, o Email. o Website o Post to the MSHN Website.	Quality Manager	Monthly
MSHN will have active participation of Network providers and members in the QAPIP processes. *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section IV*	• Document discussion and source of feedback to ensure follow up.	Committee/ Council Leads	9/30/2024
MSHN will provide and/or make available to consumers & stakeholders, including providers and the general public, the QAPIP Report, QAPIP Plan and other quality reports. *Contract Schedule A—1(K)(3)(a*	• Distribute the completed Board approved QAPIP Effectiveness Review (Report) and QAPIP Plan through o Committee/councils, o MSHN Constant Contact, o Email. o Website o Post to the MSHN Website. • Ensure CMHSP contractors have opportunity to receive the QAPIP. (DMC-check websites) • Provide to members upon request. • Distribute QAPIP progress reports which include but are not limited to Consumer Satisfaction Survey Results, Key Priority Measures, MMBPIS, Behavior Treatment Review Data, Event Data, Quality policies/procedures and Customer Service Reports to RCAC.	Quality Manager	Annually Annually As needed. Quarterly
Performance Measurement and Quality reports are made available to stakeholders and general public. *Contract Schedule A—1(K)(3)(a)*	• Upload to the MSHN website the following documents: QAPIP Plan and Report, Satisfaction Surveys, Performance Measure Reports; MSHN Scorecard, and MSHN Provider Site Review Reports, in addition to communication through committees.	Leadership	Quarterly

MDHHS Performance Measures	Objectives/Activities	Assigned Lead	Frequency/ Due Date
MSHN will meet or exceed the measure performance using standardized indicators including those established by MDHHS in the Medicaid contract and analyze causes of negative outliers.	• Review/Identify regional key performance indicators. • Monitor performance and review progress.	Quality Manager and Assigned Measure Stewards	Annually Quarterly
MSHN will evaluate the impact and effectiveness of the QAPIP • Performance of the measures, • Outcomes and trended results • Results of efforts to support community integration for members receiving LTSS. • Analysis of improvements in healthcare and services as a result of the QI activities. • Trends in service delivery and health outcomes over time including monitoring of progress	• Establish a standardized process for MSHN committee/council to monitor the impact of intervention (quality improvement) on assigned performance areas. • Establish standard process for quality improvement in collaboration with committee/councils to analyze outliers and develop/identify regional improvement strategies used to identify barriers and interventions.	Quality Manager	Quarterly
MSHN will meet or exceed the MMBPIS standards for Indicators as required by MDHHS.	• Monitor performance and review progress (including barriers, improvement efforts, recommendations, and status of recommendations). • Develop/identify regional improvement strategies used to identify barriers and interventions in collaboration with committee. • Monitor the effectiveness of interventions.	Quality Manager	Annually Annually Quarterly
MSHN will demonstrate an increase in compliance with access standards for the priority populations.	• Monitor performance and review progress (including barriers, improvement efforts, recommendations, and status of recommendations). • Develop/identify regional improvement strategies used to identify barriers and interventions.	SUD Care Navigator	Quarterly
Performance Improvement Projects	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**

PIP 1: Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the Black/ African American population and the white population.	• Collaborate with PIP Team members and relevant committee. • Utilize quality tools to identify barriers and root causes. • Implement interventions. • Evaluate the effectiveness of interventions. • Submit PIP 1 to HSAG as required for validation. • Submit to MDHHS with QAPIP Evaluation.	Quality Manager	Quarterly Annually Annually Annually 6/30/2024 2/28/2024 2/28/2025
PIP 2: The racial or ethnic disparities between the black/African American penetration rate and the index (white) penetration rate will be reduced or eliminated.	• Collaborate with PIP Team members and relevant committee. • Utilize quality tools to identify barriers and root causes. • Implement interventions. • Evaluate the effectiveness of interventions. • Submit to MDHHS with QAPIP Evaluation.	Quality Manager	Quarterly Annually Annually Annually 2/28/2024 2/28/2025
Quantitative and Qualitative Assessment of Member Experiences	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**
MSHN will obtain a qualitative and quantitative assessment of member experiences for all representative populations, including members receiving LTSS and • Assess issues of quality, availability, accessibility of care, • take specific action as needed, identifying sources of dissatisfaction, • outline systematic action steps, • evaluate the effects of improvement activities and, • communicate results to providers, recipients, and the Governing Body. *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section X(A-D)*	• Complete an assessment/survey of member experience of care representative of all served, addressing issues of quality, availability, and accessibility of care. (MI, IDD, SUD, LTSS)	Quality Manager	6/30/2024
	• Implement MHSIP for individuals receiving SUD services.	Quality Manager	6/30/2024
	• Complete member experience annual report with causal factors, interventions, feedback provided from relevant committees/councils, and an evaluation of impact of the interventions to improve satisfaction.	Quality Manager	9/30/2024
	• Identify sources of dissatisfaction and document Provider Network action steps for improvement in the QIC action plan	Quality Manager	8/30/2024
	• Establish a QI Team to streamline surveys and processes. Identify sources of feedback to include in the regional assessment of member experiences. Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations).	Quality Manager	3/31/2024
	• Complete an RFP for administration and analysis by an external vendor.	Quality Manager	6/30/2024
MSHN will adhere to the timeliness standards for Appeal and Grievance Reporting	• Implement a corrective action plan process for FY24 reporting when CMHSPs do not meet the 95% timeliness standard for Appeal and Grievance reporting	Customer Services Manager	1/31/2024

Event Monitoring and Reporting	Objectives/Activities	Assigned Lead	Frequency/ Due Date
MSHN will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored, reported, and followed up on as specified in the PIHP Contract and the MDHHS Critical Incident Reporting and Event Notification Policy. *42 CFR § 441.302(h)* *42 CFR §438.330(b)(5)(ii)* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section VIII*	• Develop training documents and complete training outlining the requirements of reporting critical, sentinel, and risk events.	Quality Manager	4/2024
	• Validate / reconcile reported data through the CRM.	Quality Manager	Quarterly
	• Establish electronic process for submission of sentinel events/ immediate notification, remediation documentations, and written analysis for those deaths that occurred within one year of discharge from state operated service.	Quality Manager	9/2024
	• Implement the use of the Root Cause Analysis template with standardized elements.	Quality Manager	9/2024
	• Complete the CIRS Performance Reports (including standards, trends, barriers, improvement efforts, recommendations, and status of recommendations to prevent reoccurrence) quarterly. • Complete CIRS Process Improvement Report.	Quality Manager	Quarterly
Improve timeliness of remediation response in the CIRS-CRM	• Develop dashboard for tracking and monitoring submission timelines and remediation timelines.	Quality Manager	9/2024
Medicaid Event Verification	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**
MSHN will address and verify whether services reimbursed by Medicaid were furnished to enrollees by affiliates, providers, and subcontractors. *Contract Schedule A—1(K)(2)(a),QAPIPs for Specialty PIHPs, Section XII(A,B*	• Complete Medicaid Event verification reviews in accordance with MSHN policy and procedure.	MEV Auditor	Annually
	• Complete The MEV Annual Methodology Report identifying trends, patterns, strengths and opportunities for improvement, and actions taken.	Chief Compliance and Quality officer	12/31/2023 12/31/2024
Utilization Management Plan	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**
MSHN will establish a Utilization Management Plan in accordance with the MDHHS requirements: • Procedures to evaluate medical necessity, criteria used, information sources, and process to review and	• MSHN to complete performance summary quarterly reviewing under / over utilization, medical necessity criteria, and the process used to review and approve provision of medical services. Identify CMHSPs/SUDPs requiring improvement and present/provide to relevant committees/councils.	Chief Population Health Officer	Quarterly/ Annually
	• Review tools for determining medical necessity for community living supports; recommend regional best practice	Chief Population Health Officer	April 2024

approve provision of medical services. • Mechanisms to identify and correct under and over utilization. • Prospective, concurrent and retrospective procedures are established and include required components. *42 CFR §438.330(b)(3)*	• Continued analysis of differences in amount/ duration of services received by individuals enrolled in waivers and non-waiver individuals. • Develop and monitor reports and identify any areas where improvement is needed. • Integrate standard assessment tools into REMI- MichiCANS implementation.	Chief Population Health Officer Chief Information Officer	January 2024 Quarterly
Service Authorizations Denials Report demonstrates 90% or greater compliance with timeframe requirements for service authorization decisions and ABD notices.	• Oversight of compliance with policy through primary source verification during Delegated Managed Care Reviews.	Chief Population Health Officer	Annually
	• Monitor REMI process for tracking timeliness of authorization decisions, developing improvement plans	Chief Population Health Officer	Annually
Oversight of "Vulnerable People"/Long Term Supports and Services	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**
MSHN will establish mechanisms to assess the quality and appropriateness of care furnished to members with special healthcare needs, as identified by MDHHS in the Quality Strategy. *42 CFR 438.330 (b)(4)*	• Analyze performance reports (including barriers, improvement efforts, recommendations, and status of recommendations) for community integration and assessment of care between settings.	MSHN-CBHO	Annually/ Quarterly
Mechanisms to assess the quality and appropriateness of care furnished to members using long-term services and supports, 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. *42 CFR 438.330 (b)(5)(i)*	• Develop process and identify report to monitor aggregate data on the quality and appropriateness of care for those receiving LTSS. • Establish process and identify report to monitor aggregate data for assessment of care between care settings. • Analyze performance reports (including barriers, improvement efforts, recommendations, and status of recommendations) for community integration and assessment of care between settings. • Include information in the QAPIP description, workplan, evaluation.	CBHO	Annually/ Quarterly
Individuals receiving LTSS will be offered opportunities to participate in the community.	• MSHN clinical team will review community integration during regional site reviews, implementing quality improvement when evidence of community integration is not found, and monitor for effectiveness to ensure community integration is occurring.	Waiver staff	Annually

Practice Guidelines	Objectives/Activities	Assigned Lead	Frequency/ Due Date
MSHN will demonstrate an increase in fidelity to the EBP-Assertive Community Treatment Michigan Field Guide, on average minutes per week per consumer.	• Monitor utilization summary of the average. • Recommend improvement strategies where adverse utilization trends are detected.	Chief Population Health Officer	Quarterly
MSHN will demonstrate an increase in the implementation of Person-Centered Planning and Documentation in the IPOS	• Establish a Person-Centered Planning QI Team to review process steps to identify efficiencies. • Develop report to monitor, analyze, and improve the amount/scope and duration of services received by individuals enrolled in waivers and those not enrolled in waiver programs/services.	Quality Manager Chief Population Health Officer	6/30/2024 1/2024
Behavior Treatment	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**
MSHN will analyze Behavior Treatment Data where intrusive or restrictive techniques have been approved for use and where physical management or 911 call to law enforcement have been used in an emergency behavioral crisis. Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section IX	• MSHN quality manager will work with IT/PCE to coordinate a more streamlined approach to data submission in REMI	Quality Manager	9/30/2024
	• MSHN will reach out to State Workgroup about training opportunities (including Direct Care Workers) • CMHSPs will share details of their training platforms with others (internal training, contracted trainers, etc.) • Regional BTR Workgroup will work together to provide/offer training opportunities for those working in direct care roles	Waiver Administrator	10/2024
MSHN will adhere to the MDHHS Technical Requirement for Behavior Treatment Plans. Contract Schedule A—1(K)(2)(a) QAPIPs for Specialty PIHPs, Section IX	• BTR Workgroup members will share documentation and processes for consistent monitoring and tracking purposes. • CMHSPs will identify ways to incorporate standards into their EMR. • CMHSPs will share progress on EMR development of BTP standards. • MSHN will continue to review BTP charts through the DMC Review and the MDHHS 2024 Site Review. • MSHN will offer individual trainings as needed/requested. • MSHN will make regional BTPRC Training recording accessible to providers and stakeholders	Waiver Administrator	10/2024

Provider Monitoring	Objectives/Activities	Assigned Lead	Frequency/ Due Date
MSHN will monitor the provider network including affiliates or subcontractors to which it has delegated managed care functions, including service and support provision, following up to ensure adherence to the required functions.	• Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	Compliance Administrator	Annually
	• Coordinate quality improvement plan development, incorporating goals and objectives for specific growth areas based on the site reviews, and submission of evidence for the follow up reviews.	Functional Area Leads	9/30/2023
MSHN will demonstrate an increase in compliance with the External Quality Review (EQR)-Compliance Review.	• Implement corrective action plans for areas not in full compliance, and quality improvement plans for recommendations. See CAP for specific action steps and assigned leads.	Compliance Administrator	9/30/2024
MSHN will demonstrate full compliance with the EQR-Performance Measure Validation Review.	• Verify Medicaid Eligibility and data accuracy through primary source verification.	Quality Manager	Quarterly
	• Validate data collection process, both administrative and manual.	Quality Manager	Annually
	• Develop / modify ongoing training documents.	Quality Manager	Annually
MSHN will demonstrate an increase in compliance with the MDHHS 1915 Review.	• Provide technical assistance to CMHSPs related to standards. • Develop and monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data.	Waiver Staff	9/30/2023
Provider Qualifications	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**
Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements	• Will evaluate the MDHHS credentialing report for CMHSP timeliness in decision making and credentialing activities.	Compliance Administrator	Biannually
	• Will complete additional monitoring for those CMHSP who demonstrate a compliance rate of =<90% based on the credentialing report.	Compliance Administrator	Quarterly
	• Will complete primary source verification and review of the credentialing/recredentialing policy and procedure during the DMC review.	Compliance Administrator	Annually
	• Will complete primary source verification for professionals that have/require the designation of Qualified Intellectual Disability Professional (QIDP).	Waiver Staff	Annually

An effective performance measurement system allows an organization to evaluate the safety, accessibility, quality and appropriateness, effectiveness, clinical outcomes and an evaluation of member experience of the services in which an individual receives. MSHN utilizes a balanced score card to monitor organizational performance. Organizational performance include, but are not limited to MDHHS required metrics. Areas that perform below the standard are included in the annual QAPIP Work Plan.

Figure 2. Organizational QAPIP Performance Measures for FY24
(Will be included)

Key Performance Indicators	**Regulatory Reference**
Access to Preventive/Ambulatory Health Services (AAP)* The percentage of members who had an ambulatory or preventative care visit. Ages 20-44, 45-64, 65+, Total 20+.	MDHHS PIHP Contract: BHH
Adherence to antipsychotic medications for individuals with schizophrenia. (SAA-AD) Percentage of Adults Age 18 and Older with Schizophrenia or Schizoaffective Disorder who were Dispensed and Remained on an Antipsychotic Medication for at Least 80 Percent of their Treatment Period. CCBHC age 19-64 CCBHC Program Benchmark 56.7%. Complete Validation	MDHHS PIHP Contract: CCBHC QBP NCQA/HEDIS-CMS Adult Core Set FY24 PIHP Performance Bonus Incentive Program
Admission to a Facility from the Community (AIF-HH) Ages 18-64, 65-74, 75-84, 85+, Total 18+. Short Term Stay 1-20 days, Medium Term Stay 21-100, Long-Term Stay >= 101 days.	MDHHS PIHP Contract: BHH, OHH CMS Health Home Core Set (2023)
Analyze and monitor BH TEDS records to improve housing and employment outcomes for persons served.	FY24PIHP Performance Bonus Incentive Program
Antidepressant Medication Management Acute Phase (AMM-BH)/(AMM-AD) ^ CCBHC Ages 18+. Program Benchmark 49.1%.	MDHHS PIHP Contract: CCBHC NCQA/HEDIS-CMS Adult Core Set
Antidepressant Medication Management Cont. Phase (AAM-BH)/(AMM-AD) ^CCBHC ages 18+. Program Benchmark 29.8%	MDHHS PIHP Contract: CCBHC CMS Adult Core Set (2023)
Behavior Treatment Plan standards met vs. standards assessed from the delegated managed care reviews.	MDHHS PIHP Contract: Technical Requirement for Behavior Treatment Plans.
BH-TEDS submitted monthly	MDHHS Contract
Colorectal Cancer Screening (COL-HH). Ages 46/45-49, 50-64, 65-75, Total	MDHHS PIHP Contract: BHH, OHH CMS Health Home Core Set (2023)
Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages	Utilization Management
Controlling High Blood Pressure (CBP-HH) (P4P20%)* Ages 18-64, 65-85, Total ages 18-85 (increase)	MDHHS PIHP Contract: OHH, BHH CMS Health Home Core Set (2023)
Depression Remission at Twelve Months (DEP-REM-12) Ages 12+ Program Benchmark 13%	MDHHS PIHP Contract: CCBHC Core Measure Set
Diabetes Monitoring- This measure is used to assess the percentage of members 18-64 years of age with schizophrenia and diabetes who had a low-density lipid protein cholesterol (LDL-C) test and hemoglobin A1c.	NCQA/HEDIS

Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD-AD)^ CCBHC ages 18-64. Program Benchmark 80.9%.	MDHHS PIHP Contract: CCBHC NCQA/HEDIS-CMS Adult Core Set (2023)
Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries* Reduction in Ambulatory Care: Emergency Department (ED) Visits (AMB-HH) (P4P 50%) Ages 0-17, 18-64, 65+, Total.	MDHHS PIHP Contract: OHH CMS Health Home Core Set (2023)
Engagement of Substance Use Disorder Treatment (Alcohol and Other Drug Abuse and Dependent Treatment).(IET-34 HH) Ages 13-17, 18-64, 65+, Total 13+. CCBHC ages 13+ Program Benchmark 12.4%.	MDHHS PIHP Contract: BHH, OHH, CCBHC CMS Health Home Core Set (2023)
Follow up After Hospitalization for Mental illness within 7/30 days (FUH-AD) The percentage of discharges for adults who were hospitalized for treatment of selected mental illness or intentional self harm diagnosis and who had a follow up visit with a mental health provider within 30 days of discharge.	MDHHS/PIHP Contract: Integrated Health Performance Bonus Requirements MDHHS PIHP Contract: OHH, BHH, CCBHC NCQA/HEDIS-CMS Adult Core Set
Follow up After Hospitalization for Mental Illness within 7/30 days. (FUH-CH) The percentage of discharges for children who were hospitalized for treatment of selected mental illness or intentional self harm diagnosis and who had a follow up visit with a mental health provider within 30 days of discharge.	MDHHS/PIHP Contract: Integrated Health Performance Bonus Requirements MDHHS PIHP Contract: OHH, BHH, CCBHC NCQA/HEDIS-CMS Child Core Set
Follow-Up After Emergency Department Visit for Mental Illness: (FUM 30 HH)Ages 6 to 17, 18-64, 65+, and Total 6+. CCBHC 6+ Program Benchmark 77.2%.	MDHHS PIHP Contract: OHH, BHH, CCBHC CMS Adult Core Set (2023)
Follow-Up After Emergency Department Visit for Mental Illness: (FUM-7 HH)Ages 6 to 17, 18-64, 65+, and Total 6+. CCBHC 6+ Program Benchmark 62.1.	MDHHS PIHP Contract: OHH, BHH, CCBHC CMS Health Home Core Set (2023)
Follow-Up After Emergency Department Visit for Substance use (Alcohol and Other Drug Dependence): (FUA-30 HH)* Ages 13 to 17, 18-64, 65+, and Total 13+. CCBHC 13+ Benchmark 63.6.	MDHHS PIHP Contract: OHH, BHH, CCBHC CMS Adult Core Set (2023)
Follow-Up After Emergency Department Visit for Substance use (Alcohol and Other Drug Dependence): (FUA-7 HH) Ages 13 to 17, 18-64, 65+, and Total 13+. CCBHC 13+ Program Benchmark 21.5.	MDHHS PIHP Contract: OHH, BHH, CCBHC CMS Adult Core Set (2023)
Follow-up care for children prescribed ADHD medication. C & M Phase (ADD-CH)^ Program Benchmark 69.7%.	MDHHS PIHP Contract: CCBHC NCQA/HEDIS-CMS Child Core Set (2023)
Follow-up care for children prescribed ADHD medication. Initiation. (ADD-CH)^ Program Benchmark 63.4%.	MDHHS PIHP Contract: CCBHC NCQA/HEDIS-CMS Child Core Set (2023)
Housing Status (HOU). Rate reported for 10 categories of living situations.	MDHHS PIHP Contract: CCBHC SAMHSA
Initiation of Substance use Disorder Treatment (Alcohol and Other Drug Abuse and Dependent Treatment) (IET-14 HH) Ages 13-17, 18-64, 65+, Total 13+. CCBHC ages 13+. Program Benchmark 43.9%. QBP Benchmark 25%.	MDHHS PIHP Contract: OHH, BHH, CCBHC CMS Adult Core Set (2023)
Inpatient Utilization (IU-HH). Rate of acute inpatient care and services per 1000 enrollee month among enrollees. Ages 0-17, 18-64, 65+, and Total.	MDHHS PIHP Contract: BHH , OHH CMS Health Home Core Set (2023)
Integrate standardized assessment tools into REMI	
Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements. MDHHS Review	QAPIP_HSAG/ MDHHS Waiver Review Corrective Action Plan

Major Depressive Disorder, Adult (MDD): Suicide Risk Assessment (SRA-Adults)* Age 18+.Benchmark 67.7%	MDHHS PIHP Contract: CCBHC AMA-PCPI
Major Depressive Disorder, Child and Adolescent (MDD): Suicide Risk Assessment (SRA-BH-C)* Ages 6-17. Program Benchmark 47.9%.	MDHHS PIHP Contract: CCBHC AMA-PCPI
Medicaid Event Verification review demonstrates improvement of previous year results with the documentation of the service date and time matching the claim date and time of the service. CMHSP/SUD	MDHHS PIHP Contract: Medicaid Services Verification Technical Requirement
Medicaid Event Verification review demonstrates improvement of previous year results with the documentation of the service provided falls within the scope of the service code billed.	MDHHS PIHP Contract: Medicaid Services Verification Technical Requirement
Monitor, collect, and report grievance, appeal, and fair hearing information	MDHHS PIHP Contract: CCBHC
MSHN ACT programs will demonstrate an increase in the fidelity for average minutes per week per consumer (120 minutes).	ACT Standards
MSHN will assess the quality and appropriateness of care furnished to members(vulnerable people) receiving LTSS	QAPIP_HSAG/ MDHHS Waiver Review Corrective Action Plan
MSHN will be in compliance with PIHP Contract Requirements.	QAPIP_HSAG/ MDHHS Waiver Review
MSHN will be in full compliance with the Adverse Benefit Determination Notice Requirements	QAPIP_HSAG/ MDHHS Waiver Review Corrective Action Plan
MSHN will demonstrate an increase in compliance rate for the implementation of Person-Centered Planning and Documentation in the IPOS	QAPIP_HSAG/ MDHHS Waiver Review Corrective Action Plan
MSHN will demonstrate an increase in compliance with the External Quality Review (EQR)-Compliance Review.	QAPIP_HSAG/ MDHHS Waiver Review
MSHN will demonstrate an increase in compliance with the MDHHS 1915 Review.	QAPIP_HSAG/ MDHHS Waiver Review
MSHN will demonstrate full compliance with time frames of service authorization decisions in accordance with the MDHHS requirements.	QAPIP_HSAG/ MDHHS Waiver Review Corrective Action Plan
MSHN will meet or exceed a 90% rate of compliance of Medicaid delivered services in accordance with MDHHS requirements	MDHHS PIHP Contract: Medicaid Services Verification Technical Requirement
MSHN's Habilitation Supports Waiver slot utilization will demonstrate a consistent minimum or greater performance of 95% HSW slot utilization. (FYTD)	MDHHS PIHP Contract: The MDHHS requirement of 95% slot utilization or greater.
Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements. MDHHS Review	QAPIP_HSAG/ MDHHS Waiver Review Corrective Action Plan
Patient Experience fo Care Survey (PEC) Ages 18+	MDHHS PIHP Contract: CCBHC SAMHSA Metrics and Quality Measures (2016)
Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines.	MDHHS PIHP Contract: QAPIP UM
Percent of adult discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days	MDHHS PIHP Contract: Reporting Requirements MMBPIS Indicator 4a2

Percent of all Medicaid Children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours	MDHHS PIHP Contract: Reporting Requirements MMBPIS Indicator 1
Percent of child discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days	MDHHS PIHP Contract: Reporting Requirements MMBPIS Indicator 4a1
Percent of discharges from a substance abuse withdrawal unit who are seen for follow up care within seven days.	MDHHS PIHP Contract: Reporting Requirements MMBPIS Indicator 4b1
Percent of MI and DD adults readmitted to an inpatient psychiatric unit within 30 days of discharge	MDHHS PIHP Contract: Reporting Requirements MMBPIS Indicator 10
Percent of MI and DD children readmitted to an inpatient psychiatric unit within 30 days of discharge	MDHHS PIHP Contract: Reporting Requirements MMBPIS Indicator 10
Percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).*	MDHHS PIHP Contract: Reporting Requirements MMBPIS Indicator
Percentage of children with developmental disabilities (not including children in the Children's Waiver Program) in the quarter who receive at least one service each month other than case management and Respite.*	MDHHS PIHP Contract: Reporting Requirements MMBPIS
Percentage of consumers indicating satisfaction with mental health services (child and adult)	MDHHS PIHP Contract: Qualitative and Quantitative assessment of member experiences (QAPIP Technical Requirement)
Percentage of consumers indicating satisfaction with SUD services	MDHHS PIHP Contract: Qualitative and Quantitative assessment of member experiences (QAPIP Technical Requirement)
Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination*	MDHHS PIHP Contract: Reporting Requirements MMBPIS Indicator
Percentage of individuals indicating satisfaction with long term supports and services.(Standard 80%)	MDHHS PIHP Contract: Qualitative and Quantitative assessment of member experiences (QAPIP Technical Requirement)
Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person centered plan	QAPIP_HSAG/ MDHHS Waiver Review
Percentage of Medicaid recipients having received PIHP managed services.*	MDHHS PIHP Contract: Reporting Requirements MMBPIS Indicator
Plan All-Cause Readmission Rate (PCR-AD) The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.Ages: Total 18-64. CCBHC age 18+ Program Benchmark 12.1.	MDHHS PIHP Contract: CCBHC, BHH, OHH CMS Health Home Core Set (2023)

Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92-HH)(Ages 18-64, 65+, and Total) (lower rate indicates better performance)	MDHHS PIHP Contract: BHH, OHH CMS Health Home Core Set (2023)
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC) Ages 18+. Benchmark 48.7%	MDHHS PIHP Contract: CCBHC CMS Core Set
Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF) Ages 18-64 >18.5 and <25 kg/m2. Benchmark 32.5%. Ages 65+. >23 and <30 kg/m2.	MDHHS PIHP Contract: CCBHC CMS Core Set
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC). Ages 18+. Program Benchmark 48.6%	MDHHS PIHP Contract: CCBHC CMS Core Set
Providers demonstrate increased compliance with the MDHHS/MSHN Credentialing and Staff Qualification requirements. (SUD Network and CMHSP Network)	QAPIP_HSAG/ MDHHS Waiver Review Corrective Action Plan
Reduction in Ambulatory Care: Emergency Department (ED) Visits (AMB)*P4P	MDHHS PIHP Contract: BHH CMS Health Home Core Set (2023)
Reduction in number of visits to the emergency room for individuals in care coordination plans between the PIHP and MHP	MDHHS PIHP Contract: Integrated Care
Screening for Depression and Follow-Up Plan (CDF-HH) Ages ~~12-17~~, 18-64, 65+ and Total 12+. CCBHC 12+ Program Benchmark 37.2%.	MDHHS PIHP Contract: CCBHC, BHH, OHH
Service utilization remains consistent or increases over previous year due to improved access to services through the use of telehealth	Utilization Management
The disparity between the white population and at least one minority group who engaged in treatment within 34 calendar days will be reduced. (IET-Engagement disparity)	FY24 PIHP Performance Bonus Incentive Program
The disparity between the white population and at least one minority who initiated treatment within 14 calendar days will be reduced. (IET-Initiation disparity)	FY24 PIHP Performance Bonus Incentive Program
The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness standards including the written disposition letter (30 calendar days) of a standard request for appeal.	MDHHS PIHP Contract: Appeal and Grievance Resolution Processes Technical Requirement
The percentage (rate per 100) of Medicaid grievances are resolved with a written disposition sent to the consumer within 90 calendar days of the request for a grievance.	MDHHS PIHP Contract: Appeal and Grievance Resolution Processes Technical Requirement
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year. (Rolling 12 months)	HEDIS measure
The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders (SUD). (MMBPIS Indicator 2e)	MDHHS PIHP Contract: Michigan Mission Based Performance Indicator System
Time to Initial Evaluation (I-EVAL): Mean Number of Days until Initial Evaluaton (Program Benchmark-20.8)	MDHHS PIHP Contract: CCBHC CMS Core Set

Time to Initial Evaluation (I-EVAL): Percent of consumers with an initial evaluation within 10 Business Days. Total (all ages) Program Benchmark 57.8%	MDHHS PIHP Contract: CCBHC CMS Core Set
Use of Multiple Concurrent Antipsychotics - The percentage of children and adolescents 1-17 who were on two or more concurrent antipsychotic medications	HEDIS measure
Use of Pharmacotherapy for Opioid Use Disorder (OUD-HH) Ages: 18-64. Total rate(Rate 1) and four separate rates for Buprenorphine(Rate 2), Oral naltrexone (Rate 3), Long-acting, injectable naltrexone (Rate 4), Methadone(Rate 5).	MDHHS PIHP Contract: BHH, OHH CMS Health Home Core Set (2023)
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)^ Ages 3-17. Program Benchmark 44.3%.	MDHHS PIHP Contract: CCBHC CMS Child Core Set (2023)
Will demonstrate an increase in the percent of the individuals identified as a priority population who are seen within the required timeframes.	MDHHS PIHP Contract: Access Standards
Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following a psychiatric hospitalization (adults and children)	MDHHS/PIHP Contract: Integrated Health Performance Bonus Requirements
Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following an emergency department visit for alcohol or drug use.	MDHHS/PIHP Contract: Integrated Health Performance Bonus Requirements
Youth/Family Patient Experience of Care Survey (PEC)	MDHHS PIHP Contract: CCBHC SAMHSA Metrics and Quality Measures (2016)

Evaluation of Quality Improvement Program Plan Effectiveness FY2023
Community Mental Health Authority of Clinton, Eaton and Ingham Counties

Table of Contents

Overview

An evaluation of the QIP plan is completed at the end of each calendar year. The evaluation summarizes activity that occurred around the goals and objectives of the CMHA-CEI's Quality Improvement Program Plan and progress made toward achieving the goals and objectives.

Michigan's Mission Based Performance Indicator System (MMBPIS) Results

MDHHS, in compliance with federal mandates, establishes measures in the areas of access, efficiency, and outcomes. Data is abstracted regularly, and quarterly reports are compiled and submitted to the PIHP for analysis and regional benchmarking and to MDHHS. In the event that CMHA-CEI performance is below the identified goal, the QI team will facilitate the development of a Corrective Action Plan (CAP). The CAP will include a summary of the current situation, including causal/contributing factors, a planned intervention, and a timeline for implementation. CAPs are submitted to the PIHP for review and final approval.

Indicator #1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. Standard = 95%

Indicator #2a: The percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. No standard

Indicator #3: Percentage of new persons during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional. No standard.

Indicator #4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. Standard = 95%

Indicators #5 and #6: The total number of persons receiving a face-to-face assessment with professionals that result in decisions to deny CMHSP services and total number of persons receiving mental health service following a second opinion.

Indicator #10: The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less

CMHA-CEI saw improvements in performance indicators 1, 2a, 3, and 4a from FY22 to FY23. There was continued compliance with PI 10 from FY22 to FY23

Indicator	**Total FY2022**	FY 2023 Q1	FY 2023 Q2	FY2023 Q3	FY2023 Q4	**Total FY2023**
1 - Total	95.39%	97.50%	96.41%	97.48%	99.13%	97.72%
1 - Children	93.69%	97%	94.98%	93.73%	97.18%	98.51%
1 - Adults	96.78%	97.74%	97.20%	99.10%	100.00%	97.63%
2a - Total	47.50%	78.53%	80.47%	75.30%	70.87%	76.29%
2a – IDD-C	15.08%	12.50%	18.52%	5.66%	6.14%	93.18%
2a – IDD-A	46.00%	30.77%	40.00%	42.86%	20.69%	55.55%
2a – MI-C	65.98%	83.98%	85.30%	87.91%	85.88%	58.48%
2a – MI-A	42.25%	83.50%	87.34%	83.17%	80.72%	57.29%
3 - Total	50.54%	51.14%	65.05%	64.97%	68.02%	62.30%
3 – IDD-C	69.42%	80.85%	98.91%	97.66%	95.31%	93.18%
3 – IDD-A	33.61%	30.77%	75.00%	81.82%	34.62%	55.55%
3 – MI-C	44.07%	47.67%	57.48%	62.98%	65.79%	58.48%
3 – MI-A	53.39%	50.34%	61.90%	54.44%	62.47%	57.29%
4a - Total	98.00%	97.80%	99.16%	99.60%	99.53%	99.02%
4a - Children	98.75%	100%	96.65%	100.00%	100.00%	99.16%
4a - Adult	97.51%	97.18%	100.00%	99.51%	99.46%	99.04%
10 - Total	9.68%	13.51%	12.59%	11.69%	10.10%	11.97%
10 - Children	7.63%	10%	7.14%	13.11%	14.71%	11.24%
10 - Adults	9.96%	14.29%	13.60%	11.36%	9.49%	12.18%

Table 1. Performance Indicator results by quarter: Data shown for full population of CMHA-CEI Consumers submitted to MDHHS. Includes the average percentage for FY22, percentage for each quarter and average for FY23. Standard for compliance for 95% or higher for PI 1 and 4a, and 15% or lower for PI 10. There is no standard for PI 2a and 3.

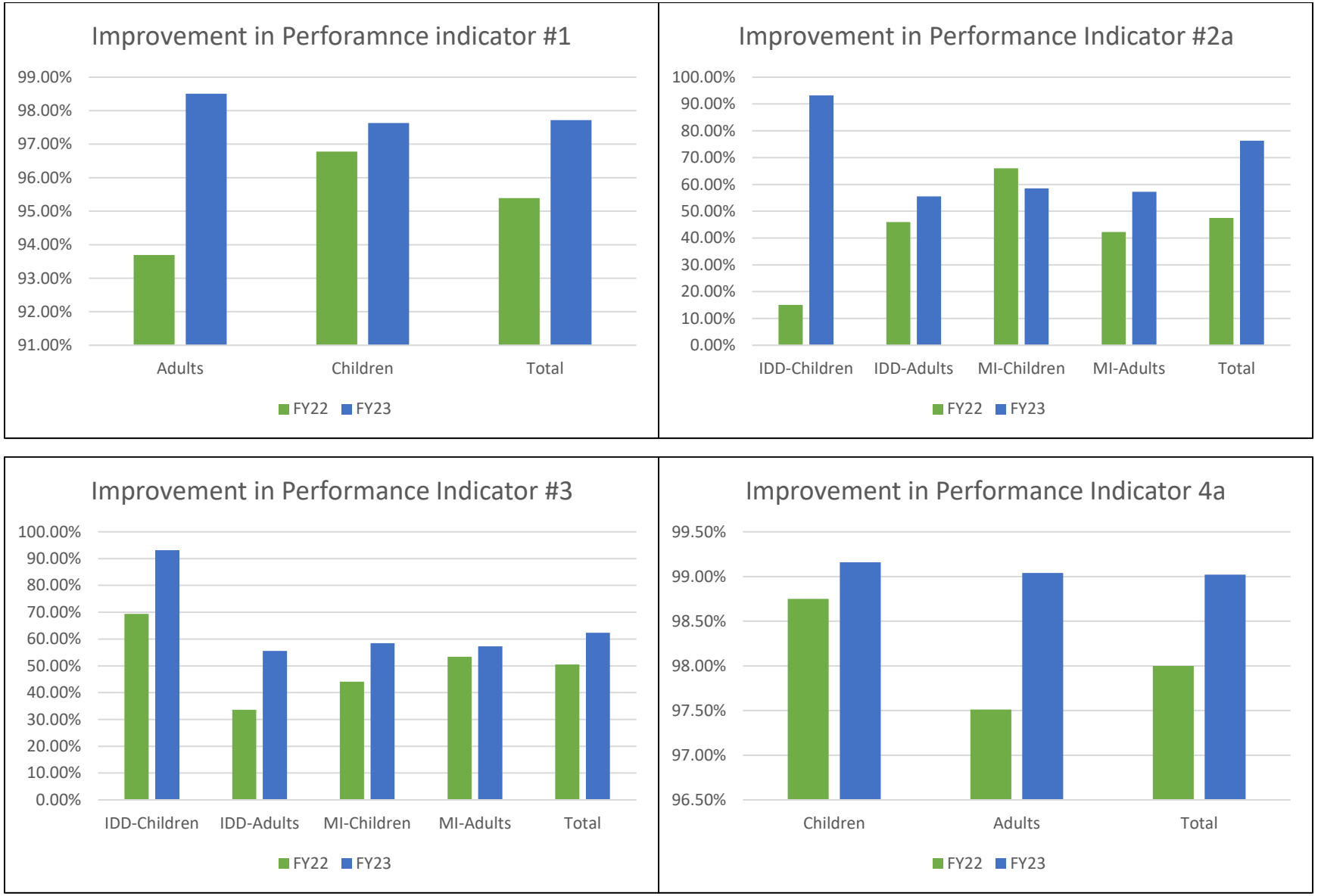


Figure 1. Improved Compliance in Performance Indicators: In data submitted to MDHHS representing the full population of CMHA-CEI consumers, the rates of compliance improved for PIs 1, 2a, 3, and 4a. While there was no significant change in for PI 10 (not pictured), compliance was maintained in FY23.

	FY22 Total	FY 23 Q1	FY 23 Q2	FY 23 Q3	FY 23 Q4	FY23 Total
Total # of new persons receiving an initial non-emergent face-to face professional assessment	3205	800	993	1044	1018	3855
Total # of persons assessed but denied CMHSP Service	418	61	117	114	105	397
Total # of persons requesting second opinion	22	2	4	1	2	9
Total # of persons receiving mental health service following a second opinion	21	1	3	1	2	7

Table 2. Denial of services and second opinions: Data in this table represents PIs 5 and 6, the full population of CMHA-CEI consumers submitted to MDHHS. In FY 2022, roughly 13% initial assessments led to a denial of services. Of those who were denied, 5% requested a second opinion. In FY 2023, roughly 10% of initial assessments led to a denial of services. Of those who were denied, only 2% requested a second opinion.

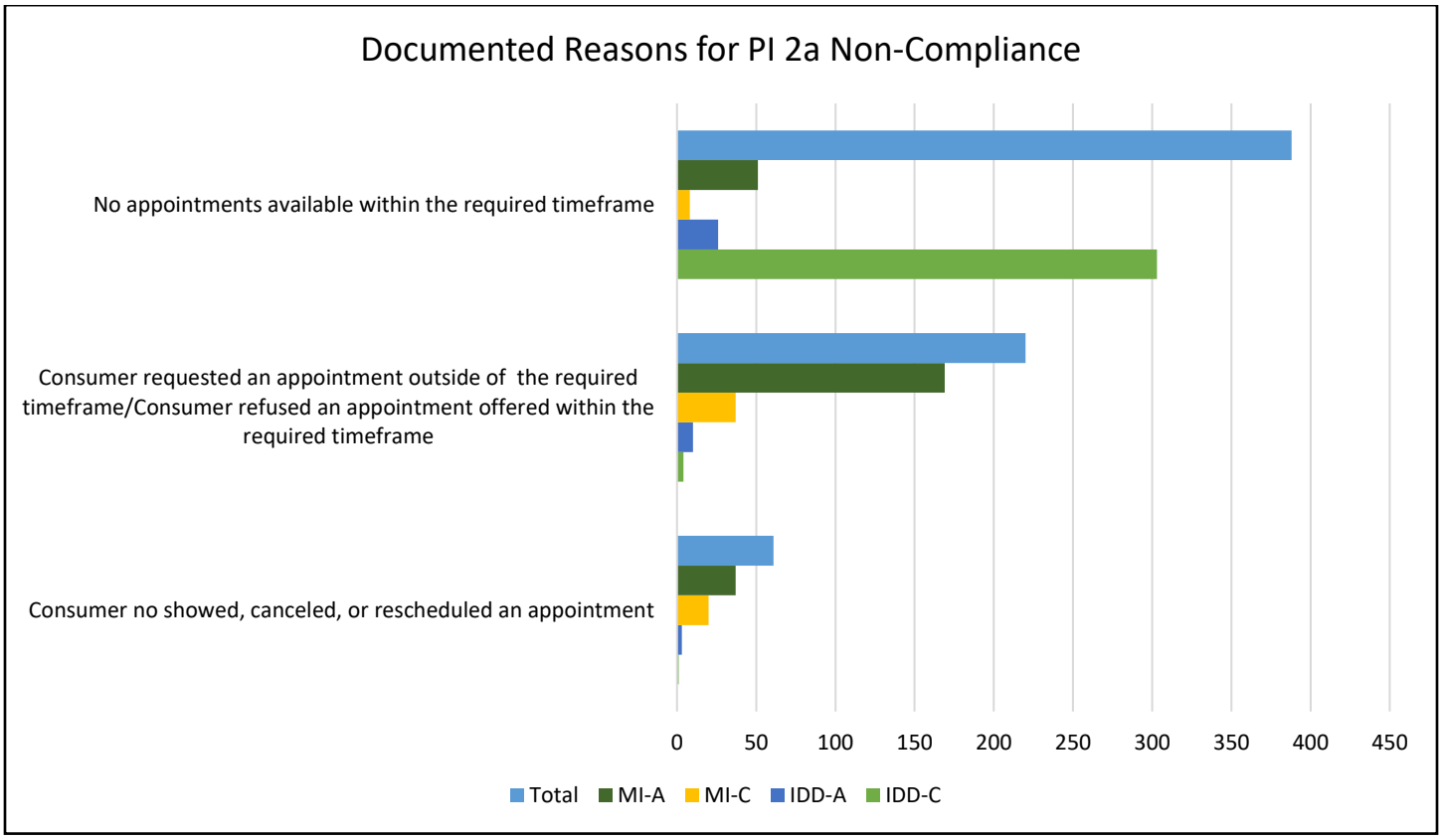


Figure 2. Documentation for timeliness from inquiry to assessment over 14 days: While there are no exceptions for PI 2a, Mid-State Health Network began tracking and navigating the documented reasons for non-compliance. The top documented reasons in FY23 were no appointments available, consumer refusal, and no-show/cancellations. Data shown in figure represents the full population of CMHA-CEI consumers submitted to MDHHS. Data is also shown broken in to categories of population of adults with mental illness (MI-A), children with mental illness (MI-C), adults with intellectual developmental disabilities (IDD-A), and children with intellectual developmental disabilities (IDD-C)

Full Population	Q1	Q2	Q3	Q4	FY2023
No Documentation/Blank	520	56	49	79	704
No appointments available within the required timeframe	55	97	109	127	388
Consumer requested an appointment outside of the required timeframe/Consumer refused an appointment offered within the required timeframe	65	46	58	51	220
Consumer rescheduled an appointment	26	13	11	2	52
Other (autism consumer, guardianship, missing disability designation, rapid access, documentation, referred out for services)	4	4	3	1	12
Consumer canceled/no showed for an appointment	6	1	0	2	9
Staff Cancel/Reschedule	3	0	0	1	4
IDD-Children	**Q1**	**Q2**	**Q3**	**Q4**	**FY2023**
No appointments available within the required timeframe	43	91	89	80	303
No Documentation/Blank	4	4	7	27	42
Consumer requested an appointment outside of the required timeframe/Consumer refused an appointment offered within the required timeframe	1	0	3	0	4
Other (autism consumer, guardianship, missing disability designation, rapid access, documentation, referred out for services)	0	1	1	0	2
Staff Cancel/Reschedule	1	0	0	0	1
Consumer rescheduled an appointment	1	0	0	0	1
IDD-Adults	**Q1**	**Q2**	**Q3**	**Q4**	**FY2023**
No appointments available within the required timeframe	3	5	2	16	26
No Documentation/Blank	4	3	0	6	13
Consumer requested an appointment outside of the required timeframe/Consumer refused an appointment offered within the required timeframe	3	2	5	0	10
Other (autism consumer, guardianship, missing disability designation, rapid access, documentation, referred out for services)	4	3	1	1	9
Consumer rescheduled an appointment	2	0	0	0	2
Staff Cancel/Reschedule	1	0	0	0	1
Consumer canceled/no showed for an appointment	1	0	0	0	1

MI-Children	Q1	Q2	Q3	Q4	FY2023
No Documentation/Blank	242	44	34	33	353
Consumer requested an appointment outside of the required timeframe/Consumer refused an appointment offered within the required timeframe	28	6	3	0	37
Consumer rescheduled an appointment	10	4	0	2	16
No appointments available within the required timeframe	7	0	0	1	8
Consumer canceled/no showed for an appointment	3	0	0	1	4
MI-Adults	**Q1**	**Q2**	**Q3**	**Q4**	**FY2023**
No Documentation/Blank	270	5	8	13	296
Consumer requested an appointment outside of the required timeframe/Consumer refused an appointment offered within the required timeframe	33	38	47	51	169
No appointments available within the required timeframe	2	1	18	30	51
Consumer rescheduled an appointment	13	9	11	0	33
Consumer canceled/no showed for an appointment	2	1	0	1	4
Staff Cancel/Reschedule	1	0	0	1	2
Other (autism consumer, guardianship, missing disability designation, rapid access, documentation, referred out for services)	0	0	1	0	1

Table 3. Complete breakdown of documented reasons for PI 2a non-compliance

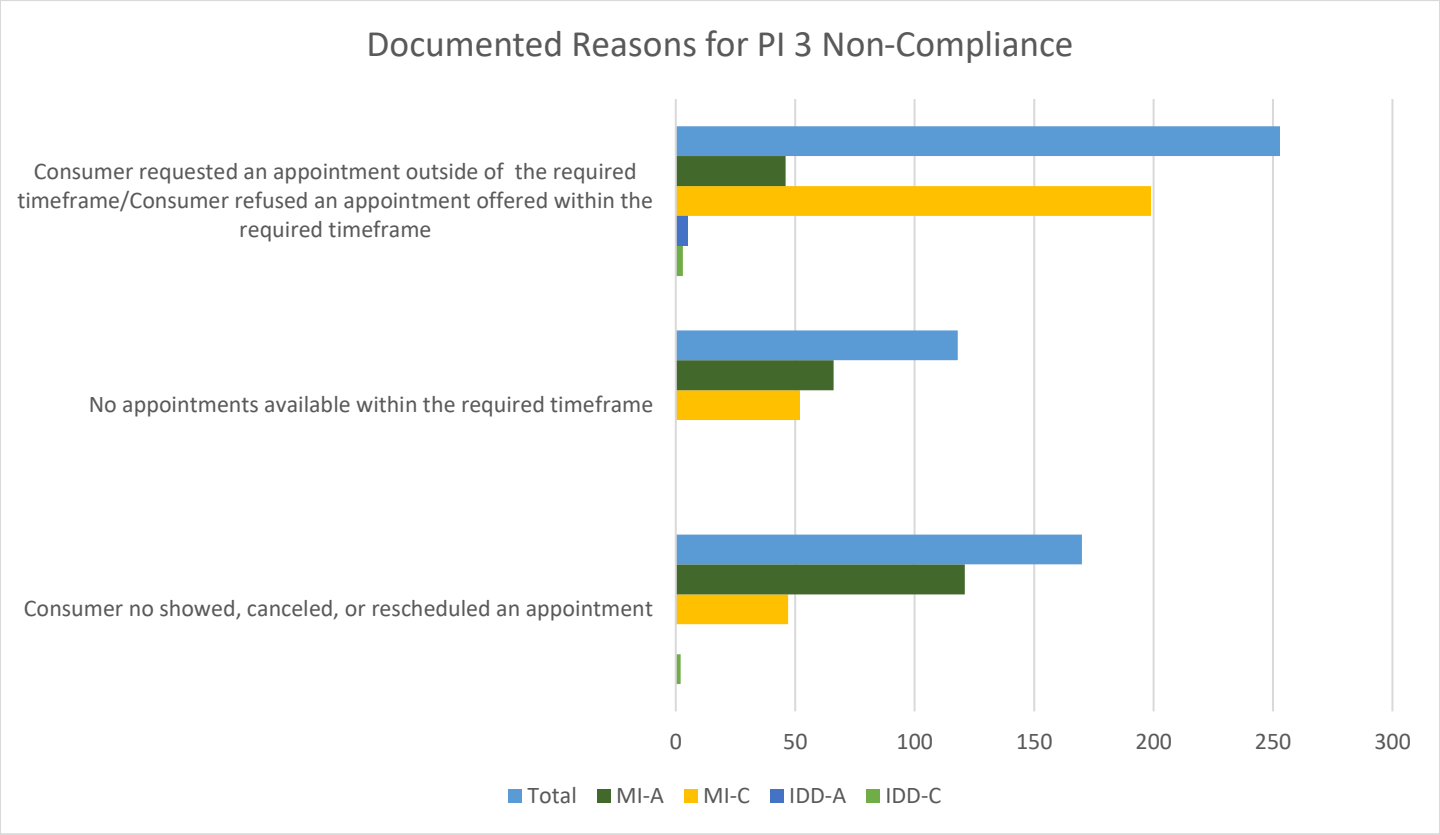


Figure 3. Documentation for timeliness from assessment to start of treatment over 14 days: While there are no exceptions for PI 3, Mid-State Health Network began tracking and navigating the documented reasons for non-compliance. The top documented reasons in FY23 consumer refusal, no appointments available, and no-show/cancellations. Data shown in figure represents the full population of CMHA-CEI consumers submitted to MDHHS. Data is also shown broken in to categories of population of adults with mental illness (MI-A), children with mental illness (MI-C), adults with intellectual developmental disabilities (IDD-A), and children with intellectual developmental disabilities (IDD-C)

Full Population	Q1	Q2	Q3	Q4	FY2023
No Documentation/Blank	49	146	173	176	544
Consumer requested an appointment outside of the required timeframe/Consumer refused an appointment offered within the required timeframe	114	69	37	33	253
No appointments available within the required timeframe	32	15	50	21	118
Consumer canceled/no showed for an appointment	65	14	7	3	89
Consumer rescheduled an appointment	49	18	7	7	81
Staff Cancel/Reschedule	8	3	0	1	12
Consumer chose not to use CMHSP/PIHP services, chose provider outside of network	5	2	1	0	8
IDD-Children	**Q1**	**Q2**	**Q3**	**Q4**	**FY2023**
No Documentation/Blank	5	2	3	6	16
Consumer requested an appointment outside of the required timeframe/Consumer refused an appointment offered within the required timeframe	3	0	0	0	3
Consumer canceled/no showed for an appointment	1	0	0	0	1
Consumer rescheduled an appointment	1	0	0	0	1
IDD-Adults	**Q1**	**Q2**	**Q3**	**Q4**	**FY2023**
No Documentation/Blank	5	2	2	14	23
Other (autism consumer, guardianship, missing disability designation, rapid access, documentation, referred out for services)	0	2	0	3	5
Consumer requested an appointment outside of the required timeframe/Consumer refused an appointment offered within the required timeframe	4	1	0	0	5
Assessment determined not eligible for specialty mental health services	0	2	0	0	2
MI-Children	**Q1**	**Q2**	**Q3**	**Q4**	**FY2023**
Consumer requested an appointment outside of the required timeframe/Consumer refused an appointment offered within the required timeframe	90	52	30	27	199
No Documentation/Blank	1	55	62	47	165
No appointments available within the required timeframe	32	10	10	0	52
Consumer rescheduled an appointment	23	6	4	3	36
Consumer canceled/no showed for an appointment	7	2	1	1	11
Staff Cancel/Reschedule	3	2	0	0	5

Consumer chose not to use CMHSP/PIHP services, chose provider outside of network	5	1	0	0	6
MI-Adults	Q1	Q2	Q3	Q4	FY2023
No Documentation/Blank	38	87	106	109	340
Consumer canceled/no showed for an appointment	57	12	6	2	77
No appointments available within the required timeframe	0	5	40	21	66
Consumer requested an appointment outside of the required timeframe/Consumer refused an appointment offered within the required timeframe	17	16	7	6	46
Consumer rescheduled an appointment	25	12	3	4	44
Staff Cancel/Reschedule	5	1	0	1	7
Consumer chose not to use CMHSP/PIHP services, chose provider outside of network	4	1	1	0	6

Table 4. Complete breakdown of documented reasons for PI 3 non-compliance

Efficiency Objective:	FY 2022-2023											
	Oct-Dec 2022			Jan-Mar 2023			April-June 2023			July-Sept 2023		
	Total Num	# met Obj	% met Obj	Total Num	# met Obj	% met Obj	Total Num	# met Obj	% met Obj	Total Num	# met Obj	% met Obj
1) The number of consumers who complete treatment successfully. **(ITRS Outpatient Clinton & Ingham)**	90	15	16.6%	116	18	15.51%	148	24	16.21%	105	18	17.14%
2) 95% of clients will have a Primary Care Physician by discharge. **(House of Commons)**	40	31	78%	58	44	76%	46	26	61%	40	31	78%
3) 90% of clients will have a Primary Care Physician by discharge. **(CATS Program)**	202	161	79.7%	257	227	88.33%	204	182	90.55%	121	101	83.47%
4) 80% of clients will successfully discharge. **(The Recovery Center)**	77	52	67.49%	98	66	68.12%	95	60	63.16%	81	48	59.26%

Table 5. Efficiency objectives from ITRS Programs. Mid-State Health Network collects PI data from Substance Use Disorder programs separately from MI and IDD programs. The following data was tracked quarterly for the four SUD programs within CMHA-CEI

Performance Improvement Project

Project Description 1- Reduction in Access Disparities

Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or

eliminating the racial or ethnic disparities between the black/African American population and the white population without a decline in the index population rate.

Study Question 1:
Do the targeted interventions reduce or eliminate the racial or ethnic disparities between the black/African American population and the white population who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment without a decline in performance for the White population? Once the disparity has been statistically eliminated, the elimination of the disparity will need to be maintained throughout the life of the project.

Study Indicators:
Indicator 1: The percentage of new persons who are black/African American and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.

Numerator: Number (#) of black/African American individuals from the denominator who received a medically necessary ongoing covered services within 14 calendar days of the completion of the biopsychosocial assessment.

Denominator:
Number (#) of black/African American individuals who are new and who have received a completed Biopsychosocial Assessment within the Mid-State Health Network region and are determined eligible for ongoing services.

Indicator 2: The percentage of new persons who are white and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.

Numerator: Number (#) of white individuals from the denominator who started a medically necessary ongoing covered service within 14 calendar days of the completion of the biopsychosocial assessment.

Denominator: Number (#) of white individuals who are new and have received a completed a biopsychosocial assessment within the measurement period and have been determined eligible for ongoing services.

The records submitted for the MMBPIS reporting to MDHHS will be used for both denominators.

The PIP will analyze administrative data, focusing on Medicaid individuals (both adults and children) who are new to services and have undergone a Biopsychosocial Assessment by the PIHP within the measurement period. Race and ethnicity information (African American/Black and White) will be extracted from the race/ethnicity field in the 834 file, which transfers enrollment details from the insurance sponsor to the payer. The eligible population will be identified using the PIHP Michigan Mission Based Performance Indicator System (MMBPIS) Codebook.

Time Period of Report Cumulative data compared to baseline	Date Due to MSHN	Date Reviewed in Committee/Council	Date Due to MDHHS

CY21 Baseline	N/A	May/June	6/30/2023
CY22 (1/1/2022 12/31/2022)	N/A	April/May/June	6/30/2023
CY23Q2 (1/1/2023-06/30/2023)	March	August	N/A
CY23 (1/1/2023-12/31/2023)	TBD	April/May/June	6/30/2024
CY24Q2 (1/1/2023-06/30/2023)	March	August	N/A
CY24 (1/1/2024-12/31/2024)	TBD	April/May/June	6/30/2025

Table 6. Timeline for reporting PIP data

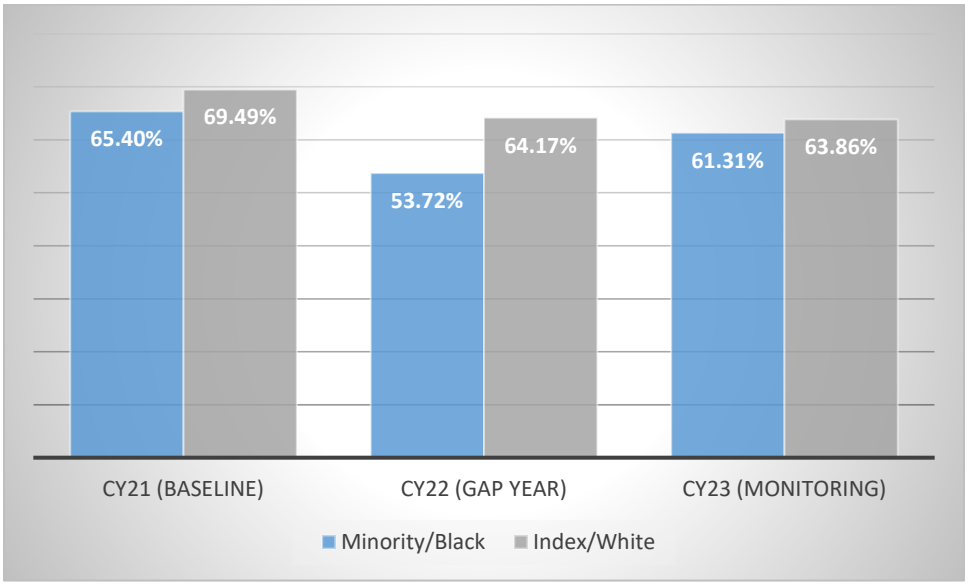


Figure 4. Longitudinal data of those who received a medically necessary service within 14 days of a completed biopsychosocial assessment. The rate of access to services for Index/White population group has demonstrated a downward trend from the baseline year as indicated in the Table 6. The Black/African American population group increased from CY22. Table 7 includes the CMHA-CEI counts and rates of those who qualify for inclusion in this project.

	CY21			CY22			CY23Q2		
	In-Compliance	Grand Total	Rate	In-Compliance	Grand Total	Rate	In Compliance	Grand Total	Rate
Bay-Arenac									
Black (Non-Hispanic)	41	69	59.42%	38	64	59.38%	24	38	63.16%
White (Non-Hispanic)	560	820	68.29%	649	897	72.35%	328	476	68.91%
Unknown	67	103	65.05%	53	74	71.62%	84	121	69.42%
CEI									
Black (Non-Hispanic)	254	500	50.80%	279	574	48.61%	178	275	64.73%
White (Non-Hispanic)	746	1320	56.52%	764	1477	51.73%	509	772	65.93%
Unknown	118	232	50.86%	130	231	56.28%	151	228	66.23%
Central MI									
Black (Non-Hispanic)	39	59	66.10%	74	105	70.48%	40	52	76.92%
White (Non-Hispanic)	1076	1471	73.15%	1681	2250	74.71%	789	1070	73.74%
Unknown	104	145	71.72%	125	173	72.25%	180	235	76.60%
Gratiot									
Black (Non-Hispanic)	7	11	63.64%	9	13	69.23%	6	8	75.00%
White (Non-Hispanic)	374	463	80.78%	373	474	78.69%	185	245	75.51%
Unknown	21	27	77.78%	22	28	78.57%	28	37	75.68%
Huron									
Black (Non-Hispanic)	1	3	33.33%		3	0.00%	1	2	50.00%
White (Non-Hispanic)	126	177	71.19%	143	240	59.58%	74	122	60.66%
Unknown	14	19	73.68%	14	20	70.00%	12	27	44.44%
Ionia									
Black (Non-Hispanic)	8	12	66.67%	5	10	50.00%	4	9	44.44%
White (Non-Hispanic)	399	555	71.89%	443	716	61.87%	270	487	55.44%

Table 7. Results of Mid-State Health Network Performance Improvement Project for Access- Reduction in disparities. The full report, including barriers and planned interventions can be found in the MSHN Annual QAPIP: https://midstatehealthnetwork.org/download_file/view/8135fa83-20e7-4d7b-b6a7-7a9aa36dca8c/193

Project Description 2 – Reduction of Disparities in Penetration Rate:

Reducing or eliminating racial or ethnic disparities between the African American/Black minority penetration rate and the index (white) penetration rate.

Study Question 1:
Do the targeted interventions reduce or eliminate the racial or ethnic disparities in the penetration rate between the black/African American penetration rate and the index (white) penetration rate of those who are eligible for Medicaid services?

Study Indicators:
Numerator: The number of unique Medicaid eligible individuals who are black/African American and have received a PIHP managed service. (CMHSPs Combined)
Numerator: The number of unique Medicaid eligible individuals who are white and have received a PIHP managed service. (CMHSPs Combined)

Denominator:
The number of unique Medicaid eligible individuals within the Mid State Health Network region. (CMHSPs Combined)

Data Source and Collection Method: (Manual/Administrative/Hybrid, Frequency of committee review)
The PIP will utilize administrative data for the analysis. The data source will be a standard report within REMI which includes a programmed pull from claims/encounters and the 834 eligibility files. The estimated percentage of reported administrative data completeness at the time the data are generated is 95% complete.

Time Period of Report	Data Due to MSHN	Date Reviewed in Committee	Date Due to MDHHS
CY21 Baseline	NA	August	NA
CY22 (1/1/2022-12/31/2022)	NA	March	NA
CY23Q2 (1/1/2023-06/30/2023)	NA	August	NA
CY23 (1/1/2023-12/31/2023)	NA	March	NA

Table 8. Timeline for reporting PIP data

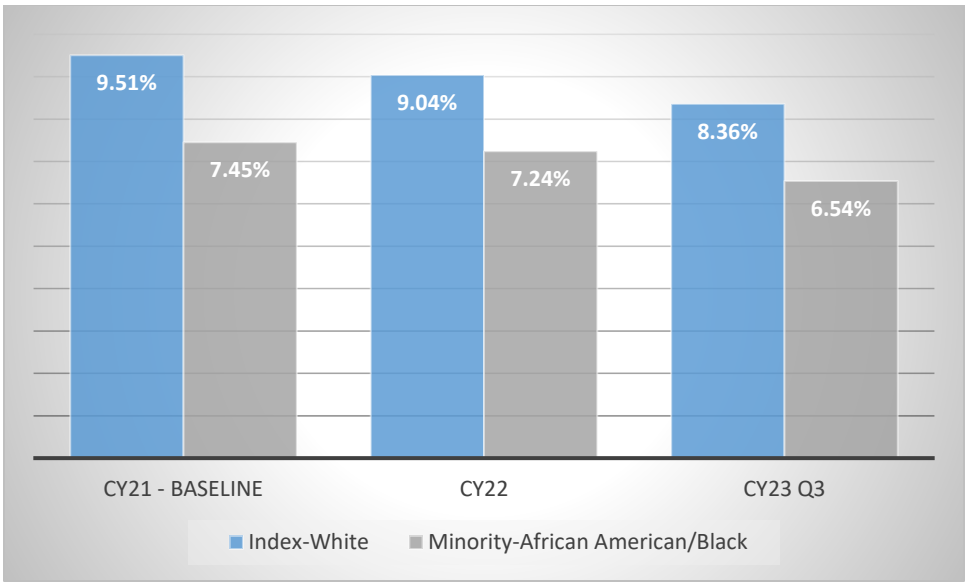


Figure 5. MSHN CMHSP Penetration Rates. Table 10 includes the CMHA-CEI counts and rates of those who qualify for inclusion in this project. A full breakdown of penetration rates across all reported races/ethnicities can be found in the Annual MSHN QAPIP:
https://midstatehealthnetwork.org/download_file/view/7363619c-f6c0-4def-a3c8-bfc04ef75858/193

CY2021	Total Population	Total Consumers Served	CY 21 Minority Penetration Rate	CY21 Index/White Penetration Rate
African American / Black	70267	5236	7.45%	9.51%
White	373783	35532	9.51%	9.51%
CY2022	Total Population	Total Consumers Served	CY22 Minority Penetration Rate	CY22 Index/White Penetration Rate
African American/ Black	72377	5241	7.24%	9.04%
White (Non-Hispanic)	385878	34891	9.04%	9.04%
CY23Q3	Total Population	Total Consumers Served	CY22 Minority Penetration Rate	CY22 Index/White Penetration Rate
African American/ Black	72518	4743	6.54%	8.36%
White (Non-Hispanic)	379529	31731	8.36%	8.36%

Table 9. Penetration rates for reporting periods for all MSHN CMHSPs combined. This table shows just the African American/Black consumers and White/Index population. A full breakdown of penetration rates across all reported races/ethnicities can be found in the Annual MSHN QAPIP:
https://midstatehealthnetwork.org/download_file/view/7363619c-f6c0-4def-a3c8-bfc04ef75858/193

Organization	Total Population	Total Served	Penetration Rate
CMHSPs Combined	1068153	81689	7.65%
African American/ Black	72518	4743	6.54%
White (Non-Hispanic)	379529	31731	8.36%
Bay-Arenac	81788	8816	10.78%
African American/ Black	1991	225	11.30%
White (Non-Hispanic)	33692	3776	11.21%
CEI	275288	16329	5.93%
African American/ Black	30555	1711	5.60%
White (Non-Hispanic)	77747	5211	6.70%
Central MI	179116	16234	9.06%
African American/ Black	3140	297	9.46%
White (Non-Hispanic)	75843	7131	9.40%
Gratiot	28254	2973	10.52%
African American/ Black	298	33	11.07%
White (Non-Hispanic)	11965	1288	10.76%
Huron	18523	1872	10.11%
African American/ Black	96	10	10.42%
White (Non-Hispanic)	8390	871	10.38%
Ionia	37122	4056	10.93%
African American/ Black	363	32	8.82%
White (Non-Hispanic)	15792	1793	11.35%
LifeWays	141717	10671	7.53%
African American/ Black	8687	586	6.75%
White (Non-Hispanic)	52570	4196	7.98%
Montcalm	46975	4516	9.61%
African American/ Black	362	48	13.26%
White (Non-Hispanic)	20466	2036	9.95%
Newaygo	39358	3497	8.89%
African American/ Black	408	40	9.80%
White (Non-Hispanic)	16770	1543	9.20%
Saginaw	153105	10340	6.75%
African American/ Black	26597	1795	6.75%
White (Non-Hispanic)	36010	2765	7.68%
Shiawassee	46174	2477	5.36%
African American/ Black	357	26	7.28%
White (Non-Hispanic)	20620	1125	5.46%
Tuscola	38038	2359	6.20%
African American/ Black	376	31	8.24%
White (Non-Hispanic)	16558	1035	6.25%

Table 10. Penetration rates for all CMHSPs in the MSHN region. Results across all reported races/ethnicities can be found in the Annual MSHN QAPIP: https://midstatehealthnetwork.org/download_file/view/7363619c-f6c0-4def-a3c8-bfc04ef75858/193

Grievances, Appeals, and Fair Hearings

When a consumer/guardian has a Compliant they can file a grievance through the QCSRR office. Staff then work with representatives of the CMHA-CEI Program in question respond to the grievance, send an acknowledgement letter within 3 days of the receipt of the grievance and then a disposition letter with the determination of the resolution of the grievance within 90 days. Consumers can file a Local appeal or an Administrative Fair Hearing (if they are a Medicaid Beneficiary) and have been denied a requested service(s) or have had their current service(s) delayed, reduced, suspended or terminated.

	Total in FY22	Total in FY23
# of Grievances	16	13
# of Appeals	7	8
# of Fair Hearings	0	2

Table 11. Number of grievances, appeals, and fair hearings for CMHA-CEI

Incident Reporting

General Incidents

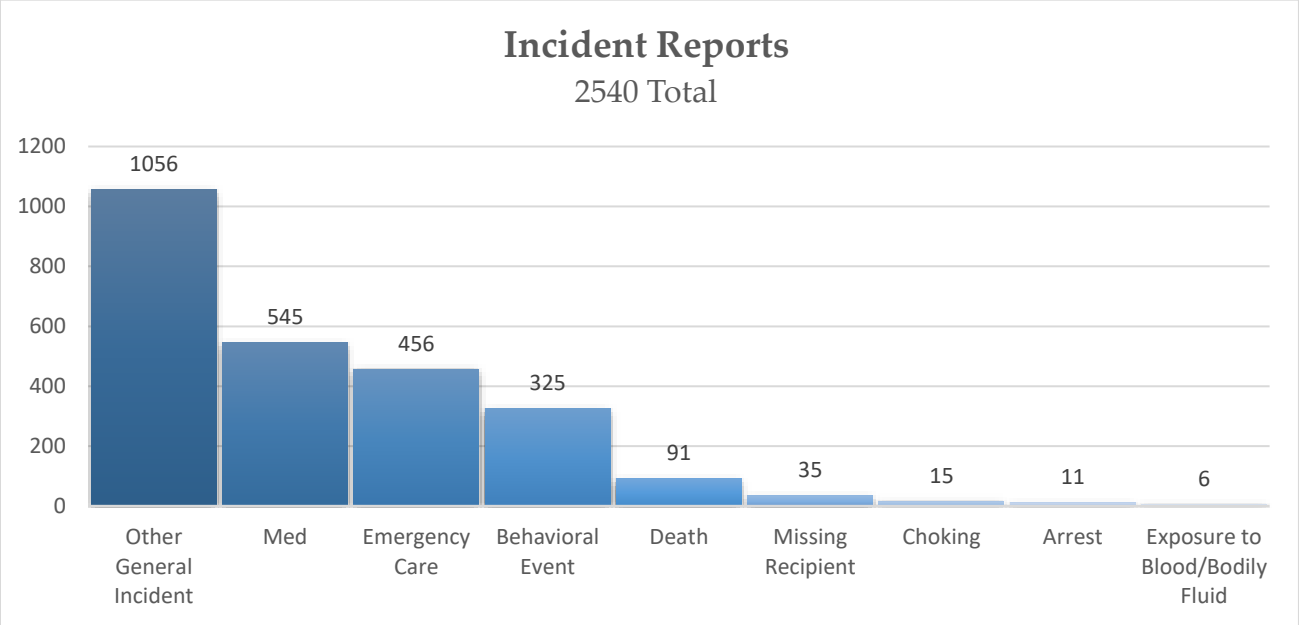


Figure 6. General incident reports by category. Data shows count of IRs completed in FY23

General incidents include consumer deaths, behavioral episodes, arrests, physical illness and injuries. The Critical Incident Review Committee (CIRC) provides oversite of the critical/sentinel event processes, which involve the reporting of all unexpected incidents involving the health and safety of the consumers within the CMHA-CEI's service delivery area. Membership consists of the Director of QCSRR, Medical Director, compliance staff, QI staff, and representation from all four clinical programs as applicable. The goal of CIRC is to review consumer deaths and assign a cause of death, and to review critical incidents,

including consumer deaths, to ensure a thorough review was conducted and, if needed, provide a plan to ensure similar incidents do not reoccur. Incident report data is reviewed by CIRC for policy review and implementation, patterns, trends, compliance, education and improvement, and presentation to QICC.

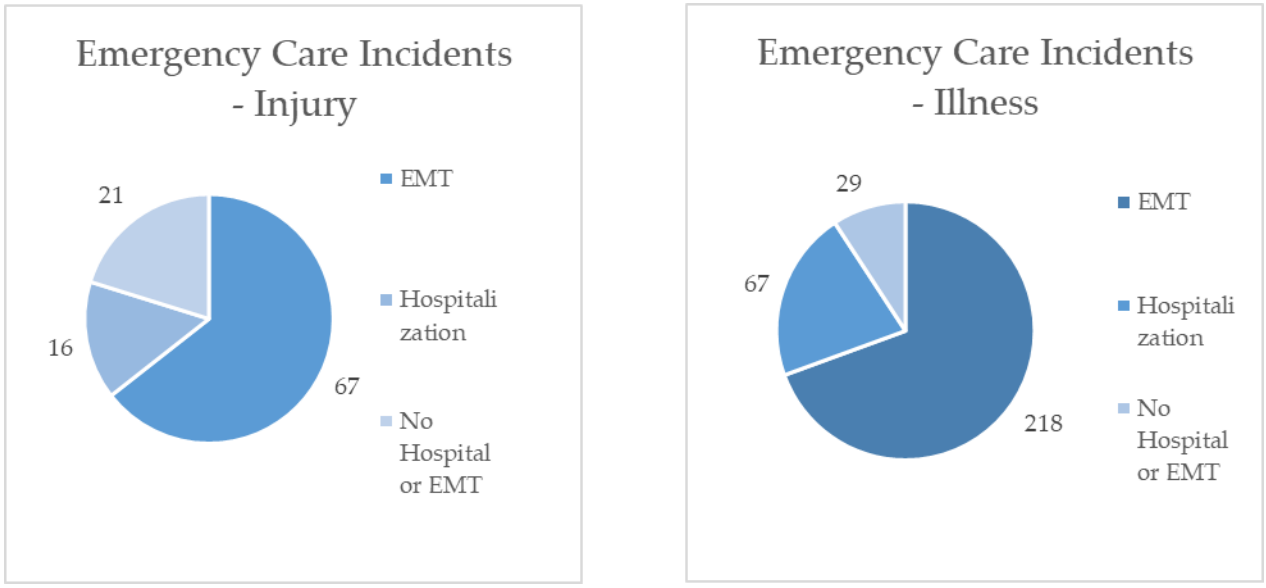


Figure 7. Emergency Care incidents resulting in EMT, Hospitalization, caused by injury or illness

Medication Incidents

Medication incidents include missed medications, wrong dose, MAR staff signing error, wrong person/medication, wrong time and/or wrong day, MAR transcription error, adverse reaction, missing recipient, and wrong route of administration. Medication incidents are reviewed quarterly at MAP, which consists of the Medical Director, QCSRR Director, pharmacy representative, and QI staff.

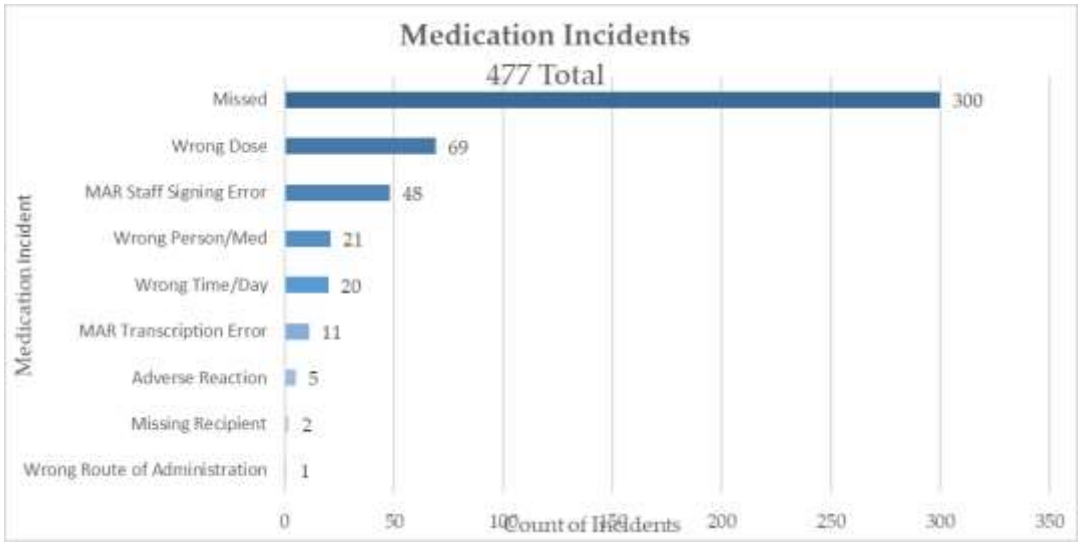


Figure 8. Medication incident reports by category. Data shows count of IRs completed in FY23

Deaths

Age	Count
30 and below	6
30-50	18
50-70	42
70-90	22
90+	0
Total	**88**

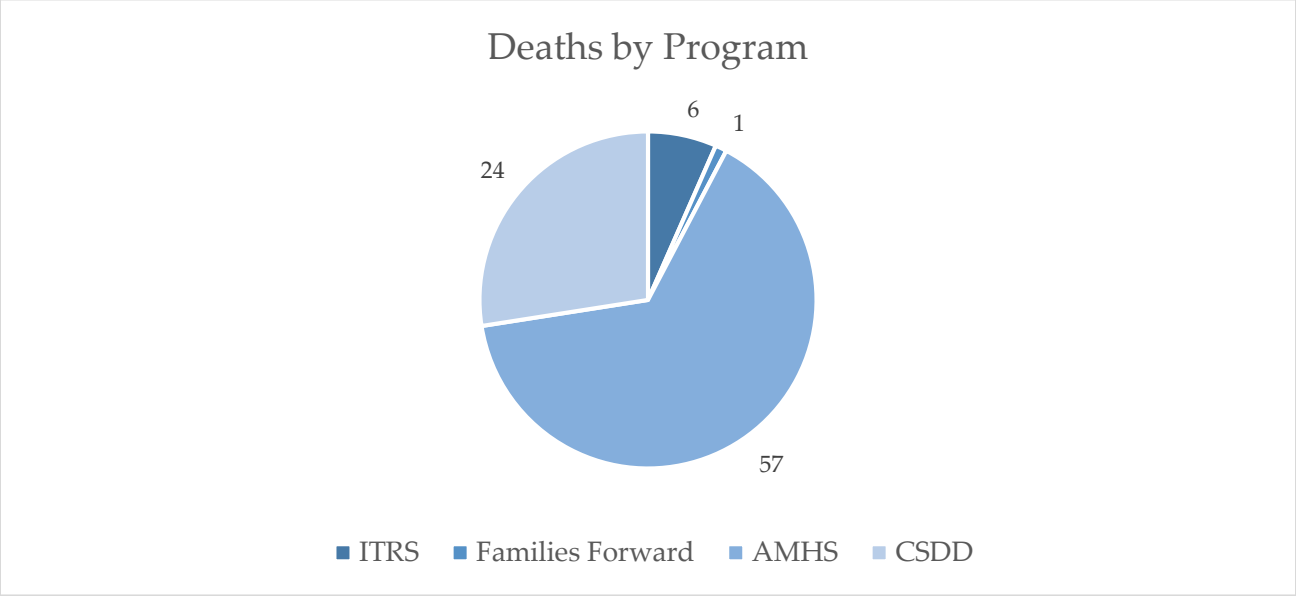


Figure 9. Count of Deaths by age and by CMHA-CEI Program

Sentinel Event Reports

Per CMHA-CEI's Sentinel Event Procedure, 1.1.14, a Sentinel Event is defined as "an unexpected occurrence to a recipient of services involving death or serious physical (loss of limb or function) or psychological injury, or the risk thereof. (Risk thereof includes any process variation that would most likely would result in a sentinel event if it reoccurred). All sentinel events are reviewed at CIRC monthly. If the event is determined to be sentinel, and in-depth review of the consumer's chart is conducted to help determine cause and steps to reduce reoccurrence in the future. Sentinel events are reported to MSHN and MDHHS when required.

Sentinel Event Type	Count
Accidental Overdose	13*
Accidental Choking	5
Suicide	1
Homicide	1
Car Accident	1
Total	**21**

*one accidental overdose that did not result in death

Sentinel Event Age	Count
30 and below	4
30-50	9
50-70	8
70+	0
Total	**21**

Table 12. Count of Sentinel Events by type and age

Staff Injuries/Vehicle Accidents

Ensuring safe driving and proper vehicle maintenance is essential when CMHA-CEI employees are operating CHMA-CEI owned vehicles. Drivers of CMHA-CEI vehicles must meet all driver license requirements as established by Michigan law, Procedure 2.2.5 Driving Records, and comply with CMHA-CEI's vehicle insurance carrier. All vehicle accidents are reported to the Safety Director and Safety Committee who then reviews all accident reports and makes determinations and recommendations based on the review.

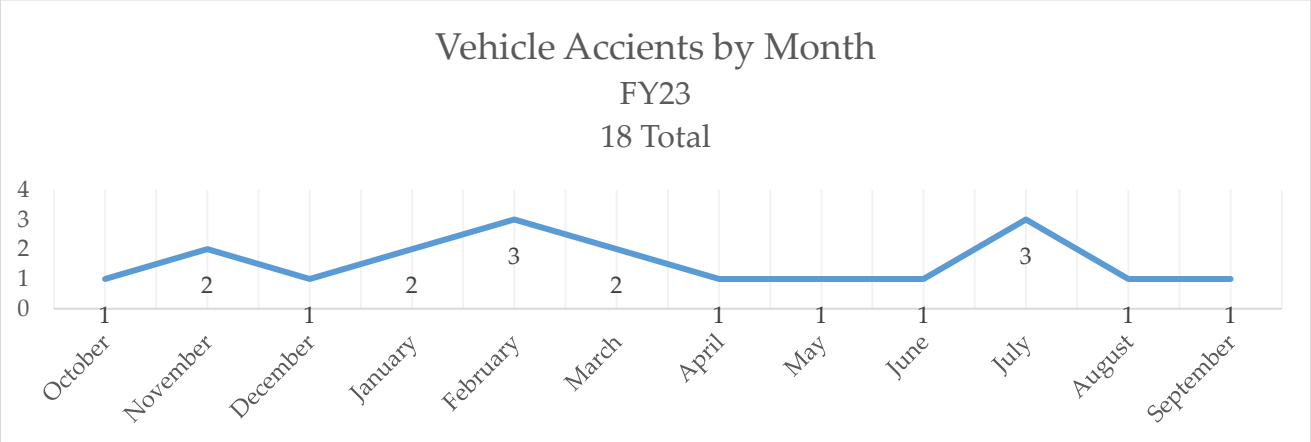
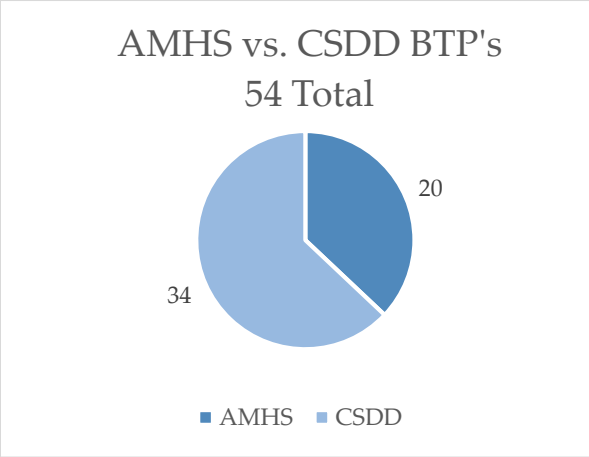


Figure 10. Vehicle Accidents by month in FY23

Behavior Treatment Committee (BTC)

In FY2023, CMHA-CEI's Behavior Treatment Committee conducted 240 reviews, which includes expedited, quarterly, annual, and new plan reviews. All Behavior Treatment Plans are monitored through CHMA-CEI's Behavior Treatment Committee which come from several different agencies throughout the tri-county area. The BTC consists of the Medical Director, AMHS Representative, CSDD Representative, Recipient Rights (ex-officio), and QI.



Internal vs. Contract BTP's	Count
CMHA-CEI	30
Beacon	9
ROI	5
Centria Healthcare	4
Flatrock	4
Great Lakes Center for Autism	2
Total BTP's	**54**

Figure 11. Count of Behavior Treatment Plans by CMHA-CEI program and Internal vs. Contract Providers

Medicaid Event Verification Audit

For FY23, there were two Medicaid Event Verification audits held by MSHN during June and December 2023. MSHN tracks a variety of attributes of claims during each MEV review. The attributes tested during the Medicaid Event Verification review include A.) The code is allowable service code under the contract, B.) Beneficiary is eligible on the date of service, C.) Service is included in the beneficiary's individual plan of service or in the treatment plan, D.) Documentation of the service date and time matches the claim date and time of the service, E.) Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed, F.) Amount billed does not exceed contractually agreed upon amount, G.) Amount paid does not exceed contractually agreed upon amount, and H.) Modifiers are used in accordance with the HCPCS guidelines.

CMHSP	A	B	C	D	E	F	G	H
BABH	100%	100%	100%	97.21%	79.81%	99.68%	100%	97.23%
CEI	100%	100%	100%	98.87%	83.60%	100%	100%	57.66%
CMHCM	100%	100%	100%	98.44%	91.48%	99.65%	100%	85.64%
Gratiot	100%	100%	100%	99.21%	88.29%	99.65%	99.68%	95.26%
Huron	100%	100%	100%	98.29%	82.59%	99.66%	100%	96.83%
LifeWays	100%	98.11%	100%	96.62%	81.11%	99.66%	99.15%	75.01%
Montcalm	100%	100%	100%	97.40%	88.42%	99.76%	100%	97.01%
Newaygo	99.00%	100%	100%	97.15%	85.74%	98.83%	99.66%	82.66%
Saginaw	99.72%	100%	99.30%	97.70%	78.05%	99.69%	97.01%	86.27%
Shiawassee	99.12%	100%	100%	95.58%	90.27%	99.71%	100%	98.88%
The Right Door	100%	100%	100%	98.91%	84.50%	100%	100%	89.24%
Tuscola	100%	100%	100%	98.86%	93.05%	99.67%	99.35%	94.53%
MSHN Average	**99.84%**	**99.82%**	**99.93%**	**97.96%**	**85.36%**	**99.65%**	**99.51%**	**86.65%**

Table 13. Summary of CMHSP MEV Reviews for Mid-State Health Network

During FY24 Q1, MSHN began to track an additional score in addition to the valid claim's percentage – the average of attributes tested.

	MEV Review Claims Test Percentages by CMHSP, FY24 Q1								
CMHSP | Attribute Tested	A	B	C	D	E	F	G	Average %	% of Valid Claims
Central	99.25%	100%	92.83%	97.74%	90.19%	99.25%	86.55%	95.12%	73.58%
CEI	100%	100%	100%	99.36%	95.18%	100%	90.91%	97.92%	90.68%
Montcalm	100%	100%	65.17%	100%	89.05%	99.50%	100%	93.39%	70.15%
Newaygo	100%	100%	94.38%	96.79%	95.98%	100%	77.89%	95.01%	79.52%
The Right Door	100%	100%	99.69%	97.20%	79.44%	100%	88.26%	94.94%	76.32%
Tuscola	100%	100%	88.26%	98.38%	76.11%	83.00%	89.24%	90.71%	69.23%
FY24 Q1 Average	99.88%	100%	90.06%	98.25%	87.66%	96.96%	88.81%	94.52%	76.58%

Table 14. FY24 Q1 chart of valid claims percentages

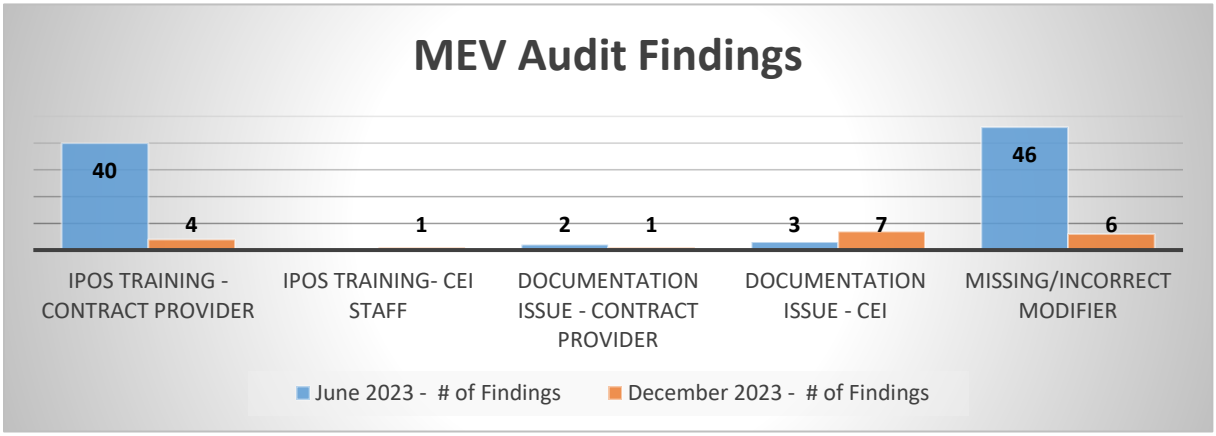


Figure 12. MEV Audit Findings. In FY24, QI began to track findings from MEV audits and their associated categories, in order to identify trends and opportunities for targeted improvements.

The June MEV audit included a review of SUD specific claims, which are identified separately below.

Findings from the June 2023 CMH MEV audit are as follows:

- Line 77. Consumer discharged from BCU on 1/31/23. H0018 service should not be reported on the day of discharge.
- Line 86. 12a-6:30p is 74 units, not 72 (billed). Per CEI, this claim has been corrected by the finance team to reflect the accurate units.
- Line 170. Service was 70 minutes, 5 units could have been billed as service code (T1002) is "up to 15 minutes".
- Line 258. Documentation is missing a start/stop time. Unable to verify units billed.
- Line 300. One staff log is missing a Time In/Out. Unable to locate IPOS training for D. Smith, Kerry Herrguth, Victoria Smith.
- Lines 22, 23, 25-29, 31, 33-39, 41. Unable to locate IPOS training for [redacted]
- Lines 211-213, 216-219, 221, 222. Unable to locate IPOS training for [redacted]. Per CEI, provider (Gateway) stated that there was a technical issue with their IPOS tracking system. By the time they caught the issue and resolved it, the technician, [redacted] had left the company and they were unable to have a signature for Tristan Straub's IPOS form.

- Lines 259-264, 267-277. Unable to locate IPOS training for CLS/PC Beacon staff.
- Line 300. One staff log is missing a Time In/Out. Unable to locate IPOS training for [redacted], [redacted] [redacted] [redacted]
- Lines 16, 152, 231, 236, 245, 254, 256. Missing staff credential modifier, AF.
- Line 40. Location on progress note says "12-Home", but narrative says supervision was conducted via telehealth. Telehealth, missing GT modifier. Per CEI, claim has been corrected by the finance team.
- Lines 43, 58, 158, 168. Staff signs as a LLMSW, but HM modifier is billed. HO modifier should be billed.
- Line 57. U7 modifier should not be billed for T2025 service.
- Lines 82, 83, 85, 86. Missing staff credential modifier, HM.
- Lines 170, 171, 173, 175, 177, 179, 183. Missing HH modifier.
- Lines 173, 179. Staff, [redacted] has a Bachelor's degree, HN modifier should be billed, not HM.
- Line 189. Missing group modifier (and progress note is missing number of patients served in group.)
- Lines 190, 192, 194, 196, 198, 200, 202, 204, 240, 298. Staff signs as a LMSW, but HM modifier is billed. HO modifier should be billed.
- Lines 206, 208. HM modifier billed and staff does not sign with credential, but there is transcript uploaded from Spring Arbor University. Per LARA, staff is a LMSW. HO modifier should be billed.
- Line 230, 249. Staff signs as a RN, TD modifier should be billed, not AG.
- Lines 244, 252, 253. Staff signs as an RN, TD modifier should be billed, not AF.
- Line 250. Staff, [redacted] has a Bachelors degree, HN modifier should be billed, not HM.
- Lines 265, 296. Missing staff credential modifier, AH.

The following Corrective Action Plan was submitted and accepted by MSHN to address the above findings:

- Line 77. Claim has been sent to the clinician and has been corrected in the system
- Line 86. Correction has been uploaded to Box> Final reports>2023-06>CMH – titled "June 2023 MEV Corrections"
- Line 170. The current set-up of the service code in the system does not allow for correction at this time. The Finance team is aware of the issue and is researching how to correct the system structure, and plan to have this completed by 9/30/23. Once a solution is identified, the claim will be corrected and evidence will be uploaded to Box
- Line 258. Training has occurred with contract provider Beacon regarding documentation requirements, and need to include required information.
- Line 300. IPOS training documents for this claim were unable to be located and determined to be missing. IPOS training sheet for current plan located, but not plan that covered these services. This is an ongoing point of improvement, and this particular case has been brought to program coordinators, the Contract Quality Workgroup, and training continues to be

provided on this requirement and importance. This claim has been provided to Finance and the funding source was switched to CMHA-CEI's General Fund, and not Medicaid.

- Lines 22, 23, 25-29, 31, 33-39, 41. CEI was unable to locate documentation of original IPOS training to Centria Staff, and Provider Centria was unable to locate the IPOS training for [redacted]. Training provided to CEI staff and Centria on requirement to maintain documentation of IPOS training and required elements.
- Lines 211-213, 216-219, 221, 222. Provider Gateway has evaluated and corrected their IPOS tracking system. Training has occurred with provider regarding required elements of IPOS training and requirement to maintain documentation records
- Lines 259-264, 267-277. CEI staff was unable to locate documentation of original IPOS training to Beacon staff, and Beacon was unable to locate their copy of IPOS training. Training provided to CEI staff and Beacon on requirement to maintain documentation of IPOS training and required elements.
- Line 300. IPOS training documents for this claim were unable to be located and determined to be missing. IPOS training sheet for current plan located, but not plan that covered these services. This is an ongoing point of improvement, and this particular case has been brought to program coordinators, the Contract Quality Workgroup, and training continues to be provided on this requirement and importance. This claim has been provided to Finance and the funding source was switched to CMHA-CEI's General Fund, and not Medicaid.
- Lines 16, 152, 231, 245. Lines have been sent to CMHA-CEI Finance team and have been corrected
- Line 40. Correction has been uploaded to Box> Final reports>2023-06>CMH – titled "June 2023 MEV Corrections"
- Lines 43, 58, 158, 168. Lines have been sent to CMHA-CEI Finance team and have been corrected
- Line 57. Lines have been sent to CMHA-CEI Finance team and have been corrected
- Lines 86 Lines have been sent to CMHA-CEI Finance team and have been corrected
- Lines 173,179. Lines have been sent to CMHA-CEI Finance team and have been corrected
- Lines 173, 179. Lines have been sent to CMHA-CEI Finance team and have been corrected
- Lines 190, 192, 194, 196, 198, 200, 202, 204, 240, 298. Lines have been sent to CMHA-CEI Finance team and have been corrected
- Lines 206, 208. Lines have been sent to CMHA-CEI Finance team and have been corrected
- Lines 244, 253. Lines have been sent to CMHA-CEI Finance team and have been corrected
- Line 250. Line has been sent to CMHA-CEI Finance team and has been corrected
- Line 265, Uploaded June 2023 MEV Audit - CMH Claim Corrections to Box
- Lines 236, 254, 256 Uploaded June 2023 MEV Audit - CMH Claim Corrections to Box Folder
- Lines 170 The current set-up of the service code in the system does not allow for correction at this time. The Finance team is aware of the issue and is researching how to correct the system structure. Once a solution is identified, the claim will be corrected and evidence will be uploaded to Box.
- Line 171, 175, 177, 183. Clinician no longer a staff member at CEI to confirm co-occurring diagnosis, service has been errored and not billed

- Lines 82, 83, 85 Delay in obtaining proof due to contracts needing to finalize rates for new codes, that has been completed and now CEI Finance team is working on obtaining proof of correction for the listed claims, evidence will be uploaded as soon as it is available, to Box.
- Line, 296 Finance team is working on obtaining proof of correction, evidence will be uploaded to Box
- Line 189 Additional updated Claim information has been uploaded to Box
- Line 230, 249. CEI's Finance team has reviewed the claim information and determined there is a system software issue with how the system is sending the claim information to the warehouse. A ticket has been submitted to the software vendor to correct the system, and once the reporting issue is corrected in the software CEI's Finance team will void and resubmit the corrected claim. Evidence of correction will be uploaded once available.
- Line 252. CEI's Finance team has reviewed the claim information and determined there is a system software issue with how the system is sending the claim information to the warehouse. A ticket has been submitted to the software vendor to correct the system, and once the reporting issue is corrected in the software CEI's Finance team will void and resubmit the corrected claim. Evidence of correction will be uploaded once available.

Findings from the June 2023 SUD MEV audit are as follows:

- Line 8. Progress note Start Time is 9am with a Duration of 90 Minutes. End Time should be 10:30a, not 10a.
- Lines 19, 21, 22, 25, 26, 28, 31, 33, 34, 36. Missing HH modifier.
- Lines 49, 55. Staff is a psychiatrist, AF modifier should be billed, not AG.
- Lines 2-4. Unit rate billed ($1,087.87) for H0010 exceeds contract rate ($369.50). Correct amount paid.
- Lines 5,6. Unit rate billed ($157.41) for H0002 exceeds contract rate ($43.00). Correct amount paid.
- Line 7. Unit rate billed ($177.05) for H0006 exceeds contract rate ($41.00). Correct amount paid.
- Line 9. Unit rate billed ($268.34) for 90853 exceeds contract rate ($106.50). Correct amount paid.
- Lines 10-14, 60, 61. Unit rate billed ($1,087.87) for H0010 exceeds contract rate ($406.50). Correct amount paid.
- Lines 15-17. Unit rate billed ($553.87) for H0018 exceeds contract rate ($82.00). Correct amount paid.
- Lines 19, 21, 28, 36. Unit rate billed ($324.77) for 90837 exceeds contract rate ($129.00). Correct amount paid.
- Lines 22, 25, 26, 31, 33, 34, 38, 50. Unit rate billed ($53.35) for H0038 exceeds contract rate ($24.00). Correct amount paid.
- Lines 24, 30. Unit rate billed ($220.20) for 90853 exceeds contract rate ($59.00). Correct amount paid.
- Line 40. Unit rate billed ($231.19) for H0001 exceeds contract rate ($176.00). Correct amount paid.

- Lines 42, 46, 51, 58. Unit rate billed ($250.93) for 90834 exceeds contract rate ($100.00). Correct amount paid.
- Line 44. Unit rate billed ($324.77) for 90837 exceeds contract rate ($117.00). Correct amount paid.
- Lines 49, 55. Unit rate billed ($269.65) for 99213 exceeds contract rate ($100.00). Correct amount paid.
- Lines 52, 57. Unit rate billed ($316.63) for 90832 exceeds contract rate ($65.00). Correct amount paid.
- Line 62. Unit rate billed ($157.41) for H0002 exceeds contract rate ($47.50). Correct amount paid.
- Lines 63, 66, 67, 70, 71. Unit rate billed ($73.45) for S9976 exceeds contract rate ($23.50). Correct amount paid.

*Overbilling findings listed were given a singular finding to account for all occurrences. MSHN reviews this per MDHHS guidance and we have been very lenient on what is submitted as plan of correction for Attribute F findings as we understand the complexities with it. While it may not be able to be corrected, the plan could include the challenges involved in correcting/changing this process.

The following Corrective Action Plan was submitted and accepted by MSHN to address the above findings:

- Line 8. Corrected note in system, will upload example to Box folder
- Lines 19, 21, 22, 25, 26, 28, 31, 33, 34, 36. Please have MSHN void these claims internally
- Lines 49, 55. Please have MSHN void these claims internally

Findings from the December 2023 MEV are as follows:

- Line 85. Unable to locate documentation to support claim. Per CEI, they have contacted the camp multiple times to provide a copy of the service document but have not received any documentation from them thus far. CEI is continuing efforts, will address in the CAP.
- Line 277. Documentation shows that patient was admitted on 6/21 and discharged on 6/28. Day of discharge should not be billed. Should void and rebill as 6/27/23. Provider uploaded evidence of voided encounter to Box. **No further action required.**
- Line 14. Unable to locate IPOS training for [redacted]. Per CEI, Gateway Pediatrics was unable to provide a copy of the IPOS training for this staff member.
- Lines 16, 18. Unable to locate IPOS training for [redacted]. Per CEI, Gateway Pediatrics was unable to provide a copy of the IPOS training for this staff member.
- Line 17. Unable to locate IPOS training for [redacted] Per CEI, Gateway Pediatrics was unable to provide a copy of the IPOS training for this staff member.
- Lines 35, 36. Documentation lacks narrative of what occurred during the session - it just says the word "Respite". Per CEI, they are unable to provide additional documentation. There had been some confusion around required elements, and there was an impression that the respite documentation just needed to have the respite code, date, time, and employee

signature. The assigned QA has updated the provider on the need to include some narrative on what occurred during the session. **No further action required.**

- Line 85. Unable to locate documentation to support claim. Per CEI, they have contacted the camp multiple times to provide a copy of the service document but have not received any documentation from them thus far. CEI is continuing efforts, will address in the CAP.
- Line 89. Unable to locate IPOS training for Destiny Peterson. Per CEI, staff provided last-minute/emergency respite services to the consumer and there is no IPOS training document.
- Lines 297, 299, 303, 305, 307, 309, 311. All community psych notes have the exact same/similar narrative. No notes on what occurred during each session specifically. Per CEI, consumer is no longer active and clinician that provided the service/notes no longer works for CEI. CEI will follow up with the coordinator that the staff reported to and they may be able to provide some additional information.
- Line 35, 36. Missing staff credential modifier, HM. Per CEI finance team, claims are from last fiscal year and HM modifier was not part of the provider contract. There is no rate for the T1005 with the HM modifier added; the only rate in the system is for T1005:C2 U7 so because of this they did not make the change because then the claim would not have a rate. However, a staff credential modifier is required for the T1005 service code per the code chart.
- Lines 42, 49, 287. Staff is an RN, TD modifier should be used, not AG. Per CEI, finance team is in the process of correcting these claims – this is related to issues from last MEV audit, and has been determined to be an issue in the EHR (Streamline Smartcare) system. CEI has submitted this issue to Streamline and it is being currently worked on but the 'fix' has not been finalized yet. Finance team has placed this claim in 'error status' and we will rebill once we have the fix in place. Proof of final correction can be provided once available. Provider uploaded evidence of claims in "error status". **No further action required.**
- Line 57. HH modifier billed in error? Per provider, Lines 47, 51, 53, 55 (T1017) do not require the use of an HH modifier. Need to verify why the HH modifier applies on this claim line.
- Lines 59, 209, 213, 217, 235, 238. Staff is a psychiatrist, AF modifier should be used, not AG. Provider uploaded evidence of correction. **No further action required.**
- Lines 293, 295, 301. Note is missing number of group participants. Billing is missing a U modifier. Per CEI, there was an error in the system that did not allow for the correct service code for multi-family groups to be selected and access to the correct code is in progress.

The following Corrective Action Plan was submitted and accepted by MSHN to address the above findings:

- Line 85. CEI's Finance department will void the claims and has initiated recoupment of funds from YMCA of Metropolitan Lansing
- Line 14. – CEI's Finance department will void the claims and has initiated recoupment of funds from Gateway Pediatrics.
- Lines 16, 18. – CEI's Finance department will void the claims and has initiated recoupment of funds from Gateway Pediatrics.

- Line 17. – CEI's Finance department will void the claims and has initiated recoupment of funds from Gateway Pediatrics.
- Line 89. - It is standard process for the Treatment Plan author to train the CLS / Respite provider in a consumer's treatment plan prior to providing CLS/Respite services, and to document that training in a contact note in the EHR. However, when there is a need for emergency respite services to be provided, the treatment plan author may not be available to provide the training in the treatment plan to the CLS / Respite provider. Moving forward, in those situations, the standing Respite/CLS Coordinator will review the essential elements of the consumer's TX plan and the goals/ objectives related to the CLS/ Respite service with the CLS / Respite provider prior to the service occurring, and this training will be documented by a contact note in the EHR.
- Lines 297, 299, 303, 305, 307, 309, 311 – Staff training regarding service documentation standards was provided at the 2/8/24 unit staff meeting
- Line 35, 36. – Uploaded to 'Additional Documentation' folder in Box "Line 35_36 Modifier correction." CEI's finance team was able to update the authorization to include the HM modifier.
- Line 57. – Verified with clinician that during this service they discussed the consumer's substance use, but it is not discussed at every service.
- Lines 293, 295, 301. - Uploaded to 'Additional Documentation' folder in Box "Line 293_295_301 Voids". Services will be corrected once the correct code is set up in the system.

FY23 Chart Review Results

Chart Review Process

Chart reviews are completed on a quarterly basis by the Quality Improvement and Utilization Management team. Specific programs to be chart reviewed are selected through the Quality Improvement and Compliance Committee and Program Need. A random sample of charts are selected with the unit's charts that are being reviewed that quarter.

Reviews will be completed at least quarterly and will address:

a) Quality of service delivery as evidenced by the record of the consumer;
b) Appropriateness of services;
c) Patterns of services utilization; and
d) Model fidelity, when an evidence-based practice is identified.

QCSRR compiles the aggregate data and forward to the Clinical Programs. QI will schedule a meeting with the clinical program to review results, determine areas of improvement, and develop a plan to address the issues identified, if needed.

The clinical record review results will be discussed quarterly at the Quality Improvement and Compliance Committee.

Timeframe is when the actual chart reviews were completed, Reviews include documentation from the previous 12 months prior to the review quarter.

Timeframe	Programs for Chart Review
FY23 1st Quarter	ACT
FY23 2nd Quarter	AMHS CM-Waverly
FY23 3rd Quarter	FF
FY23 4th Quarter	CSDD
Aggregate Chart Review Standard Ratings	
Completely Met	100% Compliance
Substantially Met	85-99% Compliance
Partially Met	70-84% Compliance
Not Met	69% and Below

Table 15. Chart Review Schedule and Results

FY23 Q1 Chart Review Results - ACT

Standards	All Programs		ACT Cedar		ACT Louisa	
Intake/Assessment	**# of Charts**		#		#	
Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	29	59%	14	79%	14	43%
Are consumer's needs & wants are documented?	29	97%	14	100%	14	93%
Present and history of behavior and/or symptoms are documented and specify if observed or reported	29	97%	14	100%	14	93%
Substance use (current and history) included in assessment?	28	100%	14	100%	13	100%
Current physical health conditions are identified?	28	100%	13	100%	14	100%
Current health care providers are identified?	28	93%	13	88%	14	96%
Previous behavioral health treatment and response to treatment identified?	29	97%	14	100%	14	93%
Present and history of trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma) using a validated, population-appropriate screening tool?	29	40%	14	46%	14	36%
Did crisis screening and other life domain needs screening occur?	29	97%	14	100%	14	93%
Was consumer offered the opportunity to develop a Crisis Plan? CARF: It is recommended that when the assessment identifies a potential risk for suicide, violence, or other risky behaviors, a safety plan be completed that includes actions to be taken to restrict access to lethal means, preferred interventions necessary for personal and public safety, and advance directives, when available.	29	83%	14	86%	14	79%
Pre-Planning						

Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan? Address when/where meeting will be held, who will be invited, specific format or tool, and accommodations needed?	29	72%	14	75%	14	71%
Person Centered Planning /IPOS						
Has the LOCUS been completed in the past year?	29	51%	14	67%	14	38%
The IPOS must be prepared in person-first singular language and can be understandable by the person with a minimum of clinical jargon or language.	29	91%	14	89%	14	93%
The IPOS includes the following components described below: A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.	29	97%	14	100%	14	93%
The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured. (If the consumer identifies a want/need, make sure it is included in the TX Plan)	29	60%	14	68%	14	54%
The setting in which the person lives was chosen by the person and what alternative living settings were considered by the person. The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment & work in competitive integrated settings, engage in community life, control person resources, and receive services in the community to the same degree of access as individuals not receiving services and supports from the mental health system.	28	96%	14	93%	13	100%
The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system. Make note if there are any ranges used for services and give a 1 (MDHHS cited for med clinic, psychology, CLS)	29	84%	14	86%	14	86%

The services which the person chooses to obtain through arrangements that support self-determination.	13	96%	9	94%	4	100%
Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).	29	67%	14	71%	14	61%
The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.	21	62%	9	78%	11	45%
A timeline for review. (Are reviews occuring at least every 6 months?)	28	93%	13	96%	14	89%
If applicable, the IPOS addresses health and safety issues.	27	76%	14	64%	13	88%
If applicable, identified history of trauma is effectively addressed as part of PCP.	18	39%	11	41%	6	42%
Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	29	55%	14	68%	14	39%
Consumer has ongoing opportunities to provide feedback on satisfaction with treatment, services, and progress towards valued outcomes?	27	96%	13	96%	13	96%
Delivery and Evaluation						
Are services being delivered consistent with plan in terms of scope, amount and duration? Pay close attention to Case Management! (score 0 if services are not occurring as authorized) Look at June, July, August months	28	36%	13	42%	14	25%
Monitoring and data collection on goals is occurring according to time frames established in plan?	29	76%	14	86%	14	64%
Are periodic reviews occurring according to time frames established in plan?	28	77%	14	89%	14	64%
Program Specific Service Delivery						
For ACT services: all members of the team routinely have contact with the individual	28	91%	13	88%	14	93%
For ACT service: majority of services occur in consumer home or community 2017 language: services are delivered in the community	28	93%	13	92%	14	93%

For medication services, informed consent was obtained for all psychotropic medications?	29	10%	14	21%	14	0%
Is there evidence of outreach activities following missed appointments?	17	62%	7	71%	10	55%
Is there evidence of coordination with Primary Care Physician in the record?	28	16%	13	19%	14	14%
Integrated Physical and Mental Health Care						
The CMHSP will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it.	29	78%	14	86%	14	75%

Table 16. Chart Review Results for ACT

FY23 Q2 Chart Review Results – AMHS Case Management

Standard	All Programs		Team 1		Team II		Team 3		Waverly	
Intake/Assessment	**Total Charts**									
Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	52	83%	12	75%	10	75%	14	79%	16	84%
Are consumer's needs & wants are documented?	55	96%	13	96%	11	100%	14	100%	17	97%
Present and history of behavior and/or symptoms are documented and specify if observed or reported	56	100%	13	100%	11	100%	14	96%	18	100%
Substance use (current and history) included in assessment?	53	100%	13	100%	9	89%	13	92%	18	94%
Current physical health conditions are identified?	53	100%	12	100%	10	90%	13	92%	18	89%
Current health care providers are identified?	51	90%	12	79%	10	100%	11	86%	18	94%
Previous behavioral health treatment and response to treatment identified?	56	98%	13	96%	11	95%	14	96%	18	100%
Present and history of trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma) using a validated, population-appropriate screening tool?	56	57%	13	54%	11	36%	14	39%	18	75%
Did crisis screening and other life domain needs screening occur?	56	100%	13	92%	11	100%	14	100%	18	100%

Was consumer offered the opportunity to develop a Crisis Plan? CARF: It is recommended that when the assessment identifies a potential risk for suicide, violence, or other risky behaviors, a safety plan be completed that includes actions to be taken to restrict access to lethal means, preferred interventions necessary for personal and public safety, and advance directives, when available.	51	89%	12	88%	10	80%	13	81%	16	88%
Pre-Planning										
Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan? Address when/where meeting will be held, who will be invited, specific format or tool, and accommodations needed?	55	65%	13	62%	11	55%	13	31%	18	67%
Person Centered Planning /IPOS										
Has the LOCUS been completed in the past year?	56	100%	13	92%	11	91%	14	100%	18	94%
The IPOS must be prepared in person-first singular language and can be understandable by the person with a minimum of clinical jargon or language.	54	84%	13	92%	11	91%	13	88%	17	85%
The IPOS includes the following components described below: A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.	54	86%	13	81%	11	64%	13	73%	17	68%
The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured. (If the consumer identifies a want/need, make sure it is included in the TX Plan)	54	60%	13	54%	11	55%	13	58%	17	62%

The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.	54	86%	13	88%	11	91%	13	88%	17	88%
Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).	54	82%	13	81%	11	50%	13	73%	17	88%
The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.	48	50%	11	68%	10	50%	12	75%	15	47%
A timeline for review. (Are reviews occurring at least every 6 months?)	53	94%	12	96%	11	100%	13	100%	17	76%
If applicable, the IPOS addresses health and safety issues.	42	97%	11	77%	9	72%	10	90%	12	83%
If applicable, identified history of trauma is effectively addressed as part of PCP.	39	85%	8	75%	8	69%	11	77%	12	75%
Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	54	28%	13	54%	11	0%	13	46%	17	29%
Delivery and Evaluation										
Are services being delivered consistent with plan in terms of scope, amount and duration?	52	40%	13	46%	10	40%	13	42%	16	44%
Monitoring and data collection on goals is occurring according to time frames established in plan?	54	62%	13	50%	11	64%	13	54%	17	68%
Are periodic reviews occurring according to time frames established in plan?	42	91%	9	78%	9	67%	10	100%	14	75%
Program Specific Service Delivery										
For medication services, informed consent was obtained for all psychotropic medications?	37	20%	12	33%	9	17%	13	19%	3	17%
Is there evidence of outreach activities following missed appointments?	51	60%	13	38%	10	75%	11	55%	17	71%

Is there evidence of coordination with Primary Care Physician in the record?	49	11%	11	5%	10	10%	12	8%	16	16%
Integrated Physical and Mental Health Care										
The CMHSP will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it.	55	73%	13	54%	11	82%	14	68%	17	94%

Table 17. Chart Review results for AMHS Case Management

FY23 Q3 Chart Review Results - FF

Standard	# of Charts Reviewed	All Programs	36108 Intensive Outpatient		36111 Eaton C&A Intensive Op GCP		36112 Clinton C&A Intensive Op		37401 FGS-Home Based GCB		38102 Early Intervention Services		38118 Eaton Co PYC GC	
Intake/Assessment	**Total Charts**		#		#		#		#		#		#	
Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	36	72%	11	27%	2	100%	2	100%	12	100%	6	75%	3	83%
Are consumer's needs & wants are documented?	47	88%	15	67%	3	100%	2	100%	14	100%	10	95%	3	100%
Present and history of behavior and/or symptoms are documented and specify if observed or reported	47	88%	15	70%	3	67%	2	100%	14	100%	10	100 %	3	100%
Substance use (current and history) included in assessment?	40	74%	15	43%	3	83%	2	100%	7	93%	10	90%	3	100%
Current physical health conditions are identified?	45	80%	14	54%	3	100%	2	100%	14	86%	9	100 %	3	83%
Current health care providers are identified?	47	83%	15	63%	3	100%	2	100%	14	89%	10	90%	3	100%
Previous behavioral health treatment and response to treatment identified?	43	79%	15	57%	3	67%	2	100%	14	100%	7	79%	2	100%
Present and history of trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma) using a validated, population-appropriate screening tool?	46	67%	15	40%	3	100%	2	100%	14	64%	9	100 %	3	67%
Did crisis screening and other life domain needs screening occur?	47	89%	15	67%	3	100%	2	100%	14	100%	10	100 %	3	100%

Was consumer offered the opportunity to develop a Crisis Plan? CARF: It is recommended that when the assessment identifies a potential risk for suicide, violence, or other risky behaviors, a safety plan be completed that includes actions to be taken to restrict access to lethal means, preferred interventions necessary for personal and public safety, and advance directives, when available.	47	89%	15	67%	3	100%	2	100%	14	100%	10	100 %	3	100%
Pre-Planning														
Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan? Address when/where meeting will be held, who will be invited, specific format or tool, and accommodations needed?	46	68%	15	80%	3	33%	2	50%	14	54%	9	78%	3	100%
Person Centered Planning /IPOS														
If they are in the SEDW, has the CAFAS/PECFAS been completed quarterly	8	100%	N/A	N/A	2	100%	2	100%	4	100%	N/A	N/A	3	83%
The IPOS must be prepared in person-first singular language and can be understandable by the person with a minimum of clinical jargon or language.	46	76%	15	67%	3	100%	2	75%	14	68%	9	94%	3	100%
The IPOS includes the following components described below: A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.	44	83%	13	69%	3	83%	2	50%	14	89%	9	94%	3	50%
The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured.	45	52%	14	21%	3	33%	2	100%	14	82%	9	61%	3	100%

(If the consumer identifies a want/need, make sure it is included in the TX Plan)														
The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.	45	84%	14	86%	3	100%	2	100%	14	71%	9	89%	3	100%
Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).	45	93%	14	86%	3	100%	2	75%	14	96%	9	100 %	3	0%
The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.	45	64%	14	93%	3	33%	2	50%	14	71%	9	44%	3	0%
A timeline for review. (Are reviews occurring at least every 6 months?)	44	51%	15	10%	3	67%	2	100%	13	92%	8	63%	3	100%
If applicable, the IPOS addresses health and safety issues.	32	91%	13	85%	1	0%	N/ A	N/A	10	100%	5	100 %	3	100%
If applicable, identified history of trauma is effectively addressed as part of PCP.	41	71%	15	53%	2	100%	1	50%	12	79%	8	75%	3	100%
Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	45	33%	14	36%	3	0%	2	50%	14	36%	9	44%	3	0%
Delivery and Evaluation														
Are services being delivered consistent with plan in terms of scope, amount and duration?	44	56%	13	42%	3	67%	2	100%	14	61%	9	61%	3	33%
Monitoring and data collection on goals is occurring according to time frames established in plan?	41	79%	14	64%	3	100%	2	100%	14	86%	7	93%	1	0%
Are periodic reviews occurring according to time frames established in plan?	32	50%	13	19%	0	0%	N/ A	N/A	10	90%	6	58%	3	33%
Program Specific Service Delivery														

Did all authorized services begin within 2 weeks of the start date? If not, was an ABDN sent due to service delay or was there a note that the family agreed to delay start of services?	47	86%	15	83%	3	100%	2	100%	14	75%	10	95%	3	100%
For medication services, informed consent was obtained for all psychotropic medications?	25	48%	9	50%	2	50%	1	100%	12	38%	1	100 %	N/ A	N/A
Is there evidence of outreach activities following missed appointments?	45	77%	15	63%	3	67%	2	100%	13	100%	9	67%	3	67%
Is there evidence of coordination with Primary Care Physician in the record?	45	52%	7	14%	3	67%	2	100%	14	68%	9	67%	3	83%
Integrated Physical and Mental Health Care														
The CMHSP will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it.	47	69%	8	31%	3	100%	2	100%	14	79%	10	95%	3	83%

Table 18. Chart Review Results for Families Forward

FY23 Q4 Chart Review Results – CSDD

Standard	# of Charts Reviewed	All Programs	87411 FSP Case Mgt		87301 Life Consultation	
	Total Charts		**Total Charts**	**%**	**Total Charts**	**%**
is Client Info (Admin) section on sexual orientation completed? Or is info in another spot?	56		15	0%	41	0%
Intake/Assessment						
Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	56	84%	15	87%	41	81%
Are consumer's needs & wants are documented?	56	100%	15	100%	41	100%
Consumer chart reflects input and coordination with others involved in treatment.	56	100%	15	100%	41	100%
Substance use (current and history) included in assessment?	51	87%	11	60%	40	95%
Current health care providers are identified by name and contact information, including primary care physician?	56	79%	15	80%	41	80%
Previous behavioral health treatment and response to treatment identified?	55	100%	15	100%	40	100%
Present and history of trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma) using a validated, population-appropriate screening tool? - include the specific date of the screening tool we locate	55	70%	14	90%	41	63%
Was consumer offered the opportunity to develop a Crisis Plan?.	56	100%	15	100%	41	100%
Pre- Planning						
Did pre-planning occur prior to Person- Centered Planning meeting or the development of a plan? If they occur same day, there needs to be a documented reason that the family/person chose to do so	56	78%	15	73%	41	73%
Pre-planning addressed when and where the meeting will be held. Pre-planning addressed who will be invited (including whether the person has allies	56	86%	15	73%	41	88%

who can provide desired meaningful support or if actions need to be taken to cultivate such support). Pre-planning identified any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and making a plan for how to deal with them. Pre-planning addressed the specific PCP format or tool chosen by the person to be used for PCP. Pre-planning addressed what accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication). Pre-planning addressed who will facilitate the meeting. Pre-planning addressed who will take notes about what is discussed at the meeting. When Applicable (Autism, Self-Determination, HSW Home-Based, CWP, SEDW): Evidence enrollee had an ability to choose among various waiver services. Evidence enrollee had an opportunity to choose their providers.						
Person Centered Planning /Individual Plan of Service						
The IPOS must be prepared in person- first singular language and can be understandable by the person with a minimum of clinical jargon or language. For children's services: The plan is family-driven, and youth guided.	56	82%	15	80%	41	83%
The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured.	56	69%	15	76%	41	67%
The setting in which the person lives was chosen by the person and what alternative living settings were considered by the person. The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment & work in competitive integrated settings, engage in community life, control person resources,	56	89%	15	86%	41	94%

and receive services in the community to the same degree of access as individuals not receiving services and supports from the mental health system.						
The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system. - make sure to check for ranges	56	71%	15	80%	41	61%
There is documentation of any restriction or modification of additional conditions & documentation includes: 1. The specific & individualized assessed health or safety need. 2. The positive interventions and supports used prior to any modifications or additions to the PCP regarding health or safety needs. 3. Documentation of less intrusive methods of meeting the needs, that have been tried but were not successful. 4. A clear description of the condition that is directly proportionate to the specific assessed health or safety need. 5. A regular collection and review of data to measure the ongoing effectiveness of the modification. 6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. 7. Informed consent of the person to the proposed modification. 8. An assurance that the modification itself will not cause harm to the person.	15	93%	4	100%	11	91%
The services which the person chooses to obtain through arrangements that support self-determination.	35	96%	8	100%	27	93%
Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).	54	81%	15	87%	39	84%
A timeline for review.	56	100%	15	100%	41	100%
Accommodations available for individuals accessing services who experience hearing or vision impairments, including that such disabilities are addressed in clinical assessments and service plans as requested by the person receiving services - also relevant for people with BTPs so look for that connection if there	32	100%	7	100%	25	100%
If applicable, the IPOS addresses health and safety issues.	46	91%	11	91%	35	93%
If applicable, identified history of trauma is effectively addressed as part of PCP.	36	81%	10	90%	26	92%
Autism Only: Beneficiaries IPOS addresses the needs. A. As part of the IPOS, there is a comprehensive individualized ABA behavioral plan	15	93%	13	92%	2	100%

of care that includes specific targeted behaviors for improvement, along with measurable, achievable, and realistic goals for improvement. The IPOS must address risk factors identified for the child and family, specify how the risk factor may be minimized and describe the backup plan for each identified risk. For example, a risk factor might be how to ensure consistent staffing in the event a staff did not show up. The backup plan is that the agency has a staff who is already trained in this child's IPOS, and that staff person can be sent in the event a staff does not show up to provide a service.						
Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	55	52%	15	57%	40	53%
Consumer has ongoing opportunities to provide feedback on satisfaction with treatment, services, and progress towards valued outcomes.	54	96%	15	90%	39	100%
Customer Service						
ABDNs - was the ABDN sent?? Timeline: 14 calendar days Decisions to deny or authorize service in an amount, duration or scope that is less than requested are made by a health care professional who has the appropriate clinical expertise in treating the consumer's condition or disease?	21	71%	6	75%	15	63%
The CMHSP provides Medicaid consumers with written service authorization decisions no later than 14 calendar days following receipt of a request for service authorization, unless the PIHP has authorized an extension; or the CMHSP provides Medicaid consumers with written service authorization decisions no later than 72 hours following receipt of a request for expedited service authorization, if warranted by the consumer's health or functioning, unless the PIHP has authorized an extension.	16	97%	5	100%	11	94%
The reasons for the service denial decision(s) is/are clearly documented and provided to the recipient.	20	80%	6	91%	14	68%
When denied or when services were authorized in an amount, duration or scope that was less than requested was the involved provider, if applicable, informed verbally or in writing of the action?	19	89%	6	100%	13	80%

A second opinion from a qualified health care professional within or outside the network is available to consumers upon request, at no cost to the consumer.	16	100%	5	100%	11	100%
DELIVERY AND EVALUATION						
Are services being delivered consistent with plan in terms of scope, amount, and duration?	52	56%	13	27%	39	63%
Monitoring and data collection on goals is occurring according to time frames established in plan?	54	92%	15	77%	39	98%
Are periodic reviews occurring according to time frames established in plan and as warranted by clinical changes and needs.	54	94%	14	86%	40	97%
PROGRAM SPECIFIC SERVICE DELIVERY						
For medication services: · informed consent was obtained for all psychotropic medication · evidence consumer informed of their right to withdraw consent at any time Med Consents need a physical signature	21	88%	2	25%	19	92%
Is there a physician prescription or referral for each specialized service (Physical Therapy, Occupational Therapy, Speech Therapy, durable medical equipment etc.)?	6	50%	2	50%	4	50%
Is there direct access to a specialist, as appropriate for the individual's health care condition?	22	100%	7	100%	15	100%
Is there evidence of outreach activities following missed appointments?	25	82%	7	79%	18	100%
Is there evidence of coordination with Primary Care Physician in the record? If not, is there evidence of referral to a PCP? If client declined referral, is there documentation of client decline?	56	50%	15	56%	41	58%
For Self-Determination: There is a copy of the SD Budget	4	0%	n/a	n/a	4	0%
There is a copy of the SD Agreement	4	0%	n/a	n/a	4	0%
There is evidence that individual has assistance selecting, employing, and directing & retaining qualified providers.	13	92%	1	100%	11	91%
For Autism Benefit/Applied Behavioral Analysis: Beneficiaries ongoing determination of level of service (every six months) has evidence of measurable and ongoing improvement in targeted behaviors as demonstrated with ABLLS-R or VB-MAPP.	14	89%	12	87%	2	100%

For Autism Benefit/Applied Behavioral Analysis: Observation Ratio: Number of Hours of ABA observation during a quarter are ≥ to 10% of the total service provided.	13	92%	12	92%	1	100%
Discharge /Transfers						
For closed cases, was the discharge summary/transfer completed in a timely manner? (Consistent with CMSHP policy) 30 days from date of last contact	8	56%	3	67%	5	50%
Does the discharge/transfer documentation include: a. Statement of the reason for discharge; and Individual's status /condition at discharge	8	56%	3	50%	5	60%
b. Does the discharge record include a plan for re-admission to services if necessary?	8	75%	3	100%	5	60%
Does the documentation include: a. Recommendations. b. Referrals; and c. Follow up contacts	7	43%	3	33%	4	50%
Integrated Physical and Mental Health Care						
The CMHSP encourages all consumers eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services.	56	84%	15	73%	41	84%
As authorized by the consumer, the CMHSP includes the results of any physical health care findings that relate to the delivery of specialty mental health services and supports in the person- centered plan.	44	89%	11	91%	33	88%
The CMHSP will ensure that a basic health care screening/health appraisal, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it.	56	60%	15	53%	41	73%

Table 19. Chart Review Results for CSDD

Provider Monitoring

Overview

CMHA-CEI has three quality advisors who conduct site visits for contract sites for the following contract types:

- Applied Behavior Analysis/Autism provider
- Hospitals/Partial Hospital
- Fiscal Intermediary
- Community Living Support (CLS)/Respite/Nursing
- Residential type A & B
- Pre-Vocational Training/Skill Building
- CMH-CEI-Residential and Non Residential

Quality advisors conduct three types of site visits annually, a recipient rights review, a quality and compliance review, and a home and community based review, if necessary. Items reviewed during the site visits include:

- Recipient Rights training dates for all staff (initial and annual)
- CMHA-CEI required staff training
- Background checks
- Person Centered Plan training and implementation
- Community inclusion documentation
- Documentation related to restrictions (if applicable)
- Medicaid Event Verification – documentation of billed services
- Tour of the site/facility for health or safety concerns

A full in-person site reviews resumed in FY23 for all in-catchment sites. An option for virtual reviews were available for out-of-catchment sites, and where a positive COVID-19 case was identified at the home. Quality Advisors continued to assist providers in navigating COVID-19 protocol, reporting requirements, and other burdens providers experienced.

Site Visit Overview

- 240 Site reviews were conducted in FY23
- Overall completion rate (from initial visit date to full compliance) was an average of 52 days, which was approximately similar to FY22 (50 days) and improvement from for FY21 (57 days).
    - Approximately 48% of sites reviews required a Plan of Correction (POC) for Quality and Compliance (QC), and only 22% required a Recipient Rights (RR) portion of the review in FY23.
    - More site visits were conducted in march (N=26) and December (N=30). Refer to the graph below for more site information data.

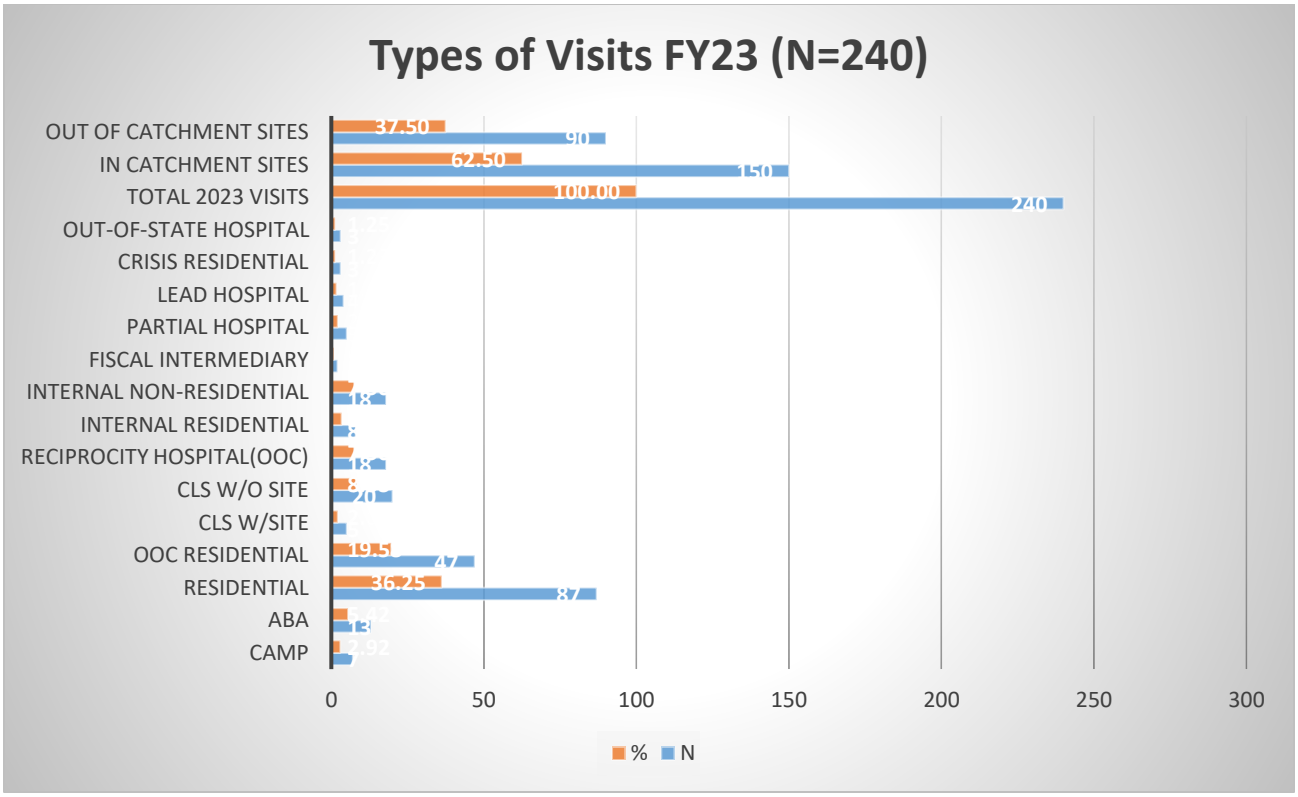


Figure 13. Types of visits completed in FY23.

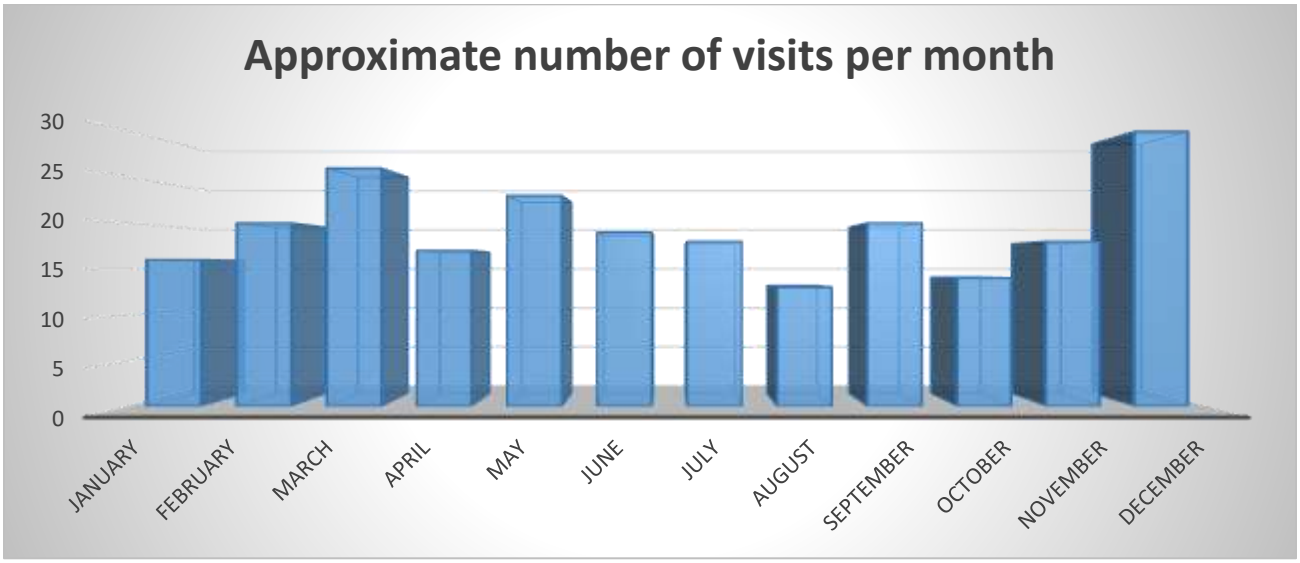


Figure 14. The number of site visited on each month in FY23.

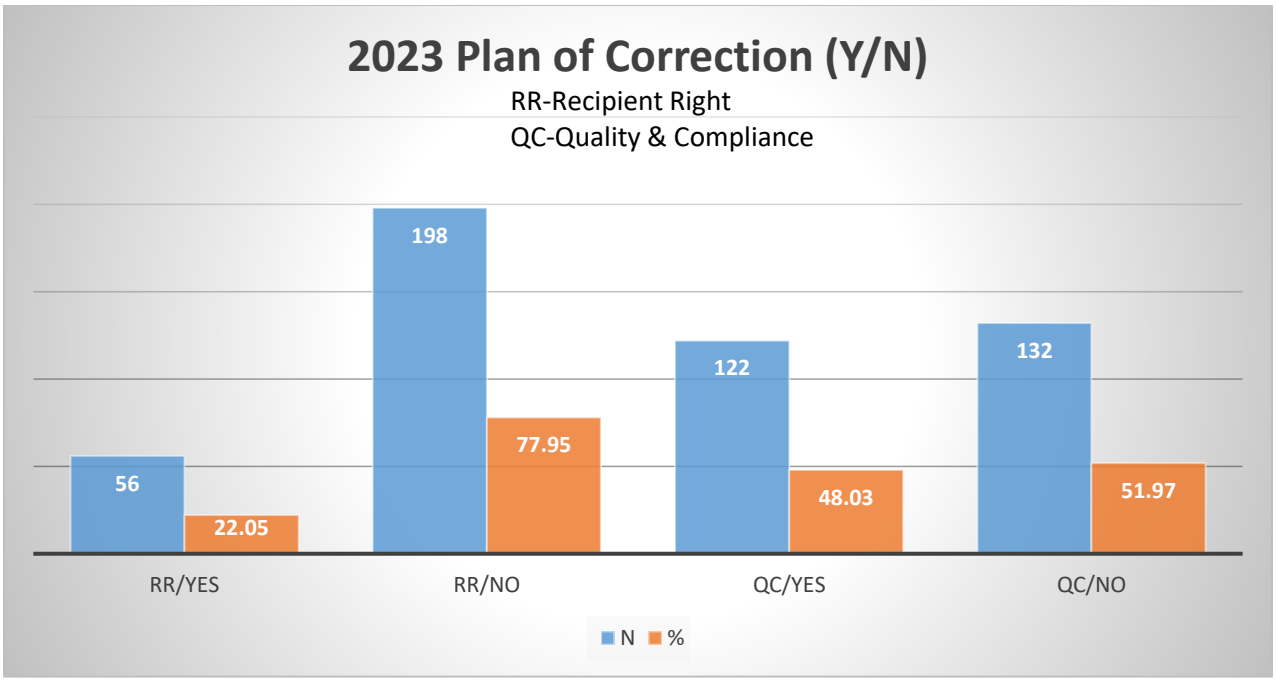


Figure 15. Number of sites requiring Plan of Correction (POC).

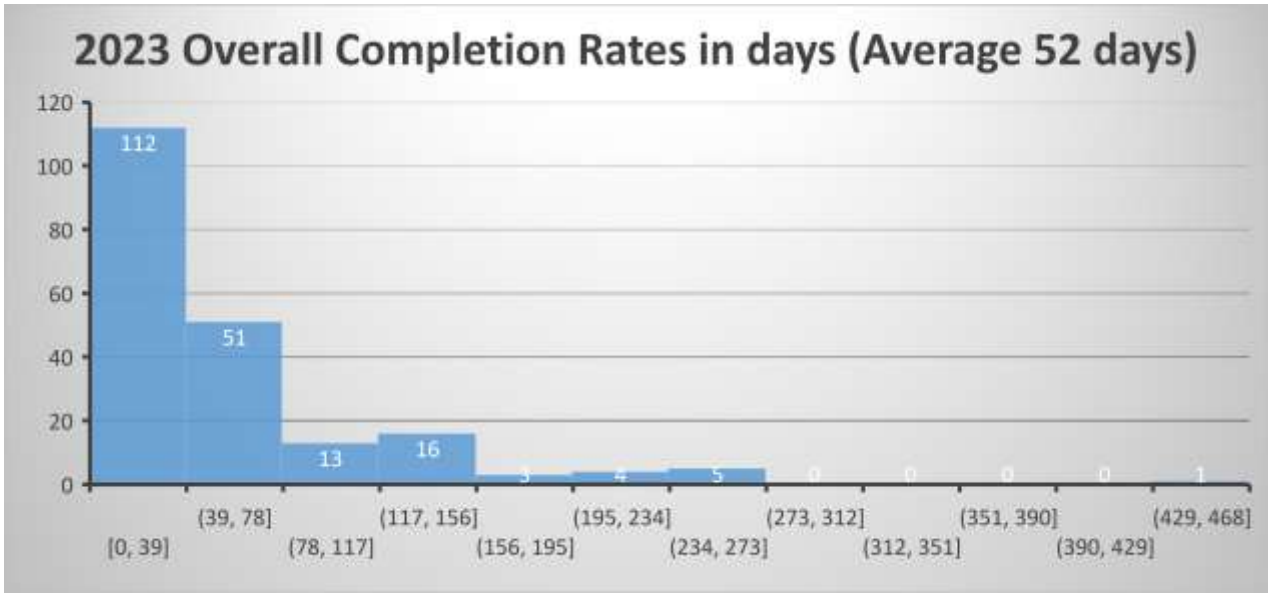


Figure 16. The overall completion rates (days) for FY23.

Improvement Opportunities

Our vision is to facilitate ongoing collaboration by providing support, advocacy and education to contracted service providers. Quality advisors along with Contract & Finance Dept. and Clinical programs continue to assist providers in the following areas in the coming year:

- Improved online training system (i.e., CMHA-CEI online system, Improving MI Practices system, and other platforms)
- Collaborate with other CMHs to improve review process for Out of Catchment sites (i.e., Reciprocity process)
- Enhance the use of CMHA-CEI provider access portal
- Utilize onboarding process to address important topics pertained to compliance (Contract & Finance, and QA's)
- Continue to revise site visit process and documentation to improve efficiency
- Collect, review and assess site visit data on a regular basis to make informed choices and target areas for improvement.
- Improved communication with clinical programs and providers on training needs for direct care staff, specific to supplemental plans such as BTPs, nutrition plans, etc.

Policy and Procedure Review

CMHA-CEI hosts 353 policies and procedures in the PolicyStat Document Management System. The system is available for all staff to view and for applicable staff to edit and manage documents. Policies and procedures are to be reviewed at least annually.

All policies and procedures were reviewed within the one-year timeline, for 100% compliance. CMHA-CEI began transitioning all policies, Procedures, Guidelines, Forms, and Plans into a cloud-based Policy Management System. The system will automate prompts for annual updates and reviews to maintain CARF Compliance.

The review process for policies and procedures is built into the PolicyStat system, with specific workflows and areas for each document type. Policies and procedures are categorized into four areas: Administrative, Clinical, Human Resources, and Finance. The following report from PolicyStat tracks the workflow turnaround time for policies and procedures:

Area	Approval Steps	Days Per Flow	Days Per Step
Finance Policies	2	37	18.5
Administrative Procedures	2.7	31.4	11.8
Finance Procedures	2	31.4	15.7
Clinical Procedures	2.7	26.7	10
Administrative Policies	2.5	26	10.5
Clinical Policies	2.8	20.3	7.4
Human Resources Procedures	2	6.4	3.1
Human Resources Policies	2	5	2.5

Table 20. Workflow turnaround time for policies and procedures in PolicyStat

HSAG Report FY23

The Health Services Advisory Group (HSAG) conducted its annual evaluation of Mid-State Health Network's data systems, focusing on the processing of data used for reporting performance indicators to the Michigan Department of Health and Human Services (MDHHS). The evaluation covered eligibility and enrollment data, medical services data (claims and encounters), Behavioral Health Treatment Episode Data Set (BH-TEDS) data production, and oversight of affiliated Community Mental Health Centers (CMHSPs), which includes CMHA-CEI.

Eligibility and Enrollment Data System:

- No concerns were identified with how Mid-State Health Network processed eligibility and enrollment data.
- The process included contracting with PCE for data processing, utilizing the Regional Electronic Medical Information (REMI) system, and implementing pre- and post-processing edits for accuracy.
- Adequate reconciliation and validation processes were in place to ensure accurate and complete eligibility and enrollment information.
- Medical Services Data System (Claims and Encounters):
- No major concerns were found in how Mid-State Health Network processed claims and encounter data.
- Mid-State Health Network delegated claims processing to contracted CMHSPs, with validation processes in place at key transmission points.
- Performance indicator data were captured quarterly, and comprehensive technical specifications ensured consistency in reporting across CMHSPs.
- Behavioral Health Treatment Episode Data Set (BH-TEDS) Data Production:
- Mid-State Health Network used REMI to collect, manage, and produce BH-TEDS data in alignment with MDHHS specifications.
- The process included validation edits, file requirements, and additional data quality checks beyond state requirements.
- BH-TEDS records were submitted to the State after thorough validation, and response files were reviewed and corrected by CMHSPs.
- PIHP Oversight of Affiliate CMHSPs:
- HSAG found sufficient oversight of Mid-State Health Network's 12 affiliated CMHSPs.
- Oversight included standard templates, consistent communication, monthly committee meetings, and on-site evaluations.
- Corrective action plans were implemented for CMHSPs not meeting required standards.

PIHP Actions Related to Previous Recommendations:

- HSAG identified issues during the SFY 2022 audit, and Mid-State Health Network addressed them with corrective action plans.
- Recommendations included ensuring compliance with indicator specifications, addressing inconsistencies in methodology, and enhancing BH-TEDS validation processes.

- Mid-State Health Network monitored and implemented changes, leading to improvements and efficient closure of identified issues.

Overall, the evaluation indicates that Mid-State Health Network has effective processes in place for data processing, validation, and oversight, with responsive actions taken to address previous recommendations.

Strengths and Opportunities for Improvement:

Strength #1: Mid-State Health Network's affiliated CMHSPs actively participated in Quality Improvement Council (QIC) meetings, contributing to identifying causal factors, barriers, and effective interventions. Best practices were shared among CMHSPs and PIHPs, promoting collaboration and knowledge sharing.

Strength #2: Mid-State Health Network effectively utilized Corrective Action Plans (CAPs) with delegated CMHSPs, fostering close collaboration and monitoring of performance improvement efforts. This approach aided in identifying and addressing systemic issues through process improvements and enhanced oversight.

Weaknesses:

Weakness #1: During CMHA-CEI's PSV for Indicator #1, a data entry error resulted in an incorrect wait time being documented for one case. Although this did not significantly impact the rate, the recommendation is to review all abnormal disposition completed dates and times, provide additional training when errors occur, and have the QI team review all Indicator #1 "out-of-compliance" items before submission.

In summary, HSAG's identified weaknesses primarily related to data entry errors, misinterpretation of compliance criteria, and the need for ongoing validation processes. Recommendations focus on corrective actions, additional training, collaborative reviews, and enhancements to validation processes to improve accuracy and quality in performance measure reporting.

MSHN Audit

MSHN conducted a complete virtual desk audit of CMHA-CEI in June 2023. Findings were as follows:

CMH Delegated Managed Care Tool	Finding
Information (Customer Services) 1.2	Unable to locate a process or method to ensure materials are provided in an understandable format and written at a 6.9 grade reading level in the uploaded policies.
Service Authorization & Utilization Management (UM) 5.1	No policy or procedure for CEI for a UM program, only the MSHN UM plan. Partial credit given due to some of this is addressed in the Clinical Record Reviews Procedure.

Grievance + Appeals (Customer Service) 6.13	Two out of five reviewed grievances were resolved beyond the required 90 day timeframe. One out-of-compliance grievance was resolved at 89 days, but the Notice of Grievance Resolution was not sent until 15 days after the grievance was resolved. The Notice of Grievance Resolution marks the end of the grievance resolution process. The grievance process does not end when staff have completed their investigation.
Behavior Treatment Plan Review Committee 9.6	Reviewer did not see this standard addressed in the procedure listed above, and did not find evidence that the BTPRC has a way to link the use of Physical Interventions to the required BTPRC review required by this standard.
Provider-Staff Credentialing (Provider Network) 11.7	Credentialing and Re-Credentialing Procedure 2.1.8H Section II.D Background Checks Procedure 2.1.08O Verification of Credentials Record review Results: Initial Credentialing [redacted] • CEI reported to MSHN as initial credentialing 8/2022. File provided indicates initial credentialing 12/2021. • [redacted] attested to having no prior disciplinary action, yet the CEI LARA PSV indicates past probation and fine. No evidence acknowledging this discrepancy. • No evidence of credentialing decision letter sent to provider. • No evidence of credentialing decision letter sent to individual. [redacted] • CEI reported [redacted] as having been recredentialed in 9/2022 on the MDHHS Credentialing report. However, the file indicates 9/2022 was initial credentialing. • No evidence of credentialing decision letter sent to provider. Reviewer noted that CEI indicated they have recently implemented credentialing decision letters or are in the process of implementing. For corrective action, please provide details of when/how CEI has updated process to become compliant. Also please address process for identifying application discrepancies and how those are handled
Provider-Staff Credentialing (Provider Network) 11.9	Recredentialing was found to have not been completed timely. Recredentialing File Review Results Re-Credentialing

	Amy Adams • Recredentialing was not completed within 2-year time requirement. Allysa Pennington • MCBAP PSV was not completed in a timely manner. The PSV was dated 201 days prior to the credentialing decision. The maximum timeframe is 180 days before. • Recredentialing was not completed within 2-year time requirement. Reviewer noted CEI is currently under corrective action for untimely recredentialing (within two years mo/yr) and will continue to be until sample review of bi-annual report meets established compliance percentage.
Provider-Staff Credentialing (Provider Network) 11.21	Monitoring and Profiling Procedure 1.6.02 To ensure that licensing and certification requirements are met in both states, it is expected the CMH will verify license/certifications from other states. CEI policy states: "All licenses, registrations or certifications must be for the state of Michigan. If an employee is licensed in a state other than Michigan that license will not be considered as part of the credentialing process and HR staff will not verify licenses from other states." Source: MDHHS/PIHP Contract, MSHN Credentialing and Re-credentialing policies and procedures
Ensuring Health & Welfare-Olmstead (Quality Improvement) 13.2	Incident Report Procedure 3.3.07 Sentinel Events Procedure 1.1.14 QI Committees Org Chart QI has had ongoing efforts to improve the incident reporting process improve reporting and monitoring. All incidents reported go through multiple stages of review, and QI has increased monitoring, which improved the level of accurate and timely reports. QI has also piloted a process in FY23 with our CMHSP programs to improve incident review time by increasing outreach to reviewers, which has had positive results and feedback. QI is evaluating the expansion to other programs in the future. QI Updates – QICC PowerPoint - Slides 18-24 review incidents MSHN Reviewer SDG: Unable to validate 2 of the 5 events reviewed. Additionally, no events reported for a record that had a clinical review that identified several EMTs due to injury during the reporting period.

Ensuring Health & Welfare-Olmstead (Quality Improvement) 13.3	Sentinel Events Procedure 1.1.14 Language related to an individual who was discharged from a state operated service within the previous 12 months was not included in the policy or on a form.
Ensuring Health & Welfare-Olmstead (Quality Improvement) 13.6	Sentinel Events Procedure 1.1.14 Root Cause Analysis Questions RCA Fishbone diagram info_on_fishbone_process CMHA-CEI Quality Improvement Program Plan FY2023 - Page 8: Critical Incident Review Committee (CIRC) MSHN Reviewer SDG: Documentation of the dates of the Sentinel Event Determination and RCA were not within the required timelines. Primary source does not demonstrate compliance with timelines.
Ensuring Health & Welfare-Olmstead (Quality Improvement) 13.10	Performance Indicator Procedure 1.1.12 Procedure 1.1.12 MSHN Reviewer SDG: Non Compliant-Dates for submission was changed to 15th of month to allow for extra time to ensure accuracy of submitted data. Indicator 2a-Mild to moderate are not excluded. Indicator 4a and 10 exclusions/exceptions are not consistent with MDHHS-Please review and make necessary adjustments. Primary Source Verification-more than 50% of the sample records reviewed were unable to be validated. MSHN will continue to review a sample prior to submission to MDHHS.
Program Specific – Non Waiver	
ACT 1.6	Demonstration during chart review. CEI is non-compliant with this standard based on the Power BI report with date range 10.1.22 - 3.31.23. Average minutes per week are calculated by: Units per Consumer x 15 minutes = Total average minutes per consumer Total average minutes per consumer / number of weeks in report range = Average minutes per week per consumer Between 10.1.22 - 3.31.23, CEI had 82 units per consumer. 82 units X 15 minutes = 1,230 1,230 minutes / 26 weeks = 47 minutes per week per consumer on average.
Self-Determination 2.4	Person Centered Planning Procedure 3.3.25 Self Determination Procedure 3.3.25D

	Unable to locate the procedures to prevent gaps in service. This was not met based on the feedback. If additional supporting evidence is located, please provide it with the corrective action response.
Crisis Residential 6.6	BCU Treatment Plan Example. This example indicates that a person was admitted 3/24/2022 and the plan was completed 3/27/2022. This does not meet the standard. Is there additional supporting evidence like a policy or tracking form that ensures the plans are completed within the required timeline? *Highly recommend adding this language to the program description in the section that discusses treatment planning being a service that is provided in the program or a program policy. Highly recommend a process is developed to ensure this is happening in the required timeline.
Autism Benefit/ABA - 8.2	Reviewed the following staff credentialing files: [redacted], BCBA: missing evidence of IPOS training , BT: missing evidence of IPOS training
Autism Benefit/ABA - 8.4	Repeat finding for staff credentialing.
Children's Intensive Crisis Stabilization 9.1	While the policy addresses the age and populations served, it seems exclusive with the operating guidelines. Please see recommendations that includes a broader definition of crisis situations from the MSA 17-25.
SUD Delegated Managed Care Tool	
Information (Customer Service) 2.2	Recipient-Enrollee Rights Procedure 3.6.12A Limited English Proficiency Procedure 3.6.10B MSHN Guide to Services 2023 I am unable to locate the method CEI uses to ensure documents are easily understood at a 6.9 grade reading level. Please share where this process is documented.
Grievance and Appeals 4.7	Notice Review - Seven Adverse Benefit Determination Notices records were requested for review. Only five were available for review, and those five met the standard.
Quality 6.2	Incident Reporting Policy 3.3.07 Admin Violent-Non Violent Incident 8.1.10 MSHN_FY2023_QAPIP_Plan MSHN_FY2023_QAPIP_RepOrt SDG-Partial Compliance-The SUD Sentinel Events are not identified in the policy/procedures.
Individual Treatment, Recovery Planning, Documentation Standards	Person Centered Planning Procedure 3.3.25 Person Centered Planning

7.9	Policy 3.3.25 I was unable to locate any evidence of this in the policy or procedure indicated. Please note SUD programming has additional policies and procedures at the state level. I did not locate evidence in the policy or procedure indicating the policy for SUD treatment planning was followed or for these timeframes.
Individual Treatment, Recovery Planning, Documentation Standards 7.10	Person Centered Planning Procedure 3.3.25 Person Centered Planning Policy 3.3.25 I was unable to locate specific requirements for treatment plan reviews in the policy. Please share where this is located or provide additional evidence to meet this standard.
Individual Treatment, Recovery Planning, Documentation Standards 7.12	The provider marked this NA. However, this is not indicating that MAT services are offered. This is indicating that people who are receiving MAT would be treated according to the standard, even if the MAT is provided else where. A MAT policy was uploaded. However, it does not include the required language regarding All persons who are eligible to receive treatment are served including those who use MAT as part of their recovery plan. There is no precondition or pressure to adopt an accelerated tapering schedule and/or a mandated period of abstinence as a condition of receiving treatment. Disparaging, delegitimizing, and/or stigmatizing of MAT is prohibited with individual clients or in the public domain.
Provider Staff Credentialing 9.7	Credentialing and ReCredentialing Procedure 2.1.8H Section II.D Background Checks Procedure 2.1.08O Verification of Credentials (Office Use Only) Initial credentialing file review identified the following findings: Nichole Brunn • No evidence of primary source verification MCBAP CAADC. • No evidence of credentialing decision letter sent to provider. L. Markee • No evidence of primary source verification MCBAP CAADC. • No evidence of credentialing decision letter sent to provider.

Provider Staff Credentialing 9.9	Credentialing and Re-Credentialing Procedure 2.1.8H Section II.F Recredentialing file review identified the following findings: [redacted] • No PSV for MCBAP certification from MCBAP. D. Richey • No PSV for MCBAP certification from MCBAP. • Re-credentialing was not completed within the two-year timeframe.

Table 21. MSHN Audit Findings

MSHN approved the following Corrective Action Plan to address the above findings:

CMH Delegated Managed Care Tool	Finding
Information (Customer Services) 1.2	CMHA-CEI will begin to review informational materials for 6.9 reading level by checking through the Flesch-Kincaid tool in Microsoft Word or utilizing ChatGPT. Currently created materials will all be reviewed and updated as necessary by September 30, 2023. The Recipient/Enrollee Rights Procedure will be updated by 7/31/23 with this process. An example of checking reading level for our Recipient Rights poster is uploaded and meets the requirements at 4.1 grade level
Service Authorization & Utilization Management (UM) 5.1	CEI will create a UM plan that will include all the recommended areas by 8/31/23
Grievance + Appeals (Customer Service) 6.13	The Compliance team will review the current tracking system for grievance resolution, and identify how to improve the tracking to ensure that grievances are resolved or extended as appropriate, and notices are sent out within the 90 day timeframe. The review of the system will be completed by August 31st.
Behavior Treatment Plan Review Committee 9.6	CMHA-CEI Quality Advisors review incident reporting requirements with providers during annual site visits including a review of completed incidents to ensure compliance. Any provider found to be out of compliance with incident reporting requirements during the site visit process is placed on a plan of correction (see attached: Site Visit OG, CLS Review Tool). Resources are given to providers to help train new staff throughout the year, including the attached Incident Reporting Cheat Sheet and the IR Powerpoint (slide 10). Both of these resources have been updated to specifically identify standard 9.6.

	The QI team reviews all incident reports received through the CMHA-CEI IR system and prepares IRs for regular review by the BTC. In addition to the periodic review at full BTC meetings, physical management and police involvement incidents will also be reviewed at weekly BTC planning meetings to ensure timely identification of trends that will require additional review of the plan and possible modification. We were previously interpreting this standard incorrectly – that three incidents of physical management or three incidents of police involvement separately would require additional review of the plan vs. any combination of physical management/police involvement incidents totaling three within 30-days. Through IR review processes, QI staff will follow the revised procedure and ensure that plans receive additional review as required. The QI team will also develop an additional review form that can be utilized by the BTC to facilitate and document the review of the treatment plan and/or BTP as required by standard 9.6.
Provider-Staff Credentialing (Provider Network) 11.7	CMHA-CEI created a credentialing decision letter process and implemented this on February 3, 2023. A copy of a sample letter is attached. The Credentialing Verification/Credentialing Committee Form has been updated to include verifying the letter has been completed. Updated Credentialing Verification Form is attached. HR created a process of reviewing and addressing application discrepancies in July 2023. Credential Verification Form now includes a review of application information, documentation of discrepancies, a review with the applicant, and a review by the Credentialing Committee justifying the discrepancy (if applicable). Updated Credentialing Verification Form is attached.
Provider-Staff Credentialing (Provider Network) 11.9	HR added a Substance Use Disorder Certification to the Credentialing and Re-Credentialing Procedure - Attachment A: Primary Source Verification (PSV) to include 180 day timeframe.
Provider-Staff Credentialing (Provider Network) 11.21	HR updated the Credentialing and Re-Credentialing Procedure to include employees who reside an provide services in a boarding state.
Ensuring Health & Welfare-Olmstead (Quality Improvement)	CMHA-CEI QI staff have started the process to review all incidents reported and follow up with staff if further

13.2	review/information is needed. This process will be monitored monthly during agency Critical Incident Review Committee.
Ensuring Health & Welfare-Olmstead (Quality Improvement) 13.3	Death Report Form and associated procedure will be updated by 8/31/2023 to include a question on discharge from state operated service within the previous 12 months.
Ensuring Health & Welfare-Olmstead (Quality Improvement) 13.6	CMHA-CEI will update Sentinel Event Review Form by 8/31/2023 to clearly show date that event was determined to be sentinel and date the investigation began. Educate staff through email by 8/31/23 that when sending a notification of a death to the medical Director additional information is included in the email on if they death was not expected so the Medical Director can review and determine if it would be a sentinel event sooner.
Ensuring Health & Welfare-Olmstead (Quality Improvement) 13.10	Policy and Procedure will be updated by 7/31/2023 to reflect current requirements and expectations. CMH will review MMBPIS process prior to next quarterly submission to ensure correct information is being submitted
Program Specific – Non Waiver	
ACT 1.6	1) AMHS Supervisor to work with CMHA-CEI IS department to create a report within SmartCare to pull the amount of minutes of face-to-face contacts each week for each consumer in order to demonstrate that consumers are receiving the amount, scope, and duration of services for ACT level of care. The report will be pulled and monitored on a monthly basis both administratively and with the ACT team members. (Included in this discussion is a way to document and monitor consumers who are incarcerated for long periods of time.) 2) Each ACT team will increase group opportunities for consumers they are supporting by at least one group per team. Special attention will be given to ensure there is a group option for consumers with co-occurring substance use disorders in line with AMHS Guidelines and MIFAS review recommendations. Each ACT team lead will work with staff to review ways to increase clinical contacts. Ways to increase engagement with clients will occur within the daily team meetings as well as individual supervision with staff.
Self-Determination 2.4	The Self Determination Procedure- 3-3-25D has been updated to include language in Section II.A.9 that identifies the self-determination program coordinator and assigned case managers

	will monitor the service agreement to ensure there are no gaps in services during transition to or from a Self-Directed Service arrangement.
Crisis Residential 6.6	The Bridges Crisis Unit (BCU) Coordinator completed a training of Client Service Specialists and Mental Health Therapists for BCU on this finding, related to the BCU Treatment Plan and Review being completed within 24 hours of admission to the program. The Agenda from the 6/21/23 meeting has been uploaded, titled "CSS Meeting Agenda June 21 2023." The coordinator used specific treatment documents during the training refresher; review of the EHR form 'BCU Treatment Plan/Review' document was completed. The review of the BCU Treatment Plan/Review document, in addition to the BCU Termination document, included timeframes of completion, requirements within the goals/objectives, discharge planning activity documentation while at BCU, as well as activities after discharge. Copies of the example documents reviewed during training are uploaded, titled "Crisis Residential Training Documents." In addition, the Bridges Crisis Unit program statement section regarding "Services Provided" has been updated to include specific language that identifies the plan will be created within 24 hours of admission.
Autism Benefit/ABA - 8.2	CEI to provide updated training to CM team on IPOS training requirements at 7/20/23 Team Meetings. CEI to also provide updated provider training on IPOS training requirements by 9/1/23.
Autism Benefit/ABA - 8.4	CEI to provide updated training to staff reviewing credentialing to ensure accuracy prior to approval and services rendered. Training to be completed by 7/21/23.
Children's Intensive Crisis Stabilization 9.1	The Operating Guideline 6.2.11 Intensive Crisis Stabilization Services has been updated to include the definitions of Crisis Situation under section II.A, and the Goals of Intensive Crisis Stabilization have been added under section II.B.
SUD Delegated Managed Care Tool	
Information (Customer Service) 2.2	CMHA-CEI will begin to review informational materials for 6.9 reading level by checking through the Flesch-Kincaid tool in Microsoft Word or utilizing ChatGPT. Currently created materials will all be reviewed and updated as necessary by September 30, 2023. The Recipient/Enrollee Rights Procedure will

	be updated by 7/31/23 with this process. An example of checking reading level for our Recipient Rights poster is uploaded and meets the requirements at 4.1 grade level
Grievance and Appeals 4.7	Updated ITRS Admin Recipient Rights & Grievances 8.1.2 Section II.A.11 to include process of uploading a copy of the ADB to REMI. Attachment named: Admin Recipient Rights & Grievances 8.1.2
Quality 6.2	Uploaded additional existing Operating Guideline, titled "Admin Incident Review for Substance Use Disorder (SUD) Providers 8.1.25" which identifies SUD events. CEI will also update our sentinel event procedure and incident report procedure to include SUD event types by 7/31/23
Individual Treatment, Recovery Planning, Documentation Standards 7.9	Updated ITRS Admin Recipient Rights & Grievances 8.1.2 Section II.A.9 to include language on Treatment Planning.
Individual Treatment, Recovery Planning, Documentation Standards 7.10	Updated ITRS Admin Recipient Rights & Grievances 8.1.2 Section II.A.9 to include language on Treatment Planning.
Individual Treatment, Recovery Planning, Documentation Standards 7.12	Updated ITRS Admin Recipient Rights & Grievances 8.1.2 Section II.A.12 to include required language on use of MAT.
Provider Staff Credentialing 9.7	HR has added both of these process to the Credentialing Verification Form. Updated Credentialing Verification Form is attached.
Provider Staff Credentialing 9.9	HR added a Substance Use Disorder Certification to the Credentialing and Re-Credentialing Procedure - Attachment A: Primary Source Verification (PSV) to include 180 day timeframe.

Table 22. MSHN Audit Corrective Action Plan

Consumer Satisfaction Survey

Summary

This year, CEI distributed 5,514 total surveys with an overall rate of return of 14.6%. See the breakdown for each of the four programs below, compared to previous years when possible:

Survey Response by Program						
	Distributed 2023	% Returned	Distributed 2022	% Returned	Distributed 2020	% Returned

		2023		2022		2020
AMHS	2338	17.1%	2153	18.3%	1998	13.1%
FF	1759	7.2%	1180	9.5%	970	9.4%
CSDD Adults	926	21.7%	961	22.6%	--	--
CSDD Youth	491	12.2%	454	11.2%	--	--
Total	**5514**	**14.6%**	**4748**	**16.3%**	**2968**	**11.9%**

Table 23. Surveys distributed and returned by program in 2023, 2022, and 2020. Survey response was not measurable in 2021

The purpose of this survey is to fulfill this portion of our MSHN contract and to help CMHA-CEI (1) gauge the level of satisfaction among its consumers who were receiving services and (2) determine ways it could improve its practices to better serve its consumers. The results of the survey help to measure the quality of CEI services. This evaluation report summarizes the levels of satisfaction with the CMH service system.

Adult consumers participating in AMHS and CSDD Adult programs completed the MHSIP thirty-six-question survey. This survey template provided by MSHN used a six-point Likert scale with the following options: Strongly Agree (1), Agree (2), Neutral (3), Disagree (4), Strongly Disagree (5), and Not Applicable (9).

Child consumers participating in Families Forward and CSSD Youth programs, or their families if the consumer was younger than 13, completed the YSSF twenty-six-question survey. This survey template provided by MSHN used a five-point Likert scale with the following options: Strongly Agree (5), Agree (4), Neutral (3), Disagree (2), and Strongly Disagree (1). Please note that this numerical order is flipped when compared to the MHSIP survey administered to the adult-focused programs.

Results from AMHS, Families Forward and CSDD programs are reported to MSHN for the annual analysis and report which provides CEI with year-over-year regional comparisons and subscale ratings for those services. Although consumers from CSDD programs were previously surveyed in FY20, that data is unfortunately not able to be directly compared to the FY22 and FY23 data as different survey questions were asked.

Additionally, ITRS programs distributed the SUD consumer satisfaction survey in FY23. One hundred thirteen (113) total consumers representing four ITRS programs were surveyed on the quality of the care they received using a series of fifteen questions across six subscales. This survey used a five-point Likert scale with the following options: Strongly Agree (5), Agree (4), Neutral (3), Disagree (2), and Strongly Disagree (1).

Procedure

Surveys were mailed out, as well as handed directly, to consumers who received services from AMHS, Families Forward, or CSDD programs between 7/31/23 and 9/1/23. Response methods included mail, phone, face-to-face, and electronic submission. Data results in this report came from self-selected consumers who chose to return questionnaires voluntarily. The survey respondents were anonymous, although consumers were given the option to identify themselves if they wished to be contacted at a later date for follow-up. Survey respondents were given the opportunity to be entered in a drawing for local gift cards in an attempt to increase the percentage of respondents. This was new in 2023 and unfortunately resulted in a decreased response rate.

Findings

Across all programs, the difference between the highest and lowest-performing questions was relatively small. This indicates that consumers are generally satisfied with CEI services. However, year-over-year, questions on the quality of staff and services have often scored slightly higher than those regarding treatment outcomes.

Across all programs, the most common survey response method was face-to-face.

CSDD Adult was the only program surveyed where a majority of consumers received assistance completing the survey. AMHS also had multiple responders who required assistance.

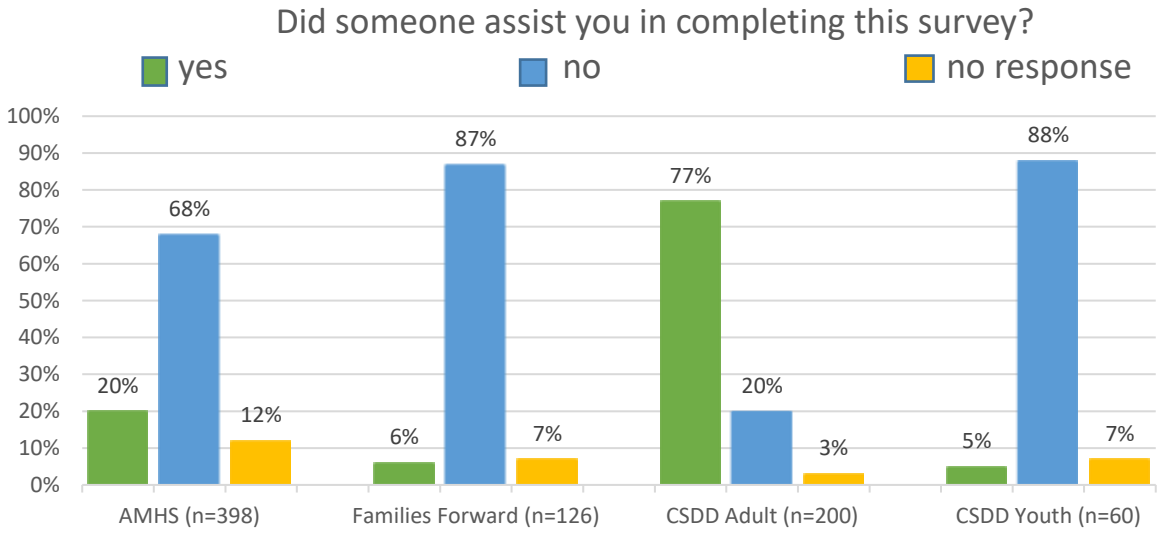


Figure 17. Percentage of respondents with assistance completing satisfaction survey

Analysis of Findings

AMHS – Lower numerical score indicates greater satisfaction.

- The average score of all responses was 1.87.
- Top three positive responses:
  1. I like the services that I received (1.59)
  11. I felt comfortable asking questions about my treatment, services and medication (1.62)
  5. Staff were willing to see me as often as I felt it was necessary (1.63)

- Lowest three negative responses:
  28. My symptoms are not bothering me as much (2.26)
  35. I feel I belong in my community (2.18)
  26. I do better in school and/or work (1.96)
- Performance across the seven MHSIP subscales (calculated by MSHN):
  - Subscales measure consumer perceptions of: General Satisfaction, Participation in Treatment Planning, Quality and Appropriateness, Access, Social Connectedness, Functioning, and Outcome of Services.
  - Scored best: General Satisfaction
  - Scored worst: Outcome of Services and Functioning
  - Since FY22, four subscale ratings decreased (General Satisfaction, Access, Quality and Appropriateness, Participation in Treatment Planning) and three subscale ratings increased (Outcome of Services, Functioning and Social Connectedness).
  - Depending on the individual subscale, CEI scored near average or slightly below average when compared to other CMH agencies in the region.

Families Forward – Higher numerical score indicates greater satisfaction.

- The average score of all responses was 4.24.
- Top three positive responses:
  12. Staff treated me with respect. (4.64)
  14. Staff spoke with me in a way that I understood. (4.63)
  13. Staff respected my family's religious/spiritual beliefs. (4.59)
- Lowest three negative responses:
  19. My child is doing better in school and/or work. (3.72)
  21. I am satisfied with our family life right now. (3.76)
  18. My child is better able to cope when things go wrong. (3.77)
- Performance across the seven YSSF subscales (calculated by MSHN):
  - Subscales measure consumer perceptions of: Cultural Sensitivity, Participation in Treatment, Access, Appropriateness, Social Connectedness, Social Functioning, and Outcomes.
  - Scored best: Cultural Sensitivity
  - Scored worst: Social Functioning
  - All subscale ratings decreased since FY22 except for Outcome of Services, which increased.
  - Depending on the individual subscale, CEI scored near average when compared to other CMH agencies in the region.

CSDD Adult – Lower numerical score indicates greater satisfaction.

- The average score of all responses was 1.82.
- Top three positive responses:
  36. In a crisis, I would have the support I need from family and friends (1.50)
  27. I am satisfied with my housing situation (1.56)
  34. I have people with whom I can do enjoyable things (1.58)
- Lowest three negative responses:
  23. I am better able to deal with crisis (2.27)
  31. I am better able to handle things when they go wrong (2.26)

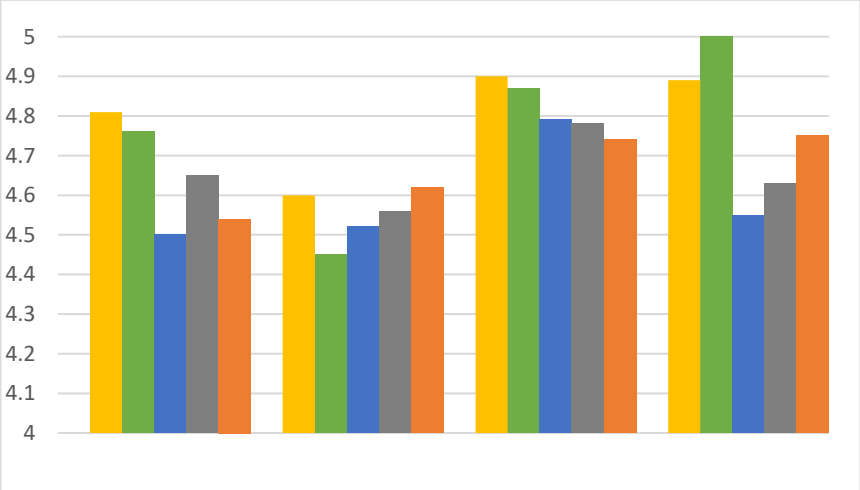
28. My symptoms are not bothering me as much (2.24)

CSDD Youth – Higher numerical score indicates greater satisfaction.

- The average score of all responses was 4.25.
- Top three positive responses:
  - 2. I helped choose my child's services. (4.58)
  - 21. I am satisfied with our family life right now. (4.56)
  - 20. My child is better able to cope when things go wrong. (4.53)
- Lowest three negative responses:
  - 3. I helped chose the goals in my child's service plan. (3.75)
  - 5. I felt my child had someone to talk to when they were troubled. (3.93)
  - 4. The people helping my child stuck with us no matter what. (3.95)

ITRS – Higher numerical score indicates greater satisfaction.

- The average satisfaction score across all subscales and programs was 4.70.
- Overall, CCCC, (Clinton County Counseling Center) received the highest average score at 4.81 and HOC (House of Commons) received the lowest average score with 4.55
- The highest-rated subscale, generally, was Welcoming Environment with an average score of 4.80.
- The lowest-rated subscale, generally, was Appropriateness/Choice with Services with an average score of 4.59.



	CATS (n=42)	HOC (n=22)	CCCC (n=39)	TRC (n=10)
Welcoming Environment	4.81	4.6	4.9	4.89
Cultural/Ethnic Background	4.76	4.45	4.87	5
Appropriateness and Choice with Services	4.5	4.52	4.79	4.55
Treatment Planning/Progress Towards Goals	4.65	4.56	4.78	4.63
Coordination of Care/Referrals to Other Resources	4.54	4.62	4.74	4.75

Figure 18. Average Scores of ITRS SUD 2023 Consumer Satisfaction Survey

National Core Indicators Survey

The NCI Survey is a collaboration between participating states, Human Services Research Institute, and the National Association of State Directors of Developmental Disabilities Services. Information about specific 'core indicators' are gathered to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety. The NCI survey aims to assess family and adult consumer perceptions of and satisfaction with their community mental health system and services.

Consumers are selected at random and asked if they would like to participate in the in person survey. Data gathered through this survey is intended to assist in informing strategic planning, legislative reports, and prioritize quality improvement initiatives.

During the 2023-2024 survey, a total of 57 consumers consented to participate in the survey. This was a 62% increase compared to the previous survey year.

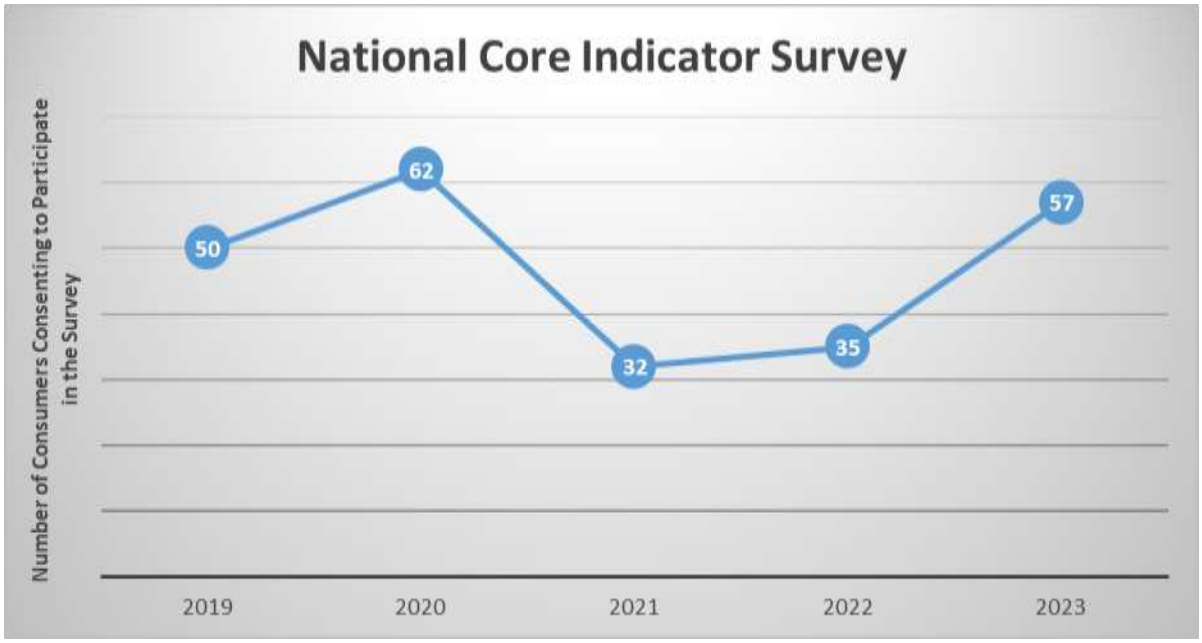


Figure 19. Count of consumers consenting to participate in the NCI Survey by year

Quality Improvement and Performance Measurement Report for CARF Accredited CMHA-CEI Programs

CMHA-CEI is nationally accredited through the Commission on Accreditation of Rehabilitation Facilities (CARF).

CARF International has announced that Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI) has been accredited through June 30, 2026. This is the seventh consecutive Three-Year Accreditation that the international accrediting body has given to CMHA-CEI. The agency retained accreditation for eighteen clinical programs, and all administrative units. Accreditation for two additional programs, Family Support Case Management (IDD-Children), and Adult Outpatient Case Management, were added.

CARF highlighted several strengths of the agency in its accreditation report, including the following:

- CMHA-CEI offers a varied continuum of treatment programs and services to clients with mental health and substance use disorders. The organization also provides outpatient treatment and residential treatment to clients referred from within the criminal justice system. The programs and services are provided in multiple locations for clients in all stages of recovery in order to make the treatment process, from detox to outpatient, as simple and consistent as possible.
- The buildings and grounds of all of the organization's locations are immaculate. They provide welcoming, attractive, comfortable, and safe environments for clients, their families, personnel, and other stakeholders
- The workforce culture is very welcoming, and it is apparent that staff members are dedicated to CMHA-CEI's success. Staff members creatively ensure that clients' needs are met within the resources of the organization and community while displaying sensitivity to cultural diversity, utilizing complementary approaches, and accommodating individual preferences. As a team of professionals, staff members model care that is passionate, compassionate, and mutually respectful. Organization-wide cooperation and open communication practices are apparent.
- The Consumer Advisory Council supports the voices of the clients and promotes positive change. The council works to help establish and implement best practices in the organization's programs and services.

An application to renew accreditation was completed in December 2023 and the survey was conducted in June 2023. CMHA-CEI was granted a three-year accreditation for all administrative units (General Administration, Properties & Facilities, Human Resources, Finance/Contracts, Quality, Customer Service, and Recipient Rights), as well as 20 clinical programs in Adult Mental Health Services (AMHS), Families Forward (FF), Community Services for the Developmentally Disabled (CSDD), and Integrated Treatment and Recovery Services (ITRS).

CMHA-CEI Department	CMHA-CEI Program	**CARF Core Program**
AMHS	ACT - Cedar	ACT
AMHS	ACT – Louisa	ACT
AMHS	Team I Case - Management	Case Management - MH
AMHS	Team II Case Management	Case Management - MH
AMHS	Team 3 Case Management	Case Management – MH
AMHS	Outreach CM	Case Management - MH
AMHS	Older Adult Services	Case Management - MH
AMHS	ECCC	Case Management - MH
AMHS	CCCC	Case Management - MH
AMHS	MROP	Case Management - MH
AMHS	Waverly Wellness	Case Management - MH
ITRS	ITRS Outpatient	Outpatient Treatment Alcohol and other drugs – Adults
ITRS	CATS	Outpatient Treatment Alcohol and other drugs – Criminal Justice
ITRS	House of Commons	Residential Treatment Alcohol and other drugs – Criminal Justice
ITRS	The Recovery Center	Detoxification/Withdrawal Support Treatment Alcohol and other drugs – Adults
FF	Parent-Young Child Program	Intensive Family Bases Services – Early Intervention
FF	Parent-Infant Program	Intensive Family Bases Services – Early Intervention
FF	Family Guidance Services	Intensive Family Bases Services – Home Based
CSDD	Life Consultation	Case Management – psychosocial rehab
CSDD	Family Support Case Management	Case Management – psychosocial rehab

Table 24. CMHA-CEI CARF Accredited programs

The QI Team are charged with facilitating and preparing each unit for the survey. Part of survey preparation includes submitting annual efficiency measures and outcomes data from CARF accredited programs in the form of a Quality Improvement and Performance Measurement Plan.

The plan is composed of a data from performance indicators, satisfaction surveys, incident reports, and other internal QI initiatives.

Standard Number for Recommendation	Step(s) to Address the Recommendation	Completion Date (Actual or Estimated)
1.A.3.k. **1.A.3.l.** **1.A.3.m.**	Annual review of administrative and human resources procedures will specifically address these CARF Standards. HR will develop and maintain a comprehensive succession plan, in addition to our current succession planning procedure. Chief Executive Officer, Chief Human Resources Officer, and Properties and Facilities Supervisor will include CARF language in upcoming strategic plan, DEI plan,	12/31/24
1.G.4.a. **1.G.4.b.** **1.G.4.c.** **1.G.4.d.**	While contracted psychiatrists are reviewed every two years for re-credentialing, CMHA-CEI will begin to review the contracts for providers in CARF accredited programs annually. In addition, the QI team will include consumer's treated by contract providers in clinical record reviews at least annually, and the results of the review will be shared with necessary programs.	12/31/24
1.H.7.a.(1) **1.H.7.a.(2)** **1.H.7.b.** **1.H.7.c.(1)** **1.H.7.c.(2)** **1.H.7.c.(3)** **1.H.7.c.(4)** **1.H.7.c.(5)** **1.H.7.d.**	CMHA-CEI Property and Facilities Department will conduct unannounced safety drills at each shift and each location annually. The safety drills will include analysis on performance, and the results of the safety drills will be shared at bi-monthly Safety Committee meetings and tri-annual Quality Improvement and Compliance Committee meetings.	12/31/24
1.H.15.a.(1) **1.H.15.a.(2)** **1.H.15.b.(1)**	Property and Facilities Department will ensure that health and safety inspections are completed annually by a qualified external authority and receive a written report with areas inspected. The report will be shared at Safety Committee meetings, Quality Improvement and Compliance Committee meetings, and with the Directors Group.	12/31/24
1.I.3.a. **1.I.3.g.**	HR will develop and maintain a comprehensive succession plan, in addition to our current succession planning procedure.	12/31/24
1.I.11.a. **1.I.11.b.** **1.I.11.c.** **1.I.11.d.** **1.I.11.e.** **1.I.11.f.** **1.I.11.g.**	HR will develop and maintain a comprehensive succession plan, in addition to our current succession planning procedure.	12/31/24

2.A.1.c. **2.A.1.d.**	QI will review CARF program descriptions prior to submitting yearly updates to CARF. Agency will add CARF documents in policy management system PolicyStat, prompting program leadership to review scope of services annually	12/31/24
2.A.3.b.	QI will complete a thorough review of procedures and the program descriptions of CARF accredited programs and ensure that updated admissions and transition criteria are included	12/31/24
2.A.13.a. **2.A.13.b.** **2.A.13.c.**	QI will work with Medical director to review and update medication procedure, program descriptions, and applicable operating guidelines to adhere to this CARF standard	08/31/24
2.A.26.a.	Agency will make use of uniform supervision note a priority initiative led by the Quality Improvement and Compliance Committee. QI will meet with all clinical departments to confirm best supervision practice. Conformance to this standard will be added to the agency Quality Improvement Plan for 2024-2025 and evaluation of Quality of 2025-2026	9/30/25
2.A.33.	QI and applicable leadership will review the current ethical code of conduct and include standards that address boundaries related to peer support services.	12/31/24
2.B.3.d.	QI and applicable leadership will make updates to applicable procedures that address this CARF standard.	11/30/24
2.B.12.d.	Quality Improvement and Compliance Committee will collaborate with Zero Suicide Workgroup to address the implementation of universal screen for suicide. Medical Director will work with both groups to update the Suicide Risk Assessment Procedure	11/30/24
2.B.13.h.(1) **2.B.13.h.(2)** **2.B.13.h.(3)** **2.B.13.m.(14)** **2.B.13.n.(1)(b)** **2.B.13.n.(2)(a)** **2.B.13.n.(2)(b)** **2.B.13.n.(2)(c)** **2.B.13.n.(2)(d)**	Language from this standard will be added to clinical record review tool. Records from consumers from each CARF accredited program will be reviewed to this standard and plan of correction will be in place for programs missing this information from the assessment. If necessary, QI will work with Information Systems to update assessment template in Electronic Health System to include necessary fields.	9/30/25
2.B.14.a. **2.B.14.b.(1)** **2.B.14.b.(2)** **2.B.14.b.(3)** **2.B.14.b.(4)** **2.B.14.c.**	Language from this standard will be added to clinical record review tool. Records from consumers from each CARF accredited program will be reviewed to this standard and plan of correction will be in place for programs missing this information from the assessment. If necessary, QI will work with Information Systems to update assessment template in Electronic Health System to include necessary fields.	9/30/25
2.C.4.a. **2.C.4.b.**	QI will continue to look for crisis and safety plans during quarterly record reviews. For individuals	9/30/25

2.C.4.c. **2.C.4.d.(1)** **2.C.4.d.(2)** **2.C.4.d.(3)** **2.C.4.d.(4)(a)** **2.C.4.d.(4)(b)** **2.C.4.d.(5)(a)** **2.C.4.d.(5)(b)** **2.C.4.d.(6)**	with potential risk, a more detailed review of safety plans will occur. QI will follow-up with applicable program individually when this standard is not met to ensure a timely correction	
2.C.5.a.	Language from this standard will be added to clinical record review tool. Records from consumers from each CARF accredited program will be reviewed to this standard and plan of correction will be in place for programs missing this information from the treatment plan. If necessary, QI will work with Information Systems and The Recovery Center to ensure treatment plan documentation is included in health record	9/30/25
2.D.1.d. **2.D.1.e.** **2.D.1.f.(1)** **2.D.1.f.(2)** **2.D.1.f.(3)** **2.D.1.f.(4)(a)** **2.D.1.f.(4)(b)**	QI will review CARF program descriptions prior to submitting yearly updates to CARF. Agency will add CARF documents in policy management system PolicyStat, prompting program leadership to review scope of services annually. QI will complete a thorough review of procedures and the program descriptions of CARF accredited programs and ensure that updated admissions and transition criteria are included	12/31/24
2.D.2.	QI will add language from this standard to clinical record reviews. To ensure this process is reviewed quarterly, clinical records from consumers who have been discharged or transferred will be included in each quarter. When necessary, QI will follow-up with programs with a corrective action plan when standard is not met.	12/31/25
2.D.3.a.(1) **2.D.3.a.(2)** **2.D.3.b.(1)** **2.D.3.b.(2)** **2.D.3.c.** **2.D.3.d.** **2.D.3.e.** **2.D.3.f.** **2.D.3.g.(1)** **2.D.3.g.(2)** **2.D.3.g.(3)** **2.D.3.g.(4)** **2.D.3.h.**	QI will complete a thorough review of procedures and the program descriptions of CARF accredited programs and ensure that updated admissions and transition criteria are included. QI will add language from this standard to clinical record reviews. To ensure this process is reviewed quarterly, clinical records from consumers who have been discharged or transferred will be included in each quarter. When necessary, QI will follow-up with programs with a corrective action plan when standard is not met.	9/30/25
2.D.4.b.	QI will add language from this standard to clinical record reviews. To ensure this process is reviewed quarterly, clinical records from consumers who have been discharged or	9/30/25

	transferred will be included in each quarter. When necessary, QI will follow-up with programs with a corrective action plan when standard is not met.	
2.D.5.	QI will add language from this standard to clinical record reviews. To ensure this process is reviewed quarterly, clinical records from consumers who have been discharged or transferred will be included in each quarter. When necessary, QI will follow-up with programs with a corrective action plan when standard is not met.	9/30/25
2.E.5.a. **2.E.5.b.** **2.E.5.o.** **2.E.5.p.**	QI will work with Medical director to review and update medication procedure, program descriptions, and applicable operating guidelines to adhere to this CARF standard	12/31/2024
2.E.8.a.(1) **2.E.8.a.(2)** **2.E.8.a.(3)** **2.E.8.a.(4)(a)** **2.E.8.a.(4)(b)** **2.E.8.a.(4)(c)** **2.E.8.a.(4)(d)** **2.E.8.a.(4)(e)** **2.E.8.a.(5)(a)(i)** **2.E.8.a.(5)(a)(ii)** **2.E.8.a.(5)(a)(iii)** **2.E.8.a.(5)(b)** **2.E.8.a.(5)(c)(i)** **2.E.8.a.(5)(c)(ii)** **2.E.8.b.(1)** **2.E.8.b.(2)** **2.E.8.b.(3)**	QI will work with Medical director to review and update medication procedure, program descriptions, and applicable operating guidelines to adhere to this CARF standard	12/31/2024
2.G.2.c. **2.G.2.e.**	The agency Records Department and QI team will notify program staff immediately when paper copies scanned into Electronic Health Record are illegible. In an effort to mitigate this issue, the agency will continue to promote use of electronic forms and documentation processes built into electronic health record.	12/31/25
2.G.4.o.	QI will continue to look for crisis and safety plans during quarterly record reviews. For individuals with potential risk, a more detailed review of safety plans will occur. QI will follow-up with applicable program individually when this standard is not met to ensure a timely correction	9/30/25
2.H.1.b.(4) **2.H.1.d.(2)**	QI will add language from this standard to clinical record reviews. To ensure this process is reviewed quarterly, clinical records from consumers who have been discharged or transferred will be included in each quarter. When necessary, QI will follow-up with programs with a corrective action plan when standard is not met.	9/30/25

2.H.4.b.(2) **2.H.4.b.(4)**	QI will begin documenting more detailed results from clinical record reviews and add these information and associated goals in annual Quality Improvement Plan. These goals will be reviewed in the annual Evaluation of QIP Effectiveness	9/30/25
5.E.6.a.(3) **5.E.6.b.** **5.E.6.c.** **5.E.6.e.** **5.E.6.f.**	Integrated Treatment and Recovery Services will identify the process for obtaining assessments for each client that includes the identified components	9/30/25
5.E.8.a.(1) **5.E.8.a.(2)** **5.E.8.a.(3)** **5.E.8.a.(4)** **5.E.8.a.(5)** **5.E.8.b.**	Integrated Treatment and Recovery Services will identify where in the clinical record to appropriately capture this information, and will inform clinical staff regarding documentation standards. Language from this standard will be added to clinical record review tool. Records from consumers from each CARF accredited program will be reviewed to this standard and plan of correction will be in place for programs missing this information from the treatment plan.	9/30/25

Table 25. Recommendations for corrective action and quality improvement plan for CARF

Outcomes Management: Performance Indicator and Consumer Satisfaction Report

MDHHS, in compliance with federal mandates, establishes measures in the areas of access, efficiency, and outcomes. Data is abstracted regularly, and quarterly reports are compiled and submitted to the PIHP for analysis and regional benchmarking and to MDHHS. In the event that CMHA-CEI performance is below the identified goal, the QI team will facilitate the development of a Corrective Action Plan (CAP). The CAP will include a summary of the current situation, including causal/contributing factors, a planned intervention, and a timeline for implementation. CAPs are submitted to the PIHP for review and final approval.

Full details of outcomes management are outlined in the Michigan Mission Based Performance Indicators and Consumer Satisfaction sections of this document.

ICDP and CC360 Data

To assist CMHA-CEI Departments with Performance Improvement QI has been working to learn ICDP/CC360 Data Systems to pull consumer data. In FY23, QI accessed the Integrated Care Delivery Platform (ICDP) to pull Service Utilization data for consumers enrolled in CCBHC services. QI increased access to monitor CCBHC specific measurements and address Care Alerts noted in the program. The Care Alerts identified as priorities to be addressed in FY23 were Adherence to Antipsychotics for Patients with Schizophrenia, Diabetes Monitoring, Cardiovascular Screening, Follow-Up After Hospitalization for Mental Illness - Adults, Follow-Up After Hospitalization for Mental Illness – Child, and Access to Primary Care for Children. In FY24 QI will continue to monitor CCBHC specific measurements and address priority Care Alerts noted in the program.

Annual Submission to MDHHS FY23

Requests for Service and Disposition of Requests

	CMH Point of Entry-Screening	DD All Ages	Adults with MI	Children with SED	Unknown and All Others	Total
1	Total # of people who telephoned or walked in	664	3166	1642	1072	6544
2	Of the # in Row 1 (all people who telephoned or walked in), total # of people referred out due to non-mental health needs	51	105	35	41	232
3	Of the # in Row 1 (all people who telephoned or walked in) total # of people who requested services the CMHSP provides, irrespective of eligibility	613	3061	1607	1031	6312
4	Of the # in Row 3 (People requested services the CMHSP provides), total # of people who met eligibility and were scheduled for intake/biopsychosocial assessment	11	301	27	12	351
5	Of the # in Row 3 (People requested services the CMHSP provides), total # of people who met eligibility and were scheduled for intake/biopsychosocial assessment	602	2760	1580	1019	5961
6	Of the # in Row 3 (People requested services the CMHSP provides), total # of people with other circumstance - Describe below on line 32	Unknown	Unknown	Unknown	Unknown	Unknown
7	Is Row 1 (all people who telephoned or walked in) an unduplicated count in each category? Answer Yes or No for each category	No	No	No	No	No
	CMHSP Assessment	DD All Ages	Adults with MI	Children with SED	Unknown and all others	Total
8	Of the # in Row 5 (Scheduled for intake/biopsychosocial Assessment) - total # of people who did not receive	Unknown	Unknown	Unknown	Unknown	Unknown

	intake/biopsychosocial assessment (dropped out, no show, etc.)					
9	Of the # in Row 5 (Scheduled for intake/biopsychosocial Assessment) - total # of people who were not served because they were MA FFS enrolled and referred to other MA FFS providers (not health plan)	Unknown	Unknown	Unknown	Unknown	Unknown
10	Of the # in Row 5 (Scheduled for intake/biopsychosocial Assessment) - total # of people who were not served because they were MA HP enrolled and referred out to MA health plan	Unknown	Unknown	Unknown	Unknown	Unknown
11	Of the # in Row 5 (Scheduled for intake/biopsychosocial Assessment) - total # of people who otherwise did not meet CMHSP non-entitlement intake/assessment criteria.	151	880	290	862	2183
11a	Of the # in Row 11 (did not meet CMHSP non-entitlement intake/assessment criteria) - total # of people who were referred out to other mental health providers	151	880	290	862	2183
11b	Of the # in Row 11 (did not meet CMHSP non-entitlement intake/assessment criteria) - total # of people who were not referred out to other mental health providers					
12	Of the # in Row 5, how many people met the CMHSP eligibility criteria?	451	1880	1290	157	3778
13	Of the # in Row 12 (Met CMHSP intake criteria) - total # of people who met emergency/urgent/priority conditions criteria	15	571	426	33	1045
14	Of the # in Row 12 (Met CMHSP intake criteria) - total # of people who met regular/routine/usual admission criteria	436	1309	864	124	2733
15	Of the # in Row 12 (Met CMHSP intake criteria) - total # of people who were put on a waiting list					0

15a	Of the # in Row 15 (Put on a waiting list) - total # of people who received some CMHSP services, but wait listed for other CMHSP services					0
15b	Of the # in Row 15 (Put on a waiting list) - total # of people who were waitlisted for all CMHSP services					0
16	Other - explain					0

Table 26. Annual Report to MDHHS

MSHN FY23 CCBHC Performance Measures

Performance rates are provided based on data available. Data is obtained from the Integrated Care Data Platform (ICDP) and Care Connect 360 (CC360). The performance rates obtained from CC360 are in *italics*. MDHHS provided the mean performance rates from DY1/FY22. The performance level is determined by the most current data available. A performance level of green indicates meeting or exceeding the target value.

Quality Bonus Performance Measures-Based on data available, each CCBHC met/exceeded the standard for the QBP measures.

Performance Areas	Key Performance Indicators	Organization	Actual Value (%) DY1 (FY22)	Actual Value (%) June 2023	Actual Value (%) September 2023	Target Value	Performance Level
CCBHC Quality Bonus Performance (QBP) Measures	Follow-Up After Hospitalization for Mental Illness (FUH -30 Adults)	Michigan Medicaid	*63.55%*	*64.15%*	Not Available	≥58%	
		MSHN Medicaid	*70.08%*	*71.44%*	Not Available	≥58%	
		Michigan CCBHC	*70.1%*	*66.67%*	Not Available	≥58%	
		CEI	67.6%	*71.25%*	71.7%	≥58%	
		The Right Door	91.0%	*86.55%*	65.3%	≥58%	
		SCCMHA	79.2%	*78.03%*	68.2%	≥58%	
	Follow-Up After Hospitalization for Mental Illness (FUH-30 Child/Adolescents)	Michigan Medicaid	*81.61%*	*81.67%*	Not Available	≥70%	
		MSHN Medicaid	*88.39%*	*86.89%*	Not Available	≥70%	
		Michigan CCBHC	*83.5%*	*83.6%*	Not Available	≥70%	
		CEI	92.1%	68.8%	82.7%	≥70%	
		The Right Door	94.7%	73.3%	76.5%	≥70%	

		SCCMHA	100.0%	76.9%	73.3%	≥70%	
	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD)	Michigan Medicaid	*57.74%*	*56.00%*	Not Available	≥58.5%	
		MSHN Medicaid	*62.0%*	*60.83%*	Not Available	≥58.5%	
		Michigan CCBHC	*56.7%*	*55.60%*	Not Available	≥58.5%	
		CEI	55.1%	*56.54%*	76.0%	≥58.5%	
		The Right Door	73.4%	*69.88%*	94.4%	≥58.5%	
		SCCMHA	70.8%	*59.27%*	64.4%	≥58.5%	
	Initiation of Alcohol and Other Drug Dependence Treatment (IET 14)	Michigan Medicaid	*38.03%*	*36.79%*	Not Available	≥I -25%	
		MSHN Medicaid	*40.09%*	*36.91%*	Not Available	≥I -25%	
		Michigan CCBHC	*43.9%*	*41.17%*	Not Available	≥I -25%	
		CEI	41.0%	*39.59%*	Not Available	≥I -25%	
		The Right Door	28.4%	*38.35%*	Not Available	≥I -25%	
		SCCMHA	45.0%	*36.36%*	Not Available	≥I -25%	
	Key Performance Indicators	**Organization**	**Actual Value (%) DY1 (FY22)**	**Actual Value (%) June 2023**	**Actual Value (%) September 2023**	**Target Value**	**Performance Level**
	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-Adult)	Michigan Medicaid	Not Available	*66.73%*	Not Available	≥23.9%	
		MSHN Medicaid	Not Available	*73.84%*	Not Available	≥23.9%	
		Michigan CCBHC	*67.7%*	*71.53%*	Not Available	≥23.9%	
		CEI	37.3%	74.1%	75.0%	≥23.9%	
		The Right Door	15.3%	80.1%	74.0%	≥23.9%	
		SCCMHA	31.0%	69.8%	78.0%	≥23.9%	
	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-Child)	Michigan Medicaid	Not Available	*66.73%*	Not Available	≥12.5%	
		MSHN Medicaid	Not Available	*73.84%*	Not Available	≥12.5%	
		Michigan CCBHC	*47.9%*	*71.53%*	Not Available	≥12.5%	
		CEI	27.1%	88.1%	75.0%	≥12.5%	
		The Right Door	18.8%	76.1%	74.0%	≥12.5%	
		SCCMHA	10.0%	9.0%	78.0%	≥12.5%	

Table 27. Quality Bonus Performance Measures

CCBHC State Reported Measures- A standard was set by MSHN at the beginning of DY2 for those measures that did not have an eternal standard. Focus areas include coordination related to follow up after emergency department visits for mental illness, and screening for diabetes.

CCBHC State Repo	**Key Performance Indicators**	**Organization**	**Actual Value (%) DY1 (FY22)**	**Actual Value (%) June 2023**	**Actual Value (%) September 2023**	**Target Value**	**Performance Level**

	Housing Status (HOU)		Not Available	Not Available	Not Available	TBD	
	Follow-Up After Emergency Department Visit for Mental Illness (FUM) Initiation (7 days)	Michigan Medicaid	*45.74%*	*45.44%*	Not Available	≥DY1	
		MSHN Medicaid	*48.37%*	*47.09%*	Not Available	≥DY1	
		Michigan CCBHC	*62.1%*	*60.82%*	Not Available	≥DY1	
		CEI	*55.50%*	*50.53%*	57.56%	≥DY1	
		The Right Door	*68.66%*	*56.25%*	50.00%	≥DY1	
		SCCMHA	*64.44%*	*54.25%*	41.29%	≥DY1	
	Follow-Up After Emergency Department Visit for Mental Illness (FUM) Engagement (30 days)	Michigan Medicaid	*60.40%*	*60.67%*	Not Available	≥DY1	
		MSHN Medicaid	*64.51%*	*64.19%*	Not Available	≥DY1	
		Michigan CCBHC	77.2%	*76.43%*	Not Available	≥DY1	
		CEI	*72.51%*	*69.89%*	64.2%	≥DY1	
		The Right Door	*77.61%*	*71.25%*	70.0%	≥DY1	
		SCCMHA	*84.44%*	*73.11%*	78.1%	≥DY1	
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA 7) (CC360. Excludes unassigned)	Michigan Medicaid	*14.64%*	*27.45%*	Not Available	≥DY1	
		MSHN Medicaid	*15.89%*	*29.93%*	Not Available	≥DY1	
		Michigan CCBHC	*21.55%*	*40.02%*	Not Available	≥DY1	
		CEI	*20.07%*	*38.83%*	Not Available	≥DY1	
		The Right Door	*17.14%*	*52.8%*	Not Available	≥DY1	
		SCCMHA	*4.55%*	*55.4%*	Not Available	≥DY1	
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-30) (CC360. Excludes unassigned)	Michigan Medicaid	*23.78%*	*42.54%*	Not Available	≥DY1	
		MSHN Medicaid	*25.51%*	*43.84%*	Not Available	≥DY1	
		Michigan CCBHC	*63.6%*	*59.74%*	Not Available	≥DY1	
		CEI	*30.48%*	*57.95%*	Not Available	≥DY1	
		The Right Door	*25.71%*	*67.44%*	Not Available	≥DY1	
		SCCMHA	*13.64%*	*62.86%*	Not Available	≥DY1	
	Plan All-Cause Readmission Rate (PCR-AD)^	Michigan Medicaid	*9.34% O/E 1.0*	*8.94% O/E .96*	Not Available	≥DY1	
		MSHN Medicaid	*9.09% O/E .97*	*8.89% O/E .95*	Not Available	≥DY1	
		Michigan CCBHC	*12.1%*	Not Available	Not Available	≥DY1	
		CEI	Not Available	10.8%	11.5%	≥DY1	
		The Right Door	Not Available	14.7%	14.0%	≥DY1	
		SCCMHA	Not Available	15.9%	17.2%	≥DY1	
		Michigan Medicaid	*76.34%*	*77.25%*	Not Available	≥DY1	

	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD-AD)^	MSHN Medicaid	*79.16%*	*80.45%*	Not Available	≥DY1	
		Michigan CCBHC	*80.9%*	*81.11%*	Not Available	≥DY1	
		CEI	*85.73%*	*84.62%*	80.0%	≥DY1	
		The Right Door	*81.71%*	*84.92%*	97.1%	≥DY1	
		SCCMHA	*82.04%*	*81.50%*	79.1%	≥DY1	
	Follow-up care for children prescribed ADHD medication. Initiation Phase (ADD-CH)^	Michigan Medicaid	Not Available	*66.73%*	Not Available	≥DY1	
		MSHN Medicaid	Not Available	*73.84%*	Not Available	≥DY1	
		Michigan CCBHC	*63.4%*	*71.53%*	Not Available	≥DY1	
		CEI	Not Available	71.4%	72.0%	≥DY1	
		The Right Door	Not Available	100.0%	100.0%	≥DY1	
		SCCMHA	Not Available	89.4%	84.8%	≥DY1	
	Follow-up care for children prescribed ADHD medication. C & M Phase (ADD-CH)^	Michigan Medicaid	Not Available	*66.73%*	Not Available	≥DY1	
		MSHN Medicaid	Not Available	*73.84%*	Not Available	≥DY1	
		Michigan CCBHC	*69.7%*	*71.53%*	Not Available	≥DY1	
		CEI	Not Available	92.2%	93.2%	≥DY1	
		The Right Door	Not Available	100.0%	100.0%	≥DY1	
		SCCMHA	Not Available	93.6%	96.9%	≥DY1	
	Antidepressant Medication Management Acute Phase, 12 weeks (AMM-AD) ^	Michigan Medicaid	*55.88%*	*57.02%*	Not Available	≥DY1	
		MSHN Medicaid	*58.67%*	*59.75%*	Not Available	≥DY1	
		Michigan CCBHC	*49.1%*	*51.67%*	Not Available	≥DY1	
		CEI	*53.35%*	*52.88%*	76.5%	≥DY1	
		The Right Door	*56.64%*	*66.9%*	23.0%	≥DY1	
		SCCMHA	*43.75%*	*44.7%*	72.4%	≥DY1	
	Antidepressant Medication Management Cont. Phase (AMM-AD) ^	Michigan Medicaid	*33.60%*	*34.60%*	Not Available	≥DY1	
		MSHN Medicaid	*35.46%*	*36.57%*	Not Available	≥DY1	
		Michigan CCBHC	*29.8%*	*31.01%*	Not Available	≥DY1	
		CEI	*31.64%*	*32.93%*	Not Available	≥DY1	
		The Right Door	*32.74%*	*45.1%*	Not Available	≥DY1	
		SCCMHA	*37.50%*	*25.2%*	Not Available	≥DY1	
	Engagement of Alcohol and Other Drug Dependence Treatment MSHN (IET 34)	Michigan Medicaid	*11.17%*	*11.25%*	Not Available	≥DY1	
		MSHN Medicaid	*14.04%*	*13.78%*	Not Available	≥DY1	
		Michigan CCBHC	*12.4%*	*12.41%*	Not Available	≥DY1	
		CEI	*10.84%*	*14.13%*	Not Available	≥DY1	

		The Right Door	*9.80%*	*13.24%*	Not Available	≥DY1	
		SCCMHA	*18.87%*	*15.91%*	Not Available	≥DY1	

Table 28. CCBHC State Reported Measures

Clinic Reported Measures- A standard was set by MSHN at the beginning of DY2 for those measures that did not have an eternal standard. Focus areas include access to services, and processes for preventative/screening follow up.

	Key Performance Indicators	Organization	Actual Value (%) DY1 (FY22)	Actual Value (%) June 2023	Actual Value (%) September 2023	Target Value	Performance Level
CCBHC Reported Measures	Time to Initial Evaluation (I-EVAL): Percent of consumers with an initial evaluation within 10 Business Days. Total (all ages)	Michigan CCBHC	*57.8%*	Not Available	Not Available	≥DY1	
		CEI	64.1%	66.2%	67.0%	≥DY1	
		The Right Door	77.5%	66.2%	81.0%	≥DY1	
		SCCMHA	56.9%	20.8%	34.0%	≥DY1	
	Time to Initial Evaluation (I-EVAL): Mean Number of Days until Initial Evaluation	Michigan CCBHC	*20.80*	Not Available	Not Available	<=10 days	
		CEI	12.82%	8.86	11	<=10 days	
		The Right Door	14.77%	10.64	7	<=10 days	
		SCCMHA	18.57%	19.20	17	<=10 days	
	Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)	Michigan CCBHC	*32.5%*	*71.53*	Not Available	≥DY1	
		CEI	7.9%	11.2%	9.0%	≥DY1	
		The Right Door	38.1%	31.6%	31.0%	≥DY1	
		SCCMHA	24.4%	37.1%	35.0%	≥DY1	
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents 3-11 (WCC-CH)^	Michigan CCBHC	*44.3% (ages 3-17)*	Not Available	Not Available	≥DY1	
		CEI	0.0%	0.0%	4.0%	≥DY1	
		The Right Door	93.4%	56.7%	67.0%	≥DY1	
		SCCMHA	84.0%	58.5%	64.0%	≥DY1	
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents 12-17 (WCC-CH)^	Michigan CCBHC	*44.3% (ages 3-17)*	Not Available	Not Available	≥DY1	
		CEI	0.4%	0.0%	6.0%	≥DY1	
		The Right Door	79.8%	51.2%	52.0%	≥DY1	
		SCCMHA	68.9%	59.2%	72.0%	≥DY1	
		Michigan CCBHC	*48.7%*	Not Available	Not Available	≥DY1	
		CEI	3.3%	0.0%	21.0%	≥DY1	

	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	The Right Door	47.9%	47.4%	42.0%	≥DY1	
		SCCMHA	61.0%	44.2%	40.0%	≥DY1	
	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	Michigan CCBHC	*48.6%*	Not Available	Not Available	≥DY1	
		CEI	0.0%	13.6%	18.0%	≥DY1	
		The Right Door	36.8%	64.2%	64.0%	≥DY1	
		SCCMHA	58.0%	66.4%	65.0%	≥DY1	
	Screening for Depression and Follow-Up Plan: Age 18-64 (CDF-AD)	Michigan CCBHC	*37.2%*	Not Available	Not Available	≥DY1	
		CEI	1.2%	3.4%	4.0%	≥DY1	
		The Right Door	40.7%	42.3%	37.0%	≥DY1	
		SCCMHA	73.8%	46.2%	39.0%	≥DY1	
	Screening for Depression and Follow-Up Plan: Age 65+ (CDF-AD)	Michigan CCBHC	*37.2%*	Not Available	Not Available	≥DY1	
		CEI	0.7%	1.9%	4.0%	≥DY1	
		The Right Door	44.4%	27.3%	31.0%	≥DY1	
		SCCMHA	85.7%	23.2%	25.0%	≥DY1	
	Depression Remission at Twelve Months (DEP-REM-12) The Right Door	Michigan CCBHC	*13.0%*	Not Available	Not Available	≥DY1	
		CEI	0.0%	0.0%	0.0%	≥DY1	
		The Right Door	2.5%	1.0%	2.0%	≥DY1	
		SCCMHA	0.0%	2.4%	4.0%	≥DY1	

Table 29. Clinical reported Measures

Next Steps:

- Identify barriers and interventions to eliminate barriers and improve performance rates.
- Discuss evidenced based practices that are proving to be effective and share best practices from other CCBHCs who are performing well.
- Continue to assess data accuracy and develop useful reports for internal monitoring.
- Continue to work with MDHHS in ensuring state reported measures are available through CC360, and /or received by MDHHS.
- Evaluate the impact of system changes on the performance rates. This includes but is not limited to encounter code changes, attributions, and any limitations of the HEDIS value sets.

References

Behavior Treatment Plans: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines/behavior-treatment-plans

CARF International: https://carf.org/

Certified Community Behavioral Health Clinics Demonstration Program: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/ccbhc

CMHA-CEI Quality and Compliance: http://ceicmh.org/about-us/quality-and-compliance

Health Services Advisory Group: https://www.hsag.com/en/about/what-we-do-services/

MDHHS Reporting Requirements: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting

MSHN Delegated Managed Care Reviews: https://midstatehealthnetwork.org/provider-network-resources/provider-requirements/cmhsps/delegated-managed-care-reviews

MSHN QAQIP: https://midstatehealthnetwork.org/stakeholders-resources/quality-compliance/compliance-reports

Michigan's Mission Based Performance Indicator System: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/reportsproposals/michigans-mission-based-performance-indicator-system

National Core Indicators: https://www.nationalcoreindicators.org

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Figure 1. Improved Compliance in **Performance Indicators: In data submitted to MDHHS representing the full population of CMHA-CEI consumers, the rates of compliance improved for PIs 1, 2a, 3, and 4a. While there was no significant change in for PI 10 (not pictured), compliance was maintained in FY23.**

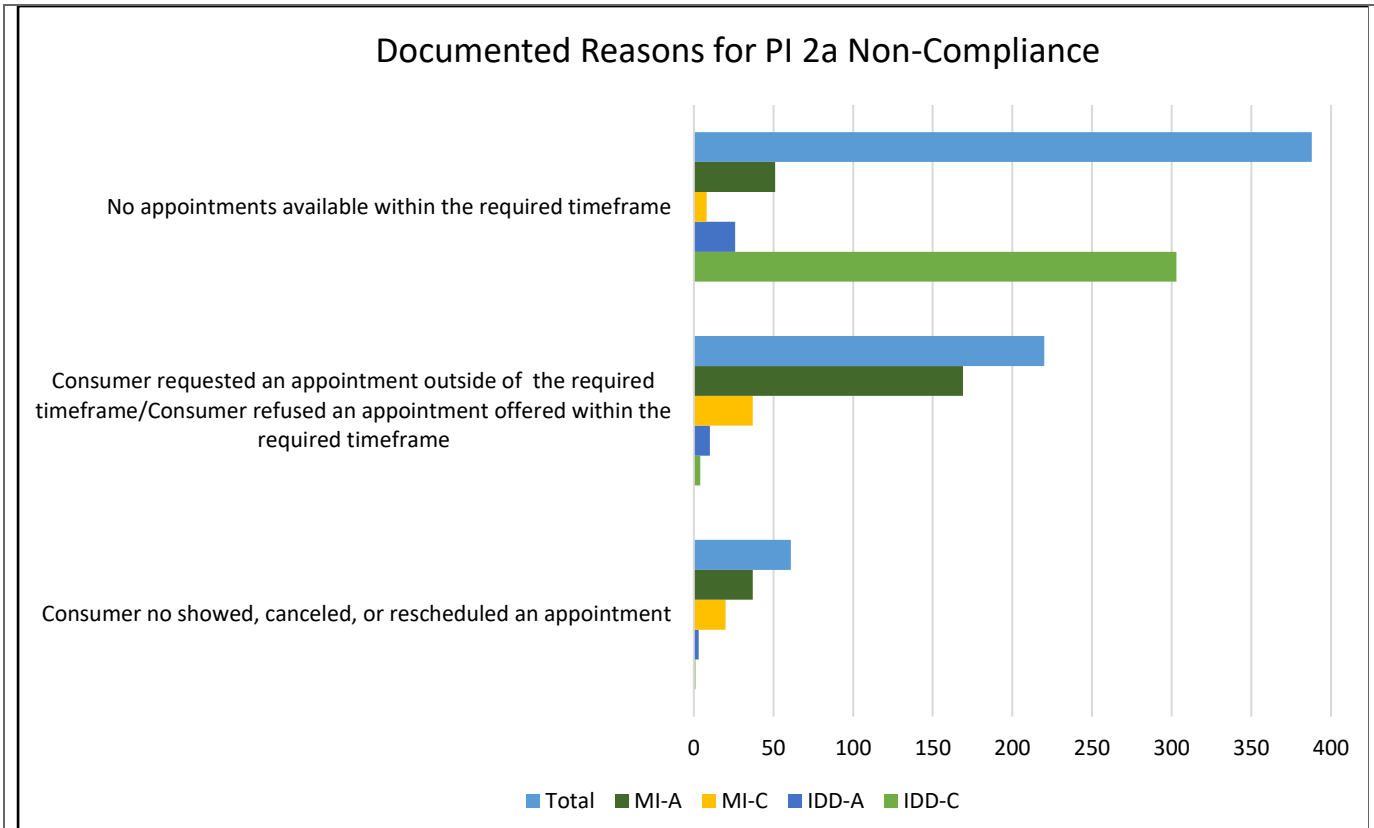

Figure 2. Documentation for timeliness from inquiry to assessment over 14 **days: While there are no exceptions for PI 2a, Mid-State Health Network began tracking and navigating the documented reasons for non-compliance. The top documented reasons in FY23 were no appointments available, consumer refusal, and no-show/cancellations. Data shown in figure represents the full population of CMHA-CEI consumers submitted to MDHHS. Data is also shown broken in to categories of population of adults with mental illness (MI-A), children with mental illness (MI-C), adults with intellectual developmental disabilities (IDD-A), and children with intellectual developmental disabilities (IDD-C)**

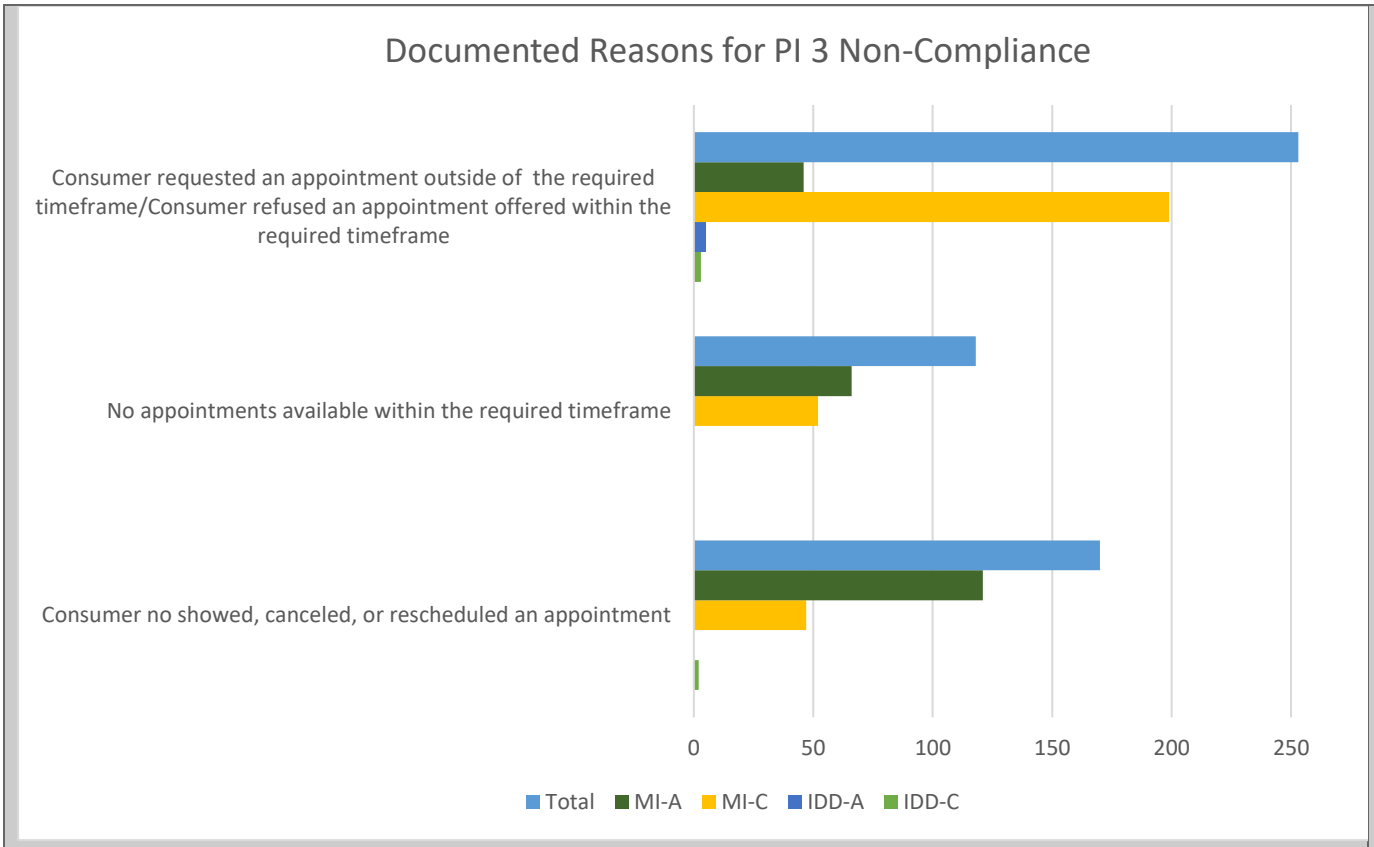

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Figure 3. Documentation for timeliness from assessment to start of treatment over 14 ***days: While there are no exceptions for PI 3, Mid-State Health Network began tracking and navigating the documented reasons for non-compliance. The top documented reasons in FY23 consumer refusal, no appointments available, and no-show/cancellations. Data shown in figure represents the full population of CMHA-CEI consumers submitted to MDHHS. Data is also shown broken in to categories of population of adults with mental illness (MI-A), children with mental illness (MI-C), adults with intellectual developmental disabilities (IDD-A), and children with intellectual developmental disabilities (IDD-C)***

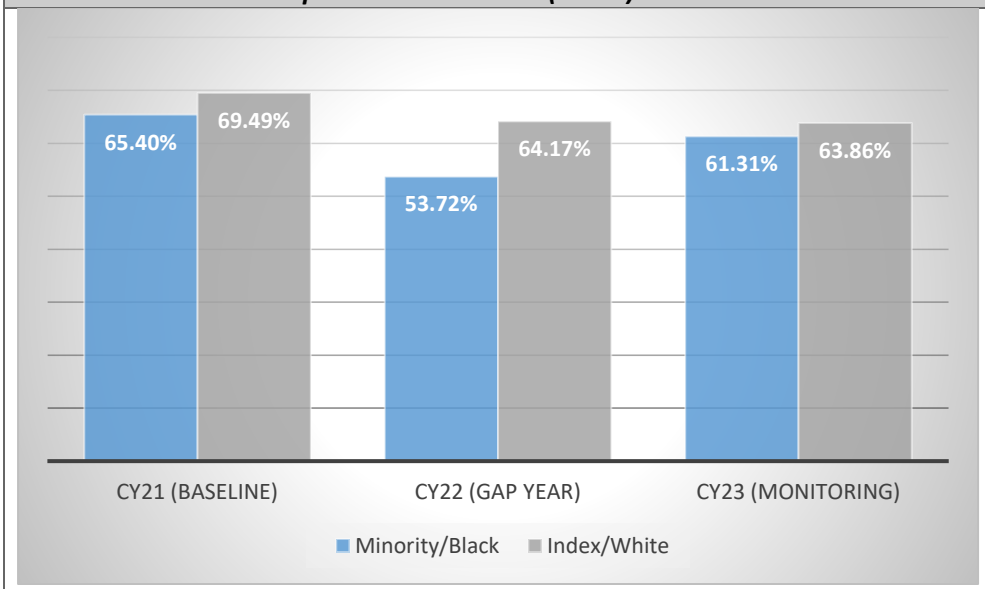

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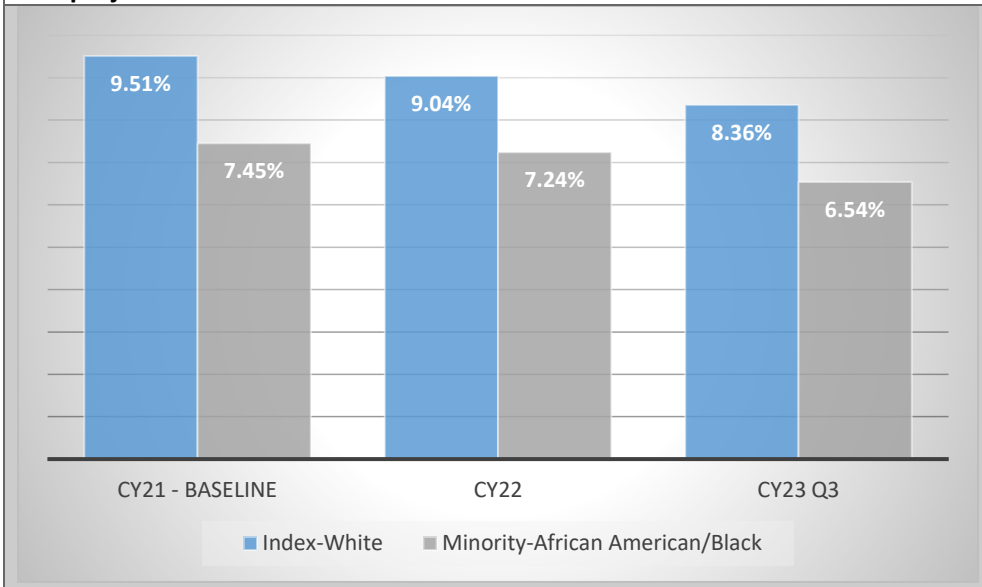
Figure 4. Longitudinal data of those who received a medically necessary service within 14 days of a completed biopsychosocial assessment**. The rate of access to services for Index/White population group has demonstrated a downward trend from the baseline year as indicated in the Table 6. The Black/African American population group**

increased from CY22. Table 7 includes the CMHA-CEI counts and rates of those who qualify for inclusion in this project.	
 Figure 5. MSHN CMHSP Penetration Rates**. Table 10 includes the CMHA-CEI counts and rates of those who qualify for inclusion in this project. A full breakdown of penetration rates across all reported races/ethnicities can be found in the Annual MSHN QAPIP: https://midstatehealthnetwork.org/download_file/view/7363619c-f6c0-4def-a3c8-bfc04ef75858/193**	16
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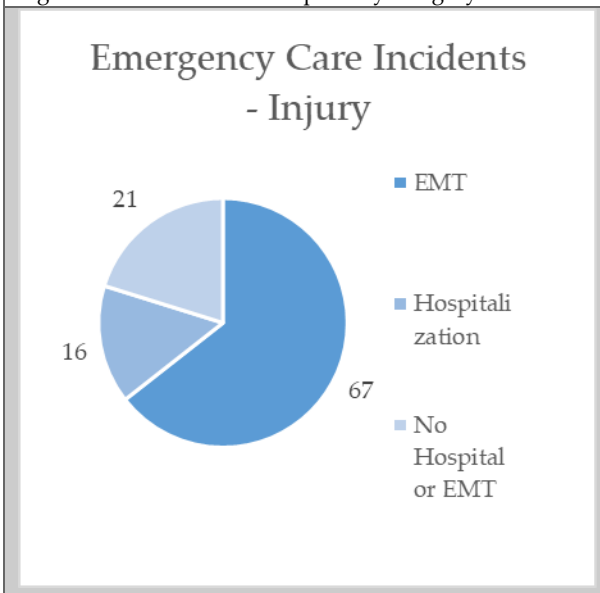 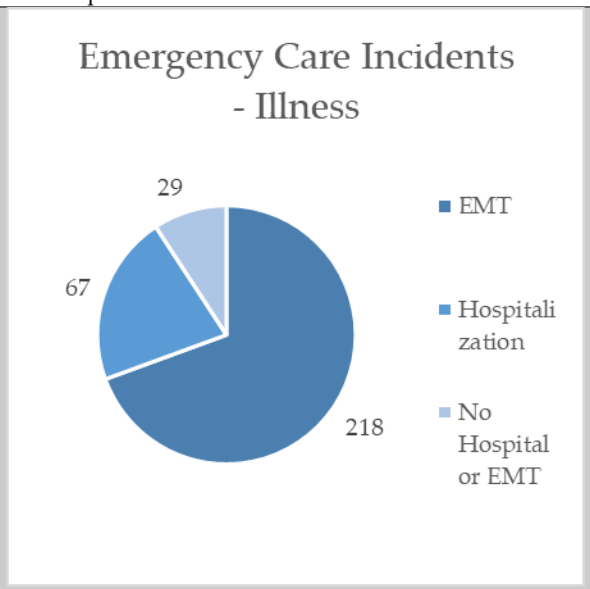 Figure 7. Emergency Care incidents resulting in EMT, Hospitalization, caused by injury or **illness**	19

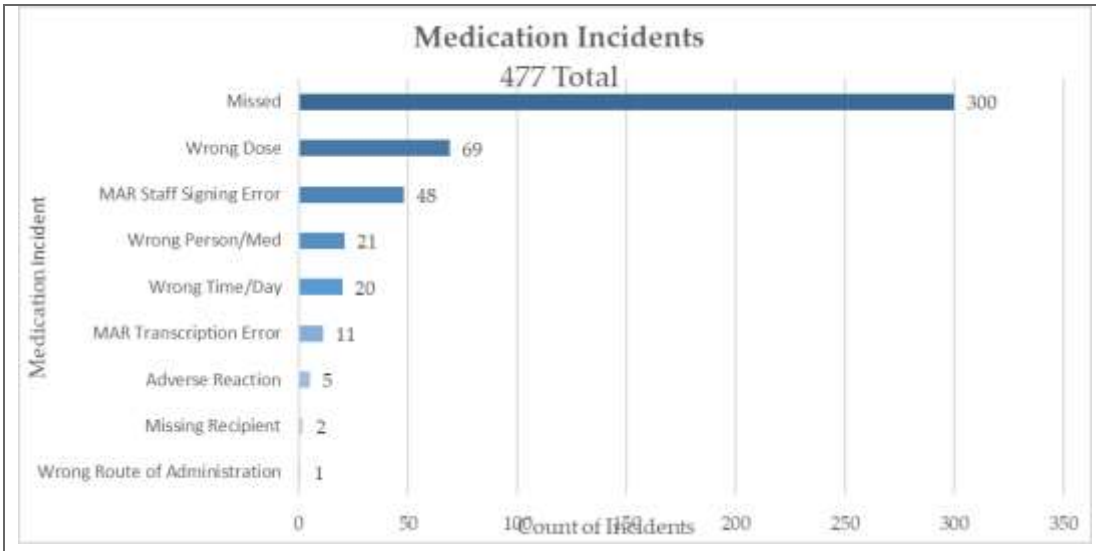

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Figure 8. Medication incident reports by category. Data shows count of IRs completed in **FY23**

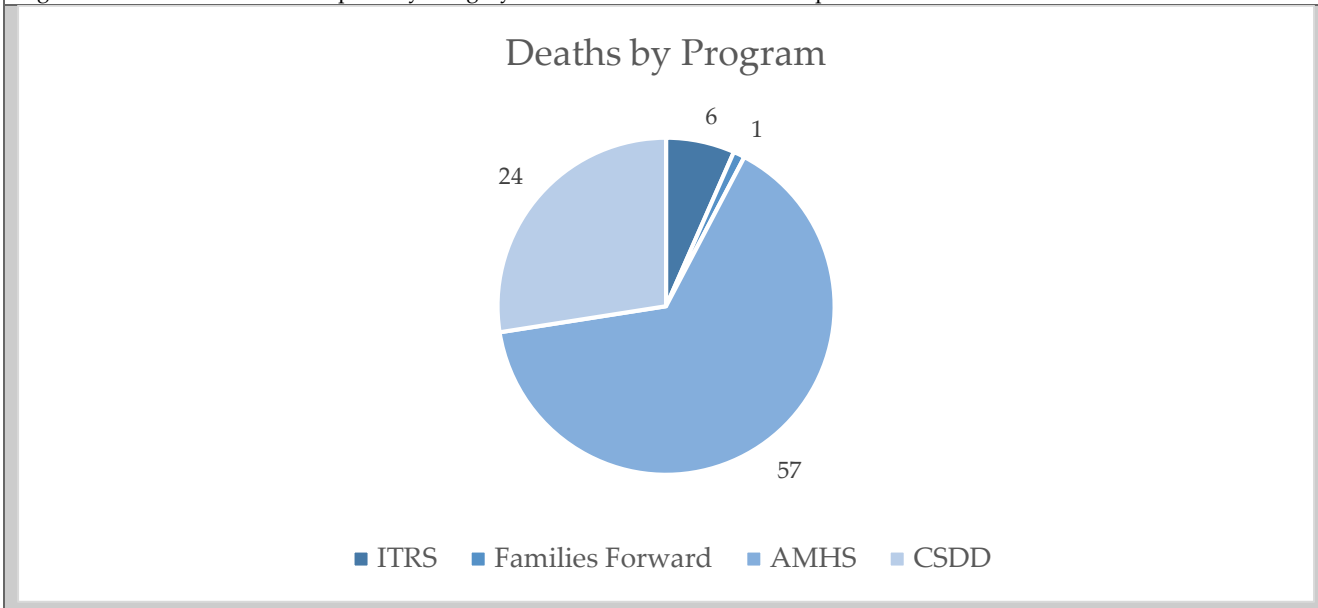

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Figure 9. Count of Deaths by age and by CMHA-CEI **Program**

Figure 10. Vehicle Accidents by month in FY23

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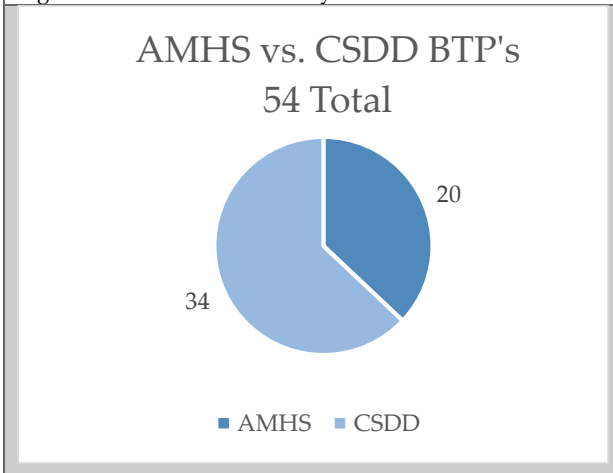

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Figure 11. Count of Behavior Treatment Plans by CMHA-CEI program and Internal vs. Contract **Providers**

List of Tables

MEV Review Claims Test Percentages by CMHSP, FY24 Q1

CMHSP | Attribute Tested	A	B	C	D	E	F	G	Average %	% of Valid Claims
Central	99.25%	100%	92.83%	97.74%	90.19%	99.25%	86.55%	95.12%	73.58%
CEI	100%	100%	100%	99.36%	95.18%	100%	90.91%	97.92%	90.68%
Montcalm	100%	100%	65.17%	100%	89.05%	99.50%	100%	93.39%	70.15%
Newaygo	100%	100%	94.38%	96.79%	95.98%	100%	77.89%	95.01%	79.52%
The Right Door	100%	100%	99.69%	97.20%	79.44%	100%	88.26%	94.94%	76.32%
Tuscola	100%	100%	88.26%	98.38%	76.11%	83.00%	89.24%	90.71%	69.23%
FY24 Q1 Average	99.88%	100%	90.06%	98.25%	87.66%	96.96%	88.81%	94.52%	76.58%

MSHN

Mid-State Health Network

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

Annual Report FY2023

Prepared By: MSHN Quality Manager – 11/2023
Reviewed and Approved By: Quality Improvement Council – 12/2023
Reviewed By: MSHN Leadership – 12/20/2023
Reviewed By: MSHN Operations Council – 12/18/2023
Reviewed and Approved By: MSHN Board – 1/30/2024

Contents

I. Introduction

Mid-State Health Network (MSHN) is a regional entity, which was formed pursuant to 1974 P.A. 258, as amended, MCL §330.1204b, as a public governmental entity separate from the CMHSP Participants that established it. The CMHSP Participants formed MSHN to serve as the prepaid inpatient health plan ("PIHP") for the twenty-one counties designated by the Michigan Department of Health and Human Services as Region 5. Effective January 2014, MSHN entered into its first contract with the State of Michigan for Medicaid funding, and entered into subcontracts with the CMHSPs in its region for the provision of Mental Health, Substance Use Disorder, and Developmental Disabilities services. The contract was expanded in 2014 to include an expanded Medicaid benefit, the Healthy Michigan Plan. The CMHSP Participants include Bay-Arenac Behavioral Health Authority, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network , Huron Behavioral Health, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health Authority, Saginaw County Community Mental Health Authority, Shiawassee Health and Wellness, The Right Door and Tuscola Behavioral Health Systems. Effective October 1, 2015, MSHN took over the direct administration of all public funding for substance use disorder (SUD) prevention, treatment and intervention within the region and expanded the provider network to include SUD providers.

The MSHN Quality Assessment and Performance Improvement Program (QAPIP) is reviewed annually for effectiveness. The evaluation includes a review of the components of the QAPIP to ensure alignment with the contract requirements, a review of the status of the QAPIP Workplan and impact on the desired outcome, and a committee/council annual review with accomplishments and goals for the upcoming year. The QAPIP Plan and associated QAPIP Work Plan was effective. Recommendations for the Annual QAPIP Plan, which includes a description of each activity and a work plan for the upcoming year, are included in the FY24 QAPIP Plan. The Board of Directors will receive the Annual QAPIP Report and approve the Annual QAPIP Plan for FY24. The measurement period for this annual QAPIP Evaluation is October 1, 2022, through September 30, 2023. The scope of MSHN's QAPIP is inclusive of all CMHSP Participants, the Substance Use Disorder Providers, and their respective provider networks in the MSHN region.

II. Performance Measurement and QAPIP Work Plan FY23 Review

MSHN monitors longitudinal performance through an analysis of regional trends. Performance is compared to the previous measurement period or other specifically identified targets. A status of "met" or "not met" is received. When minimum performance standards or requirements are "not met", CMHSP Participants/SUD Providers participate in a quality improvement process. The assigned committee/council in collaboration with other relevant committees/councils develop interventions designed to improve the performance of the measure. *Indicates data that has not been finalized. Based on performance and the performance measurement requirements, a recommendation is made to "continue", "discontinue", or "modify". Considerations for recommendations are based on changes in requirements and performance.

a) Michigan Mission Based Performance Indicator System

The Michigan Department of Health and Human Services (MDHHS), in compliance with Federal mandates, establishes measures in access, efficiency, and outcomes. Pursuant to its contract with MDHHS, MSHN is responsible for ensuring that its CMHSP Participants and Substance Use Disorder

Providers are measuring performance through The Michigan Mission Based Performance Indicator System.

Goal: MSHN will meet or exceed the MMBPIS Standards for the indicators as required by MDHHS.

Status: MSHN completed the objectives of the workplan. As a result, an increase in the accuracy of the data reported was demonstrated through the HSAG Performance Measure Validation. Established processes will further improve data accuracy over the next year. Access to services demonstrated the most challenge due to the workforce shortage and decreased appointment availability.

Barriers were identified and interventions were implemented. Beginning in FY24 a standard was applied to Indicator 2 and 3. MSHN has implemented a performance improvement project to address the performance of Indicator 3. The QAPIP was effective.

Attachment 2 MMBPIS Summary Report FY23

Strategic Priority	Michigan Mission Based Performance Indicator System (MMBPIS)	Committee	FY22	FY23	Status/ Recommendation
Better Care	Indicator 1: Percentage of Children who receive a Prescreen within 3 hours of request (>= 95% or above)	QIC	97.75%	98.40%	Met/Continue
Better Care	Indicator 1: Percentage of Adults who receive a Prescreen within 3 hours of request (>= 95% or above)	QIC	98.90%	99.45%	Met/Continue
Better Care	Indicator 2. a. The percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children. (No Standard)	QIC	62.35%	59.72%	No Standard/ Continue
Better Care	Indicator 2. E. The percentage of new persons during the quarter receiving a face to face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorder.	QIC/SUD	73.91%	*75.25%	No Standard / Continue
Better Care	Indicator 3: The percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children). (No Standard)	QIC	62.44%	62.14%	No Standard/ Continue
Better Care	Indicator 4a1: Follow-Up within 7 Days of Discharge from a Psychiatric Unit-Children (>= 95%)	QIC	97.36%	97.47%	Met/Continue
Better Care	Indicator 4a2: Follow-Up within 7 Days of Discharge from a Psychiatric Unit- Adults (>= 95%)	QIC	95.72%	96.64%	Met/Continue
Better Care	Indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (>=95%)	QIC/SUD	97.34%	97.87%	Met/Continue
Better Care	Indicator 10a: Re-admission to Psychiatric Unit within 30 Days-Children (standard is <=15%)	QIC	4.04%	9.20%	Met/Continue
Better Care	Indicator 10b: Re-admission to Psychiatric Unit within 30 Days- Adults (standard is <=15%)	QIC	10.24%	12.66%	Met/Continue

b) Performance Based Incentive Payment Measures

Performance incentives have been established to support initiatives as identified in the MDHHS comprehensive Quality Strategy. Data is currently available only through CY23Q1.

Attachment 3 FY23 Q2-Q3 Integrated Health Quarterly Report

Strategic Priority	Joint Metrics	Committee	CY22	CY23Q1	Status/ Recommendations
Better Care	J.2 a. The percentage of discharges for adults (18 years or 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 practitioner within 30 days after discharge. FUH Report (Standard-58%) Data Source CC360	QIC	69.88%	70.92%	Met/Continue
Better Care	J.2 b. The percentage of discharges for children (6-17 years) 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 practitioner within 30 days after discharge. Follow-Up After Hospitalization Mental Illness Children (Standard-70%) Data Source CC360	QIC	87.87%	86.34%	Met/Continue
Better Care	J.2 c. Racial/ethnic group disparities will be reduced. (*Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences) *Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following a psychiatric hospitalization (adults and children)*	QIC	0	Not Available	Continue
Better Care	J.3 a. Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Standard 27%) based on CY21	UMC/IC	43.25%	44.26%	Met/Continue
Better Care	J.3 b. Reduce the disparity BSC Measures for FUA. *Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following an emergency department visit for alcohol or drug use.*	UMC	2*	Not Available	Continue

The Certified Community Behavior Health Clinics review data quarterly to identify any areas of improvement needed and to share best practice with other CCBHCs within the region. The table below provides the performance of the Quality Bonus Payment measures. MDHHS has provided the finalized performance data for FY22. MSHN utilizes the Integrated Care Data Platform (ICDP) and Care Connect 260 to monitor performance throughout the year. The data in the table below is obtained from ICDP and has not been finalized by MDHHS.

CCBHC Quality Bonus Payments	Committee	FY22	FY23	Status/ Recommendations
Follow-Up After Hospitalization for Mental Illness (FUH -Adults) MSHN. Standard-58%	CCBHC QI	CEI: 68% Right Door: 91% SCCMHA: 79%	CEI: 62% Right Door: 61% SCCMHA: 70%	Met/Continue
Follow-Up After Hospitalization for Mental Illness (FUH-Child/Adolescents) MSHN. Standard 70%	CCBHC QI	CEI: 92% Right Door: 95% SCCMHA: 100%	CEI: 69% Right Door: 73% SCCMHA: 77%	Partial Met/Continue

Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD) MSHN. Standard 58.5%	CCBHC QI	CEI: 55% Right Door: 73% SCCMHA: 71%	CEI: 59% Right Door: 95% SCCMHA: 57%	Partial Met/Continue
Initiation of Alcohol and Other Drug Dependence Treatment MSHN. Standard I-25%	CCBHC QI	CEI: 41% Right Door: 28% SCCMHA: 45%	CEI: 52% Right Door: 33% SCCMHA: 49%	Met/Continue
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-Child) MSHN. Standard 12.5%	CCBHC QI	CEI: 27% Right Door: 19% SCCMH: 10%	CEI: 89% Right Door: 83% SCCMHA: 21%	Met/Continue
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-Adults) MSHN. Standard 23.9%	CCBHC QI	CEI: 37% Right Door: 15% SCCMH: 31%	CEI: 75% Right Door: 74% SCCMHA: 78%	Met/Continue

c) Performance Improvement Projects

MDHHS requires the PIHP to complete a minimum of two performance improvement projects per waiver renewal period. MSHN has approved the two Non-clinical Performance Improvement Project to address access to services for the historically marginalized groups within the MSHN region for CY22 through CY25.

Status: Interventions to address the identified barriers have been identified and are in development. Effectiveness will be determined following the review of CY23 data, which will be available in March of 2024.

Attachment 4 PIP #1 Access-Reduction of Disparities Monitoring
Attachment 5 PIP #2 Penetration Rate CY21-CY23YTD

Strategic Priority	Performance Improvement Projects	Committee	CY21	CY22	CY23 YTD	Status/ Recommendations
Better Care	PIP 1– Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population. Black/African American population White population	QIC	Baseline 65.04% 69.49%	53.72% 64.17%	61.31% 63.86%	Not Met/Continue
Better Care	PIP 2- Reducing or eliminating the racial or ethnic disparities between the black/African American minority penetration rate and the index (white) penetration rate. Black/African American population White population	QIC	Baseline 7.45% 9.51%	7.24% 9.04%	6.54% 8.36%	Not Met/Continue

d) Adverse Event Monitoring

Adverse Events include any event that is inconsistent with or contrary to the expected outcomes of the organization's functions that warrants PIHP review. Subsets of the adverse events will qualify as "reportable events" according to the MDHHS Critical Event Reporting System. These include MDHHS defined sentinel events which include unexpected deaths, critical incidents, and risk events.

Status: MSHN met the standards. The QAPIP was effective.

Attachment 6 MSHN Critical Incident Performance Summary
Attachment 7 MSHN Critical Incident Process Summary
Attachment 8 MSHN Critical Incident Performance SUDTP Report

	Event Monitoring and Reporting	Committee	FY22	FY23	Status/ Recommendations
Better Care	The rate of critical incidents per 1000 persons served will demonstrate a decrease from the previous year. (CMHSP) (excluding deaths)	QIC	8.561	7.41	Met/Continue
Better Care	The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous year. (CMHSP) (Natural Cause, Accidental, Homicidal)	QIC	6.405	5.77	Met/Discontinue
Better Care	The rate, per 1000 persons served, of Suicide Death will demonstrate a decrease from previous year. (CMHSP)	QIC	0.384	.116	Met/Continue with the addition of unexpected deaths
Better Care	The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from previous year. (SUDP)	QIC/SUD	1.535	.000	Met/Discontinue

e) Behavior Treatment

MDHHS requires data to be collected based on the definitions and requirements that have been set forth within the MDHHS Standards for Behavioral Treatment Review and the MDHHS Quality Assessment and Performance Improvement Program Technical Requirement attached to the Pre-Paid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) contract.

MSHN delegates the responsibility for the collection and evaluation of data to each local CMHSP Behavior Treatment Review Committee (BTRC), including the evaluation of effectiveness of the BTRC by stakeholders.

Status: MSHN did not meet each standard.

Attachment 9 MSHN Behavior Treatment Data

Strategic Priority	Behavior Treatment	Committee	FY22	FY23	Status/ Recommendations
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period. (Standard-95%)	CLC	72%	88%	Not Met/Continue
Better Care	The percent of emergency interventions per person served during the reporting period will decrease from previous year.	QIC	0.91%	0.93%	Not Met/Continue

f) Stakeholder and Assessment of Member Experiences

The aggregated results of the surveys and/or assessments, and other data were collected, analyzed, and reported by MSHN in collaboration with the QI Council, the Clinical Leadership Committee, the Customer Services Committee, and Regional Consumer Advisory Council, who identified areas for improvement and recommendations for action as appropriate. Regional benchmarks and/or national benchmarks were used for comparison. The findings were incorporated into program improvement action plans as needed. Actions are taken on survey results of individual cases, as appropriate, to identify and investigate sources of dissatisfaction and determine appropriate follow-up at the CMHSP Participant/SUD Provider level. The reports have been presented to the MSHN governing body, the Operations Council, Regional Consumer Advisory Council, CMHSP Participants and SUD Providers, and accessible on the MSHN website, Findings are also shared with stakeholders on a local level through such means as advisory councils, staff/provider meetings and printed materials.

- Mental Health Statistics Improvement Program (MHSIP)-Adults with a Mental Health illness, Individuals with an Intellectual Developmental Disability.
- Youth Satisfaction Survey (YSS) Youth with a Severe Emotional Disturbance, Individuals with an Intellectual Developmental Disability
- Substance Use Disorder Satisfaction Survey-Individuals with a substance use disorder.
- Home and Community Based Services Survey-Individuals receiving Long Term Supports and Services (LTSS)
- Provider Network Survey-Organizations who contract with MSHN (every other year)
- Committee/Council Survey-Provider representatives on MSHN committees/councils (every other year)
- National Core Indicator Survey-Individuals receiving LTSS
- Appeals and Grievance Data, and customer complaints-All individuals receiving services.

Status: MSHN Met the standard by obtaining an 80% or higher.
MSHN in collaboration with the NCI Advisory Council will identity focus areas for FY24.

Attachment 10 MSHN Executive Summary Member Satisfaction FY2023 Annual Report
Attachment 11 National Core Indicator Summary

Strategic Priority	Stakeholder and Assessment of Member Experiences	Committee	FY22	FY23	Status/ Recommendations
Better Care	Percentage of consumers indicating satisfaction with SUD services. (Standard 80%/3.50)	QIC	95%	90%	Met/Continue
Better Care	Percentage of children and/or families indicating satisfaction with mental health services. (Standard 80%)	QIC	87%	81%	Met/Continue
Better Care	Percentage of adults indicating satisfaction with mental health services. (Standard 80%)	QIC	83%	80%	Met/Continue
Better Care	Percentage of individuals indicating satisfaction with long term supports and services.(Standard 80%)	QIC	83%	80%	Met/Continue
Strategic Priority	**Member Appeals and Grievance Performance Summary**	**Committee**	**FY22**	**FY23**	**Status/ Recommendations**
Better Care	Percentage (rate per 100) of Medicaid consumers who are denied overall eligibility were resolved with a written notice	UMC	93.94%	97.4%	Met/Continue

	letter within 14 calendar days for a standard request of service. (Standard 95%)				
Better Care	The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness standards including the written disposition letter (30 calendar days) of a standard request for appeal. (Standard 95%)	CSC	96.71%	98.85%	Met/Continue
Better Care	The percentage (rate per 100) of Medicaid grievances are resolved with a written disposition sent to the consumer within 90 calendar days of the request for a grievance. (Standard 95%)	CSC	95.12%	100%	Met/Continue

g) Clinical Practice Guidelines

MSHN supports and requires the use of nationally accepted and mutually agreed upon clinical practice guidelines including Evidenced Based Practices (EBP) to ensure the use of research -validated methods for the best possible outcomes for service recipients as well as best value in the purchase of services and supports.

Practice guidelines are monitored and evaluated through data analysis and MSHN's site review process to ensure CMHSP participants and SUDT providers, at a minimum, are incorporating mutually agreed upon practice guidelines within the organization. Additionally, information regarding evidenced based practices is reported through the annual assessment of network adequacy.

The use of practice guidelines and the expectation of use are included in provider contracts. Practice guidelines are reviewed and updated annually or as needed and are disseminated to appropriate providers through relevant committees/councils/workgroups. All practice guidelines adopted for use are available on the MSHN website.

Status: MSHN did not meet the standard.

Attachment 12 ACT Utilization FY23
Attachment 9 Behavior Treatment Review Data

Strategic Priority	Clinical Practice Guidelines	Committee	FY22	FY23	Status/ Recommendations
Better Care	MSHN will demonstrate full compliance with the use of MDHHS required practice guideline. (PM) Inclusion, Consumerism, Personal Care in Non-Specialized Residential Settings, Family Driven and Youth Guided, Employment Works Policy and Practice Guidelines.	CLC	100%	100%	Met/Discontinue
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period. (95% Standard) see Section IV. e	CLC	72.2%	88%	Not Met/Continue
Better Care	MSHN's ACT programs will demonstrate fidelity for an average of minutes per week per consumer (85%/96 minutes-100%/120 minutes).	UMC	2/7	1/8	Not Met/Continue

h) Credentialing and Re-credentialing

MSHN has established written policy and procedures[1] in compliance with MDHHS's Credentialing and Re-Credentialing policy for ensuring appropriate credentialing and re-credentialing of the provider network. Whether directly implemented, delegated, or contracted, MSHN shall ensure that credentialing activities occur upon employment/contract initiation, and minimally every two (2) years thereafter. MSHN written policies and procedures[2] also ensure that non-licensed providers of care or support are qualified to perform their jobs, in accordance with the Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes chart.

Credentialing, privileging, primary source verification and qualification of staff who are employees of MSHN, or under contract to the PIHP, are the responsibility of MSHN. Credentialing, privileging, primary source verification and qualification of CMHSP Participant/SUD Provider staff and their contractors is delegated to the CMHSP Participants/SUD Providers. MSHN monitors CMHSP Participant compliance with federal, state, and local regulations and requirements annually through an established process including desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies.

MSHN updated the Credentialing review process in 2022 to include monitoring of the timeliness of decision making and credentialing activities for the CMHSP participants. Any CMHSP participants scoring less than 90% on the file review would be subject to additional review of credentialing and re-credentialing records.

Status: In 2023, six of the twelve CMHSPs scored under 90%. Staff qualifications are reviewed during the MDHHS Site Review and internally through the Delegated Managed Care Review. Based on the DMC review in FY23, improvement has been made. This will continue to be monitored until the MDHHS Site Review has been completed to allow for consistent comparisons.

Strategic Priority	Staff Qualifications	Committee	FY22	FY23	Status/ Recommendations
Better Provider	Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements. FY22 MDHHS Review, FY23 DMC review	Leadership	88%	99%	Met/Continue
Better Provider	Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements. FY22 MDHHS Review, FY23 DMC Review	Leadership	89%	94%	Met/Continue

[1] Provider Network Credentialing/Recredentialing Policy and Procedure
[2] Provider Network Non-Licensed Provider Qualifications

i) Verification of Services

MSHN has established a written policy and procedure for conducting site reviews to provide monitoring and oversight of the Medicaid and Healthy Michigan funded claims/encounters submitted within the Provider Network. MSHN verifies the delivery of services billed to Medicaid and Healthy Michigan in accordance with federal regulations and the state technical requirement.

Data collected through the Medicaid Event Verification process is aggregated, analyzed, and reported for review. Opportunities for improvements at the local or regional level are identified. The findings from this process, and any follow up needed, are reported annually to MDHHS through the Medicaid Event Verification Service Methodology Report.

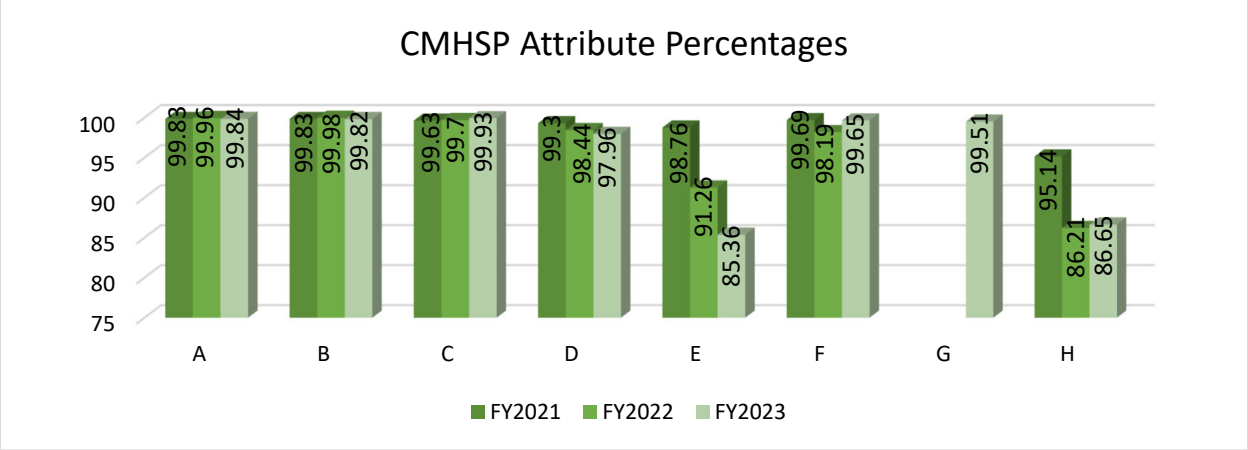
Process improvements implemented from previous MEV reviews included modifications to the forms for the claims review, summary report, plan of correction and data tracking to improve accuracy and ease of understanding how the data was represented. Improvements were also implemented to ensure proper and accurate reporting of information as part of the Office of Inspector General new reporting requirements for audit activities. The MEV forms continue to be standardized for consistency for each review. Additional improvements are being considered for FY2024 based on feedback received through the Provider network. One of the recommendations for improvement includes creating an MEV review guide for providers which would establish what documentation is required for each attribute and which findings will require voiding versus a plan of correction. The construction of this guide is currently underway.

Regionally the CMHSPs have shown slight improvements from FY2022 to FY2023 for the following attributes:

1. C: Service is included in the beneficiary's individual plan of service
2. F: Amount billed does not exceed contractually agreed upon amount
3. G: Amount paid does not exceed contractually agreed upon amount
4. H: Modifiers are used in accordance with the HCPCS guidelines

Note: FY23 Attributes F & G listed above were combined in FY22 under F.) Amount billed and paid does not exceed contractually agreed upon amount. Furthermore, Attribute H.) Modifiers are used in accordance with the HCPCS guidelines was Attribute G in FY22.

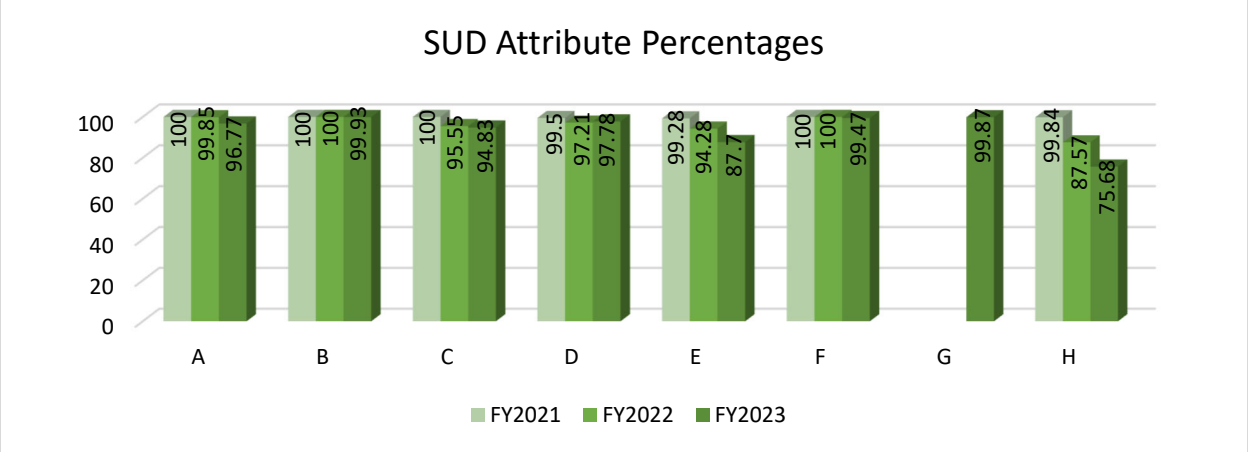
These improvements may be attributed to an increased focus on improving the quality of documentation, improved staff trainings, ongoing monitoring and oversight, and increased education and technical assistance provided by the Medicaid Event Internal Auditor during the review process. In addition, MSHN has safeguards in place to guard against duplicate and incomplete claims being submitted.



Regionally the SUD providers did not show significant improvements from FY2022 to FY2023. However, the SUD provider scores were already at a high level and most of the scores remained in the mid-high nineties. The attributes that had slight improvements from FY2022 to FY2023 were:

1. C: Service is included in the beneficiary's individual plan of service
2. D: Documentation of the service date and time matches the claim date and time of the service

This may be attributed to continued training and technical assistance provided by MSHN to the providers as part of the MEV site reviews. The SUD provider network is also improving their understanding of the required supporting documentation to show compliance with the attributes.



Note: The above chart does not include the same SUD providers from year to year but is representative of the region.

MSHN will continue to provide ongoing support to our provider network to ensure compliance with the attributes reviewed during the MEV site reviews. This will include training opportunities and identified quality improvements based on data trends.

MSHN also reviews the event verification results with the following council and committees:

- MSHN Compliance Committee (internal committee)
- Regional Compliance Committee (external committee consisting of members of the CMHSPs)
- MSHN Quality Improvement Council (external committee consisting of members of the CMHSPs)
- MSHN Operations Council (internal committee)

Councils and committees review and provide feedback for region-wide performance improvement opportunities. In addition, discussion and sharing regarding local improvement opportunities provides collaboration efforts to increase compliance.

Status: MSHN did not meet the goal as indicated below for FY23.

Strategic Priority	Medicaid Event Verification	Committee	FY22	FY23	Status/ Recommendations
Better Care	Medicaid Event Verification review demonstrates improvement of previous year results with the use of modifiers in accordance with the HCPCS guidelines.	CCC	CMHSP: 86.21% SUD: 87.57%	CMHSP: 86.65% SUD: 75.68%	Not Met/Continue

j) Utilization Management

MSHN ensures access to publicly funded behavioral health services in accordance with the Michigan Department of Health and Human Services contracts and relevant Medicaid Provider Manual and Mental Health Code requirements.

Utilization review functions are delegated to CMHSP Participants in accordance with MSHN policies, protocols, and standards. This includes local-level prospective, concurrent, and retrospective reviews of authorization and utilization decisions and/or activities regarding level of need and level and/or amount of services, consistent with PIHP policy, standards, and protocols.

A Regional Utilization Management Committee comprised of each CMHSP Participant assists in the development of standards and reviews/analyzes region-wide utilization activity and trends. Communication with individuals regarding UM decisions, including adverse benefit determination notice, right to second opinion, and grievance and appeals will be included in this delegated function.

MSHN retains utilization review functions for substance use disorder (SUD) services in accordance with MSHN policies, protocols, and standards. This includes local-level prospective, concurrent, and retrospective reviews of authorization and utilization decisions and/or activities regarding level of need and level and/or amount of services, consistent with PIHP policy, standards, and protocols. Initial service eligibility decisions for SUD services are delegated to SUD providers through the use of screening and assessment tools.

MSHN ensures that screening tools and admission criteria are based on eligibility criteria established in contracts and policy and are reliably and uniformly administered. MSHN policies are designed to integrate system review components that include PIHP contract requirements and the CMHSP Participant's/SUD Provider roles and responsibilities concerning utilization management, quality assurance, and improvement issues.

MSHN has established criteria for determining medical necessity, and the information sources and processes that are used to review and approve provision of services. MSHN and its CMHSP Participants/SUD Providers use standardized population-specific assessments or level of care determination tools as required by MDHHS. Assessment and level of care tools guide decision making regarding medical necessity, level of care, and amount, scope, and duration of services. No one assessment shall be used to determine the care an individual receives, rather it is part of a set of

assessments, clinical judgment, and individual input that determine level of care relative to the needs of the person served.

MSHN has mechanisms to identify and correct under-and over-utilization of services as well as procedures for conducting prospective, concurrent, and retrospective reviews. MSHN ensures through policy and monitoring of the CMHSP Participants/SUD Providers that qualified health professionals supervise review decisions and any decisions to deny or reduce services are made by health care professionals who have appropriate clinical licensure and expertise in treating the beneficiary's condition. Through policy and monitoring of CMHSP Participants/SUD Providers, MSHN shall ensure that reasons for treatment decisions are clearly documented and available to persons served; information regarding all available appeals processes and assistance through customer services is communicated to the consumer; and notification requirements are adhered to in accordance with the MDHHS/PIHP Contract.

Status: Effective/Continue

Attachment 13 MSHN Behavioral Health Quarterly Report
Attachment 14 FY23 Service Auth Denial Report
Attachment 3 FY23Q2-Q3 Integrated Health Quarterly Report

k) Long Term Supports and Services for Vulnerable Adults

MSHN ensures that long term supports, and services are consistently provided in a manner that supports community integration and considers the health, safety, and welfare of consumers, family, providers, and other stakeholders. MSHN assesses the quality and appropriateness of care furnished and community integration by monitoring of population health through data analytics software to identify adverse utilization patterns and to reduce health disparities, and by conducting individual clinical chart reviews during program specific reviews to ensure assessed needs are addressed and in the individual's treatment plan and during transitions between care settings. In addition to the behavior treatment data, and adverse event data, MSHN monitors key priority measures as approved by Operations Council.

MSHN encourages community integration to occur more than once per week. Community integration is discussed with individuals at a minimum during the time of the person-centered planning to ensure their wants and desires are noted during the planning process. Documentation of community integration has been seen regularly during oversight reviews. Currently, there is not a systemic issue related to community integration as evidenced by the site review results.

Status: Met/Continue

Attachment 13 MSHN Behavioral Health Quarterly Report

Strategic Priority	Priority Measures	Committee	FY22	FY23	Status/ Recommendations
Better Value	Reduction in number of visits to the emergency room for individuals in care coordination plans between the PIHP and MHP (Target 100%)	UM/ IC	78%	Not Available	/Continue

Better Care	Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines. (Target 100%)	UM	100%	100%	Met/Continue
Better Care	Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan. (Standard 100%)	UM	85%	70.1 68.2%	Not Met/Continue Explore options for more accurate monitoring.
Better Care	Service utilization remains consistent or increases over previous year due to improved access to services through the use of telehealth. (Standard 0% decrease over previous FY)	UM	+10%	-	Unknown, unable to monitor after March. Discontinue
Better Value	Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages (Standard <=5%)	UM	1%	1%	Met/Continue
Better Care	MSHN will be in full compliance with the Adverse Benefit Determination notice requirements.	UM	95%	95%	Met/Continue
Better Care	MSHN's Habilitation Supports Waiver slot utilization will demonstrate a consistent minimum or greater performance of 95% HSW slot utilization.	CLC	93.50%	94%	Not Met/Continue
Better Care	Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS. (Standard 95%)	CLC	93%	87%	Not Met/Continue
Strategic Priority	**Priority Measures**	**Committee**	**FY22**	**FY23**	**Status/ Recommendations**
Better Health	MSHN will demonstrate improvement from previous reporting period of the percentage of patients 8-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Diabetes Screening Report (Data Source-ICDP) Michigan 2020-84.43%	QIC	81.74%	81.42%	Not Met/Continue
Better Health	MSHN will demonstrate an increase from previous measurement period in the percentage of individuals 25 to 64 years of age with schizophrenia or bipolar who were prescribed any antipsychotic medication and who received cardiovascular health screening during the measurement year. Cardiovascular Screening (Data Source-ICDP)	CLC	43.10%	48.65%	Met/Discontinue-will utilize cardiovascular monitoring measure.
Better Health	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. (Data Source-ICDP) Michigan 2020-44.44%	CLC	76.27%	76.96%	Met/Continue

Better Health	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. (Data Source-ICDP) Michigan 2020 54.65%	CLC	96.04%	96.84%	Met/Continue
Better Care	Plan All-Cause Readmissions-The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (<=15%) (Data Source-ICDP) Michigan 2020 9.09%	UM	10.88%	13.64%	Met/Continue
Better Care	The percentage of members 20 years and older who had an ambulatory or preventative care visit. Adult Access to Care (>=75%) (Data Source – ICDP) Michigan 2020 82.49%	UM	86.35%	87.46%	Met/Continue
Better Care	The percentage of members 12 months-19 years of age who had a visit with a PCP. Children Access to Care (>=75%) (Data Source-ICDP) Michigan 2020 89.64%	UM	95.19%	95.59%	Met/Continue

l) Provider Monitoring and External Reviews

MSHN monitors compliance with federal and state regulations annually through a process that includes any combination of desk review, site review verification activities, and/or other appropriate oversight and compliance enforcement strategies. CMHSPs Participants/SUD Providers that are unable to demonstrate acceptable performance may be required to provide corrective action, may be subject to additional PIHP oversight and interventions, and may be subject to sanctions imposed by MSHN, up to and including contract termination.

The PIHP is subject to external reviews through MDHHS and/or an external quality reviewer contracted by MDHHS to ensure quality and compliance with all regulatory requirements. MSHN collaborates with MDHHS and the external quality reviewer to provide relevant evidence to support compliance. In accordance the MDHHS-PIHP, all findings that require improvement based on the results of the external reviews are incorporated into the QAPIP Priorities for the following year. An action plan will be completed that includes the following elements: improvement goals, objectives, activities, timelines, and measures of effectiveness in response to the findings. The improvement plan will be available to MDHHS upon request.

The following external reviews were completed for FY23:

- HSAG Performance Measure Validation Review-Received a status of “Reportable”
- HSAG Compliance Review-Corrective Action Follow up from 2021 and 2022. All CAPs were accepted except Standard XII-Health Information Systems 7. Application Programming Interface.
- HSAG Performance Improvement Project-Received a status of “Met” the PIP received 100% validation.
- MDHHS Waiver Review- 90 Day Follow up was completed.

MSHN filed an appeal for standards P.5.1 and P.5.2 which were not found to be in full compliance.

Status: Effective/Continue
The findings and recommendations will be incorporated into the QAPIP Performance Measures and Work Plan for FY24.

Strategic Priority	Provider Monitoring	Committee	FY22	FY23	Status/ Recommendations
Better Provider	Provider surveys demonstrate satisfaction with REMI enhancements - Provider Portal (SUD Network) (Standard >=3.50)	Leadership	3.60	3.73	Met/Discontinue
Better Provider	SUD providers satisfaction demonstrates 80% or above with the effectiveness and efficiency of MSHN's processes and communications (SUD Network) (Standard >= 3.50)	Leadership	3.95	4.09	Met/Continue
Better Provider	MSHN will demonstrate an increase in compliance with the External Quality Review-Compliance Review. Comprehensive Score for FY21 and FY22. (Next measurement is FY25)	QIC/CLC	87%	NA	Met/Continue

m) Quality Priorities and Work Plan FY23

Organizational Structure and Leadership	Objectives/Activities	Assigned Lead	Frequency/ Due Date	Status/ Recommendations
MSHN will have an adequate organizational structure with clear administration and evaluation of the QAPIP	To develop in collaboration with the QIC the annual QAPIP evaluation and QAPIP plan. (QAPIP Description, QAPIP Work Plan and Organizational Chart of the QAPIP).	Quality Manager	11.30.2023	Complete/Continue
	Development of a process to monitor the progress of the quality workplan performance measures inclusive of other departments designated responsibilities in the QAPIP.	Quality Manager	9.30.2023	Complete/Continue Recommend development of standard templates for use in organizational performance improvement projects and QI plan.
Governance	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**	**Status/ Recommendations**
Board of Directors will approve the QAPIP Plan and Report	To submit the annual QAPIP Plan and Report to the Board. (Attachment 17-MSHN Governing Board Form)	MSHN Deputy Director	1.1.2023 1.31.2024	Complete/Continue
Board of Directors review QAPIP Progress Reports	To submit QAPIP progress reports to the Board. (Balanced Scorecard Review, Quarterly Department Reports)	MSHN Deputy Director	Quarterly	Complete/Consider agenda item related to MSHN Performance and indicate any discussion
QAPIP description, associated work plan, and list of members of the Governing Body will be submitted to Michigan Department of Health and Human Services annually by February 28th	To submit the Board approved QAPIP Report and Plan to MDHHS. (via MDHHS FTP Site)	MSHN Quality Manager	1.31.2023 1.31.2024	Complete/Continue
Include the role of recipients of service in the QAPIP	QAPIP Description, and Organizational Chart of the QAPIP.	MSHN Quality Manager	1.31.2023 1.31.2024	Complete/Continue

Mechanisms for Communication of Process and Outcome Improvements	Objectives/Activities	Assigned Lead	Frequency/ Due Date	Status/ Recommendations
The QAPIP Plan and Report will be provided annually to network providers and to members upon request.	Distribute the completed Board approved QAPIP Effectiveness Review (Report) through committee/councils, MSHN Constant Contact, and email. Post to the MSHN Website. Ensure CMHSP contractors receive the QAPIP.	MSHN Quality Manager	2.28.2023 2.28.2024	Complete/Continue
Guidance on Standards, Requirements, and Regulations	Complete MSHN Contract Monitoring Plan and Medicaid Work Plan, post updates to MSHN Website, and distribute through committee/councils, MSHN Constant Contact.	MSHN Leadership	As needed, minimum annually	Complete / Continue
Consumers & Stakeholders receive reports on key performance indicators, consumer satisfaction survey results and performance improvement projects	Present reports on Consumer Satisfaction Survey Results, Key Priority Measures, MMBPIS, Behavior Treatment Review Data, Event Data, Quality policies/procedures and Customer Service Reports to RCAC.	MSHN Customer Services Manager	Quarterly	Complete/Continue
Performance Measurement and Quality reports are made available to stakeholders and general public	Upload to the MSHN website the following documents: QAPIP Plan and Report, Satisfaction Surveys, Performance Measure Reports; MSHN Scorecard, and MSHN Provider Site Review Reports, in addition to communication through committees/councils.	Leadership	Quarterly	Complete/Continue
MDHHS Performance Indicators	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN will meet or exceed the MMBPIS standards for Indicators as required by MDHHS.	Complete quality checks on data prior to submission through affiliate uploads in REMI. (Verify Medicaid Eligibility, Data Accuracy)	CMHSP Participants	3/15/2023 6/15/2023 9/15/2023 12/10/2023	Complete/Continue
	Complete performance summary reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees' councils.	QIC	10/27/2022 1/27/2023 4/28/2023 7/28/2023	Complete/Continue

	Complete primary source verification of submitted records during the DMC review.	MSHN-QM	Annually	Complete/Discontinue Recommend completing primary source during external review and prior to Quarterly submission to MDHHS.
	Ensure accuracy of data through REMI validations, and increased sample for those that had findings during external reviews.	MSHN-QM	Annually	Complete/Discontinue
MSHN will demonstrate an increase in compliance with access standards for the priority populations.	Establish a mechanism to monitor access requirements for priority populations.	MSHN-QM MSHN-UCM Director	1/27/2023	Complete/Continue
Performance Improvement Projects	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
PIP 1: Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population.	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees/councils. Submit PIP 1 to HSAG as required for validation.	MSHN-QM QIC	Quarterly 6/30/2023 6/30/2024	Complete/Continue
PIP 2: The racial or ethnic disparities between the black/African American penetration rate and the index (white) penetration rate will be reduced or eliminated.	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees/councils. Submit to MDHHS with QAPIP Evaluation and/or upon request.	MSHN-QM QIC	Quarterly 2/28/2024	Complete/Continue

Quantitative and Qualitative Assessment of Member Experiences	Objectives/Activities	Assigned Lead/ Committee	Frequency/ Due Date	Status/ Recommendations
MSHN will obtain a qualitative and quantitative assessment of member experiences for all representative populations, including members receiving LTSS, and take specific action as needed, identifying sources of dissatisfaction, outlining systematic action steps, monitoring for effectiveness, and communicating results.	Develop proposal for the administration of qualitative and quantitative assessment of member experience, and provider satisfaction for the region.	MSHN-Quality Manager	3/31/2023	Not complete/Continue
	Implement standard survey/assessment for all populations (SUD, CCBHC, MH, SED, IDD) that provides meaningful and actionable data.	QIC, MSHN Quality Manager	6/30/2023	Not complete/Continue. Recommend MHSIP be used for SUD
	Document and CMHSP / Provider Network action steps for improvement in the QIC action plan	CMHSP participants	9/30/2023	Complete/Continue
	Complete member experience annual report with causal factors, interventions, and feedback provided from relevant committees/councils.	QIC, MSHN Quality Manager	8/30/2023	Complete/Continue
Quantitative and Qualitative Assessment of Member Experiences	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN will demonstrate full compliance with the completion of a SIS assessment in accordance with the MDHHS required guidelines. (1x every three years)	Review internal report for compliance rate, identify causal factors and interventions for not meeting the standard. (How many have received a SIS within 3 years. How many meet the criteria for the completion of a SIS assessment.)	MSHN-CBHO CLC	Quarterly	Discontinued by MDHHS
MSHN will meet or exceed the standard for Appeals and Grievance resolution in accordance with the MDHHS standards.	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations).	MSHN-Customer Services Manager CSC	Quarterly	Completed/Continue
Event Monitoring and Reporting	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored,	Establish standard data element for mortality reviews	MSHN QM, QIC	4/30/2023	Complete/Discontinue
	Establish standard data elements/form for a Root Cause Analysis	MSHN QM, QIC	4/30/2023	Complete/Discontinue

reported, and followed up on as specified in the PIHP Contract.	Develop Dashboard for tracking and monitoring timeliness	MSHN QM, QIC	4/30/2023	In Progress/Continue
	Develop training documents, including policies/procedures based on the new requirements and process for reporting	MSHN QM, QIC	2/28/2023	In Progress/Continue
	Develop control charting with upper and lower control limits	MSHN QM, QIC	2/28/2023	In Progress/Continue
	Complete the CIRS Performance Reports (including standards, trends, barriers, improvement efforts, recommendations, and status of recommendations to prevent reoccurrence) quarterly.	MSHN QM, QIC	3/23/2023 6/22/2023 9/22/2023 12/15/2023	Complete/Continue Recommend continuing a process improvement report and performance report.
Medicaid Event Verification	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN will meet or exceed a 90% rate of compliance of Medicaid delivered services in accordance with MDHHS requirements.	Complete Medicaid Event verification reviews in accordance with MSHN policy and procedure.	MSHN-MEV Auditor	See annual schedule	Complete/Continue
	Complete The MEV Annual Methodology Report identifying trends, patterns, strengths and opportunities for improvement.	MSHN-CQCO MSHN MEV Aud.	12/31/2022 12/31/2023	Complete/Continue
Utilization Management Plan	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN will establish a Utilization Management Plan in accordance with the MDHHS requirements	Complete/review the MSHN Utilization Management Plan.	MSHN-UCM Dir.	2023	Complete/Continue
	MSHN to complete performance summary quarterly reviewing under / over utilization, medical necessity criteria, and the process used to review and approve provision of medical services. Identify CMHSPs/SUDPs requiring improvement and present/provide to relevant committees/councils.	MSHN-UCM Director	Quarterly/ Annually	Complete/Continue
	Utilize uniform screening tools and admission criteria. LOCUS, CAFAS, MCG, ASAM, SIS, DECA	MSHN-UCM Director	Quarterly/ Annually	Complete/Continue. SIS was discontinued.

				MichiCans and MiCAS will be implemented
MSHN will demonstrate full compliance with timeframes of service authorization decisions in accordance with the MDHHS requirements.	Oversight of compliance with policy through primary source verification during Delegated Managed Care Reviews.	MSHN-UCM Dir.	Annually	Complete/Continue
	Monitor REMI process for tracking timeliness of authorization decisions, developing improvement plans	MSHN-UCM Director	Quarterly/ Annually	Complete/Continue
MSHN will meet or exceed the standard for compliance with the adverse benefit determination notices completed as required.	Oversight of compliance in accordance with the 42 CFR 438.404 with during Delegated Managed Care Reviews.	MSHN-Customer Service Manager	Annually	Complete/Continue
Practice Guidelines	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN will demonstrate an increase in the implementation of Person-Centered Planning and Documentation in the IPOS	Establish a Person-Centered Planning QI Team to review process steps to identify efficiencies.	MSHN-QM/QIC	1/31/2023	In progress/Continue
	MSHN will coordinate a regional training to address Person Centered Planning and the development of the Individual Plan of Service.		1/31/2023	Not complete/Modify to include provision of resources
MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period. (Standard-95%)	Monitor compliance with standards. DMC	MSHN Waiver Administrator, CLC	Annually	Completed/Continue
	Implement Behavior Treatment Training Modules	MSHN Waiver Administrator, CLC	1/31/2023	Complete/Discontinue
MSHN will demonstrate an increase in fidelity to the Evidenced Based Practice-Assertive Community Treatment Michigan Field Guide, on average minutes per week per consumer.	Complete a quarterly utilization summary of the average minutes per week/per consumer that will include the identification of barriers, interventions, and progress. Explore adding to the Program Specific DMC	MSHN-UCM Director UMC	Quarterly	Complete/Continue

Oversight of "Vulnerable People"/Long Term Supports and Services	Objectives/Activities	Assigned Lead/ Committee	Frequency/ Due Date	Status/ Recommendations
MSHN will assess the quality and appropriateness of care furnished to members (vulnerable people) receiving LTSS.	Analyze performance reports (including barriers, improvement efforts, recommendations, and status of recommendations) for community integration and assessment of care between settings.	MSHN-CBHO	Annually/ Quarterly	Complete/Continue
Behavior Treatment	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
The percentage of emergency physical interventions per person served during the reporting period will decrease from previous year.	Develop BTPR Module Specifications/Development (subgroup)	CLC/QIC	6/30/2023	Not Started/Continue
	Develop control charting with upper and lower control limits for track and trend data.	QIC	2/28/2023	In Progress/Continue
Provider Monitoring	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN will be in compliance with PIHP Contract Requirements.	Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	MSHN-QAPI	Annually	Complete/Continue
	Coordinate quality improvement plan development, incorporating goals and objectives for specific growth areas based on the site reviews, and submission of evidence for the follow up reviews.	Relevant committees	9/30/2023	Complete/Continue
MSHN will demonstrate an increase in compliance with the External Quality Review (EQR)-Compliance Review.	Implement corrective action plans for areas that were not in full compliance, and quality improvement plans for recommendations. See CAP for specific action steps. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	MSHN QM	9/30/2023	Complete/Continue

MSHN will demonstrate full compliance with the EQR-Performance Measure Validation Review.	Implement quality improvement plans for recommendations provided by the external quality review team. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	MSHN-QM-QIC MSHN-CIO-ITC	9/30/2023	Complete/Continue
MSHN will demonstrate an increase in compliance with the MDHHS 1915 Review.	Monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data.	MSHN-Waiver Managers, CBHO	9/30/2023	Complete/Continue
Provider Qualifications	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements.	Complete Primary Source Verification utilizing the Credentialing Report submitted to MDHHS	Leadership/ PNM	Quarterly	Not Complete/Discontinue
	Require individual remediation for records that are not in full compliance with the credentialing requirements, and additional monitoring for those CMHSPs that have a compliance rate of =<90%.	Leadership/ PNM	Annually	Complete/Continue with modifications
	Primary Source Verification and review of the credentialing/recredentialing policy and procedure will occur during the DMC review. Providers who score less than 90% on the file review will be subject to additional review of credentialing and re-credentialing records.	Leadership/ PNM	Annually	Not complete/Continue with modifications
	Include primary source verification for professionals that have/require the designation of Qualified Intellectual Disability Professional (QIDP).	QIC/PNM	Annually	In Progress/Continue
Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements.	Develop regional guidelines for training documentation consistent with MDHHS expectations.	QIC	1/31/2023	Complete/Discontinue
	Continue to update the training grid as required.	QIC/PNM	1/31/2023	Complete Discontinue

III. MSHN Councils Annual Reports FY23

Team Name: Mid-State Health Network Operations Council

Team Leader: Joe Sedlock, MSHN Chief Executive Officer

Report Period: 10.01.2022 through 9.30.2023

Purpose of Council or Committee: The MSHN Board has created the Operations Council to advise the Pre-paid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) concerning the operations of the Entity. Respecting that the needs of individuals served and communities vary across the region, it will inform, advise, and work with the MSHN CEO to bring local perspectives, local needs, and greater vision to the operations of the Entity so that effective and efficient service delivery systems are in place that are accountable to the entity board, funders and the citizens who make our work possible.[3]

A. Past Year Accomplishments. FY23

- Reviewed and approved the FY22 Operations Council Annual Report
- Supported the forming of the 1915(i) Workgroup
- Reviewed and approved the FY22 QAPIP Annual Report
- Reviewed and approved the FY23 QAPIP Plan
- Supported MSHN position to appeal citations for the use of service ranges language in plans of service.
- Encouraged and supported MSHN in approaching MDHHS to offer to work together on special populations issues.
- Discussed and reviewed the Operating Agreement in regard to the local funds for OHH and BHH.
- Planned for the FY2024-2025 Strategic Plan Process
- Requested MSHN/region to look for opportunities to do more advocacy with MDHHS regarding how the state determines State Hospital placement.
- Supported the proposal to MSHNs Board of Directors to extend the Provider Staffing Crisis Stabilization Program thru the end of FY23.
- Supported MSHN and SWMBH collaboration in dialogue with MDHHS to assist with improving access for Children in Child Welfare.
- Reviewed and supported the Service Authorization Denial Summary and Procedure
- Reviewed MSHN Strategic Plan
- Examined Regional Savings Estimates-CMHSP regional partners to take a closer watch on current budget and expenditures. May need to develop regional strategy and/or regional cost containment plans.
- Discussed and reviewed the CFAP resolution
- Collaboration on issues raised by DHHS regarding Children's Access Issues
- Reviewed the FY22 Network Adequacy Addendum report
- Reviewed and approved FY24 ABA Contract
- Reviewed and approved FY24 Financial Management Services Contract
- Reviewed and approved the MSHN/CMHSP FY24 Medicaid Subcontract
- Reviewed and approved FY24 MSHN Training Grid
- Reviewed the FY23 budget amendment and the FY24 budget
- Monthly reviews of MDHHS disenrollment reports

[3] Article III, Section 3.2, MSHN/CMHSP Operating Agreement

- Supported MSHN to advocate with MDHHS to correct technological problems in the Customer Relationship Management (CRM) system and EGrAMS.
- Reviewed and approved the Ops Council Charter annual review
- Reviewed BCBS and Medicare Advantage services for Crisis Stabilization, Urgent Care and Mobile Crisis to encourage CMHSPs to consider participating.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Relating to conflict free access and planning, advocate for system reform changes that comply with the federal rule that are in the best interests of beneficiaries, their families and supporters, and the communities served by the public behavioral health system.
Work with MDHHS and other stakeholders to improve access to the services and supports of the public behavioral health system, including regional penetration rate monitoring.
Ensure effective and efficient regional operations and consider centralization of functions where efficiencies can be obtained.
As a region and as individual entities: address, reduce, and eliminate health disparities.
Address funding adequacy especially in light of ongoing workforce shortages and provider stabilization requirements
Monitor and expand Behavioral Health Homes, Opioid Health Homes and Certified Community Behavioral Health Clinics in the MSHN region
Continue to educate MDHHS and other stakeholders on the governmental (non-commercial) nature of the public behavioral health system and work to avoid shaping the system to function like a private health plan
Work with MDHHS to establish a practical vision for use of the State CRM and work toward implementation

Team Name: Finance Council
Team Leader: Leslie Thomas, Chief Financial Officer
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The Finance Council shall make recommendations to the Mid-State Health Network (MSHN) Chief Finance Officer (CFO), Chief Executive Officer (CEO) and the Operations Council (OC) to establish all funding formulas not otherwise determined by law, allocation methods, and the Entity's budgets. The Finance Council may advise and make recommendations on contracts for personnel, facility leases, audit services, retained functions, and software. The Finance Council may advise and make recommendations on policy, procedure, and provider network performance. The Council will also regularly study the practices of the Entity to determine economic efficiencies to be considered.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- FY 2022 Audits received unqualified opinions and clean Compliance Examinations.
- FY 2022 Fully funded Internal Service Fund and Savings of $47.8 M – both together total 14.4% of the 15% target which is an accomplishment.
- Improve accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
•FY 2023 Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 2023 and February 2024. The audits will be available to the PIHP once they are reviewed by their respective Board of Directors. The goal is to have all fiscal CMHSP reports by April 2024 and compliance exams by June 2024. A favorable fiscal audit will be defined as those issued with an unqualified opinion. A favorable compliance audit will be defined as one that complies in all material aspects with relevant contractual requirements.
•Meet targeted goals for spending and reserve funds: Determination will be made when the FY 2023 Final Reports due to MDHHS March 31, 2024, are received from the CMHSPs to the PIHP. The goal for FY 2023 will be to spend at a level to maintain MSHN's anticipated combined reserves to 15% as identified by the board. This goal does not override the need to ensure consumers in the region receive medically necessary care.
•Work toward a uniform costing methodology: The PIHP CFO will participate in a Statewide workgroup initiated by MDHHS and Milliman to establish standard cost allocation methods. Regionally, Finance Council will review rates per service and costs per case for service codes identified in the Service Use and Analysis report suite. Finance Council will evaluate if action is needed based on State comparisons.
•Improve accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds.
•If applicable, develop regional and local cost containment strategies to align projected revenue and expenses.

Team Name: Information Technology Council
Team Leader: Steven Grulke, MSHN CIO
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The MSHN IT Council (ITC) is established to advise the Operations Council (OC) and the Chief Executive Officer (CEO) and will be comprised of the Chief Information Officer (CIO) and the CMHSP Participants information technology staff appointed by the respective CMHSP CEO/Executive Director. The IT Council will be chaired by the MSHN CIO. All CMHSP Participants will be equally represented.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Representation from each CMHSP Participant at all Meetings.
    - There was a 95% attendance rate during FY23 ITC Meetings. 100% attendance occurred in 6 meetings. Participation remains active as we are a highly collaborative group, sharing expertise and project strategies.
- Successfully submit MDHHS required data according to MDHHS requirements regarding quality, effectiveness and timeliness.
    - We exceeded 95% compliance standard for submitting BH-TEDS with all three transaction types: Mental health, substance use, and crisis records. (M, A, Q transactions).
- Several initiatives that ITC assisted with during FY23 are:
    - COB changes in 2023

- MCG Indicia Upgrades
- Foster Care Served Numbers for CMHSA advocacy to MDHHS
- CRM Module Implementation
- MDHHS Medicaid Redetermination – ongoing
- Detailed files for updated EQI
- Withdrawal Management BH-TEDS Adjustments – MDHHS
- Addition of the 'TF' Modifier in EHRs for mild to moderate CCBHC designation
- EVV advocacy along with CMHSA

- Facilitate health information exchange (HIE) processes:
  - Continued pilot process with MDHHS and MiHIN for Substance Use Disorder eConsent in MI Gateway. MSHN is ahead of all other pilots in this implementation.
- Goals Established by Operations Council:
  - Improvements with balanced scorecard reporting
  - Continue trending COVID-19 and telehealth reports (ended in May with emergency orders)
- Meet external quality review requirements:
  - Health Services Advisory Group (HSAG) conducted a review for MDHHS and evaluated performance measures and information systems capabilities. Both areas were successful and approved, with 1 compliance finding.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Representation from each CMHSP Participant at all Meetings
Successfully submit MDHHS required data according to MDHHS requirements regarding quality, effectiveness and timeliness.
Collaborate to develop systems or processes to meet MDHHS requirements (e.g. BH-TEDS reporting, Encounter reporting).
Work on outcome measure data management activities as needed.
Improve balanced scorecard reporting processes to achieve or exceed targeted amounts for IT.
Transition health information exchange (HIE) processes to managed care information system, when appropriate, to gain efficiencies in data transmissions.
Meet IT audit requirements (e.g., EQRO).

Team Name: Quality Improvement Council
Team Leader: Sandy Gettel Quality Manager
Report Period Covered: 10.01.2022-9.30.2023
Purpose of Council or Committee:
The Quality Improvement Council has been established to advise the Operations Council and the Chief Executive Officer concerning quality improvement matters. The Quality Improvement Council will be comprised of the Quality Manager, the CMHSP Participants' Quality Improvement staff appointed by each respective CMHSP Participant Chief Executive Officer/Executive Director, consumer representatives appointed through an application process, and a MSHN SUD staff representing Substance Use Disorder services as needed. The Quality Improvement Council will be chaired by the Quality Manager. All CMHSP Participants will be equally represented on this council.

Annual Evaluation Process

A. Past Year Accomplishments FY23 (10.1.2022 through 9.30.2023)

- Completed and submit a MSHN Board approved QAPIP Plan and Report to MDHHS by the required due date (February 28th, 2023)
- Approved the Quality policies and procedures ensuring they are in compliance with regulatory requirements and have been communicated to the providers.
- Developed regional guidelines for training documentation consistent with MDHHS
- Completed Member Experience Annual Survey
- Achieved the performance standards for each areas within the QAPIP, participating in quality improvement efforts as identified:
    - Behavior Treatment Review-Provide Data to BTPR Workgroup
    - Michigan Mission Based Performance Indicator System (MMBPIS)-Collaborated with MDHHS for recommended revisions and standards for Indicator 2, 3 and other indicators. Executed a targeted remediation based on external results of primary source verification. Developed process for Medicaid eligibility verification prior to submission. Added validation step prior to submission.
    - Develop standardized elements/form for mortality reviews and root cause analysis.
    - Achieve a Performance Improvement Project Validation from the External Quality Reviewers

B. Upcoming Year's Goals FY24 (10.1.2023 through 9.30.2024)

Goal	Objectives/Activities	Frequency/ Due Date
Submit Board approved QAPIP Plan, Evaluation and Workplan by 2/28/2024	• Collaborate with other committees/councils to complete an annual effectiveness review with recommendations to be incorporated into the MSHN regional report. • Collaborate with committees/councils to develop regional QAPIP workplan. • Review/revise QAPIP Plan to include new regulations	Annually 2/28/2024
Improve health outcomes for those served in the region.	• Review regional key performance indicators. • Review regional performance (BSC/Dashboard) • Develop/identify regional improvement strategies used to identify barriers and interventions. • Analyze outliers and establish process for quality improvement in collaboration with committee/councils.	Annually Quarterly Annually- Annually

	• Monitor the effectiveness of interventions	Quarterly
Establish effective quality improvement programs for CCBHC, health homes.	• Identify regional key performance indicators. • Develop/modify data platforms/reports for performance monitoring. • Establish performance monitoring schedule. • Develop/identify regional improvement strategies.	Annually Annually Annually Annually
Adhere to critical incident and event notification reporting requirements by developing an efficient and effective critical incident monitoring system	• Develop training documents and complete training outlining the requirements of reporting critical, sentinel, and risk events. • Validate / reconcile reported data through the CRM. • Improve timeliness of remediation response in the CIRS-CRM • Develop dashboard for tracking and monitoring timelines. • Establish electronic process for submission of sentinel events/ immediate notification, and remediation documentations.	Annually Quarterly Quarterly 2/28/2024 4/30/2024
Achieve full compliance for the MDHHS Review.	• Ensure corrective action plans are implemented to address deficiencies.	Annually
Improve member experience of care	• Complete an assessment/survey of member experience of care representative of all served, addressing issues of quality, availability, and accessibility of care. (MI, IDD, SUD, LTSS) • Identify sources of dissatisfaction • Increase response rate-streamline surveys and process. • Outline actions step for follow up. • Evaluate the effects of activities implemented to improve satisfaction. • Complete an RFP for administration and analysis by an external vendor.	Annually Annually Annually Annually Annually 6/30/2024
Achieve full compliance for the HSAG External Quality Review - Compliance	• Ensure corrective action plans and recommendations are implemented to address deficiencies.	Annually
Achieve Reportable Status for the HSAG External Quality Review – Performance Measure Validation	• Verify Medicaid Eligibility and data accuracy through primary source verification. • Validate data collection process, both administrative and manual. • Develop / modify ongoing training documents.	Quarterly Annually Annually
Achieve 100% Validation Status for the HSAG External Quality Review- Performance Improvement Project	Implement 2 PIPs • Validate data • Utilize quality tools to identify barriers and root causes • Implement interventions • Evaluate the effectiveness of interventions	 Annually Annually Annually Quarterly

b) MSHN Advisory Councils FY23 Annual Reports

Team Name: Consumer Advisory Council
Team Leader: Todd Koopmans, Chairperson; Dan Dedloff, MSHN Staff Liaison
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The Consumer Advisory Council will be the primary source of consumer input to the MSHN Board of Directors related to the development and implementation of Medicaid specialty services and supports and Substance Use Disorder requirements in the region. The Consumer Advisory Council includes representatives from all twelve (12) Community Mental Health Services Program (CMHSP) Participants of the region.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Reviewed the changes to the FY23 MSHN Consumer Handbook
- Reviewed Quality Improvement Performance Measure Reports that included Performance Indicators, Behavior Treatment Review and Oversight, Critical Incidents, Grievance and Appeals, and Medicaid Fair Hearings
- Reviewed and provided feedback on the MSHN Satisfaction Survey results
- Reviewed and provided feedback on the MSHN Compliance Plan
- Reviewed and provided feedback on the 2023 MSHN Delegated Managed Care Reviews
- Reviewed and provided feedback on the 2024/2025 MSHN Strategic Plan
- Reviewed and provided feedback on the Quality Assessment and Performance Improvement Plan
- Reviewed and provided feedback on the MSHN Website Redesign
- Reviewed and provided feedback on MSHN Adverse Benefit Determination Training
- Education and discussion on Implicit bias, Health Disparities & MSHN Activities on Diversity, Equity, and Inclusion
- Education and discussion on Integrated Care
- Education and discussion on Michigan Medicaid Autism Benefit
- Education and discussion on HCBS Rule Updates
- Education and discussion on Conflict Free Access and Planning
- Collaboration with the Healthy Democracy Healthy People
- Education and discussion on the outcomes from the Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) and Compliance reviews
- Reviewed and revised the RCAC Charter
- Discussion and feedback on MSHN Council/Committee Survey Results
- Discussed the Public Behavioral Health System Redesign and explored advocacy opportunities.
- Improved practices for ongoing communication between MSHN and local councils
- Ongoing discussion on ways to strengthen Person Centered Planning, Independent Facilitation, and Self Determination Implementation
- Reviewed and approved RCAC annual effectiveness report
- Continued online meetings through Zoom and added an in-person meeting option.
- Explore system improvements for services directed to youth

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Provide input on regional educational opportunities for stakeholders
Provide input for ongoing strategies for the assessment of primary/secondary consumer satisfaction
Review regional survey results, including SUD Satisfaction Survey and external quality reviews
Annual review and provide feedback on the QAPIP
Annual review and feedback on the Compliance Plan
Review of the MSHN FY24 Consumer Handbook
Review and advise the MSHN Board relative to strategic planning and advocacy efforts
Provide group advocacy within the region for consumer-related issues
Explore ways to improve Person Centered Planning, Independent Facilitation, and Self Determination Implementation
Improve communication between the Regional Consumer Advisory Council and the local CMH consumer advisory groups
Explore ways to get more consumers involved in the RCAC and local consumer councils
Public Behavioral Health System Redesign Advocacy
Improve access to peer support specialists through CMHSPs

c) MSHN Oversight Policy Board FY23 Annual Report

Team Name: Substance Use Disorder (SUD) Oversight Policy Board
Team Leader: Chairperson Steve Glaser, SUD Board Member
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The Mid-State Health Network (MSHN) Substance Use Disorder (SUD) Oversight Policy Board (OPB) was developed in accordance with Public Act 500 of 2012, Section 287 (5). This law obliged MSHN to "establish a substance use disorder oversight policy board through a contractual agreement between [MSHN] and each of the counties served by the community mental health services program." MSHN/s twenty-one (21) counties each have representation on the OPB, with a designee chosen from that county. The primary decision-making role for the OPB is as follows:

- Approval of any portion of MSHN's budget containing local funding for SUD treatment or prevention, i.e. PA2 funds
- Has an advisory role in making recommendations regarding SUD treatment and prevention in their respective counties when funded with non-PA2 dollars

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Received updates and presentations on the following:
    - MSHN SUD Strategic Plan
    - MSHN SUD Prevention and Treatment Services
- Approval of Public Act 2 Funding for FY22 & related contracts
- Approved use of PA2 funds for prevention and treatment services in each county
- Received presentation on FY23 Budget Overview
- Received PA2 Funding reports – receipts & expenditures by County
- Received Quarterly Reports on Prevention and Treatment Goals and Progress
- Received Financial Status Reports on all funding sources of SUD Revenue and Expenses
- Provided advisory input to the MSHN Board of Directors regarding the overall agency strategic plan and SUD budget
- Received written updates from Deputy Director including state and federal activities related to SUD
- Received updates on MDHHS State Opioid Response Site Visit Results
- Shared prevention and treatment strategies within region
- Received information and education on opioid settlement and strategies
- Provided input on the FY24-26 MSHN SUD Strategic Plan
-

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Approve use of PA2 funds for prevention and treatment services in each county
Improve communications with MSHN Leadership, Board Members and local coalitions
Orient new SUD OPB members as reappointments occur
Increase communication with local counties/coalitions regarding use of state and local opioid settlement funding
Monitor SUD spending to ensure it occurs consistent with PA 500
Revise and sign new Intergovernmental Agreement

d) MSHN Committee FY23 Annual Reports

Team Name: Clinical Leadership Committee
Team Leader: Todd Lewicki, MSHN Chief Behavioral Health Officer
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The MSHN Operations Council (OC) has created a CLC to advise the Prepaid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) and the OC concerning the clinical operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CEO and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Address workforce shortage.
- 1915(i) service oversight transition to PIHP for annual eligibility authorizations.
- Regional input into Conflict Free Access and Planning.
- Address Wraparound services as appropriate.
- Complete appeal of service range issue with MDHHS and waiver versus non-waiver service use.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Regional input into Conflict Free Access and Planning.
Review and address need for increasing access to children's services, including acute care.
Review, report, and increase use of CRM/OPEN Beds.
Address crisis resources uniformly across the region.
Address implementation of 988/MiCAL.
Address psychiatric residential treatment facility (PRTF) as MDHHS begins implementation, as appropriate.
Advocate for crossover multi-discipline process for ICSS.
Convert region to use of the CANS.
Address Inpatient Access issues and emergency department boarding.
MSHN will identify the group most appropriate to address system reform objectives (including what, who, by when, related metrics (if any).
Establish and/or work with providers to increase specialized housing options within the region.
Continue advocacy around conflict free access and planning consistent with MSHN Board adopted resolution.

Team Name: Regional Medical Directors Committee (RMDC)
Team Leader: Zakia Alavi, MD, MSHN Chief Medical Officer
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee:
As created by the MSHN Operations Council (OC), the RMDC functions to advise the MSHN Chief Medical Officer (CMO), the MSHN Chief Executive Officer (or designee), the MSHN Chief Behavioral Health Officer (CBHO), and the OC concerning the behavioral health operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CMO, CEO (or designee), CBHO, and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Review and input into the behavioral health home initiative.
- Continued attention to Behavior Treatment Plan Review Committee feedback on medication guidelines.
- Addressed controlled substance prescription law and shared feedback with MDHHS.
- Reviewed planned updates and gave feedback to PCE prescriber module.
- Input into Population health and Integrated Care Plan and Quarterly Reports.
- Addressed staffing status for psychiatry.
- Continued input into Conflict Free Access and Planning discussion.
- Discussed DEI initiative.
- Reviewed critical incident report.
- Reviewed telemedicine bulletin MMP 23-10 and processes.
- Review and input into regional crisis residential service.
- Review and input into data, including MSHN performance improvement projects, health equity analysis.
- Review RMDC survey responses.
- Reviewed possibility of writing standards regarding nurse practitioners and physician's assistants.
- Reviewed issue of worker burnout.
- Reviewed and provided input into clinical care pathways relating to the CMH work when someone goes to the emergency room.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Address youth access to CMH services.
Continued input into behavior treatment processes.
Ongoing input into population health and integrated care.
Return to OpenBeds process conversation and define further.
Incorporate medical point of view into resource decisions, care decisions, increasing collaborative efforts. (Includes grant opportunities). Provide input into clinical leadership processes, improve linkages with CLC.
Improve collaboration with MDHHS around processes related to CMH functions (i.e., determination of hospitalization).

Team Name: Utilization Management Committee

Team Leader: Skye Pletcher, Chief Population Health Officer, MSHN

Report Period: 10.01.2022 through 9.30.2023

Purpose of Council or Committee: The Utilization Management Committee (UMC) exists to assure effective implementation of the Mid-State Health Network's UM Plan and to support compliance with requirements for MSHN policy, the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract and related Federal & State laws and regulations.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- 1915(i) service oversight transition to PIHP for annual eligibility authorizations.
- Regional input into Conflict Free Access and Planning.
- Advocacy and appeal with MDHHS for the use of service ranges in person centered plans for waiver and non-waiver services.
- Regional monitoring of timely service authorization decisions and issuance of adverse benefit determination notices, as appropriate.
- Regional monitoring of acute service utilization using MCG Behavioral Health Guidelines and achieved >95% adherence to medical necessity criteria

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
NEW - Regional input into Conflict Free Access and Planning.
NEW - Address inpatient access issues and emergency department boarding.
NEW – Review regional process for addressing in-region COFR arrangements
NEW – Implementation of MichiCANS and MiCAS
CONTINUE - Establish performance improvement priorities identified from monitoring of delegated utilization management functions.
CONTINUE - Recommend improvement strategies where adverse utilization trends are detected.
CONTINUE - Recommend opportunities for replication where best practice is identified.
CONTINUE - Address succession planning for UMC members relative to skill set needed by committee members.
CONTINUE - Continued analysis of differences in amount/scope/duration of services received by individuals enrolled in waivers and non-waiver individuals.

Team Name: Regional Compliance Committee
Team Leader: Kim Zimmerman, Chief Quality and Compliance Officer
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee:
The Compliance Committee will be established to ensure compliance with requirements identified within MSHN policies, procedures, and compliance plan; the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract; and all related Federal and State laws and regulations, inclusive of the Office of Inspector General guidelines and the 42 CFR 438.608.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Revised and approved the 2023 MSHN Compliance Plan
- Provided feedback and approval for the FY2022 Annual Compliance Summary Report
- Reviewed and updated the committee charter.
- Reviewed HSAG Compliance Site Review Findings – Developed plan of correction for findings specific to compliance standards
- Reviewed Compliance Section for Managed Care Program Annual Report (MCPAR)
- Provided feedback on MEV site review process and updates.
- Reviewed proposed revisions to the 42 CFR Part 2 to ensure regional compliance.
- Consensus on use of signatures within the Electronic Health Records
- Reviewed results council/committee surveys- implemented changes based on feedback.
- Provided feedback on 2024-2025 MSHN Strategic Plan
- Updated Privacy Notice to ensure compliance with federal and state standards and developed consistent distribution processes.
- Medicaid Policy Updates: Telehealth compliance and end of public health emergency
- Reviewed the revised FY2023 OIG Quarterly Report changes, guidance documents, fraud referral form, and submission requirements.
- Ongoing review of 21st Century Cures Act for compliance with standards
- Ongoing review of CMH Patient Access Rule and InterOp Station for compliance with standards
- Reviewed trends in the OIG Quarterly Reports for needed systemic changes, etc.
- Reviewed information provided at the PIHP Compliance Officers meetings and MSHN Compliance Committee meetings.
- Provided consultation on local compliance related matters.
- Reviewed and provided feedback on MSHN compliance policies and procedures.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Identify compliance related educational opportunities including those aimed at training compliance officers
Review methods of assessing risks and findings for detection of fraud and abuse for potential improvements and efficiencies

Team Name: Provider Network Committee
Team Leader: Leslie Thomas, MSHN CFO
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: PNMC is established to provide counsel and input to Mid-State Health Network (MSHN) staff and the Operations Council (OC) with respect to regional policy development and strategic direction. Counsel and input will typically include: 1) network development and procurement, 2) provider contract management (including oversight), 3) provider qualifications, credentialing, privileging and primary source verification of professional staff, 4) periodic assessment of network capacity, 5) developing inter- and intra-regional reciprocity systems, and 6) regional minimum training requirements for administrative, direct operated, and contracted provider staff. In fulfilling its charge, the PNMC understands that provider network management is a Prepaid Inpatient Health Plan function delegated to Community Mental Health Service Programs (CMHSP) Participants. Provider network management activities pertain to the CMHSP direct operated and contract functions.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Addressed findings from HSAG audit, specific to provider credentialing and recredentialing systems; revised policies and procedures.
- Established regionally approved and executed CRU agreement with FHPCC.
- Continued to refine and support the statewide and intra-regional provider performance monitoring protocols resulting in improved provider performance and administrative efficiencies.
- Established and continued with an intra-regional provider performance monitoring protocol for ABA/Autism provider network; continued regional provider performance monitoring for Fiscal Intermediary and Inpatient Psychiatric Services.
- Establish relevant key performance indicators for the PNMC scorecard.
- Continued to monitor and refine regional provider directory to ensure compliance with managed care rules.
- Reviewed, revised, and issued regional contracts for Autism/ABA, Inpatient Psychiatric, and Fiscal Intermediary Services.
- Improved and continued coordination with regional recipient rights officers to support contract revisions.
- Continued implementation of statewide training reciprocity plan within the MSHN region.
- Development and continued support of regional training coordinators workgroup to support implementation.
- Completed and rolled out regional web-based provider application.
- Provided input into PCE Provider Management Module enhancements.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Address recommendations from the 2023 assessment of Network Adequacy as it relates to provider network functions; update the Assessment of Network Adequacy to address newly identified needs;
Develop an action plan to address repeat findings related to provider credentialing and recredentialing process requirements through training/technical assistance and monitoring; monitoring and oversight of CMHSPs demonstrate improvement in credentialing and credentialing systems;
Establish relevant key performance indicators for the PNMC scorecard;

Monitor and implement Electronic Visit Verification as required by MDHHS;
Initiatives to support reciprocity: •Contracting: ✓ Develop regionally standardized boilerplate and statement of work for: Therapeutic Camps, Community Living Supports, Residential, Vocational; Independent Facilitation Procurement: ✓ Fully implement the use of a regional web-based provider application; ✓ Publish provider selection processes on MSHN web; •Monitoring: ✓ Fully implement specialized residential reciprocity provider monitoring plan; ✓ Training: ✓ All CMHSPs will have 100% of applicable trainings vetted in accordance with the training reciprocity plan;
Advocate for direct support professionals to support provider retention (e.g. wage increase; recognition)
Develop and implement regionally approved process for credentialing/re-credentialing reciprocity
Develop regionally standardized boilerplate and statement of work for: CLS / Specialized Residential Services

Team Name: Customer Services Committee
Team Leader: Dan Dedloff, Customer Service & Rights Manager
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The Customer Services Committee was formed to draft the Consumer Handbook and to develop policies related to the handbook, the Regional Consumer Advisory Council (RCAC), and Customer Services. The Customer Services Committee (CSC) will continue as a standing committee to assure the handbook is maintained in a compliant format, and to support development and implementation of monitoring strategies to assure regional compliance with CS standards. This committee will be supported by the Chief Compliance and Quality Officer and will report through the Quality Improvement Council (QIC).

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Reviewed, revised, facilitated publication of, and completed regional distribution for the MSHN FY23 Consumer Handbook
- Facilitated publication and electronic regional distribution of the MSHN FY23 Consumer Handbook: Spanish language version for each of the 12 CMHSP and the MSHN SUD Provider Handbook
- Reviewed, analyzed and reported regional customer service information for:
    - Grievances
    - Appeals
    - Medicaid Fair Hearings
    - Recipient Rights
- Defined what would be considered a cultural competency request (CCR) to support network adequacy.
- Reviewed the FY22 HSAG Compliance Review results and collaborated to develop the HSAG corrective action plan.
- Reviewed and provided feedback on the Mid-State Health Network (MSHN) 2024/2025 Strategic Plan.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Conduct an annual review and revise the MSHN Consumer Handbook to reflect contract updates and regional changes
Continue reporting and monitoring Customer Service information
Continue to explore regional Customer Service process improvements
Continue to develop, where applicable, MSHN standardized regional forms
Continue to identify Educational Material/Brochures/Forms for standardization across the region
Complete the bi-annual review, update, and approval of the MSHN Customer Service Policies and Procedure.
Develop and distribute an Adverse Benefit Determination Frequently Asked Questions document.

Team Name: Regional Equity Advisory Committee for Health (REACH)
Team Leader: Shelly Milligan (REACH Facilitator); Dani Meier, Chief Clinical Officer (MSHN Lead)
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee:

REACH is an advisory body of community stakeholders established for the following purposes:

- Ensure attention to issues of equity, including reducing health disparities in access and delivery of quality behavioral health and substance use disorder (SUD) prevention, treatment and recovery programs.
- Inform development and review of MSHN policies, procedures and practices through the lens of diversity, equity and inclusion (DEI).
- Incorporate a trauma-informed perspective that accounts for historical and racialized trauma.
- Address stigma and bias that may impact health outcomes.

Annual Evaluation Process:

A. Past Years Accomplishments. FY23

- REACH assisted with review of "Better Equity" strategic priority as MSHN updated its FY24-25 MSHN Strategic Plan.
- REACH assisted with review of MSHN's updates to its FY24-26 SUD strategic plan, in particular, the goals related to reducing health disparities was shared with REACH for their review.
- REACH participated in preparation and planning for MSHN's *Equity Upstream* Spring Lecture series. Several REACH members participated in various capacities in the actual trainings.
- REACH was part of preparation and planning for MSHN's *Equity Upstream* Learning Collaborative (LC) and continues to support direction and strategies related to LC activities.
- REACH members are and will be assisting with mechanisms to engage community members in seeking feedback from impacted minority communities who are underrepresented in our treatment population.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
1. Increase data sharing around equity activities and reducing health disparities
2. Support community engagement to inform Learning Collaborative activities
3. Review LC Action Plans relative to impacting health disparities
4. Support for IDEA Workgroup's internal review of MSHN policies, hiring, etc.

e) MSHN Workgroups FY22 Annual Reports

Team Name: Autism Benefit Workgroup
Team Leader: Tera Harris, Waiver Coordinator
Report Period: 10.01.2022 through 9.30.2023
Purpose of the Autism Benefit Workgroup: The Autism Benefit Workgroup was established to initiate and oversee coordination of the autism benefit for the region. The Autism Benefit Workgroup is comprised of the MSHN Waiver Coordinator, the Community Mental Health Service Provider (CMHSP) autism benefit staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director, and other subject matter experts as relevant. The Autism Benefit Workgroup is chaired by the MSHN Waiver Coordinator. All CMHSPs are equally represented on this workgroup.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Helped MSHN region transition to and ensure understanding of post-pandemic policies.
- Developed a monitoring system to address timely service delivery.
- Encouraged attendance and participation in Michigan Autism Council and Autism Alliance of Michigan meetings.
- Served as advocates for the region while working to inform and collaborate with newly formed MDHHS autism section.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Table 3

Goal	Objectives/Activities	Frequency/Due Date
Improve and develop solutions to ensure timely service delivery as evidenced by an increase in network provider capacity including, but not limited to, qualified licensed practitioners (to complete comprehensive diagnostic evaluation) and Applied Behavior Analysis providers (to carryout treatment).	1. Outreach to providers within the state to increase opportunities for autism benefit enrollees to participate in medically necessary services. 2. Share list of available providers with the region as well as regional results of ongoing monitoring of current providers. 3. CMHSP representatives will connect with available providers in consideration of additional contracts.	Frequency: throughout the fiscal year. Due date: 9/30/2024
Adjust to code changes and new policy language.	1. Become aware of and understand the changes that are implemented by MDHHS. 2. Advocate for stabilization of policy to support quality service delivery. 3. Inform network and stakeholders when policy changes are proposed	Frequency: throughout the fiscal year. Due date: 9/30/2024

	and initiated.	
Ensure regional representation at quarterly MSHN Autism Workgroups.	1. MSHN to continue to send workgroup meeting invitations and agendas in a timely manner to encourage attendance. 2. Follow-up with CMHSPs that do not have consistent representation at quarterly workgroup meetings.	Frequency: throughout the fiscal year. Due date: 9/30/2024

Team Name: Children's Waiver Program (CWP) Workgroup
Team Leader: Tera Harris, Waiver Coordinator
Report Period: 10.01.2022 through 9.30.2023
Purpose of the CWP Workgroup: The CWP Workgroup was established to initiate and oversee coordination of the CWP for the region. The CWP Workgroup is comprised of the MSHN Waiver Coordinator, the Community Mental Health Service Provider (CMHSP) CWP staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director, and other subject matter experts as relevant. The CWP Workgroup is chaired by the MSHN Waiver Coordinator. All CMHSPs are equally represented.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Completed two separate CWP 101 trainings (10.04.2022 and 10.18.2022), with virtual options, in partnership with MDHHS (141 attendees total).
- Ensured full implementation of corrective action plan related to MDHHS and MSHN CWP findings.
- Helped MSHN region transition to and ensure understanding of post-pandemic policies.
- Demonstrated continued improvement on DMC reviews as evidenced by increased compliance scores (FY21 average chart review score 93.98%; FY23 average chart review score 98.53%).

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Table 2
Goal
Increase network provider capacity including, but not limited to, specialty services (recreation therapy, art therapy, and music therapy), CLS, and respite.
Prepare for upcoming MDHHS Home and Community Based Waiver Review to occur in 2024.
Begin to introduce and familiarize the region with the MichiCANS assessment system during the soft launch period with the required full implementation set for October 2024.
Continue to increase attendance rates at quarterly workgroup meetings to ensure all CMHSPs are adequately informed and have the resources available to enroll and maintain a youth in the CWP.

Team Name: Home and Community-Based Services (HCBS) Workgroup
Team Leader: Kara Hart, Home & Community Based Services Waiver Administrator
Report Period Home and Community-Based Services (HCBS) Workgroup**:** 10.01.2022 through 9.30.2023
Purpose of Council or Committee:
The HCBS Workgroup was established to initiate and oversee coordination of the HCBS program for the region. The HCBS Workgroup is comprised of the Waiver Administrator (Adults), Waiver Coordinators, and the Community Mental Health Service Provider (CMHSP) HCBS staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director. The Waiver Administrator chairs the HCBS Workgroup, and the Waiver Coordinators facilitate. All CMHSPs are equally represented.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Completed site visits and data cleanup regarding the 2020 HCBS Final Rule Survey Data.
- Surveyed, assessed, and remediated, when necessary, individuals/providers for HCBS Compliance.
- Facilitated discussion on the expectations and concerns relating to the MDHHS Community Transition Program (MCTP) releasing individuals into HS facilities.
- Provided information regarding HCBS Final Rule and their intersection with the BTP process.
- Allowed for the discussion of complex cases and the barriers to placing individuals of high needs.
- Provided updates regarding HCBS sites determined to be Heightened Scrutiny.
- Provided ongoing updates regarding MDHHS role changes and structural shifts as it relates to HCBS.
- Provided support, guidance, and reminders regarding the WSA.
- Reviewed best practice strategies to address potential barriers to attaining full HCBS resolution.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Establish a monitoring process to ensure HCBS settings within the Mid-State Health Network region maintain positive HCBS compliance status.
Continue to remediate and validate HCBS survey responses and provisional approval data as it becomes available from MDHHS.
Work to resolve identified conflicts between HCBS compliance and licensing (LARA) recommendations to ensure site and case compliance with MDHHS guidelines and expectations.
Continue to provide clear guidance on MDHHS guidelines and expectations for the provisional approval process.

Team Name: Habilitative Supports Waiver Workgroup
Team Leader: Victoria Ellsworth, Waiver Coordinator
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The HSW Workgroup was established to initiate and oversee coordination of the HSW program for the region. The HSW Workgroup is comprised of the Waiver Coordinator and the Community Mental Health Service Provider (CMHSP) HSW staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director. The HSW Workgroup is chaired by the Waiver Coordinator. All CMHSP's are equally represented.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Identified potential candidates for enrollment in the HSW to increase slot allocation.
- Distributed monthly HSW reports and monthly overdue and coming due data.
- Tracking and reporting on reason for and number of HSW recertification pend backs from both MHSN and MDHHS.
- Worked through continued challenges related to monitoring initial HSW applications and recertifications for restrictive and intrusive technique and/or Behavior Treatment Plans.
- Received information provided by MDHHS and successfully implemented changes.
- Continued to implement adjustments related to service delivery and administrative tasks due to COVID-19 pandemic.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Ensure full implementation of corrective action related to MDHHS and MSHN HSW findings.
Demonstrate improvement on DMC review scores for HSW program specific standards and clinical charts.
Achieve a minimum 95% utilization of allocated HSW slots for the region.
Eliminate monthly unsubmitted/past due HSW recertifications based on established due dates from MSHN and MDHHS.
Increase the timeliness of responses to concerns related to initial HSW applications and recertification reviews to align with the 15-day protocol requested by MDHHS.
Ensure transition, as appropriate, from HSW to 1915(i) for all cases that are being disenrolled or going into inactive status.
Prepare for the upcoming MDHHS Home and Community Based Waiver Review set to occur in 2024.

Team Name: Serious Emotional Disturbance Waiver (SEDW) Workgroup
Team Leader: Tera Harris, Waiver Coordinator
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee:
The SEDW Workgroup was established to initiate and oversee coordination of the SEDW for the region. The SEDW Workgroup is comprised of the MSHN Waiver Coordinator, the Community Mental Health Service Provider (CMHSP) SEDW staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director, and other subject matter experts as relevant. The SEDW Workgroup is chaired by the MSHN Waiver Coordinator. All CMHSPs are equally represented.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Increased overall enrollments by six percent (from August 2022-August 2023). This included one CMHSP that did not have enrollees, adding one enrollee. Eleven out of 12 CMHSPs now have enrollees.
- Completed two separate SEDW 101 trainings (10.03.2022 and 10.17.2022), with virtual options, in partnership with MDHHS (154 attendees total).
- Helped MSHN region transition to and ensure understanding of post-pandemic policies.
- Completed full implementation of corrective action plan related to MDHHS and MSHN SEDW findings.
- Held regional Wraparound consultation with Heather Valentiny (MDHHS) on July 6, 2023 (35 attendees).

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Increase network provider capacity including but not limited to, specialty services (recreation therapy, art therapy, and music therapy), CLS, and respite, as appropriate.
Begin to introduce and familiarize the region with the MichiCANS assessment system during the soft launch period with the required full implementation set for October 2024.
Review and respond to system changes as influenced by Michigan Intensive Child and Adolescent Service Array (MICAS).
Prepare for upcoming MDHHS Home and Community Based Waiver Review to occur in 2024.

IV. Definitions/Acronyms

Community Mental Health Services Program (CMHSP): A program operated under Chapter 2 of the Michigan Mental Health Code - Act 258 of 1974 as amended.

CMHSP Participant refers to one of the twelve-member Community Mental Health Services Program (CMHSP) participant in the Mid-State Health Network.

Contractual Provider refers to an individual or organization under contract with the MSHN Pre-Paid Inpatient Health Plan (PIHP) to provide administrative type services including CMHSP participants who hold retained functions contracts.

Critical Incident Reporting System (CIRS): Suicide; Non-suicide death; Arrest of Consumer; Emergency Medical Treatment due to injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of physical management; Hospitalization due to Injury or Medication Error: Hospitalization due to injury related to the use of physical management.

Customer: For MSHN purposes customer includes all Medicaid eligible individuals (or their families) located in the defined service area who are receiving or may potentially receive covered services and supports. The following terms may be used within this definition: clients, recipients, enrollees, beneficiaries, consumers, primary consumer, secondary consumer, individuals, persons served, Medicaid Eligible.

Long Term Services and Supports (LTSS)- Older adults and people with disabilities who need support because of age; physical, cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves, and who receive care in home-community based settings, or facilities such as nursing homes. (42 CFR §438.208(c)(1)(2)) MDHHS CQS – identify the Home and Community Based Services Waiver. MI-Choice to be recipients of LTSS.

Prepaid Inpatient Health Plan (PIHP): In Michigan a PIHP is defined as an organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR part 401 et al June 14, 2002, regarding Medicaid managed care. (In Medicaid regulations, Part 438. Prepaid Health Plans (PHPs) that are responsible for inpatient services as part of a benefit package are now referred to as "PIHP" The PIHP also known as a Regional Entity under MHC 330.1204b also manages the Autism ISPA, Healthy Michigan, Substance Abuse Treatment and Prevention Block Grant and PA2. "

Provider Network: Refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP's subcontractors.

Research: (as defined by 45 CFR, Part 46.102) means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.

Root Cause Analysis (RCA): Root Cause Analysis: A root cause analysis (JCAHO) or investigation (per CMS approval and MDHHS contractual requirement) is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance." (JCAHO, 1998)

Sentinel Event (SE): Is an "unexpected occurrence" involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1998). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event

Stakeholder: A person, group, or organization that has an interest in an organization, including consumers, family members, guardians, staff, community members, and advocates.
Subcontractors: Refers to an individual or organization that is directly under contract with CMHSP and/or SRE to provide services and/or supports.
SUD Providers: Refers to substance use disorder providers directly contracted with MSHN to provide SUD treatment and prevention services.
Vulnerable Person- An individual with a functional, mental, physical inability to care for themselves.

Acronyms

ABA: Applied Behavioral Analysis
BTPRC: Behavior Treatment Plan Review Committee
BHH: Behavioral Health Home
CBHO: Chief Behavioral Health Officer
CCC: Corporate Compliance Committee
CCBHC: Certified Community Behavioral Health Clinic
CLC: Clinical leadership Committee
COFR: County of Financial Responsibility
CSC: Customer Services Committee
CMS: Center for Medicare/Medicaid Services
CQS: Comprehensive Quality Strategy
CWP: Child Waiver Program
EQR: External Quality Review
FC: Finance Committee
HCBS: Home and Community Based Standards
HSAG: Health Services Advisory Group
HSW: Habilitation Supports Waiver
ITC: Information Technology Committee
MEV: Medicaid Event Verification
MHSIP: Mental Health Statistics Improvement Program
MMBPIS: Michigan Mission Based Performance Indicator System
OHH: Opioid Health Home
PNMC: Provider Network Management Committee
QIC: Quality Improvement Council
SEDW: Severe Emotional Disturbance Waiver
UMC: Utilization Management Committee
YSS: Youth Satisfaction Survey

VII. Attachments

Attachment 01 MSHN QAPIP Communication

Attachment 02 MMBPIS Performance Summary FY23Q3

Attachment 03 FY23 Q2-Q3 Integrated Health Quarterly Report

Attachment 04 PIP #1 Access-Reduction of Disparities Monitoring

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QUALITY IMPROVEMENT PROGRAM PLAN FY2024

10/01/2023 - 9/30/2034

PREPARED BY: CMHA-CEI QUALITY IMPROVEMENT TEAM – MARCH 2024

APPROVED BY: BOARD OF DIRECTORS –

Community MENTAL HEALTH
CLINTON • EATON • INGHAM

Together we can.

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SECTION 1: OVERVIEW

Purpose

Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI) is the Community Mental Health Service Provider (CMHSP) for Clinton, Eaton, and Ingham Counties. The Quality Improvement Program (QIP) provides assurance that CMHA-CEI achieves alignment with healthcare reform and demonstrates to its consumers, advocates, community organizations, health care providers, and State policymakers that it is distinctly competent as an efficient, high-performing, evidence-based, quality-focused, and customer-focused provider of mental health and substance use disorder services. CMHA-CEI's QIP aligns with quality standards and expectations of the Michigan Department of Health and Human Services (MDHHS), Mid-State Health Network (MSHN), the Balanced Budget Act (BBA), the Commission on Accreditation of Rehabilitation Facilities (CARF), and Certified Behavioral Health Clinic (CCBHC). MSHN has delegated the responsibility of the development and implementation of a QIP in accordance with its Quality Assessment and Performance Improvement Plan to each of the CMHSP members within the region. CMHA-CEI annually develops a QIP plan to assure high quality services to our consumers.

Introduction

The QIP establishes a framework for quality and accountability for the safety of consumers. CMHA-CEI's QIP plan details the structure, scope, activities, and functions of the CMHA-CEI's overall Quality Improvement Program. The QIP plan describes core activities and functions that are conducted by CMHA-CEI and its network of contracted service providers. It is the responsibility of CMHA-CEI to ensure that the QIP meets applicable Federal and State laws, contractual requirements, and regulatory standards. The term of the QIP plan begins 10/01/2023 and ends 09/30/2024. Upon expiration of the term, the QIP plan shall remain in effect until CMHA-CEI's Board of Directors approves a new QIP plan. The QIP incorporates by reference any and all policies and procedures necessary to operate as a CMHSP.

Mission, Vision, and Philosophy

Mission

The organization's mission is to fulfill two complementary but distinct roles in realizing this vision:

> As a behavioral healthcare provider: Providing, directly and through partnerships, a comprehensive set of person-centered, high quality, and effective behavioral health and developmental disability services to the residents of this community.
>
> As an advocate, catalyst, thought leader, and convener: Fostering the transformation of all aspects of community life, eliminating inequities, and promoting the common good for all, especially for persons with mental health needs.

Vision

CMHA-CEI holds this vision of a community: As one in which any person with a mental health need has access to a wide range of resources to allow them to seek their desired quality of life and to participate, with dignity, in the life of the community, with its freedoms and responsibilities. As well as one that is defined by justice for persons with mental health needs. Persons with mental health needs include those with a mental illness, an emotional disturbance, a developmental disability, and/or a substance use disorder

Clinical Philosophy

CMHA-CEI will strive to serve persons with a broad range of mental health and substance abuse needs. Further, the organization has a primary commitment (as per statutory guidance provided by the Michigan Mental Health Code) to persons with serious and persistent mental illness or an impairing personal life crisis, children who are seriously emotionally disturbed, and persons with significant developmental disabilities. These principles apply to the services and supports directly provided by or contracted through CMHA-CEI.

Scope of the QIP

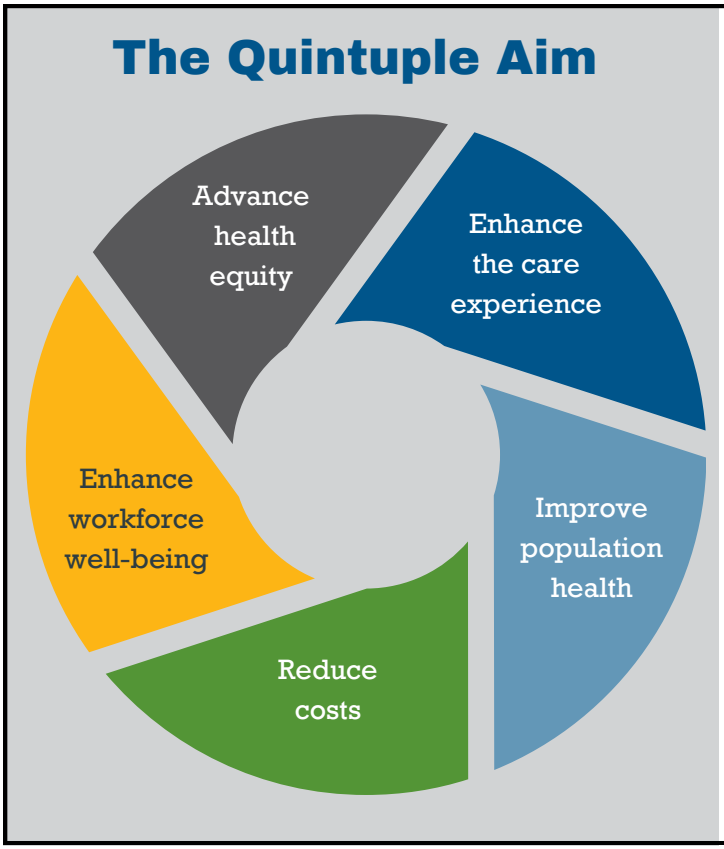
The scope of the QIP includes all of CMHA-CEI as community mental health service provider and Certified Behavioral Health Clinic (CCBHC), and its contractors. It identifies the essential processes and aspects of care, both clinical and non-clinical, required to ensure quality supports and services for recipients. CMHA-CEI assures that all demographic groups, care settings, and types of services, including consumers, advocates, contract providers, and community groups, are included in the scope of the QIP and quality improvement processes using a continuous quality improvement (CQI) perspective.

The QIP applies to all CMHA-CEI programs and services. The objectives of the program are reflected in the organization's mission statement. A representative group of leadership and clinical staff participate in the Quality Improvement and Compliance Committee (QICC), which includes quality improvement staff. Designated program staff are responsible for performance measurement and management within their programs. This may include coordination and follow up with the Quality Improvement team. CMHA-CEI adheres to the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care.

The QIP plan serves as an ongoing monitoring and evaluation tool that measures CMHA-CEI's plans, processes and outcomes to influence practice-level decisions for consumer care. It is intended to address several functions, including but not limited to:

- Improve consumer health (clinical) outcomes that involve both process outcomes (e.g., recommendation for screening and assessments) and health outcomes (e.g., reduced morbidity and mortality, integration of behavioral and physical health).
- Improve efficiencies of managerial and clinical processes.
- Improve processes and outcomes relevant to high-priority health needs.
- Reduce waste and cost associated with system failures and redundancy.
- Avoid costs associated with process failures, errors, and poor outcomes.
- Implement proactive processes that recognize and solve problems before they occur.
- Ensure that the system of care is reliable and predictable.
- Promote a culture that seeks to continuously improve its quality of care.

CMHA-CEI utilizes the "Quintuple Aim" to help guide us in quality improvement initiatives.



The 5 components of the Health Quintuple Aim are:

1. **Improve the patient experience of care:** Focuses on providing a positive and personalized experience for patients, including improved communication, access to care, and patient engagement
2. **Improve the health of populations:** Improving the health outcomes of entire populations, rather than just individual patients, achieved through community-based interventions, and addressing social determinants of health.
3. **Reduce the per capita cost of health care:** Reducing the amount of money spent on health care for each individual, while still achieving improved health outcomes.
4. **Enhance the experience of the workforce:** Recognizes that the well-being and satisfaction of health care providers is essential to delivering high-quality care. This can be achieved through initiatives such as provider wellness programs, professional development opportunities, and more.
5. **Improve Health Equity:** Ensuring that health care is delivered in a way that is evidence-based, effective, safe, and equitably offered to all populations.

MDHHS QIP Mandate

The Michigan Department of Health and Human Services (MDHHS) mandates that CMHSPs have a QIP and a QIP plan. CMHA-CEI has several contracts with the MDHHS for the provisions of Managed Specialty Supports and Services (Medicaid), General Fund, and waiver services for mental health and substance abuse and must comply with Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 24 – Attachment P7.9.1 "Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans" and CMHSP Managed Mental Health Supports and Services Contract FY 24: Attachment C6.8.1.1 "Quality Improvement Programs for CMHSPs" and the Application for Renewal and Commitment.

CCBHC QIP Requirement

CMHA-CEI is certified as a CCCBHC by the state of Michigan. CCBHC's are required to develop, implement, and maintain an effective, CCHBC-wide-date-driven continuous quality improvement (CQI) plan for clinical services and clinical management. The CQI projects are clearly defined, implemented, and evaluated annually. The number and scope of distinct CQI projects conducted annually are based on the needs of the CCBHC's population and reflect the scope, complexity, and past performance of the CCBHC's services and operations. The CCBHC-wide CQI plan addresses priorities for improved quality of care and client safety and requires all improvement activities to be evaluated for effectiveness. The CQI plan focuses on indicators related to improved behavioral and physical health outcomes and takes actions to demonstrate improvement in CCBHC performance. The CCBHC documents each CQI project implemented, the reasons for the projects, and the measurable progress achieved by the projects. One or more individuals are designated as responsible for operating the CQI program. The QIP serves as the CCBHC CQI Plan.

SECTION 2: ORGANIZATIONAL STRUCTURE

Organizational elements and activities and their relation to the QIP, and performance improvement activities in general are detailed below:

Governance

Michigan Department of Health and Human Services (MDHHS)

The department carries out responsibilities specified in the Michigan Mental Health Code and the Michigan Public Health Code, and administers Medicaid Waivers for people with developmental disabilities, severe and persistent mental illness, serious emotional disturbance, and substance use disorders.

Prepaid Inpatient Health Plan (PIHP)

MDHHS appoints regional PIHPs to work with CMHSPs. The regional PIHP that partners with CMHA-CEI is Mid-State Health Network (MSHN). MSHN provides oversight on standards, requirements, and regulations from MDHHS and is responsible for maintaining high-quality service delivery systems for persons with serious and persistent mental illness, serious emotional disturbance, developmental disabilities, and substance use disorders.

CMHA-CEI Board of Directors

The Board of Directors is the governing body of CMHA-CEI and has ultimate responsibility for the quality of care and services delivered by the organization. It upholds CMHA-CEI's commitment to continuous quality improvement, including the allocation of resources for organizational performance-related endeavors. The Board of Directors delegates day-to-day operational responsibility and accountability for organizational performance improvement to the Chief Executive Officer. Annually, the Board of Directors reviews and formally adopts the following documents:

- Annual Quality Assessment and Performance Improvement Plan (QAPIP) created by MSHN.
- Annual Evaluation of the QAPIP created by MSHN.
- Annual Quality Improvement Program Plan.
- Ad hoc reports and position papers related to performance improvement.

Director Group

The Director Group at CMHA-CEI includes employees at the director and officer level. They are: The Chief Executive Officer, Chief Financial Officer, Chief Human Resource Officer, Chief Information Officer, Medical Director, Director of Quality, Customer Service and Recipient Rights, Director of Adult Mental Health Services, Director of Community Services for the Developmentally Disabled, Director of Families Forward, and the Director of Integrated Treatment and Recovery Services (formerly Substance Abuse Services). The Director Group determines organizational strategy and thus is a key player in the creation of the QIP. Together with the QI team, they ensure alignment between performance improvement activities and CMHA-CEI's long term vision. The Director Group actively participates in the implementation and evaluation of the QIP as outlined in the QIP plan.

CMHA-CEI Management and Staff

Chief Executive Officer

The Chief Executive Officer links the strategic planning and operational functions of the organization with the QIPs, assures coordination among organizational leaders to maintain quality and consumer safety, allocates adequate resources for the QIP, and designates a person to be the leader responsible for the QIP.

The Director of Quality, Customer Service, and Recipient Rights is the leader responsible for the daily management of the QIP, which includes implementation, monitoring, and revision.

Medical Director

The Medical Director provides clinical oversight related to the quality and utilization of services through case supervision, participation in Root-Cause Analyses (RCA), review of clinical incidents, and participation in relevant committees.

Director of Quality, Customer Service, and Recipient Rights (QCSRR)

The Director of QCSRR has overall responsibility for implementation of the QIP and provides delegated oversight and leadership for the QIP. Under the director's leadership, an integrated, interdivisional approach is taken to improve CMHA-CEI services and systems.

Quality Improvement (QI) Staff

QI staff initiate, coordinate, and collaborate on performance improvement projects at CMHA-CEI. They sit on the Quality Improvement and Compliance Committee and are also represented on several other committees and workgroups within the agency and throughout the region. QI staff also participate in regional performance-measurement activities which include data collection, review of clinical records, and provider monitoring. Other projects include application for and renewal of accreditation, assistance with preparation for various audits, and developing and implementing plans of correction.

Other CMHA-CEI Staff

All CMHA-CEI staff, volunteers, and interns contribute to quality and performance improvement processes. This occurs in a variety of ways, including program representation at the Quality Improvement and Compliance Committee, collaboration with QI staff on quality and performance-improvement activities, incident reporting, and carrying out the agency's mission and vision while providing direct care.

Committees and Advisory Bodies

MSHN Quality Improvement Council

MSHN's Quality Improvement Council was established as a mechanism for oversight and advice related to quality improvement matters. The council is chaired by MSHN's Quality Manager. Council membership includes quality and performance representatives from each of the region's participating CMHSPs. The council reports to the MSHN Operations Council and MSHN Chief Executive Officer.

Quality Improvement and Compliance Committee (QICC)

The CMHA-CEI QICC provides oversite of the QIP by supporting and guiding the implementation of quality improvement activities. Participants of QICC include the Chief Executive Officer, Director of QCSRR, Medical Director, directors of clinical programs, Chief Human Resources Officer, Chief Information Officer, Chief Financial Officer, QI staff, compliance staff, and other staff as needed. The QICC approves the QIP plan annually and has the opportunity to review, evaluate, and make suggestions as needed. Other topics covered at QICC include system-wide trends and patterns of key indicators, opportunities for improvement, discussion of results from chart reviews, agency policies and procedures, and establishment of organizational/program goals and objectives.

QICC Performance Indicator Improvement Workgroup

In 2022, The QI Team formed a workgroup within QICC composed to address processes and outcomes from Performance Indicators (PIs). The initial goals of the group are to solidify a uniform process for documenting events and episodes for PI 2a (timeliness to assessment from initial inquiry) and PI 3 (timeliness to start of service from assessment). Information Services (IS), Quality Improvement (QI), Access, and clinical programs for Adult Mental Health Services, Families Forward (Youth with Serious Emotional Disturbance), and Community Services for the Developmentally Disabled (Adult and Youth IDD) will convene regularly to discuss protocol and work to update guidelines for documenting reasons for non-compliance in the electronic health record. In 2023, the goals and objectives of the group were met and the review and reporting of Performance Indicators returned to QICC.

External Meetings and Data Review Committee

The External Meetings and Data Review Committee reviews initiatives, data, and activities that are occurring at External Meetings that CMHA-CEI staff attend. These meetings may be at the PIHP level, MDHHS Workgroups or Committees, or Community Workgroups. Membership includes the Chief Executive Officer, Director of QCSRR, Medical Director, Directors of clinical programs, Chief Human Resources Officer, Chief Information Officer, Chief Financial Officer, QI staff, contract Manager, compliance staff, and other staff as needed. The purpose of this Committee is to ensure uniformity of understanding across departments of happenings that may impact our agency and discuss action plans as needed.

Critical Incident Review Committee (CIRC)

The Critical Incident Review Committee provides oversight of the critical/sentinel event processes, which involve the reporting of all unexpected incidents involving the health and safety of the consumers within the CMHA-CEI's service-delivery area. Incidents include consumer deaths, medication errors, behavioral episodes, arrests, physical illness, and injuries. Membership consists of the Director of QCSRR, Medical Director, compliance staff, QI staff, and representation from all four clinical programs as applicable. The goal of CIRC is to review consumer deaths and assign a cause of death, and to review critical incidents, including consumer deaths, to ensure a thorough review was conducted and, if needed, provide a plan to ensure similar incidents do not reoccur. Incident report data is reviewed by CIRC for policy review and implementation, patterns, trends, compliance, education and improvement, and presentation to QICC.

Medication and Pharmacy Committee (MAP)

The Medication and Pharmacy Committee facilitates the review of all medication incidents and communication between the contracted pharmacy and clinical programs. Other ongoing objectives of the MAP committee include trend analysis of medication incidents, dissemination of medication information from the contracted pharmacy to clinical programs, response to coordination issues between the contracted pharmacy and clinical programs, and review and development of other medication-specific processes or procedures. Membership of MAP consists of the Medical Director, Agency-wide Senior Registered Nurse, representation from QI, representation from all four clinical programs, and representation from the contracted pharmacy. MAP reports to QICC.

Behavior Treatment Committee (BTC)

The BTC consists of the Chairperson, psychiatrist (who is the Chairperson), a licensed psychologist, and, as an ex-officio member, a Recipient Rights Specialist. Other members of the BTC include QI staff who request and prepare documentation and facilitate the BTC meeting. The BTC reviews and approves or disapproves any plans that propose the use of restrictive or intrusive interventions with individuals served by the public mental health system who exhibit seriously aggressive, self-injurious, or other behaviors

that place the individual or others at risk of physical harm. As part of this review, the committee evaluates the effectiveness of behavior treatment plans and the use of behavioral interventions. Data and a descriptive summary are submitted quarterly for review to CIRC, the PIHP, and MDHHS.

Safety Committee

The Safety Committee ensures that the work environment is maintained adequately and that protections from potential hazards are in place. It does so by overseeing the development and review of applicable policies, procedures, and emergency response plans. In addition, the committee monitors state and federal regulatory standards and accreditation standards.

The committee also reviews and monitors performance on various safety-related components of the environment. They include: environmental concerns related to employee and consumer infections, environmental concerns related to reported employee accidents, incidents and illnesses, safety and facility inspections at CMHA-CEI sites and group homes, and emergency drills. When trends or patterns in this data are recognized, the committee is responsible for making recommendations to management to resolve safety issues.

Consumer Advisory Council (CAC)

CMHA-CEI promotes and encourages active consumer involvement and participation within the community. The primary source of consumer input is through the CAC. As CMHA-CEI is a Certified Community Behavioral Health Clinic (CCBHC) there is a requirement through SAMHSA is to ensure consume participation. The CAC provides meaningful input to the board about policies, processes, and services to meet this requirement. The CAC meets at least quarterly and provides insight and direction to organizational strategy, advocacy, and outreach, and contributes to the monitoring and oversight of consumer and community engagement efforts. This could include but is not limited to involvement with policy and program development, performance indicator monitoring, QI projects, satisfaction findings, consumer advocacy, local access and service delivery, and consumer/family education. Membership to the CAC is open to both primary and secondary consumers.

Healthcare Integration Committee

CMHA-CEI is seen as a convener and partner in the implementation of healthcare integration by providing meaningful and manageable approaches in achieving outcomes to improve the overall quality of life for those we serve. The Healthcare Integration Committee ensures the agency is meeting the healthcare-integration vision. To help achieve this vision, the committee is specifically looking at three areas: Partnering with Primary Care Physicians, Treatment Plans and Population Health. The committee is composed of the CEO, directors, healthcare integration supervisors, clinical supervisors, finance supervisors, prevention and outreach coordinator, grant administrator, and QI staff.

Virus Task Force

The Virus Task Force is comprised of the Medical Director, CEO, Chief Human Resource Officer, Director of Quality, Customer Service and Recipient Rights, Property & Facilities Supervisor, Safety and Security Coordinator, Agency Senior RN, and QCSRR Administrative Assistant. The goals of the Virus Task Force are processing updated guidance of CDC, State, and local Health Departments; developing and reviewing internal protocols; monitoring protective equipment ordering and management; facilitating communication with staff, providers, or consumers and the public; reviewing and responding to questions received; and creating sub-groups to work on specific issues, such as training and education or other topics that may arise.

Contract Quality and Home and Community Based Services (HCBS) Workgroup

The Contract Quality and HCBS Workgroup facilitates discussion on contracted providers and HCBS compliance throughout the agency.

Trauma Workgroup

The Trauma Workgroup is comprised of staff throughout the agency including clinical directors and supervisors, the Director of Quality, Customer Service and Recipient Rights, and the Chief Executive Officer. The goal of the Trauma Workgroup is to make CMHA-CEI a trauma-informed care organization and ensure that CMHA-CEI is utilizing trauma-informed systems of care. This includes creating and maintaining a safe, calm, and secure environment with supportive care, a system-wide understanding of trauma prevalence and impact, recovery and trauma-specific services, and recovery-focused, consumer-driven services.

Certified Community Behavioral Health Clinic (CCBHC) Workgroups

CMHA-CEI has utilized various CCBHC workgroups to address and move forward the agency's goal of becoming a successful Certified Community Behavioral Health Clinic. CMHA-CEI Directors meet regularly to discuss CCBHC implementation.

Zero Suicide Workgroup

In 2023, CMHA-CEI began to implement Zero Suicide initiative across all programs with the introduction of a workgroup. The workgroups goal includes a three-year training cycle for staff and a framework for systematic, clinical suicide prevention in behavioral and physical healthcare systems. The workgroup is composed of four subgroups: clinical, training, data & improvement, and communication. Each subgroup meets monthly, and the entire group meets quarterly.

Diversity Advisory Committee (DAC)

CMHA-CEI is committed to recognizing, enhancing and supporting diversity in all forms. The goals of the DAC are: Striving toward a diverse work force which is reflective of the people we serve, promoting regular communications relating to diversity, and collaborating with community partners in diversity-promoting efforts. Members include the CEO, chief human resources officer, and representation from most clinical and administrative programs.

MSHN Data Analytics Workgroup

The Data Analytics Workgroup is a workgroup facilitated by MSHN that meets monthly to increase competence and confidence of data analysts throughout the region to use analytic tools. This workgroup uses a variety of methods to connect data and analytic tools with organizational strategy and action to inform change and assist with continuous improvement and monitoring of initiatives.

SECTION 3: QUALITY AND PERFORMANCE IMPROVEMENT AND ACTIVITIES

The Quality Improvement Team is responsible for performing quality improvement functions and ensuring that program improvements are occurring within the organization. QI operates in partnership with stakeholders including consumers, advocates, contract providers, CMHA-CEI staff, and other relevant stakeholders. The QI Team is responsible for implementing and monitoring the QIP.

Michigan Mission Based Performance Indicators

MDHHS, in compliance with federal mandates, establishes measures in the areas of access, efficiency, and outcomes. Data is abstracted regularly, and quarterly reports are compiled and submitted to the PIHP for analysis and regional benchmarking and to MDHHS. In the event that CMHA-CEI performance is below the identified goal, the QI team will facilitate the development of a Corrective Action Plan (CAP). The CAP will include a summary of the current situation, including causal/contributing factors, a planned intervention, and a timeline for implementation. CAPs are submitted to the PIHP for review and final approval. Beginning in Q3 of FY2020, changes were made to the PI process, eliminating the standard and exceptions/exclusions for indicators 2 and 3. A baseline has been collected from CMHSPs over the and MDHHS is implanting a new standard for these indicators beginning FY24. More information on CMHA-CEI's tracking of Performance Indicators can be found in the FY2023 QIP Report.

PIHP Required Performance Improvement Projects (PIP)

MDHHS requires that CMHSPs, including CMHA-CEI, complete two performance-improvement projects (PIP), per waiver renewal period. One PIP is based upon recommendations put forward by the MDHHS Quality Improvement Council. It is subject to validation by the external quality review organization and requires use of the External Quality Review (EQR)'s standard forms. The other initiative is developed by the PIHP based upon the identified needs of the individuals served by the region's CMHSPs. The initiatives are data-driven and include annual submissions of performance and tactics for improvement. The current PIPs are for FY22-FY25.

Racial or Ethnic Disparities within the Region and Populations Served

The PIP topic chosen for this cycle is, "Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population." This PIP was chosen to improve access and engagement with services addressing any racial disparities that exist during the onset of treatment. Data from calendar year 2021 were reviewed for an initial measurement for this initiative to establish baseline data. Calendar year 2023 will be the first re-measurement period, and calendar year 2024 will be the second re-measurement period. Following the re-measurement periods, interventions will be identified and actions taken to address any found disparity in service access or provision.

The second or additional PI project(s) is chosen by the PIHP. MSHN QIC has recommended and MSHN Operations Council has approved the following Non-clinical Performance Improvement Project to ensure timely access to treatment:

- Study Topic - The racial or ethnic disparities between the black/African American minority penetration rate and the index (white) penetration rate will be reduced or eliminated.
- Study Questions - Do the targeted interventions reduce or eliminate the racial or ethnic disparities in the penetration rate between the black/African American minority penetration rate and the index (white) penetration rate?

Performance is reviewed as outlined in the performance improvement project description. The summary is submitted to the external quality review organization for a validation review, and to MDHHS through the QAPIP Annual Report and upon request.

Event Monitoring

Regular event monitoring of operations and clinical choices is an important aspect of ensuring CMHA-CEI provides exemplary care and services. Results from monitoring activities are used to guide individual professional development, identify team and organizational needs, and steer organizational culture toward adopting best practices in behavioral healthcare. Below is a brief summary of monitoring activities at CMHA-CEI.

Behavior Treatment Plans and Interventions

The data on the use of intrusive and restrictive techniques must be evaluated by the CMHSPs and be available for MDHHS review. Physical management and/or involvement of law enforcement, permitted for intervention in emergencies only, are considered critical incidents that must be managed and reported according to Attachment C6.8.3.1 of the MDHHS/CMHSP Contract. The Behavior Treatment Review Committee reviews and tracks restrictive techniques in plans. The QI Team has taken a lead role in the facilitation and organization of the Behavior Treatment Committee (BTC). In addition to state reporting requirements for Behavior Plans, CMHA-CEI reviews behavioral incidents of all consumers and monitors progress at BTC.

Denials, Grievances, and Appeals

Currently, the monitoring process for denials, grievances, and appeals focuses on our ability to provide evidence of timeliness of communication (e.g., various notices sent). As our capacity for evaluation and analysis increases, CMHA-CEI will approach this monitoring activity in a manner that helps to explore any patterns in occurrence and identify process or policy changes to resolve organizational challenges. Detailed requirements may be found in Attachment C6.3.2.1 of the MDHHS/CMHSP Managed Mental Health Supports and Services Contract. Compliance Staff are responsible for tracking this data.

Incident Reporting

Incident Reporting requirements are outlined in CMHA-CEI's Incident Procedure 3.3.07. Critical incident reporting requirements are defined in attachment C6.5.1.1 of the MDHHS/CMHSP Managed Mental Health Supports and Services Contract. Critical incidents include suicide, non-suicide death, emergency medical treatment due to injury/medication error, hospitalization due to injury/medication error, and arrests. Critical incidents are captured through the organization's incident reporting process and reviewed at CIRC.

All incident reports are reviewed through a four step process:

- **Step 1:** Incident reports are reviewed by the on-site supervisor where the incident occurred to assign the appropriate incident category, and note any follow-up action taken.
- **Step 2:** For AMHS, CSDD, and Families Forward incident reports, QI reviews incident reports for quality of care issues, determines the need for additional documentation or follow-up, assure completeness of the information, and to notify the Director of QCSRR of high-risk critical incidents.
    - Monthly, QI provides AMHS, CSDD, and Families Forward with a dashboard containing incident reporting data providing insight into trends. QI shares the data with program supervisors.
- **Step 3:** All other incident reports are reviewed by the program peer reviewer to review for quality of care issues, determine the need for additional documentation or follow-up, assure completeness of the information, and to notify the Director of QCSRR of high-risk critical incidents. Incidents are then reviewed by QI staff to ensure correct categorization, note any additional follow-up needs, and to bring to the next step for review, if needed.
- Step 4: If needed, the incident report is reviewed at CIRC for overall improvement of care.

A summary of the incident reports filed and reviewed can be found in the attached FY23 QIP reports.

Sentinel Event Review

Processes to identify sentinel events, understand the cause, and take necessary action to reduce the probability of future reoccurrence are defined in CMHA-CEI's Sentinel Events Procedure 1.1.14. Sentinel events are reviewed through a root cause analysis (RCA) process that is facilitated by the QI team. Sentinel events and sentinel event plans of correction are monitored by CIRC. Sentinel events are reported to MSHN and CARF as defined in CMHA-CEI's Sentinel Events Procedure 1.1.14.

Medicaid Event Verification

CMHA-CEI partners with MSHN to conduct regular audits of billed service events to verify that they are in alignment with the documents submitted. For additional information about the Medicaid Event Verification, refer to the Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program FY18-Attachment C7.6.1 or the MSHN Medicaid Event Verification Policy.

Chart Review

CMHA-CEI regularly monitors clinical performance to ensure organizational and professional standards are upheld as defined in the Clinical Record Review Procedure 3.2.13C. QCSRR compiles the aggregate data and meets with the clinical programs to review results on a quarterly basis. QCSRR meets with the clinical program to assist in analyzing the data, determine areas of improvement, and develop a plan to address the issues identified.

Staff Injury/Accident Rate

CMHA-CEI regularly monitors staff injury, accident, and infection data as risk management considerations through the organization's Safety Committee. HR captures injury and accident information to monitor trends as a way to optimize organizational performance and decrease liability. Monitoring includes identifying provisions that require corrective action, providing enhanced training/education, and following up on corrective action plans.

Provider Monitoring

Contracted providers are regularly monitored through the QA team or the provider network team. Annually, the QA team conducts Quality and Compliance, Recipient Rights, and Home and Community Based Services Review, as applicable, at each contracted AFC home, CLS provider, ABA provider, Hospital, and Fiscal Intermediary. Equivalent reviews are also completed at all directly-run locations.

Policy and Procedure Review

Each policy and procedure in the agency is reviewed annually. The QI team oversees and monitors this process through the PolicyStat document management system in collaboration with clinical directors and administrators. Some agency plans, forms, and guidelines are also included in PolicyStat. QI has a tentative plan to add all agency Guidelines to the PolicyStat system to be monitored and reviewed by applicable programs.

Health Services Advisory Group (HSAG)

Validation of performance measures is one of three mandatory EQR activities required by the Balanced Budget Act of 1997 (BBA). State Medicaid agencies must ensure that performance measures reported by their managed care organizations (MCOs) are validated. Health Services Advisory Group, Inc. (HSAG), the EQRO for the Michigan Department of Health and Human Services (MDHHS), Behavioral Health and Developmental Disabilities Administration, conducted the validation activities for the Prepaid Inpatient

Health Plans (PIHPs) that provided mental health and substance abuse services to Medicaid-eligible recipients. The purpose of performance measure validation (PMV) is to assess the accuracy of performance indicators reported by PIHPs and to determine the extent to which performance indicators reported by the PIHPs follow state specifications and reporting requirements. CMHSPs of MSHN provided data and assisted in MSHN's HSAG review.

MSHN Audit

Every two years, MSHN conducts a full monitoring and evaluation process of CMHA-CEI. This process consists of the utilization of uniform standards and measures to assess compliance with federal and state regulations, and PIHP contractual requirements. During the interim year, MSHN's review process focuses on any elements from the previous year's findings in which compliance standards were considered to be partially or not fully met. The QI team works with the clinical and administrative programs to meet the standards MSHN monitors and facilitates the audit and plan of correction processes. The 2023 audit included a full review of all standards and a review of the corrective action plans submitted during the 2022 interim audit. The next audit will be an interim review and Medicaid Event Verification taking place in June 2024.

MDHHS Audits

Every two years, MDHHS audits the three waiver programs (Serious Emotional Disturbance Waiver, Children's Waiver Program, and Habilitation Support Waiver). Quality Improvement staff work with the clinical departments to meet the standards MDHHS has set for these programs. The 2022 Audit included a review of SEDW, CWP, and HSW. The next review will be in 2024 and will include a review of 1915i.

Quantitative and Qualitative Assessment of Experience

CMHA-CEI is committed to providing the highest quality of care and services. Central to this commitment is reaching out regularly to the individuals we serve, contract with, or work with to solicit their feedback.

Consumer Satisfaction Survey

As part of the CMHA-CEI quality improvement efforts, a consumer satisfaction survey is administered annually to persons who are receiving services. The purpose of this survey is to help the agency gauge the level of satisfaction among consumers who are currently receiving services and determine ways to improve practices to better serve consumers. The results of the survey help measure the quality of CMHA-CEI services and the evaluation report summarizes the levels of satisfaction consumers have with their services.

In 2023, the Youth Services Survey (YSS) and Mental Health Statistics Improvement Program (MHSIP) survey were distributed to all CMHA-CEI consumers who were receiving services within the reporting period. While the CMHSPs in the region are responsible for administering the survey, the PIHP collects and maintains the data and survey findings. Results of recent satisfaction survey efforts can be found in the attached QIP Report from FY22.

Stakeholder Survey

Every two years, CMHA-CEI is required by MDHHS to conduct an assessment of the mental health needs of our community. The assessment must involve public and private providers, school systems, and other key community partners and stakeholders. Stakeholders are asked to share the trends and needs they identify that may be related to, or indicative of, mental health needs in our community. CMHA-CEI leadership reviews the survey results to develop priority needs and planned actions for the agency. CMHA-CEI evaluated stakeholder concerns over the year from a survey that was conducted in 2022.

Priority needs identified during the 2022 survey included access to care, training of Direct Care Staff, Recruitment and Retention of staff, strain on crisis services, and access to housing and resources for adults with serious and persistent mental illness. CMHA-CEI will conduct another stakeholder survey in 2024.

Other Survey Processes

Beyond the recurring survey processes described above, the QI team conducts additional surveys related to specific issues or targeting other audiences. Other survey processes within the agency include:

- Agency Trauma Self-Assessment – An agency trauma workgroup was formed to expand efforts to combat the negative impact of trauma for consumers and secondary trauma for staff. In 2017, a survey was sent to all agency staff to encourage staff participation from all departments to assure broad organizational representation in the results. The results were analyzed by the Trauma Workgroup to help identify where programs and supports are needed as well as assist with targeting information and training. This survey was repeated in 2020. The results from both surveys can be found in the QIP from 2021.
- National Core Indicators (NCI) Survey - The NCI Survey is an annual collaboration between participating states, the Human Services Research Institute, and the National Association of State Directors of Developmental Disabilities Services. Information about specific 'core indicators' is gathered to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety. The NCI survey aims to assess family and adult consumer perceptions of satisfaction with their community mental health system and services. Consumers are selected at random and asked if they would like to participate in the in-person survey. Data gathered through this survey is intended to assist in informing strategic planning, legislative reports, and prioritizing quality improvement initiatives.

Organizational Performance Initiatives

The QI Team works to improve quality throughout the agency. Other tasks the QI Team works on not described above are:

CARF

QI staff apply for reaccreditation through CARF every three years. CARF is the accrediting body for all administrative programs at CMHA-CEI and a varying number of clinical programs. The triennial CARF survey determines CMHA-CEI's conformance to all applicable CARF standards on-site through the observation of services, interviews with persons served and other stakeholders, and review of documentation. In 2023, CARF conducted a digitally enabled site survey and granted CMHA-CEI the standard three-year accreditation. Corrective actions from the survey findings have been included in a Quality Improvement Plan and are listed in the attached report. The next CARF survey will be conducted in the spring or summer of 2026.

Internal Research Approvals

All research, manuscripts, or written documents related to CMHA-CEI operations (directly operated or contractual), and/or clients undertaken by CMHA-CEI employees, contractual staff, interns, students, volunteers, consultants to contractual agencies, representatives of the Michigan Department of Community Health, or other individuals must be reviewed by the Research Review Committee. Research must receive the prior written approval of the Chief Executive Officer. Activity of the Research Review Committee is facilitated by the QI team.

Data Reporting through ICDP/CC360

CMHA-CEI has access to Medicaid claims data through two sources. The Integrated Care Delivery Platform (ICDP) is a tool utilized by MSHN. Care Connect 360 (CC360) is the tool utilized by MDHHS. Through both resources, the QI team reviews data as required by MSHN and MDHHS and at the request of the clinical programs. The data available through ICDP/CC360 has also been utilized by the QI team to facilitate collaboration with community partners, review and develop performance measures, and to participate in MSHN PIP processes.

Care Alerts

CMHSPs have the ability to review Care Alerts as identified in the Integrated Care Delivery Platform (ICDP). ICDP provides specific details identifying individuals who have an active Care Alert, which can be exported and reviewed for follow up. Follow up can include reviewing services provided to the individual, coordinating with the primary clinician, or creating a systemic action plan. The Quality Improvement team has identified five Care Alerts to review and address in CY2024: Follow-Up After Hospitalization Mental Illness - Adult, and Follow-Up After Hospitalization Mental Illness – Child, Adherence to Antipsychotics with Schizophrenia, Diabetes Monitoring, Diabetes Screening, and Cardiovascular Screening.

- Follow-Up After Hospitalization Mental Illness - This measure is defined as the percentage of discharges for members who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge.
- Adherence to Antipsychotics with Schizophrenia – This measure is defined as the percentage of members 19–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.
- Diabetes Monitoring - This measure is defined as the percentage of members 18 to 64 years of age with schizophrenia and diabetes who had both a low-density lipoprotein cholesterol (LDL-C) and a hemoglobin A1c (HbA1c) test during the measurement period.
- Diabetes Screening – This measure is defined as the percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
- Cardiovascular Screening - This measure is defined as the percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year.

Annual Submission to MDHHS

Annually, the QI team submits required data to MDHHS. This data includes estimated workforce changes for the fiscal year, a summary of service requests, and waiting list information as well as community data. Every other year, the annual submission includes a needs assessment and planned action. The FY22 annual submission which was submitted in FY23 was based off the planned actions which were made in response to the needs assessment conducted in 2022. In FY23, QI will be working with other staff to create an internal Needs Assessment Report to assist the agency in identifying strengths and challenges.

State Reporting

The QI team regularly assists the agency in compiling and submitting reports to MSHN or MDHHS, as needed. Examples include the biannual credentialing report for MSHN and the annual "Special Education to the Community" report for MDHHS.

State Recertification

Every three years, the QI team submits required documentation to MDHHS to recertify CMHA-CEI as a CMHSP. Information prepared for submission includes accreditation information for CMHA-CEI and applicable contract providers, lists of all contracts with other agencies or organizations that provide mental health services under the auspices of CMHA-CEI including services provided, and identification of any changes to CMHA-CEI's provider network. CMHA-CEI was last certified in 2019 and is effective until March 9, 2022. In 2022 MDHHS began the process to move the CMHSP certification process to an updated system and all current certifications were extended for 2 years. CMHA-CEI is currently certified until March 9, 2024.

HCBS Support for the Agency

Members of the QI team, specifically Quality Advisors, act as independent verifiers to ensure that internal oversight of MDHHS and MSHN plans of correction are conflict-free. Activity includes coordination with MSHN and MDHHS on survey processes, supporting provider plan of correction development, facilitating plan of correction follow-up, on-site verification, facilitation of communication with MSHN and MDHHS, and ongoing support of education and documentation improvement processes.

Environmental Modifications

Environmental Modifications is a Medicaid Covered Service that CMHA-CEI has a higher level of review due to the higher cost and involvement of contract staff. QI staff monitor and review all requests received for environmental modifications according to the Environmental Modifications Procedure 3.6.23E. QI staff developed this procedure to ensure it meets MDHHS Medicaid Provider Manual requirements and fulfills the Scope of Work to meet the needs of the consumers we serve, so they are able to meet their goals/objectives.

Enrollee Rights and Responsibilities

CMHA-CEI is committed to treating members in a manner that acknowledges their rights and responsibilities. It is the policy of CMHA-CEI to monitor and ensure that a recipient of mental health services has all of the rights guaranteed by state and federal law, in addition to those guaranteed by P.A. 258, 1974, Chapter 7 and 7A, which provides a system for determining whether, in fact, violations have occurred; and shall ensure that firm and fair disciplinary and appropriate remedial action is taken in the event of a violation. The CEO ensures that CMHA-CEI has written policies and procedures for the operations of the rights system on file with the Michigan Department of Health and Human Services (MDHHS) – Office of Recipient Rights. Education and training in recipient rights policies and procedures are provided to its Recipient Rights Advisory Committee and staff. MDHHS routinely conducts site reviews. Annual reports from the CMHA-CEI Recipient Rights Office are submitted to MDHHS as required by Chapter 7 of the Michigan Mental Health Code. Additionally, procedures have been established to address the complaints and appeals processes through the CMHA-CEI Corporate Compliance Officer.

Utilization Management

CMHA-CEI has a Utilization Management unit under the Quality, Customer Service, and Recipient Rights Department. Utilization Management monitors the agency's resources through regular review and the collection and analysis of data. CMHA-CEI utilizes and follows CMHA-CEI Utilization Management Plan and MSHN's Utilization Management Plan. The utilization plans components address practices related to retrospective and concurrent review of clinical and financial resource utilization, clinical and programmatic outcomes, and other aspects of utilization management as deemed appropriate by directors.

Healthcare Integration Initiatives

CMHA-CEI's healthcare integration vision is to be a convener and partner in the implementation of healthcare integration by providing meaningful and manageable approaches in achieving outcomes and improving the overall quality of life for those we serve. Through the Healthcare Integration Committee, there will be three workgroups to help drive healthcare integration initiatives.

1. Primary Care Provider Status and use of Continuity of Care Document
2. Treatment Planning
3. Population Health

Healthcare Integration Programs

Healthcare Integration programs with community partners to provide Behavioral Health Consultants (BHCs) who address both health behaviors and behavioral health. Goals include functional restoration and patient activation. BHCs work as integrated members of the medical team. There are currently 12 clinics in the community that have CMHA-CEI BHCs.

Certified Community Behavioral Health Clinic (CCBHC) Continuous Quality Improvement Plan

CCBHC is a model of care and a way of providing quality, accessible treatment to consumers using data and evidence-based practices. In 2018, CMHA-CEI was awarded a two-year federal grant to expand services for individuals with a diagnosis of Serious Mental Illness, Serious Emotional Disturbance, Substance Use Disorder, or Co-Occurring Disorders and are uninsured, underinsured, or have commercial insurance. CMHA-CEI was additionally awarded a two-year expansion CCBHC grant through April 2022. In April 2022, CMHA-CEI was also awarded full certification of its Certified Community Behavioral Health Clinic through the Michigan Department of Health and Human Services. The certification is valid for two years.

The CQI plan focuses on improved patterns of care delivery, including reductions in emergency department use, rehospitalization, and repeated crisis episodes.

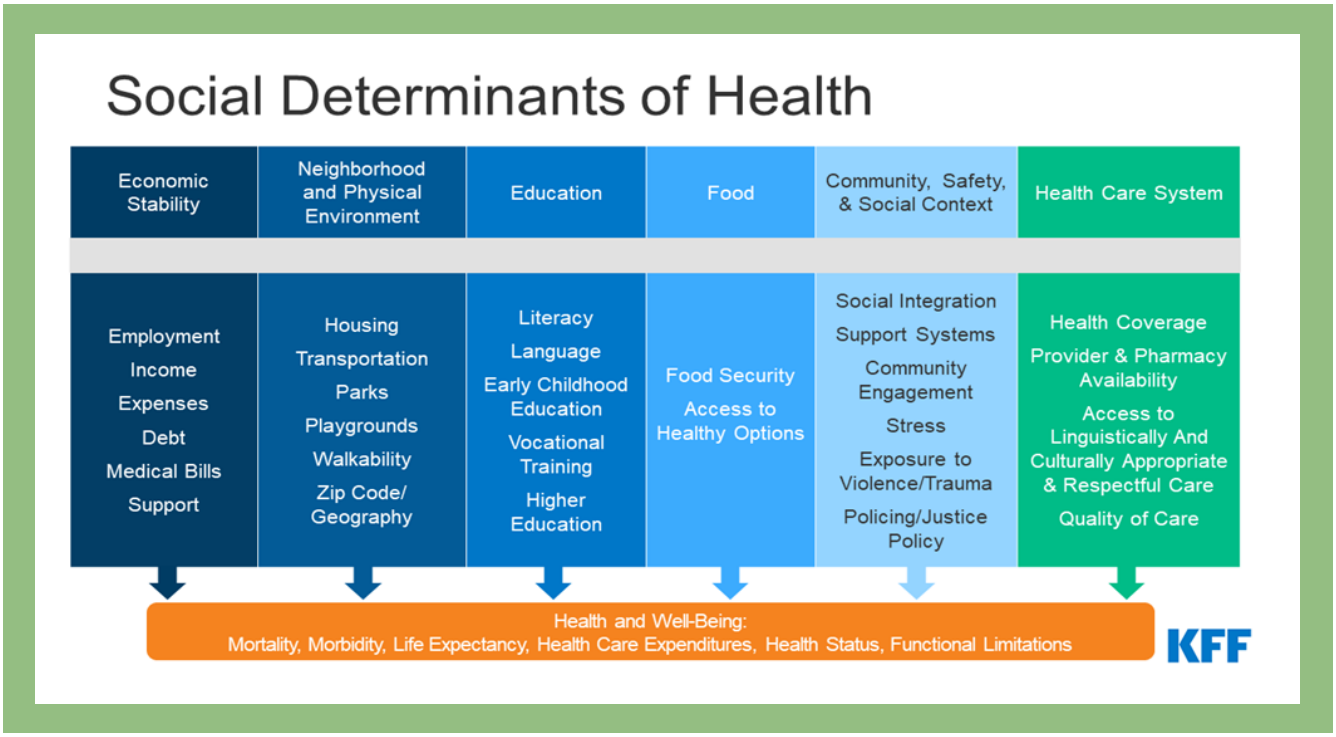
The CQI plan report will track:

1. Deaths by suicide or suicide attempts of people receiving services;
2. Fatal and non-fatal overdoses;
3. All-cause mortality among people receiving CCBHC services; and
4. 30-day hospital readmissions for psychiatric or substance use reasons;

The CQI plan also reports on the CCBHC-collected quality measure including:

1. Time to initial evaluation
2. Preventative Care Screenings: Adult BMI Screening and Follow-up
3. Weight Assessment for Children/Adolescents
4. Tobacco use: Screening and Cessation
5. Alcohol Use: Screening and brief counseling
6. Suicide Risk Assessment Adult and Child
7. Screening for Clinical Depression and Follow-up
8. Depression Remission at twelve months

The CQI plan report will also report data on health disparities and utilizes Performance Improvement Projects to track and improve outcomes. The CQI plan report will also begin to look at what Social Determinants of Health (SDOH) and how CMHA-CEI may be able to assist to improve the health and well-being of those we serve.



SECTION 4: ADDITIONAL AGENCY PLANS MONITORED BY QI

Risk Assessment Plan

In FY23, the QI team worked with staff across the agency to develop an agency-wide Risk Management Plan. The Risk Management Plan will assist the agency to address risks and increase awareness about identifying risk and how to minimize it. Ongoing monitoring of action steps identified in the Risk Assessment will be completed by the QI team and agency leadership.

Accessibility Plan

In FY23, the QI team worked with CMHA-CEI leadership to develop an agency-wide Accessibility Plan. This plan identifies barriers, actions for the removal of identified barriers, and provides the status of progress relative to planned actions. The assessment and management control tool developed for the plan assesses organizational accessibility barriers, defines accountability, and monitors progress toward addressing and increasing accessibility throughout the agency. Ongoing monitoring of planned actions will be completed by the QI team and agency leadership.

Needs Assessment

In FY23, the QI team worked with Leadership to create a formal Agency Needs Assessment Report. The plan provides state and local data, input from individuals serviced and community stakeholders, and service delivery data to help address service needs and priorities for CMHA-CEI. The Needs Assessment assists to show CMHA-CEI's ongoing commitment to quality services and outcomes.

SECTION 5: EVALUATION OF QIP PLAN EFFECTIVENESS

An evaluation of the QIP plan is completed at the end of each calendar year. The evaluation summarizes activity that occurred around the goals and objectives of the CMHA-CEI's Quality Improvement Program Plan and progress made toward achieving the goals and objectives. The evaluation will describe the quality improvement activities conducted during the past year related to the goals/objectives, including a description of targeted processes and systems implemented, outcomes of those processes and systems, any performance indicators utilized, the findings of the measurement, data aggregation, assessment and analysis processes implemented, and the quality improvement initiatives taken in response to the findings.

SECTION 6: QIP PLAN GOALS AND OBJECTIVES

FY2023 Goals Review

FY23 Goal	Progress
Successful implementation of PolicyStat management system to oversee and manage policies and procedures for the agency.	Completed, agency transitioned fully to PolicyStat management system in August 2023.
Work with Information Systems Department on updating Incident Reporting System for updated MDHHS report	Completed, Updated report for MDHHS and system in February 2023
Develop an agency-wide Needs Assessment Plan	Completed, FY23 Needs Assessment Plan was developed
Begin to utilize available data for quality process improvement and to begin looking at disparities (data through chart reviews, audits, SmartCare reports, ICDP)	Completed, began to review data and include it in Needs Assessment Plan and review at Healthcare Integration Workgroup
Prepare for successful CARF accreditation in Spring 2023	Completed, CARF accreditation was awarded for 3 years on August 1, 2023.

FY2024 Goals

- Continue to work with Information Systems Department on updating Incident Reporting System for updated MDHHS report and explore Incident Reporting Software options
- Integrate CMHA-CEI Operating Guidelines into Policy Stat software
- Continue to utilize available data for quality process improvement and to begin looking at disparities (data through chart reviews, audits, SmartCare reports, ICDP)
- Develop updated Priority Needs for the agency
- Improve and expand on the data gathered for the annual Needs Assessment and Social Determinants of Health report

References:

- Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program Contract FY24:
  - Attachment P7.9.1 Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans
- MDHHS/CMHSP Managed Mental Health Supports and Services Contract FY24:
  - Attachment C6.3.2.1 Local Dispute Resolution Process
  - Attachment C6.5.1.1 Reporting Requirements
  - Attachment C6.8.1.1 Quality Improvement Programs for CMHSPs
  - Attachment C6.8.3.1 Standards for Behavior Treatment Plan Review Committees
  - Attachment C7.6.1 Compliance Examination Guidelines
- Mid-State Health Network Quality Assessment and Performance Improvement Plan (QAPIP)
- MSHN Quality Policy, Medicaid Event Verification
- MDHHS Certified Community Behavioral Health Clinic (CCBHC) Handbook
- Mid-State Health Network Utilization Management Plan
- CMHA-CEI Utilization Management Plan
- CMHA-CEI Needs Assessment
- CMHA-CEI Risk Assessment Plan
- CMHA-CEI Accessibility Plan

Agenda Item: Program and Planning Committee
Agenda Item #P-9

Month, Year: April, 2024

Major Program: Department of Quality Improvement, Customer Services and Recipients Rights and General Administration

Component Program: Customer Services

Agenda Item Title: CMHA-CEI Consumer Advisory Council Recommended Appointees

SUMMARY OF CONTRACT/PROPOSAL:
The development of a Consumer Advisory Council (CAC) was previously approved by the Board in July, 2017. The CAC provides the opportunity for consumer and community partner involvement in shaping policy and practice. The proposed objectives for the Consumer Advisory Council are as follows:

- To provide a consumer voice in determining needs, concerns, and priorities in policy, service provision, service delivery, and accessibility.
- To help identify issues, problems or need areas within provided services.
- To make recommendations to resolve problems or to embrace the opportunities needed to improver system processes.
- To promote community endeavors related to consumer empowerment and self-determination.

The Consumer Advisory Council is comprised of current and past recipients of services, and family members of those who have received services from CMHA-CEI.

The following submitted an application, was interviewed by the membership committee. CAC members voted and recommend for approval to serve a 2-year term, to expire on 5/31/2026.

- Lori Gorbis, for a 2-year term, to expire on 5/31/2026

- Faith Halick, for a 2-year term, to expire on 5/31/2026

STAFF RECOMMENDATION:
Staff recommend that the Program and Planning Committee of Community Mental Health Authority of Clinton, Eaton, Ingham Counties approve the following resolution:

The Program and Planning Committee recommends that the Community Mental Health Authority of Clinton, Eaton, Ingham Counties Board of Directors appointment the following individuals named to serve as members of the Consumer Advisory Council.

- Lori Gorbis, for a 2-year term, to expire on 5/31/2026
- Faith Halick, for a 2-year term, to expire on 5/31/2026