QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP) 2016

ANNUAL EFFECTIVENESS AND EVALUATION 2015

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QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM 2015-2016

I. OVERVIEW

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. The CMHSP Participants include Bay-Arenac Behavioral Health, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot County Community Mental Health Services Authority, , Huron County Community Mental Health Authority, The Right Door (formerly Ionia County Community Mental Health Authority), LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health Authority, Saginaw County Community Mental Health Authority, Shiawassee County Community Mental Health Authority and Tuscola County Community Mental Health Authority. In 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 FY2015 contract expanded to include administration of all public funding for substance use disorder (SUD) prevention, treatment and intervention. For FY2016, MSHN continues to sub-contract with CMHSPs within the region to provide Medicaid funded behavioral health services as well as directly contracting with Substance Use Disorder Providers within the region for the provision of all public funded SUD services.

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, the Substance Use Disorder Providers and their respective provider networks. Performance monitoring covers all important organizational functions and 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.

II. PHILOSOPHICAL FRAMEWORK

The program design is based on 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 method;
- 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 behavioral health contract providers through monitoring treatment outcomes, ensuring timeliness of processes, optimizing efficiency and 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.

III. STRUCTURE (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016) (42 Code of Federal Regulations (CFR) 438.358, 2002)

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.

IV. COMPONENTS (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016) (42 Code of Federal Regulations (CFR) 438.358, 2002)

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 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
- CMHSPs 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.

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 (Region 5 PIHP 2013 Application for Proposal for Speciality Prepaid Inpatient Health Plans, 2013, p. 2.7.3).

V. GOVERNANCE (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2015)

<u>Board of Directors</u>
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 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 an Annual Quality Assessment and Performance Improvement 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 and the result of those actions. After review of the Annual Quality Assessment and Performance Improvement Report, through the MSHN CEO the Board of Directors submits the report to the Michigan Department of Health and Human Services (MDHHS).

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 Compliance Officer (CO) as the chair of the MSHN Quality Improvement Council. In this capacity, the CO is responsible for the development, review and evaluation of the Quality Assessment and Performance Improvement Plan and Program in collaboration with the MSHN Quality Improvement Council. This Council consists of a quality representative from each CMHSP who has been appointed by the CMHSP CEO.

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 assuring ongoing monitoring and compliance with its MDHHS contract including provision of performance improvement plans as required.

Medical Director

Through consultative council involvement, the MSHN Medical Director provides leadership related to clinical service quality and service utilization standards and trends. The Medical Director is an ad hoc member of the MSHN Quality Improvement Council and demonstrates 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.

The MSHN Medical Director consults with MSHN staff regarding service utilization and eligibility decisions and is available to provide input as required for the regional QAPIP. As necessary, consultation occurs between the MSHN Medical Director and CMHSP Participant and Substance Use Disorder Medical Directors.

CMHSP Participants/SUD Providers

CMHSP Participant/SUD Provider staff have the opportunity to participate in and to support the QAPIP through organization wide performance improvement initiatives. In general, the CMHSP Participant/SUD Provider staff's role in the PIHP's performance improvement program includes:

- Participating in the data collection related to performance measures/indicators at the organizational or provider level;
- Identifying organization-wide opportunities for improvement;
- Having representation on organization-wide standing councils, committees and work groups, and
- Reporting clinical care errors, informing consumers of risks, and making suggestions to improve the safety of consumers.

Councils and Committees

MSHN has Councils and Committees that are responsible for providing recommendations and reviewing regional policy's 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, Past Year's Accomplishments and Upcoming Goals **(Section Two)**. 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 **(Section Three)**.

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.

Recipients (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

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. MSHN has formed a Regional Consumer Advisory Council that 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 requirements in the region.

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; 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.

VI. COMMUNICATION OF PROCESS AND OUTCOMES (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

The Quality Improvement Council (QIC) is responsible for monitoring and reviewing performance measurement activities. MSHN, in addition to the CMHSPs Participants/SUD Providers, identify and monitor opportunities for process and outcome improvements.

For any performance measure that falls below regulatory standards and/or established targets, plans of correction are required. After QIC meetings, reports are communicated through regular reporting via Councils, Committees, and the Board of Directors and Consumer Advisory Council meetings. Status of key performance indicators, consumer satisfaction survey results, and performance improvement (PI) projects are reported to consumers and stakeholders, as dictated by the data collection cycle. The Board of Directors receives an annual report on the status of organizational performance. Final performance and quality reports are made available to stakeholders and the general public as requested and through routine website updates.

MSHN is responsible for reporting the status of regional PI projects and verification of Medicaid services to MDHHS. These reports summarize regional activities and achievements, and include interventions resulting from data analysis.

VII. PERFORMANCE MEASUREMENT

General Methods (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

The Quality Assessment and Performance Improvement Program encourages the use of objective and systematic forms of measurement. Each measure must have a baseline measurement when possible, should be re-measured at least annually, and should be actionable and likely to yield credible and reliable data over time. Measures can be clinical and non-clinical. Desired performance ranges and/or external benchmarks are included when known. MSHN is responsible for the oversight and monitoring of the performance of the PIHP including data collection, documentation, and data reporting processes to ensure compliance with PIHP contract requirements and State and Federal processes and requirements.

MSHN implements a Balanced Score Card (**Section Four**) to monitor the effectiveness of the PIHPs strategic priorities and provides dashboards to evaluate performance overtime for all important organizational functions.

Data Collection and Analysis

Information is the critical product of performance measurement that facilitates clinical decision-making, organizational decision-making (e.g., strategic planning and day-to-day operations), performance improvement, and priorities for risk reduction. Data must be systematically aggregated and analyzed to become actionable information.

Data is aggregated at a frequency appropriate to the process or activity being studied. Statistical testing and analysis is then used as appropriate to analyze and display the aggregated data. PIHP data is analyzed over time to identify patterns and trends, and compared to desired performance levels, including externally derived benchmarks when available.

Undesirable patterns or trends in performance are identified, as well as undesirable variations in performance, and acted on as appropriate. In some instances, further data collection and analysis is necessary to isolate the causes of poor performance or excessive variability.

MSHN staff, in collaboration with the QIC, prepares an analysis of the data, including recommendations for further investigation, data collection improvements to resolve data validity concerns, and/or system improvements.

Taking Action

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

- Develop a step by step action plan;
- Limit the number of variables impacted;
- Implement the action plan, preferably on a small or pilot scale initially, and
- Collect data to check for expected results.

The process of measurement, data collection, data analysis and action planning is repeated until the desired level of performance/improvement is achieved. Sustained improvement is sought for a reasonable period of time (such as one year) before the measure is discontinued. When sustained improvement is achieved, measures move into a maintenance modality, with a periodic reassessment of performance to insure 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.

Performance Indicators

The Michigan Department of Health and Human Services (MDHHS), in compliance with Federal mandates, establishes measures in the area of 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 through the use of standardized performance indicators.

When minimum performance standards or requirements are not met, CMHSP Participants/SUD Providers will submit a form identifying causal factors, interventions, implementation timelines, and any other actions they will take to correct undesirable variation. The form will be reviewed by the MSHN CO and the MSHN contractor to ensure sufficient corrective action planning. Regional trends will be identified and discussed at the QIC for regional planning efforts and coordination. The effectiveness of the action plan will be monitored based on the re-measurement period identified.

Performance Improvement Projects

MDHHS requires the PIHP to complete a minimum of two PI projects per year. One of the two is chosen by the department based on Michigan's Quality Improvement Council recommendations. This project is subject to validation by the external quality review (EQR) organization and requires the use of the EQR's

form. The second or additional PI project(s) is chosen by the PIHP based on the needs of the population served, previous measurement and analysis of process, satisfaction, and/or outcome trends that may have an impact on the quality of service provided. The QIC approves the performance improvement projects and presents to relevant committees and councils for collaboration.

Data collected through the performance improvement projects are aggregated, analyzed and reported at the QIC meeting. The population from which a sample is pulled, the data collection timeframe, the data collection tool, and the data source are defined for each measure, whether local or regional. A description of Project/Study is written for each measure which documents why the project was chosen and identifies the data that was used to determine there was a problem and who is affected by the problem. It incorporates the use of valid standardized data collection tools and consistent data collection techniques. Each data collection description delineates strategies to minimize inter-rater reliability concerns and maximize data validity. Provisions for primary source verification of data and maintenance of documentation are also addressed in the description of the project/study. If sampling is used, appropriate sampling techniques are required to achieve a statistically reliable confidence level. The default confidence level for MSHN performance measurement activity is a 95% confidence level with a 5% margin of error.

Identification of Quality Concerns and Opportunities for Improvement
Measures are selected consistent with established MSHN QAPIP priorities, as specified in this plan. The PIHP quality management program uses a variety of means to identify system issues and opportunities for improvement.

Prioritizing Measures (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

Measures are chosen based upon selection and prioritization of projects, data collection, and analysis of data, and will be based on the following three factors:

Focus Area: Clinical (prevention or care of acute or chronic conditions; high volume or high risk services; continuity and coordination of care), or Non-Clinical (availability, accessibility, and cultural competency or services; interpersonal aspects of care; appeals, grievances, and other complaints.)

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, or accreditation requirements; relevancy to stakeholders due to the prevalence of a condition, the need for a service, access to services, complaints, satisfaction, demographics, health risks or the interests of stakeholders as determined through qualitative and quantitative assessment.

VIII. EVENT MONITORING AND REPORTING (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

MSHN submits and/or reports required events to MDHHS such as critical incidents (including sentinel events), and events requiring immediate notification as specified in the Medicaid Managed Specialty Supports Services contract within the timelines required by MDHHS.

MSHN delegates the responsibility of the process for review and follow-up of sentinel events, critical incidents, and other events that put people at risk of harm to its CMHSP Participants and SUD Providers. 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 these events, adverse events, will qualify as "reportable events" according to the MDHHS Event Reporting System. These include MDHHS defined critical incidents, risk events, and sentinel 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 within the required timeframes. MSHN will ensure that the CMHSP and SUD Provider have taken appropriate action to ensure that any immediate safety issues have been addressed.

MSHN provides oversight and monitoring of the CMHSP Participant/SUD Provider processes for reporting sentinel events, critical events, and risk events as defined in the Medicaid Managed Specialty Supports and Service Concurrent 1915 (b)/(c) Waiver Program FY16 Attachment P7.9.1 and/or events requiring immediate notification to MDHHS. In addition, MSHN oversees the CMHSP Participant/SUD Provider process for quality improvement efforts including analysis of all events and other risk factors, identified patterns or trends, the completion of identified actions, and recommended prevention strategies for future risk reduction. The goal of reviewing these events is to focus the attention of the CMHSP Participant/SUD Provider 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. Following completion of a root cause analysis, or investigation, the CMHSP will develop and implement either a plan of action or 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, time lines, and strategies for measuring the effectiveness of the action

IX. BEHAVIOR TREATMENT (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)(c) Waiver Program 2016 Attachment P1.4.1, Technical Requirement for Behavioral Treatment Plan Review Committees-2012)

MSHN delegates the responsibility for the collection and evaluation of data to each local CMHSP Behavior Treatment Review Committee, including the evaluation of the effectiveness of the Behavior Treatment Committee by stakeholders. Data is collected and reviewed 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. Only techniques approved by the Technical Requirement for Behavior Treatment Plan, agreed to by the individual or his/her guardian during the person-centered planning, and supported by current peer-reviewed psychological and psychiatric literature may be used. MSHN also receives CMHSP behavior treatment data regarding consumers on the habilitation supports waiver. This data provides sub-assurances within participant safeguards that require additional oversight & monitoring by the Michigan Department of Health and Human Services (MDHHS) for habilitation supports waiver enrollees around use of intrusive and/or restrictive techniques for behavioral control. By asking the behavior treatment committees to track these data, it provides important oversight to the protection and safeguard of vulnerable individuals. This data is shared on a quarterly basis with MDHHS. CMHSP data is reviewed as part of the CMHSP Quality Program and reported to the MSHN QIC at a defined frequency. MSHN analyzes the data on a quarterly basis to address any trends and/or opportunities for quality improvements. Data shall include numbers of interventions and length of time the interventions were used per person.

X. AUTISM BENEFIT (Medicaid Managed Specialty Supports and Services 1915(i) State plan Home and Community-Based Services Administration and Operation)

MSHN oversees provision of the autism benefit within its region. MSHN delegates to the CMHSPs the application of the policies, rules and regulations as established through MSHN. MSHN assures that it maintains accountability for the performance of the operational, contractual, and local entity efforts in implementation of the autism program. MSHN tracks program compliance through the MSHN quality improvement Strategy and performance measures required by the benefit plan. MSHN collects data on the performance of the autism benefit consistent with the 1915(i) state plan and reviews this data on a monthly basis with the CMHSPs within its region and calls for ongoing system and consumer-level improvements.

XI. QUANTITATIVE AND QUALITATIVE ASSESSMENT OF MEMBER EXPERIENCES (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

The opinions of consumers, their families and other stakeholders are 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 are surveyed by MSHN at least annually using standardized survey tools. The tools vary in accordance with service population needs, and 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. Other stakeholders provide input through a survey process. Regional benchmarks are used for comparison.

The aggregated results of the surveys are collected, analyzed and reported by MSHN in collaboration with the QI Council and Regional Consumer Advisory Council, who identify strengths, areas for improvement and make recommendations for action and follow up as appropriate. The data is used to identify best practices, demonstrate improvements, or identify problem areas. The QI Council determines appropriate action for improvements, and the resulting findings are incorporated into program improvement action plans. At the CMHSP Participant/SUD Provider level, actions is taken on survey results of individual cases, as appropriate, to identify and investigate sources of dissatisfaction and follow-up.

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

XII. PRACTICE GUIDELINES (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

MSHN supports CMHSP Participants local implementation of practice guidelines based on the Medicaid Provider Manual, the Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program, and Evidence Based Practice models. The process for determining what practice guidelines utilized is a locally driven process in collaboration with the MSHN Councils and Committees. Practices guidelines are chosen to meet the needs of persons served in the local community and to ensure that each individual receives the most efficacious services. Practice guidelines as stated above are reviewed and updated annually or as needed, and are disseminated to appropriate providers.

XIII. CREDENTIALING, PROVIDER QUALIFICATION AND SELECTION (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

In compliance with MDHHS's Credentialing and Re-Credentialing Processes (FY16 Attachment P7.1.1,), MSHN has established written policy and procedures 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 also ensure that non-licensed providers of care or support are qualified to perform their jobs.

Credentialing, privileging, primary source verification and qualification of staff who are employees of the 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 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.

XIV. MEDICAID EVENT VERIFICATION (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016 and Medicaid Event Verification Technical Requirement)

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 eligibility of the beneficiary on the date of service; that the service provided is part of the beneficiaries individualized plan of service (and provided in the authorized amount, scope and duration); services were provided by a qualified individual; the amount billed/paid does not exceed the contract amount; and appropriate modifiers were used following the HCPCS guidelines.

Data collected through the Medicaid Event Verification process is aggregated, analyzed and reported for review at the QI Council 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. All CMHSP Participants/SUD Providers of MSHN have implemented the generation of a summary of Explanations of Benefits in accordance with the MDCH 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.

XV. UTILIZATION MANAGEMENT PLAN (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

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.

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

Utilization review functions is delegated to CMHSP Participants/SUD Providers 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, and 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 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 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 decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to provide treatment. 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.

XVI. PROVIDER MONITORING (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

MSHN uses a standard written contract to define its relationship with CMHSP Participants/SUD Providers that stipulated 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. 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/SUD Provider maintain common policies, review common standards, and evaluate common outcomes. 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 as necessary. MSHN has developed a processes for coordinating and/or sharing annual contractor monitoring reviews to avoid duplication of efforts and to reduce the burden on shared contractors. CMHSPs Participants/SUD Providers that are unable to demonstrate acceptable performance are required to provide corrective action, will be subject to additional PIHP oversight and interventions, and may be subject to sanctions imposed by MSHN, up to and including contract termination.

XVII. OVERSIGHT OF "VULNERABLE PEOPLE"

MSHN assures the health and welfare of the region's service recipients by establishing standards consistent with MDHHS contract requirements and reporting guidelines for all CMHSPs and subcontracted providers. Each CMHSP Participant/SUD Provider shall have processes for addressing and monitoring the health, safety and welfare of all individuals served.

MSHN ensures that services are consistently 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.

MSHN monitors population health through data analytics software to identify adverse utilization patterns and to reduce health disparities.

MSHN monitors compliance with federal and state regulations annually through a process that may include any combination of desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies as necessary. CMHSP organizations and SUD Providers that are unable to demonstrate acceptable performance may be subject to additional PIHP oversight and intervention.

(2016). *Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program.*

(2016). *Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1*

(2013). *Region 5 PIHP 2013 Application for Proposal for Specialty Prepaid Inpatient Health Plans.*

(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.*

(2016). *Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)(c) Waiver Program*

2015 Attachment P1.4.1, Technical Requirement for Behavioral Treatment Plan Review Committees-, Revision FY'12.

(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.

SECTION TWO – ANNUAL REPORTS

I. Council FY15 Accomplishments & FY16 Goals

ANNUAL REPORT

TEAM NAME: Operations Council

TEAM LEADER: Joe Sedlock, MSHN CEO

REPORT PERIOD COVERED: 10.1.14 – 9.30.15

Purpose of the Operations Council**:** The MSHN Board has created the Operations Council (OC) 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 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.

Responsibilities and Duties: The responsibilities and duties of the OC shall include the following:

- Advise the MSHN CEO in the development of the long term plans of MSHN;
- Advise the MSHN CEO in establishing priorities for the Board's consideration;
- Make recommendations to the MSHN CEO on policy and fiscal matters;
- Review recommendations from Finance, Quality Improvement, and Information Services Councils other Councils/Committees as assigned;
- Assure policies and practices are operational, effective, efficient and in compliance with applicable contracting requirements and regulatory standards; and
- Undertake such other duties as may be delegated by the Entity Board.

Defined Goals, Monitoring, Reporting and Accountability

The OC shall establish metrics and monitoring criteria to evaluate progress on the following primary goals:

- Expanded service access (penetration rates),
- Fiscal accountability,
- Compliance, and
- Improved health outcomes/satisfaction.

Additionally, the OC seeks to assess and achieve the following secondary goals:

- Retained function contracts achieved defined results,
- Collaborative relationships are retained (Evaluation of principles and values),
- Board satisfaction with OC advisory role,
- Staff perception and sense of knowing what is going on,
- Efficiencies are realized through standardization and performance improvement, and
- Benefits are realized through our collective strength.

OC Annual Evaluation Process

a. Past Year's Accomplishments: The OC had 11 meetings during the reporting period in that time they completed the following tasks:

- Successful Health Services Advisory Group (HSAG) Performance Measure Validation and External Quality Review Performance Corrective Action Plan Submissions
- Expanded Autism Spectrum Disorder and Habilitation Supports Waiver compliance, utilization and quality management systems
- Implemented regional approach to administering the Supports Intensity Scale
- Established effective regional credentialing systems and related policies, procedures and staffing
- Improved efficiency in delegated managed care activities
- Consolidated three sub-regional entities for Substance Use Disorder administration into a single operation direct operated by MSHN resulting in savings in excess of $1.6M; reinvested savings into programs
- Successful advocacy for reducing the historical state-wide variance in PIHP Medicaid rates
- Acquired and began operationalization of (Zenith) ZTS analytics software for improved population health management
- Completed Board Retreat leading to Regional Strategic Plan
- Developed three-year substance use disorder (SUD) prevention and treatment strategic plan
- Established regional rates for SUD contracted services
- Approved Regional Training Standards
- Refined and continued implementation of CMHSP Five Year Funding Smoothing Plan
- Planned for future collaboration with Medicaid Health Plans and Physical/Behavioral Health Integration
- Began work on Home and Community Based Services Waiver Transition (Carry forward to 2016)
- Began work on Conflict Free Case Management (Carry forward to 2016)
- Developed, approved and implemented regional Risk Management Plan
- Enhanced access for citizens with substance use concerns through SUD provider network partnerships with CMHSPs on a 24/7/365 basis
- Took steps toward increased efficiency through collective inpatient contract standardization (Carry forward to 2016)
- Began metrics development (Operations Council Balanced Scorecard – reporting begins in Calendar 2016)
- Began addressing penetration rate improvement strategies (Carry forward to 2016)
- Advocacy with Certificate of Need Commission (and other policy makers) to improve access for individuals requiring psychiatric inpatient care, especially those with challenging behaviors (Carry forward to 2016)
- Completed Annual Policy Review Processes
- Completed design for centralization of event verification system
- Established framework for Organized Health Care Arrangement
- Retained commitment to core values and collective focus despite transition of nearly 45% of regional leadership in the last 24 months

b. Upcoming Goals for Fiscal Year Ending, September 30, 2016

- Improve efficiency in delegated managed care activities
- Establish and develop collaboration infrastructure between Medicaid Health Plans and MSHN, leading to enhanced collaboration with and integration of primary and behavioral health care for persons served, resulting in measurable improvements in population health
- Home and Community Based Services Waiver Transition
- Adopt a regional approach to implementing Conflict Free Case Management
- Establish effective regional utilization management systems, including regional eligibility, medical necessity, authorization, utilization review and related protocols and procedures to promote universal and equitable access to care across the region
- Increase efficiency through collective provider network management functions
- Increase focus on meaningful metrics to measure performance and impacts (Balanced Scorecard – reporting begins in Calendar 2016)
- Improve operationalization and use of (Zenith) ZTS analytics software for improved population health management
- Achieve comprehensive penetration rate improvement strategies
- Implement region-wide outreach/education effort for obtaining, keeping and using publicly funded benefits, especially Healthy Michigan Plan
- Continue advocacy with Certificate of Need Commission (and other policy makers) to improve access for individuals requiring psychiatric inpatient care, especially those with challenging behaviors

ANNUAL REPORT

TEAM NAME: Finance Council

TEAM LEADER: Leslie Thomas, MSHN CFO

REPORT PERIOD COVERED: 10.1.14 – 9.30.15

Purpose of the Finance Council

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.

Responsibilities and Duties:

Areas of responsibility:
a. Budgeting – general accounting and financial reporting;
b. Revenue analyses;
c. Expense monitoring and management - service unit and recipient centered;
d. Cost analyses and rate-setting;
e. Risk analyses, risk modeling and underwriting;
f. Insurance, re-insurance and management of risk pools;
g. Supervision of audit and financial consulting relationships;
h. Claims adjudication and payment; and
i. Audits

Monitoring and reporting of the following delegated financial management functions:
a. Tracking of Medicaid expenditures;
b. Data compilation and cost determination for rate setting;
c. FSR, Administrative Cost Report, MUNC and Sub-element preparation;
d. Verification of the delivery of Medicaid services; and
e. Billing of all third-party payers.

Monitoring and reporting of the following retained financial management functions:
a. PIHP capitated funds receipt, dissemination, and reserves;
b. Region wide cost information for weighted average rates;
c. MDHHS reporting; and
d. Risk management plan

Defined Goals, Monitoring, Reporting and Accountability

Goals:
a. Favorable fiscal and compliance audit;
b. Operate within Medicaid Capitated Funding region wide, especially during the initial five years of transitioning to a uniform capitation rate;
c. Meet targeted goals for spending and reserve funds;

d. Assure Michigan Department of Health and Human Services (MDHHS) financial reports are submitted timely and accurately;
e. Assist CFOs experiencing significant changes in funding;
f. Assure region wide rates are within acceptable deviations from state wide rates; and
g. Work toward a uniform costing methodology.
h. Tracking of HSW services and recoupments
i. Completion of Finance Council Dashboard
j. Monitoring of Healthy Michigan Enrollments and Funding
k. Uniform Administrative Costing

Annual Evaluation Process

a. Past Year's Accomplishments
    - Operate within Medicaid Capitated Funding region wide, especially during the initial five years of transitioning to a uniform capitation rate: This goal, as of the November 2015 Interim report to MDHHS is being met for FY 2015. A final analysis will be performed on the FY 2015 Final Reports due to MDHHS February 28, 2016. Finance Council is following the MSHN Finance Capitation Payments and Budget Procedure.
    - Meet targeted goals for spending and reserve funds: It is anticipated that reserves will increase when the FY 2015 FSRs are received the end of February. MSHN will continue to disburse benefit stabilization funds in fiscal year 2016 to cover anticipated PEPM deficits for some CMHSPs and to also cover 24/7 365 Substance Use Disorder (SUD) Access.
    - Assure Michigan Department of Community Health (MDHHS) financial reports are submitted timely and accurately: Due to staff transitions within MSHN, there have been a few instances requiring resubmissions however additional verification efforts are occurring to ensure this goal is met.
    - Assist CFOs experiencing significant changes in funding; Trending reports of budget to actual and revenue to expense, and Benefit Stabilization analysis reports have been utilized on a quarterly basis to keep all CFOs informed of the financial position of all CMHSPs in the MSHN region. MSHN has also developed a policy to ensure appropriate and consistent application of requests for advances.
    - Tracking of HSW services and recoupments are managed by each CMHSP CFO and MSHN's CFO. Funding adjustments result in offsets of the current month's payment.
    - Monitoring of Healthy Michigan Enrollments and Funding – MSHN contracted with CEI through April 2015 to perform requested analysis on changes in enrollment and funding. The affiliation anticipates Healthy Michigan savings and the establishment of an Internal Service Fund (ISF)

b. Upcoming Goals for Fiscal Year Ending September 30, 2016
    - Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 2015 and February 2016. The audits will be available to the PIHP once they are reviewed by their respective Board of Directors. The goal is to have all CMHSP reports by April 2016
    - Meet targeted goals for spending and reserve funds: Determination will be made when the FY 2015 Final Reports due to MDHHS February 28, 2016, are received from the CMHSPs to the PIHP. The goal for FY16 will be to spend at a level to reduce MSHN combined reserves to 7.5% as identified by the board.
    - Work toward a uniform costing methodology: Finance Council will begin working on uniform unit costing for services in FY 2016.
    - Assure region wide rates are within acceptable deviations from state wide rates: The Medicaid Uniform Cost Report (MUNC) is due to MDHHS February 28, 2016. MDHHS will compile the PIHP reports and send an analysis to the PIHPs in June of 2016. Finance Council will follow our costing procedure and utilize this report to determine rates per service and costs per case for

which we are not within one standard deviation of the PIHP averages within the state. Following the Finance Council procedure, an analysis will be performed of outliers and steps will be taken to adjust service provision or costing for service provision for all rates unless it is determined by the CEOs that our variances from the PIHP averages are acceptable.

- Completion of Finance Council Dashboard – Finance Council members continue to populate the fiscal year 2014 Dashboard. The goal is to have the dashboard complete by April 2016.
- Uniform Administrative Costing – MSHN's CFO participates in the PIHP CFO council. A workgroup of this council developed definitions, grids, and guidelines for uniform administrative costing. Due to time constraints MSHN's Finance Council will develop a subset of guidelines for this reporting cycle.
- Monitor the impact on savings and reserves related to the change in Autism funding.

ANNUAL REPORT

TEAM NAME: Information Technology Council

TEAM LEADER: Forest Goodrich, MSHN CIO

REPORT PERIOD COVERED: 10.1.14 – 9.30.15

Purpose of the 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.

Responsibilities and Duties: The responsibilities and duties of the ITC include the following:

The IT Council will provide information technology leadership by collaborating for the purpose of better understanding MDHHS and other regulatory requirements, sharing knowledge and best practices, working together to resolve operational issues that affect both CMHSPs and MSHN, and achieve practical solutions. The IT Council will assist CMHSP IT staff in keeping up to date on current technology and with MDHHS and MSHN requirements by exchanging knowledge and ideas, and promoting standard technology practices and efficiency throughout the region. The IT Council will advise the MSHN CIO and assist with MSHN IT planning that benefits both MSHN and the individual CMHSP Participants.

Defined Goals, Monitoring, Reporting and Accountability:

The IT Council shall establish metrics and monitoring criteria to evaluate progress on the following primary goals:

- 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., convert from existing CA systems to centralized system for reporting remaining CA data, including TEDS);
- Accomplish annual goals established by the IT Council and/or OC; and
- Meet IT audit requirements (e.g., EQRO).

Annual Evaluation Process:

a. Past Year's Accomplishments
    - Representation from each CMHSP Participant at all meetings:
        - There was a 90% rate of attendance at FY15 ITC meetings. Most meetings had 100% CMHs attendance.
    - Successfully submit MDHHS required data according to MDHHS requirements regarding quality, effectiveness and timeliness;

- Data submission was highly successful as we met all requirements for MDHHS. This includes: encounters, QI, PI and CIR. Year-end statistics from MDHHS showed that we were 100% timely with encounter submissions.
- Reporting processes matured and so did any file posting processes so that staff are more comfortable using them.

- Collaborate to develop systems or processes to meet MDHHS requirements, including converting to BH TEDS, converting to ICD10, converting from existing CareNet systems to centralized MSHN CareNet system.
  - The transition from 3 sub-regional entities into a single entity managing the SUD provider network took place during the last quarter of FY2015. While there is still plenty of work to be done to close out the fiscal year, the conversion is complete.
  - A MDHHS requirement to transition from ICD-9 to ICD-10 coding occurred during the last six months of FY2015. Testing and go-live is complete for the Mid State region. All 12 CMHSPs can submit valid ICD-10 coded transactions and have started that process for FY2016.
  - MDHHS also established a requirement to transition from a QI submission format for consumer demographics to a BH-TEDS submission format. Final testing is complete and all 12 CMHSPs are working on submitting their first round of records in this format. There may be some individual record issues, but as a whole, our region was the first in the State to test and pass validation for this process.
- Accomplish annual goals established by the IT Council and/or OC:
  - Any goals/recommendations set by ITC or OC were defined and achieved throughout the year.
- Meet IT audit requirements (e.g., EQRO):
  - The HSAG audit was a success as all of the documentation submitted was reviewed and approved. HSAG didn't identify any items for correction in FY2015. All 12 CMHSPs participated in the site review process and documentation supports findings and recommendations.

b. Upcoming Goals for Fiscal Year Ending September 30, 2016

- Representation from each CMHSP Participant at all meetings.
- Successfully submit MDHHS required data according to their requirements regarding quality, effectiveness and timeliness.
- Collaborate to develop systems or processes to meet MDHHS requirements, including receiving and distributing daily enrollment files (834 format), establish a process with MiHIN for accepting Admit, Discharge, Transfer (ADT) records and distributing them to CMHSPs appropriately, support developing a process for working with Medicaid Health Plans to address any quality measures and outcomes as defined by MDHHS. (Follow-up to hospitalization regardless of cause)
- Accomplish annual goals established by the IT Council and/or OC; and
- Meet IT audit requirements (e.g., EQRO)

ANNUAL REPORT

TEAM NAME: Quality Improvement Council

TEAM LEADER: Kim Zimmerman, MSHN Director of Compliance, Customer Service and Quality

REPORT PERIOD COVERED: 10.1.14 – 9.30.15

Purpose of the Council or Committee: The Quality Improvement Council was established to advise the Operations Council and the Chief Executive Officer concerning quality improvement matters. The Quality Improvement Council is comprised of the Compliance Officer (CO) and the CMHSP Participants' Quality Improvement staff appointed by the respective CMHSP Participant Chief Executive Officer/Executive Director. The Quality Improvement Council is chaired by the Compliance Officer. All CMHSP Participants are equally represented on this council.

Responsibilities and Duties: The responsibilities and duties of the QIC include the following:

- Advising the MSHN Compliance Officer and assisting with the development, implementation, operation, and distribution of the Compliance Plan, Quality Assessment and Performance Improvement Plan (QAPIP) and supporting MSHN policies and procedures.
- Reviewing and recommending changes/revisions to the Compliance Plan and QAPIP, related policies and procedures and developing new policies and procedures as needed.
- Evaluating the effectiveness of the Compliance Plan and QAPIP.
- Determining the appropriate strategy/approach to promote compliance and detect potential violations and areas of risk as well as areas of focus.
- Recommending and monitoring the development of internal systems and controls to carry out the Compliance Plan and supporting policies as part of daily operations.
- Reviewing audit results and corrective action plans, making recommendations when appropriate.
- Implementing a Peer Review Process that incorporates best practices related to the QAPIP and Compliance Plan to encourage continuous quality improvement.

Defined Goals, Monitoring, Reporting and Accountability:

The QIC established metrics and monitoring criteria to evaluate progress on the following primary goals:

- Implementation of the Quality Assessment and Performance Improvement Plan (QAPIP),
- Implementation of the Compliance Plan;
- Implementation of the action plans related to the Application for Participation (AFP);
- Compliance and oversight of the above identified areas.

Additionally, the QIC seeks to assess and achieve the following secondary goals:

- Retained function contracts achieved defined results;
- Collaborative relationships are retained;
- Reporting progress through Operations Council;
- Regional collaboration regarding expectations and outcomes;
- Efficiencies are realized through standardization and performance improvement; and
- Benefits are realized through our collective strength

Annual Evaluation Process:

a. Past Year's Accomplishments: The QIC had thirteen (13) meetings during the reporting period and in that time they completed the following tasks:
    - Reviewed and revised the MSHN Corporate Compliance Plan
    - Reviewed and revised (as needed) current regional policies and procedures in areas of Quality Improvement and Compliance
    - Developed new regional policies and procedures (as needed) in the area of Quality Improvement and Compliance
    - Implementation and reporting of regional QAPIP including:
        - Behavior Treatment Review
        - Critical Incidents
        - Performance Improvement (MMBPIS)
        - Consumer Satisfaction
    - Feedback and participation in the External Quality Review and required plans of correction
    - Revised, implemented and monitored two (2) regional Performance Improvement Projects (PIP)
    - Provided feedback on SUD integration into current policies, procedures and practices
    - Reviewed and provided feedback on the MSHN Compliance Summary report
    - Reviewed and provided feedback on the region wide MSHN Medicaid Event Verification process
    - Reviewed and provided feedback on the Home and Community Based Waiver state implementation plan
    - Provided input on annual litigation report
    - Provided input on annual fraud and abuse report
    - Reviewed and provided feedback on delegation grid
    - Provided feedback on the MDHHS 1915(c) Waiver Quality Improvement Project Plan of Correction
    - Provided input on UM Access Process
    - Reviewed and revised the MSHN QAPIP
    - Completed the annual QAPIP effectiveness plan

b. Upcoming Goals for Fiscal Year Ending, September 30, 2016
    - Report and complete an assessment of the annual effectiveness of the QAPIP
    - Conduct ongoing annual review of required policies
    - Continue implementation, monitoring and reporting of progress on the two (2) regional Performance Improvement Projects
    - Continued monitoring of quality and performance improvement related the QAPIP
        - Behavior Treatment Review
        - Critical Incidents
        - Performance Improvement (MMBPIS)
        - Consumer Satisfaction
    - Complete annual review and revisions of Corporate Compliance Plan
    - Provide Feedback on annual Compliance Summary Report
    - Review available healthcare data for identification of trends and quality improvement opportunities
    - Develop and implement a standard regional consent to release information document
    - Develop and implement a standard regional privacy notice

II. Advisory Council FY14 Accomplishments & FY15 Goals

ANNUAL REPORT

TEAM NAME: Regional Consumer Advisory Council

TEAM LEADER: Kim Zimmerman, MSHN Director of Compliance, Customer Service and Quality

REPORT PERIOD COVERED: 10.1.14 – 9.30.15

Purpose of the Consumer Advisory Council: 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 coordinating agency requirements in the region. The Consumer Advisory Council includes representatives from all twelve (12) CMHSP Participants of the region.

Responsibilities and Duties: Other responsibilities and duties of the CAC shall include the following:

- Provide representation to the MSHN CAC on behalf of the local consumer councils;
- Assist with effective communication between MSHN and the local consumer advisory mechanisms;
- Advise the MSHN Board of Directors relative to strategic planning and system advocacy efforts for public mental health;
- Advise MSHN Board of Directors related to regional initiatives for person-centered planning, self-determination, health care integration, independent facilitation, recovery, eligibility management, network configuration, and other consumer-directed options;
- Provide recommendations related to survey processes, customer satisfaction, consumer involvement opportunities, consumer education opportunities, quality and performance improvement projects and other outcome management activities;
- Focus on region-wide opportunities for stigma reduction related to mental health and substance use disorder issues.

Defined Goals, Monitoring, Reporting and Accountability

The CAC shall review aggregate reports received from the Quality Assessment and Performance Improvement Program (QAPIP), provide recommendations, and give guidance and suggestions regarding consumer-related managed care processes.

Provide feedback for regional initiatives designed to encourage person-centered planning, self-determination, independent facilitation, anti-stigma initiatives, community integration, recovery and other consumer-directed goals.

Share ideas and activities that occur at the local CMHSP level and create an environment that fosters networking, idea sharing, peer support, best practices, and resource sharing.

Annual Evaluation Process:

a. Past Year's Accomplishments: The RCAC had 4 meetings during the reporting period in that time they completed the following tasks:
   - Reviewed materials related to SUD integration such as the SAMHSA Recovery Concepts and ROSC Policy and provided feedback
   - Reviewed the Annual Compliance Report
   - Reviewed and discussed the Supports Intensity Scale (SIS) Assessment
   - Reviewed and provided input on the MHSIP and YSS satisfaction survey results
   - Reviewed and provided feedback on the SUD satisfaction survey results
   - Discussed CMHSP site reviews and outcomes
   - Reviewed the MDCH National Core Indicator (NCI) report and provided feedback on identified barriers
   - Reviewed and approved RCAC annual report
   - Reviewed and provided feedback on the Quality Assessment and Performance Improvement Program (QAPIP)
   - Reviewed the Medicaid Event Verification Process
   - Reviewed various MSHN policies and procedures for feedback
   - Updated the Vice Chair Job Description
   - Received various presentations related to Customer Service and Quality such as MDHHS site review results, Autism and HSW waiver program, Utilization Management, Substance Use Disorder, External Quality Reviews, etc.
   - Provide advocacy for consumer related issues identified as region wide barriers

b. Upcoming Goals for Fiscal Year Ending, September 30, 2016:
   - 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 MHSIP, YSS, and external quality reviews
   - Review annual compliance report
   - Annual review and feedback on QAPIP
   - Annual Review and Feedback on Compliance Plan
   - Annual review of policies and procedures related to Customer Service
   - Annual review of MSHN Customer Handbook
   - Review and advise MSHN Board relative to strategic planning and advocacy efforts

III. Oversight Board FY14 Accomplishments & FY15 Goals

ANNUAL REPORT

TEAM NAME: SUD Oversight Policy Board

TEAM LEADER: Carl Rice, PhD. SUD Board Member

REPORT PERIOD COVERED: 10.1.14 – 9.30.15

Purpose of the Board: The 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." Region 5's 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's Accomplishments: At the beginning of FY2015, the OPB was in its infancy having been formed six weeks earlier. Over the course of FY2015, the OPB accomplished the following:

- Election of OPB Board Officers and Identifying lengths of terms
- Approval of the Intergovernmental Agreement (IGA) presented on 10/29/2014
- All counties except one (20 out of 21) have signed the IGA (Gladwin has not)
- Approval of the Public Act 2 Funding Agreement
- Development and Approval of PA2 Funding Criteria
- Provided support for MSHN's regionalization of SUD functions
- Offered advisory input on Sub-Regional Entities (CEI-SRE, Saginaw, Riverhaven). MSHN completed this task, as directed by the State of Michigan, by 09/30/2015.
- Offered insight on SUD programming, funding and functions
- Approved process for receiving SUD funding requests, reviews and determinations.
- Offered recommendations and insight regarding effective use of collaborative and community efforts

b. Upcoming Goals for FY16 ending, September 30, 2016:

- Approve and monitor use of PA2 funds for prevention and treatment services in each county of Region 5;
- Monitor and provide input regarding the implementation of the three-year SUD Strategic Plan;
- Explore strategies for jail diversion in Region 5;

- Provide advisory input to the MSHN Board regarding the SUD budget;
- Monitor SUD spending to assure it occurs consistent with PA 500.

Also worth noting, the Secretary for the OPB, Patricia Wheeler, died in late August, 2015 after a battle with cancer. Her contribution to the OPB and to SUD work through the National Council on Alcoholism was significant and she will be missed.

IV. Committee & Workgroup FY14 Accomplishments & FY15 Goals

ANNUAL REPORT

TEAM NAME: Autism Benefit Workgroup

TEAM LEADER: Todd Lewicki, MSHN UM & Waiver Director

REPORT PERIOD COVERED: 10.1.14 – 9.30.15

Purpose of the Council or Committee:
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 Waiver Coordinator and the CMHSP autism benefit staff appointed by the respective CMHSP Chief Executive Officer/Executive Director. The Autism Benefit Workgroup is chaired by the Waiver Director. All CMHSPs are equally represented on this council.

Responsibilities and Duties: The responsibilities and duties of the Autism Benefit Workgroup include the following:

- Advising the MSHN Waiver Coordinator.
- Assist with the development, implementation, and operation of the autism benefit within the region, and supporting MSHN policies and procedures.
- Reviewing and recommending changes and/or revisions to policies and procedures and developing new policies and procedures as needed.
- Evaluating the effectiveness of the autism benefit program.
- Determining the appropriate strategy or approach to promote compliance and detect potential violations and areas of risk as well as areas of focus, consistent with sound clinical documentation and service billing practices.
- Recommending and monitoring the development of internal systems and controls to carry out the supporting policies as part of daily operations.
- Reviewing audit results and corrective action plans, making recommendations when appropriate.
- Implementing processes that incorporate best practices and encourage continuous quality improvement for autism program operations and service-related outcomes.

Defined Goals, Monitoring, Reporting and Accountability:
The autism benefit workgroup via the established metrics and monitoring criteria identified in the 1915(i) State Plan Amendment (iSPA) to evaluate progress on the following primary goals:

- Reduction and elimination of overdue re-evaluations;
- Reduction and elimination of overdue Individual plan of service (IPOS);
- Hours of ABA within a quarter must be within the IPOS suggested range for the intensity of service plus or minus a variance of 25%.
- Tracking of pending cases (only referred and awaiting an evaluation);

- Implementation of the agreed upon correction actions related to the Michigan Department of Health and Human Services (MDHHS) Autism Benefit site review findings;
- Compliance and oversight of the above identified areas.

Additionally, the autism benefit workgroup seeks to assess and achieve the following secondary goals:

- Collaborative relationships are retained;
- Reporting progress through the MSHN Clinical Leadership Council or MSHN Quality Improvement Council, as identified;
- Regional collaboration regarding expectations and outcomes;
- Efficiencies are realized through standardization and performance improvement; and
- Benefits are realized through our collective strength (knowledge, experience, abilities, and resources).

Annual Evaluation Process:

a. Past Year's Accomplishments

- The Autism Benefit Workgroup met quarterly and as needed to prepare for the MDHHS site review during FY15.
- The Autism Benefit Workgroup responded to the individual elements of results of the MDCH site review of the CMHSP autism programs and began work on related products.
- Updated autism policy to reflect corrective actions from FY15 MDHHS review.
- Visits with each CMHSP in the corrective plan to oversee and discuss progress.
- Established training outline for Relias.
- Reduced variance in autism code billing.
- Updated Autism policy incorporating additional iSPA elements.
- Update forms for Autism Benefit (Referral, Enrollment, Re-evaluation and Disenrollment).
- Develop reports on the 3 elements (overdue reevaluations, overdue IPOS, service outside the plus/minus 25% identified in the IPOS).
- Created guide for tracking conditions needed for autism payment.
- Completed FY2015 Site Review CAP elements with approval from MDHHS.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2016

- Develop new transfer form when consumer moving out of one CMH to another whether in region or out.
- Regional Autism Benefit Program policy anticipated updates from benefit expansion.
- Review and implementation of new autism expansion benefit, out of the EPDST.
- Improvement in autism performance indicators, with application of corrective actions started in FY15.
- Continue to address university partnerships, and contractual opportunities.
- Complete charter for Autism Workgroup to formalize ongoing work and identified points of accomplishment.

ANNUAL REPORT

TEAM NAME: BTPR Workgroup

TEAM LEADER: Kim Zimmerman, MSHN Director of Compliance, Customer Service and Quality

REPORT PERIOD COVERED: 10.01.14 - 9.30.15

Purpose of the Council or Committee:

The Behavior Treatment Plan Review Workgroup was established to ensure compliance and oversight of the delegated function of Behavior Treatment Plan (BTP) Committees to the CMHSP Participants in accordance with the Michigan Department of Community Mental Health Medicaid Managed Specialty Supports and Services Contract, P.1.4.1 Technical Requirement for Behavior Treatment Plans. The BTR Workgroup is comprised of the MSHN Compliance Officer and the CMHSP Behavior Treatment Review staff appointed by the respective CMHSP Chief Executive Officer/Executive Director. The BTR Workgroup is chaired by the MSHN Compliance Officer.

Annual Evaluation Process:

a. Past Year's Accomplishments: The BTRC had five (5) meetings during the reporting period and in that time they completed the following tasks:
   - Received and reviewed regional BTPR quarterly reports, identifying performance against targets and benchmark data
   - Developed standard data collection tool
   - Developed standardized definitions and interpretations
   - Provided feedback on external quality review
   - Received consultation from MDHHS content expert

b. Upcoming Goals for Fiscal Year Ending, September 30, 2016
   This workgroup is no longer actively meeting as the group accomplished the identified goals. No new goals need to be established at this time. The BTR data will now be reviewed and monitored during the Quality Improvement Council meetings.

ANNUAL REPORT

TEAM NAME: Clinical Leadership Committee

TEAM LEADER: Linda Schneider, CMHSP Participant
& Dani Meier, MSHN CCO

REPORT PERIOD COVERED: 10/1/14 – 9/30/15

Purpose of the Council or Committee:

The MSHN Operations Council (OC) has created a CLC to advise the Pre-paid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) and the OC concerning the clinical operations of the Entity 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 the Entity 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.

Responsibilities and Duties:

The responsibilities and duties of the CLC include the following:

- Advise the CEO and OC in the development of clinical best practice plans for MSHN (including implementation and evaluation);
- Advise the CEO and OC in areas of public policy priority including high risk, high cost, restrictive interventions, or that are problem prone;
- Provide a system of leadership support, collaborative problem solving and resource sharing for difficult case discussion ("grand rounds");
- Support system-wide sharing though communication and sharing of major initiative (regional and statewide)
- Assure clinical policies and practices are operational, effective, efficient and in compliance with applicable contracting and regulatory bodies; and
- Undertake such other duties as may be delegated by the CEO or OC.

Defined Goals, Monitoring, Reporting and Accountability:

The CLC shall establish metrics and monitoring criteria to evaluate progress on the following primary goals:

- Improved health outcomes.
- Increased use of evidenced based practices.
- Improved collaboration of the region's clinical leadership including member satisfaction with the committee process and outcomes.
- Increased use of shared resources and problem solving for difficult cases.

Additionally, the CLC seeks to assess and achieve the following secondary goals:

- CEO and OC satisfaction with CLC advisory role,
- Staff perception and sense of knowing what is going on, and
- Efficiencies are realized through standardization, performance improvement and shared resources.

Annual Evaluation Process:

a. Past Year's Accomplishments:

The CLC has discussed and acted on a broad range of clinical issues associated with the PIHP's target populations of people living with severe and persistent mental illness, developmental disabilities and substance use disorders.

The CLC served as a forum for regional and collaborative regional clinical policy development and input, problem-solving, resource identification, sharing and gaps, assessment and development of Evidence Base Practices, review of Region 5's Network Adequacy Assessment, and implementation or review of multiple initiatives. The CLC, for example, provided regional leadership and guidance for the implementation of two evidence best practices: Trauma Informed System of Care, and the expansion of Peer Health Coaches.

Among the issues the CLC addressed at different stages of the exploration, planning and implementation process are the following:

- Out-of-Network placement in particular challenging residential cases
- Trauma Informed Care including secondary trauma and sharing best practices
- Coordination of care with PCP so that best practices can be shared with others
- Preparation for LOCUS as a region-wide assessment tool
- Parent Support Partner programs
- Coordinate work of the UMC with the CLC to address common LOC tools and criteria
- SIS Implementation
- SUD Access and integration
- HCBS Transition Planning
- Conflict Free Case Management
- Adoption of BH Teds, ICD-10, DSM-V
- UM Dimensions of Need and associated data points
- Integration of SUD EMR activities with MH EMR
- Corrective action needed for the ASD site review
- Clarification of alternatives of regional Acute Care, Crisis and Residential care
- Transitioning to an integrated EMR for BH/SUD
- Assessments for Infant Mental Health

b. Upcoming Goals for Fiscal Year 2016 Ending, September 30, 2016

The CLC will be involved in monitoring, developing and recommending improvements to:

- Population health outcomes including emergency department use and access to primary care physicians in collaboration with MSHN's ongoing work with the region's Medicaid Health Plans

- Coordination of care between primary and behavioral health care services
- MH and SUD integration including movement from ROSC to RISC (Recovery Integrated Systems of Care)
- Expansion and implementation of trauma competence, gender competence and cultural competence
- Expansion and development of services to active military and veterans
- Collaboration with diversion initiatives, DOC, law enforcement and the courts
- Improved service coordination
- Expanded and integrated prevention services
- Building capacity in psychiatric services, for children and adolescents in particular
- Expansion of MAT services
- Regional consistency in access standards and delivery of services.

ANNUAL REPORT

TEAM NAME: Customer Service Committee

TEAM LEADER: Kim Zimmerman, MSHN Director of Compliance, Customer Service and Quality

REPORT PERIOD COVERED: 10.1.14 – 09.30.15

Purpose of the Customer Service Committee: This body 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 MSHN Compliance Officer (CO) and will report through the Quality Improvement Council (QIC).

Responsibilities and Duties: The responsibilities and duties of the CSC will include:

1. Advising the MSHN CO and assisting with the development, implementation and compliance of the Customer Services standards as defined in the MDCH contract and 42 CFR including the Balanced B udget Act Requirements;
2. Reviewing and providing input regarding MSHN Customer Services policies and procedures;
3. Reviewing, facilitating revisions, publication, and distribution of the Consumer Handbook;
4. Facilitating the development and distribution of regional Customer Services information materials;
5. Ensuring local-level adherence with MSHN regional Customer Services policies through i mplementation of monitoring strategies;
6. Reviewing semi-annual aggregate grievance, appeals, second opinions and recipient rights reports;
7. Reviewing audit results from EQR and MDCH site reviews and assisting in the development and o versight of corrective action plans regarding Customer Services;
8. Participating in MSHN's Delegated Managed Care Review process;
9. Assisting in the formation and support of the RCAC, as needed; and
10. Individual members serving as ex-officio member to the RCAC.

Defined Goals, Monitoring, Reporting and Accountability

The CSC shall establish metrics and monitoring criteria to evaluate progress on the following primary goals:

- Customer Service Handbook completion, updates and SUD incorporation;
- Regional Customer Service policy development;
- Tracking and reporting Customer Service information; and
- Compliance with Customer Service Standards.

Additionally, the CSC seeks to assess and achieve the following secondary goals:

- Retained function contracts achieved the defined results;
- Collaborative relationships are retained;
- Reporting progress through Quality Improvement Council;
- Regional collaboration regarding customer service expectations and outcomes;
- Efficiencies are realized through standardization and performance improvement; and
- Benefits are realized through our collective strength.

Annual Evaluation Process:

a. Past Year's Accomplishments: The CSC had eleven (11) meetings during the reporting period in which they completed the following tasks:
    - Revised MSHN Customer Service Handbook to include changes within the Region and contractual changes
    - Developed and revised regional policies and procedures in areas of Customer Service and Consumer Advisory Council
    - Developed standard templates for grievances and appeal acknowledgement and disposition letters
    - Reporting of regional customer service information including:
        - Grievances
        - Appeals
        - Second Opinions
        - Medicaid Fair Hearings
        - Recipient Rights
    - Provider feedback and participation in the External Quality Review
    - Integrated Substance Use Disorder (SUD) into current practices, policies/procedures, consumer handbook, etc.
    - Provided input on SUD provider manual
    - Provided input with establishing outcomes related to Consumer Satisfaction Surveys (MHSIP and YSS)
    - Reviewed and revised Customer Service Section of the MSHN Delegation Grid for FY15

b. Upcoming Goals for Fiscal Year Ending, September 30, 2016
    - Conduct ongoing annual review of required policies and procedures
    - Conduct annual review and revisions to MSHN Consumer Handbook to reflect regional changes and contract updates
    - Develop, where applicable, MSHN standardized elements for regional forms including:
    - Continue reporting and monitoring customer service information
    - Evaluate oversight & monitoring of regional grievances & appeals, in accordance with customer service standards
    - Review regional customer service site review results, develop region wide action plan if appropriate
    - Review consumer satisfaction surveys, develop and implement action plans as required per the customer service elements

ANNUAL REPORT

TEAM NAME: HSW Workgroup
TEAM LEADER: Todd Lewicki, MSHN UM & Waiver Director
REPORT PERIOD COVERED: 10.1.14 – 9.30.15

Purpose of the Council or Committee:
The Habilitation Supports Waiver (HSW) Workgroup was established to initiate and oversee coordination of the HSW benefit for the region. The HSW Workgroup is comprised of the Waiver Director and the CMHSP HSW Coordinator staff appointed by the respective CMHSP Chief Executive Officer/Executive Director. The HSW Workgroup is chaired by the Waiver Director.

Annual Evaluation Process:

a. Past Year's Accomplishments

- The HSW Workgroup met quarterly during FY15.
- The HSW Workgroup incorporated changes to MDHHS forms used for HSW eligibility.
- The HSW Workgroup ensured priority management of cases through child waiver and rubric.
- Reviewed and discussed upcoming HCBS changes to HSW.
- Prepared survey process for HCBS changes.
- Review potential recoupments process.
- Review HSW dashboard data and formulate plan for correction-open slots, recoupments, recertification data, overdue IPOS, overdue consents.
- Review CLS tools used in region.
- Coordinated and prepared for the June 2015 MDCH site review.
- Coordinate and review HSW CAP.
- Action plan and follow through on HSW CAP.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2015

- Continue to use and institute corrective process for report set for overseeing HSW performance within the region.
- Focus on filling number of slots available for consumers within the region.
- Oversee the HCBS transition process for HSW consumers and ensure proper implementation of new 1115 waiver.
- Meet quarterly to address regional needs.
- Clarify CMHSP processes and dates in relation to WSA dates.
- Complete a charter for the HSW workgroup to continue focus on HCBS transition plan.

ANNUAL REPORT

TEAM NAME: Provider Network Management Committee

TEAM LEADER: S. Vandermay/P. Bush CMHSP Participants

REPORT PERIOD COVERED: 1.1.15 – 9.30.15

Purpose of the Council or Committee: The Provider Network Management 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) credentialing, privileging and primary source verification of professional staff, and 4) periodic assessment of network capacity. 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.

Responsibilities and Duties: The responsibilities and duties of the PNMC include the following:

- Advise MSHN staff in the development of regional policies for Provider Network Management;
- Establish regional priorities for training and establish training reciprocity agreements for (CMHSP) Sub-Contractors;
- Support development of regional PNM monitoring tools to support compliance with rules, laws, and the PIHPs Medicaid contract with MDCH.
- Provide requested information and support development of periodic Network Capacity Assessment;
- Monitor results of retained functions contract for Network Capacity Assessment;
- Support development and implementation of a Regional Strategic Plan;
- Look for opportunities and recommend strategies to establish uniformity in contract language and rates, to achieve best value
- Establish regional contract negotiations reciprocity;
- Recommend and deploy strategies for sub-contractor credentialing reciprocity agreements; and
- Support development of regional agreements with Medicaid Health plan agreements.

Defined Goals, Monitoring, Reporting, and Accountability: The PNMC shall establish goals consistent with the MSHN Strategic Plan and to support compliance with the MDCH – PIHP contract including:

1. Completion of a Regional Network Capacity Assessment; establish and execute plans to address service gaps;
2. Recommend policy and practices for improved network management compliance and efficiency;
3. Establish performance improvement priorities identified from monitoring of delegated provider network management functions;

4. Increased efficiency through regional contracting when providers are shared;
5. Development of reciprocity agreements for sub-contract credentialing/re-credentialing, training, performance monitoring, and standardized contract language;
6. Implement strategies to establish regional inpatient rate negotiations for best value; and
7. Fully execute regional agreements with Medicaid Health Plans due to rebidding of health plans; strategic relationship to align with additional health plan and PIHP contract requirements.

Annual Evaluation Process:

a. Past Year's Accomplishments: The PNMC had eight meetings during the reporting period in that time they completed the following tasks:
    - Completed and had approved a regional Assessment of Network Adequacy;
    - Drafted a region-wide contract and initiated inpatient contract negotiation strategy;
    - Developed and implemented region-wide training requirements
    - Developed region-wide credentialing and re-credentialing policies and procedures; and
    - Established regional standards for professional and direct care worker training.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2016
    - Update the Assessment of Network Adequacy to address newly identified needs specifically services added as a result of Healthy Michigan Plan implementation;
        - Address network capacity issues for opiate and mediation assisted treatment; work with existing provider to meet regional consumer need;
        - Further research needs to address service capacity for children and families;
        - Improve access for designated eligible veterans;
    - Implement region-wide inpatient contract negotiations with six (6) priority inpatient hospitals;
    - Adopt standardized Fiscal Intermediary practices for contract, monitoring, and documentation of training;
    - Per the recommendation of the Operations Council, propose a plan to eliminate COFR agreements within the region, to improve intra-region efficiency, but maintain COFR agreements across regions;
    - Document regional training objectives (MSHN Training Glossary); and
    - Develop a coordinated sub-contractor/provider manual.

ANNUAL REPORT

TEAM NAME: Substance Use Disorder Workgroup

TEAM LEADER: Dani Meier, MSHN Chief Clinical Officer

REPORT PERIOD COVERED: 10.1.14 – 9.30.15

Purpose of the Council or Committee:
The SUD Workgroup was formed under the umbrella of MSHN as part of the mandate from PA500 to integrate mental health and substance use disorder treatment and prevention. Due to the size and diversity of Region 5 (21 counties including rural and urban populations), MDC/MDHHS permitted a transitional arrangement in Region 5 in which 3 former Coordinating Agencies (CA's) continued to function in their respective regions but were to operate as sub-contractors of MSHN and were to use FY 2015 to move towards regional consistency in policies, practices and services. This workgroup was established to facilitate and direct this transition and reorganization using a unified approach.

The SUD workgroup was comprised of members of all three SRE's and focused on developing regional consistency, common policies and practices, and other mandates of PA500. Initially, the SUD Workgroup was chaired by the contract designee as SUD prevention and treatment coordinator. In September, MSHN hired Dani Meier as Director for Health Integration, Treatment and Prevention and leadership of this group transitioned to this new position. An executive committee of the SUD Workgroup was also formed comprised of MSHN CEO, the Director for Health Integration, Treatment and Prevention and the Sub-Regional Entity Directors.

Responsibilities and Duties: The responsibilities and duties of the SUD Workgroup include the following:

- Serve at the discretion of the MSHN Chief Executive Officer (CEO) and MSHN's Board of Directors
- Spearhead reorganization of the SUD Coordinating Agencies into subcontracted Sub-Regional Entities (SREs)
- Develop a 3 year strategic plan for addressing substance use disorder treatment and prevention up through 2017
- Create subcommittees to work on specific parts of the transition into SREs and goals of the strategic plan

Defined Goals, Monitoring, Reporting and Accountability: The SUD Workgroup established goals and monitoring criteria to evaluate progress on the following primary goals:

1. Report to MSHN's CEO
2. Follow goals related to SUD treatment and prevention as per the FY2015-2017 Strategic Plan
3. Create a delegation grid/work plan to assign, track and monitor roles and responsibilities
4. Develop schedule for reporting as required by MDCH, LARA and other state or federal bodies.

Annual Evaluation Process:

Accomplishments of the SUD Workgroup include the following:

- Completion of MSHN's SUD 3-year Strategic Plan. This plan was written prior to FY2014 but MDCH had some requirements for final approval. The SUD Workgroup made the required revisions/additions and the plan was approved MDCH.
- Establishment of a Carenet Development Committee (CDC) to work with Netsmart (the Carenet vendor) on creating a unified and uniform Carenet system across Region 5. An April 1, 2015, target date to go live with the new system had to be pushed back to mid-April due to technical challenges, but by the end of April, a uniform Carenet system was in place for 20 of MSHN's 21 counties. Saginaw SRE was delayed due to being on an older version of Carenet, but by the end of May, Saginaw SRE was brought online with the unified Carenet system as well.
- Trainings for providers in the new Carenet system were provided via webinar across Region 5.
- A group focused on rate-setting to create a single set of rates for SUD providers in Region 5.
- The SUD Workgroup reviewed OROSC enhancement grants focused on Women's Specialty Services, expanded services for adolescents, increased multi-agency collaboration, prevention services for children of parents receiving MAT services, increasing Peer Recovery coaches and Recovery Housing. The latter two grants were awarded to a provider in the Riverhaven region.
- An RFP for MAT providers was developed and promulgated across the state to increase capacity for services related to the Opioid epidemic currently afflicting the region, state and nation. The general quality of the MAT proposals was sub-standard so the SRE's worked with existing MAT providers to expand and strengthen services.
- Consistent region-wide procedures were developed focusing on issues like recipient rights complaints, provider appeals, etc.
- Exploration of how to respond to PA200 was reviewed with Saginaw's developing a template for family members of prospective consumers to use to access court-ordered SUD treatment.
- Development of a Network Adequacy Assessment (with contractual assistance of BABHA) to identify gaps in services in Region 5.
- Development of a regionally consistent SUD Provider manual.
- Development of a uniform SUD Provider contract.
- A Subcommittee was created amongst the SREs to develop the SUD Provider Manual.
- Discussions took place re: CareNet Women's section that still needs to be created on CareNet for reporting purposes.
- A Subcommittee was created amongst the SREs to develop the site review protocol for SUD.

Starting in June, MSHN made a decision to bring SUD prevention and treatment in-house as of FY2016. Towards that end, MSHN hired a number of staff from the SUD Workgroup including 2 prevention specialists, a treatment specialist, a financial analyst, a compliance director and a recipient rights coordinator.

By the end of summer 2015, the SUD workgroup became less and less functional as the SRE's started to wind down their operations, as key players came to MSHN and others took positions elsewhere.

As of September 30, 2015, the SRE's were formally dissolved and SUD treatment and prevention came under the direct administration of MSHN.

ANNUAL REPORT

TEAM NAME: SIS Implementation Workgroup
TEAM LEADER: Todd Lewicki, MSHN UM & Waiver Director
REPORT PERIOD COVERED: 10.1.14 – 9.30.15

Purpose of the Council or Committee:

The Supports Intensity Scale (SIS) Implementation Workgroup was established to initiate and oversee coordination and implementation of the Supports Intensity Scale assessments for the region. The SIS Implementation Workgroup is comprised of the Waiver Director and the CMHSP SIS assessor staff appointed by the respective CMHSP Chief Executive Officer/Executive Director. The SIS Implementation Workgroup is chaired by the Waiver Director.

Annual Evaluation Process:

a. Past Year's Accomplishments
- The SIS Implementation Workgroup met quarterly during FY15.
- The SIS Implementation Workgroup distributed CMHSP assignments to cover region.
- Completed the General SIS procedure to add contract and billing information.
- Established a plan for interpretation of consumer declining being present to be a part of their assessment.
- Determined guidance for out of region requests.
- Developed SIS completion tracking reports.
- Formalized SIS agreement.
- Developed SIS survey for consumers and providers and plan for implementation.
- Improvement to the SIS assessment scheduling process.
- Addressed attitudinal barriers to SIS implementation.
- Begin discussions on SIS quality lead for the region.
- Formalized SIS corrective action planning for improving number of completed assessments.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2015
- Formalize procedures relating to MSHN SIS Quality Lead.
- Improvement in rate of SIS completion.
- Create SIS aggregate report for tracking level of need assessed in CMHSPs and compare to MSHN.
- MSHN continued presence at State SIS meetings for information coordination.
- Continue to ensure proper tracking and progress toward meeting weekly, monthly, and annual assessment targets.
- Continue review and tracking of enhanced SIS completion reporting and gather data on declined and refused assessment.
- Complete MSHN SIS workgroup charter for purpose of data oversight, ensuring completion of assessments in timely fashion, and efficient use of quality lead.

ANNUAL REPORT

TEAM NAME: Utilization Management Committee
TEAM LEADER: Todd Lewicki, MSHN UM & Waiver Director
REPORT PERIOD COVERED: 10.1.14 – 9.30.15

Purpose of the 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 Mental Health Prepaid Inpatient Health Plan Contract and related Federal & State laws and regulations.

Responsibilities and Duties: The responsibilities and duties of the UMC include the following:

- Develop and monitor a regional utilization management plan;
- Set utilization management priorities based on the MSHN strategic plan and/or contractual/public policy expectations;
- Recommend policy and practices for access, authorization and utilization management standards that are consistent with requirements and represent best practices;
- Participate in the development of access, authorization and utilization management monitoring criteria and tools to assure regional compliance with approved policies and standards;
- Support development of materials and proofs for external quality review activities;
- Establish improvement priorities based on results of external quality review activities;
- Recommend regional medical necessity and level of care criteria;
- Review and monitor utilization patterns and analysis to detect and recommend remediation of over/under or inappropriate utilization; and
- Recommend improvement strategies where adverse utilization trends are detected.

Defined Goals, Monitoring, Reporting and Accountability – As defined by the Utilization Management Plan:

1. CMHSP participants shall ensure that the access system staff are qualified, credentialed and trained consistent with the Medicaid Provider Manual, MIChild Provider Manual, the Michigan Mental Health Code and the MDCH/PIHP contract.
2. CMHSP participants shall ensure that there is no conflict of interest between the coverage determination and the access to, or authorization of, services.
3. CMHSP participants shall monitor provider capacity to accept new individuals, and be aware of any providers not accepting referrals at any point in time.
4. CMHSP participants shall routinely measure telephone answering rates, call abandonment rates and timeliness of appointment and referrals at any point in time. Any performance issues shall be addressed through the PIHP Quality Assurance and Process Improvement Plan.
5. CMHSP participants shall assure that the access system maintains medical records in compliance with state and federal standards.
6. The CMHSP participants shall work with individuals, families, local communities, and others to address barriers to using the access system, including those caused by lack of transportation.

Annual Evaluation Process:

a. Past Year's Accomplishments: The UMC had ten meetings during the reporting period in that time the following tasks were completed:
   - Updated the regional Utilization Management Plan that included attention to:
     - Training and Educations
     - Consistent Regional Benefit
     - Consistent Global Criteria
   - UM Action Plan clarification to include performance improvement actions from delegated functions site reviews, and also include:
     - Scope of services to be included in primary care access.
     - Health outcomes, Self-determination and Emergency room utilization.
   - Added to consistent data review around:
     - Community and state inpatient utilization
     - Autism Benefit
     - Consumer demographics
     - Healthy Michigan penetration
     - CAFAS scores
     - Monitoring population outcomes (key performance indicators)
     - NGRI data by PIHP
   - Policy review using data related to UM.
   - BH-TEDS data review.
   - Mid-State Supplemental Values (MSSV) Dataset creation, review and approval.
   - Planning around improving HMP penetration rate.
   - Inclusion of SUD staff into UM Committee.
   - Inclusion of IT staff as ad hoc into UM processes and supplemental data planning.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2016
   - Follow utilization management priorities based on the MSHN strategic plan and/or contractual/public policy expectations;
   - Recommend policy and practices for access and authorization standards that are consistent with requirements and represent best practices;
   - Recommend regional medical necessity and level of care criteria;
   - Review and monitor utilization patterns and analysis to detect and recommend remediation of over/under or inappropriate utilization;
   - Establish performance improvement priorities identified from monitoring of delegated utilization management functions; and
   - Recommend improvement strategies where adverse utilization trends are detected;
   - Fully implement BH-TEDS and MSSV datasets into UM data reporting;
   - Ensure guiding policy is established regarding HMP eligibility for CMHSP services;
   - Recommend areas of focus for population health measures;
   - Complete plan for increasing HMP penetration;
   - Integration of substance use disorder (SUD) into UM practices.

SECTION THREE – PERFORMANCE MEASUREMENTS

I. Behavior Treatment Review Reports

Summary Report

Title of Measure: Behavior Review Data

Committee/Department: Quality Improvement Council

Reporting Period (month/year): From FY2015-Q4

Data Analysis: (threats to validity; statistical testing; reliability of results; statistical significance; need for modification of data collection strategies)

The study is required by the Michigan Department of Community Health (MDCH). The data collected is based on the definition and requirements that have been set forth within the Behavioral Technical Requirements 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. Data will be collected and reviewed 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. This data is to be reviewed as part of the CMHSP Quality Improvement Program (QIP) and reported to the PIHP Quality Committee (Quality Assessment and Improvement Program). MSHN monitors that the local CMHSP BTRC follows the requirements outlined within the Technical Requirement for Behavior Treatment Review Committees. MSHN will analyze the data on a quarterly basis to address any trends and/or opportunities for quality improvements. Data shall include numbers of interventions and length of time the interventions were used per person. (MSHN Final Draft Quality Assessment and Performance Improvement Plan, pg. 8)

Data Interpretation: (performance against targets and benchmark data)

Study Question 1: Has the proportion of individuals who have received a restrictive/intrusive intervention decreased over time?

Numerator: The total number of individuals that have an approved behavior treatment plan that include a restrictive and/or intrusive intervention.

Denominator: The total number of individuals who are actively receiving services during the reporting period.

This question reviews the rate per 100 of plans approved with restrictive and intrusive interventions approved per the number of individuals who have been served per quarter. Currently each CMHSP has a process in place to approve all plans which include restrictive and intrusive interventions as required

on a quarterly basis.

Currently, MSHN is taking steps to standardize this process by:

- Receiving clarification from MDCH regarding the actual requirement for the monitoring of the restrictive and intrusive interventions. Clarification has been received, and it was determined that monitoring of restrictive and intrusive interventions should occur at the CMHSP level and not at the PIHP level.
- Participating in the MDCH Behavioral Treatment Work Group to review the technical requirements attached to the Medicaid Specialty Supports and Services contract.
- Discussing the process at Regional BTRC meetings.
- Identifying and defining standard restrictive and intrusive techniques used consistently throughout MSHN. Most commonly used interventions have been defined for regional use.

FY15Q1

Out of the 12 CMHSP's, 327 individuals have an approved behavior treatment plan that include a restrictive and/or intrusive intervention. That equates to 1.26% (327/26023) consumers served in the region for FY15Q1 as of January 31, 2015 and have an approved plan for behavior treatment with a restrictive or intrusive intervention. Both the consumers served and the number of plans have decreased. The rate of consumers with a plan has decreased at a higher rate (6.8%) than the rate of consumers served has decreased (1.16%).

FY15Q2

Out of the 12 CMHSP's, 347 individuals have an approved behavior treatment plan that include a restrictive and/or intrusive intervention. That equates to 1.38% (347/25175) consumers served in the region for FY15Q2 as of March 31, 2015 and have an approved plan for behavior treatment with a restrictive or intrusive intervention.

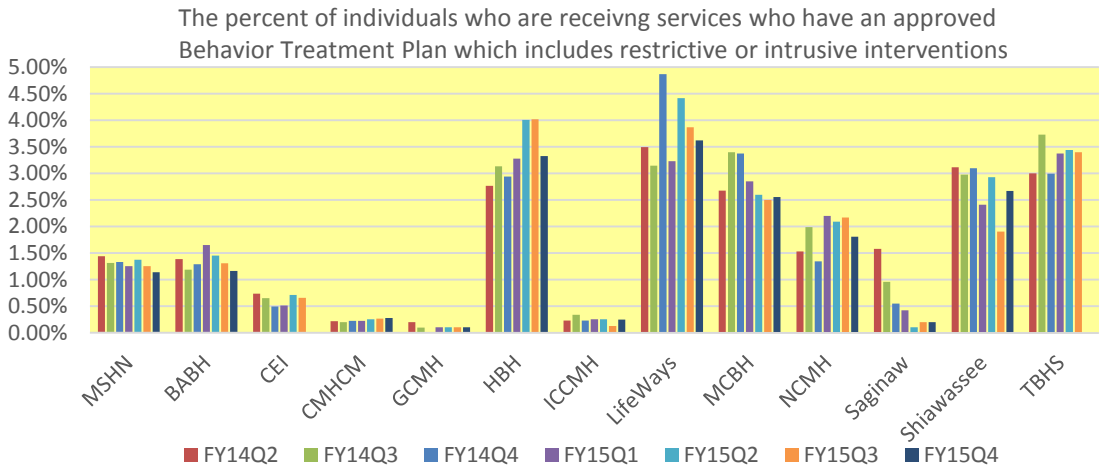
FY15Q3

Out of the 12 CMHSP's, 331 individuals have an approved behavior treatment plan that include a restrictive and/or intrusive intervention. That equates to 1.26% (331/26360) consumers served in the region for FY15Q3 as of July 31, 2015 and have an approved plan for behavior treatment with a restrictive or intrusive intervention.

FY15Q4

Out of the 12 CMHSP's, 306 individuals have an approved behavior treatment plan that include a restrictive and/or intrusive intervention. That equates to 1.14% (306/26778) consumers served in the region for FY15Q4 as of October 30, 2015 and have an approved plan for behavior treatment with a restrictive or intrusive intervention.

Figure 1



Study Question 2: Has the proportion of individuals who have received physical intervention decreased overtime?

This will be monitored by looking at the numerators and the denominators below.

Numerator: The total number of individuals with whom more than one emergency physical intervention was used during the reporting period.

Denominator: The total number of individuals with whom emergency physical interventions were used during the reporting period.

Numerator: The total number of individuals with whom emergency physical intervention were used during the reporting period.

Denominator: The total number of individuals who are actively receiving services during the reporting period.

FY15Q1

During this reporting period there were 232 emergency physical interventions used. Less than 1% (.89% - 232/26023) of the individuals (Medicaid) served received an emergency physical intervention. This is a slight increase in the rate per 100 consumers served from the previous reporting period. Of those who received a service, 65 experienced an emergency physical intervention. Of those 65 who received an emergency physical intervention, 31 (48%) individuals received more than one physical intervention. Figure 3 demonstrates the number of individuals who received an emergency physical intervention and the number of individuals who received more than 1 emergency physical intervention during the reporting period. Figure 2 identifies an increase for TBHS in emergency physical interventions. The number of "hands down" had increased. Further discussion regarding this intervention is below.

FY15Q2

During this reporting period there were 279 emergency physical interventions used. More than 1% (1.11% - 279/25175) of the individuals (Medicaid) served received an emergency physical intervention.

This is an increase in the rate per 100 consumers served from the previous reporting period. Of those who received a service, 67 experienced an emergency physical intervention. Of those 67 who received an emergency physical intervention, 30 (45%) individuals received more than one physical intervention. Figure 3 demonstrates the number of individuals who received an emergency physical intervention and the number of individuals who received more than 1 emergency physical intervention during the reporting period. Figure 2 identifies the percent of individuals served who received an emergency physical intervention.

FY15Q3

During this reporting period there were 199 emergency physical interventions used. More than .75% (199/26360) of the individuals (Medicaid) served received an emergency physical intervention. This is a decrease in the rate per 100 consumers served from the previous reporting period. 77 individuals received an emergency physical intervention. Of the 77 who received an emergency physical intervention, 25 (32%) individuals received more than one physical intervention. Figure 3 demonstrates the number of individuals who received an emergency physical intervention and the number of individuals who received more than 1 emergency physical intervention during the reporting period. Figure 2 identifies the percent of individuals served who received an emergency physical intervention.

FY15Q4

During this reporting period 65 individuals received an emergency physical intervention. A total of 161 emergency physical interventions were used. Less than 1% (.60% -161/26778) of the individuals (Medicaid) served received an emergency physical intervention. This is a decrease in the rate per 100 consumers served from the previous reporting period. Of the 65 who received an emergency physical intervention, 34 (52%) individuals received more than one physical intervention. Figure 3 demonstrates the number of individuals who received an emergency physical intervention and the number of individuals who received more than 1 emergency physical intervention during the reporting period. Figure 2 identifies the percent of individuals served who received an emergency physical intervention.

Figure 2

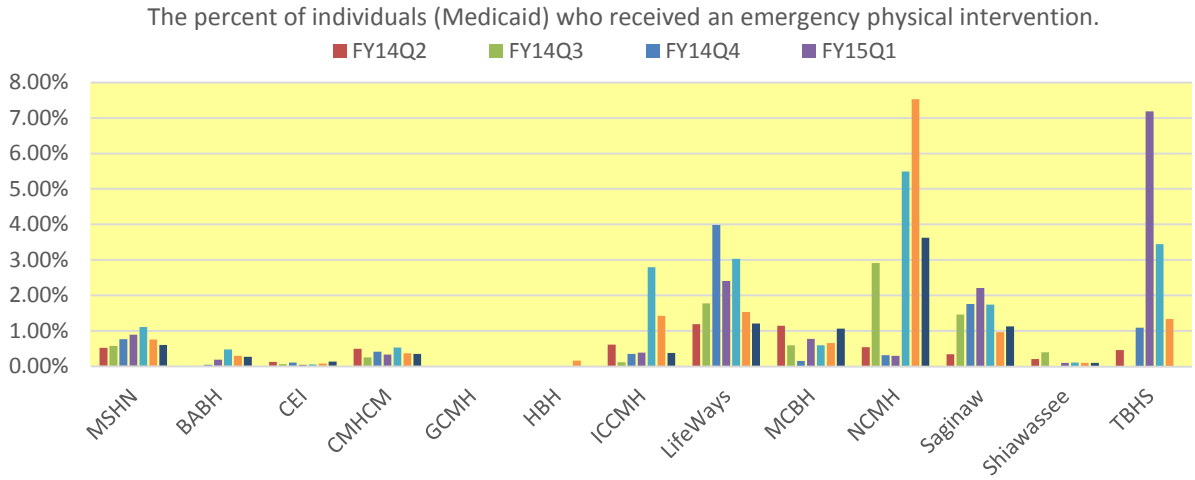


Figure 3

The top row for each CMHSP is the number of individuals who received more than one emergency physical intervention during the reporting period. The bottom row is the total number of individuals who received an emergency physical intervention during the reporting period.

	FY15Q1	FY15Q2	FY15Q3	FY15Q4
MSHN	**31**	**30**	**25**	**34**
	65	**67**	**77**	**65**
BABH	2	6	3	4
	4	8	7	6
CEI	0	0	0	0
	2	2	3	**5**
CMHCM	4	0	4	8
	11	10	13	22
GCMH	0	0	0	0
	0	0	0	0
HBH	0	0	0	0
	0	0	1	0
ICCMH	1	1	0	0
	2	1	0	2
LifeWays	10	7	6	8
	17	11	12	14

	FY15Q1	FY15Q2	FY15Q3	FY15Q4
MCBH	1	2	1	2
	3	2	2	4
NCMH	0	2	2	2
	2	4	4	2
Saginaw	7	7	5	7
	16	17	29	16
Shiawassee	0	0	0	0
	1	1	1	1
TBHS	6	5	4	3
	7	11	5	4

FY15Q1

Two hundred and thirty two (232) emergency physical interventions were used during FY15Q1 across the Mid-State Health Network Region. Figure 4 provides additional data on the types of interventions that were used. A decrease is exhibited in each area except the use of Hands Down with resistance. This is an area that additional education and discussion should take place to ensure consistency of reporting. Without clear guidance of this intervention this can be reported differently since it is very close to a prompt or guidance. The numbers of this particular intervention has fluctuated throughout reporting periods and can be misleading if not reported accurately.

FY15Q2

Two hundred and seventy-nine (279) emergency physical interventions were used during FY15Q2 across the Mid-State Health Network Region. Figure 4 provides additional data on the types of interventions that were used. An increase in percentage is exhibited in the area of supine hold (4 to 28), and other (0-7), however; the distribution of numbers indicate an increase in the wrap hold, escorts, and hands down with resistance as well.

FY15Q3

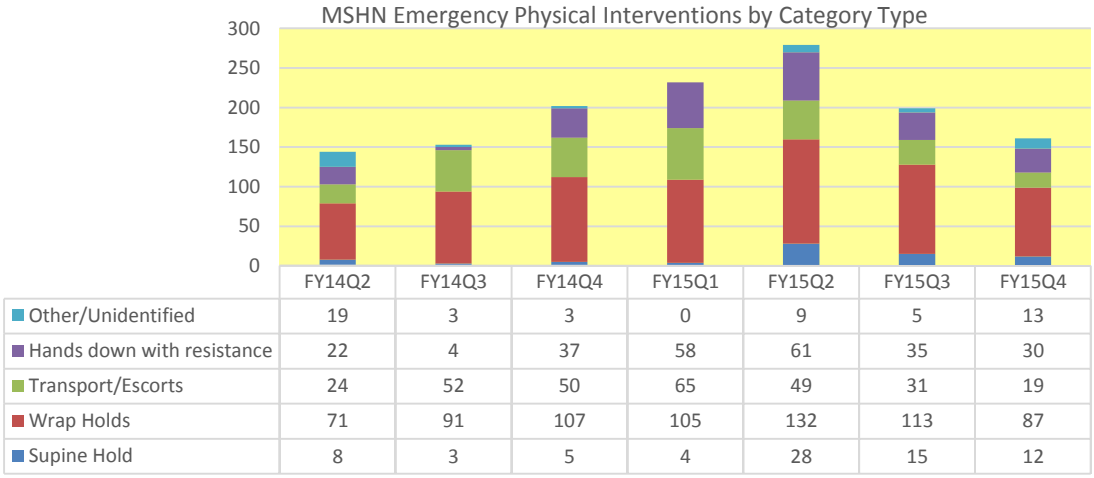
One hundred and ninety-nine (199) emergency physical interventions were used during FY15Q3 across the Mid-State Health Network Region. Figure 4 provides additional data on the types of interventions that were used. A decrease in number of interventions was exhibited in each area. According to the distribution of interventions, the Wrap Hold category did have the highest percentage of interventions.

FY15Q4

One hundred and ninety-nine (161) emergency physical interventions were used during FY15Q4 across the Mid-State Health Network Region. Figure 4 provides additional data on the types of interventions that were used. A decrease in number of interventions was exhibited in each area except the area of "other". According to the distribution of interventions, the Wrap Hold category did have the highest percentage of interventions.

Figure 4

Physical Intervention	**FY15Q1**	**FY15Q2**	**FY15Q3**	**FY15Q4**
Supine Hold	(4)2%	(28)10%	(15)8%	(12)7%
Wrap Hold (wrap around hold, CPI team hold, NAPPI capture wrap, standing wrap, seated wrap, body hug, basket wrap, 1-2 stability hold, chair stability hold)	(105)45%	(132)47%	(113)57%	(87)54%
Transport/Escort (come along, CPI Transport, primary escort, 2 person escort, modified transport)	(65)28%	(49)18%	(31)16%	(19)12%
Hands down with resistance	(58)25%	(61)22%	(35)18%	(30)19%
Other/Unidentified	0%	(9)3%	(5)3%	(13)8%
MSHN Total	(232)100%	(279)100%	(199)100%	(161)100%



	FY14Q2	FY14Q3	FY14Q4	FY15Q1	FY15Q2	FY15Q3	FY15Q4
Other/Unidentified	19	3	3	0	9	5	13
Hands down with resistance	22	4	37	58	61	35	30
Transport/Escorts	24	52	50	65	49	31	19
Wrap Holds	71	91	107	105	132	113	87
Supine Hold	8	3	5	4	28	15	12

The length of time for the interventions was based on each individual intervention. It was agreed by the BTRC/QI Council that the length of time will be reported based on time intervals of ≤ 5 minutes, 6-10 minutes, and 11-15 minutes. This process for reporting will become standardized over the next year. Figure 5 identifies the number of interventions and the length of time for each, 3 were reported to be outside of the 15 minute window, and 22 were reported as unknown. Follow up regarding the unreported and reported outside of the window is being completed at each CMHSP to ensure a process is in place to collect the length of time for each intervention.

Figure 5

Length of time of intervention	FY15Q1	FY15Q2	FY15Q3	FY15Q4
The total number of interventions within this time frame ≤ 5 minutes	145	150	87	74
The total number of interventions within this time frame 6-10 minutes	57	49	31	29
The total number of interventions within this time frame 11-15 minutes	23	54	41	31

Study Question 3: Has the proportion of incidents in which police have been called for assistance by staff to manage a behavioral incident decreased?

Numerator: The total number of incidents requiring phone calls made by staff to police for behavioral assistance.

Denominator: The total number of individuals who are actively receiving services during the reporting period.

FY15Q1

As demonstrated in Figure 6, the rate of phone calls for police assistance per 100 consumers served for FY15Q1 was .19% (50/26023). The total number of reported incidents requiring phone calls for police assistance throughout MSHN during FY15Q1 was 50. Nine CMHSP Participants utilized police assistance during this reporting period. This is an increase in the number of CMHSPs who utilized the police for behavioral assistance, however; there was a decrease in the actual number of calls.

FY15Q2

As demonstrated in Figure 6, the rate of phone calls for police assistance per 100 consumers served for FY15Q2 was .14% (35/25175). The total number of reported incidents requiring phone calls for police assistance throughout MSHN during FY15Q2 was 35. Seven CMHSP Participants utilized police assistance during this reporting period. This is a decrease in the number of CMHSPs who utilized the police for behavioral assistance.

FY15Q3

As demonstrated in Figure 6, the rate of phone calls for police assistance per 100 consumers served for FY15Q3 was .17% (44/26360). The total number of reported incidents requiring phone calls for police assistance throughout MSHN during FY15Q3 was 44. Nine CMHSP Participants utilized police assistance during this reporting period. This was an increase in the number of CMHSPs who utilized the police for behavioral assistance. It should be noted that police interventions are used primarily for individuals with a mental illness. Behavior Treatment plans are not developed for individuals who have a diagnosis of mental illness.

FY15Q4

As demonstrated in Figure 6, the rate of phone calls for police assistance per 100 consumers served for FY15Q4 was .17% (65/26778). The total number of reported incidents requiring phone calls for police assistance throughout MSHN during FY15Q4 was 65. Eleven CMHSP Participants utilized police assistance during this reporting period. This was an increase in the number of CMHSPs who utilized the police for behavioral assistance. It should be noted that police interventions are used primarily for

individuals with a mental illness. Behavior Treatment plans are not developed for individuals who have a diagnosis of mental illness.

Figure 6

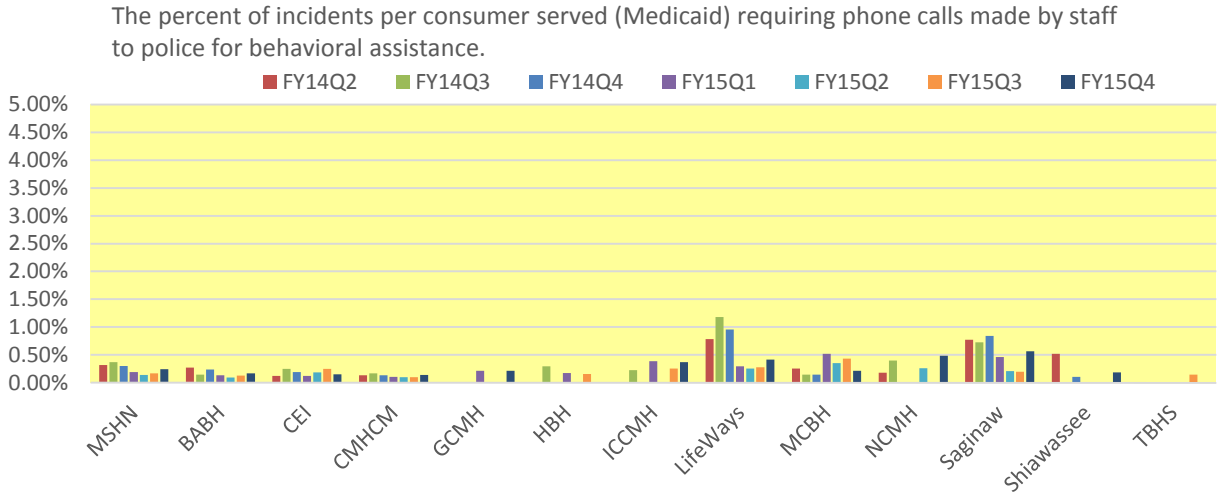
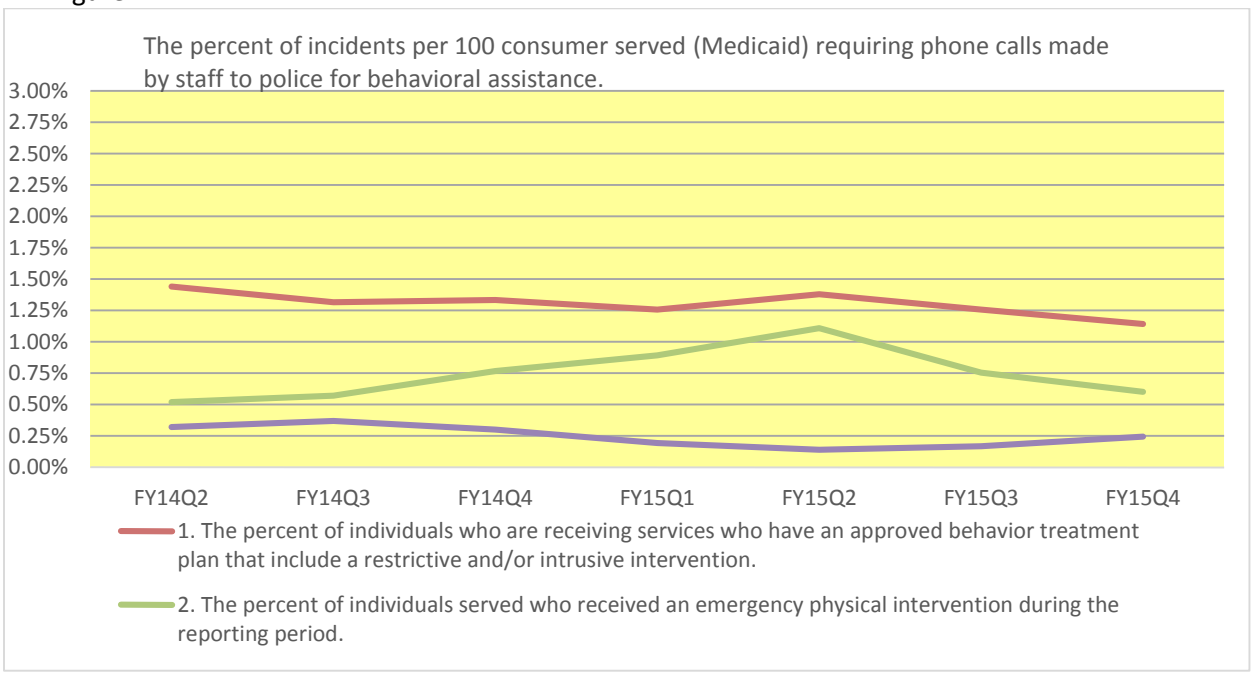


Figure 7



Conclusions:

Study Question 1: Has the proportion of individuals who have received a restrictive/intrusive intervention decreased over time? 1.44% (FY14Q2) compared to 1.14% (FY15Q4) of the individuals served have a Behavior Treatment Plan with Intrusive and/or Restrictive Interventions. This indicates that the proportions has decreased since the beginning of this project.

Study Question 2: Has the proportion of individuals who have received physical intervention decreased overtime? .52% (FY14Q2) compared to .60% (FY15Q4) have received an emergency physical intervention. This indicates that an increase has occurred overtime. During this time period. The PIHP has developed consistent definitions and reporting mechanisms. This may have affected the increase of the data that is reported to the PIHP. There was an upward trend in the data until FY15Q2. The data reported continues to demonstrate a downward trend since FY15Q2. This should continue to be monitored to ensure that the trend continues down ward and interventions put in place have been effective.

Study Question 3: Has the proportion of incidents in which police have been called for assistance by staff to manage a behavioral incident decreased? .32% (FY14Q2) compared to .24% (FY15Q4) indicates a decrease in the proportion of incident in which the police have been called for police assistance with a behavioral incident.

When viewing Figure 7, one observation is that as the percentage of behavior plans and police calls for staff assistance decreased, the percentage of emergency physical interventions increased. In FY15Q2, the percentage of behavior plans increased slightly and the percentage of police calls stabilized. The physical interventions began to trend downward in FY15Q3.

Improvement Strategies:

Continue to monitor the number of plans. Monitor to see if there is a correlation between the number of plans decreasing and the number of phone calls to police or emergency physical interventions increasing.

It is recommended that a review of the reported emergency interventions occur to identify the time frames of any unreported time frames of the emergency physical interventions and the factors for the interventions to be longer than 15 minutes.

To continue to monitor the rate of phone calls to Police for staff assistance for each CMHSP. Each CMHSP should review for any trends with particular settings, explore alternative interventions, and take appropriate action to decrease as necessary without affecting the safety of the staff, community or the individuals served.

It is also recommended that each CMHSP ensure that interpretations and definitions are consistent across the region. CMHSPs will continue to work on reporting accuracies consistent with MSHN.

Analysis by: Sandra Gettel, Quality Manager
MSHN Behavior Treatment Contract Designee

Date: 12-13-2015

II. Critical Incident Reports

MSHN Quarterly Critical Incident Report (FY 2015)

Data Submission Date: 10/31/2015

Board	Incident Type	Quarter 1 Totals (Oct-Dec)	Quarter 2 Totals (Jan-Mar)	Quarter 3 Totals (Apr-Jun)	Quarter 4 Totals (Jul-Sep)	FY Total (Oct-Sep)	FY Incidents Per 1000 Residents
Bay Arenac Behavioral Health	Suicide	0	0	1	2	3	0.0245
	Non-Suicide Death	5	12	4	3	24	0.1962
	EMT due to Injury/Medication Error	9	7	5	10	31	0.2534
	Hospitalization due to Injury/Medication Error	1	0	0	2	3	0.0245
Census: 122,319	Arrest	1	3	1	3	8	0.0654
	Total	**16**	**22**	**11**	**20**	**69**	**0.5641**
CMH Central Michigan	Suicide	0	0	0	1	1	0.0036
	Non-Suicide Death	7	10	12	18	47	0.1698
	EMT due to Injury/Medication Error	27	41	38	27	133	0.4805
	Hospitalization due to Injury/Medication Error	3	4	4	2	13	0.0470
Census: 276,784	Arrest	5	0	4	6	15	0.0542
	Total	**42**	**55**	**58**	**54**	**209**	**0.7551**
CMHA CEI	Suicide	1	2	2	2	7	0.0150
	Non-Suicide Death	10	12	14	12	48	0.1027
	EMT due to Injury/Medication Error	23	41	20	22	106	0.2268
	Hospitalization due to Injury/Medication Error	1	1	0	1	3	0.0064
Census: 467,321	Arrest	0	1	1	0	2	0.0043
	Total	**35**	**57**	**37**	**37**	**166**	**0.3552**
Gratiot CMH	Suicide	0	0	0	0	0	0.0000
	Non-Suicide Death	3	3	1	1	8	0.1906
	EMT due to Injury/Medication Error	3	1	0	0	4	0.0953
	Hospitalization due to Injury/Medication Error	0	0	0	0	0	0.0000
Census: 41,968	Arrest	0	0	0	0	0	0.0000
	Total	**6**	**4**	**1**	**1**	**12**	**0.2859**
Huron Behavioral Health	Suicide	0	0	0	0	0	0.0000
	Non-Suicide Death	0	1	1	2	4	0.1241
	EMT due to Injury/Medication Error	0	0	0	0	0	0.0000
	Hospitalization due to Injury/Medication Error	0	0	0	0	0	0.0000
Census: 32,224	Arrest	1	0	1	0	2	0.0621
	Total	**1**	**1**	**2**	**2**	**6**	**0.1862**

Board	Incident Type	Quarter 1 Totals (Oct-Dec)	Quarter 2 Totals (Jan-Mar)	Quarter 3 Totals (Apr-Jun)	Quarter 4 Totals (Jul-Sep)	FY Total (Oct-Sep)	FY Incidents Per 1000 Residents
Ionia CMH	Suicide	1	0	0	0	1	0.0156
	Non-Suicide Death	1	1	2	3	7	0.1093
	EMT due to Injury/Medication Error	0	2	0	0	2	0.0312
	Hospitalization due to Injury/Medication Error	0	0	0	0	0	0.0000
	Arrest	0	0	0	0	0	0.0000
Census: 64,073	**Total**	**2**	**3**	**2**	**3**	**10**	**0.1561**
Lifeways	Suicide	0	1	1	0	2	0.0097
	Non-Suicide Death	6	3	8	1	18	0.0872
	EMT due to Injury/Medication Error	16	4	15	4	39	0.1889
	Hospitalization due to Injury/Medication Error	0	1	7	1	9	0.0436
	Arrest	1	0	1	0	2	0.0097
Census: 206,470	**Total**	**23**	**9**	**32**	**6**	**70**	**0.3390**
Montcalm Behavioral Health	Suicide	0	0	0	0	0	0.0000
	Non-Suicide Death	0	0	3	0	3	0.0475
	EMT due to Injury/Medication Error	5	2	3	4	14	0.2219
	Hospitalization due to Injury/Medication Error	0	1	0	1	2	0.0317
	Arrest	3	4	5	0	12	0.1902
Census: 63,105	**Total**	**8**	**7**	**11**	**5**	**31**	**0.4912**
Newaygo CMH	Suicide	0	0	0	1	1	0.0000
	Non-Suicide Death	6	1	3	1	11	0.2292
	EMT due to Injury/Medication Error	0	2	3	1	6	0.1250
	Hospitalization due to Injury/Medication Error	0	0	0	0	0	0.0000
	Arrest	1	0	0	1	2	0.0417
Census: 48,001	**Total**	**7**	**3**	**6**	**4**	**20**	**0.4167**
Saginaw CMH	Suicide	0	0	0	0	0	0.0000
	Non-Suicide Death	13	12	10	14	49	0.2493
	EMT due to Injury/Medication Error	14	15	6	30	65	0.3307
	Hospitalization due to Injury/Medication Error	0	0	0	5	5	0.0254
	Arrest	2	6	2	4	14	0.0712
Census: 196,542	**Total**	**29**	**33**	**18**	**53**	**133**	**0.6767**
Shiawassee CMH	Suicide	0	0	0	0	0	0.0000
	Non-Suicide Death	2	3	1	2	8	0.1161
	EMT due to Injury/Medication Error	4	0	1	3	8	0.1161
	Hospitalization due to Injury/Medication Error	0	0	0	0	0	0.0000
	Arrest	0	0	0	0	0	0.0000
Census: 68,900	**Total**	**6**	**3**	**2**	**5**	**16**	**0.2322**

Board	Incident Type	Quarter 1 Totals (Oct-Dec)	Quarter 2 Totals (Jan-Mar)	Quarter 3 Totals (Apr-Jun)	Quarter 4 Totals (Jul-Sep)	FY Total (Oct-Sep)	FY Incidents Per 1000 Residents
Tuscola BH Systems	Suicide	0	0	0	0	0	0.0000
	Non-Suicide Death	2	0	1	0	3	0.0553
	EMT due to Injury/Medication Error	0	1	1	1	3	0.0553
	Hospitalization due to Injury/Medication Error	2	0	1	0	3	0.0533
	Arrest	0	0	0	0	0	0.0000
Census: 54,263	**Total**	**4**	**1**	**3**	**1**	**9**	**0.1659**
MSHN TOTALS	Suicide	2	3	4	6	15	0.0091
	Non-Suicide Death	55	58	60	57	230	0.1401
	EMT due to Injury/Medication Error	101	116	92	102	411	0.2503
	Hospitalization due to Injury/Medication Error	7	7	12	12	38	0.0231
	Arrest	14	14	15	14	57	0.0347
Census: 1,641,970	**Total**	**179**	**198**	**183**	**191**	**751**	**0.4574**

III. Medicaid Event Verification Report

Pre-Paid Inpatient Health Plan

Medicaid Services Verification Methodology Report

Fiscal Year 2015

Methodology Report Outline

Introduction & Background

Process Summary

Data Analysis

A. Summary of analysis
B. Study Results
C. Data Chart

Deficiencies

A. Fiscal Year 2015 Deficiencies
B. Repeated Deficiencies

Performance Improvement

Future Outlook

Introduction & Background

In accordance and compliance with the Medicaid Managed Specialty Supports and Services Contract[1], Mid-State Health Network (MSHN) submits the Medicaid Event Methodology Report that summarizes the verification activities across the PIHP region. The region includes twelve (12) Community Mental Health Specialty Program (CMHSP) participants; Bay-Arenac Behavioral Health, Community Mental Health for Clinton-Eaton-Ingham Counties, Community Mental Health for Central Michigan, Gratiot County Community Mental Health Services, Tuscola Behavioral Health Systems, Huron County Behavioral Health, The Right Door (Ionia County Community Mental Health), LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Mental Health Center, Saginaw County Community Mental Health Authority, and Shiawassee County Community Mental Health Authority. Also included in the PIHP region for FY2015 were three sub-regional entities (CEI, Bay Arenac and Saginaw) that sub-contracted with MSHN to be responsible for administration of substance use disorder treatment and prevention services.

MSHN delegated the Medicaid Event Verification (MEV) process to the CMHSPs, which was inclusive of the Sub-Regional Entities, for fiscal year 2015. MSHN conducts oversight of the CMHSP process through desk reviews of their policy and procedures, including a review of the Quality Assessment and Performance Improvement Plan (QAPIP) that is inclusive of the MEV review. In addition, MSHN completed on-site reviews of the CMHSPs that includes a random sample and review of their MEV process.

Since the Michigan Department of Health and Human Services (MDHHS) indicated new process requirements would be included in the FY16 contract, MSHN allowed the CMHSPs to continue their current MEV methodology as previously reviewed by MDHHS. Now that the MDHHS Medicaid Event Verification Technical Requirement is part of the FY2016 contract, MSHN has developed a MEV policy and procedure following the requirements identified in the MEV Technical Requirement provided by MDHHS and will ensure regional compliance going forward.

Process Summary

Medicaid claims verifications were conducted quarterly or monthly as determined by the CMHSP procedure, utilizing a random sample. The random sample size selection varied by each CMHSP depending on the size and approved procedure of the CMHSP, ranging from a minimum number of charts or claims to a minimum percentage of charts or claims.

The summary incorporates services that are documented in the CMHSP electronic health record and those services not documented in the EHR (paper charts and/or contracted providers).

[1] Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 16 – Attachment P7.9.1 – Section XIII

Data Analysis

Summary of Analysis

Records and claims were reviewed over the course of the full fiscal year, October 1, 2014 – September 30, 2015. Data presented in the below chart is relative to the CMHSP procedure of percent and/or number of records selection of claims.

While the CMHSPs collected and verified various elements, two (2) indicators were consistent across the region.

1. Services Identified in the Person Centered Plan, and
2. Billed Services match Documentation

Nine (9) of the twelve (12) CMHSPs verified through the MEV process the following:

1. Services Identified in the Medicaid Manual

Montcalm and Saginaw CMHSPs reported total percent of clean claims which included the verification of the above elements but did not separate out each element. A clean claim was defined as meeting all the required elements.

LifeWays reported a staggered scale of Substantial Compliance, Partial Compliance and Non-Compliance. LifeWays MEV process also included additional elements to verify appropriate treatment goals (authorized, measurable, scope, consistent with person centered plan, etc.).

In addition, CEI CMHSP verified records selected were Medicaid Eligible at the time of service. Other CMHSPs have an automated process of verification through the electronic health record and eligibility file download.

Lastly, four (4) of the twelve (12) CMHSPs further defined the records by service program area for informational purpose.

Study Results	*2014*	*2015*
MSHN Consumer Medicaid Eligible	97.5%	99.66%
MSHN Services Identified in the Medicaid Manual	100.0%	99.85%
MSHN Services Identified in the Person Centered Plan	98.2%	95.41%
MSHN Billed Services Match Documentation	98.2%	99.08%
MSHN Clean Claims	97.2%	93.24%

Indicator		MSHN	BABH	CMH CM	CEI	GCCMH	HBH	Ionia	Lifeway s	Montcalm	Newaygo	Saginaw	Shiawassee	Tuscola
	Records / Claims Reviewed		Claims	Records	Claims	Claims	Claims	Claims	Records	Claims	Claims	Records	Claims	Records
	Direct		840	0			0		0				504	109
	Contracted		1,170	387			8,133		1,285				62	137
	Total		2,010	387	12,838	399	8,133	2,962	1,285	1,428	1,034	1,233	566	246
1	Consumer Medicaid Eligible													
	% Compliant	**99.66%**	100%	100%	97.31%		100%		100%	100%			100%	100%
	Claim Lines Compliant	17,782	2,010		12,493				1,285	1,428			566	
	Total Claim Lines	18,127	2,010		12,838				1,285	1,428			566	
2	Services Identified in the Medicaid Manual													
	% Compliant	**99.85%**	100%	100%			100%		100%	100%		98.78%	100%	100%
3	Services Identified in the Person Centered Plan													
	% Compliant	**95.41%**	99.65%	100%	87.16%	100%	100%	97.33%	96%	71.78%	97.58%		100%	100%
	Claim Lines Compliant	19,046	1,974		11,190	399		2,883		1,025	1,009		566	
	Total Claim Lines	21,208	1,981		12,838	399		2,962		1,428	1,034		566	
4	Billed Services match Documentation													
	% Compliant	**99.08%**	98.33%	100%	99.58%	100%		95.31%	98.10%	100%	99.52%		100%	100%
	Claim Lines Compliant	20,976	1,947		12,784	399		2,823		1,428	1,029		566	
	Total Claim Lines	21,207	1,980		12,838	399		2,962		1,428	1,034		566	
5	% Clean Claim													
	% Compliant	**93.24%**	97.01%						97.40%	71.78%		100%	100%	
	Claim Lines Compliant	855,798	1,950							1,025		852,257	566	
	Total Claim Lines	856,261	2,010							1,428		852,257	566	
6	Service Programs													
	Childrens Services	297		0					55			134	108	
	Community Living Supports	721		59					555			45	62	
	Crisis Intervention	4		0					0			0	4	
	Targeted Case Management & Support Coordination	548		1					142			280	125	
	Inpatient	58		0					0			58	0	
	Outpatient	254		16					109			0	129	
	Other	713		4					376			208	125	
	Residential Homes	516		297					48			171	0	
	SUD	79		0					0			79	0	
	Vocational	281		10					0			258	13	
	Total	3,471		387					1,285			1,233	566	

* The claims reported by Huron were not based on a review of records. The claims were reported based on the checks built into the EHR that ensures a services not authorized as Medicaid covered service are not submitted, and that authorized services are documeted in the person centered plan.

**MSHN percentages of clean claims were totaled using the average of the percentage compliant reported for each CMHP. This was used instead of the complaint claim lines/total claim lines due to some CMHSPs not reporting total claim lines but only the percentage compliant.

Deficiencies

Fiscal Year 2015 Deficiencies

MSHN requires deficiencies found during the Medicaid Event Verification process be resolved immediately through one or more of the following methods:

- Billing records re-billed with correct information (e.g. code change, funding source change);
- Billed services in error voided;
- Person centered plans updated with correct authorization; and
- Reduction to future payments on subcontractor claims

For deficiencies found as a system issue, network providers are required to document a corrective action plan and demonstrate sufficient monitoring and oversight to ensure implementation. Corrective action plans may consist of education and training, data software system changes, and process changes along with related expected timelines for implementation.

CMHSPs review and monitor the corrective action plan. If deemed necessary by the CMHSPs, additional follow up and sampling of selected elements is completed in an effort to ensure system and process change.

Note: Some deficiencies were noted during FY2015 due to Electronic Health Record implementation with process and procedure changes implemented.

MSHN monitors the CMHSPs MEV policy and procedures and verifies compliance through the on-site review and sampling of the CMHSPs MEV supporting documentation.

During MSHN Delegated Managed Care Reviews of all 12 CMHSPs, 632 units of services were reviewed from 78 unique cases. Of the 632 units of service reviewed by MSHN 36 units were not valid. Of the 36 invalid units, 27 units did not have supporting documentation (27 units were from one case review), 9 units were provided for a person who was not eligible on the date of service provided (9 units from 2 case reviews), and 1 unit of service was not authorized in the person centered plan (1 case review). MSHN verified 596 units of service. The compliance rate was 94.3% for the sample of MEV completed during the FY2015 Delegated Managed Care Reviews. The three (3) cases that had units that were not able to be verified were placed on a corrective action plan to correct the invalid claims and ensure an appropriate process was in place to prevent future invalid claims.

If suspicion of fraud or abuse is apparent, CMHSPs are required to report to MSHN for further review and follow up. As part of MSHN's ongoing compliance process, MSHN completes an initial investigation to determine if reporting to MDHHS and/or the Office of Health Service Inspector General is required. This process occurs throughout the year as the report is received.

Repeated Deficiencies

CMHSPs are required to monitor repeated deficiencies as part of their local MEV process. Also as part of the annual Delegated Managed Care Review completed by MSHN, any repeated deficiencies are monitored and require plans of correction.

At this time it would not be an accurate process to compare deficiencies from FY2014 to FY2015 as only 3 quarters were included in the FY2014 review due to the PIHP contract beginning on January 1, 2014. Once reviews are completed for FY2016, MSHN will review the identify areas of repeat deficiencies.

Performance Improvement

Performance improvement over previous MEV results vary from each CMHSP relative to their respective process. Process changes and improvements in automated system verifications is expected to increase the validation results in future years.

Verification results and related corrective action plans are presented to the following council and committees:

Note: MSHN council and committee membership consists of representatives from each CMHSP.

- MSHN Regional Consumer Advisory Council
- MSHN Quality Improvement Council
- MSHN Corporate Compliance 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 local CMHSP compliance.

Future Outlook

MSHN has included the MEV technical requirements as presented by MDHHS in the contract. MSHN has developed and has an approved MEV Review policy and procedure to ensure regional compliance with the new requirements. Beginning FY2016 MSHN has started the MEV review process for contracted providers.

IV. Autism Report

PIHP: Region 5/Mid-State Health Network **Date(s): April 20, 21, and 23, 2015**

DIMENSIONS/INDICATORS	Yes	No	FINDINGS	REMEDIAL ACTION	MSHN ACTION	CMHSP Follow Up Response Review
1915 (I) QUALITY IMPROVEMENT STRATEGY-PERFORMANCE MEASURES (PAGES 38-46)						
1. Beneficiaries IPOS addresses the needs.	56	0				
2. Beneficiaries IPOS are updated within 365 days of their last plan of service.	54	0	2 N/A due to not being 365 days since last plan of service.	CEI-1st IPOS dated 5/13/14; 2nd IPOS dated and signed 5/5/15		CEI-The IPOS was in fact completed on 5/4/2015, less than 365 days in the year.
3. Beneficiaries services and supports are provided as specified in the IPOS, including: A. Amount B. Scope C. Duration D. Frequency	19	35	2 children had limited data to calculate this performance measure due to recently starting ABA services.	BABH-The IPOS will be amended no later than August 15, 2015 to reflect the correct authorized hours that allow a range of only 25% of the approved hours. Staff will be in-serviced and the WSA modified (if needed) by August 15, 2015. CEI-ABA hours adjusted based on actual hours used over a six month period. Staff developed a spread sheet that summarizes ABA hrs & supervision hrs/month to monitor for any outliers. CEI staff have also updated all CEI consumers receiving ABA so that each individual's PCP accurately reflects the average hours they are receiving (which includes the family's input re: what is manageable for them). Central-Supervisor monitoring service provision, due to numerous issues, including illness in beneficiary family, parental strife. Random monthly review of records, including supervisor audits to ensure compliance with amount, scope, and duration. Gratiot-Plan has been put into place to monitor the number of hours each beneficiary is receiving and amended accordingly. Reviewing hours received versus number of hours authorized in the IPOS. If there is a difference, a special staffing will be held to address the hours issue along with input from the family. IPOS to be amended if discrepancy continues. Ionia-All IPOS will be amended to the level of service that is being provided through the IPOS process plus or minus a variance of 25%. IPOS will be completed whenever families report changes in ability to participate in ABA services. Hours in IPOS will reflect what the family can reasonably commit not to the amount, scope and duration that have been recommended. ICCMH will continue to use Standard	MSHN will monitor response to these corrective findings through an onsite visit and review to the CMHSP, to be accomplished on or prior to 8/26/15 (90 days after issue of MDHHS Site Review letter).	BABH-BABH completed trainings with key staff over the month of July and early August 2015 for the standard. All SC/CSM staff are completing a BABH form that required to cover level of intensity and other key information. The BCBA also shares her schedule of hours monthly to be shared with the workers, who then detect any shift in hours provided due to BCBA supervision requirements. This process is being added to the BABH ABA protocol. Central-Random record reviews are occurring and all have been reviewed to date. The overall tool is being revised to incorporate additional autism benefit elements. Documentation has been made in attempts engage the family and a tracking availability sheet is kept and reviewed to ensure problem areas can be identified. This is also in an attendance procedure. This has directly filtered into the addendum process. Gratiot-Transitioning to Streamline. The IT department has set up a report to send to the program for monthly review and action. Gratiot is documenting this into their program

				Practice for ABA Services Minimizing Risk Factors to ensure barriers like transportation are reduced so families can participate in ABA. LifeWays- Operating procedure update to reflect process change: during preplan if the recommended intensity of care is different than what the family is willing to engage in, the CSM will note this in the plan and submit authorizations at the level agreed to by the family and team with continued dialogue and monitoring to assess for increased engagement opportunities on an on-going basis. Saginaw-working to ensure that the amount of units being provided is the amount requested for authorization. IPOS will be addended where appropriate, to reflect number of hours family agree to and update to the WSA to reflect accurate number of hours, with completion of actions by August 26, 2015. Shiawassee-determined that if individuals are not meeting what they have requested for hours a team meeting will be held to come to a consensus of appropriateness of hourly allotment. Hours will be adjusted in accordance with outcome of the meeting in PCP addendum and WSA. Supervision will be monitored within an internal tracking system to assist BCBA with being in compliance with assuring supervision ratio is per ISPA requirements.		manual to ensure continuity. Saginaw-Corrections to the cases that were cited have been made. There is also a change of hours request form that documents the need for the change in hours. This was also updated in a procedure. Ionia-Now putting in what the family specifically wants in their plan in terms of hours. Then, if the family needs more, then the addendum is created. Staff check in with family to determine whether the number of days and/or hours is sufficient. Another children's CSM has been hired in anticipation of the autism expansion. Currently focused under the Ionia PCP policy relating to consumer choice. CEI-A set of protocols have been put together for the autism benefit that covers testing, WSA uploads, billing for services. Tracking of actual hours versus WSA hours and reports are being sent to the case workers and providers to address the issue of differences in hours. This is going to be documented to ensure compliance. Monthly meetings with providers are being used to coordinate and communicate expected changes that are within standards. There is also an ADOS checklist used to gather and keep relevant dates for each child. LifeWays-This has been added to the Clinical Program Management/Autism policy 15 in LifeWays operating procedures. A discussion is occurring

						with families to talk about the recommended hours versus the desired hours by the family. If there was enough of a clinical change or change in circumstances, the plan may be addended versus holding with original hours, i.e. situational versus level of care change. Shiawassee-Staff are going in the WSA on a weekly basis to ensure that the appropriate hours are being provided. This is also being addressed in individual progress notes. This is also being documented in the quarterly document to identify any issues relating to if parents are not meeting the hours and do not consent to an addendum. VB-MAPP re-evals also address whether or not there has been progress, i.e. not making progress because have only attended 42% of the sessions.
4. Beneficiaries are informed of their right to choose among providers as evidenced by documentation the Pre-Planning Meeting summary	50	5	1 N/A child had Pre-Plan on file but family did not want to participate.	BABH-The pre-planning document has been modified to add a check box as a reminder to staff to review the services available and choice of providers. Staff will be in-serviced by July 30, 2015. LifeWays- The right to choose among providers will be included in the pre-plan with expected completion by August 26, 2015	MSHN will monitor response to these corrective findings through an onsite visit and review to the CMHSP, to be accomplished on or prior to 8/26/15 (90 days after issue of MDHHS Site Review letter).	BABH-Staff were trained in the requirement to have this element in the pre-plan. A checkbox was placed in the EMR to cover this element. PCP workgroup at BABH will be covering this as well. LifeWays-The request has been sent to PCE in July to incorporate the checkbox into the pre-plan. This will occur once the BH-TEDS additions have been made to the system. In the meantime, this is being placed in the notes section of the pre-plan.
5. Beneficiaries providers of the ABA services meet credentialing standards.			Please see credentialing report.	See files provided.	MSHN will monitor response to these corrective findings through an onsite visit and review to the CMHSP, to be accomplished on or prior to 8/26/15 (90 days after issue of MDHHS Site Review letter).	

6. Beneficiaries Independent Assessment development of IPOS are consistent with MDCH policies and procedures against conflict of interest as evidenced by: A. IPOS is developed through a person centered planning process; B. The assigned individual overseeing the development of the IPOS does not provide ABA services; C. The authorization of ABA services is performed by the Utilization Management unit.	56	0				
7. Beneficiaries ABA Service authorization was completed by Utilization Management (UM) staff who are free from conflict of interest as evidenced by documentation that the staff does not provide any other service to that beneficiary.	56	0				
8. Number and percent of administrative hearings related to utilization management issues (amount, scope, duration, of services).			No administrative hearings related to utilization management issues were reported.			
9. Beneficiaries whose average hours of ABA services during a quarter were within the suggested range for the intensity of service plus or minus a variance of 25%.	19	37	Please see quarter performance letter.	Shiawassee-Team meetings will be held with individuals and families not accessing hourly allotment within the 25% above or below specified in the ISPA. Meeting outcome will drive ABA hourly allotment and be documented in PCP addendum and WSA.	MSHN will monitor response to these corrective findings through an onsite visit and review to the CMHSP, to be accomplished on or prior to 8/26/15 (90 days after issue of MDHHS Site Review letter).	Shiawassee-Staff are going in the WSA on a weekly basis to ensure that the appropriate hours are being provided. This is also being addressed in individual progress notes. This is also being documented in the quarterly document to identify any issues relating to if parents are not meeting the hours and do not consent to an addendum. VB-MAPP re-evals also address whether or not there has been progress, i.e. not making progress because have only attended 42% of the sessions.

10. Number and percent of cost-settlement recoveries made in accordance with MDCH policies and procedures as evidence by: A. valid encounters reported in the data warehouse for ABA services delivered B. PIHP reporting on Medicaid Contract Settlement worksheet specify difference between interim payments received and actual expenditures.			All cost settlement recoveries were made in accordance with MDHHS policies and procedures.			
11. Beneficiaries receive information on how to report abuse, neglect & exploitation on an annual basis as evidenced by documentation the PrePlanning Meeting summary.	39	17	5 of the 17 children received information on how to report abuse, neglect & exploitation as evidence in their PCP documentation.	BABH-The process for this has been modified to capture the information in the pre-planning document. New pre-plans effective immediately will have this documented in the pre-plan narrative. Staff will be in-serviced no later than July 30. All families have been informed of the process it was documented on the Acknowledgement of Receipt Form. Information will be added to the pre-plan, completed by August 26, 2015. LifeWays- The receipt of information on how to report abuse, neglect, & exploitation annually will be included in the pre-plan with expected completion by August 26, 2015 Saginaw-The information will be included in the pre-plan with expected completion by August 26, 2015. TBHS-This modification to the pre-plan is being completed as part of a larger forms revision process that is currently being coordinated with the EHR vendor. Anticipated completion date is 9/30/15.	MSHN will monitor response to these corrective findings through an onsite visit and review to the CMHSP, to be accomplished on or prior to 8/26/15 (90 days after issue of MDHHS Site Review letter).	BABH-Staff were trained in the requirement to have this element in the pre-plan. At this time, staff are documenting in the pre-plan that this information has been given. BABH is also reviewing with the EMR provider to add the radio-button so that staff do not accidentally overlook this standard. TBHS-TBHS has contacted their EMR vendor and this is being incorporated into their electronic pre-plan. Saginaw-It is currently in the person centered plan. This is being transitioned into the new EMR to be placed in the pre-plan. In the meantime, it will be placed in the additional comments field of the pre-plan. LifeWays- The request has been sent to PCE in July to incorporate the checkbox into the pre-plan. This will occur once the BH-TEDS additions have been made to the system. In the meantime, this is being placed in the

						notes section of the pre-plan.
12. Beneficiaries requiring hospitalization due to injury related to the use of physical management.			Zero of the beneficiaries required hospitalization.			
13. Number and percent of critical incidents reported for beneficiaries into the Event Reporting System in compliance with MDCH policy and procedures for timeliness.			Zero critical incidents were reported for beneficiaries.			
19.6 ABA INTERVENTION-Medicaid Provider Manual Mental Health Substance A Section 19 Applied Behavior Analysis						
Beneficiaries IPOS are reviewed both at intervals specified in the iSPA (ex. 3 months) and when there were changes in needs.	48	7	1 N/A due to child not being enrolled in services at least 3 months.	CEI-#21425 is now having a quarterly review of his IPOS beginning with his new IPOS dated 6/3/2015. Gratiot-Tracking system put in place to track all beneficiary quarterly reviews due dates. LifeWays- Training with internal workgroup through the ABA and CSM external providers to discuss process enhancements. To be covered on July 13, 2015. TBHS-Periodic review was completed and on file, but was submitted beyond the established timeframe. Education was provided to the responsible staff member and additional mechanisms for monitoring were implemented to ensure compliance with established due dates. Completion date – 6/5/15.	MSHN will monitor response to these corrective findings through an onsite visit and review to the CMHSP, to be accomplished on or prior to 8/26/15 (90 days after issue of MDHHS Site Review letter).	Gratiot-An electronic spreadsheet was created to track due dates for all ABA cases. This will also be documented in the autism program manual. TBHS-A tracking form includes due dates specifically and exclusively for the ABA program. The periodic review was noted as having been completed, but submitted late. Subsequently, periodic reviews have been submitted within the appropriate timeframe. There is a procedure in place (Quarterly reporting) that establishes timeframes review as well as another procedure that establishes paperwork requirements. CEI-The quarterly review of the consumer was completed on 6/3/2015. The next one is due on 9/3/2015. LifeWays-Meeting held on July 13th, 2015, where providers received communication on this element.

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 VBMAPP.	49	6	1 N/A due to the child not being enrolled in services at least 6 months.	CEI #3521 had the ABLLS-R administered by ROI staff on 1/30/15. Copy is now on file in CEI's electronic record. Central-The Autism Supervisors have developed a spreadsheet of all CMHCM VB-MAPP activity and due dates to monitor and ensure compliance. Implemented June 2015. LIfeWays-Training with internal workgroup through the ABA and CSM external providers to discuss process enhancements. To be covered on July 13, 2015. Shiawassee-Tracking documentation system developed with BCBA and implemented to assure timely compliance.		Central-Currently is using the spreadsheet and has discussed how it will be implemented most efficiently. It is going to management team to identify an individual who will send communications about how this area will be regularly shared. It is also being identified in the UM Manual to institutionalize this process. External providers are being trained in the EMR as to how to use for the benefit. Scheduled for the week of 8/18/2015. CEI-A copy was reviewed and is also in the EMR. CEI protocols guide standards around timeline expectations. LifeWays- Meeting held on July 13th, 2015, where providers received communication on this element. Shiawassee-Notes are now kept on when quarterlies and VB-MAPPS are done. It is also set up in Outlook to indicate when re-evals are due. The EMR is also used to identify when assessments are coming due.

V. Performance Improvement Project – HEDIS

Diabetes Screening for Antipsychotics

MSHN PIP Report

Measure Definition

Certain medications used to treat psychiatric disorders may increase the risk of obesity and diabetes and thus CVD, where mortality is greater for this population.[1]

This baseline measure is modeled on the HEDIS measure "Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)" (see details at: NQF 1932), though it does not use the same measurement year timeframe.

The measure looks at the percentage of patients between 18 and 64 years of age with schizophrenia or bipolar disorder, who were dispensed a second-generation antipsychotic (SGA) medication and had a diabetes screening test during the measurement year[2]. The measure excludes patients with diabetes (determined either by diagnostic codes on claims or the presence of prescriptions for diabetic medications) to ensure that we are looking at screening and not ongoing monitoring.

Evaluation

HSAG evaluates the technical structure of the PIP to ensure that Mid-State Health Network designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., study question, indicator(s), population, sampling techniques, data collection methodology, and data analysis plan) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well Mid-State Health Network improves its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results). The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that any reported improvement in outcomes is related to a given PIP.

1American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, and North American Association for the Study of Obesity. (2004). Consensus development conference on antipsychotic drugs and obesity and diabetes. Diabetes care, 27(2). Available at: http://care.diabetesjournals.org/content/27/2/596.full#sec-3

2 I.e. One or more glucose or HbA1c tests.

Study Topic/Indicator/Goal

PIP Topic	Study Indicator	Study Goal
Increasing Diabetes Screening for Consumers with Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications.	*The indicator is the proportion of the eligible population having at least one diabetes screening completed in the measurement year.*	*To ensure that adult consumers with schizophrenia or bipolar disorder who are prescribed antipsychotic medication are receiving the necessary diabetes screenings because taking antipsychotic medications is associated with increased risk of developing diabetes.*

The study topic selected by Mid-State Health Network addressed CMS' requirements related to quality outcomes— specifically, the quality and accessibility of care and services.

Identified Barriers and Interventions

The identification of barriers in achieving the stated goal was completed through causal/barrier analysis. Each CMHSP reviewed their local baseline data and provided feedback regarding the barriers to the PIHP using their local quality improvement process. The PIHP utilized the regional Quality Improvement Council to further identify region wide barriers to receiving a glucose test or an HbA1c test as well as the interventions to overcome the barriers. The process used for the causal/barrier analysis was brainstorming and the completion of a fishbone diagram.

The common barriers within the region are:

Behavioral Health services beneficiary not understanding the importance of having a primary care physician and maintaining regular appointments to address health care needs.

☐☐Limited number of primary care physicians accepting Medicaid patients.

☐☐Lack of awareness of benefit coverage for diabetes testing.

☐☐Lack of coordination exists between behavioral health system and primary care physicians.

To assist with overcoming the identified barriers, MSHN is currently implementing the following interventions:

☐☐Provide education to consumers during the person-centered planning process and during face-to-face Interactions about the importance of ongoing monitoring by a primary care physician.

☐☐Community Mental Health agencies will coordinate with the consumer and primary care physician regarding the completion of testing.

Remeasurement Period One Goal

Remeasurement period one covered the time period of October 01, 2014 through September 30, 2015.
The goal is to show an increase of 1% over the baseline rate of diabetes screenings (Note: Not the same as a 1 percentage-point increase).

This goal will be measured during the next reporting period.

Explanation of Scoring

Each required activity is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable,* or *Not Assessed*.

HSAG looks at the following stages: Design, Implementation and Evaluation and Outcomes.

The Study Design looks at if MSHN designed a scientifically sound study supported by the use of key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP's solid design allowed for the successful progression to the next stage of the PIP process.

The Study Implementation and Evaluation looks to see if MSHN progressed to completing causal/barrier analysis using quality improvement tools and implementing interventions likely to impact outcomes. The health plan submitted and analyzed baseline data in this year's validation. For the next annual validation, study outcomes will be assessed by comparing Mid-State Health Network's Remeasurement 1 results with the baseline.

Results: (Review of 17 elements)

Name of Project/Study	Type of Annual Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Increasing Diabetes Screening for Consumers with Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications	Initial Submission	71%	51%	Partially Met
	Resubmission	100%	100%	Met
Percentage Score of Evaluation Elements *Met*—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*. **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*. **Overall Validation Status**—Populated from the PIP Validation Tool and based on the percentage scores.				

Conclusion/Summary

The **Mid-State Health Network** PIP received a *Met* score for 100 percent of critical evaluation elements and for 100 percent of the overall evaluation elements in the Study Design and Implementation and Evaluation stages. The performance of this PIP suggests a thorough application of the PIP design, appropriate analysis of the results, and implementation of system interventions related to barriers identified through quality improvement processes.

Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

VI. Performance Improvement Project – RAS

Overview of Mid-State Health Network Recovery Assessment Scale

Consumer

Introduction

The following overview of Mid-State Health Network's (MSHN) Recovery Assessment Scale was developed to assist MSHN Community Mental Health Service Program (CMHSP) participants and other stakeholders develop a better understanding of the strengths and weaknesses in MSHN's recovery-oriented care. This report was developed utilizing voluntary self-reflective surveys from 3,421 consumers representing all 12 CMHSPs. The survey results were aggregated and scored as outlined in the University of Sydney instructions.

The information from this report is intended to support discussions on improving recovery-oriented practices by understanding how the various CMHSP practices may facilitate or impede recovery. The information from this overview should not be used draw conclusions or make assumptions without further analysis.

Any questions regarding the report should be sent to Min Lee, MSHN Analyst, at min.lee@midstatehealthnetwork.org.

MSHN Summary

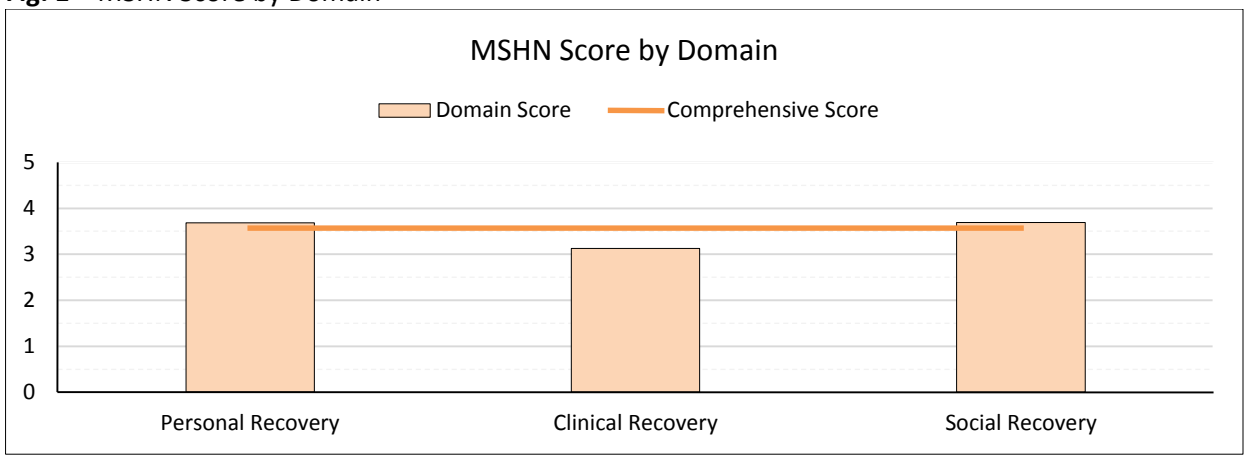
The responses from the Recovery Assessment Scale survey were scored as a comprehensive total and into three separate domains. The comprehensive score measures how the system is performing as a whole, and the performance of three separate parts:

- Personal Recovery
  - Questions: 1, 3, 4, 5, 7, 8, 9, 10, 11, 15 and 17
- Clinical Recovery
  - Questions: 2, 13 and 14
- Social Recovery
  - Questions: 6, 18, 19 and 20
- Uncategorized questions
  - Questions: 12 and 16

596 respondents from Saginaw County CMH, 811 respondents from CMH for Central Michigan, 227 respondents from Shiawassee County CMH, 496 respondents Bay-Arenac Behavioral Health Authority, 290 respondents form Community Mental Health Authority of CEI, 170 respondents Montcalm Center for Behavioral Health, 57 respondents from Ionia County CMH, 142 respondents from Gratiot County CMH, 78 respondents from Huron Behavioral Health, 62 respondents from Tuscola Behavioral Health System, 152 respondents from Newaygo County CMH, and 340 respondents from Lifeways CMH were aggregated for this overview.

Figure 1 illustrates how MSHN's 12 CMHSPs scored themselves comprehensively and in the three separate domains. The comprehensive score was 3.57, Personal Recovery domain was 3.68, Clinical Recovery domain was 3.13, and the Social Recovery was 3.69

Fig. 1 – MSHN Score by Domain



MSHN CMHSP Summary

The responses from the Recovery Assessment Scale survey were also analyzed by CMHSP and scored comprehensively and by the separate domains.

Figure 2 illustrates how each CMHSP scored comprehensively. Bay Arenac scored 3.44, CEI scored 3.68, Central scored 3.41, Gratiot scored 3.50, Huron scored 3.63, Ionia scored 3.41, Lifeways scored 3.52, Montcalm scored 3.50, Newaygo scored 3.63, Saginaw scored 3.87, Shiawassee scored 3.72, Tuscola scored 3.47, and the MSHN average was 3.57.

Fig. 2 – Comparison of CMHSP Comprehensive Score

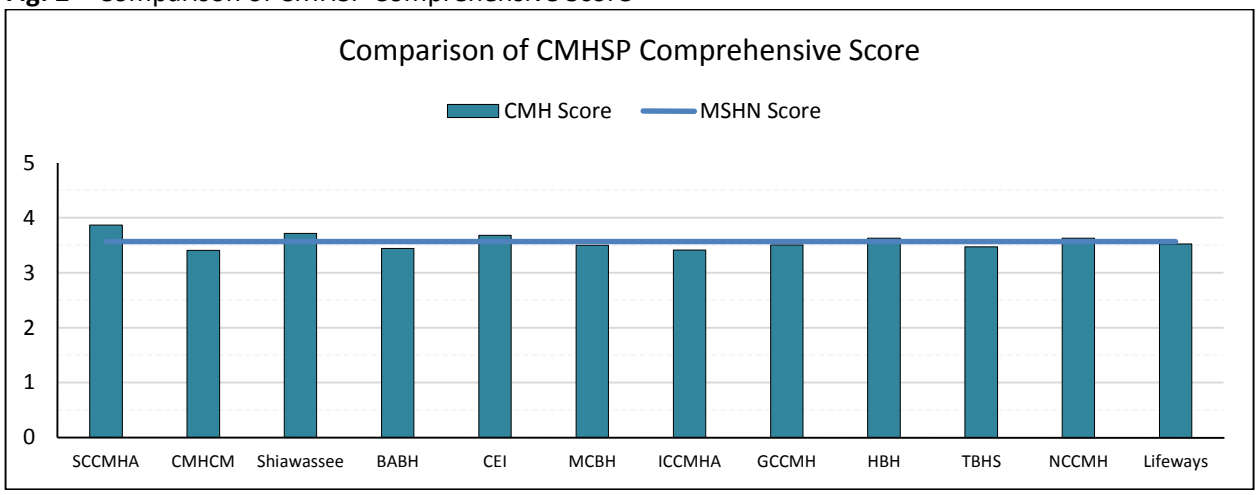


Figure 3 illustrate how each CMHSP scored in the Personal Recovery domain. Bay Arenac scored 3.54, CEI scored 3.80, Central scored 3.55, Gratiot scored 3.64, Huron scored 3.69, Ionia scored 3.48, Lifeways scored 3.63, Montcalm scored 3.60, Newaygo scored 3.77, Saginaw scored 4.04, Shiawassee scored 3.84, Tuscola scored 3.62, and the MSHN average was 3.68.

Fig. 3 – Comparison of CMHSP Personal Recovery Score

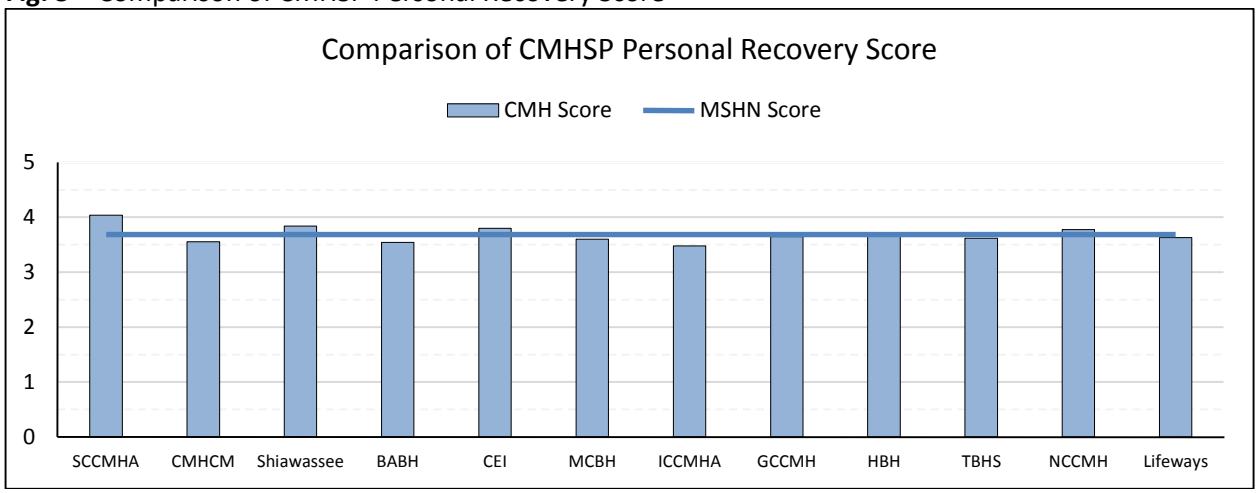


Figure 4 illustrates how each CMHSP scored in the Clinical Recovery domain. Bay Arenac scored 3.07, CEI scored 3.38, Central scored 2.65, Gratiot scored 3.03, Huron scored 3.28, Ionia scored 3.07, Lifeways scored 3.21, Montcalm scored 3.00, Newaygo scored 3.24, Saginaw scored 3.43, Shiawassee scored 3.17, Tuscola scored 3.02, and the MSHN average was 3.13.

Fig. 4 – Comparison of CMHSP Clinical Recovery Score

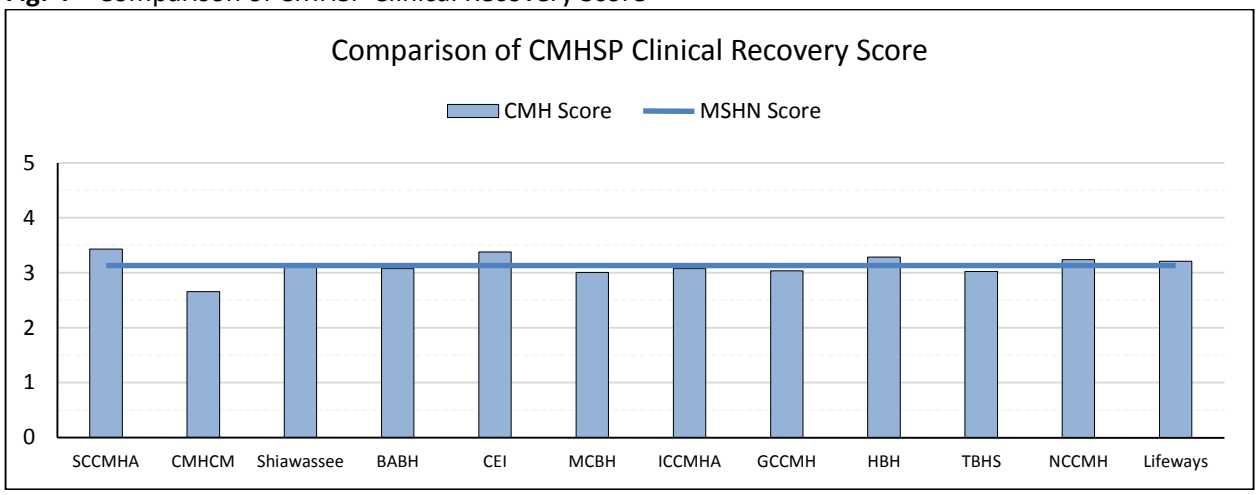
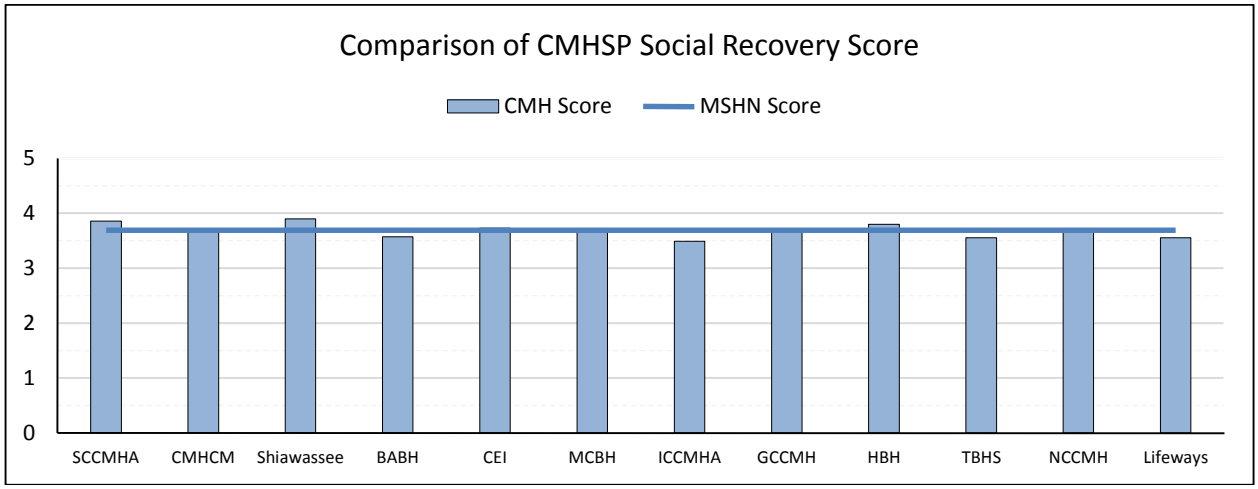


Figure 5 illustrates how each CMHSP scored in the Social Recovery domain. Bay Arenac scored 3.57, CEI scored 3.73, Central scored 3.71, Gratiot scored 3.69, Huron scored 3.80, Ionia scored 3.49, Lifeways scored 3.56, Montcalm scored 3.73, Newaygo scored 3.72, Saginaw scored 3.86, Shiawassee scored 3.90, Tuscola scored 3.55, and the MSHN average was 3.69.

Fig. 5. – Comparison of CMHSP Social Recovery Score



MSHN Recovery Assessment Scale Domain Response

The responses from the Recovery Assessment Scale survey were analyzed by domain questions and responses. This analysis was performed by each CMHSP, and can be found here. The question that each number associates with can be found here.

Figure 6 illustrates how MSHN's 12 CMHSPs responded to the 11 Personal Recovery domain questions. For question number 1, 46.6% of responses strongly agreed, 38.9% agreed, 10.4% were neutral, 2.3% disagreed, and 1.8% strongly disagreed. For question number 3, 41.4% strongly agreed, 42.8% agreed, 10.6% neutral, 3.3% disagreed, 1.9% strongly disagreed. For question number 4, 23.0% strongly agreed, 36.3% agreed, 29.3% neutral, 7.7% disagreed, and 3.6 strongly

disagreed. For question number 5, 35.1% strongly agreed, 35.8 agreed, 19.8% neutral, 5.8% disagreed, and 3.6% strongly disagreed. For question number 7, 15.2% strongly agreed, 32.7% agreed, 32.7% neutral, 13.9% disagreed, and 5.4% strongly disagreed. For question number 8, 22.3% strongly agreed, 37.3% agreed, 22.2% neutral, 11.4% disagreed, and 6.7% strongly disagreed. For question number 9, 26.7% strongly agreed, 41.5% agreed, 23.3% neutral, 5.3% disagreed, and 3.1% strongly disagreed. For question number 10, 27.5% strongly agreed, 40.0% agreed, 24.1% neutral, 5.3% disagreed, 3.0% strongly disagreed. For question number 11, 26.8% strongly agreed, 39.0% agreed, 22.9% neutral, 7.5% disagreed, 3.8% strongly disagreed. For question number 15, 25.1% strongly agreed, 45.4% agreed, 17.2% neutral, 9.3% disagreed, and 2.9% strongly disagreed. For question number 17, 23.6% strongly agreed, 45.7% agreed, 15.9% neutral, 11.8% disagreed, 2.9% disagreed.

Fig. 6 – MSHN – Personal Recovery Domain Response

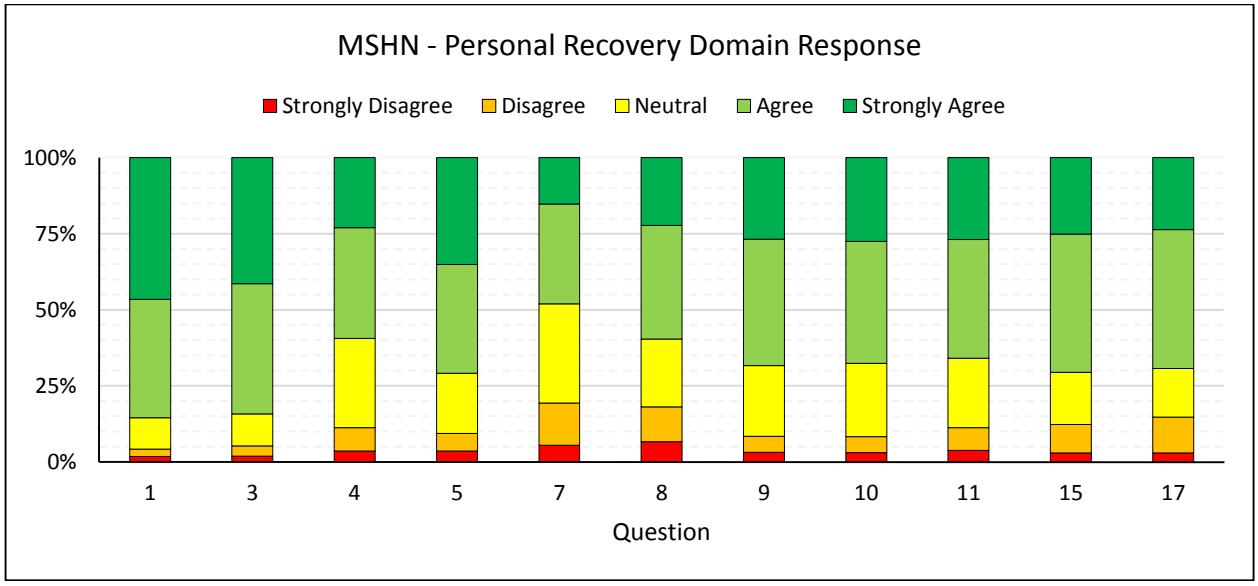


Figure 7 illustrates how MSHN's 12 CMHSPs responded to the three Clinical Recovery domain questions. For question number 2, 18.6% strongly agreed, 36.4% agreed, 30.0% neutral, 10.7% disagreed, and 4.3% strongly disagreed. For question number 13, 10.5% strongly agreed, 23.0% agreed, 22.2% neutral, 26.9% disagreed, and 17.4% strongly disagreed. For question number 14, 11.0% strongly agreed, 28.1% agreed, 25.8% neutral, 21.8% disagreed, and 13.4% strongly disagreed.

Fig. 7 – MSHN – Clinical Recovery Domain Response

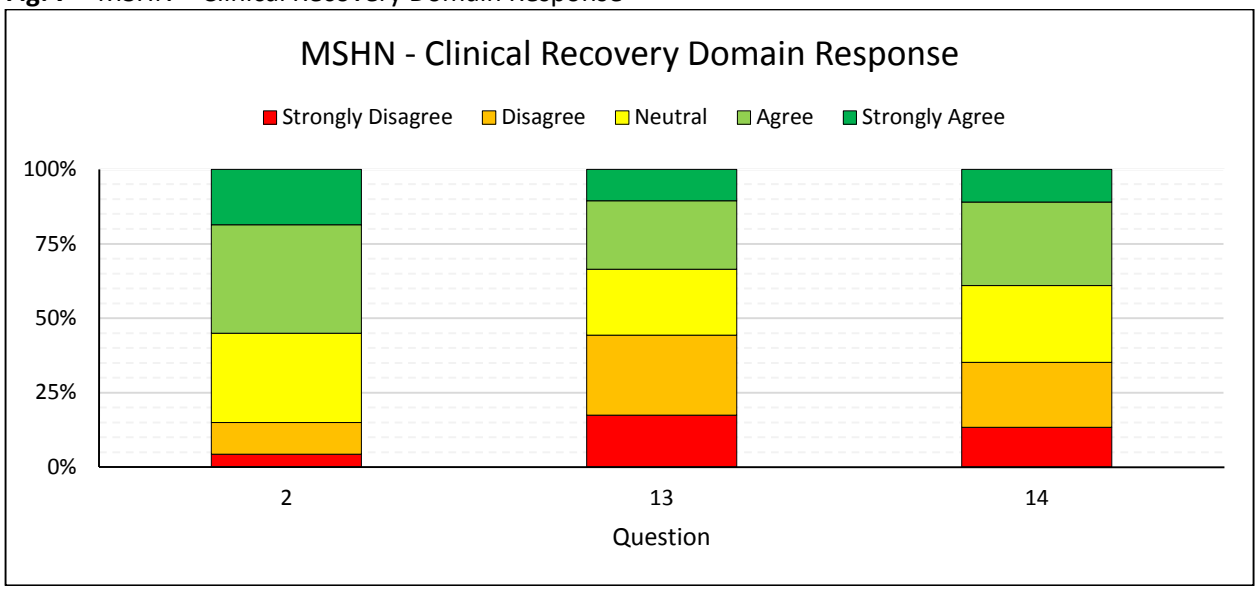


Figure 8 illustrates how MSHN's 12 CMHSPs responded to the four Social Recovery domain questions. For question number 6, 32.3% of the responses strongly agreed, 41.7% agreed, 17.8% neutral, 5.3% disagreed, and 2.9% strongly disagreed. For question number 18, 32.0% of responses strongly agreed, 42.6% agreed, 15.5% neutral, 6.3% disagreed, and 3.7% strongly disagreed. For question number 19, 27.7% strongly agreed, 41.9% agreed, 21.3% neutral, 6.0% disagreed, and 3.1% strongly disagreed. For question 20, 23.9% strongly agreed, 37.7% agreed, 20.1% neutral, 12.0% disagreed, and 6.3% strongly disagreed.

Fig. 8 – MSHN – Social Recovery Domain Response

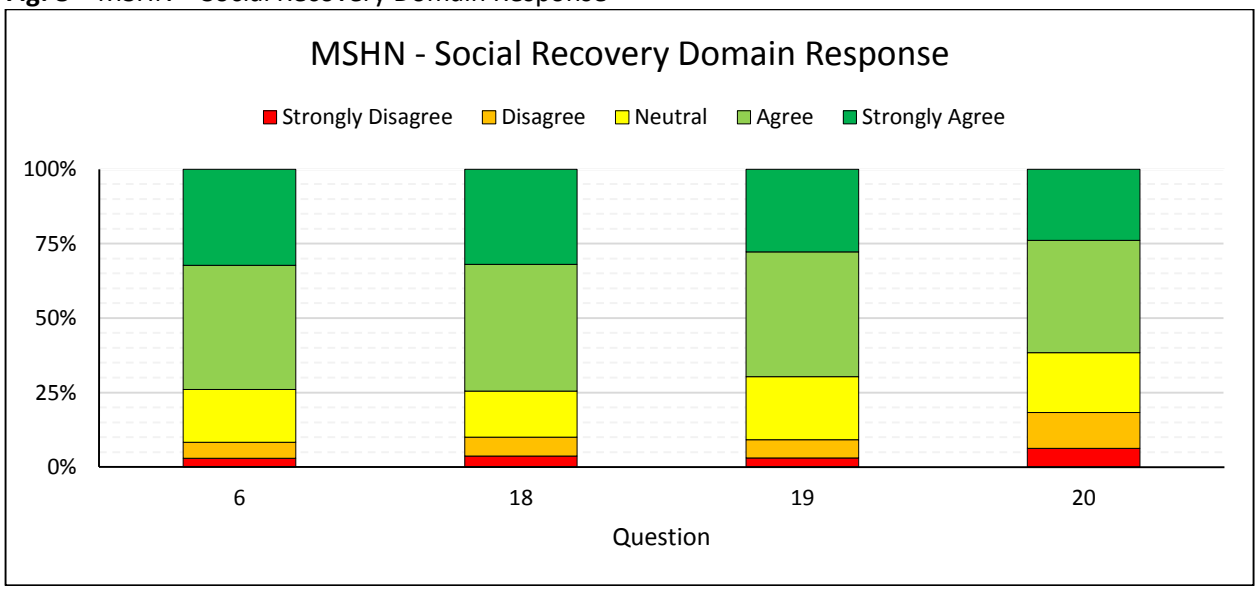
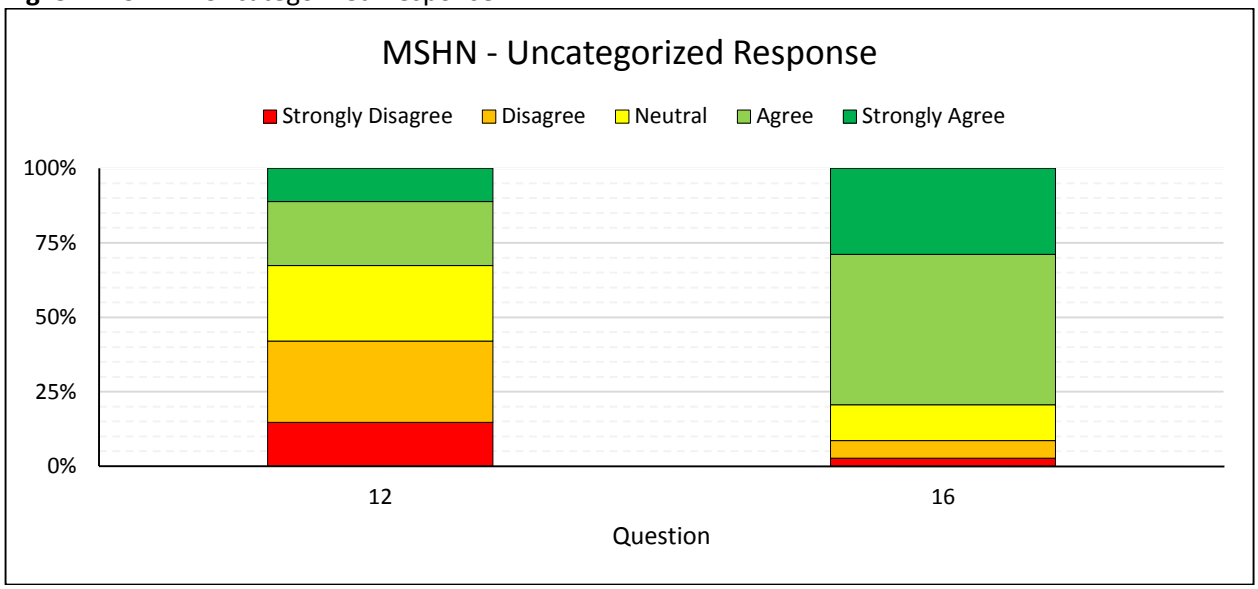


Figure 9 illustrates how all 12 CMHSPs responded to two uncategorized questions. For question number 12, 11.1% of the responses strongly agreed, 21.5% agreed, 25.4% neutral, 27.3% disagreed, and 14.7% strongly disagreed. For question number 16, 28.8% of the responses strongly agreed, 50.6% agreed, 12.1% neutral, 5.9 % disagreed, and 2.6% strongly disagreed.

Fig. 9 – MSHN – Uncategorized Response



VII. Consumer Satisfaction Surveys – MHSIP & YSS

Quality Assessment and Performance Improvement Program
2015 Perception of Care Report Assertive Community Treatment Home-Based Services Program

Introduction

The Michigan Department of Community Health (MDCH) requires a survey be administered annually to programs identified by the Michigan Quality Improvement Council. The Michigan QI Council has chosen the Assertive Community Treatment program and the Home-Based Services program for 2013. The two programs will have the opportunity to complete the Mental Health Statistics Improvement Program (MHSIP) and the Youth Satisfaction Survey for Families (YSSF) over a two-week period of time. MDCH provides implementation guidelines and instructions to each Prepaid Inpatient Health Plan (PIHP). Each PIHP is to administer the survey within the time frame allotted by MDCH. The survey results are returned to MDCH via supplied excel workbook.

Each PIHP, in collaboration with the Community Mental Health Services Program (CMHSP) and their contracted providers; have utilized the MHSIP and the YSSF to conduct a region wide perception of care survey to determine any areas that may be deficient within the region. The data obtained by each CMHSP was provided to MSHN for regional analysis. The survey outcomes reported to the Mid-State Health Network Quality Council for FY14 will be compared to the Baseline Perception of Care Report that was prepared of the 2013 data.

Survey Response Rates

Clinicians tracked who was given a survey with a tally form for each program. Consumers were given an option to decline answering the survey questions. Those consumers who declined were removed from the total number of surveys distributed. The response rates were calculated by dividing the number of surveys that were returned by the number of surveys that were distributed. Figure 1 and Figure 2 indicate the return rate for each CMHSP by program where data was available prior to February 10th.
Any surveys received after February 10th were not included in the results.

Figure 1

MHSIP-ACT	2014 Distributed	2014 Received	2014 Declined	2014 Response Rates	2013 Response Rates
MSHN	516	171	92	33%	41%
Bay-Arenac	25	16	0	64%	41%
CEI	60	8	12	13%	44%
Central Mi	112	23	30	21%	55%
Gratiot	NA	NA	NA	NA	*
Huron	30	7	0	23%	18%
Ionia	NA	NA	NA	NA	50%
Lifeways	189	70	29	37%	23%
Montcalm	24	6	3	25%	26%
Newaygo	NA	NA	NA	NA	17%
Saginaw	32	22	0	69%	85%
Shiawassee	24	9	1	38%	45%
Tuscola	20	10	17	50%	87%

*No data available

Figure 2

YSS-Home-Based Services	2014 Distributed	2014 Received	2014 Declined	2014 Response Rates	2013 Response Rates
MSHN	1294	283	22	22%	32%
Bay-Arenac	53	15	0	28%	15%
CEI	469	43	2	9%	37%
Central Mi	166	51	4	31%	24%
Gratiot	67	28	0	42%	95%
Huron	14	14	0	100%	10%
Ionia	44	23	0	52%	*
Lifeways	225	76	5	34%	15%
Montcalm	47	15	6	32%	20%
Newaygo	5	5	0	100%	*
Saginaw	17	10	0	59%	13%
Shiawassee	31	3	5	10%	43%
Tuscola	74	**36	1	*56%	56%

**May include individuals who have received services from the child case management program
*No data available

Methodology

Two survey populations were identified to be part of the sample. The sample was a convenience sample of all who were scheduled to be seen within a pre-identified time frame. The survey populations were broken into program types. Assertive Community Treatment (ACT) and Home-Based Services (HBS) were given a choice of any two-week time frame in November through December. All adult consumers within the ACT program will receive the MHSIP 44. The raw data was required to be received by MDCH no later than February 20, 2015.

MDCH will prepare an analysis, which will include comparison data of PIHPs in Michigan and CMHSPs within each PIHP.

The Youth, 17 years and younger, who are receiving services from the Home-Based Services program will receive the YSS-36. The raw data was required to be received by MDCH no later than February 20, 2015. MDCH will prepare an analysis, which will include comparison data of the PIHPs in Michigan and CMHSPs within each PIHP in Michigan.

The consumers did have the option to decline participation. If the consumer declined, this was noted and removed from the number distributed.

There were two optional changes in the implementation process for FY2012. Based on discussions with Substance Abuse and Mental Health Services Administration (SAMHSA) and information from other states that implement the YSS and MHSIP, the MDCH Quality Improvement Council decided that PIHPs can opt to assign numerical identifiers to the MHSIP and YSS in order to identify the respondents. The PIHP was to use the selected field in the data entry forms to inform MDCH whether they have chosen to
assign identifiers. These identifiers are for the PIHPs use only, and are not to be shared with MDCH. MSHN did not require the use of use identifiers for the survey.

<u>Scoring</u>
MHSIP – Seven domains are included in the survey. Each domain has multiple questions related to the domain topic. The domains are as follows: general satisfaction, access to care, quality of care, participation in treatment, outcomes of care, functional status, and social connectedness. Each question in the domain is required to have a response choice of 1 - 5 in order for the domain to be included in the sample. If one question is left blank, the responses of the remaining questions for that domain are excluded from the calculations of that domain. There are 6 response choices for each question within the domain, which are assigned a numeric value. Note that the number of responses included in the domain average and domain percentage of agreement could be less than that of each individual question as a result of the exclusion of unanswered questions when calculating the domain.

Strongly Agree=1 Agree=2
Neutral=3 Disagree=4
Strongly Disagree=5 Not
Applicable=9

The mean of each individual question is calculated. Those less than or equal to 2.5 are considered to be “in agreement”. The total number of respondents who were “in agreement” is then divided by the total respondents. The resultant number is then multiplied by 100 to provide a percentage.

Those questions that have a “Blank” or a response of “Not Applicable” were removed from the sample.

YSS – There are six domains included in the survey. Each domain has several individual questions related to the domain topic. Each question in the domain is required to have a response choice of 1 - 5 in order for the domain to be included in the sample. If one question is left blank, the responses of the remaining questions for that domain

are excluded from the calculations of that domain. The domains are as follows: quality and appropriateness (satisfaction with service), access to care, family participation in treatment planning, outcomes of care, cultural sensitivity of staff, and social connectedness. There are 5 response choices for each question within the domain, which are assigned a numeric value.

Strongly Agree=5 Agree=4
Neutral=3 Disagree=2
Strongly Disagree=1

The mean of each individual question is calculated. Those greater than or equal to 3.5 are considered to be "in agreement". The total number of respondents who are "in agreement" is then divided by the total respondents. The resultant number is then multiplied by 100 to provide a percentage. Those questions that have a "blank" are removed from the sample.

Data Analysis

Each survey was entered into an excel spreadsheet. The ACT and HBS programs were categorized by numeric codes provided by MDCH.

The results are analyzed as follows: PIHP

- By Domain
- By Domain Line Item

CMHSP (Attachments A YSS and Attachment B MHSIP)

- By Domain
- By Domain Line Item

Survey Findings

The Youth Perception of Care Survey

Figure 3 demonstrates the percentage of agreement for each domain. Please refer to the scoring methodology above with questions related to the calculations. Those who responded to the survey indicated agreement consistent or at an increased percentage compared to those who responded for the 2013 survey. Each domain scored above the desired threshold of 80% except the "Perception of Outcomes of Services". MSHN scored the highest in the Cultural Sensitivity, Access, and the Perception of Treatment domains. This indicates that the location of services (98%, 314/319), and times that services were available (95%, 303,318), are acceptable to the families who responded to the survey. Staff in the MSHN speak to the children in Home-Based services in a way they understand (99%, 313/316) and treat the children with respect (98%, 310/317). Staff respect their family's religious or spiritual beliefs and are sensitive to each person's cultural or ethnic background (93%, 284/307). Families felt they were able to participate in their child's treatment (97%, 308/318) by choosing their child's services (90%, 286/318) and treatment goals (96%, 305/318). The percentage of respondents who were in agreement with the survey questions for the domain "Perception of Outcomes of Services" was 65%, which was below the desired threshold of 80%, however; a slight increase from the previous year. The respondents indicated that their child was better at handling their daily life (69%, 214/312) and coping when things go wrong (59%,

182/311). Families indicated that their child gets along better with friends and other people (63%, 197/311) and their family (67%, 210/314). Sixty-five percent (203/310) indicated that their child was doing better in school and/or work. Families indicated that their child is able to do things that he/she wants to do (66%, 205/311). Sixty-one percent (189/309) of the families who responded to the survey indicated that they were happy with their family life right now. The percentages and respondent numbers for each CMHSP Participant is located in Attachment A.

Figure 3

Youth Survey	Appropriateness		Perception of Access		Perception of Cultural Sensitivity		Perception of Participation in Treatment		Perception of Outcome of Services		Perception of Social Connectedness	
	2013	**2014**	2013	**2014**	2013	**2014**	2013	**2014**	2013	**2014**	2013	**2014**
MSHN	90%	**92%**	98%	**98%**	98%	**99%**	95%	**95%**	63%	**65%**	92%	**92%**
BABH	64%	**80%**	93%	**93%**	91%	**100%**	86%	**93%**	46%	**53%**	77%	**93%**
CEI	86%	**93%**	99%	**100%**	99%	**100%**	95%	**91%**	55%	**73%**	86%	**86%**
CMHCM	91%	**92%**	100%	**96%**	100%	**100%**	100%	**98%**	59%	**55%**	100%	**94%**
Gratiot	97%	**100%**	97%	**100%**	100%	**100%**	97%	**100%**	81%	**79%**	94%	**100%**
HBH	100%	**79%**	100%	**100%**	100%	**100%**	100%	**93%**	0%	**57%**	100%	**86%**
Ionia	93%	**91%**	100%	**96%**	100%	**100%**	100%	**96%**	64%	**62%**	93%	**91%**
Lifeways	90%	**93%**	96%	**97%**	93%	**99%**	97%	**96%**	57%	**63%**	90%	**97%**
MCBH	91%	**87%**	100%	**93%**	100%	**100%**	100%	**87%**	64%	**71%**	100%	**93%**
NCMH	100%	**100%**	100%	**100%**	100%	**100%**	60%	**80%**	100%	**40%**	100%	**60%**
Saginaw	100%	**90%**	100%	**100%**	100%	**100%**	100%	**90%**	100%	**70%**	100%	**90%**
Shiawassee	100%	**100%**	100%	**100%**	100%	**100%**	100%	**100%**	60%	**67%**	100%	**67%**
TBHS	91%	**94%**	97%	**100%**	97%	**97%**	91%	**94%**	75%	**74%**	97%	**89%**

Figure 4

Youth – Home-Based Services	2013	2014
Access		
Q8. The location of services was convenient for us.	96.3%	**98%**
Q9. Services were available at times that were convenient for us.	96.3%	**95%**
Participation in Treatment		
Q2. I helped to choose my child's services.	91.0%	**90%**
Q3. I helped to choose my child's treatment goals.	98.0%	**96%**
Q6. I participated in my child's treatment.	96.7%	**97%**
Cultural Sensitivity		
Q12. Staff treated me with respect.	96.3%	**98%**
Q13. Staff respected my family's religious/spiritual beliefs.	93.4%	**94%**
Q14. Staff spoke with me in a way that I understand.	98.4%	**99%**
Q15. Staff were sensitive to my cultural/ethnic background.	93.3%	**93%**
Appropriateness		
Q1. Overall, I am satisfied with the services my child received.	92.3%	**93%**
Q4. The people helping my child stuck with us no matter what.	90.7%	**91%**
Q5. I felt my child had someone to talk to when she/he was troubled.	87.8%	**90%**
Q7. The services my child and/or family received were right for us.	90.7%	**77%**
Q10. My family got the help we wanted for my child.	86.1%	**82%**

Q11. My family got as much help as we needed for my child.	79.9%	**77%**
Outcomes		
Q16. My child is better at handling daily life.	65.4%	**69%**
Q17. My child gets along better with family.	67.2%	**67%**
Q18. My child gets along better with friends and other people.	64.6%	**63%**
Q19. My child is doing better in school and/or work.	62.0%	**65%**
Q20. My child is better able to cope when things go wrong.	57.5%	**59%**
Q21. I am satisfied with our family life right now.	55.8%	**61%**
Q22. My child is better able to do things he or she wants to do.	63.4%	**66%**
Social Connectedness		
Q23. I know people who will listen and understand me when I need to talk.	87.6%	**88%**
Q24. I have people that I am comfortable talking with about my child's problems.	88.4%	**91%**
Q25. In a crisis, I would have the support I need from family or friends.	76.1%	**80%**
Q26. I have people with whom I can do enjoyable things.	78.5%	**87%**
Functioning		
Q16. My child is better at handling daily life.	65.4%	**69%**
Q17. My child gets along better with family.	67.2%	**67%**
Q18. My child gets along better with friends and other people.	64.6%	**63%**
Q19. My child is doing better in school and/or work.	62.0%	**65%**
Q20. My child is better able to cope when things go wrong.	57.5%	**59%**
Q22. My child is better able to do things he or she wants to do.	63.4%	**66%**

MHSIP

Figure 5 demonstrates the percentage of agreement for each domain. Please refer to the scoring methodology above with questions related to the calculations. Those who responded to the survey indicated agreement consistent or at an increased percentage compared to those who responded for the 2013 survey except "Perception of Functioning" and "Perception of Social Connectedness". Each domain scored above the desired threshold of 80% except the "Perception of Functioning". MSHN scored the highest in the Quality and Appropriateness, Participation in Treatment Planning, and the Perception of Access domains. Those who responded to the survey indicated that staff gave them the information needed to manage their illness (100%), information about their rights (91%, 154/169), and side effects to watch for (85%, 142/168) take responsibility for living their life (93%, 155/167). Staff were sensitive to my cultural background (90%, 142/157) and respected my wishes about who to and not to give my information to (93%, 155/167). The respondents indicated that staff believed they could grow, change and recover (92%, 153), and they could complain if needed (85%, 142/168). The respondents also believed that staff encouraged them to use consumer run programs (100%). Individuals felt comfortable asking questions about their treatment (86%, 144/168) and they not staff decided their treatment goals (86%, 134/156). Those who participated believed that the location of services were convenient (100%) and staff were able to see them as often as the individual felt necessary (100%) at times that were good for them (92%, 155/192). The respondents indicated that they were able to see the psychiatrist when wanted (83%. 139/168) and were able to get all the services they needed (87%, 147/169). In general, all survey respondents indicated they like the services they received (100%) and would refer to a friend or family member (100%). Figure 6 provides the number who agreed with each question and the percent who agreed for each question within the domain. Please refer to the scoring methodology above with questions related to the calculations.

Figure 5

Adult Survey	General Satisfaction		Perception of Access		Perception of Quality and Appropriateness		Perception of Participation in Treatment		Perception of Outcome of Services		Perception of Functioning		Perception of Social Connectedness	
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	
MSHN	86%	**90%**	91%	**92%**	89%	**97%**	86%	**94%**	73%	**84%**	84%	**73%**	84%	**82%**
BABH	84%	**71%**	92%	**79%**	91%	**89%**	92%	**90%**	72%	**50%**	96%	**60%**	92%	**73%**
CEI	79%	**100%**	83%	**100%**	82%	**100%**	72%	**100%**	73%	**100%**	79%	**88%**	94%	**100%**
CMHCM	89%	**86%**	98%	**91%**	86%	**95%**	90%	**90%**	74%	**92%**	83%	**89%**	84%	**68%**
HBH	89%	**100%**	88%	**86%**	89%	**100%**	88%	**100%**	83%	**75%**	88%	**67%**	100%	**50%**
Ionia	100%		100%		100%		100%		100%		100%		67%	
Lifeways	86%	**90%**	94%	**97%**	89%	**98%**	82%	**97%**	82%	**86%**	87%	**71%**	78%	**86%**
MCBH	100%	**100%**	80%	**100%**	100%	**100%**	100%	**100%**	50%	**100%**	60%	**80%**	100%	**80%**
Newaygo	75%		100%		100%		100%		67%		33%		67%	
Saginaw	94%	**95%**	88%	**95%**	91%	**100%**	85%	**95%**	80%	**92%**	90%	**86%**	88%	**95%**
Shiawassee	80%	**100%**	90%	**67%**	89%	**100%**	80%	**88%**	86%	**67%**	100%	**33%**	89%	**100%**
TBHS	72%	**90%**	85%	**80%**	86%	**78%**	81%	**80%**	44%	**57%**	68%	**60%**	69%	**60%**

Figure 6

Adult – ACT Program	2013	2014
General Satisfaction		
Q1. I like the services that I received.	87.6%	**100%**
Q2. If I had other choices, I would still choose to get services from this mental health agency.	83.4%	**93%**
Q3. I would recommend this agency to a friend or family member.	84.0%	**100%**
Access		
Q4. The location of services was convenient.	82.7%	**100%**
Q5. Staff were willing to see me as often as I felt it was necessary.	90.6%	**100%**
Q6. Staff returned my calls within 24 hours.	85.8%	**91%**
Q7. Services were available at times that were good for me.	88.3%	**92%**
Q8. I was able to get all the services I thought I needed.	83.7%	**87%**
Q9. I was able to see a psychiatrist when I wanted to.	79.8%	**83%**
Quality/Appropriateness		
Q10. Staff believed that I could grow, change and recover.	86.9%	**92%**
Q12. I felt free to complain.	79.4%	**85%**
Q13. I was given information about my rights.	89.7%	**91%**
Q14. Staff encouraged me to take responsibility for how I live my life.	87.7%	**93%**
Q15. Staff told me what side effects to watch for.	78.4%	**85%**
Q16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	86.8%	**93%**
Q18. Staff were sensitive to my cultural/ ethnic background (e.g., race, religion, language, etc.).	82.1%	**90%**
Q19. Staff helped me obtain the information I needed so that I could take charge of managing my illness and disability.	87.7%	**100%**
Q20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis	83.9%	**100%**

phone line, etc.).		
Participation in Treatment Planning		
Q11. I felt comfortable asking questions about my treatment, services, and medication.	86.0%	**86%**
Q17. I, not staff, decided my treatment goals.	79.5%	**86%**
Outcomes		
Q21. I deal more effectively with daily problems.	80.4%	**84%**
Q22. I am better able to control my life.	80.6%	**82%**
Q23. I am better able to deal with crisis.	75.8%	**80%**
Q24. I am getting along better with my family.	78.2%	**75%**
Q25. I do better in social situations.	68.3%	**71%**
Q26. I do better in school and/or work.	57.8%	**62%**
Q27. My housing situation has improved.	68.6%	**77%**
Q28. My symptoms are not bothering me as much.	70.8%	**67%**
Functioning		
Q28. My symptoms are not bothering me as much.	70.8%	**67%**
Q29. I do things that are more meaningful to me.	80.2%	**75%**
Q30. I am better able to take care of my needs.	82.0%	**79%**
Q31. I am better able to handle things when they go wrong	73.7%	**73%**
Q32. I am better able to do things that I want to do.	78.7%	**78%**
Social Connectedness		
Q33. I am happy with the friendships I have.	84.9%	**77%**
Q34. I have people with who I can do enjoyable things.	80.3%	**79%**
Q35. I feel I belong in my community.	70.5%	**70%**
Q36. In a crisis, I would have the support I need from family or friends.	81.1%	**79%**

Recommendations/Improvement Opportunities

It is recommended that each CMHSP take this information to their local Consumer Council, review each domain and each question to identify areas of deficiency. It is recommended to provide information regarding local process for follow up regarding consumer satisfaction scores and follow up of dissatisfaction. The QI Council recommended that an acceptable threshold be set at an 80% rate of agreement per domain. Each domain that is below 80% is subject to a corrective action/improvement plan. It was also recommend that those with a low number of returned responses review their process and determine if additional action may need to be taken. The low number of responses may result in an acceptable threshold based on the standard set or it may result in an unacceptable threshold. The low numbers may not allow the results to be generalized throughout the population. CMHSP Participants may be subject to an improvement plan based on performance below the desired threshold.

Submitted by: Sandra Gettel, BABH as MSHN Contract Designee 3/11/2015

Quality Assessment and Performance Improvement Program
2015 Perception of Care Report
Assertive Community Treatment
Home-Based Services Program

Attachment A

MSHN
Mid-State Health Network

Youth Survey		MSHN	BABH	CEI	CMHCM	Gratiot	HBH	Ionia	Lifeways	MCBH	NCMH	Saginaw	Shiawassee	TBHS
Appropriateness	**Domain Average %**	**92%**	**80%**	**93%**	**92%**	**100%**	**79%**	**91%**	**93%**	**87%**	**100%**	**90%**	**100%**	**94%**
1. Overall, I am satisfied with the services my child received.	% Agreement	93%	80%	91%	96%	96%	86%	87%	95%	100%	100%	100%	67%	92%
	# Agree	296	12	39	49	27	12	20	72	15	5	10	2	33
	# Valid Respondents	319	15	43	51	28	14	23	76	15	5	10	3	36
4. The people helping my child stuck with us no matter what.	% Agreement	91%	93%	91%	94%	100%	86%	96%	86%	87%	80%	80%	100%	97%
	# Agree	290	14	39	47	28	12	22	65	13	4	8	3	35
	# Valid Respondents	318	15	43	50	28	14	23	76	15	5	10	3	36
5. I felt my child had someone to talk to when she/he was troubled.	% Agreement	90%	87%	88%	84%	100%	79%	100%	87%	87%	80%	90%	67%	100%
	# Agree	283	13	38	41	28	11	23	65	13	4	9	2	36
	# Valid Respondents	316	15	43	49	28	14	23	75	15	5	10	3	36
7. The services my child and/or family received were right for us.	% Agreement	77%	40%	54%	69%	78%	60%	100%	79%		100%	100%		100%
	# Agree	75	2	7	9	7	3	9	22		1	1		14
	# Valid Respondents	98	5	13	13	9	5	9	28		1	1		14
10. My family got the help we wanted for my child.	% Agreement	82%	73%	77%	80%	96%	64%	87%	82%	73%	80%	90%	67%	89%
	# Agree	258	11	33	39	26	9	20	62	11	4	9	2	32
	# Valid Respondents	316	15	43	49	27	14	23	76	15	5	10	3	36
11. My family got as much help as we needed for my child.	% Agreement	77%	73%	67%	76%	89%	57%	78%	76%	67%	80%	90%	67%	89%
	# Agree	244	11	29	38	25	8	18	58	10	4	9	2	32
	# Valid Respondents	318	15	43	50	28	14	23	76	15	5	10	3	36
Perception of Access	**Domain Average %**	**98%**	**93%**	**100%**	**96%**	**100%**	**100%**	**96%**	**97%**	**93%**	**100%**	**100%**	**100%**	**100%**
8. The location of services was convenient for us.	% Agreement	98%	100%	98%	100%	100%	100%	96%	100%	87%	100%	90%	100%	100%
	# Agree	314	15	42	51	28	14	22	76	13	5	9	3	36
	# Valid Respondents	319	15	43	51	28	14	23	76	15	5	10	3	36

9. Services were available at times that were convenient for us.	% Agreement	95%	87%	100%	96%	100%	93%	83%	93%	93%	100%	100%	100%	100%
	# Agree	303	13	43	49	27	13	19	71	14	5	10	3	36
	# Valid Respondents	318	15	43	51	27	14	23	76	15	5	10	3	36
Perception of Cultural Sensitivity	**Domain Average %**	**99%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**99%**	**100%**	**100%**	**100%**	**100%**	**97%**
12. Staff treated me with respect.	% Agreement	98%	100%	100%	98%	96%	79%	100%	99%	100%	100%	100%	100%	97%
	# Agree	310	15	43	50	27	11	23	73	15	5	10	3	35
	# Valid Respondents	317	15	43	51	28	14	23	74	15	5	10	3	36
13. Staff respected my family's religious/spiritual beliefs.	% Agreement	94%	93%	95%	90%	96%	100%	86%	96%	100%	100%	90%	67%	97%
	# Agree	294	13	39	45	27	14	19	71	15	5	9	2	35
	# Valid Respondents	312	14	41	50	28	14	22	74	15	5	10	3	36
14. Staff spoke with me in a way that I understand.	% Agreement	99%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%	100%	97%
	# Agree	313	15	43	50	28	14	23	72	15	5	10	3	35
	# Valid Respondents	316	15	43	50	28	14	23	74	15	5	10	3	36
15. Staff were sensitive to my cultural/ethni	% Agreement	93%	80%	93%	96%	96%	100%	75%	93%	93%	100%	90%	100%	94%
	# Agree	284	12	39	48	27	14	15	66	13	5	9	3	33
	# Valid Respondents	307	15	42	50	28	14	20	71	14	5	10	3	35
Perception of Participation in Treatment	**Domain Average %**	**95%**	**93%**	**91%**	**98%**	**100%**	**93%**	**96%**	**96%**	**87%**	**80%**	**90%**	**100%**	**94%**
2. I helped to choose my child's services.	% Agreement	90%	93%	86%	92%	100%	93%	87%	86%	93%	100%	80%	100%	92%
	# Agree	286	14	37	46	28	13	20	65	14	5	8	3	33
	# Valid Respondents	318	15	43	50	28	14	23	76	15	5	10	3	36
	% Agreement	96%	100%	95%	100%	96%	93%	91%	100%	80%	80%	80%	67%	100%
	# Agree	305	15	41	50	27	13	21	76	12	4	8	2	36

3. I helped to choose my child's treatment	# Valid Respondents	318	15	43	50	28	14	23	76	15	5	10	3	36
6. I participated in my child's treatment.	% Agreement	97%	100%	93%	100%	100%	93%	96%	99%	87%	100%	90%	100%	97%
	# Agree	308	15	40	50	28	13	22	75	13	5	9	3	35
	# Valid Respondents	318	15	43	50	28	14	23	76	15	5	10	3	36
Perception of Outcome of Services	**Domain Average %**	**65%**	**53%**	**73%**	**55%**	**79%**	**57%**	**62%**	**63%**	**71%**	**40%**	**70%**	**67%**	**74%**
16. My child is better at handling daily life.	% Agreement	69%	60%	71%	65%	82%	43%	61%	70%	57%	40%	90%	100%	75%
	# Agree	214	9	29	32	23	6	14	52	8	2	9	3	27
	# Valid Respondents	312	15	41	49	28	14	23	74	14	5	10	3	36
17. My child gets along better with family.	% Agreement	67%	67%	77%	59%	82%	50%	61%	64%	64%	40%	70%	67%	75%
	# Agree	210	10	33	29	23	7	14	47	9	2	7	2	27
	# Valid Respondents	314	15	43	49	28	14	23	74	14	5	10	3	36
18. My child gets along better with friends and other people.	% Agreement	63%	47%	71%	48%	89%	57%	65%	56%	64%	40%	80%	67%	75%
	# Agree	197	7	30	23	25	8	15	41	9	2	8	2	27
	# Valid Respondents	311	15	42	48	28	14	23	73	14	5	10	3	36
19. My child is doing better in school and/or work.	% Agreement	65%	67%	69%	60%	82%	64%	74%	57%	64%	40%	80%	33%	69%
	# Agree	203	10	29	29	23	9	17	41	9	2	8	1	25
	# Valid Respondents	310	15	42	48	28	14	23	72	14	5	10	3	36
20. My child is better able to cope when things go wrong.	% Agreement	59%	40%	62%	51%	82%	36%	61%	57%	57%	40%	90%	67%	58%
	# Agree	182	6	26	24	23	5	14	42	8	2	9	2	21
	# Valid Respondents	311	15	42	47	28	14	23	74	14	5	10	3	36
21. I am satisfied with our family life right now.	% Agreement	61%	60%	69%	45%	71%	71%	59%	63%	64%	60%	50%	33%	65%
	# Agree	189	9	29	22	20	10	13	46	9	3	5	1	22
	# Valid Respondents	309	15	42	49	28	14	22	73	14	5	10	3	34

22. My child is better able to do things he or she wants to do.	% Agreement	66%	67%	69%	54%	82%	71%	64%	61%	79%	20%	70%	33%	78%
	# Agree	205	10	29	26	23	10	14	45	11	1	7	1	28
	# Valid Respondents	311	15	42	48	28	14	22	74	14	5	10	3	36
Perception of Social Connectedness	**Domain Average %**	**92%**	**93%**	**86%**	**94%**	**100%**	**86%**	**91%**	**97%**	**93%**	**60%**	**90%**	**67%**	**89%**
23. I know people who will listen and understand me when I need to talk.	% Agreement	88%	87%	83%	88%	100%	86%	83%	92%	79%	60%	90%	100%	89%
	# Agree	280	13	35	45	28	12	19	70	11	3	9	3	32
	# Valid Respondents	317	15	42	51	28	14	23	76	14	5	10	3	36
24. I have people that I am comfortable talking with about my child's problems.	% Agreement	91%	93%	86%	88%	96%	86%	87%	95%	100%	60%	90%	100%	92%
	# Agree	288	14	36	45	27	12	20	72	14	3	9	3	33
	# Valid Respondents	317	15	42	51	28	14	23	76	14	5	10	3	36
25. In a crisis, I would have the support I need from family or	% Agreement	80%	93%	76%	75%	93%	71%	78%	79%	79%	60%	90%	67%	86%
	# Agree	254	14	32	38	26	10	18	60	11	3	9	2	31
	# Valid Respondents	317	15	42	51	28	14	23	76	14	5	10	3	36
26. I have people with whom I can do enjoyable	% Agreement	87%	93%	83%	88%	89%	86%	83%	85%	93%	60%	90%	67%	94%
	# Agree	274	14	35	44	25	12	19	64	13	3	9	2	34
	# Valid Respondents	315	15	42	50	28	14	23	75	14	5	10	3	36

Attachment B

Quality Assessment and Performance Improvement Program
2015 Perception of Care Report
Assertive Community Treatment
Home-Based Services Program

Adult Survey		MSHN	BABH	CEI	CMCMH	HBH	Lifeways	MCBH	Saginaw	Shiawassee	TBHS
General Satisfaction	**Domain Average %**	**90%**	**71%**	**100%**	**86%**	**100%**	**90%**	**100%**	**95%**	**100%**	**90%**
1. I like the services that I received.	% Agreement	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	# Agree	170	16	8	23	7	70	6	22	8	10
	# Valid Respondents	170	16	8	23	7	70	6	22	8	10
2. If I had other choices, I would still choose to get services from this mental healthcare agency.	% Agreement	93%	93%	100%	95%	100%	93%	100%	95%	78%	90%
	# Agree	158	14	8	21	7	65	6	21	7	9
	# Valid Respondents	169	15	8	22	7	70	6	22	9	10
3. I would recommend this agency to a friend or family member.	% Agreement	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	# Agree	171	16	8	23	7	70	6	22	9	10
	# Valid Respondents	171	16	8	23	7	70	6	22	9	10
Perception of Access	**Domain Average %**	**92%**	**79%**	**100%**	**91%**	**86%**	**97%**	**100%**	**95%**	**67%**	**80%**
4. The location of services was convenient.	% Agreement	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	# Agree	171	16	8	23	7	70	6	22	9	10
	# Valid Respondents	171	16	8	23	7	70	6	22	9	10
5. Staff were willing to see me as often as I felt it was necessary.	% Agreement	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	# Agree	273	32	11	32	9	111	8	34	19	17
	# Valid Respondents	273	32	11	32	9	111	8	34	19	17
6. Staff returned my calls within 24 hours.	% Agreement	91%	87%	100%	95%	100%	94%	100%	81%	75%	80%
	# Agree	149	13	8	21	7	64	5	17	6	8
	# Valid Respondents	164	15	8	22	7	68	5	21	8	10
7. Services were available at times that were good for me.	% Agreement	92%	81%	100%	96%	100%	91%	100%	95%	88%	80%
	# Agree	155	13	8	22	7	64	5	21	7	8
	# Valid Respondents	169	16	8	23	7	70	5	22	8	10

8. I was able to get all the services I thought I needed.	% Agreement	87%	75%	100%	91%	100%	90%	100%	91%	50%	70%
	# Agree	147	12	8	21	7	63	5	20	4	7
	# Valid Respondents	169	16	8	23	7	70	5	22	8	10
9. I was able to see a psychiatrist when I wanted to.	% Agreement	83%	67%	100%	52%	86%	91%	100%	91%	88%	70%
	# Agree	139	10	8	12	6	63	6	20	7	7
	# Valid Respondents	168	15	8	23	7	69	6	22	8	10
Perception of Quality and Appropriateness	**Domain Average %**	**97%**	**89%**	**100%**	**95%**	**100%**	**98%**	**100%**	**100%**	**100%**	**78%**
10. Staff believed that I could grow, change and recover.	% Agreement	92%	88%	100%	77%	100%	91%	100%	100%	100%	90%
	# Agree	153	14	8	17	7	64	6	21	7	9
	# Valid Respondents	167	16	8	22	7	70	6	21	7	10
12. I felt free to complain.	% Agreement	85%	73%	75%	91%	86%	84%	100%	95%	67%	80%
	# Agree	142	11	6	21	6	58	6	20	6	8
	# Valid Respondents	168	15	8	23	7	69	6	21	9	10
13. I was given information about my rights.	% Agreement	91%	86%	100%	87%	100%	90%	100%	95%	89%	90%
	# Agree	154	12	8	20	7	63	6	21	8	9
	# Valid Respondents	169	14	8	23	7	70	6	22	9	10
14. Staff encouraged me to take responsibility for how I live my life.	% Agreement	93%	80%	100%	91%	100%	93%	100%	95%	100%	90%
	# Agree	155	12	8	21	7	63	6	21	8	9
	# Valid Respondents	167	15	8	23	7	68	6	22	8	10
15. Staff told me what side effects to watch for.	% Agreement	85%	73%	100%	83%	100%	84%	100%	91%	50%	90%
	# Agree	142	11	8	19	7	58	6	20	4	9
	# Valid Respondents	168	15	8	23	7	69	6	22	8	10
16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	% Agreement	93%	73%	100%	91%	100%	97%	100%	100%	78%	80%
	# Agree	155	11	8	20	7	66	6	22	7	8
	# Valid Respondents	167	15	8	22	7	68	6	22	9	10

18. Staff were sensitive to my cultural/ethnic background (e.g., race, religion, language, etc.).	% Agreement	90%	82%	100%	95%	100%	91%	80%	91%	89%	78%
	# Agree	142	9	8	21	7	58	4	20	8	7
	# Valid Respondents	157	11	8	22	7	64	5	22	9	9
19. Staff helped me obtain the information I needed so that I could take charge of managing my illness and disability.	% Agreement	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	# Agree	161	10	8	22	7	67	6	22	9	10
	# Valid Respondents	161	10	8	22	7	67	6	22	9	10
20. I was encouraged to use consumer run programs (support groups, drop-in centers, crisis phone line, etc.).	% Agreement	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	# Agree	159	11	8	22	6	67	5	22	8	10
	# Valid Respondents	159	11	8	22	6	67	5	22	8	10
Perception of Participation in Treatment	**Domain Average %**	**94%**	**90%**	**100%**	**90%**	**100%**	**97%**	**100%**	**95%**	**88%**	**80%**
11. I felt comfortable asking questions about my treatment, services and medication.	% Agreement	86%	57%	100%	78%	100%	89%	100%	95%	75%	80%
	# Agree	144	8	8	18	7	62	6	21	6	8
	# Valid Respondents	168	14	8	23	7	70	6	22	8	10
17. I, not staff, decided my treatment goals.	% Agreement	86%	73%	88%	80%	100%	89%	83%	91%	88%	70%
	# Agree	134	8	7	16	7	57	5	20	7	7
	# Valid Respondents	156	11	8	20	7	64	6	22	8	10
Perception of Outcome of Services	**Domain Average %**	**84%**	**50%**	**100%**	**92%**	**75%**	**86%**	**100%**	**92%**	**67%**	**57%**
21. I deal more effectively with daily problems.	% Agreement	84%	73%	88%	82%	100%	86%	100%	91%	78%	60%
	# Agree	136	8	7	18	7	57	6	20	7	6
	# Valid Respondents	161	11	8	22	7	66	6	22	9	10
22. I am better able to control my life.	% Agreement	82%	64%	88%	76%	86%	82%	100%	91%	78%	80%
	# Agree	131	7	7	16	6	54	6	20	7	8
	# Valid Respondents	160	11	8	21	7	66	6	22	9	10
23. I am better able to deal with crisis.	% Agreement	80%	73%	100%	75%	86%	82%	100%	81%	89%	50%
	# Agree	126	8	8	15	6	54	5	17	8	5

	# Valid Respondents	157	11	8	20	7	66	5	21	9	10
24. I am getting along better with my family.	% Agreement	75%	73%	75%	81%	57%	74%	83%	86%	71%	60%
	# Agree	118	8	6	17	4	48	5	19	5	6
	# Valid Respondents	157	11	8	21	7	65	6	22	7	10
25. I do better in social situations.	% Agreement	71%	64%	75%	63%	71%	72%	80%	82%	63%	60%
	# Agree	109	7	6	12	5	46	4	18	5	6
	# Valid Respondents	154	11	8	19	7	64	5	22	8	10
26. I do better in school and/or work.	% Agreement	62%	60%	50%	56%	75%	61%	75%	69%	50%	71%
	# Agree	64	3	3	9	3	27	3	9	2	5
	# Valid Respondents	103	5	6	16	4	44	4	13	4	7
27. My housing situation has improved.	% Agreement	77%	80%	83%	74%	83%	75%	50%	100%	50%	67%
	# Agree	115	8	5	14	5	49	3	21	4	6
	# Valid Respondents	150	10	6	19	6	65	6	21	8	9
28. My symptoms are not bothering me as much. (Outcomes)	% Agreement	67%	50%	88%	80%	67%	64%	83%	73%	63%	40%
	# Agree	105	5	7	16	4	43	5	16	5	4
	# Valid Respondents	157	10	8	20	6	67	6	22	8	10
Perception of Functioning	**Domain Average %**	**73%**	**60%**	**88%**	**89%**	**67%**	**71%**	**80%**	**86%**	**33%**	**60%**
28. My symptoms are not bothering me as much. (Functioning)	% Agreement	67%	50%	88%	80%	67%	64%	83%	73%	63%	40%
	# Agree	105	5	7	16	4	43	5	16	5	4
	# Valid Respondents	157	10	8	20	6	67	6	22	8	10
29. I do things that are more meaningful to me.	% Agreement	75%	64%	88%	71%	71%	79%	80%	86%	50%	60%
	# Agree	120	7	7	15	5	53	4	19	4	6
	# Valid Respondents	159	11	8	21	7	67	5	22	8	10
30. I am better able to take care of my needs.	% Agreement	79%	73%	75%	86%	71%	76%	100%	91%	67%	70%
	# Agree	127	8	6	18	5	51	6	20	6	7

	# Valid Respondents	161	11	8	21	7	67	6	22	9	10
31. I am better able to handle things when they go wrong.	% Agreement	73%	64%	75%	77%	71%	71%	100%	91%	44%	50%
	# Agree	117	7	6	17	5	47	6	20	4	5
	# Valid Respondents	161	11	8	22	7	66	6	22	9	10
32. I am better able to do things that I want to do.	% Agreement	78%	55%	88%	75%	86%	82%	100%	82%	57%	60%
	# Agree	119	6	7	15	6	51	6	18	4	6
	# Valid Respondents	153	11	8	20	7	62	6	22	7	10
Perception of Social Connectedness	**Domain Average %**	**82%**	**73%**	**100%**	**68%**	**50%**	**86%**	**80%**	**95%**	**100%**	**60%**
33. I am happy with the friendships I have.	% Agreement	77%	91%	100%	65%	50%	77%	83%	86%	89%	60%
	# Agree	121	10	6	15	3	49	5	19	8	6
	# Valid Respondents	157	11	6	23	6	64	6	22	9	10
34. I have people with who I can do enjoyable things.	% Agreement	79%	73%	57%	83%	50%	83%	67%	95%	67%	70%
	# Agree	126	8	4	19	3	54	4	21	6	7
	# Valid Respondents	159	11	7	23	6	65	6	22	9	10
35. I feel I belong in my community.	% Agreement	70%	73%	86%	55%	50%	72%	40%	86%	88%	50%
	# Agree	109	8	6	12	3	47	2	19	7	5
	# Valid Respondents	156	11	7	22	6	65	5	22	8	10
36. In a crisis, I would have the support I need from family or friends.	% Agreement	79%	73%	71%	77%	50%	83%	83%	91%	88%	50%
	# Agree	124	8	5	17	3	54	5	20	7	5
	# Valid Respondents	157	11	7	22	6	65	6	22	8	10

VIII. Performance Indicators – MMBPIS

Summary Report

Title of Measure: Michigan Mission Based Performance Indicators **MI/DD Adult/Child Data**

Reporting Period (month/year): FY15Q3

Data Analysis: (threats to validity; statistical testing; reliability of results; statistical significance; need for modification of data collection strategies)

The data is fully valid and reliable. The data is obtained through the state reporting process. This measure allows for exclusions and exceptions. Exceptions are those that chose to have an appointment outside of the 14 days, refuse an appointment that was offered the dates or offered appointments must be documented. Those excluded are those who are dual eligible (i.e. Medicaid/Medicare).

For those CMHSPs who have contracted providers, those numbers are included in the total for that CMHSP. That CMHSP is responsible for insuring that action is taken to improve performance when needed. There may be times when each provider has only one who has not been in compliance, however, when combined, it results in a percentage that is less than the expected threshold. CMHSPs will document action taken to resolve such an issue in the future.

Indicator 1 defines disposition as the decision that was made to refer or not to refer for inpatient psychiatric care. The start time is when the consumer is clinically, medically and physically cleared and available to the PIHP or CMHSP. The stop time is defined as the time when the person who has the authority approves or disapproves the hospitalization. For the purposes of this measure, the clock stops, although other activities to complete the admission may still be occurring.

Indicator 2 defines a new person as an individual who has not received services at that CMHSP/PIHP within the previous 90 days. A professional assessment is defined as a face to face assessment with a professional designed to result in a decision to provide ongoing services from a CMHSP. OBRA consumers are excluded from this count.

Indicator 3 indicates that those consumers who are in respite or medication only services may be excluded if they go beyond the 14 day window; other environmental circumstances also apply. See MDCH full instructions for more specific information regarding those situations.

Indicator 4 does not include dual eligible in the count. Consumers who choose to have an appointment outside of the 7 day window or refuse an appointment within the 7 day window, and those who no show and do not reschedule. Consumers who choose to not use CMHSP services may be documented as an exception.

Indicator 10 (old 12) indicates those consumers who choose to not use a CMHSP are documented as an exception, and not included in the count.

The above information was taken from the Performance Indicator Codebook. Please refer to that document for any additional or more specific instructions.

Data Interpretation: (performance against targets and benchmark data)
Key: Green = Above the standard
Red = Below the standard

Indicator 1: Percentage of Children/Adults who received a Prescreen within 3 hours of Request – In Figure 1, MSHN performed above the 95% standard. MSHN demonstrated a 99.54% (433/435) of the children who requested a pre-screen received one within 3 hours, and 99.11% (1788/1804) of the adults who requested a prescreen received one within 3 hours. 11 of the 12 CMHSP Participants demonstrated performance above the standard of 95% for children. All CMHSP Participants met the standard for the adults. The one CMHSP who performed below the standard will be subject to an improvement plan.

Indicator 2: Initial Assessment within 14 Days - Children/Adults – In Figure 1, MSHN exhibited a standard of 98.96% (3133/3166) for all population groups. Figure 1 exhibits each CMHSP's performance related to the specific population group. 11 CMHSP Participants demonstrated performance above the standard for the MI-Child and 12 CMHSPs for MI-Adults. 8 CMHSP Participants demonstrated performance above the standard for DD-C. One CMHSP Participant did not perform above the standard (3 did not have eligible individuals to report for this population). 11 CMHSP Participants demonstrated performance above the standard for DD-Adults (1 did not have any eligible individuals to report for this category). Each SRE did perform above the standard for the SA population.

Figure 1

	Indicator 1		Indicator 2					
	% Children	% Adults	% MI-C	MI-A %	DD_C %	DD-A %	SA %	Total %
BABH	100.00%	100.00%	96%	100%	50%	100%	97%	97%
CMH for Central MI	98.59%	99.26%	99%	100%	100%	100%	*	99%
CMHA CEI	100.00%	98.11%	100%	98%	100%	100%	99%	99%
Gratiot CMH	100.00%	100.00%	100%	100%	*	100%	*	100%
HBH	100.00%	100.00%	100%	100%	*	*	*	100%
Ionia CMH	100.00%	100.00%	100%	100%	*	100%	*	100%
Lifeways	100.00%	97.99%	96%	100%	100%	100%	*	99%
MCBH	94.74%	100.00%	98%	99%	100%	100%	*	99%
Newaygo CMH	100.00%	100.00%	96%	100%	100%	100%	*	99%
Saginaw CMH	100.00%	99.79%	100%	100%	100%	95%	99%	100%
Shiawassee CMH	100.00%	97.37%	91%	100%	100%	100%	*	97%
Tuscola CMH	100.00%	100.00%	100%	100%	100%	100%	*	100%
MSHN	**99.54%**	**99.11%**	**98.63%**	**99.62%**	**98.59%**	**98.91%**	**98.34%**	**98.96%**

* Denotes no eligible consumers for that particular indicator for this reporting period.

Indicator 3: Start of Service within 14 Days – In Figure 2, MSHN demonstrated an average of 98.08% (2551/2601) for the total of all population categories for this measure. Figure 2 exhibits each CMHSP's performance related to the specific population group. MSHN performed above the standard for each population group. 9 of the CMHSP Participants demonstrated performance above the standard for MI-child. 8 of the CMHSP Participants demonstrated performance above the standard for MI-Adults. 8 of the CMHSP Participants demonstrated performance above the standard for DD-child. 3 CMHSP Participants demonstrated performance below the standard for DD-child and 4 did not have any eligible individuals to report for this population. 8 CMHSP Participants demonstrated performance above the

standard for DD-A (2 did not have any eligible individuals to report for this population). The SREs reported full compliance with this indicator for the SA population.

Indicator 4a: Follow-Up within 7 Days of Discharge from IP – In Figure 2, MSHN demonstrated a rate of 100 % (95) for children with a diagnosis of mental illness. All CMHSP Participants demonstrated performance above the 95% standard. MSHN exhibited a 96.36% (424/440) for adults who have a diagnosis of mental illness. 3 of the 12 CMHSP Participants performed below the desired level.

Indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit – MSHN demonstrated a 95.10% (194/204) standard for individuals who were seen within 7 days of discharge from a detox unit. 1 SRE did not meet the desired performance level and is currently under a corrective action plan.

Indicator 10: Re-admission to Psychiatric Unit within 30 Days – In Figure 2, MSHN demonstrated a 5.98% (7/117) for children who were re-admitted within 30 days of being discharged from a psychiatric hospitalization. 12 CMHSP Participants demonstrated performance above the desired performance level for this indicator. MSHN demonstrated a 9.30% (53/570) for adults, 1 of the CMHSP Participants demonstrated performance below the desired performance level for this indicator. Both population groups for this indicator did meet the standard for MSHN.

Figure 2

	Indicator 3						Indicator 4a		4b	Indicator 10	
	% MI-C	% MI-A	% DD-C	% DD-A	% SA	Total	% Children	% Adults	% All	% Children	% Adults
BABH	100%	99%	*	100%	100%	100%	100%	100%	89%	9%	5%
CMH for Central MI	98%	99%	100%	100%	*	98%	100%	100%	*	0%	5%
CMHA CEI	99%	94%	100%	100%	100%	99%	100%	96%	100%	8%	9%
Gratiot CMH	90%	100%	*	100%	*	95%	100%	92%	*	0%	8%
HBH	89%	92%	*	*	*	91%	100%	100%	*	0%	0%
Ionia CMH	100%	95%	50%	50%	*	93%	100%	92%	*	0%	13%
Lifeways	88%	93%	83%	85%	*	91%	100%	95%	*	6%	13%
MCBH	98%	100%	89%	100%	*	98%	100%	92%	*	0%	6%
Newaygo CMH	100%	100%	100%	100%	*	100%	100%	100%	*	0%	7%
Saginaw CMH	100%	96%	100%	100%	99%	99%	100%	95%	100%	10%	9%
Shiawassee CMH	100%	93%	100%	100%	*	97%	100%	100%	*	0%	0%
Tuscola CMH	100%	100%	*	*	*	100%	100%	100%	*	0.00%	15.79 %
MSHN	**97.15%**	**97.43%**	**92.31%**	**93.85%**	**99.89 %**	**98.08 %**	**100.%**	**96.36 %**	**95.10 %**	**5.98%**	**9.30%**

* Denotes no eligible consumers for that particular indicator for this reporting period.

Figure 3 indicates that Indicator 3 – Adults and children with a Developmental Disability receiving an ongoing service within 14 days of the assessment requires review. The result was only 4 individuals in the region that did not meet the standard for each indicator population group, however, only 52 DDC and 65 DDA individuals were eligible for which places MSHN with a 92.31% and 93.85% respectively. MSHN will continue to monitor individual CMHSP performance requiring improvement plans as needed

to ensure performance remains above the standard across the PIHP, and that interventions are effective in addressing the deficiencies.

Figure 3

MMBPIS		FY14Q2	FY14Q3	FY14Q4	FY15Q1	FY15Q2	FY15Q3
Indicator 1a & 1b: Pre-screen within 3 hours of request	Child	97.98%	98.71%	99.46%	99.02%	99.76%	99.54%
	Adult	98.97%	99.51%	99.78%	99.25%	99.06%	99.11%
Indicator 2: % of Persons Receiving an Initial Assessment within 14 calendar days of First Request	MI-Child	98.63%	98.86%	99.46%	99.33%	99.35%	98.63%
	MI-Adult	99.34%	98.53%	98.96%	99.74%	99.50%	99.62%
	DD-Child	97.50%	100.00%	100.00%	100.00%	97.96%	98.59%
	DD-Adult	100.00%	97.89%	98.70%	98.39%	94.87%	98.91%
	SA	100.00%	97.57%	99.09%	98.74%	97.39%	98.34%
	Total	99.21%	98.36%	99.12%	99.27%	98.60%	98.96%
Indicator 3: % of Persons Who Started Service within 14 days of Assessment	MI-Child	95.67%	97.11%	97.11%	95.43%	95.16%	97.15%
	MI-Adult	97.86%	97.02%	97.02%	97.09%	96.98%	97.43%
	DD-Child	96.36%	100.00%	100.00%	100.00%	97.37%	92.31%
	DD-Adult	88.64%	95.65%	95.65%	100.00%	97.83%	93.85%
	SA	100.00%	100.00%	100.00%	99.35%	100.00%	99.89%
	Total	93.84%	98.11%	98.11%	98.11%	97.98%	98.08%
Indicator 4a, and Indicator 4b: Persons seen within 7 days of Inpatient Discharge and Substance Abuse Detox	Child	98.80%	100.00%	100.00%	95.61%	98.11%	100.00%
	Adult	94.00%	98.53%	97.29%	97.66%	98.54%	96.36%
	SA	98.63%	98.32%	98.32%	98.25%	97.77%	95.10%
Indicator 10: % of Discharges Readmitted to Inpatient Care within 30 days of Discharge	Child	6.80%	7.03%	8.00%	8.55%	9.92%	5.98%
	Adult	8.77%	11.95%	11.40%	*11.25%	9.56%	9.30%
Below Standard	*noted data change (revised data is 10.96%) after report submitted to MDCH.						
Above Standard							

Those indicators that are listed under “Best Practice” are those that have met the standard for 95% for all populations for 3 or more quarters. Since corrective action plans often are in place for 4 quarters before they reach full impact, it may not be unusual for someone to have a corrective action plan in place and still meet the criteria for “Best Practice”. For those who have indicators listed under the “Best Practice” column it may be useful to share what is being done with others.

All CMHSPs who demonstrate performance below the standard for each population group will submit a corrective action plan to MSHN CCO within 30 days of the presentation of this report. This will be due before the next Quality Improvement Council Meeting unless otherwise stated by the MSHN CCO. The corrective action plan should include a specific date of impact, and clearly identify the indicator in which the action is addressing.

Figure 4 through 7 exhibit the percentage of exceptions that were reported for the total population. The variance might indicate a difference in practice or definition.

Figure 4: Indicator 2 - Exception Report

Indicator 2	FY14Q2	FY14Q3	FY14Q4	FY15Q1	FY15Q2	FY15Q3
BABH	17.62%	19.05%	11.09%	8.98%	7.49%	17.60%
Gratiot	21.28%	3.80%	5.48%	2.53%	3.64%	3.61%
TBHS	56.41%	54.81%	52.58%	41.89%	51.32%	43.01%
CMHCM	4.96%	8.43%	7.33%	8.57%	8.72%	8.81%
Lifeways	12.95%	11.34%	10.81%	12.43%	15.08%	12.98%
Saginaw	1.97%	1.70%	1.46%	0.25%	2.30%	1.36%
Newaygo	3.40%	4.65%	16.51%	9.70%	2.78%	.68%
Ionia	21.74%	10.00%	7.06%	11.21%	2.86%	5.81%
Shiawassee	13.89%	7.41%	7.32%	6.45%	8.00%	0%
HBH	3.70%	7.02%	3.03%	3.33%	1.28%	0%
CEI	15.61%	15.38%	17.21%	11.25%	13.79%	16.79%
MCBH	0.00%	0.91%	0.98%	2.42%	4.70%	1.10%
Saginaw CA	0.00%	NA	NA	NA	NA	NA
CEI CA	15.81%	NA	NA	NA	NA	NA
RCA	5.63%	NA	NA	NA	NA	NA
NIMSAS	30.30%	NA	NA	NA	NA	NA
MSHN	11.52%	11.57%	8.88%	8.88%	9.24%	9.39%

Figure 4 : The following are exceptions for Indicator 2: Consumers who request an appointment outside the 14 calendar day period or refuse an appointment offered that would have occurred within the 14 calendar day period, or do not show for an appointment or reschedule it. Dates offered or refused must be documented.

Figure 5: Indicator 3 - Exception Report

Indicator 3	FY14Q2	FY14Q3	FY14Q4	FY15Q1	FY15Q2	FY15Q3
BABH	26.96%	14.41%	5.49%	4.48%	3.97%	18.25%
Gratiot	2.63%	8.96%	5.80%	11.69%	9.20%	10.81%
TBHS	16.67%	12.99%	13.73%	8.57%	25.42%	21.95%
CMHCM	22.78%	15.70%	16.50%	20.45%	19.17%	19.66%
Lifeways	15.79%	15.84%	13.73%	11.98%	18.38%	20.50%
Saginaw	19.82%	10.92%	13.27%	11.30%	16.24%	13.97%
Newaygo	30.53%	15.74%	8.24%	12.17%	11.34%	11.93%
Ionia	13.21%	100.00%	8.82%	18.48%	23.26%	11.11%
Shiawassee	9.38%	17.14%	4.65%	14.29%	15.15%	0%
HBH	23.53%	29.09%	45.28%	21.05%	33.85%	25%
CEI	36.64%	16.69%	10.71%	13.62%	11.22%	15.47%
MCBH	10.53%	15.53%	10.23%	11.93%	11.57%	10%
Saginaw CA	0.00%	NA	NA	NA	NA	NA
CEI CA	0.00%	NA	NA	NA	NA	NA
RCA	0.00%	NA	NA	NA	NA	NA
NIMSAS	24.49%	NA	NA	NA	NA	NA
MSHN	18.79%	16.02%	12.23%	12.53%	13.27%	13.99%

Figure 5: The following are exceptions for Indicator 3: Consumers who request an appointment outside the 14 calendar day period or refuse an appointment offered that would have occurred within the 14 calendar day period, or do not show for an appointment or reschedule it. Dates offered or refused must be documented.

OR

Consumers for whom the intent of service was medication only or respite only and the date of service exceeded the 14 calendar days. May also exclude environmental modifications where the completion of a project exceeds 14 calendar days. It is expected, however, that minimally a request for bids/quotes has been issued within 14 calendar days of the assessment. Lastly, exclude instances where consumer is enrolled in school and is unable to take advantage of services for several months.

Figure 6a: Indicator 4a - Exception ReportIndicator 4a	FY14Q2	FY14Q3	FY14Q4	FY15Q1	FY15Q2	FY15Q3
BABH	23.29%	12.50%	8.86%	5.94%	4.27%	6.25%
Gratiot	50.00%	36.84%	0.00%	13.33%	15.38%	0%
TBHS	42.86%	10.00%	0.00%	21.05%	33.33%	38.46%
CMHCM	0.00%	16.39%	18.92%	100%	18.31%	22.22%
Lifeways	18.92%	22.63%	22.31%	19.01%	26.72%	21.35%
Saginaw	28.57%	34.21%	28.70%	25.23%	16.33%	20.91%
Newaygo	28.57%	33.33%	16.67%	39.13%	23.08%	18.75%
Ionia	37.50%	14.29%	12.50%	20.00%	47.37%	12.50%
Shiawassee	14.29%	11.11%	26.67%	19.23%	18.75%	33.33%
HBH	25.00%	21.05%	12.50%	12.50%	21.05%	6.25%
CEI	37.63%	46.94%	50.35%	36.00%	41.86%	56.39%
MCBH	19.05%	29.63%	31.43%	40.00%	11.76%	32.50%
MSHN	24.89%	28.31%	25.49%	23.67%	22.72%	26.21

The following are exceptions for Indicator 4a: Consumers who request an appointment outside the seven-day period or refuse an appointment offered that would have occurred within the seven calendar day period, or do not show for an appointment or reschedule it. Must document dates of refusal or dates offered.
OR
Consumers who choose not to use CMHSP/PIHP services. For the purposes of this indicator, Providers who provide substance abuse services only, are currently not considered to be a CMHSP/PIHP service. Therefore, a 3 would be chosen and they would be considered an exception.

Figure 6b: Indicator 4b - Exception Report

Indicator 4b	FY14Q2	FY14Q3	FY14Q4	FY15Q1	FY15Q2	FY15Q3
Riverhaven	37.04%	20.93%	27.69%	30.68%	34.21%	19.64%
CMHCM	50.00%	64.86%	60.00%	NA	NA	NA
Saginaw	85.29%	58.33%	61.90%	46.67%	61.40%	40%
CEI	46.67%	39.74%	42.96%	39.86%	47.10%	50.59%
MSHN	54.36%	32.85%	45.70%	38.04%	45.09%	38.55%

The following are exceptions for 4b: Consumers who request an appointment outside the seven-day period or refuse an appointment offered that would have occurred within the seven calendar day period, or do not show for an appointment or reschedule it. Must document dates of refusal or dates offered.
OR
Consumers who choose not to use CA/CMHSP/PIHP services.

Figure 7: Indicator 10 - Exception Report

Indicator 10	FY14Q2	FY14Q3	FY14Q4	FY15Q1	FY15Q2	FY15Q3
BABH	10.77%	0.00%	0.00%	0.00%	0.00%	0.00%
Gratiot	50.00%	36.84%	0.00%	0.00%	0.00%	0.00%
TBHS	0.00%	0.00%	0.00%	0.00%	16.67%	0.00%
CMHCM	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Lifeways	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Saginaw	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Newaygo	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Ionia	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Shiawassee	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
HBH	16.00%	0.00%	0.00%	0.00%	0.00%	0.00%
CEI	30.43%	34.93%	40.71%	27.42%	37.21%	50.38%
MCBH	0.00%	0.00%	22.86%	0.00%	0.00%	0.00%
MSHN	10.78%	10.14%	9.29%	5.32%	7.64%	8.76%

The following are exceptions for Indicator 10: Discharges who choose not to use CMHSP/PIHP Services.

	Performance Below Standard Requiring Action	Intervention plan in place and being monitored to reach full impact	Regional Best Practice (≥ 3 data points)
BABH	2c	2a,2b, 2d, 3a, 3b, 3d	1, 4, 10
Gratiot	3a 4a2	3b,3a, 3b, 3d , 10a	1, 2, 4,
TBHS	10b	1a, 1b, 2a, 2b, 2d,4a2	3, 4,
CMHCM		3a 3d	1, 2, 4, 10
Lifeways	3a 3b 3c 3d	3a,3b, 10, 10b	1, 2, 4
Saginaw		2c,2d, 3a, 3b, 3c, 3d, 4a1, 4a2,10b	1
Newaygo		3a, 3c, 4a2, 10b	1, 2
Ionia	3c 3d 4a2	1a,1b, 10a, 10b, 2a	
Shiawassee	2a 3b	2a, 2b, 2d, 3a, 4a2, 10a, 3b, 10b	1
HBH	3a 3b	2a, 3a, 3b, 10b	1, 4
CEI	3b	1a, 3a, 3c, 3d, 4a1, 4a2,3b, 10a	1, 2, 10
MCBH	1a 3c 4a2	,3a, 3d, 4a2, 10a	2,
CEI CA			2,3,4
Riverhaven		4b	2,3
Saginaw CA			2, 3, 4

Improvement Strategies:

Those indicators that are listed under "Best Practice" are those that have met the standard for 95% for all populations for 3 or more quarters. Since corrective action plans often are in place for 4 quarters before they reach full impact, it may not be unusual for someone to have a corrective action plan in place and still meet the criteria for "Best Practice". For those who have indicators listed under the "Best Practice" column, it may be useful to share what is being done with others.

All CMHSPs who demonstrate performance below the standard for each population group will submit a corrective action plan to MSHN CCO within 30 days of the presentation of this report. The highlighted indicators currently do not have a plan in place. The Corrective action plan is due before the next Quality Improvement Council Meeting unless otherwise stated by the MSHN CCO. The corrective action plan should include a specific date of impact, and clearly identify the indicator in which the action is addressing.

CMHSPs should review data prior to submission to ensure the appropriate data elements are submitted according to the format as indicated in the instructions. The exception data should be identified based on the definitions provided in the instruction document. This information will be reviewed during the Quality Improvement Council meeting to ensure there is a clear understanding of the expectations.

Completed By: Sandra Gettel **Date:** 10-20-2015

Quality Manager - MSHN Contract Designee

IX. Provider Network Monitoring Review

Monitoring and Auditing

Internal Audits

The Fiscal Year 2015 Mid State Health Network monitoring and oversight review of the CMHSP Provider Network included a review of the Delegated Managed Care Functions as well as the Program Specific Requirements to ensure compliance with federal and state requirements.

CMHSP Delegated Managed Care Functions – Review: Includes fifteen (15) standards and one hundred and fifty-four (154) elements. The full review consisted of an on-site visit to the CMHSP Participant to conduct consumer chart reviews, review and validate process requirements, review new standards since the last audit, analyze performance and encounter data, interview staff, and monitor FY14 desk-audit corrective action plans. Compliance percent is calculated as number of standards correct (total of the 12 CMHSPs) over total number of standards (multiplied by 12 CMHSPs).

1. Information and Customer Services – (10) – 89.6%
2. Enrollee Rights and Protections – (9) – 99.1%
3. Access and Availability – (8) – 93.8%
4. Provider Network – (11) – 95.5%
5. Service Authorization & Utilization Management – (10) – 90.8%
6. Grievance and Appeals – (19) – 95.8%
7. Person-Centered Planning and Documentation Standards – (17) – 97.5%
8. Advance Directives – (6) – 95.8%
9. Coordination of Care – (4) – 97.9%
10. Behavior Treatment Plan Review – (10) – 88.3%
11. Consumer Involvement – (3) – 98.6%
12. Provider/Staff Credentialing – (18) – 90.3%
13. Quality and Compliance – (11) – 98.1%
14. Ensuring Health & Welfare* – (9) – 97.7%
15. Information Technology – (9) – 100%

** New Standard*

CMHSP Program Specific Site Review: This section was new for the Fiscal Year 2015 site review. It includes ten (10) standards and a total of sixty-eight (68) elements. The focus of this section is to ensure compliance with the Michigan Department of Health & Human Services (MDHHS) Program Specific Requirements.

Compliance percent is calculated as the number of standards correct over total number of standards (based on the number of participating CMHSPs).

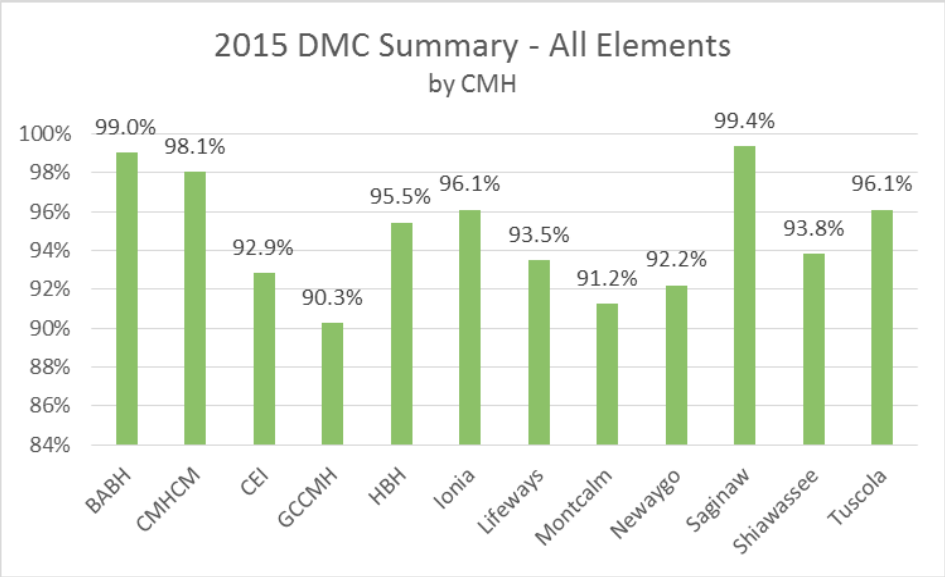
1. Jail Diversion – (8) – 93.8%
2. Assertive Community Treatment – (6) – 98.1%
3. Self Determination – (10) – 95.4%
4. Peer Delivered and Operated Services – (2) – 100%
5. Home-Based Services – (5) – 95%
6. Clubhouse Psycho-Social Rehabilitation (4) – 100%
7. Crisis Residential Services - (10) – 93.1%
8. Targeted Case Management – (4) – 91.7%

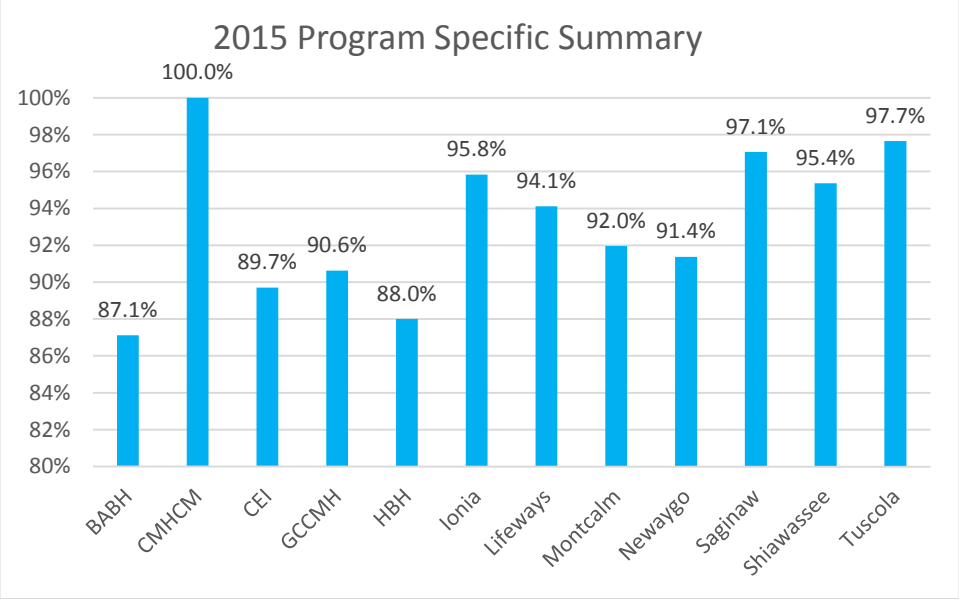
9. Habilitation Supports Waiver – (5) – 95.0%
10. Autism Benefit/Applied Behavioral Analysis – (14) – 86.7%

Status: As of 12/2/15

- 12 of 12 CMHSP full site visits completed by MSHN staff
- 11 of 12 Corrective Action Plan's received from the CMHSP's
- 11 of 12 Corrective Action Plan's reviewed and approved by MSHN staff

Summary of 2015 DMC & Program Specific Review:





Next Steps:

MSHN will verify CMHSP implementation of corrective action plans during the 2016 interim year site review scheduled to begin in March, 2016 and complete all twelve CMHSPs by December, 2016. The scope of the interim year review will include:

- Corrective Action Plan Compliance Review
- New Standard Review
- External/Internal Audit follow up (since last review) - HSAG, Autism, HSW
- Performance Improvement Project Review and Technical Assistance
- New Funding Review and Technical Assistance - 24/7 access funding, and behavioral health funding

MSHN will review the standards that fell below 95% compliance within the appropriate workgroups, committees, and councils as part of an ongoing performance improvement process.

SECTION FOUR – EVALUATION AND PRIORITIES

I. 2015 QAPIP Annual Effectiveness Review

QAPIP Annual Effectiveness Review					
	Objective	**Evaluation Method**	**Met, Partial, Unmet**	**Strategic Planning Objective**	**Council / Committee**
Components					
	Provide Oversight & Monitoring of the Provider Network	Implement Compliance Monitoring activities	Met	Enhance organizational quality & compliance	Quality Improvement Council
		Implement QAPIP	Met		Quality Improvement Council
	Guidance on Standards, Requirements & Regulations	Council & Committee review of MDCH Contract and External Quality Review Requirements	Met		All Council & Committees
Governance					
	Board sets policy related to quality management	MSHN Quality Policies	Met	Enhance organizational quality & compliance	Board of Directors
	Board annually approves QAPIP & related priorities	Board approval of MSHN QAPIP	Met		Board of Directors
	QAPIP updated annually and reviewed by the QIC	Updated QAPIP	Met		Quality Improvement Council
Communication of Process and Outcomes					
	QIC monitors performance activity	Performance Measure Reports	Met	Enhance organizational quality & compliance	Quality Improvement Council
	Identify opportunities for process and outcome improvements	Recommendations included in PM Reports	Met		All Council & Committees
	Require corrective action plans for measures below regulatory standards and/or targets	Corrective action plan submissions & reviews	Met		Quality Improvement Council
	Regular reports to Councils, Committees, Board of Directors and Advisory Councils	Council & Committee Annual Reports	Met		All Council & Committees
	Consumers & Stakeholders receive reports on key performance indicators, consumer satisfaction survey results and performance improvement projects	RCAC Reports on Consumer Satisfaction Survey Results and Recovery Survey Assessment; MMBPIS available on website	Met	Increase the voice of MSHN's customers and key stakeholder.	Regional Consumer Advisory Council
	Board of Directors receive annual report on status of organizational performance	MSHN Balanced Scorecard	Met	Enhance organizational quality & compliance	MSHN CEO
	Performance and Quality reports are made available to stakeholders and general public	MSHN website includes: QAPIP, Compliance Plan, MMBPIS, EQR Results	Met	Increase the voice of MSHN's customers and key stakeholder.	MSHN Staff
Performance Measurement					
	Performance Indicators	MMBPIS Reports	Met	Improve Access to Care	Quality Improvement Council
	Performance Improvement Projects	PIP - RSA Report; PIP - HEDIS Report	Met	Assume increased responsibility for healthcare outcomes.	Quality Improvement Council
Event Monitoring and Reporting					
	Critical Incident Reporting to MDHHS	Critical Incident Performance Reports	Met	Assume increased responsibility for healthcare outcomes.	Quality Improvement Council
	Trends and patterns identified	Critical Incident Reporting occurs on a monthly basis to QIC; Trends & Patterns are identified and reviewed on a quarterly basis	Met		Quality Improvement Council
	Oversight of CMHSP risk analysis and reduction	Desk review of policy and procedure completed in FY14 and On-site reviews completed in FY15	Met		Quality Improvement Council
Behavior Treatment					
	Quarterly analysis of adherence to BTR Standards	BTR Performance Reports	Met	Improved treatment /service outcomes	Quality Improvement Council
	Trends and patterns identified	BTR Performance Reports includes patterns and related improvement recommendations	Met		Quality Improvement Council & Behavior Treatment Plan Review Workgroup
Autism Waiver Monitoring					
	Monitor compliance with Autism Benefit program requirements	Quarterly Autism Reports	Met	Improved treatment /service outcomes	Autism Workgroup
	Trends and patterns identified	Quarterly Autism Reports	Met		Autism Workgroup
	Oversight of CMHSP corrective action related to the MDHHS site review	Corrective action plan response & updates	Met		Autism Workgroup

QAPIP Annual Effectiveness Review					
	Objective	**Evaluation Method**	**Met, Partial, Unmet**	**Strategic Planning Objective**	**Council / Committee**
Quantitative and Qualitative Assessment of Member Experiences					
	Surveys analyzed	MHSIP & YSS Report	Met	Improved treatment /service outcomes	Quality Improvement Council
	Surveys shared with QIC, and RCAC	MHSIP & YSS Report shared with QIC and RCAC	Met	Increase the voice of MSHN's customers and key stakeholder.	Quality Improvement Council & Regional Consumer Advisory Council
	Identified strengths and opportunities for improvement	FY15 completed regional surveys (MHSIP & YSS); comparison to baseline data completed	Met	Improved treatment /service outcomes	Quality Improvement Council & Regional Consumer Advisory Council
Practice Guidelines					
	CMHSP implementation of practice guidelines	Utilization Management Plan and Committee Report	Met	Improved treatment /service outcomes	Utilization Management Committee
		MSHN desk review verifications of local implementation; FY15 on-site reviews completed	Met	Improved treatment /service outcomes	Utilization Management Committee
Credentialing, Provider Qualification and Selection					
	Ensure CMHSP adherence to MSHN credentialing policy	Credentialing/Re-Credentialing policy has been developed in accordance with MDHHS contract requirements; FY15 on-site review completed	Met	Enhance organizational quality & compliance	Provider Network Committee
Medicaid Event Verification					
	Verifies delivery of services billed to Medicaid	CMHSP Medicaid Event Methodology Reports	Met	Enhance organizational quality & compliance	Quality Improvement Council
	Results aggregated, analyzed and reported at QIC	FY14 MEV Report developed; QIC to review in February	Met		Quality Improvement Council
	Opportunities identified for improvement	FY14 MEV Report reviewed by QIC; FY15 report completed and to be reviewed in January QIC meeting	Met		Quality Improvement Council
	Reported annually to MDHHS	FY14 MEV Report sent to MDHHS; FY15 Report completed and to be sent in January	Met		MSHN Deputy Director
Utilization Management Plan					
	UM Committee develops standards for utilization	Utilization Management Plan and Committee Report	Met	Public resources are used efficiently and effectively.	Utilization Management Committee
	Utilization activity and trends are reviewed and analyzed	Utilization Management Plan and Committee Report	Met		Utilization Management Committee
	Uniform screening tools and admission criteria	Utilization Management Committee - reviewing current state	Partial	Improved treatment /service outcomes	Utilization Management Committee
	Identification of under-and-over utilization	Utilization Management Reports	Met	Public resources are used efficiently and effectively.	Utilization Management Committee
Provider Monitoring					
	CMHSP annual monitoring of provider subcontractors	Annual Compliance Report; Desk review of CMHSPs; Site review completed in FY15	Met	Enhance organizational quality & compliance	Quality Improvement Council
	MSHN monitoring of CMHSPs compliance	Annual Compliance Report; Desk review of CMHSPs; Site review completed in FY15	Met		Quality Improvement Council
Oversight of "Vulnerable People"					
	CMHSPs monitor health, safety and welfare of individuals served	Performance Objective Reports - AFP Updates; 95% Data Completeness Reports	Met	Ensure coordinated access to all behavioral health services (including SUD services)	Quality Improvement Council
	Related concerns are acknowledged and action taken as appropriate	Performance Objective Reports - AFP Updates; 95% Data Completeness Reports - Includes reporting on actions	Met		Quality Improvement Council

II. MSHN Strategic Plan Priorities & Objectives

Priorities/Objective	Strategies	Goal-Potential Measures/Metrics	By When	Status
Ensure coordinated access to all behavioral health services (including SUD services)	Develop SUD Policy Board		August 2014	Met
	Successful implementation of SUD transition plan	1. All CMHSPs to assume access functions for SUD consumers.	October 2014	Met
		2. Implementation of plan for transition of retained and contracted administrative functions.	October 2014	Met
	Ensure continuity of provider network to provide total continuum of care for all behavioral health services (including SUD) adequate to community demand of insured persons for specialty care.	1. Successful transition of provider network as evidenced by authorization for services and data flow through PIHP to MDCH.	October 2014	Met
		2. Ensuring compliance, quality and competency – as measured by provider network plan and performance monitoring (incorporating SUD service providers).	Through 2015	Partial (SUD site review tool is complete and provider site reviews will begin in 2016)
	Effective Management of all funding streams and uniform procedures	1. Incorporation of SUD (non-Medicaid) dollars into quarterly finance reports to MHSN Board.	March 2015	Met
		2. 2014 Finance Audit conducted in 2015 will include policy and process review for financial management of SUD.	March 2015	Met
		3. Successful compliance in fiscal audits.	Through 2015	Met
Effectively use data and analytic strategies to assess and improve the health of our communities	Determine needs for PIHP-level data analytics.	1. MSHN is able to generate meaningful reports from available data files including: MDHHS client level data extract, QI-Client demographic, encounter, Performance Improvement and other data/information collected, generated or stored on behalf of the entity.	Through 2015	Met
		2. Regional analysis is used to inform and drive performance improvement efforts.	Through 2015	Partial (Data analytics committee continues to meet and review data resources/needs. Next step to take data to regional committees to inform decision making.)
		3. Analysis is used to identify regional population health priorities that drive evidence based interventions to	Through 2015	Met

		improve behavioral and primary healthcare outcomes.		
	Program level data analytics	1. Analytic tools are used to inform and improve service utilization patterns.	Through 2015	Partial (Data analytics committee continues to meet and review data resources/needs. Next step to take data to regional committees to inform decision making.)
		2. Where appropriate, analysis informs development of regional service access and level of care criteria.	Through 2015	Met
	Consumer level data analytics	1. CMHSP staff are trained and use CC360 to support improved person-centered planning specific to other health conditions.	Through 2015	Partial (CMHSP staff are trained, have access to CC360 and are working on changing processes to include other health conditions in their plans.)
		2. The system demonstrates improved performance related to coordination with primary health care and annual health assessment of the population served.	September 2017	In Process; Not due yet
Assume increased responsibility for healthcare outcomes.	Adopt HEDIS measures to assess health care status/outcomes for specific chronic conditions.	Evaluate applicability of appropriate models, including but not limited to the Parks/Missouri Model.	December 2015	Met
		Determine chronic conditions to be monitored and HEDIS measures to be collected.	June 2015	Met
		Establish data definition (numerator, denominator, source, threshold, etc.)	September 2015	Met
		Assess results.	September 2016	In Process; Not due yet
	Incorporate language in CMHSP contracts that requires use of Care Connect 360.	75% of treatment plans contain objectives to improve the consumer's healthcare status.	October 2014 contract	????
	Promote local integrated care delivery models	Complete a regional meta-analysis of local integration care delivery models and the outcomes being achieved.	March 2016	In Process: Not due yet
	Consumers have an identified primary physician or health home	95% of EMR records name the primary care clinic or physician	September 2016	In Process; Not due yet
	With MHPs determine common sub-populations of consumers with chronic illness and disease and	Develop a project with at least one MHP and one CMHSP to address a chronic disease, or to address a social determinate of	March 2015	Met

	develop collaborative strategies for health intervention and management	health that is a barrier to ambulatory health care access of that results in high utilization of local emergency departments		
Improve Access to Care	Based on the Assessment of Network Capacity, establish expanded provider network to meet defined needs.	Timeliness of screening, assessment, first service is consistently met across the region, for all sub-populations at 95%	September 2015	Met
		All Healthy Michigan expanded SUD services are regionally available.	December 2014	Partial (MDHHS still defining service array; Base services are available region wide; this goal is part of FY16 strategic plan)
		Out-of-region placements (improve performance over baseline)	September 2015	Met
	Establish regional strategies to engage more Medicaid eligible beneficiaries in care	Improve penetration rates 10% over 2013 baseline	September 2015	Partial (A metrics has been established and is being reviewed regularly by the UM committee.)
Public resources are used efficiently and effectively	With other PIHPs and MDHHS, adopt a consistent administrative cost model.		October 2015	Partial (PIHP/CFO's reviewing administrative cost model and proposing changes to state)
	Negotiate reductions in contractual PIHP administrative requirements.	% of total PIHP Administrative Costs is at or below the MI average.	October 2014	Met
	Establish regional standards for financial reporting and accountability to provide for timely revenue and expense adjustments.	Performance actual to budget is within 5.0% of target.	September 2015	Met
	Assure effective financial and accounting policies, processes and defined separation of duties.	Receive an unqualified fiscal audit	March 2015	Met
	Implementation of the regions utilization management plan demonstrates achievement of defined goals.	MSHN has utilization patterns that are within normal statistical limits when benchmarked against statewide benchmarks.	September 2016	In Process; Not due yet
Improved treatment/service outcomes	Implement standardized assessment tools for defined sub-populations	Establish procedures for routine implementation of SIS for Persons with I/DD	September 2014	Met
		With MDHHS identify and deploy a standardized assessment for MIA.	November 2014	Partial (The LOCUS has been identified, but MDHHS has not sent out

				implementation guidelines or contractual expectations. Partially deployed in the MSHN region presently.)
		With MDHHS identify and deploy a standardized assessment for Children/Adolescents with SED.	February 2015	Met
		With MDHHS identify and deploy a standardized assessment for persons with primary substance use disorders.	April 2015	Not Met (Part of FY16 Strategic Plan)
		Assessment results demonstrate improvement over baseline.	Through October 2017	In Process; Not due yet
	Implementation of a Recovery Tool	Recovery assessment demonstrates improvement over 2015 baseline	September 2016	In Process; Not due yet
		Average regional consumer satisfaction ratings are 92% or higher	September 2016	In Process; Not due yet
Enhance organizational quality & compliance	Compliance with data reporting accuracy and timeliness	Date timeliness indicators are met 100%	September 2015	Not Met
		Data accuracy 95%	September 2015	Partial
	As necessary, consistent policies/procedures are deployed across the region	Results of HSAG external quality review improve over 2014 baseline	September 2016	In Process; Not due yet
		Policy review to plan 95%	September 2015	Met
	Implementation of the QAPIP and the PIPs results in achievement of desired outcomes	MSHN performance compared to statewide fingertip baseline is at the state average or higher	September 2016	In Process; Not due yet
Regional Leadership around public policy initiatives that support improved health outcomes and system stability	Develop and implement a regional advocacy plan	Communication related to regional advocacy efforts	September 2015	Met
		Achieve progress towards funding equity	October 2015	In Progress (Multi-year smoothing plan is in the process of being implemented; suggest revised "due by" date of October 2016)
		Strengthen advocacy efforts and skills of MHSN Board members	October 2015	Partial (MSHN provides significant volumes of information of an educational nature to board members. Advocacy-specific training has not been delivered to board members by MSHN)
	Remove non-value added/unfunded	Updates on outcomes of contract negotiation	October 2014	Met

	expectations from the MDHHS contract			
Increase the voice of MSHN's customers and key stakeholders	Regional educational opportunities and input sessions around new initiatives (i.e.: SIS, Autism, SUD integration)	Establish learning communities for at least three performance improvement or regional planning efforts.	September 2016	Met
	Implement the charter of the Consumer Advisory Council	The RCAC reports 95% satisfaction with the input process and action on recommendations	September 2015	Met
	Establish processes to evaluate key stakeholder input and satisfaction.	Network providers (CMHSP Participants) and their council/committee members report 95% satisfaction with input and planning processes	September 2015	Met

III. QAPIP Priorities for Fiscal Year 2016

2016 QAPIP Priorities			
Priority	**Measure**	**Strategic Planning Objective**	**Assigned Council / Committee**
Governance			
As necessary, consistent policies/ procedures are deployed across the region.	Results of HSAG External Quality Review improve over 2015 baseline.	Enhance organizational quality & compliance	Quality Improvement Council
	Policy review to Plan is at target		
Develop and implement a regional advocacy plan.	Communication related to regional advocacy efforts.	Regional Leadership around public policy initiatives that support improved health outcomes and system stability	Operations Council & Board of Directors
	Strengthen advocacy efforts and skills of MSHN Board members.		
Implement SUD Strategic Plan & integration into MSHN Operations	Implementation plan targets achieved	Demonstrate improved coordination of behavioral health and primary care	SUD Oversight Policy Board
Develop and deploy plan for regional accreditation	Complete accreditation readiness plan	Regional Leadership around public policy initiatives that support improved health outcomes and system stability	Quality Improvement Council
	Implement necessary/improvements to meet accreditation requirements		
Communication of Process and Outcomes			
Establish processes to evaluate key stakeholder input and satisfaction.	Network Providers (CMHSP Participants) and their council/committee members report 95% satisfaction with input and planning processes	Increase the voice of MSHN's customers and key stakeholder	Quality Improvement Council
Performance Measurement			
MSHN health measures indicate improvements in health care status/outcomes for specific chronic conditions	Demonstrates regional improvement in persons screened for diabetes in accordance with HEDIS criteria	Assume increased responsibility for healthcare outcomes.	Quality Improvement Council
Increase Provider Network use of available healthcare data	Audited treatment records contain an objective to improve the consumer's healthcare status		Quality Improvement Council

2016 QAPIP Priorities			
Priority	**Measure**	**Strategic Planning Objective**	**Assigned Council / Committee**
Event Monitoring and Reporting			
Critical Incident trends and patterns identified	Trends & Patterns to be identified over an annual cycle	Assume increased responsibility for healthcare outcomes.	Quality Improvement Council
Oversight of CMHSP risk analysis and reduction	On-site reviews conducted in FY16		
Quantitative and Qualitative Assessment of Member Experiences			
Identified strengths and opportunities for improvement from MHSIP & YSS	FY16 complete regional survey	Improved behavioral health treatment/service outcomes	Quality Improvement Council & Regional Consumer Advisory Council
Stakeholder input demonstrates effective, efficient and collegial operations	Define and implement ongoing strategies for the assessment of primary/secondary consumer satisfaction	Increase the voice of MSHN's customers and key stakeholders	
Practice Guidelines			
CMHSP implementation of practice guidelines	On-site reviews conducted in FY16	Improved behavioral health treatment /service outcomes	Utilization Management Committee
Credentialing, Provider Qualification and Selection			
MSHN credentialing/re-credentialing policy and procedures	MSHN deploys a comprehensive credentialing/re-credentialing policy and process that are consistent with MDHHS standards and best practices	Enhance organizational quality & compliance	Provider Network Committee
	CMHSP site reviews conducted in FY16		

2016 QAPIP Priorities			
Priority	**Measure**	**Strategic Planning Objective**	**Assigned Council / Committee**
Medicaid Event Verification			
Develop and Implement Regional Medicaid Event Verification Methodology	Provider Network MEV audits completed in accordance with new contractual guidance	Enhance organizational quality & compliance	Quality Improvement Council
	Compliance with Medicaid Standards improves over baseline		
Utilization Management Plan			
Implementation of the region's utilization management plan	MSHN adopts site review protocols for UM review that are consistent with the regionally adopted UM guidelines	Public resources are used efficiently and effectively	Utilization Management Committee & Clinical Leadership Committee
Implement standardized assessment tools for defined sub-populations.	With MDHHS identify and deploy a standardize assessment for MIA.	Improved behavioral health treatment/service outcomes	
	With MDHHS identify and deploy a standardize assessment for persons with primary substance use disorders.		
Establish regional strategies to engage more eligible beneficiaries in care	Fully implement the region's access and authorization practice guidelines to achieve a common benefit	Improve Access to Care	
Provider Monitoring			
CMHSP annual monitoring of provider subcontractors	On-site reviews conducted in FY16	Enhance organizational quality & compliance	Quality Improvement Council & Provider Network Committee
MSHN monitoring of CMHSPs compliance	On-site reviews conducted in FY16		
Increased compliance and performance of the Provider Network through sufficient oversight and monitoring	Quality review tools are developed and implemented across the SUD Provider Network		

IV. MSHN Balanced Scorecard

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SECTION FIVE –DEFINITIONS

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.

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. (Modified from the MDCH-PIHP proposed 2015 contract)

MMBPIS: Michigan Mission Based Performance Indicator System

MSHN: Mid-State Health Network

MDHHS: Michigan Department of Health and Human Services

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 a Sub-Regional Entity (SRE) that is directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP's and SRE'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 or not 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.

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

Sub-Regional Entity: refers to the entities that have sub-contracted with MSHN to be responsible for administration of substance use disorder treatment and prevention in their respective regions.

SECTION SIX –ATTACHMENTS

Attachment A: MSHN Monitoring Tools **(NEED TO INSERT A LINK)**

Attachment B: MSHN RSA Survey Templates **(NEED TO INSERT A LINK)**