MSHN

Mid-State Health Network

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

Annual Plan FY2020

Annual Report FY2019

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SECTION ONE – ANNUAL PLAN

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM 2019-2020

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 Authority, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network , Huron 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 Health and Wellness, The Right Door and Tuscola Behavioral Health Systems. 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 FY2020, 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.

The mission of MSHN is to ensure access to high-quality, locally delivered, effective and accountable public behavioral health and substance use disorder services provided by its participating members. The vision of MSHN is to continually improve the health of our communities through the provision of premiere behavioral healthcare and leadership. MSHN organizes and empowers a network of publicly funded community partnerships essential to ensure quality of life while efficiently and effectively addressing the complex needs of the most vulnerable citizens in our region. Responsibilities of the Quality Management Program are outlined in the Quality Assessment and Performance Improvement Plan (QAPIP). The scope of MSHN's QAPIP 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. ORGANIZATIONAL STRUCTURE AND LEADERSHIP (Medicaid Managed Specialty Supports and Services Program Contract- Attachment P7.9.1, 2020) (42 Code of Federal Regulations (CFR) 438.358, 2002)

a) Structure

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

b) Components

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

- Implementation of Compliance Monitoring activities as outlined in the MSHN Corporate

Compliance Plan
- Develop and Implementation of Quality Improvement Program in accordance with PIHP Quality Assessment and Performance Improvement Plan
- Staff Oversight and Education
- Conducting Research (if applicable)

MSHN will provide guidance on standards, requirements and regulations from the MDHHS, the External Quality Review, the Balanced Budget Act, and/or other authority that directly or indirectly affects MSHN PIHP operations.

MSHN will retain responsibility for developing, maintaining, and evaluating an annual QAPIP 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 Specialty Prepaid Inpatient Health Plans, 2013, p. 2.7.3).

c) Governance

Board of Directors

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

Through the Operations Council, Substance Use Disorder Oversight Policy Board and MSHN CEO, the MSHN's Board of Directors receives 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 to improve performance. 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 Quality Manager as the chair of the MSHN Quality Improvement Council. In this capacity, the Quality Manager under the direction of the Director of Compliance, Customer Service and Quality, 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.

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

The Regional Medical Directors Committee that includes membership of the MSHN Medical Director and the CMHSP Participant Medical Directors, provide leadership related to clinical service quality and service utilization standards and trends. The MSHN 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 and MSHN Addictions Treatment Medical Director consults with MSHN staff regarding service utilization and eligibility decisions and is available to provide input as required for the regional QAPIP.

CMHSP Participants/SUD Providers

A quality representative from each CMHSP is appointed by the CMHSP CEO to participate in the MSHN Quality Improvement Council. Substance Use Disorders services is represented on the Council by MSHN SUD Staff. 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,
- Responsible for communication between the PIHP QIC and their local organization.

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. 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.

Regional Medical Directors

The Regional Medical Directors Committee that includes membership of the MSHN Medical Director and the CMHSP participant Medical Directors, provide leadership related to clinical service quality and service utilization standards and trends.

SUD Oversight Policy Board

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

SUD-Provider Advisory Council (PAC)

The PAC is charged with serving in an advisory capacity to MSHN to offer input regarding SUD policies, procedures, strategic planning, monitoring and oversight processes, to assist MSHN with establishing and pursuing state and federal legislative, policy and regulatory goals, and to support MSHN's focus on evidence-based, best practice service and delivery to persons served.

Regional Consumer Advisory Council (RCAC)

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

Recipients

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

In addition to the participation of recipients of services in quality improvement activities, MSHN and the CMHSP Participants/ SUD Providers strive to involve other stakeholders including but not limited to providers, family members, community members, and other service agencies whenever possible and appropriate. Opportunities for stakeholder participation include the PIHP governing body membership; 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.

IV. PERFORMANCE MEASUREMENT (Medicaid Managed Specialty Supports and Services Program Contract- Attachment P7.9.1, 2020)

a) Establishing Performance Measures:

The Quality Assessment and Performance Improvement Program encourages the use of objective and systematic forms of measurement. Each established measure should align with MSHN's goals and priorities and needs to have clear expectations, promote transparency, and be accountable through ongoing monitoring.

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.

The PIHP quality management program uses a variety of means to identify system issues and opportunities for improvement. The measures established reflect the organizational priorities, have a baseline measurement when possible, have an established re-measurement frequency (at least annually) and should be actionable and likely to yield credible and reliable data over time.

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.

Prioritizing Measures

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, cultural competency; interpersonal aspects of care; appeals, grievance, 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.)

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

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

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 performance improvement 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.

b) Data Collection and Setting Performance Targets:

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

When a performance measure has an established performance target set through contract

requirements, then that target will be utilized to measure performance. If there is no set performance target, baseline data should be considered prior to setting a target. Baseline data is a snapshot of the performance of a process or outcome that is considered normal, average, or typical over a period. The baseline may already be established through historical data or may still need to be collected. If baseline data is not available for an established measure, then the measure should be implemented for a period (typically up to one year) prior to establishing performance targets. When collecting baseline data, it is important to establish a well-documented, standardized and accurate method of collecting the data and set ongoing frequencies to review the data (monthly, quarterly, etc.)

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

When establishing performance targets, the following should be considered (as defined in the Health Resources and Service Administration (HRSA) Quality ToolKit):

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

Targets may be defined in several ways including the following:

a) Defining a set target percentage for achievement - to meet the outcome being measured.
b) Defining a percentage increase/decrease change to be achieved.

c) Data Analysis and Reporting:

The data should be reviewed at the established intervals and analyzed for undesirable patterns, trends, or variations in performance. In some instances, further data collection and analysis may be necessary to isolate the causes of poor performance or excessive variability.

The appropriate council, committee, or workgroup, in collaboration with the QIC, will prepare a written analysis of the data, citing trends and patterns, including recommendations for further investigation, data collection improvements to resolve data validity concerns, and/or system improvements.

Region wide quality improvement efforts will be developed based on the patterns and trends identified and will be reviewed for effectiveness at established intervals within the appropriate MSHN council, committees, workgroups, etc. In some instances, provider level corrective action may be necessary in addition to, or in lieu of, region wide improvement efforts.

d) Performance Improvement Action Steps:

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

- 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.

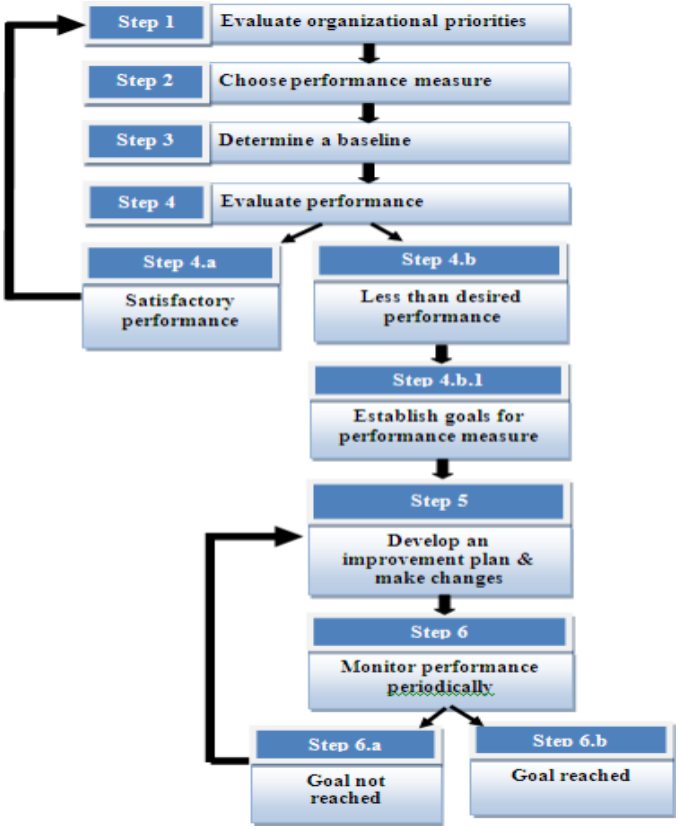
The process of measurement, data collection, data analysis and action planning is repeated until the desired level of performance/improvement is achieved. Sustained improvement is sought for a reasonable period of time (such as one year) before the measure is discontinued. When sustained improvement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

When the established minimum performance standards or requirements are not met, CMHSP Participants/SUD Providers will submit a corrective action plan the includes the following:

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

The appropriate MSHN staff, council, committee, workgroup, etc. will monitor the implementation and effectiveness of the plans of correction. The effectiveness of the action plan will be monitored based on the re-measurement period identified.

Process Map of Performance Management Pathway (defined by HRSA)



e) Communication of Process and Outcomes: -

The MSHN Quality Improvement Council (QIC) is responsible for monitoring and reviewing performance measurement activities including identification and monitoring of opportunities for process and outcome improvements in collaborations with other committees and councils, and the CMHSP Participants and SUD Providers.

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.

V. STAKEHOLDER FEEDBACK (Medicaid Managed Specialty Supports and Services Program Contract- Attachment P7.9.1, 2020)

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, and organizations provider services to consumers are surveyed by MSHN at least annually using a standardized survey or assessment tool. The tools vary in accordance with service population needs, 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.

The aggregated results of the surveys and/or assessments 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. Regional benchmarks and/or national benchmarks are used for comparison. The data is used to identify best practices, demonstrate improvements, or identify growth areas. The QI Council determines appropriate action for improvements. The findings are incorporated into program improvement action plans. At the CMHSP Participant/SUD Provider level, actions are taken on survey results of individual cases, as appropriate, to identify and investigate sources of dissatisfaction and determine appropriate follow-up.

Survey or assessment results are included in the annual PIHP QAPIP Report and presented to the MSHN governing body, 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.

VI. SAFETY AND RISK MONITORING: (Medicaid Managed Specialty Supports and Services Program Contract- Attachment P7.9.1, 2020)

a) Adverse Events

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 Critical Event Reporting System. These include MDHHS defined sentinel events, critical incidents, and risk events. MSHN also ensures that each CMHSP Participant/SUD Provider has a system in place to monitor these events, utilizing staff with appropriate credentials for the scope of care, and within the required timeframes.

MSHN submits and/or reports required events to MDHHS including 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. MSHN will ensure that the CMHSP and SUD Providers have taken appropriate action to ensure that any immediate safety issues have been addressed, including the identification of a sentinel event within three business days in which the critical incident occurred and the commencement of a root cause analysis within two business days of the identification of the sentinel event. Following completion of a root cause analysis, or investigation, the CMHSP will develop and implement either a plan of action 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.

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 FY19 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

b) Medicaid Event Verification (Medicaid Managed Specialty Supports and Services Program Contract and Medicaid Event Verification Technical Requirement-Attachment P.6.4.1)

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

Medicaid Event Verification for Medicaid and Healthy Michigan Plan includes testing of data elements from the individual claims/encounters to ensure the proper code is used for billing; the code is approved under the contract; the eligibility of the beneficiary on the date of service; that the service provided is part of the beneficiaries individualized plan of service (and provided in the authorized amount, scope and duration); the service date and time; services were provided by a qualified individual and falls within the scope of the code billed/paid; the amount billed/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 and MSHN have implemented the generation of a summary of Explanations of Benefits in accordance with the MDHHS Specialty Mental Health Services Program contract. This will provide an additional step to ensure that consumers are aware of service activity billed to their insurance.

VII. CLINICAL STANDARDS (Medicaid Managed Specialty Supports and Services Program Contract)

a) Utilization Management -

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

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

activity relative to the people they serve through directly operated or contracted services.

Initial approval or denial of requested services is delegated to CMHSP Participants/SUD Providers, including the initial screening and authorization of psychiatric inpatient services, partial hospitalization, and initial and ongoing authorization of services for individuals receiving community services. All service authorizations are based on medical necessity decisions that establish the appropriate eligibility relative to the identified services to be delivered. Communication with individuals regarding UM decisions, including adverse benefit determination notice, right to second opinion, and grievance and appeals will be included in this delegated function.

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

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

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

MSHN has established criteria for determining medical necessity, and the information sources and processes that are used to review and approve provision of services.

MSHN 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.

b) Practice Guidelines

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 were utilized is a locally driven process in collaboration with the MSHN Councils and Committees. Practice guidelines are chosen to meet the needs of persons served in the local community and to ensure that everyone receives the most efficacious services. Practice guidelines as stated above are reviewed and updated annually or as needed and are disseminated to appropriate providers.

c) 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.

d) Cultural Competence

MSHN and its Provider Network shall demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area. Such commitment includes acceptance and respect for the cultural values, beliefs and

practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services.

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

e) Autism Benefit (Medicaid Managed Specialty Supports and Services Early and Periodic Screening, Diagnosis and treatment (EPSDT) 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. 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 EPSDT state plan and reviews this data monthly to quarterly with the CMHSPs within its region and calls for ongoing system and consumer-level improvements. This data is shared with the MDHHS as required, for reporting individual-level and systemic-level CMHSP quality improvement efforts.

Autism Benefit Review

Initial eligibility is managed through MSHN in a review of clinical content and then submitted to MDHHS for ABA service approval. Re-evaluations shall address the ongoing eligibility of the autism benefit participants and are updated annually. All providers of ABA services shall meet credentialing standards as identified in the EPSDT benefit and Michigan Medicaid Manual to perform their function.

f) Behavior Treatment

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 Standards of 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 has been piloted and tracked in the MSHN region and 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 analyzed on a quarterly basis by MSHN and is available to MHHS upon request. 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. MSHN also uses this data to provide oversight via the annual site review process at each of the CMHSPs. Data shall include numbers of interventions and length of time the interventions were used per person.

e) Trauma (MDHHS Trauma Policy)

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

VIII. PROVIDER STANDARDS

a) Credentialing/Qualification and Selection

In compliance with MDHHS's Credentialing and Re-Credentialing Processes (FY20 Attachment P7.1.1, FY20 Attachment PII.B.A), 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 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 and SUD Provider compliance with federal, state, and local regulations and requirements annually through an established process including desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies.

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

b) Provider Monitoring and Follow-Up

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

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

c) External Reviews

The PIHP is subject to external reviews through MDHHS or an external auditor to ensure compliance with all regulatory requirements. MSHN collaborates with MDHHS and the external auditor to provide relevant evidence to support compliance. In accordance the Medicaid Managed Specialty Supports and Services Program FY20 7.0 Provider Network Services 7.9.1 External Quality Review. All findings that require improvement based on the results of the external reviews are incorporated into the QAPIP Priorities for the following year. An action plan will be completed that includes the following elements: improvement goals, objectives and activities in response to the findings. The improvement plan will be available to MDHHS upon request.

X. Quality Assessment and Performance Improvement Priorities (QAPIP) FY2020

The QAPIP priorities for FY20 are determined based on areas that have not demonstrated the desired performance for FY19. The QAPIP priorities shall guide quality efforts for FY20. Figure 1 demonstrates how MSHN will meet the contractual requirements for the elements of the QAPIP as required by MDHHS.

Figure 1. QAPIP Elements

Strategic Priority	Event Monitoring and Reporting	Indicator
MSHN will improve behavioral health services and supports and outcomes for all populations served	Critical Incident Reporting to MDHHS	Critical Incident Performance Reports completed quarterly
	*Trends, patterns, strengths and opportunities for improvement identified.	Critical Incident Reports will include patterns and trends, identification of improvement recommendations and action steps as needed.
	Oversight of CMHSP risk analysis and reduction	Providers will upload data as required. Delegated Managed Care Review will conduct primary source verification and ensure a process exists for follow up related to recommendations and Improvement plans are completed.
Strategic Priority	**Behavior Treatment**	**Indicator**
MSHN will improve behavioral health services and supports and outcomes for all populations served	Quarterly Analysis of Data	BTR Performance Reports completed quarterly
	Trends, patterns, strengths and opportunities for improvement identified.	BTR Performance Reports will include patterns and trends, identification of improvement recommendations and action steps as needed.
	Oversight of CMHSP risk analysis and reduction	Providers will upload data as required. Delegated Managed Care Review will conduct primary source verification and ensure a process exists for follow up related to recommendations and Improvement plans are completed.
Strategic Priority	**Autism Waiver Monitoring**	**Indicator**
MSHN will improve access to services and supports	Quarterly Analysis of Data	Autism Performance Reports completed quarterly.
	Trends, patterns, strengths and opportunities for improvement identified.	Autism Reports will include patterns and trends, identification of improvement recommendations and action steps as needed.
	*Oversight of CMHSP Autism benefit program requirements and corrective action related to the MDHHS site review	Providers will upload data as required. Delegated Managed Care Review will conduct primary source verification and ensure a process exists for follow up related to recommendations and Improvement plans are completed.

Strategic Priority	Quantitative and Qualitative Assessment of Member Experiences	Indicator
Improve the Role of MSHN Consumers and Key Stakeholders	Opportunities for consumer feedback related to member experiences.	The Recovery Self-Assessment will be completed annually
		A Consumer Satisfaction Survey will be completed annually
MSHN will improve behavioral health services and supports and outcomes for all populations served	*Trends, patterns, strengths and opportunities for improvement identified.	Annual Report of Recovery Assessment will be completed annually
		Annual Report of Consumer Satisfaction Survey will be completed annually
Strategic Priority	**Practice Guidelines**	**Indicator**
Improve access to services and supports	MSHN Communication of practices guidelines	Utilization Management Plan and related policies/procedure will include a process for communicating practice guidelines.
	CMHSP Implementation of Practice Guidelines	MSHN desk review will verify local implementation of practice guidelines
Strategic Priority	**Credentialing, Provider Qualification and Selection**	**Indicator**
Enhance Regional Quality & Compliance	*Process to ensure CMHSP and SUD Providers adherence to MSHN credentialing policy	A process will be developed to increase compliance with the MDHHS/MSHN credentialing policy.
	CMHSP and SUD Providers adherence to MSHN credentialing policy	Delegated Managed Care Review will ensure credentialing is completed as required.
Strategic Priority	**Medicaid Event Verification**	**Indicator**
Public resources are used efficiently and effectively	Verifies delivery of services billed to Medicaid	The completion of the PIHP Medicaid Event Methodology Report
	Trends, patterns, strengths and opportunities for improvement identified.	The MEV Annual Methodology Report will be completed and reviewed with QIC and Compliance committee annually
	Reported annually to MDHHS	The annual MEV Methodology Report will be submitted to MDHHS as required

Strategic Priority	Utilization Management Plan	Indicator
Public resources are used efficiently and effectively	UM Committee develops standards for utilization	The MSHN Utilization Management Plan will be completed/reviewed annually.
	Trends, patterns of under / over utilization, strengths and opportunities for improvement are identified.	MSHN Utilization Management Reports will be completed quarterly/annually.
	*MSHN will have a process to ensure that, for service authorization decisions not reached within required timeframes ABD notices will be completed.	Delegated Managed Care Review (DMC) review
Strategic Priority	**Utilization Management Plan**	**Indicator**
MSHN will improve access to supports and services.	*MSHN will have a documented process for extending service authorization timeframes in certain circumstances.	DMC Review
	Uniform screening tools and admission criteria	Utilization Management Committee – LOCUS
Strategic Priority	**Provider Monitoring**	**Indicator**
Enhance organizational quality & compliance	CMHSP annual monitoring of provider subcontractors	Annual Delegated Managed Care (DMC) Site Review are completed bi-annually. New standards and required corrective action is completed in the interim year.
	MSHN monitoring of CMHSPs and SUD Provider Network compliance	
Strategic Priority	**Oversight of "Vulnerable People"**	**Indicator**
MSHN will improve its population health and integrated health activities	CMHSPs monitor health, safety and welfare of individuals served	Annual DMC site reviews-clinical record reviews. Key priorities measures
	Trends, patterns, strengths and opportunities for improvement identified.	Individual corrective action plans will be completed for areas out of compliance. An annual report will be completed to identify regional action for improvement.

*Identifies required corrective action from external reviews.

QAPIP activities as exhibited in Figure 2 are aligned with the MSHN Strategic Plan Priorities contributing to Better Health, Better Care, and Better Provider Systems for the individual we serve.

Figure 2. Strategic Plan Priorities

Better Health		
Improve Population and Integrated Health Activities		
Strategic Objective	**Goal/Measurement**	**Task/Activity**
MSHN will expand the use and adoption of the Regional Electronic Medical Information (REMI) System and other applicable software platforms in use across the region to support improved population health outcomes, coordinated and integrated care activities, effectiveness and efficiency.	1. MSHN will improve and standardize processes for exchange of data between MSHN and MHPs; CMHSPs and MSHN. MSHN and SAPT Providers and will facilitate CMHSP-to-CMHSP data exchange in order to reduce duplication when gathering needed information for reporting.	MMBPIS Affiliate Upload and aggregation in REMI; Critical Incident reporting system developed in REMI
MSHN will work with CMHSPs to MONITOR key indicators, supported by MSHN data analysis tools and analytics, such that these metrics inform both regional and county contractual performance targets, and are value added for decision making at councils, committees and board governance levels at MSHN and at all CMHSPs.	1. MSHN will continue to monitor and increase performance related to selected priority measures, key performance indicators and MDHHS's required metrics.	See performance measurement data

Better Care		
Improve Access to Care		
Strategic Objective	**Goal/Measurement**	**Task/Activity**
MSHN and participating CMHSPs establish processes to assist individuals served in maintaining eligibility for Medicaid and/or Healthy Michigan Program coverage.	1. MSHN will monitor CMHSP and SAPT provider consumer verification practices through its site review process and Medicaid event verification audit.	Medicaid Event Verification Site Review Process
	1. Fully implement the region's access and authorization practice guidelines to achieve a common benefit.	Admissions and Benefits workgroup developed access and authorization guidelines
	2. Standardize practices for documentation of medical necessity to assure people are receiving an appropriate scope, duration and intensity of care.	Development within the appropriate committee in collaboration with the CMHSPs.
	3. MSHN will ensure there are uniform access and utilization management criteria in place and will monitor admissions and denials for conformity with the established criteria.	Development within the appropriate committee in collaboration with the CMHSPs.
Improve the Role of MSHN Consumers and Key Stakeholders		
Stakeholder feedback demonstrates effective, efficient and collaborative operations.	1. Deploy a survey tool to measure participating provider satisfaction and achieve 80% satisfaction with the effectiveness and efficiency of MSHN's processes and communications.	Work Force Survey
MSHN will improve and integrate stakeholder and consumer input and utilize compiled input to improve system performance and provide feedback to stakeholders on systems improvements made.	1. Improve communications linkages between provider input forums, executive leadership and governance.	In development
	2. Evaluate feasibility of survey consolidation and streamlining.	Obtaining information

Enhance Regional Quality and Compliance		
Strategic Objective	**Goal/Measurement**	**Task/Activity**
MSHN will provide leadership on improving the consistency and implementation of person-centered planning, self-determination and independent facilitation in the region.	1. MSHN will strengthen MSHN QAPI reviews of person-centered planning, independent facilitation and self-determination implementation in its provider network oversight activities.	Improvements to the DMC Site Review Process
	2. MSHN will use data gathered in its provider network oversight activities to develop specific training and/or learning communities to strengthen person-centered planning, independent facilitation and self-determination implementation.	Improvements to the DMC Site Review Process
Better Value		
Regional Public Policy Leadership Supports Improved Health Outcomes and System Stability		
Strategic Objective	**Goal/Measurement**	**Task/Activity**
MSHN will ensure consistent, standardized, and cost-effective operations and will position the region for continued success regardless of payer structure.	1. MSHN ensures full implementation of agreed upon regionally standardized processes at all CMHSPs and the PIHP.	BTPRC, MMBPIS, RSA, Critical Incidents, Satisfaction Survey
	2. MSHN evaluates penetration rate, cost and other metrics and addresses undesirable variation through its councils and committees in order to promote standardized, consistent and cost-effective operations across the region.	See performance measurement data
MSHN's Provider Network Management Systems are effective and efficient.	1. MSHN publishes provider performance data to consumers and the public.	Available on Website

Better Provider System		
MSHN ensures that it engages a provider network with adequate capacity and competency		
Strategic Objective	**Goal/Measurement**	**Task/Activity**
MSHN enhances existing quality assessment and performance improvement systems that promote continuous improvement and enhanced accountability for clinical and fiscal performance.	1. MSHN will develop and begin reporting on the provider scorecard.	MMBPIS, Adverse Event Reporting, Satisfaction Survey
	2. MSHN will strengthen regional performance improvement systems in the SAPT provider network.	MMBPIS, Adverse Event Reporting, Recovery Assessment, Satisfaction Survey
	3. MSHN will provide training and education related to data integrity, reporting standards, use of data in decision making and provider development.	Documentation and training completed during committee/council/work group meetings.
	4. MSHN will integrate fiscal information and performance results into its quality assessment and performance improvement systems.	Priority Measures, MMBPIS, Adverse Events, Recovery Assessment, Satisfaction Survey
MSHN engages in activities to simplify administrative complexity and enhance provider satisfaction.	2. MSHN will develop internal functional area annual plans (inclusive of provider responsibilities related to strategic projects/initiatives, and operational requirements such as audits, annual plans, reporting requirements, etc.) To identify overlap/redundancy and opportunities for cross functional collaboration to streamline processes.	In development

An effective performance measurement system allows MSHN to evaluate the safety, accessibility and appropriateness, the quality and effectiveness, and outcomes of the services provided. An effective performance measurement system also allows for an evaluation of satisfaction of the services in which an individual receives. Figure 3 demonstrates performance measurements used to monitor the performance of MSHN.

Figure 3. Performance Measurement

Performance Measurement	Indicator
Performance Indicators (Michigan Mission Based Performance Indicator System-MMBPIS)	Indicator 1: Percentage of Children/Adults who received a Prescreen within 3 hours of request (standard is 95% or above)
	Indicator 2: Initial Assessment within 14 Days - Children/Adults (standard is 95% or above) Indicator 2. a. Effective on and after January 1, 2020, the percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children.
	Indicator 2 b. Effective on and after January 1, 2020, the percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders.
	Indicator 3: Start of Service within 14 Days (standard is 95% or above) Indicator 3: Effective on and after January 1, 2020, percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children).
	Indicator 4a: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (standard is 95% or above)
	Indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (standard is 95% or above)
	Indicator 10: Re-admission to Psychiatric Unit within 30 Days (standard is 15% or less)
Performance Improvement Projects	PIP – The degree to which programs implement recovery-oriented practices. (standard is >=3.50)
	PIP - The percentage of members 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year. (standard is 7% increase from baseline) HEDIS Diabetes Monitoring Report

Priority Measures	The percentage of discharges for adults who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. FUH Report, Follow-Up After Hospitalization Mental Illness Adult (standard-58%)
	The percentage of discharges for children who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. Follow-Up After Hospitalization Mental Illness Children (standard-70%)
	The percentage of members 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year. (standard is 7% increase from baseline) HEDIS Diabetes Monitoring Report.
	The percentage of patients `8-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Diabetes Screening Report (Increase from previous measurement period)
	The percentage of individual 25 to 64 years of age with schizophrenia or bipolar who were prescribed any antipsychotic medication and who received cardiovascular health screening during the measurement year. Cardiovascular Screening (increase from previous measurement period)
	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. FU Children ADHD Med Initiation Phase
	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. FU Children ADHD Med Continuation & Monitoring (C&M) Phase
	Plan All-Cause Readmissions-The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (<=15%)
	The percentage of members 20 years and older who had an ambulatory or preventative care visit. Adult Access to Care (>=75%)
	The percentage of members 12 months-19 years of age who had a visit with a PCP. Children Access to Care (>=75%)

	The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within (34)30 days of the initiation visit (Initiation of Alcohol and Other Drug (AOD) Treatment,(above national numbers)
	The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within (34)30 days of the initiation visit (Initiation of Alcohol and Other Drug (AOD) Treatment, (above national numbers)
Contract Requirement	Identification of enrollees who may be eligible for services through the Veteran's Administration (baseline).
Contract Requirement	Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS. (standard-95%)
Contract Requirement	Percentage (rate per 100) of Medicaid consumers who are denied overall eligibility were resolved with a written notice letter within 14 calendar days for a standard request of service. (standard-95%)
Contract Requirement	The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness standards including the written disposition letter (30 calendar days) of a standard request for appeal. (standard-95%)
Contract Requirement	The percentage (rate per 100) of Medicaid second opinion requests regarding inpatient psychiatric hospitalization denials which are resolved in compliance with state and federal timeliness standards, including receiving a written provision of disposition (standard-95%)
Contract Requirement	The percentage (rate per 100) of Medicaid grievances are resolved with a written disposition sent to the consumer within 90 calendar days of the request for a grievance (standard-95%)

Performance Measurement	Indicator
Event Monitoring and Reporting	The rate of arrests, per 1000 persons, served will demonstrate a decrease from previous year.
	The rate, per 1000 persons served, of persons who received emergency medical treatment for an injury or medication error will demonstrate a decrease from previous year.
	The rate, per 1000 persons served, of individuals who were Hospitalized for an injury or medication error will demonstrate a decrease from previous year.
	The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous year.
	The rate, per 1000 persons served, of Suicide Deaths will demonstrate a decrease from previous year.
	The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from previous from previous year.
Performance Measurement	**Indicator**
Behavior Treatment	The percent of individuals who have an approved Behavior Treatment Plan which includes restrictive and intrusive techniques will decrease from previous year.
	The percent of emergency physical interventions per person served during the reporting period will decrease from previous year.
	The percent of incidents per consumer served requiring phone calls made by staff to police for behavioral assistance during the reporting period will decrease from previous year.
Performance Measurement	**Indicator**
Quantitative and Qualitative Assessment of Member Experiences	I am involved in my community and organization (RSA-Involvement) (>=3.5)
	Services I receive are tailored to my wants and needs (RSA-Individually Tailored Services) (>=3.5)
	I am given opportunities to discuss or be connected to my diverse treatment needs (RSA Diversity of Treatment) (>=3.5)
	I am given choices about my treatment and care that I receive (RSA-Choice) (>=3.5)
	Staff support and encourage me in various ways to fulfill my life goals (RSA-Life Goals) (>=3.5)
Performance Measurement	**Indicator**
Medicaid Event Verification	Medicaid Event Verification review demonstrates improvement of previous year results with the documentation of the services provided falling within the scope of the service code billed (CMHSP results).
	Medicaid Event Verification review demonstrates improvement of previous year results with the service being included in the persons individualized plan of service (SUD results).

XI. 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.

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

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

purposes. For example, some demonstration and service programs may include research activities.

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

SUD Providers: Refers to Substance Use Disorder providers directly contracted with MSHN to provide SUD treatment and prevention services.

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SECTION TWO-ANNUAL REPORTS

I. COUNCIL FY19 ACCOMPLISHMENTS & FY20 GOALS

ANNUAL REPORT
TEAM NAME: Mid-State Health Network Operations Council **TEAM LEADER:** J. Sedlock, MSHN Chief Executive Officer **REPORT PERIOD COVERED:** 10.1.18 – 9.30.19

Purpose of the Council or Committee:
The MSHN Board has created an 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 MSHN CEO to bring local perspectives, local needs, and greater vision to the operations of the Entity so that effective and efficient service delivery systems are in place that are accountable to the entity board, funders and the citizens who make our work possible.[1]

Responsibilities and Duties[2]: 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 and regulatory bodies[3];and
- Undertake such other duties as may be delegated by the Entity Board.

Defined Goals, Monitoring, Reporting and Accountability[4]
The Operations Council 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.

[1] Article III, Section 3.2, MSHN/CMHSP Operating Agreement
[2] Ibid., unless otherwise footnoted
[3] Operations Council Charter, February 2014.
[4] Ibid.

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.

Annual Evaluation Process:

a. Past Year's Accomplishments:

- Reviewed and recommended for MSHN Board Approval the FY 19 MSHN Compliance Plan
- Reviewed and recommended for MSHN Board Approval the FY 19 MSHN Utilization Management Plan
- Reviewed and recommended for MSHN Board Approval the FY 19 MSHN Assessment of Network Adequacy
- Reviewed and recommended for MSHN Board Approval the FY 19 MSHN Regional Population Health and Integrated Care Plan
- Reviewed and recommended for MSHN Board Approval the FY 19 Quality Assessment and Performance Improvement Program Plan and Annual Report
- Monitored regional performance on key measures and balanced scorecard measures
- Reviewed and approved new and updated MSHN/Regional Policies
- Reviewed and planned for implementation of changes to the MDHHS/MSHN Specialty Supports and Services Contract and several amendments
- Reviewed and approved adjustments to the MSHN Delegated Managed Care Review Template
- Reviewed and approved adjustments to the Medicaid Sub-Contracting Agreement and related Delegation Grid
- Planned for the separation of one CMHSP from the region to participate in the 298 pilots and assessed impacts on regional operations
- Developed policy guidance on due diligence activities in the event a CMHSP from outside the existing MSHN region is to be considered for 'membership' in the region
- Supported regional participation in the state's Integrated Care for Kids initiative
- Developed policy on bylaws revisions and review
- Supported MSHN involvement and approved processes for working with local hospitals and health systems to improve follow-up for individuals with a substance use disorder diagnosis after emergency room visit
- Developed strategies for responding to statewide PIHP funding level variances

and LRE/MDHHS Contract cancellation intention/notice
- Discussed implications and reviewed MSHN regional plans for compliance with new waiver requirements, including staffing implications at the PIHP and implications and work processes at the CMHSP level
- Discussed and planned implementation of region-wide direct care worker wage increases, including and beyond those required in MDHHS appropriations
- Planned for involvement in Section 298 – related management of the Unenrolled population and discussed benefits and implications of being involved outside established regional boundaries; secured legal opinion
- Determined method for in-region financing of Autism services
- Extensively discussed and evaluated benefits and implications of MSHN contracting directly with the Michigan Department of Corrections to provide SUD Treatment Services to Parolees/Probationers under MDOC supervision; secured legal opinion
- Reviewed and implemented several corrective action plans resulting from external reviews/audits of regional and CMHSP operations
- Extensively discussed and clarified the roles and responsibilities of the regional entity and CMHSP Participants in regional operations and new ventures
- Discussed and made initial plans to collaborate on the establishment of a crisis residential services exclusively for the benefit of the consumers served in the MSHN region
- Received and discussed detailed presentation and information on MSHN management of the Substance Abuse Prevention and Treatment System and liquor tax funding utilization
- Established quarterly Operations Council focus on strategic issues and priorities
- Discussed, planned and implemented regional network adequacy standards required under MDHHS/MSHN contract
- Discussed and analyzed implications of the legalization of marijuana for recreational use on regional and CMHSP operations, especially from a human resources management perspective
- Implemented regional approach to ensuring parity required under federal rules
- Planned regional budgets and budget adjustments in light of MDHHS rate setting/resources available
- Planned transition of regional financing resulting from sunset of regional smoothing plan
- Updated regional psychiatric inpatient contract and site review protocols
- Updated regional fiscal intermediary contract and site review protocols
- Provided input into regional workforce survey and planned utilization of results
- Reinforced regional change management process relative to

standardized systems

- Established an Autism Operations Regional Standardization workgroup
- Streamlined Committee and Workgroup Systems resulting in fewer resource commitments without sacrificing regional collaboration systems or quality
- Approved several regional implementation plans resulting from rule changes or clarifications regarding Behavior Tech exclusions, disqualified providers, and others.
- Routine updates to Council and Committee Charters
- Routine monitoring of regional finances, savings estimates and fiscal projections
- Planned implementation across the region for inpatient and training reciprocity systems developed by all PIHPs
- Centralized Relias Training contract for benefit of regional CMHSP Participants; expanded access to the Relias Training Platform
- Exhaustively updated, reviewed, debated and edited the MSHN/CMHSP Operating Agreement for ratification by all regional participants and the regional entity

b. Upcoming Goals for Fiscal Year Ending, September 30, 2020:

- Assist MSHN with implementation of the 2018-2020 Regional Strategic Plan objectives;
- Establish systems to improve performance in metrics outlined in the MDHHS Performance Incentive Bonus section and MSHN Key Performance Indicators, including follow-up after hospitalization for mental illnesses between PIHPs and MHPs and within the MSHN region, Follow-up to persons with an SUD diagnosis following contact with an Emergency Room; Plan All Cause Readmission, increase in Patient Centered Medical Homes; better support for veterans
- Home and Community Based Services Waiver Transition implementation;
- 1115 (and associated) Waiver implementation and workflow engineering changes;
- Identify and implement improvements in region-wide approaches to inpatient care, from pre-admission screening systems to provider performance monitoring to contracting and all related systems; expand use of telehealth services
- Improve consistency, standardization and cost-efficiency in retained and delegated managed care activities;
- Full implementation of the parity software solution within the region;
- Increase efficiency through collective provider network management functions;
- Continue advocacy for systemic improvement in access to inpatient care and identify and develop sub-inpatient regional crisis response systems/options;

ANNUAL REPORT
TEAM NAME: Finance Council
TEAM LEADER: Leslie Thomas MSHN Chief Finance Officer
REPORT PERIOD COVERED: 10.1.18 - 9.30.19

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:

- Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 2018 and February 2019. 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 2019. A favorable fiscal audit will be defined as those issued with an unqualified opinion. A favorable compliance audit will be defined as one that complies in all material aspects with relevant contractual requirements.
- Meet targeted goals for spending and reserve funds: Determination will be made when the FY 2018 Final Reports due to MDHHS February 28, 2019, are received from the CMHSPs to the PIHP. The goal for FY18 will be to spend at a level to maintain MSHN's anticipated combined reserves to 7.5% as identified by the board. This goal does not override the need to ensure consumers in the region receive medically necessary care.
- Work toward a uniform costing methodology: MSHN has developed a Service Use Analysis suite of reports as a guideline for this process. The reports have been used to guide service activity data collection to identify significant variances related to service functions. The first phase of the process includes the review of five high volume codes.
- Assure region wide rates are within acceptable deviations from state wide rates: The Medicaid Uniform Cost Report (MUNC) is due to MDHHS February 28, 2019. MDHHS will compile the PIHP reports and send an analysis to the PIHPs in June of 2019. Finance Council will follow the MSHN costing methodology and utilize MUNC to identify rates per service and costs per case exceeding one standard deviation of the state PIHP average. Following the Finance Council costing methodology, an analysis will be performed of outliers and recommendations offered to address service provision or costing for service provision as applicable.
- Completion of Finance Council Dashboard – MSHN staff and Finance Council members completed its work to populate the fiscal year 2018 Dashboard.
- Uniform Administrative Costing – MSHN's CFO participates in the PIHP CFO council. The PIHP CFO council developed definitions, grids, and guidelines for uniform administrative costing. Finance Council members agreed to follow the methodology guidance from MSHN. CMHSPs must show evidence of meeting MSHN's guidelines through its Administrative Cost Report (ACR) narrative.
- Monitor the impact on savings and reserves related to the change in Autism funding.

- Determine how New Managed Care Rules impact our Region and implement changes as necessary.
- Improve accuracy of interim reporting and projections in order to plan for

potential risk related to use of reserve funds.

- Monitor Medicaid expansion for any changes related to the Affordable Care Act and its impact on the region.
- Monitor changes related to 1115 waiver and its impact on the region's funding.

Annual Evaluation Process

Past Year's Accomplishments

- FY 2018 fiscal audits were complete and submitted by the PIHP and 12 CMHSPs. The PIHP's and all of the CMHSP audits rendered an unqualified opinion. Compliance Examinations were finalized for the PIHP and all CMHSPs. The PIHP's Compliance Examination is completed after the CMHSPs to ensure all adjustments to Medicaid and Healthy Michigan Plan are included. The PIHP received findings as a result of ones issued to two CMHSPs. The other 10 CMHSPs had no findings and complied in all material aspects with attestation standards set forth by the American Institute of Certified Public Accountants. The Finance Council dashboard was eliminated for FY 2018 as other reports such as the Service Use and Analysis suite provides duplicate and more detailed information.
- MSHN achieved a fully funded (7.5%) Internal Service Fund for FY 2018. In addition, the region boasted savings of more than $7 M which is approximately 1.3% of revenue for a total risk reserve of 8.8%. In May 2018, MSHN's board approved an increase from 7.5% to 15% reserves.
- FY 18 Autism revenue was sufficient to cover expenditures. A FY 18 Savings per Final FSR document contains the confirmation and was shared with Finance Council members in March 2019.
- FSR expense reporting respectively is as follows:
    - Medicaid Projection to Interim – Variances for MSHN and ten CMHSPs were less than 3%. The overall regional variance was 2.69%
    - HMP Projection to Interim – The regional variance was .07%.
    - Medicaid Interim to Final – MSHN and all CMHSP variances were less than 3%. The regional variance total was -.04%.
    - HMP Interim to Final – MSHN and eight CMHSPs had variances of less than 3%. The regional variance total was 1.18%.
- One significant impact of the new Managed Care Rules relates to calculation of the Medical Loss Ratio (MLR) for PIHPs. PIHP CFOs reviewed the rule and defined a consistent calculation methodology. This information has been shared with MDHHS, Operations Council, and Finance Council. The new tool will be used for FY 2018 reporting.

Upcoming Goals for Fiscal Year Ending September 30, 2020 Goals:

- Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 2019 and February 2020. 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 2020. A favorable fiscal audit will be defined as those issued with an unqualified opinion. A favorable compliance audit will be defined as one that complies in all material aspects with relevant contractual requirements.

- Meet targeted goals for spending and reserve funds: Determination will be made when the FY 2019 Final Reports due to MDHHS February 28, 2020, are received from the CMHSPs to the PIHP. The goal for FY20 will be to spend at a level to maintain MSHN's anticipated combined reserves to 15% as identified by the board. This goal does not override the need to ensure consumers in the region receive medically necessary care.
- Work toward a uniform costing methodology: The PIHP CFO will participate in a Statewide workgroup initiated by MDHHS and Community Mental Health Administration to establish standard cost allocation methods. The goal is to reduce unit cost variances for each CPT or HCPCS. The Medicaid Uniform Cost Report (MUNC) is due to MDHHS February 28, 2020. MDHHS compiles PIHP reports and send an analysis to the PIHPs in June of 2020. Finance Council will review rates per service and costs per case for service codes identified in the Service Use and Analysis report suite. Finance Council will evaluate if action is needed based on State comparisons.
- Uniform Administrative Costing – MSHN's CFO participates in the PIHP CFO council. The PIHP CFO council developed definitions, grids, and guidelines for uniform administrative costing. Finance Council members agreed to follow the methodology guidance from MSHN. CMHSPs must show evidence of meeting MSHN's guidelines through its Administrative Cost Report (ACR) narrative.
- Monitor the impact on savings and reserves related to addition of Serious Emotional Disturbances (SED) Waiver and Children's Waiver funding now included in the PIHP's capitation. Both programs were previously funded directly to the CMHSPs on a fee- for-service basis.
- Improve accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds.
- Monitor changes related to 1115 waiver and its impact on the region's funding.

ANNUAL REPORT
TEAM NAME: Information Technology Council **TEAM LEADER:** Forest Goodrich, MSHN Chief Information Officer
REPORT PERIOD COVERED: 10.1.2018 – 9.30.2019

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., BH-TEDS reporting, SIS encounters, Rendering Provider NPI reporting);
- Accomplish annual goals established by the IT Council and/or OC, such as:
    - Continue to work on quality and outcome measures as needed for the MSHN region.
    - Improve balanced scorecard reporting processes to achieve or exceed target amounts.
    - Transition health information exchange (HIE) processes to managed care information system, when appropriate, to gain efficiencies in data transmissions.
- Meet IT audit requirements. (EQRO)

Annual Evaluation Process:

1. Past Year Accomplishments

Representation from each CMHSP Participant at all meetings;
- There was a 98% attendance rate at FY19 ITC meetings. 100% attendance occurred in 9 meetings.

Successfully submit MDHHS required data regarding quality, effectiveness and

timeliness;

- As a region, we strive to report all required data to MDHHS. This includes: Encounters, BH-TEDS, Quality Improvement, Performance Improvement and Critical Incidents. MDHHS reported we were 100% timely with encounter submissions.
- We exceeded the 95% standard for submitting BH-TEDS, as MDHHS reported our region at 97%.

Collaborate to develop systems or processes to meet MDHHS requirements; Several initiatives that ITC assisted with during this fiscal year are:

- Added new elements to the managed care information system (MCIS) to ensure more consistent and standardized ways of collecting and reporting information. Performance Indicator reporting, Critical Incident reporting, Grievance and Appeals reporting, building a complete Provider directory, Medicaid enrollment and payment processing, and penetration rate reporting were implemented in the MCIS.
- CMHSPs planned for and built into their EMR systems a standardized method for submitting a new BH-TEDS standard (Q record) for crisis only persons.
- Maintain secure ftp site for distributing and receiving protected health information datasets from MDHHS and for MDHHS is be used by the CMHSPs and MSHN.

Facilitate health information exchange processes;

- Negotiated a statement of work with MiHIN to receive any use case datasets and the right to use MIDIGATE as a data viewer and for reconciling processes.
- Began planning a standard template for mental health ADTs being sent to MiHIN.

Goals established by Operations Council;

- Continued improvements to balanced scorecard reporting for IT council review and monitoring.
- Implemented MCG to meet the parity requirements for acute care services and develop an integration plan for EMR use.

Meet external quality review requirements;

- We had a successful review this year as conducted by Health Services Advisory Group for MDHHS. There were no findings nor recommendations.

2. Goals for fiscal year ending September 30, 2020
   - Active participation by all CMHSP representatives at each monthly meeting.
   - Meet current reporting requirements as defined by MDHHS.
   - Continue supporting data management activities related to outcome measures as needed.
   - Keep transitioning health information exchange (HIE) processes to managed care

information system to gain efficiencies.

- Work with MiHIN and GLHC merger to retain a standard agreement for HIE use.
- Work toward achieving goals established by Operations Council.
- Prepare for and pass audit requirements of the external quality review.

ANNUAL REPORT
TEAM NAME: Quality Improvement Council
TEAM LEADER: Sandy Gettel, MSHN Quality Manager
REPORT PERIOD COVERED: 10.1.18 – 9.30.19

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 MSHN Quality Manager, the CMHSP Participants' Quality Improvement staff appointed by the respective CMHSP Participant Chief Executive Officer/Executive Director and a MSHN SUD staff representing Substance Use Disorder services. The Quality Improvement Council is chaired by the MSHN Quality Manager. All Participants are equally represented on this council.

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

- Advising the MSHN Quality Manager and assisting with the development, implementation, operation, and distribution of the Quality Assessment and Performance Improvement Plan (QAPIP) and supporting MSHN policies and procedures;

Reviewing and recommending changes/revisions to the QAPIP, related policies and procedures and developing new policies and procedures as needed; Evaluating the effectiveness of the 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 Quality Assessment and Performance Improvement Program and supporting policies as part of daily operations;
- Reviewing audit results and corrective action plans, making recommendations when appropriate.

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 action plans related to the Application for Participation (AFP);
- Performance Measures related to Quality Improvement (QI)
- 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 eleven (11) meetings during the reporting period and in that time completed the following tasks:
   - Reviewed and revised the FY18-FY19 MSHN Quality Assessment and Performance Improvement Plan;
   - Reviewed the annual Medicaid Event Verification Report;
   - Reviewed the Quality Assessment Performance Improvement (QAPI) Quarterly Report which includes trends, strengths and growth areas from site reviews that occurred within the quarter;
   - Reviewed and approved the FY19 Delegated Managed Care Site Review Tools;
   - Reviewed key performance indicators (Diabetes Screening, Follow Up to Hospitalization, Diabetes Monitoring) identifying trends and action steps as needed;
   - Developed Project Instructions on how to utilize Care Alerts in ICDP, to provide for accuracy and consistency in data reported for Diabetes Screening Measure;
   - Developed the Project Description and implemented the Performance Improvement Project for FY19-FY21 titled Recovery Self-Assessment;
   - Reviewed the Recovery Self-Assessment data (Administrator, Provider, Persons in Recovery) identifying trends and growth areas;
   - Reviewed the baseline data for the performance measure "Diabetes Monitoring for Schizophrenia Diagnosis" identifying barriers and interventions; received external quality review report indicating 100% validation score;
   - Reviewed the Critical Incident Data quarterly, identifying trends and areas of focus to develop improvement efforts related to deaths. Incorporated the submission of critical incidents for MDHHS's Critical Incident Reporting System through an affiliation upload process, developing training documents to assist with new process;
   - Reviewed the Michigan Mission Based Performance Indicator System (MMBPIS) Summary Quarterly Report identifying trends and actions steps for improvement. Incorporated the submission of the MMBPIS data through an affiliation upload process in the REMI, developing training documents to assist with new process; provided feedback to inform the MDHHS MMBPIS workgroup for development of new performance indicators;
   - Reviewed the Behavior Treatment Review Data quarterly identifying trends and growth areas, revising the definitions and process to be consistent with the MDHHS Behavioral Treatment Standards in coordination with the MSHN Behavioral Treatment Work Group;
   - Reviewed and revised current regional policies and procedures in areas of Quality Improvement;
   - Provided Feedback and participated in the External Quality Reviews (Performance Improvement Project, Performance Measurement Validation, Compliance);
   - Completed the FY18-19 annual QAPIP effectiveness review;
   - Reviewed the QIC balanced scorecard performance report quarterly;
   - Completed annual review and update of QIC charter.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2020

- 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;
- Continue quarterly monitoring of quality and performance improvement related to the QAPIP, streamlining the reporting and improvement process in coordination with clinical committees/councils when relevant.
    - Behavior Treatment Review
    - Critical Incidents
    - Performance Improvement (MMBPIS)
    - Consumer Satisfaction
- Review available healthcare data for identification of trends and quality improvement opportunities;
- Develop a process to measure stakeholder feedback and/satisfaction;
- Develop a process to strengthen and to ensure training for Person-Centered Planning, Independent Facilitation and Self Determination implementation;
- Will perform at or above standard for identified performance measures.

II. ADVISORY COUNCIL FY19 ACCOMPLISHMENTS & FY20 GOALS

ANNUAL REPORT
TEAM NAME: Regional Consumer Advisory Council **TEAM LEADER:** Tina Bertram, Chair Person **REPORT PERIOD COVERED:** 10.1.18 – 9.30.19

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:

- Past Year's Accomplishments: The RCAC had 5 meetings during the reporting period in that time they completed the following tasks:
    - Reviewed the FY18 Annual Compliance Report
    - Reviewed changes to the FY19 MSHN Consumer Handbook
    - Reviewed Quality Improvement Performance Measure Reports that included Performance Indicators, Behavior Treatment Review and Oversight, Critical Incidents, Grievance and Appeals, and Medicaid Fair Hearings
    - Reviewed and provided feedback on the SUD satisfaction survey results
    - Reviewed and approved RCAC annual effectiveness report
    - Reviewed and provided feedback on the Quality Assessment and Performance Improvement
    - Annual review of the MSHN RCAC policy for feedback
    - Education on MSHN SUD Peer Recovery Supports from MSHN staff
    - Reviewed outcomes from Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) and Performance Improvement Project (PIP) annual reviews
    - Reviewed and revised council charter
    - Reviewed and provided feedback regarding MSHN's Strategic Plan
    - Improved practices for ongoing communication between MSHN and local councils
    - Provided input on MSHN's QIC-CSC Balanced Scorecard
    - Discussed ways to strengthen Person Centered Planning, Independent Facilitation and Self Determination Implementation
    - Improved group dynamic and cohesiveness

- Upcoming Goals for Fiscal Year 2020 Ending, September 30, 2020:
    - Provide input on regional educational opportunities for stakeholders
    - Provide input for ongoing strategies for the assessment of primary/secondary consumer satisfaction
    - Review regional survey results including SUD Satisfaction Survey and external quality reviews
    - Review annual compliance report
    - Annual review and feedback on QAPIP
    - Annual review and feedback on Compliance Plan
    - Annual review of the MSHN RCAC policy
    - Annual review of MSHN Consumer Handbook
    - Review and advise the MSHN Board relative to strategic planning and advocacy efforts
    - Provide group advocacy within the region for consumer related issues
    - Explore ways to improve Person Centered Planning, Independent Facilitation and Self Determination Implementation
    - Convene special work sessions to develop letters of support/advocacy on regional issues to address time sensitive legislation as a group
    - Improve communication between the Regional Consumer Advisory Council and the local CMH consumer advisory groups.

ANNUAL REPORT
TEAM NAME: Substance Use Disorder Provider Advisory Committee (SUD-PAC)
TEAM LEADERS: Jeanne Diver, Treatment Specialist; Jill Worden, Prevention Lead; Melissa Davis, QAPI Manager; and Dani Meier, Chief Clinical Officer
REPORT PERIOD COVERED: 10.1.18 – 9.30.19

Purpose of the Council or Committee: MSHN Leadership has created a Substance Use Disorder Provider Advisory Committee (SUD-PAC) to serve in an advisory capacity to MSHN regarding SUD policies, procedures, strategic planning, monitoring and oversight processes, to assist MSHN with establishing and pursuing state and federal legislative, policy and regulatory goals, and to support MSHN's focus on evidence-based, best practice service and delivery to persons served.

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

- Serve as liaison between MSHN and SUD provider network
- Evaluate MSHN strategic plan as it relates to the SUD system and provide input into regional implementation of strategic action items;
- Provide input on MSHN's Quality Assurance Reviews (review process, standards, QI enhancement);
- Evaluate annual provider satisfaction survey results and provide input into regional action;
- Support implementation of evidence-based best practice service delivery to persons served;
- Provide input and advocacy on prevention (PX), treatment (TX), and recovery network policies & procedures;
- Support and provide input on MSHN and MDHHS performance improvement initiatives.
- Provide input on MSHN's Prevention, Treatment and Recovery annual plan processes;
- Provide input on regional concerns that impact providers and/or clients (e.g. barriers to access);
- Support fulfilment of state and federal legislative, policy and regulatory goals;

Defined SUD-PAC Goals:

- Enhance communication between MSHN and SUD Provider Network
- Strengthen SUD strategic objectives and implementation
- Assess MSHN's Quality Assurance Reviews for clarification
- Identify methods to encourage feedback to satisfaction surveys process
- Support delivery of evidence-based best practices
- Promote clarification of prevention, treatment, and recovery network policies/procedures
- Uphold MSHN and MDHHS performance improvement initiatives

- Identify methods to improve MSHN's Prevention, Treatment, and Recovery annual plan process
- Ensure regional concerns that impact providers and/or clients are identified
- Promote clarification of state and federal legislative, policy and regulatory goals

Past Accomplishments:

In the past year, the SUD-PAC has done the following:

- Reviewed and provided input to the Credentials-Claims Verification Process;
- Continued to review and receive GAIN Updates;
- Created method for provider feedback to PAC representative during quarterly SUD Provider Meetings;
- Offered input on SUD provider audit process and tools;
- Generated awareness of and participation in MSHN focus groups

- Reviewed the following:
    - MSHN's new website
    - Required trainings
    - Annual contract review procedure
    - Provider network communication with PAC
    - Recovery Self-Assessment implementation and report
    - Revised performance indicators
    - Provider satisfaction survey results
    - Provider Workforce Attraction and Retention
    - Proposed contract changes
    - QAPI quarterly reports
    - OROSC changes to the Youth Inspector for SYNAR Requirements
    - Assessment of Network Adequacy 2018 for anticipated policy changes that may impact the provider network
    - Department of Corrections' components in MDHHS' proposal for PIHPs
    - PAC calendar
    - SYNAR Youth Inspectors process
    - OPB Updates
    - Scheduled SUD Provider Meetings
    - PAC members' travel reimbursement
    - SUD Provider Manual changes

Goals for Fiscal Year 2020; Ending September 30, 2020

In the coming fiscal year, the SUD-PAC will:

- Reassess SUD-PAC's efficacy and areas for improvement
- Serve as ongoing conduit for information between MSHN and provider network
- Review changes and updates to policies, procedures and regulations from MSHN, MDHHS and other state and federal bodies as they relate to SUD.

III. OVERSIGHT BOARD FY19 ACCOMPLISHMENTS & FY20 GOALS

ANNUAL REPORT
TEAM NAME: SUD Oversight Policy Board
TEAM LEADER: Chairman Deb Thalison, SUD Board Member
REPORT PERIOD COVERED: 10.1.18 – 9.30.19

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

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

Annual Evaluation Process:

a. Past Year's Accomplishments:
   - Received updates on the following:
     - MSHN Strategic Plan
     - MSHN SUD Prevention & Treatment Services
   - Election of OPB Board Officers
   - Approval of Public Act 2 Funding for FY19 & related contracts
   - Approved use of PA2 funds for prevention and treatment services in each county
   - Approved Communication and Updates to the SUD Intergovernmental Agreement (3-year 21 County Agreement)
   - Received PA2 Funding reports – receipts & expenditures by County
   - Received Quarterly Reports on Prevention and Treatment Goals and Progress
   - Received Financial Status Reports on all funding sources of SUD Revenue and Expenses
   - Received updates on Licensing and Regulatory Affairs Rule Changes (LARA)
   - Approved MSHN allocation process of PA2 use by county for prevention and treatment
   - Received FY18 Compliance Reports & Quarterly FY19 Reports
   - Received information on MDHHS State Targeted Response Grants
   - Received update on FY18 Notification of Funding Availability (NOFA) Spending & Outcomes
   - Received update on FY19 NOFA Release
   - Received education and talking points for Preventing Youth Access to Marijuana
   - Received presentation on Public Health in the Midst of The Opioid Epidemic: Syringe Access and Naloxone
   - Received updates on legislative activities related to SUD funding and section 298

b. Upcoming Goals for FY20 ending, September 30, 2020:

- Approve use of PA2 funds for prevention and treatment services in each county;
- Improve communications with MSHN Leadership, Board Members and local coalitions
- Orient new SUD OPB members as reappointments occur
- Share prevention and treatment strategies within region
- Provide advisory input to the MSHN Board of Directors regarding the overall agency strategic plan and SUD budget; and
- Monitor SUD spending to ensure it occurs consistent with PA 500.

IV. COMMITTEE & WORKGROUP FY19 ACCOMPLISHMENTS & FY20 GOALS…

ANNUAL REPORT
TEAM NAME: Clinical Leadership Committee
TEAM LEADER: Todd Lewicki MSHN Chief Behavioral Health Officer
REPORT PERIOD COVERED: 10/1/17 – 9/30/18

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:

Past Year's Accomplishments:

- Review and recommend delegated managed care site review tool for FY19.
- Refine MSHN training grid.
- Met monthly for 11 of 12 months in FY19, per plan.
- Identify and provide input for Retroactive Sampling for MCG and parity.
- Oversaw School Safety Workgroup efforts and recommendations.
- Introduced efficiencies relating to shared meetings with the MSHN Utilization Management Committee.
- Addressed drafting of ECT policy and procedure.
- Reviewed data relative to the quarterly Balanced Scorecard.
- LOCUS exception testing input.
- Began work with the Admissions and Benefits Standardization Workgroup around eligibility and level of care for parity.
- Received reports on HCBS progress and provided input and queries into the process.
- Began discussions on crisis residential unit needs for the PIHP region.
- Clarified policy relative to SUD transportation.
- Began tracking Intensive Crisis Stabilization Services data monthly.
- Recommendation to discontinue MSSV data due to recent improvements with BH-TEDS reporting.
- Addressed state court administration office and mental health code changes.
- Establish process for Indian Health Service: Tribally-operated facility/Urban Indian Clinic in policy.
- Established regional plan to enhance parent support partners and youth peer support services.
- Autism Alliance of Michigan data request plan.
- Input into new service Overnight Health and Safety Support.
- Review and input into MDHHS Site Review Report.
- Addressed new HSW Recertification process for FY20.
- Began to explore opportunities related to increasing definition of Conflict Free Case Management.
- Continue to review and follow MDHHS policy changes for incorporation into PIHP and CMHSP practices (Electronic Visit Verification, Caring 4 Students, Non-Emergency Ambulance Transportation, etc.).
- Discussed PCP formats and shared best practices.
- Upcoming B3 changes and the 1115 Waiver.

Goals for Fiscal Year 2019; Ending September 30, 2020

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

- Medical Population health outcomes in collaboration with MSHN's ongoing work with the region's Medicaid Health Plans;
- Review and address opportunities for increasing integration with primary care,
- Continue to partner with UMC around the implementation of regional consistency in use of LOCUS, CAFAS/PECFAS, SIS, GAIN, and any identified tool for 1915i eligibility;
- Ongoing efforts to strengthen coordination of care between primary and behavioral health care

services and seek to expand best practices;
- Ongoing HCBS Rule implementation;
- Ongoing Parity Rule implementation;
- Input into finalization of clinical protocols for support of regional consistency in access standards and delivery of services;
- Continued implementation of competencies in diagnosis and treatment of co-occurring conditions, trauma, gender competence and cultural competence (including military competency training);
- Continuing partnership opportunities with the Regional Medical Director's Committee;
- Building capacity in crisis residential psychiatric services;
- Address ongoing initiatives, including School Safety, Integrated Health, Staff Burnout, Telehealth, and other ongoing program requirements;
- Maintain consistent information, insight, and input into policy changes at MDHHS relating to the PIHP system of care and integration.

Role and Perspectives of Medical Directors:

- Continue to leverage the partnership with MSHN Medical Director, Dr. Zakia Alavi, to address Medical Director perspectives and carry forward CLC content to the Regional Medical Director's Committee.

ANNUAL REPORT
TEAM NAME: Utilization Management Committee
TEAM LEADER: Skye Pletcher**,** MSHN Director of Utilization and Care Management
REPORT PERIOD: 10.01.2018 – 9.30.2019

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;
- Perform utilization management functions sufficient to analyze and make recommendations relating to controlling costs, mitigating risk and assuring quality of care;
- 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.
- Ensure committee coordination and information sharing to address continuity and efficiency of PIHP processes.

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

- Define specifics of regional requirements or expectations for CMHSP Participants and SUD Providers relative to prospective service reviews (pre-authorizations), concurrent reviews and retrospective reviews for specific

services or types of services, if not already addressed in policy;

- Define any necessary data collection strategies to support the MSHN UM Program, including how the data resulting from the completion of any mandatory standardized level of care, medical necessity or perception of care assessment tools will be used to support compliance with MSHN UM policies;
- Define metrics for population-level monitoring of regional adherence to medical necessity standards, service eligibility criteria and level of care criteria (where applicable);
- Define expected or typical population service utilization patterns and methods of analysis to identify and recommend possible opportunities for remediation of over/under utilization;
- Set annual utilization management priorities based on the MSHN strategic plan and/or contractual/public policy expectations;
- Recommend improvement strategies where service eligibility criteria may be applied inconsistently across the region, where there may be gaps in adherence to medical necessity standards and/or adverse utilization trends are detected (i.e., under or over utilization); and
- Identify focal areas for MSHN follow-up with individual CMHSP Participants and SUD Providers during their respective on-site monitoring visits.

<u>Annual Evaluation Process:</u>

a. Past Year's Accomplishments: The UMC had eleven meetings during the reporting period. In that time the following tasks were completed:
    - A thorough review of the UMC annual report schedule was conducted in order to evaluate the ongoing relevance and effectiveness of the data being reviewed by the committee. A number of recommendations were made related to eliminating areas of redundancy where similar data is being monitored by more than one regional committee or certain regional processes have become more automated and standardized over time resulting in there no longer being a need for data monitoring by the committee.
    - Ongoing review of data reports related to performance on regional UM and integrated health priority measures with CMH participants reporting on change strategies when performance is outside of established expected thresholds
    - Participation by several UMC members on a regional Admission and Benefit Stabilization Workgroup (ABSW). This workgroup completed the development of regional common service benefit grids for each eligible service population based on level of need using standardized assessment tools (LOCUS for adults with serious mental illness, CAFAS for children with serious emotional disturbance, SIS for individuals with

intellectual and/or developmental disabilities, and ASAM for individuals with substance use disorders)

- Implemented and refined an exception-based review system of over/under utilization of services according to the common LOCUS benefit grid for adults with serious mental illness. UMC members performed quarterly retrospective reviews of outlier cases and reported back to the committee regarding any necessary change strategies to address underlying reasons for over/under utilization at the local level such as staff training needs
- Ongoing cross-functional dialogue with QI Council, Clinical Leadership Committee (CLC), and Provider Network Management. UMC and CLC implemented a staggered scheduling approach for committee meetings during FY19 in which each committee met individually for one hour to address agenda items specific to their respective content areas and both committees participated in a joint session for one hour to address agenda items for which there is significant cross-functional content. This resulted in increased efficiency and better use of committee members' time and resources Expanded SUD reporting in committee to include monitoring of SUD Residential Utilization and Detox Recidivism. UMC provided feedback regarding insufficient network adequacy for these services in certain portions of the region contributing to potential underutilization. MSHN issued a Request for Proposals (RFP) during FY19 for SUD residential and withdrawal management services in the Northwest portion of the region which resulted in an approved contract for a new provider of these services in Montcalm County in FY20.
- UMC authored a new regional policy for the use of the evidence-based MCG Behavioral Health Guidelines to determine medical necessity for acute care services in accordance with Federal Mental Health Parity Requirements. Additionally, UMC authored an accompanying regional procedure to define the expectations for conducting retrospective reviews of acute care services using the MCG Behavioral Health Guidelines
- Implemented a quarterly retrospective review process for acute care services using the MCG Behavioral Health Guidelines and established a regional target of 95% or more correct application of medical necessity criteria. During FY19 the target was achieved for all quarters in which reviews were conducted.

ANNUAL REPORT
TEAM NAME: Regional Compliance Committee
TEAM LEADER: Kim Zimmerman, Director of Customer Services, Compliance, Quality Improvement
Report Period Covered: 10.1.2018-9.30.2019

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

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

- Advising the MSHN Director of Customer Service, Compliance and Quality Improvement on matters related to Compliance
- Assist in the review of, and compliance with, contractual requirements related to program integrity and 42 CFR 438.608
- Assist in developing reporting procedures consistent with federal requirements
- Assist in developing data reports consistent with contractual requirements
- Assisting with the review, implementation, operation, and distribution of the MSHN Compliance Plan
- Reviewing and updating, as necessary, MSHN policies and procedures related to Compliance
- Evaluating the effectiveness of the Compliance Plan
- Determining the appropriate strategy/approach to promote compliance and detect potential violations and areas of risk as well as areas offocus
- Recommending and monitoring the development of internal systems and controls to carry out the Compliance Plan and supporting policies as part of dailyoperations.
- Reviewing compliance related audit results and corrective action plans, making recommendations when appropriate.
- Assisting in development and implementation of compliance related training.

Defined Goals, Monitoring, Reporting and Accountability
The Compliance Committee shall establish metrics and monitoring criteria to evaluate progress:

- As defined in the Compliance Plan

Annual Evaluation Process

Past Year's Accomplishments

- Revised and approved MSHN Compliance Plan
- Completed annual revision and approval for MSHN compliance policies and procedures
- Standardized the Office of Inspector General (OIG) quarterly reporting process

- Developed a disqualified provider policy for the region
- Reviewed Medicaid Policy Bulletins and implemented changes locally as needed
- Provided feedback for the statewide Compliance Training
- Reviewed information provided at PIHP/OIG meetings
- Reviewed information provided at the PIHP Compliance Officers meetings
- Provided feedback and approval for the annual Compliance Summary Report
- Developed OIG quarterly reporting process within REMI for use by CMHSPs
- Updated the MSHN Privacy Notice
- Provided feedback on breach notification templates
- Reviewed outcomes from external site reviews for necessary changes and compliance related issues
- Provided consultation on local compliance related matters

Upcoming Goals for Fiscal Year Ending, September 30, 2020

- Implement the quarterly OIG report submission and aggregation in REMI
- Complete revisions to the Compliance Plan, policies and procedures and reporting as needed and as identified by the OIG
- Review changes to state and federal regulations/guidelines and develop and implement changes regional and locally as needed
- Identify compliance related training/education needs
- Review data identified as part of the quarterly reports, delegated managed care reports and external site reviews for any trends, areas of non-compliance and develop processes to address

ANNUAL REPORT
TEAM NAME: Provider Network Management Committee
TEAM LEADER: Carolyn Watters, MSHN Director of Provider Network Management Systems
REPORT PERIOD COVERED: 10.1.18 – 9.30.19

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 MDHHS.
- 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;
- Continue to develop intra-regional reciprocity systems to increase efficiencies;
- Recommend and deploy strategies for sub-contractor credentialing reciprocity agreements.

Defined Goals, Monitoring, Reporting, and Accountability: The PNMC shall establish goals consistent with the MSHN Strategic Plan and to support compliance with the MDHHS/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:

Past Year's Accomplishments: The PNMC had ten meetings during the reporting period in that time they completed the following tasks:

- Ensured regional compliance with Behavioral Health and Developmental Disabilities (BHDDA) Network Adequacy Standards for ACT, Clubhouse, OTPs, Home-Based Services, and Wraparound;
- Addressed recommendations from the 2018 assessment of Network Adequacy as it relates to provider network functions, particularly around reciprocity;
- Provided input into the regionally standardized Applied Behavior Analysis/Autism contract;
- Completed annual performance monitoring protocol in accordance with the regional quality monitoring and evaluation policy and procedure, operationalizing systems for FI and Inpatient providers;
- Executed change management process to evaluate and update regionally standardized contract templates;
- Continued to refine the regional provider directory in accordance with managed care rules;
- Through the Training Coordinators, began implementation of statewide training reciprocity plan within the MSHN region (strategic priority);
- CMHSPs expanded regional autism service capacity to ensure sufficient network capacity to meet consumer demand (strategic priority);
- Coordinated focus groups for CMHSP provider network to identify primary workforce concerns and issues (strategic priority).

Upcoming Goals for Fiscal Year Ending, September 30, 2020

- Address recommendations from the 2019 assessment of Network Adequacy as it

relates to provider network functions; update the Assessment of Network Adequacy to address newly identified needs;

- Address findings from HSAG audit, specific to provider credentialing and recredentialing systems;
- Continue to refine and support the statewide and intra-regional provider performance monitoring protocols resulting in improved provider performance and administrative efficiencies (strategic priority);
- Recommend intra-regional provider performance monitoring protocol for ABA/Autism provider network to Operations Council; implement during FY20 to establish baseline regional performance data;
- Establish relevant key performance indicators for the PNMC scorecard;
- Continue to monitor and refine regional provider directory to ensure compliance with managed care rules; provide input into PCE Provider Management Module enhancements;
- Fully implement statewide training reciprocity plan within the MSHN region (strategic priority);
- Address provider capacity for residential, employment and other community living related services at the network level as a result of HCBS transition and CAP remediation (strategic priority).

ANNUAL REPORT
TEAM NAME: Customer Service Committee
TEAM LEADER: Dan Dedloff, MSHN Customer Service & Rights Specialist
REPORT PERIOD COVERED: 10.1.18 – 09.30.19

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

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

1. Advising the MSHN Director of Quality, Compliance, and Customer Service and assisting with the development, implementation and compliance of the Customer Services standards as defined in the Michigan Department of Health and Human Services (MDHHS) contract and 42 CFR including the Balanced Budget 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 implementation of monitoring strategies;
6. Reviewing semi-annual aggregate denials, grievances, appeals, second opinions, recipient rights and Medicaid Fair Hearings reports;
7. Reviewing audit results from EQR and MDHHS site reviews and assisting in the development and oversight of corrective action plans regarding Customer Services;
8. Assisting in the formation and support of the RCAC, as needed; and
9. 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 and the Grievance and Appeal Technical Requirement, PIHP Grievance System for Medicaid Beneficiaries.

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 eight committee meetings during the reporting period in which they completed the following tasks:
   - Reviewed, revised, facilitated publication of, and completed regional distribution for the MSHN FY19 Consumer Handbook
   - Facilitated publication and electronic regional distribution of the MSHN FY19 Consumer Handbook: Spanish language version
   - Reviewed and revised regional policies and procedures in areas of Customer Service/Customer Handbook, Customer/Consumer Service Policy, Regional Consumer Advisory Council, Information Accessibility/Limited English Proficiency (LEP), Medicaid Beneficiary Appeals/Grievances, Advance Directives, Customer Service/Confidentiality & Privacy, and Reporting Medicaid Beneficiary Appeals, Grievances, Recipient Rights and Administrative Hearings.
   - Review, analyze and report regional customer service information including:
     - Denials
     - Grievances
     - Appeals
     - Second Opinions
     - Medicaid Fair Hearings
     - Recipient Rights
   - Regional standardization of the Grievance Submission Form and the Grievance Resolution Notice Template.
   - Review and implementation of legal citations for the Adverse Benefit Determination incorporation.
   - Worked to update and improve electronic health record system regarding Grievance and Appeals modules to meet state requirements.

b. Upcoming Goals for Fiscal Year 2020 Ending, September 30, 2020
   - Conduct ongoing annual review of required policies and procedures
   - Conduct annual review and revisions to the MSHN Consumer Handbook to reflect contract updates and regional changes
   - Continue to develop, where applicable, MSHN standardized elements of regional forms
   - Continue reporting and monitoring customer service information
   - Evaluate oversight & monitoring of regional grievances & appeals, in accordance with customer service standards
   - Increase the percentage met for the MSHN Denial, Appeal, Grievance, and Second Opinion Report
   - Continue to identify Educational Material/Brochures/Forms for standardization across the region
   - Continue to explore regional Customer Service process improvements

ANNUAL REPORT
TEAM NAME: Autism Operations Workgroup
TEAM LEADER: Carolyn Watters, MSHN Director of Provider Network Barb Groom, MSHN Autism Coordinator
Report Period Covered: 10.1.2018 – 9.30.2019

Purpose of the Regional Autism Operations Workgroup: The MSHN Operations Council has created this ad hoc, temporary, Regional Autism Operations Workgroup to make recommendations to MSHN and participating CMHSPs with regard to standardizing, across the MSHN region, clinical procedures, forms, tools and systems as well as administrative procedures, forms, tools and systems that are associated with autism services, provider network procurement (including contracting), provider network management (including provider performance monitoring and performance improvement), credentialing and privileging, and any other related systems.

This workgroup is administratively organized as a workgroup accountable to the Clinical Leadership Committee and is expected to provide a monthly written report to the chairperson of that Committee. Written reports will also be distributed to PNMC and Autism Workgroup members. The work of the Workgroup will respect that the needs of individuals served and communities vary across the region, and the goal of improved consistency of operations and standardization of operations across the region. The Workgroup is expected to make recommendations to improve the effectiveness and efficiency of autism services across the region.

Responsibilities and Duties: The responsibilities and duties of the Regional Autism Operations Workgroup shall include the following. All work is expected to be completed by August 2019 for implementation in Fiscal Year 2020:

- Develop and submit to the Operations Council a detailed work plan that addresses the responsibilities and duties that follow below. (Due by the end of the second meeting of the Workgroup)
- Identify best practices for Autism service delivery;
- Develop a single set of Autism provider performance standards, including regional quarterly non- compliance measures as well as administrative standards such as staff credentialing, contract compliance, performance improvement and any related/applicable standards as identified by the workgroup;
- Develop a single, regional Autism provider performance monitoring (site review) template (inclusive of recipient rights review standards/criteria);
- Develop a single Autism provider contract template to be used for all subcontracted Autism providers;
- Develop any necessary recommended policies, procedures, forms, templates or

other tools necessary to achieve regional consistency and standardization of operations;
- Consult with MSHN/CMHSP colleagues of different subject matter expertise to ensure work products are endorsed by other MSHN Councils and/or Committees;
- Coordinate with any MDHHS effort related to reduced administrative cost in the Autism program;
- Provide minutes/notes of its meetings to the (CLC, PNMC, and Autism Workgroup)
- As appropriate, identify current issues and recommend solutions to Operations Council to reduce administrative burden of Autism service responsibilities, resulting in advocacy efforts at the department level;
- As appropriate, review related state and federal policy/contract language and recommend regional response to Operations Council for public comment;
- Undertake such other responsibilities as may be necessary to achieve the desired outcomes and deliverables detailed in this Workgroup Charter.

<u>Accomplishments</u>
- Developed a detailed work plan that addresses the responsibilities and duties thatfollow below.
- Identify best practices for Autism service delivery;
- Developed a single set of Autism provider performance standards, as well as administrative standards such as staff credentialing, contract compliance, performance improvement, and recipient rights. Note: MDHHS eliminated quarterly non-compliance measures.
- Developed a single, regional Autism provider performance monitoring (site review)template (inclusive of recipient rights review standards/criteria);
- Developed a single Autism provider contract template to be used for all subcontracted Autism providers;
- Evaluated existing ASD Service Delivery policy for necessary edits;
- Consulted with MSHN/CMHSP colleagues of different subject matter expertise to ensure work products are endorsed by other MSHN Councils and/or Committees;
- Provided minutes/notes of its meetings to the (CLC, PNMC, and Autism Workgroup)

ANNUAL REPORT
TEAM NAME: HSW Workgroup
TEAM LEADER: Katy Hammack
REPORT PERIOD COVERED: 10.1.18 – 9.30.19

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 MSHN Waiver Coordinator and the CMHSP HSW Coordinator staff appointed by the respective CMHSP Chief Executive Officer/Executive Director. The HSW Workgroup is chaired by the Waiver Coordinator.

Annual Evaluation Process:

a. Past Year's Accomplishments
   - The HSW Workgroup continued to endorse Culture of Gentleness in homes for HCBS best practice.
   - Addressed HCBS site reviews procedures and issues.
   - Addressed changes at MDHHS for HSW, most notably the recertification process.
   - Addressed data accuracy between the WSA and REMI and use of LARA data for accuracy.
   - Began work on REMI and use of audit module for HCBS site reviews.
   - Addressed noted trends from HCBS visits and data, including person- centered planning, activity logs, and behavior plans.
   - Trends in new HSW applications and recertifications.
   - Completed Residential Living Arrangement report.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2020
   - Continue to use and institute corrective processes in overseeing HSW performance within the region.
   - Address underutilization of HSW slots in the region; create plan to improve this.
   - Continue to lead with HCBS Rule Transition activities, including PIHP and CMHSP roles and responsibilities.
   - Lead region into next phase of HCBS compliance.
   - Review and provide input to quarterly HCBS Report (to be developed)
   - Address policy and procedure changes for HSW and HCBS.
   - Continue improving the REMI HCBS review and remediation process.
   - Include HCBS Coordinators in HSW meetings as warranted for reporting and

planning.

- Review and respond to ongoing monthly HSW reports and identified performance issues and best practices.
- Provide recommendations and guidance to Clinical Leadership relating to HSW and HCBS Rule Transition.
- Use of SIS data and encounter data to enhance focus on addressing individuals' needs and to provide broad system perspective on service needs and trends.
- Continue focus on increasing the number of slots available for consumers within the region.
- Continue to oversee the HCBS rule change as set forth by MDHHS including but not limited to:
  a. Assisting providers in coming into compliance with the HCBS rule.
  b. Participating in onsite reviews of providers in the process of implementing corrective action plans.
  c. Assisting in the transition process for beneficiaries residing in settings that are unable or unwilling to come into compliance.
  d. Continue the ongoing monitoring of providers and CMHSP collaboration with regards to the HCBS rule.
- Ensure proper implementation of new i waiver once approved by the Centers for Medicare and Medicaid (CMS).
- Meet quarterly to address regional needs.

ANNUAL REPORT
TEAM NAME: Behavior Treatment Review Work Group
TEAM LEADER: Sandy Gettel, MSHN Quality Manager
REPORT PERIOD: 10.01.2018 – 9.30.2019

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 Behavioral Treatment Review Standards. The BTR Workgroup is comprised of the MSHN Quality Manager and the CMHSP Behavior Treatment Review staff appointed by the respective CMHSP Chief Executive Officer/Executive Director, and other subject matter experts as relevant. The BTR Workgroup is chaired by the MSHN Quality Manager.

Defined Goals, Monitoring, Reporting, and Accountability

- Review the revised Behavioral Treatment Standards FY17;
- Review definitions of physical interventions, restrictive and intrusive interventions for consistency of reporting;
- Develop guidelines for restrictions requiring Behavior Treatment Plan approval, as it relates to the Home and Community Based Standards;
- Review quarterly data for improvement efforts interventions and modifications as needed to ensure value.

Annual Evaluation Process:

Past Year's Accomplishments:

a) 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 trends and areas of improvement;
    - Reviewed and updated standardized definitions and interpretations for restrictive and intrusive interventions;
    - Developed the Frequently Asked Questions document to assist with interpretations;
    - Identified needs for training as it relates to assessing and incorporating restrictive and intrusive interventions in a Behavior Plan for all populations.
    - Developed draft for guidelines for medication use for behavioral control (intrusive intervention) in collaboration with the Regional Medical

Directors;

- Developing data collection system to combine the waiver data collection for behavioral treatment review with the quarterly data collection required through the QAPIP for all who have a plan with restrictive and intrusive intervention, those who have had an emergency physical intervention, and 911 call for behavioral assistance;

b) Upcoming Goals for Fiscal Year Ending, September 30, 2020

- Move topic discussions and data review to the Clinical Leadership Committee in collaboration with BTPRC Subject Matter Experts;
- Continue to finalize guidelines related to Medication for Behavioral control in collaboration with the Regional Medical Directors;
- Complete the development of the streamlined data collection process for restrictive and intrusive interventions, emergency physical interventions, and 911 calls; obtain approval and evaluate effectiveness of new process;
- Training for development of Behavior Treatment Plan and Person-Centered Plan development including restrictions.
- Develop process to ensure restrictions are reviewed through BTPRC and PCP development.
- Identify Standards or supported documentation related to BTPRC Processes and regional consensus decisions.

SECTION THREE-EVALUATION AND PRIORITIES

I. ANNUAL EFFECTIVENESS REVIEW OF QAPIP PRIORITIES-FY19

2019 QAPIP Annual Plan Review			
Strategic Planning Objective	**Goal/Measurement**	**Task/Activity**	**Status** (Met, Unmet, Partial)
	Components		
Enhance organizational quality & compliance	Provide Oversight & Monitoring of the Provider Network	Implement Compliance Monitoring activities	Met
		Implement QAPIP	Met
	Guidance on Standards, Requirements & Regulations	Council & Committee review of MDHHS Contract and External Quality Review Requirements	Met
	Governance		
Enhance organizational quality & compliance	Board sets policy related to quality management	MSHN Quality Policies	Met
	Board annually approves QAPIP & related priorities	Board approval of MSHN QAPIP	Met
	QAPIP updated annually and reviewed by the QIC	Updated QAPIP and QIC approval	Met
	Communication of Process and Outcomes		
Enhance organizational quality & compliance	QIC monitors performance measurement activity	Performance Measure (PM) Reports	Met
	Identify opportunities for process and outcome improvements	Recommendations included in PM Reports	Met
	Require corrective action plans for measures below regulatory standards and/or targets	Corrective action plan submissions & reviews	Met
	Regular reports to Councils, Committees, Board of Directors and Advisory Councils	Council & Committee Annual Reports	Met

Strategic Planning Objective	Goal/Measurement	Task/Activity	Status (Met, Unmet, Partial)
Increase the voice of MSHN's customers and key stakeholder	Consumers & Stakeholders receive reports on key performance indicators, consumer satisfaction survey results and performance improvement projects	Consumer Satisfaction Survey Results, Recovery Self-Assessment, National Core Indicator (NCI) Survey	Met
		Customer Service Reports	Met
		Behavioral Treatment Review Oversight Report	Met
		Performance Improvement Projects: Recovery Self-Assessment	Met
		Performance Improvement Projects: Diabetes Monitoring	Met
		Michigan Mission Based Performance Indicator System (MMBPIS)	Met
		HEDIS Measures: FUH-Adult and Child, Diabetes Screening	Met
		MSHN Balanced Score Card	Met
Enhance organizational quality & compliance	Board of Directors receive annual report on status of organizational performance	MSHN Scorecard, Annual QAPIP Effectiveness Review Report	Met
Increase the voice of MSHN's customers and key stakeholder	Performance and Quality reports are made available to stakeholders and general public	MSHN website includes: Quality Assessment Performance Improvement Plan, Compliance Plan, Compliance Reports, MMBPIS Summary, External Site Reviews, Internal Site Reviews, Satisfaction Survey Reports, Recovery Assessment Reports	Met

Strategic Planning Objective	Goal/Measurement	Task/Activity	Status
	Event Monitoring and Reporting		
Assume increased responsibility for healthcare outcomes	Critical Incident Reporting to MDHHS	Critical Incident Performance Reports	Met
	Trends and patterns identified	Critical Incident Reporting occurs on a quarterly basis to QIC; Trends & Patterns are identified and reviewed on a quarterly basis	Met
	Oversight of CMHSP risk analysis and reduction	On-site reviews completed at CMHSP's as part of DMC review in FY19	Met
	Behavior Treatment		
Improved behavioral health treatment/service outcomes	Quarterly Analysis of Data	BTR Performance Reports	Met
	Trends and patterns identified	BTR Performance Reports includes patterns and related improvement recommendations	Met
	Autism Waiver Monitoring		
Improved access to care	Process for identifying trends and patterns	Monthly Autism Reports	Met
	Process for oversight of CMHSP Autism benefit program requirements and corrective action related to the MDHHS site review	Ongoing monitoring of corrective action plan responses and implementation outcomes	Met
	Compliance with Autism Benefit program requirements	Monthly Autism Reports; FY19 on-site CMHSP DMC Program Specific Review	Partial
	Compliance with Autism Benefit program requirements	MDHHS Autism Review	Partial

Strategic Planning Objective	Goal/Measurement	Task/Activity	Status (Met, Unmet, Partial)
	Quantitative and Qualitative Assessment of Member Experiences		
Improved behavioral health treatment/service outcomes	Surveys analyzed	Recovery Self-Assessment	Met
		The National Core Indicator (NCI) Survey	Met
Increase the voice of MSHN's customers and key stakeholder	Surveys shared with QIC and RCAC	Recovery Self-Assessment	Met
		The National Core Indicator Survey	Met
Improved behavioral health treatment/service outcomes	Identified strengths and opportunities for improvement	Recovery Self-Assessment	Met
		The National Core Indicator (NCI) Survey	Met
	Practice Guidelines		
Improve access to care	CMHSP implementation of practice guidelines	Utilization Management Plan and Committee Report	Met
		MSHN desk review verifications of local implementation; FY19 on-site reviews completed	Met
	Credentialing, Provider Qualification and Selection		
Enhance organizational quality & compliance	Process to ensure CMHSP adherence to MSHN credentialing policy	Credentialing/Re-Credentialing policy has been developed in accordance with MDHHS contract requirements; FY19 on-site review completed;	Met
	CMHSP adherence to MSHN credentialing policy	External onsite review	Partial

Strategic Planning Objective	Goal/Measurement	Task/Activity	Status
	Medicaid Event Verification		
Public resources are used efficiently and effectively	Verifies delivery of services billed to Medicaid	The completion of the PIHP Medicaid Event Methodology Report	Met
	Results aggregated, analyzed and reported at QIC	FY19 MEV Report completed and reviewed with QIC	Met
	Opportunities identified for improvement	FY19 MEV Report reviewed by; Discussion on improvements to the process and review of trends of non-compliance	Met
	Reported annually to MDHHS	FY19 MEV Report sent to MDHHS	Met
	Utilization Management Plan		
Public resources are used efficiently and effectively	UM Committee develops standards for utilization	Utilization Management Plan and Committee Report	Met
	Utilization activity and trends are reviewed and analyzed	Utilization Management Plan and Committee Report	Met
	Identification of under-and-over utilization	Utilization Management Reports	Met
Improved behavioral health treatment outcomes	Uniform screening tools and admission criteria	Utilization Management Committee – LOCUS	Met
	Provider Monitoring		
Enhance organizational quality & compliance	CMHSP annual monitoring of provider subcontractors	Annual Delegated Managed Care (DMC) Site Review, MEV reviews, and Financial auditing completed for FY19.	Met
	MSHN monitoring of CMHSPs and SUD Provider Network compliance		Met
	Oversight of "Vulnerable People"		
Assume increased responsibility for healthcare outcomes	CMHSPs monitor health, safety and welfare of individuals served	Annual DMC site reviews-clinical record reviews	Met
	Related concerns are acknowledged, and action taken as appropriate	Annual DCM site reviews- plans of correction	Met

Annual Strategic Plan Priorities Review

Better Health			
Improve Population and Integrated Health Activities			
Strategic Objective	**Goal/Measurement**	**Task/Activity**	**Status/ Recommendation**
MSHN will expand the use and adoption of the Regional Electronic Medical Information (REMI) System and other applicable software platforms in use across the region to support improved population health outcomes, coordinated and integrated care activities, effectiveness and efficiency.	1. MSHN will improve and standardize processes for exchange of data between MSHN and MHPs; CMHSPs and MSHN. MSHN and SAPT Providers and will facilitate CMHSP-to-CMHSP data exchange in order to reduce duplication when gathering needed information for reporting.	MMBPIS Affiliate Upload and aggregation in REMI; Critical Incident reporting system developed in REMI	Complete and Ongoing
MSHN will work with CMHSPs to MONITOR key indicators, supported by MSHN data analysis tools and analytics, such that these metrics inform both regional and county contractual performance targets, and are value added for decision making at councils, committees and board governance levels at MSHN and at all CMHSPs.	1. MSHN will continue to monitor and increase performance related to selected priority measures, key performance indicators and MDHHS's required metrics.	See performance measurement data	Complete and Ongoing

Better Care			
Improve Access to Care			
Strategic Objective	**Goal/Measurement**	**Task/Activity**	**Status**
MSHN and participating CMHSPs establish processes to assist individuals served in maintaining eligibility for Medicaid and/or Healthy Michigan Program coverage.	1. MSHN will monitor CMHSP and SAPT provider consumer verification practices through its site review process and Medicaid event verification audit.	Medicaid Event Verification Site Review Process	Complete-Ongoing
	1. Fully implement the region's access and authorization practice guidelines to achieve a common benefit.	Admissions and Benefits workgroup developed access and authorization guidelines	In Progress - Continue
	2. Standardize practices for documentation of medical necessity to assure people are receiving an appropriate scope, duration and intensity of care.	Development within the appropriate committee in collaboration with the CMHSPs.	In Progress- Continue
	3. MSHN will ensure there are uniform access and utilization management criteria in place and will monitor admissions and denials for conformity with the established criteria.	Development within the appropriate committee in collaboration with the CMHSPs.	In Progress- Continue
Improve the Role of MSHN Consumers and Key Stakeholders			
Stakeholder feedback demonstrates effective, efficient and collaborative operations.	1. Deploy a survey tool to measure participating provider satisfaction and achieve 80% satisfaction with the effectiveness and efficiency of MSHN's processes and communications.	Work Force Survey	Complete - Ongoing
MSHN will improve and integrate stakeholder and consumer input and utilize compiled input to improve system performance, and provide feedback to stakeholders on systems improvements made.	1. Improve communications linkages between provider input forums, executive leadership and governance.	In development	In Progress- Continue
	2. Evaluate feasibility of survey consolidation and streamlining.	In development	In Progress- Continue

Enhance Regional Quality and Compliance			
Strategic Objective	**Goal/Measurement**	**Task/Activity**	**Status**
MSHN will provide leadership on improving the consistency and implementation of person-centered planning, self-determination and independent facilitation in the region.	1. MSHN will strengthen MSHN QAPI reviews of person-centered planning, independent facilitation and self-determination implementation in its provider network oversight activities.	Improvements to the DMC Site Review Process	In Progress-Continue
	2. MSHN will use data gathered in its provider network oversight activities to develop specific training and/or learning communities to strengthen person-centered planning, independent facilitation and self-determination implementation.	Improvements to the DMC Site Review Process	In Progress-Continue
Better Value			
Regional Public Policy Leadership Supports Improved Health Outcomes and System Stability			
Strategic Objective	**Goal/Measurement**	**Task/Activity**	**Status**
MSHN will ensure consistent, standardized, and cost-effective operations and will position the region for continued success regardless of payer structure.	1. MSHN ensures full implementation of agreed upon regionally standardized processes at all CMHSPs and the PIHP.	BTPRC, MMBPIS, RSA, Critical Incidents	Complete-Ongoing
	2. MSHN evaluates penetration rate, cost and other metrics and addresses undesirable variation through its councils and committees in order to promote standardized, consistent and cost-effective operations across the region.	See performance measurement data	Complete-Ongoing
MSHN's Provider Network Management Systems are effective and efficient.	1. MSHN publishes provider performance data to consumers and the public.	Available on Website	Complete-Ongoing
	2. Evaluate the effectiveness of regionally organized fiscal intermediary and inpatient provider performance monitoring systems developed in prior years.	Survey indicated a positive response to the regional FI and Inpatient Provider monitoring.	Complete - Discontinue

Better Provider System			
MSHN ensures that it engages a provider network with adequate capacity and competency			
Strategic Objective	**Goal/Measurement**	**Task/Activity**	**Status**
MSHN enhances existing quality assessment and performance improvement systems that promote continuous improvement and enhanced accountability for clinical and fiscal performance.	1. MSHN will develop and begin reporting on the provider scorecard.	Recommendations being provided for performance measures.	In Progress-Continue
	2. MSHN will strengthen regional performance improvement systems in the SAPT provider network.	QAPI report includes recommendations for improvements	In Progress-Continue
	3. MSHN will provide training and education related to data integrity, reporting standards, use of data in decision making and provider development.	MMBPIS, HEDIS Measures, RSA, Critical Incidents Sentinel Events	In Progress-Continue
	4. MSHN will integrate fiscal information and performance results into its quality assessment and performance improvement systems.	Identify cost savings with improvement efforts and fiscal monitoring through the DMC process.	In Progress-Continue
MSHN engages in activities to simplify administrative complexity and enhance provider satisfaction.	1. Fully implement the REMI provider network monitoring (audit) module including provider response feature to streamline processes and promote efficiencies (including SUD and CMHSP delegated managed care audits).	Fully implemented	Complete-Discontinue
	2. MSHN will develop internal functional area annual plans (inclusive of provider responsibilities related to strategic projects/initiatives, and operational requirements such as audits, annual plans, reporting requirements, etc.) To identify overlap/redundancy and opportunities for cross functional collaboration to streamline processes.	In development	In Progress-Continue

Annual Performance Measurement Review

Performance Measurement	Indicator	Status
Performance Indicators	Michigan Mission Based Performance Indicator System (MMBPIS) Reports	Unmet
Performance Improvement Projects	PIP – Recovery Self-Assessment Report;	Met
	PIP - HEDIS Diabetes Monitoring Report	Met
Priority Measures	FUH Report, Follow-Up After Hospitalization Mental Illness Adult	Met
	Follow-Up After Hospitalization Mental Illness Children	Met
	Diabetes Monitoring Report	Met
	Diabetes Screening Report	Met
	Cardiovascular Screening	Unmet
	FU Children ADHD Med Initiation Phase	Met
	FU Children ADHD Med Continuation & Monitoring (C&M) Phase	Met
	Plan All-Cause Readmissions	Met
	Adult Access to Care	Met
	Children Access to Care	Met
	Initiation of Alcohol and Other Drug (AOD) Treatment	Met
	Engagement of Alcohol and Other Drug (AOD) Treatment	Met
Performance Measurement	**Indicator**	**Status**
Event Monitoring and Reporting	The rate of arrests, per 1000 persons, served will demonstrate a decrease from previous reporting period.	Met
	The rate, per 1000 persons served, of persons who received emergency medical treatment for an injury or medication error will demonstrate a decrease from previous reporting period.	Unmet
	The rate, per 1000 persons served, of individuals who were Hospitalized for an injury or medication error will demonstrate a decrease from previous reporting period.	Met
	The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous reporting period	Met
	The rate, per 1000 persons served, of Suicide Deaths will demonstrate a decrease from previous reporting period.	Unmet

Performance Measurement	Indicator	Status
Behavior Treatment	The percent of individuals who have an approved Behavior Treatment Plan which includes restrictive and intrusive techniques will decrease.	Unmet
	The percent of emergency physical interventions per person served during the reporting period will decrease.	Met
	The percent of incidents per consumer served requiring phone calls made by staff to police for behavioral assistance during the reporting period will decrease.	Unmet
Performance Measurement	**Indicator**	**Status**
Quantitative and Qualitative Assessment of Member Experiences	I am involved in my community and organization (RSA-Involvement)	Met
	Services I receive are tailored to my wants and needs (RSA-Individually Tailored Services)	Met
	I am given opportunities to discuss or be connected to my diverse treatment needs (RSA Diversity of Treatment)	Met
	I am given choices about my treatment and care that I receive (RSA-Choice)	Met
	Staff support and encourage me in various ways to fulfill my life goals (RSA-Life Goals)	Met
Performance Measurement	**Indicator**	**Status**
Medicaid Event Verification	Medicaid Event Verification review demonstrates improvement of previous year results with the documentation of the service date and time matching the claim date and time of the service.	Met
	Medicaid Event Verification review demonstrates improvement of previous year results with the service being included in the persons individualized plan of service for SUD providers.	Met

Attachment 1

Pre-Paid Inpatient Health Plan

Medicaid Services Verification Methodology Report

Fiscal Year 2019

(October 1, 2018 – September 30, 2019)

Methodology Report Outline

Introduction & Background

Process/Methodology Summary

Summary of Results

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

Deficiencies/Plans of Correction

A. Fiscal Year 2019 Deficiencies
B. Repeated Deficiencies

Process/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, Clinton-Eaton-Ingham Community Mental Health Services Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network, Huron Behavioral Health, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health, Saginaw County Community Mental Health Authority, Shiawassee Health and Wellness, The Right Door, and Tuscola Behavioral Health Systems. Also, within the PIHP region are 51 substance use disorder (SUD) treatment providers that include 15 treatment providers that have multiple service locations and 38 agencies that provide prevention services.

MSHN conducts oversight of the Medicaid claims/encounters submitted within the region by completing either an onsite review or a desk review of the provider networks policy and procedures and the claims/encounters submitted for services provided for all 12 of the CMHSPs and for all substance use disorder treatment providers who provide services using Medicaid funding. Of the 51 SUD treatment providers, only the 35 providers that were in region providers, that provided Medicaid eligible services and used Medicaid funding were included in the review. The 35 providers included 64 unique service provider locations. SUD disorder treatment providers that were in another PIHP region and had a MEV review completed in that region were not included in the MEV summary.

Process Summary/Sampling Methodology

Medicaid claims verifications are conducted bi-annually (twice a year) for CMHSPs and annually (once a year) for substance use providers, utilizing a random sample. For the bi-annual CMHSP reviews, one (1) is completed as an onsite review and one (1) is completed as a desk review. During FY19 Huron Behavioral Health only had one (1) review completed as a desk review due to the onsite review being rescheduled. Based on this Huron Behavioral Health will have three (3) reviews in FY2020. Sample selection for the CMHSP includes both the direct services provided by the CMHSP and the services provided by the contract providers of the CMHSP. Substance use providers with multiple locations with distinct site licenses had a sample reviewed for each location.

The random sample is selected using a non-duplicated sample of 5% of beneficiaries served in the previous 2 quarters. The sample selection is set with parameters not to exceed a maximum of 50 and a minimum of 20 beneficiaries. The number of claims/encounters for each beneficiary selected in the sample has a maximum of 50 claims/encounters per beneficiary.

[1] Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 19 – Attachment P.6.4.1

The sample selection for CMHSPs includes at least one beneficiary from each of the following programs; Assertive Community Treatment (ACT), Autism, Crisis Residential, Home Based Services, Habilitation Supports Waiver (HSW), Self Determination, Targeted Case Management (TCM)/Supports Coordination Services, and Wraparound. Substance Use Provider samples includes at least one beneficiary from each of the following service types as applicable to the provider; Detox, Residential, Out-Patient Services, Peer Services, and Medication Assisted Treatment.

MSHN implemented a managed care information system during the second quarter of FY2018. After the implementation of the new system the sampling methodology was changed to allow samples to be pulled more efficiently from one location. The updated process started with the CMHSP data. The next stage in the sampling process will begin to move the SUD samples into the new process. There was planning and work implementation to begin moving the SUD samples into the same process in FY2019. However, the process was not completed in FY2019 but is expected to be completed in FY2020

Samples for SUD providers were pulled using Microsoft Sequel Server and Excel. Microsoft Server Sequel will use program scripts to pull the beneficiaries served during the previous two quarters from the MSHN Data Warehouse. Every beneficiary will then be assigned a random number within Excel. An additional column will then be created within Excel and the formula "=rand()" will then be used to select the random 6% of beneficiaries. Only the top 5 % of beneficiaries will be used to complete the sample for the review if all the required program types are met. If the sample does not include one beneficiary from each required program type the last beneficiary will be removed from the 5% sample and the next beneficiary on the sample list that meets the criteria will be used. If all the program types are not met with the 6% sample pulled, then the process will be run again to select additional beneficiaries. This will be done until all the required program types are selected.

The samples for the CMHSP reviews are managed in Microsoft SQL Server. A record set is extracted using query logic in Microsoft SQL Server. These scripts pull any beneficiary records where those beneficiaries had service encounters at any time during the prior six-month period. This extract is used to randomly generate 5% of the total beneficiaries in the record set. The 5% beneficiaries are determined by using script logic that has an algorithm to make sure the required program types can be met. This algorithm will run through the dataset randomly until a 5% sample is attained. If all the program types cannot be met using this algorithm, then the script runs using records for that program type until all have a selected 5% sample.

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).

Data Analysis/Summary of Results

Summary of Analysis

Records and claims were reviewed over the course of the full fiscal year, October 1, 2018 – September 30, 2019. Data presented in the below chart is relative to the 12 CMHSP's and 35

substance use disorder treatment providers which includes 64 service locations reviewed during this period.

The attributes tested during the Medicaid Event Verification review include: A.) The code is allowable service code under the contract, B.) Beneficiary is eligible on the date of service, C.) Service is included in the beneficiary's individual plan of service, D.) Documentation of the service date and time matches the claim date and time of the service, E.) Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed, F.) Amount billed and paid does not exceed contractually agreed upon amount, and G.) Modifiers are used in accordance with the HCPCS guidelines.

A 90% compliance standard is the expectation per the state technical requirement for Event Verification.

CMHSP

	A	B	C	D	E	F	G
BABHA	100%	100%	100%	99.70%	98.74%	100%	97.72%
CEI	100%	100%	97.24%	94.47%	96.03%	100%	98.67%
CMHCM	100%	100%	100%	96.20%	94.74%	100%	100%
Gratiot	100%	100%	100%	99.74%	100%	100%	99.15%
Huron*	100%	100%	90.93%	100%	92.20%	100%	99.64%
Lifeways	100%	100%	99.70%	98.85%	99.02%	100%	100%
Montcalm	100%	100%	100%	99.36%	98.30%	99.68%	85.37%
Newaygo	100%	100%	98.80%	99.53%	98.37%	100%	99.65%
Saginaw	100%	100%	100%	99.37%	97.34%	100%	100%
Shiawassee	100%	100%	100%	98.17%	98.29%	100%	96.34%
The Right Door	100%	100%	100%	99.90%	97.59%	100%	96.61%
Tuscola	100%	100%	100%	99.77%	99.58%	100%	99.70%
MSHN Average	**100%**	**100%**	**99.89%**	**98.76%**	**97.52%**	**99.97%**	**97.74%**

Note: A) The code is allowable service under the contract, B) Beneficiary is eligible on the date of service, C) Service is included in the persons individualized plan of service, D) Documentation of the service date and time matches the claim date and time of the service, E.) Documentation of the service provided falls within the scope of the service code billed, F.) Amount billed and paid does not exceed contractually agreed upon amount, and G.) Modifiers are used in accordance with the HCPCS guidelines.

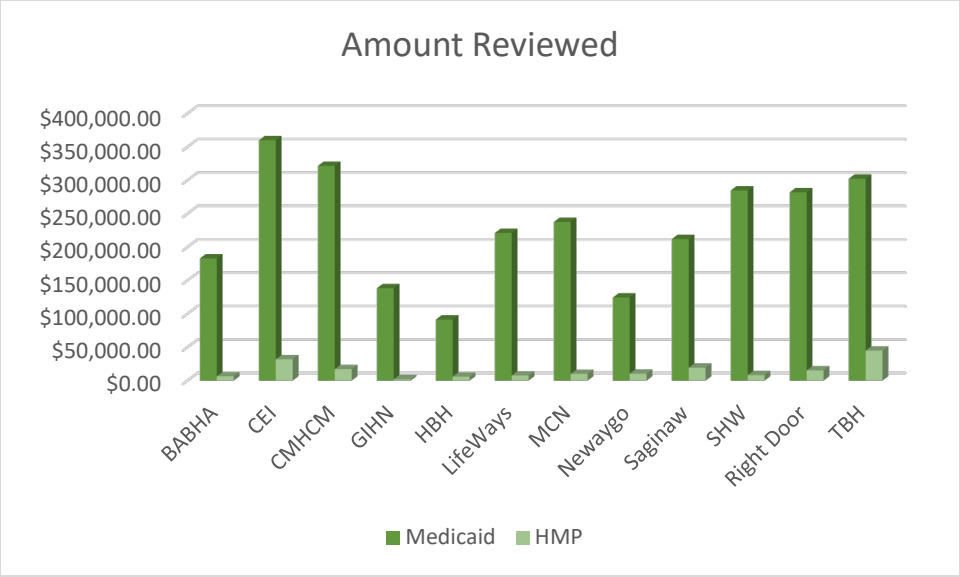
*It is noted that Huron Behavioral Health only had one MEV review during FY19 due to a review being rescheduled. Based on this Huron Behavioral Health will have three MEV reviews in FY20

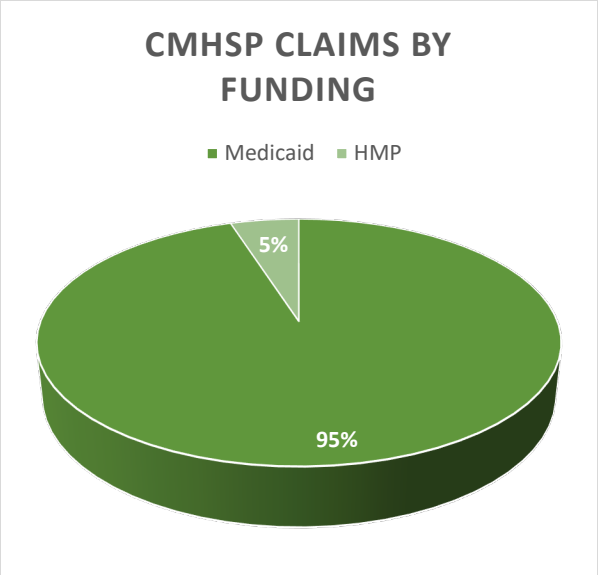
SUD

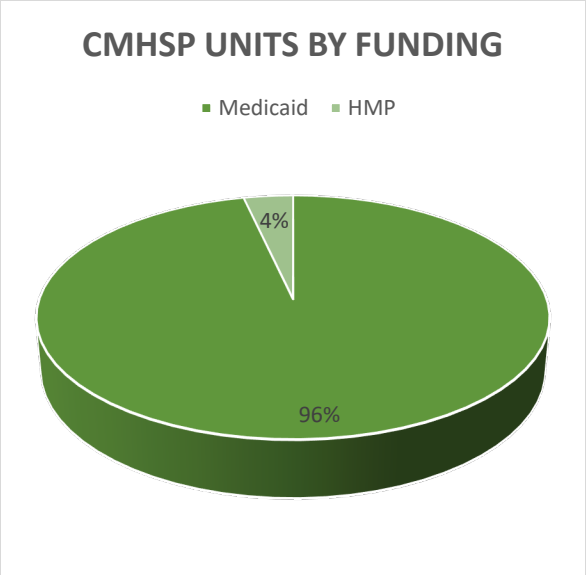
	A	B	C	D	E	F	G
SUD Providers	100%	99.39%	91.66%	97.26%	97.22%	100%	95.77%

Summary of CMHSP Claims Reviewed by Funding Source:

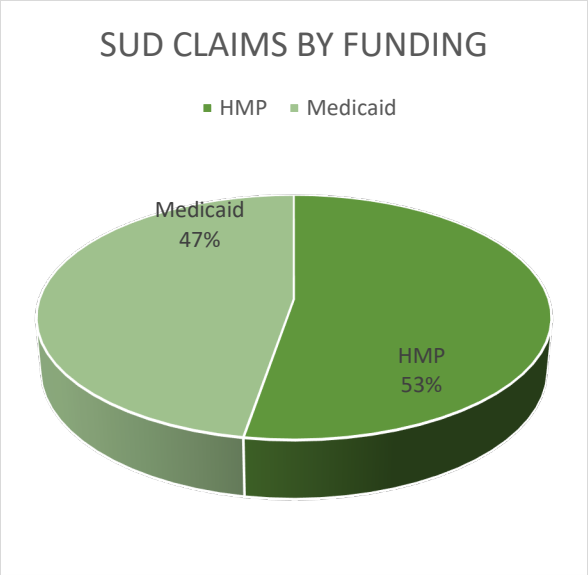
In total 15,307 claims were reviewed. Of the 15,307 claims reviewed 14,546 of the claims were billed as Medicaid and 761 of the claims were billed using Healthy Michigan Plan Funding. The 15,307 claims included 119,925 units of service. Of the 119,925 units reviewed 115,668 were billed as Medicaid and 4,297 were billed as Healthy Michigan Plan. The dollar amount of the claims reviewed totaled $3,075,085.64. Of the $3,075,085.64 reviewed $2,853,219.33 were billed using Medicaid funding and $181,866.25 were billed using Healthy Michigan funding.

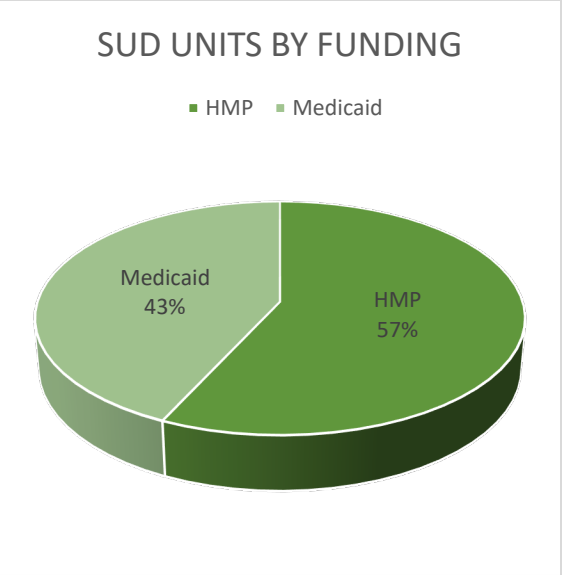






Summary of SUD Claims Reviewed by Funding Source:
In total 13,321 claims were reviewed. Of the 13,321 claims reviewed 6,284 of the claims were billed as Medicaid and 7,002 of the claims were billed using Healthy Michigan Plan Funding. The 13,321 claims included 20,633 units of service. Of the 20,633 units reviewed 8,887 were billed as Medicaid and 11,746 were billed as Healthy Michigan Plan. The dollar amount of the claims reviewed totaled $917,187.12. Of the $917,187.12 reviewed $416,076.58 were billed using Medicaid funding and $501,110.54 were billed using Healthy Michigan funding.





The services reviewed for the CMHSPs were from ACT, autism, crisis residential, homebased, HAB waiver, self-determination, targeted case management and supports coordination, and wraparound. As some people were enrolled in more than one program and services were counted in more than one program, the overall total of claims/encounters do not match the claims/encounters total from the total by funding source. The program total is based on program enrollment and not by independent service provided such as assessments, outpatient, treatment plan reviews, and medication reviews.

CMHSP Services Reviewed by Program			
Program	**Claims**	**Units**	**Amount**
ACT	422	868	$78,324.54
Autism	1,977	8,362	$244,426.81
Crisis Residential	112	164	$75,875.37
Habilitation Supports Waiver	2,777	30,884	$675,743.58
Home Based Services	1,161	4,991	$400,153.14
Self Determination	1,843	27,697	$179,352.92
Targeted Case Management and Supports Coordination	8,081	59,324	$1,615,602.31
Wraparound	252	1,250	$85,012.01

The services reviewed for the SUD provider were from detox and residential, outpatient, peer delivered services, and medication assisted treatment. As some people were enrolled in more than one program and services were counted in more than one program the overall total of claims/encounters do not match the claims/encounters total from the total by funding source. The program total is based on program enrollment and not by independent service provided such as assessments, psychotherapy, treatment plan reviews, and medication reviews.

SUD Services Reviewed by Program			
Program	**Claims**	**Units**	**Amount**
Detox/Residential	1,610	2,643	$412,054.00
Medication Assisted Treatment	6,046	6,329	$102,641.54
Outpatient	4,392	8,169	$360,348.23
Peer Services	1,784	5,039	$61,899.06

Deficiencies/Corrective Action

Fiscal Year 2019 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 as necessary

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.

MSHN reviews and monitors the corrective action plans during the following review cycle to ensure implementation of the plan indicated. For substance use disorder providers, the claims/encounters are voided immediately by MSHN for any claims/encounters determined to be invalid. The CMHSPs complete their own corrections and voids for claims/encounters found to be invalid and MSHN reviews to ensure this has been completed correctly. If deemed necessary by MSHN, additional follow up and sampling of selected elements is completed to ensure system and process change.

Based on the MEV review for FY2019, 12 CMHSPs were placed on a new plan of correction and 46 substance use disorder treatment provider locations were placed on a new plan of correction. It is noted that the amount of SUD providers placed on a CAP is higher than the number of providers reviewed due to 15 SUD providers having a secondary review in FY2019. 12 CMHSPs were removed from a previous plan of correction and 47 substance use disorder treatment provider locations were removed from a previous plan of correction. There were four (4) substance use provider locations that had a repeat issue identified in the corrective action plan.

The overall findings included a total dollar amount of invalid claims identified for CMHSP's direct and indirect services of $126,608.56 and $112,499.87 for substance use disorder treatment providers. All invalid claims were corrected based on MSHN's established process.

NOTE: Many of the invalid claims related to documentation was due to a lack of understanding what documentation was needed to support the claims. In these instances, additional documentation was sent with the plan of correction to justify the claims originally found to be invalid. These units and dollars are included in the summary of disallowed amounts as they were original findings that documentation did not support during the review.

If suspicion of fraud or abuse was apparent, the CMHSPs were 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 Office of Inspector General (OIG) is required. This process occurs throughout the year as the reports are received. Beginning with the FY2019 review cycle all MEV reviews were reported quarterly to the OIG.

Repeated Deficiencies

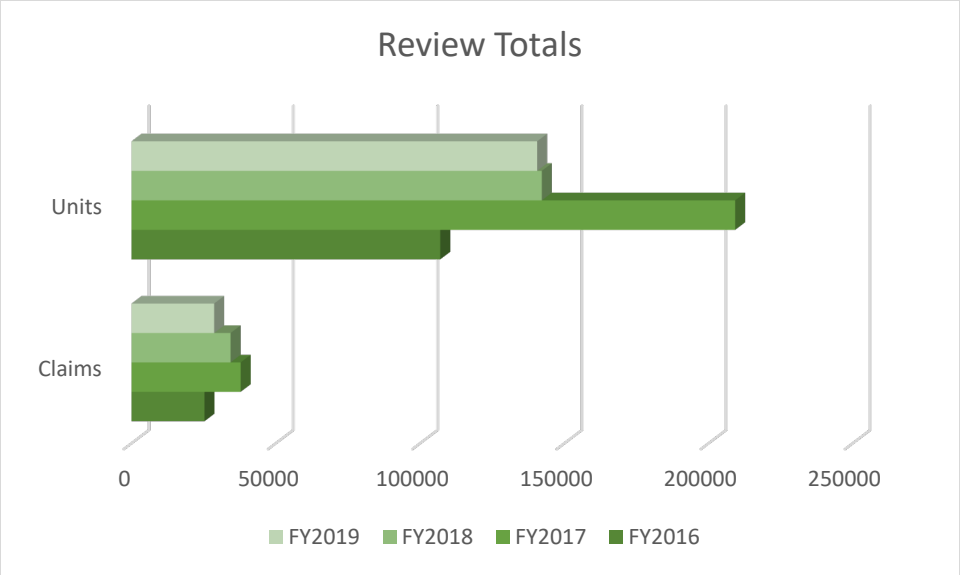
Though the MSHN combined average for CMHSPs and SUD providers did not fall below the departments 90% accuracy rate for any area reviewed, there were providers that had elements tested that fell below the 90% accuracy standard.

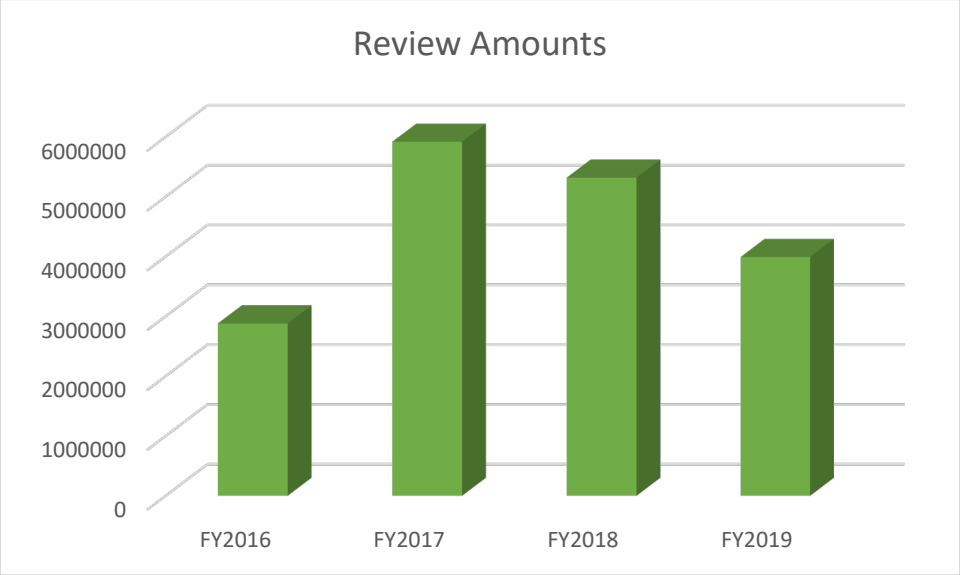
A review of the elements tested from the MEV reviews completed at each CMHSP and SUD provider during FY2018 and FY2019 indicated there were not any repeated deficiencies at the CMHSPs. There were four (4) SUD providers that had repeat deficiencies from FY2018 to FY2019. The deficiencies for the SUD providers included that the service is included in the beneficiary's individual plan of service and modifiers are used in accordance with the HCPCS guidelines.

Process/Performance Improvement

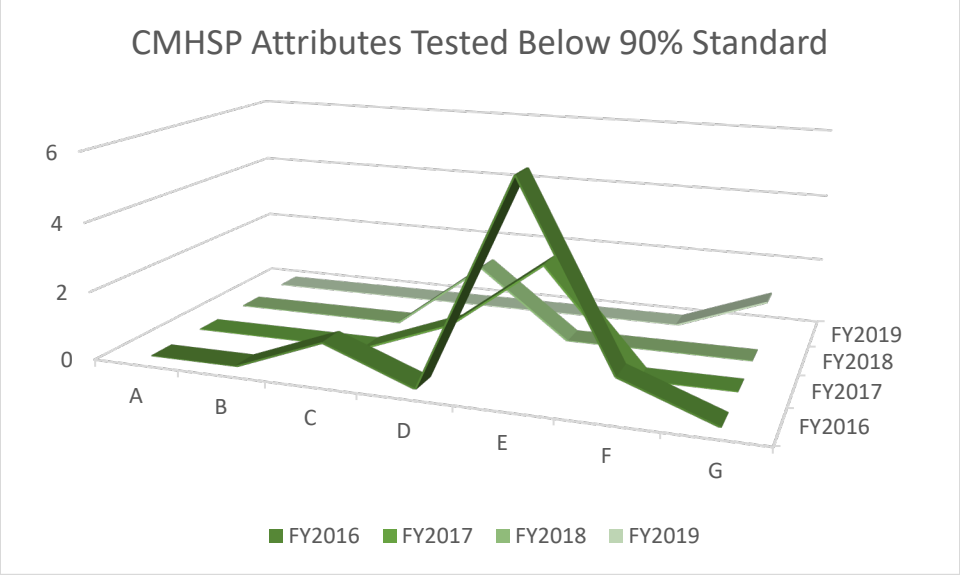
Process Improvements:
Process improvements implemented from previous MEV Reviews are the sampling efficiencies related to completing one review for SUD providers that have more than one service location instead of completing a unique full review for each location. Though one review was complete for SUD providers with multiple locations it was ensured that each location was included in the sample. This efficiency reduced the number of days spent onsite for providers with multiple service locations while still ensuring the sampling methodology was followed and all standards were reviewed.

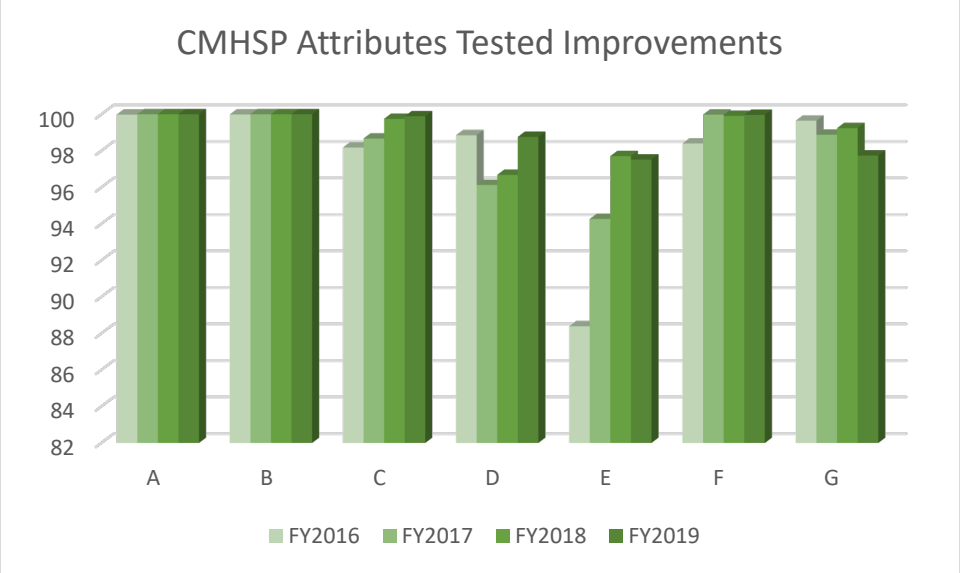
The claims, units, and amount reviewed for FY2019 is less than the claims, units, and amount reviewed for FY2018. The reduction is likely due to the efficiency of completing one review for SUD providers with multiple locations instead of one review for each location. Additionally, one (1) CMHSP review was rescheduled into FY2020.





Performance Improvements:
Additionally, during FY2016 there were 7 CMHSP's with at least one element tested that fell beneath the 90% accuracy standard. During FY2017 this was reduced to 4 CMHSPs with at least one element below the 90% accuracy standard. This was further reduced to 2 CMHSP's with at least one element falling below the 90%accuracy standard during FY2018. This reduction continued into FY2019 with one (1) CMHSP having an attribute fall below the 90% accuracy standard.





While there was one CMHSP that had an attribute fall below the 90% accuracy this was due to a change in the reporting guidelines for a specific modifier. The CMHSP made the appropriate changes to correct and resubmit the encounters and made a system change in the EMR to prevent the issue from occurring again. Regionally there was improvement shown from FY2018 to FY2019 for elements C, D, and F. This was a result of improvements put into place by many of the providers, that included the creation of new documentation standards/forms following the previous review process.

There was improvement shown from FY2018 to FY2019 for elements B, C, D, E and F for the SUD providers reviewed. It is noted that the average for SUD providers fell below the 90% accuracy standard for "service is included in the beneficiaries individual plan of service" in FY 2018. Based on this MSHN offered treatment planning training regionally and offered individualized technical assistance regarding treatment planning to providers that feel below the 90% accuracy standard and the average for this attribute was above the 90% accuracy in FY2019. All providers who fall below the required 90% accuracy standard are required to have a secondary MEV review completed. Additionally, any provider who falls below 90% accuracy standard is offered technical assistance from MSHN to help providers meet the standard and learn best practices.

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

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

- MSHN Compliance Committee
- MSHN Quality Improvement Council

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

Future Outlook

MSHN is beginning its fifth year of reviews and will focus on plans of corrections from previous reviews to ensure indicated quality improvements are taking place. MSHN will work with the CMHSPs and the SUD provider network to collaboratively develop consistent documentation that adheres to best practice standards across the region. MSHN will share best practice documentation and processes identified during reviews with CMHSP and SUD partners throughout the region as indicated. MSHN will evaluate the internal MEV policy and procedure on an ongoing basis to ensure compliance with Federal and State standards as well as to ensure consistency and best practices are followed. MSHN will work with the other PIHP's to standardize the MEV review process as appropriate. MSHN will complete a quarterly review of outstanding issues related to the MEV review and identify any trends found during the reviews in FY2020. MSHN will continue to submit quarterly reports of all MEV Reviews to the OIG for review. MSHN will share any trends from the FY2020 MEV Reviews in a quarterly report for the region through the Quality Improvement Council.

Attachment 2

Overview of Mid-State Health Network Recovery Self-Assessment Summary Report FY 2019

Persons in Recovery

Introduction

The following overview of Mid-State Health Network's (MSHN) Recovery Self-Assessment (RSA) Survey was developed to assist MSHN Provider Network 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 completed by adults receiving treatment for a substance use disorder. The respondents are outlined in Figure 1. The survey results were aggregated and scored as outlined in the Yale Program for Recovery and Community Health instructions.

Figure 1.

Agency	Respondents
RSA-R Persons in Recovery (Distinct)	777
Clubhouse	5
Case management/Supports Coordination	108
Intensive Outpatient	145
Outpatient	330
Substance Use Residential	182
Other	121

The distribution period was May 1, 2019 through May 31, 2019.

The information from this report is intended to support discussions on improving recovery-oriented practices by understanding how the various provider 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 Sandy Gettel, Quality Manager at sandy.gettel@midstatehealthnetwork.org

MSHN Summary

The responses from the Recovery Self-Assessment surveys were scored as a comprehensive total and separately as six subcategories. The tool is intended to assess the perceptions of individual recovery and the recovery environment. All items are rated using the same 5-point Likert scale that ranges from 1 = “strongly disagree” to 5 = “strongly agree.” The comprehensive score measures how the system is performing, and the subcategories measures the performance of five separate parts. The individual response score for each question in the subcategories is included to assist in determining potential action steps. A score of 3.5 and above indicates satisfaction or agreement with the statement. The “not applicable” and “do not know” responses were removed from the analysis.

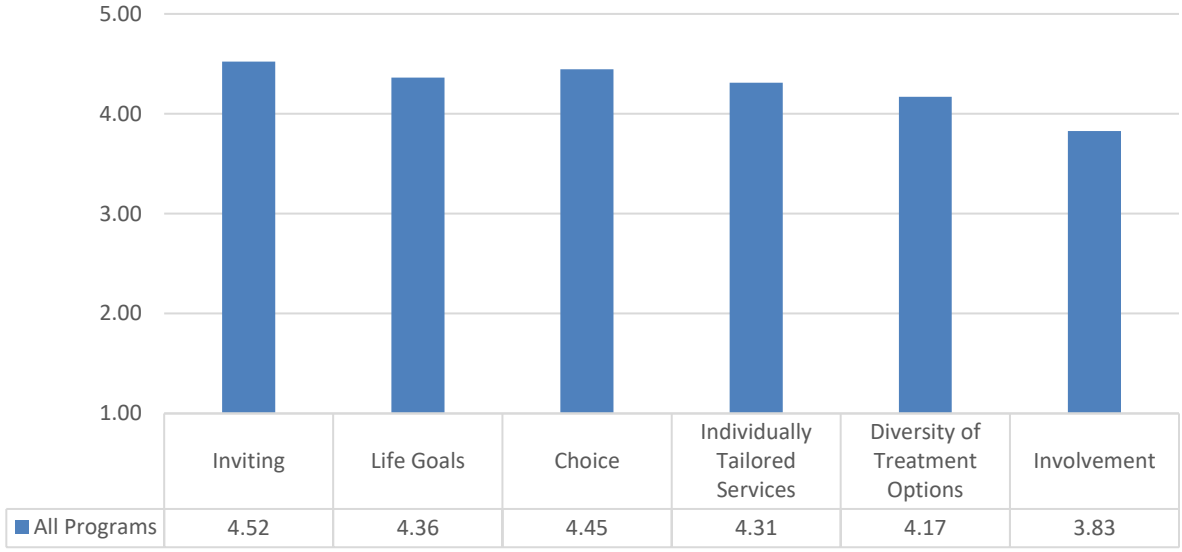
MSHN Comprehensive Summary

MSHN demonstrated a comprehensive score of 4.28 for the initial administration of the RSA-R for Persons in Recovery.

MSHN Subcategory Summary

Figure 2 illustrates how the Persons in Recovery assessed their perception of recovery during their treatment for each of the six (6) subcategories.

Figure 2 – MSHN Persons in Recovery Score by Subcategory

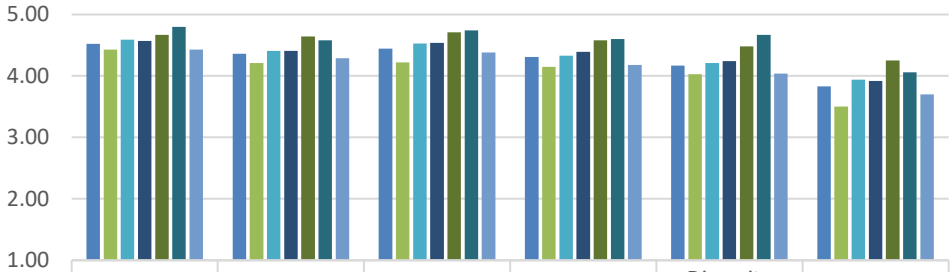


	Inviting	Life Goals	Choice	Individually Tailored Services	Diversity of Treatment Options	Involvement
All Programs	4.52	4.36	4.45	4.31	4.17	3.83

MSHN Program Summary

The responses from the Recovery Self-Assessment scores were separated by service type for each of the subcategory scores. Figure 3 illustrates the average score was 3.5 or above in each subcategory, which indicates agreement or satisfaction with each statement. The subcategory of Inviting was the highest with a range of 4.43 to 4.80. The subcategory demonstrating the lowest average was Involvement, with a range of 3.70 to 4.25.

Figure 3 – Comparison of the Subcategory Score for FY19 for each Program



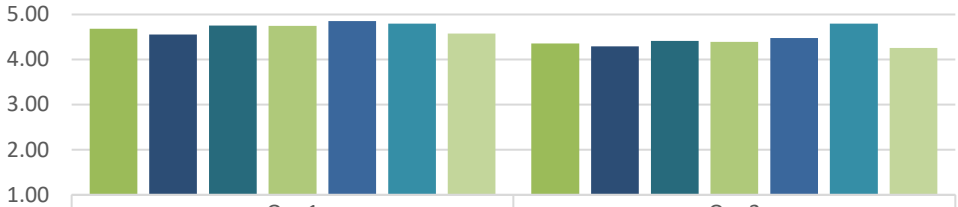
	Inviting	Life Goals	Choice	Individually Tailored Services	Diversity of Treatment Options	Involvement
All Programs	4.52	4.36	4.45	4.31	4.17	3.83
P in R-SUD Residential Mean	4.43	4.21	4.22	4.15	4.03	3.50
P in R-Intensive OPT Mean	4.59	4.41	4.53	4.33	4.21	3.94
P in R-OPT Mean	4.57	4.41	4.54	4.39	4.24	3.92
P in R-CSM/SC Mean	4.67	4.64	4.71	4.58	4.48	4.25
P in R-Clubhouse Mean	4.8	4.58	4.74	4.60	4.67	4.06
P in R-Other Mean	4.43	4.29	4.38	4.18	4.04	3.70

Invite Subcategory

The MSHN average was 4.52 for the Inviting Subcategory. Figure 4 illustrates the differences between the programs for each question for those who completed the assessment. The average score was 3.5 or above for each question which indicates agreement or satisfaction with each statement. The Invite Subcategory includes the following questions:

1. Staff welcome me and help me feel comfortable in this program.
2. The physical space of this program (e.g., the lobby, waiting rooms, etc.) feels inviting and dignified.

Figure 4 – Comparison of FY19 Individual Questions Invite Subcategory



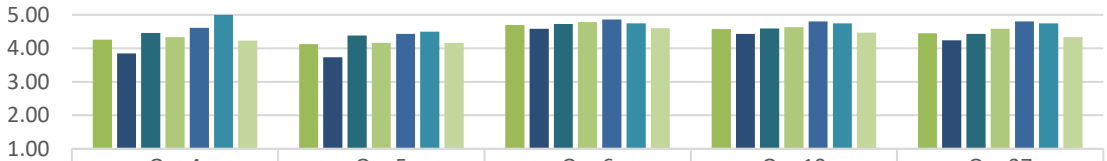
	Qu. 1	Qu. 2
Persons in Recovery All	4.68	4.36
P in R-SUD Residential Mean	4.56	4.29
P in R-Intensive OPT Mean	4.76	4.41
P in R-OPT Mean	4.75	4.40
P in R-CSM/SC Mean	4.85	4.48
P in R-Clubhouse Mean	4.80	4.80
P in R-Other Mean	4.58	4.26

Choice Subcategory

The MSHN average was 4.45 for the Choice Subcategory. Figure 5 illustrates the differences between the programs for each question for those who completed the assessment. The average score was 3.5 or above in each subcategory, which indicates agreement or satisfaction with each statement. The Choice Subcategory includes the following questions:

4: I can change my clinician or case manager if I want to.
5: I can easily access my treatment records if I want to.
6: Staff do not use threats, bribes, or other forms of pressure to get me to do what they want.
10: Staff listen to me and respect my decisions about my treatment and care.
27: Staff help me keep track of the progress I am making towards my personal goals.

Figure 5 – Choice Subcategory Comparison of FY19 Individual Questions



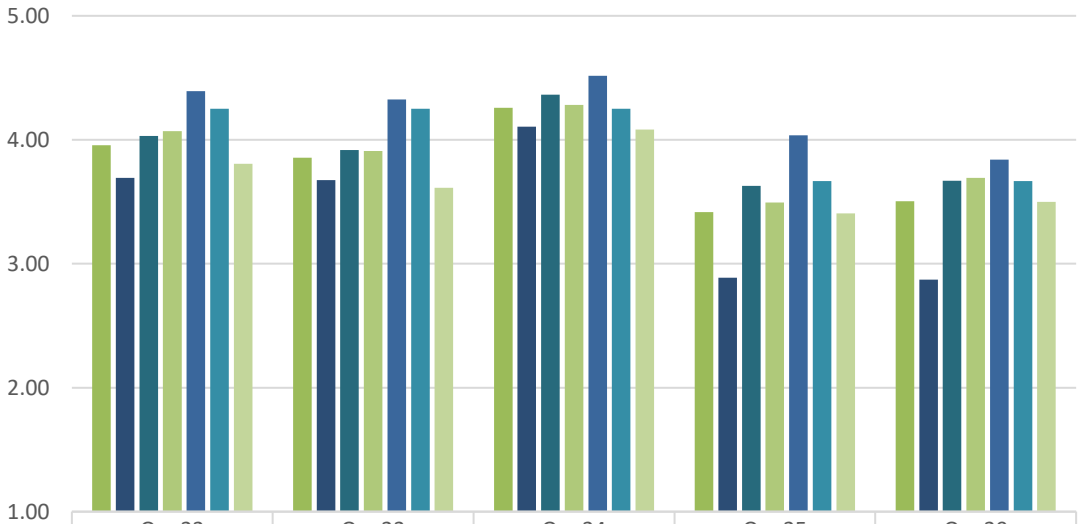
	Qu. 4	Qu. 5	Qu. 6	Qu. 10	Qu. 27
All Mean	4.26	4.13	4.70	4.57	4.45
SUD Residential Mean	3.84	3.73	4.58	4.43	4.24
Intensive OPT Mean	4.46	4.38	4.73	4.59	4.43
OPT Mean	4.34	4.16	4.79	4.63	4.58
CSM/SC Mean	4.61	4.43	4.86	4.81	4.80
Clubhouse Mean	5.00	4.50	4.75	4.75	4.75
Other Mean	4.23	4.16	4.60	4.46	4.33

Involvement Subcategory

The MSHN average was 4.36 for the Involvement Subcategory. Figure 6 illustrates the differences between the programs for each question for those who completed the assessment. The average score was 3.5 or above for questions 22, 23, and 24. Questions 25 and 29 demonstrated a score below 3.5 indicating a neutral response or disagreement with the statement for all programs. The Involvement Subcategory includes the following questions:

22. Staff help me to find ways to give back to my community, (i.e., volunteering, community services, neighborhood watch/cleanup).
23. I am encouraged to help staff with the development of new groups, programs, or services.
24. I am encouraged to be involved in the evaluation of this program's services and service providers.
25. I am encouraged to attend agency advisory boards and/or management meetings if I want.
29. I am/can be involved with staff trainings and education programs at this agency.

Figure 6 – Involvement Subcategory Comparison of FY19 Individual Questions



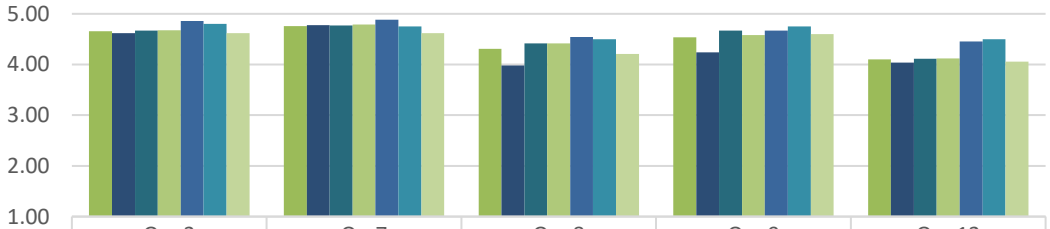
	Qu. 22	Qu. 23	Qu. 24	Qu. 25	Qu. 29
All Mean	3.96	3.86	4.26	3.42	3.50
SUD Residential Mean	3.69	3.68	4.11	2.89	2.87
Intensive OPT Mean	4.03	3.92	4.37	3.63	3.67
OPT Mean	4.07	3.91	4.28	3.49	3.69
CSM/SC Mean	4.39	4.33	4.52	4.04	3.84
Clubhouse Mean	4.25	4.25	4.25	3.67	3.67
Other Mean	3.81	3.61	4.08	3.41	3.50

Life Subcategory

The MSHN average was 4.36 for the Life Subcategory. Figure 7 illustrates the differences between the programs for each question for those who completed the assessment. The average score was 3.5 or above for all questions which indicates agreement or satisfaction with each statement. Question seventeen (17) was below for the SUD Residential Providers. The Life Subcategory is illustrated in two graphs. Figure 7 includes the following questions:

3. Staff encourage me to have hope and high expectations for myself and my recovery.
7. Staff believe that I can recover.
8. Staff believe that I have the ability to manage my own symptoms.
9. Staff believe that I can make my own life choices regarding things such as where to live, when to work, whom to be friends with, etc.
12. Staff encourage me to take risks and try new things.

Figure 7 – Life Subcategory Comparison of FY19 Individual Questions (3, 7, 8, 9, 12)

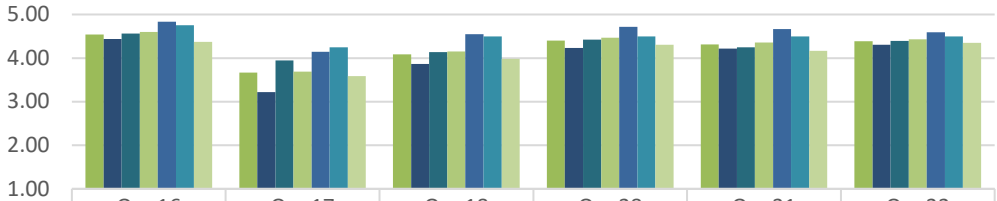


	Qu. 3	Qu.7	Qu. 8	Qu. 9	Qu. 12
All Mean	4.66	4.76	4.31	4.54	4.10
SUD Residential Mean	4.62	4.77	3.98	4.24	4.04
Intensive OPT Mean	4.67	4.77	4.42	4.67	4.12
OPT Mean	4.67	4.79	4.42	4.58	4.12
CSM/SC Mean	4.86	4.89	4.54	4.67	4.45
Clubhouse Mean	4.80	4.75	4.50	4.75	4.50
Other Mean	4.62	4.62	4.21	4.60	4.06

The Life Subcategory is illustrated in two graphs. Figure 7a includes the following questions:

16. Staff help me to develop and plan for life goals beyond managing symptoms or staying stable (e.g., employment, education, physical fitness, connecting with family and friends, hobbies).
17. Staff help me to find jobs.
18. Staff help me to get involved in non-mental health/addiction related activities, such as church groups, adult education, sports, or hobbies.
28. Staff work hard to help me fulfill my personal goals.
31. Staff are knowledgeable about special interest groups and activities in the community.
32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.

Figure 7a – Life Subcategory Comparison of FY19 Individual Questions (16,17,18, 28, 31, 32).



	Qu. 16	Qu. 17	Qu. 18	Qu. 28	Qu. 31	Qu. 32
All Mean	4.54	3.66	4.09	4.40	4.31	4.38
SUD Residential Mean	4.44	3.22	3.87	4.23	4.22	4.31
Intensive OPT Mean	4.56	3.94	4.14	4.42	4.25	4.39
OPT Mean	4.60	3.69	4.15	4.47	4.36	4.43
CSM/SC Mean	4.84	4.14	4.55	4.71	4.66	4.59
Clubhouse Mean	4.75	4.25	4.50	4.50	4.50	4.50
Other Mean	4.37	3.59	3.98	4.31	4.17	4.35

<u>Individually Tailored Services Subcategory</u>

The MSHN average was 4.31 for the subcategory of Individually Tailored Services. Figure 8 illustrates the differences between the programs for each question for those who completed the assessment. The average score was 3.5 or above for all questions which indicates agreement or satisfaction with each statement. The Individually Tailored Services Subcategory includes the following questions:

11. Staff regularly ask me about my interests and the things I would like to do in the community.
13. This program offers specific services that fit my unique culture and life experiences.
19. Staff help me to include people who are important to me in my recovery/treatment planning (such as family, friends, clergy, or an employer).
30. Staff listen, and respond, to my cultural experiences, interests, and concerns.

Figure 8 – Individually Tailored Services Subcategory Comparison of FY19 Individual Questions

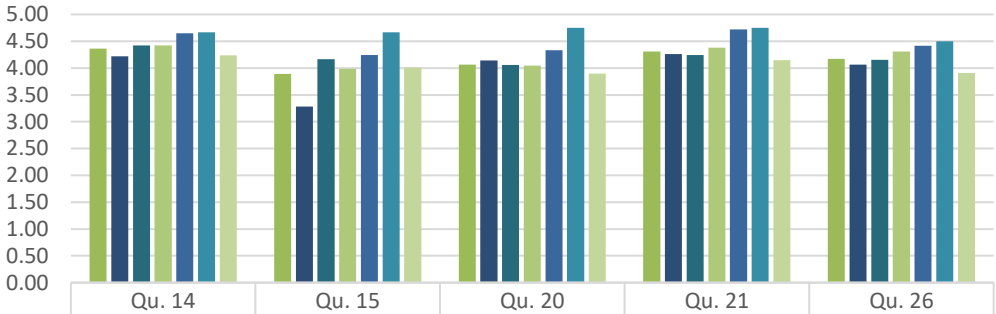
	Qu. 11	Qu. 19	Qu. 30	Qu. 13
All Mean	4.22	4.39	4.39	4.25
SUD Residential Mean	3.94	4.33	4.25	4.11
Intensive OPT Mean	4.24	4.42	4.34	4.33
OPT Mean	4.31	4.42	4.49	4.35
CSM/SC Mean	4.56	4.67	4.69	4.44
Clubhouse Mean	4.75	4.50	4.33	4.75
Other Mean	4.18	4.25	4.24	4.07

Diversity Subcategory

The MSHN average was 4.17 for the Diversity Subcategory. Figure 9 illustrates the differences between the programs for each question for those who completed the assessment. The average score was 3.5 or above for all questions which indicates agreement or satisfaction with each statement. Question fifteen (15) was below for the SUD Residential providers. The Diversity Subcategory includes the following questions:

14. I am given opportunities to discuss my spiritual needs and interests when I wish.
15. I am given opportunities to discuss my sexual needs and interests when I wish.
20. Staff introduce me to people in recovery who can serve as role models or mentors.
21. Staff offer to help me connect with self-help, peer support, or consumer advocacy groups and programs.
26. Staff talk with me about what it would take to complete or exit this program.

Figure 9 – Comparison of Diversity of Treatment Subcategory Score



	Qu. 14	Qu. 15	Qu. 20	Qu. 21	Qu. 26
All Mean	4.36	3.89	4.06	4.31	4.17
SUD Residential Mean	4.22	3.28	4.14	4.26	4.06
Intensive OPT Mean	4.42	4.17	4.06	4.24	4.15
OPT Mean	4.42	3.98	4.05	4.38	4.31
CSM/SC Mean	4.65	4.24	4.33	4.72	4.42
Clubhouse Mean	4.67	4.67	4.75	4.75	4.50
Other Mean	4.24	4.01	3.90	4.15	3.91

Comparison FY18 SUD Consumer Satisfaction and RSA-R Persons in Recovery FY19

MSHN administered the initial RSA-R Persons in Recovery for FY19. It is not a direct comparison to the previous assessment of perception of care, however Attachment 1 provides cross walk identifying questions that may yield feedback relative to previous responses to perception of care. The questions that scored the lowest in FY18 include the following:

4. I know how to contact my recipient rights advisor.
9. I was given a choice as to what provider to seek treatment from
14. Staff assisted in connecting me with further services and/or community resources.
7. I was given information about the different treatment options available that would be appropriate to meet my needs
15. My treatment plan includes skills and community supports to help me continue in my path to recovery and total wellness.

The questions that scored the highest in FY18 include the following:

5. I was informed that information about my treatment is only given with my permission.
6. My cultural/ethnic background was respected.
10. I was involved in the development of my treatment plan and goals.
1. Staff was courteous and respectful.
11. My goals were addressed during treatment.

Summary:

For the FY2019 assessment period there were 777 respondents who participated in the completion of the Recovery Self-Assessment Revised Persons in Recovery Version. The assessment consisted of six (6) separate subcategories that included Inviting, Choice, Involvement, Life Goals, Individually Tailored Services and Diversity of Treatment. All subcategories demonstrated a 3.5 or above average. The subcategory that demonstrated the lowest score was "Involvement" (3.83). The subcategory that demonstrated the highest score was "Choice" (4.45).

The questions that scored the lowest for the SUD Provider Network are identified in Attachment 1 in red font, and are as follows:

25. I am encouraged to attend agency advisory boards and management meetings if I want. (3.42)
29. I am/can be involved with staff trainings and education program at this agency. (3.50)
17. Staff help me to find jobs. (3.66)
23. I am encouraged to help staff with the development of new groups, programs, or services. (3.86)
15. I am given opportunities to discuss my sexual needs and interest when I wish. (3.89)

The questions that scored the highest for SUD Provider Network are identified in Attachment 1 in green font and are as follows:

7. Staff believe that I can recover. (4.76)
6. Staff do not use threats, bribes, or other forms of pressure to get me to do what they want. (4.70)
1. Staff welcome me and help me to feel comfortable in this program. (4.68)
3. Staff encourage me to have hope and high expectations for myself and my recovery. (4.66)
10. Staff listen to me and respect my decisions about my treatment and care. (4.57)

The analysis of the service type indicated that 4 of the lowest scoring questions were consistently low across each service program. Three of the highest scoring questions were consistently high across each service program.

The results will be reviewed further by the MSHN Quality Improvement Council, Provider Advisory Committee, and the Regional Consumer Advisory Council to determine if any trends are evident and if any regional improvement efforts would be recommended. Areas of improvement will be targeted toward below average scores (based on the regional average of all scores) and/or priority areas as identified through review of the reginal councils and committees. Each Provider should review the results by Service Program to identify any local improvement recommendations.

Report Completed by: Sandy Gettel MSHN Quality Manager **Date:** August 20, 2019

MSHN QIC Approved:

Comparison of MSHN SUD Consumer Satisfaction Survey FY15-FY18 and the RSA-R Persons in Recovery FY19

SUD Satisfaction Survey	**FY15**	**FY16**	**FY17**	**FY18**	**RSA-R Persons in Recovery** (questions that correlate to survey questions from FY15-FY18)	**FY19**
1. Staff was courteous and respectful	4.55	4.57	4.54	4.56	1. Staff welcome me and help me to feel comfortable in this program	4.68
					10. Staff listen to me and respect my decisions about my treatment and care.	4.57
					30. Staff listen, and respond, to my cultural experiences, interests, and concerns.	4.39
					6. Staff do not use threats, bribes, or other forms of pressure to get me to do what they want.	4.70
2. I would recommend this agency to others	4.45	4.54	4.53	4.54		
3. I was informed of my rights	4.46	4.56	4.52	4.51		
4. I know how to contact my recipient rights advisor	4.15	4.3	4.33	4.27		
5. I was informed that information about my treatment is only given with my permission	4.54	4.61	4.63	4.62		
6. My cultural/ethnic background was respected	4.50	4.59	4.61	4.60	13. This program offers specific services that fit my unique culture and life experiences.	4.25
					14. I am given opportunities to discuss my spiritual needs and interests when I wish.	4.36
					15. I am given opportunities to discuss my sexual needs and interests when I wish.	3.89
					32.Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.	4.38
7. I was given information about the different treatment options available that would be appropriate to meet my needs.	4.25	4.41	4.43	4.41	13. This program offers specific services that fit my unique culture and life experiences.	4.25

SUD Satisfaction Survey	FY15	FY16	FY17	FY18	RSA-R Persons in Recovery	FY19
8. I received services that met my needs and addressed my goals.	4.32	4.53	4.54	4.52	14. I am given opportunities to discuss my spiritual needs and interests when I wish.	4.36
					15. I am given opportunities to discuss my sexual needs and interests when I wish.	3.89
					10. Staff listen to me and respect my decisions about my treatment and care.	4.57
					9. Staff believe that I can make my own life choices regarding things such as where to live, when to work, whom to be friends with, etc.	4.54
9. I was given a choice as to what provider to seek treatment from.	4.01	4.36	4.35	4.29	4. I can change my clinician or case manager if I want to.	4.26
10. I was involved in the development of my treatment plan and goals.	4.38	4.56	4.57	4.56	9. Staff believe that I can make my own life choices regarding things such as where to live, when to work, whom to be friends with, etc.	4.54
					10. Staff listen to me and respect my decisions about my treatment and care.	4.57
11. My goals were addressed during treatment.	4.37	4.54	4.56	4.54	10. Staff listen to me and respect my decisions about my treatment and care.	4.57
12. My goals were changed when needed to reflect my needs.	4.17	4.42	4.47	4.47	9. Staff believe that I can make my own life choices regarding things such as where to live, when to work, whom to be friends with, etc.	4.54
					27. Staff help me keep track of the progress I am making towards my personal goals.	4.45
13. I feel that I am better able to control my life as a result of treatment.	4.26	4.49	4.54	4.54	7. Staff believe that I can recover.	4.76
					8. Staff believe that I have the ability to manage my own symptoms.	4.31

Comparison of MSHN SUD Consumer Satisfaction Survey FY15-FY18 and the RSA-R Persons in Recovery FY19

SUD Satisfaction Survey	FY15	FY16	FY17	FY18	RSA-R Persons in Recovery	FY19
14. Staff assisted in connecting me with further services and/or community resources.	3.2	4.37	4.4	4.36	20. Staff introduce me to people in recovery who can serve as role models or mentors.	4.06
					22. Staff help me to find ways to give back to my community, (i.e., volunteering, community services, neighborhood watch/cleanup).	3.96
					21. Staff offer to help me connect with self-help, peer support, or consumer advocacy groups and programs.	4.31
					23. I am encouraged to help staff with the development of new groups, programs, or services.	3.86
					25. I am encouraged to attend agency advisory boards and/or management meetings if I want.	3.42

Comparison by Service Program Type

Key	*Five Lowest Scores **Five Highest Score
Life Goals	Choice
Involvement	Individually Tailored Services
Diversity of Treatment Options	Inviting Factor

RSA-R Persons in Recovery	SUD - All	SUD Residential Mean	Intensive OPT Mean	OPT Mean	CSM/SC Mean	Clubhouse Mean	Other Mean
25. I am encouraged to attend agency advisory boards and management meetings if I want.	***3.42**	*2.89	*3.63	*3.49	*4.04	*3.67	*3.41
29. I am/can be involved with staff trainings and education program at this agency.	***3.50**	*2.87	*3.67	*3.69	*3.84	*3.67	*3.50
17. Staff help me to find jobs.	***3.66**	*3.22	*3.94	*3.69	*4.14	*4.25	*3.59
23. I am encouraged to help staff with the development of new groups, programs, or services.	***3.86**	*3.68	*3.92	*3.91	*4.33	*4.25	*3.61
15. I am given opportunities to discuss my sexual needs and interest when I wish.	***3.89**	*3.28	4.17	*3.98	*4.24	4.67	4.01
22. Staff help me to find ways to give back to my community (i.e., volunteering, community services,	**3.96**	3.69	*4.03	4.07	4.39	*4.25	*3.81
20. Staff introduce me to people in recovery who can serve as role models or mentors.	**4.06**	4.14	4.06	4.05	4.33	4.75	3.90
18. Staff help me to get involved in non-mental health related activities, such as church groups, adult education, sports, or hobbies.	**4.09**	3.87	4.14	4.15	4.55	4.50	3.98
12. Staff encourage me to take risks and try new things.	**4.10**	4.04	4.12	4.12	4.45	4.50	4.06
5. I can easily access their treatment records if I want to.	**4.13**	3.73	4.38	4.16	4.43	4.50	4.16
26. Staff talk with me about what it would take to complete or exit the program.	**4.17**	4.06	4.15	4.31	4.42	4.50	3.91

RSA-R Persons in Recovery	SUD	SUD Residential Mean	Intensive OPT Mean	OPT Mean	CSM/SC Mean	Clubhouse Mean	Other Mean
11. Staff regularly ask me about my interests and the things I would like to do in the community.	**4.22**	3.94	4.24	4.31	4.56	4.75	4.18
13. This program offers specific services that fit my unique culture and life experiences.	**4.25**	4.11	4.33	4.35	4.44	4.75	4.07
24. I am encouraged to be involved in the evaluation of this program's services and service providers.	**4.26**	4.11	4.37	4.28	4.52	4.25	4.08
4. I can change my clinician or case manager if I want to.	**4.26**	3.84	4.46	4.34	4.61	**5.00	4.23
8. Staff believe that I have the ability to manage my own symptoms.	**4.31**	3.98	4.42	4.42	4.54	4.50	4.21
31. Staff are knowledgeable about special interest groups and activities in the community	**4.31**	4.22	4.25	4.36	4.66	4.50	4.17
21. Staff offer to help me connect with self help, peer support, or consumer advocacy groups and programs.	**4.31**	4.26	4.24	4.38	4.72	4.75	4.15
2. The physical space of this program (e.g., the lobby, waiting rooms, etc.) feels inviting and dignified	**4.36**	4.29	4.41	4.40	4.48	**4.80	4.26
14. I am given opportunities to discuss their spiritual needs and interests when I wish.	**4.36**	4.22	4.42	4.42	4.65	4.67	4.24
32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.	**4.38**	4.31	4.39	4.43	4.59	4.50	4.35
19. Staff help me to include people who are important to me in my recovery/treatment planning (such as family, friends, clergy, or an employer).	**4.39**	4.33	4.42	4.42	4.67	4.50	4.25
30. Staff listen, and respond, to my cultural experiences, interests, and concerns.	**4.39**	4.25	4.34	4.49	4.69	4.33	4.24
28. Staff work hard to help me fulfill my personal goals.	**4.40**	4.23	4.42	4.47	4.71	4.50	4.31
27. Staff help me keep track of the progress I am making towards my personal goals.	**4.45**	4.24	4.43	4.58	4.80	4.75	4.33
9. Staff believe that I can make my own life choices regarding things such as where to live, when to work, whom to be friends with, etc.	**4.54**	4.24	**4.67	4.58	4.67	4.75	**4.60

RSA-R Persons in Recovery	SUD	SUD Residential Mean	Intensive OPT Mean	OPT Mean	CSM/SC Mean	Clubhouse Mean	Other Mean
16. Staff help me to develop and plan for life goals beyond managing symptoms or staying stable (e.g.employment, education, physical fitness, connecting with family and friends, hobbies).	**4.54**	**4.44	4.56	4.60	**4.84	4.75	4.37
10. Staff listen to me and respect my decisions about my treatment and care.	****4.57**	4.43	4.59	4.63	4.81	4.75	4.46
3. Staff encourage me to have hope and high expectations for myself and my recovery.	****4.66**	**4.62	**4.67	**4.67	**4.86	**4.80	**4.62
1. Staff welcome me and help me to feel comfortable in this program	****4.68**	**4.56	**4.76	**4.75	**4.85	**4.80	**4.58
6. Staff do not use threats, bribes, or other forms of pressure to get me to do what they want.	****4.70**	**4.58	**4.73	**4.79	**4.86	4.75	**4.60
7. Staff believe that I can recover.	****4.76**	**4.77	**4.77	**4.79	**4.89	**4.75	**4.62

RSA-R Persons in Recovery Assessment	Average	Total Responses	Total Valid Responses	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	blank
Inviting	**4.52**								
1. Staff welcome me and help me to feel comfortable in this program	4.68	777	767	14	5	32	109	607	10
2. The physical space of this program (e.g., the lobby, waiting rooms, etc.) feels inviting and dignified.	4.36	777	748	19	23	75	185	446	29
Life Goals	**4.36**								
3. Staff encourage me to have hope and high expectations for myself and my recovery.	4.66	777	764	10	7	34	134	579	13
7. Staff believe that I can recover.	4.76	777	737	9	7	16	89	616	40
8. Staff believe that I have the ability to manage my own symptoms.	4.31	777	681	21	25	78	156	401	96
9. Staff believe that I can make my own life choices regarding things such as where to live, when to work, whom to be friends with, etc.	4.54	777	722	10	16	56	135	505	55
12. Staff encourage me to take risks and try new things.	4.10	777	716	31	31	122	181	351	61
16. Staff help me to develop and plan for life goals beyond managing symptoms or staying stable(e.g., employment, education, physical fitness, connecting with family and friends, hobbies).	4.54	777	740	13	15	41	160	511	37
17. Staff help me to find jobs.	3.66	777	540	66	50	103	101	220	237
18. Staff help me to get involved in non-mental health related activities, such as church groups, adult education, sports, or hobbies.	4.09	777	655	31	44	101	139	340	122
28. Staff work hard to help me fulfill my personal goals.	4.40	777	738	16	20	95	129	478	39
31. Staff are knowledgeable about special interest groups and activities in the community	4.31	777	665	22	23	83	136	401	112
32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.	4.38	777	680	14	25	76	136	429	97

Choice	**4.45**								
4. I can change my clinician or case manager if I want to.	4.26	777	593	33	21	61	120	358	184
5. I can easily access their treatment records if I want to.	4.13	777	557	43	29	53	121	311	220
6. Staff do not use threats, bribes, or other forms of pressure to get me to do what they want.	4.70	777	757	22	6	22	79	628	20
10. Staff listen to me and respect my decisions about my treatment and care.	4.57	777	751	8	18	50	136	539	26
27. Staff help me keep track of the progress I am making towards my personal goals.	4.45	777	734	15	26	61	142	490	43
Individually Tailored Services	**4.31**								
11. Staff regularly ask me about my interests and the things I would like to do in the community.	4.22	777	735	28	34	98	166	409	42
13. This program offers specific services that fit my unique culture and life experiences.	4.25	777	702	14	44	79	182	383	75
19. Staff help me to include people who are important to me in my recovery/treatment planning (such as family, friends, clergy, or an employer).	4.39	777	717	21	29	61	147	459	60
30. Staff listen, and respond, to my cultural experiences, interests, and concerns.	4.39	777	706	17	19	84	135	451	71
Diversity	**4.17**								
14. I am given opportunities to discuss their spiritual needs and interests when I wish.	4.36	777	679	15	23	69	166	406	98
15. I am given opportunities to discuss my sexual needs and interest when I wish.	3.89	777	574	54	47	77	126	270	203
20. Staff introduce me to people in recovery who can serve as role models or mentors.	4.06	777	674	43	43	94	144	350	103
21. Staff offer to help me connect with self help, peer support, or consumer advocacy groups and programs.	4.31	777	709	26	26	73	161	423	68

26. Staff talk with me about what it would take to complete or exit the program.	4.17	777	688	32	47	83	136	390	89
Involvement	**3.83**								
22. Staff help me to find ways to give back to my community (i.e., volunteering, community services, neighborhood watch/cleanup).	3.96	777	644	38	53	108	145	300	133
23. I am encouraged to help staff with the development of new groups, programs, or services.	3.86	777	607	40	58	121	119	269	170
24. I am encouraged to be involved in the evaluation of this program's services and service providers.	4.26	777	673	25	29	90	133	396	104
25. I am encouraged to attend agency advisory boards and management meetings if I want.	3.42	777	544	99	71	82	89	203	233
29. I am/can be involved with staff trainings and education program at this agency.	3.50	777	506	86	47	98	76	199	271

Attachment 3

2019

Mental Health America of Franklin County

OCCUMETRICS

Listen and Learn from Your Workforce

A summary report presented to

MSHN: CMH Providers

CMH PROVIDERS WELLNESS PROFILE: THE SUMMARY

CMH PROVIDERS WELLNESS PROFILE: THE DETAILS

APPENDIX

WELLNESS PROFILE: THE SUMMARY

OVERVIEW

A report prepared for the U.S. National Mental Health Commission and the Mentally Healthy Workplace Alliance says that "workplaces play an important and active role in maintaining the mental health and wellbeing of their workers. A well-designed workplace should support individual mental health and lead to reduced absenteeism, increased employee engagement and improved productivity."

MSHN has taken an invaluable step toward investing in a healthier workplace for its provider network and requested the help of Mental Health America of Franklin County (MHAFC). Through extensive research and field testing, MHAFC has developed a science-based and data-driven assessment method allowing our research team to identify the most impactful predictors in employee retention and job satisfaction within the network of MHSN's CMH providers. We have also developed actions for consideration that are anticipated to decrease turnover intention and increase job satisfaction.

Frequent turnover tends to have a deleterious effect on staff morale and productivity and often places an even heavier workload on already stretched staff. Turnover rates among non-profits have been increasing over the last several years. COMPDATA's Turnover Report 2017[1] found **voluntary** turnover in the Midwest to be 12.5% for Not-For-Profits (15.9% overall including non-voluntary turnover), 16.1% in Healthcare (20.3% overall), and 11.2% in Services (16.2% overall). Non-profits typically report that the hardest positions to retain are in direct service, which usually include some of the lowest-paid positions in an organization. As other scientific studies have concluded, we also find that job satisfaction correlates with turnover. Employees who are satisfied with their jobs tend less frequently to look for other employment.

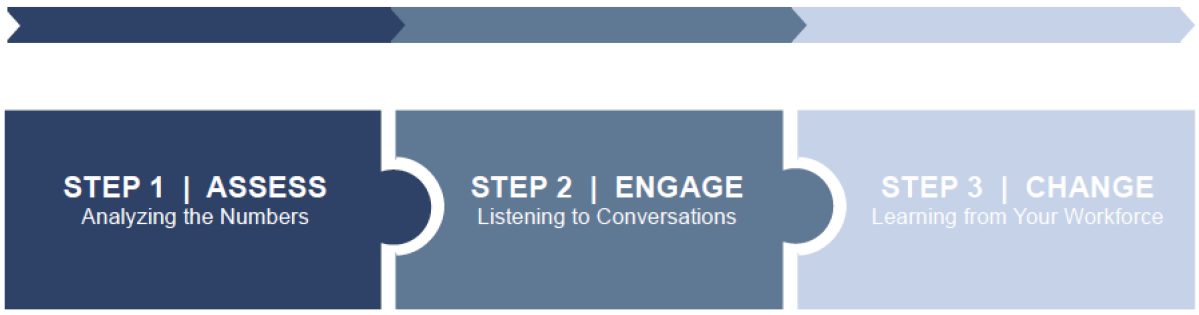
In this report, we identify workplace strengths and challenges, high- and low-scoring dimensions associated with workplace wellbeing, the most critical factors in retaining CMH employees, and actions for consideration for both MSHN and CMH providers designed to improve retention and job satisfaction.

[1] From the *Compensation Data BenchmarkPro* report, which provides cross-industry salary data for more than 560 general staff job titles from nearly 30,000 organizations across the country.

THE OCCUMETRICS PROCESS

First, we surveyed[2] employees of MSHN's CMH provider network along 10 different dimensions of workplace wellbeing described below. These results then informed what areas to explore in nine follow-up focus groups, which included groups of front line and managerial staff, totaling 84 employees. This combination of quantitative and qualitative data using multiple measures provided the information necessary to identify the primary predictors of job satisfaction and turnover intention within MSHN's CMH provider network and develop actions for consideration to improve on any issues.

- **Emotional Exhaustion**—the extent to which employees' mental and emotional reserves are depleted
- **Work Engagement**—the extent to which employees are involved, committed, enthusiastic and focused
- **Supervisor Support** and **Colleague Support**—the extent to which colleagues and managers support and encourage
- **Work Demands**—the extent of requirements on staff concerning hours, deadlines, quantity of work, taking breaks, and time pressures
- **Control/Autonomy**—the extent of independence in how to do the job
- **Interpersonal Relationships**—the nature of workplace relationships, such as friction, harassment, and bullying
- **Job Role**—the extent to which employees understand their duties and responsibilities and fit into the bigger organizational framework
- **Organizational Change**—the extent of employee involvement with organizational change and how they perceive fairness in organizational decision-making
- **Distributive Justice**—the extent to which employees perceive fairness in their pay, praise, etc.



[2] Approximately 42% of CMH employees responded to the survey, which has a +/-1.8% margin of error at a 95% confidence level (1,328 out of a potential 2,398, not including 298 subcontractor employees who responded). Including subcontractor employee responses, the total number responding is 1,626, but we are unable to provide an overall response rate that includes subcontractor employees because the total number of subcontractor employees was not provided.

WELLNESS PROFILE: THE SNAPSHOT

DISCOVERIES

The following overall indicators predicted and had the most impact:

- On **turnover intention**: *Work Engagement, Satisfaction with Pay and Benefits, Supervisor Support, Interpersonal Relationships, Work Demands,* and *Organizational Change*
- On **overall job satisfaction**: *Work Engagement, Satisfaction with Pay and Benefits, Job Role, Supervisor Support, Interpersonal Relationships, Control/Autonomy, Emotional Exhaustion, Organizational Change, Work Demands, Distributive Justice,* and *Colleague Support.*

Employees reported being motivated by the following factors about their workplace:

- The clients; mission-driven work
- Flexibility within their jobs
- Supportive co-workers
- Mostly good relationships with the CMHs

They reported being most discouraged by these conditions:

- A disproportionate amount of paperwork
- Feeling overworked and short-staffed
- Low pay and, in some cases, a lack of benefits
- Difficulty hiring and retaining appropriate, quality staff (particularly retaining newer staff and finding staff for rural areas)
- Decisions made by MSHN without consulting providers who have to implement the changes

ACTIONS FOR CONSIDERATION

MSHN and CMH providers are anticipated to benefit most from the following actions:

- Looking into paperwork v. client time ratios
- Understanding paperwork redundancies and working to consolidate/create efficiencies—reports of different governing and accrediting bodies not realizing what's being asked of providers from each other—same with auditing process
- Creating opportunities for frontline staff at provider agencies to share feedback about changes that impact them directly prior to the changes happening
- Creating time for self-care initiatives to be included in the work day
- Ensuring productivity requirements are manageable; prioritizing focus on client care over productivity
- Addressing wage and benefit concerns

WELLNESS PROFILE: THE DETAILS

STEP 1 | ASSESS: Analyzing the Numbers

The data analysis, in part, identifies factors most predictive of two outcomes: employee intent to leave and job satisfaction. These factors (or variables) give employers some insight as to what matters most to their employees when it comes to deciding whether to stay and how satisfied they are at work.

These variables were most impactful[3] and predicted 56% of the change in turnover intention (TI) and 63% of the change in job satisfaction (JS), as indicated by TI and/or JS:

Work Engagement

- It happens more and more often that I talk about my work in a negative way. (.34, TI; .22, JS)
  - "It happens more and more often that I talk about my work in a negative way" is best predicted (60%) by "During my work, I feel emotionally drained" (0.20), "I feel more and more engaged in my work" (0.19), "Lately, I tend to think less at work and do my job almost mechanically" (0.12), "I find my work to be a positive challenge" (0.11), "I have unachievable expectations placed on me" (0.10), "Over time, I can become disconnected from the type of work I do" (0.10), "Relationships at work are strained" (0.09), "There are days I feel tired before I arrive at work" (0.06), "I am clear about the goals and objectives for my department" (0.05), "After work, I tend to need more time than in the past in order to relax and feel better" (0.05), "I trust that my immediate supervisor will share important information with me" (0.04), "When decisions are made, all affected people are asked for their ideas" (0.03).
- I find my work to be a positive challenge. (.17, JS)
- My job is the only type of work that I can imagine myself doing. (.10, TI; .08, JS)
- I feel more and more engaged in my work. (.08, TI)
- When I work, I feel energized. (.07, JS)
- I find new and interesting aspects in my work. (.07, JS)
- Lately, I tend to think less at work and do my job almost mechanically. (.06, TI)

Satisfaction with Pay

- How satisfied are you with your pay? (.15, TI; .11, JS)

Satisfaction with Benefits

- How satisfied are you with your benefits, such as paid time off, medical and dental insurance, retirement plan, and other fringe benefits? (.12, TI)

Supervisor Support

- I can rely on my immediate supervisor to help me out with a work problem. (.10, TI; .09, JS)

Job Role

- I understand how my work fits into the overall aim of the organization. (.10, JS)

Interpersonal Relationships

- In the past year, I have been subjected to workplace bullying (.09, TI; .08, JS)

Satisfaction with Benefits

- How satisfied are you with your benefits, such as paid time off, medical and dental insurance, retirement plan, and other fringe benefits? (.09, JS)

Work Demands

- I have to work very intensively. (.07, TI; .05, JS)
- I am pressured to work long hours. (.06, TI)
- I have unachievable expectations placed on me. (.06, TI; .05, JS

[3] The coefficient in parenthesis is added in order to provide an idea of relative strength among the variables; the higher the coefficient, the more impactful on TI and/or JS.

Control/Autonomy

- I have a choice in deciding what I do at work. (.08, JS)

Emotional Exhaustion

- After my work, I feel worn out and wary. (.07, JS)

Organizational Change

- When decisions are made, all affected people are asked for their ideas. (.06, JS)
- When changes are made at work, I am clear how they will work out in practice. (.07 TI; .06, JS)

Distributive Justice

- The overall rewards received are fairly distributed. (.05, JS)

Colleague Support

- I get the respect at work I deserve from my colleagues. (.04, JS)

Workplace Wellbeing Aggregate Scores

(On a 0-6 scale, the higher the score the better.)

Dimensions of Workplace Wellbeing	N	Mean	Ohio Statewide*
Job Role	1513	4.84	4.81
Interpersonal Relationships	1516	4.42	4.74
Colleague Support	1571	4.20	4.33
Supervisor Support	1557	4.05	3.79
Control/Autonomy	1520	3.77	3.79
Distributive Justice	1485	3.65	3.29
Work Engagement	1587	3.52	3.65
Work Demands	1533	3.19	3.32
Organizational Change	1501	2.98	2.97
Emotional Exhaustion	1622	2.85	2.96
Workplace Wellbeing	1624	3.73	3.79

Workplace Wellbeing Scale: 0 = Never, 1 = Almost never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Very often, 6 = Always

**Statewide scores represent 5,496 employees in 28 Ohio BH organizations (1.3% margin of error at 99% confidence level)*

	N	Mean	Ohio Statewide
Overall, how satisfied are you with your current job?	1484	4.13	4.07
How satisfied are you with your pay?	1488	3.43	2.80
How satisfied are you with your benefits, such as paid time off, medical and dental insurance, retirement plan, and other fringe benefits?	1484	4.23	3.79

Satisfaction Scale: 0 = Very dissatisfied, 1 = Dissatisfied, 2 = Somewhat dissatisfied, 3 = Neither dissatisfied nor satisfied, 4 = Somewhat satisfied, 5 = Satisfied, 6 = Very satisfied

	N	Mean	Ohio Statewide
I think about quitting my job.	1488	3.66	3.65
I am actively looking for another job outside of my organization.	1482	4.34	4.20
Turnover Intention	1488	4.00	3.91

Turnover Scale: 0 = Always, 1 = Very often, 2 = Often, 3 = Sometimes, 4 = Rarely, 5 = Almost never, 6 = Never

Turnover Intention: Survey respondents indicated their turnover intention as 38% who at least sometimes thought about quitting and actively looked for another job. While this percentage doesn't statistically equate to actual turnover, our experience is that this number is often close to the prior year's actual turnover. 51% at least sometimes thought about quitting, and 34% at least sometimes actively looked for another job. The overall mean for turnover intention was 4.00 (4=Rarely).

Overall Workplace Wellbeing: "Overall Workplace Wellbeing" combines all ten dimensions of workplace wellbeing. Survey respondents averaged a score of 3.73.

Satisfaction with Pay: The aggregate mean score was 3.43. About 59% of responding staff members were *Somewhat* to *Very satisfied* with their pay. About 34% were at least *Somewhat dissatisfied* with their pay. Satisfaction with pay was a factor in both turnover intention and job satisfaction.

Satisfaction with Benefits: Satisfaction with benefits had a mean of 4.23. 74% were at least *Somewhat satisfied* and 19% were at least *Somewhat dissatisfied*. Satisfaction with benefits was a factor in turnover intention but not in job satisfaction.

STEP 2 | ENGAGE: Listening to Conversations

Focus group conversations provided fuller personal detail about workplace dynamics. In these groups, staff reported deriving the greatest job satisfaction and work engagement from their clients and the population they serve. As sources of satisfaction, they also cited their flexibility and their relationships with co-workers. They expressed concern about paperwork taking away from client care, feeling understaffed, low pay for front line staff, and an inability to hire and retain quality employees (particularly hiring in rural areas and retaining new staff). More specific information on the focus group discussions can be found in the Appendix.

Summary of focus group discussions:

- **Pay**: some dissatisfaction with pay, especially with front line staff
- **Benefits:** some dissatisfaction with benefits (some employees report not being eligible for benefits and would like to be)
- **Organizational Change**: a perception that change happens quickly and is often determined by entities who do not know how it impacts the people who have to implement the change at the provider level
- **Colleague Support**: appears to be mostly high
- **Supervisor Support**: varied based on supervisor; perception that supervisors are also stretched thin and burnt out
- **Work Engagement**: employees are mission-focused and find their jobs rewarding but overwhelming
- **Work Demands**: reported difficult workloads, particularly due to paperwork demands; most departments reported being short-staffed

Positive work experiences:

- Mission-driven work
- Flexibility
- Supportive coworkers
- Mostly supportive relationships with CMHs

Negative work experiences:

- Paperwork taking away from client care
- Unmanageable workloads; feeling short-staffed
- Low pay and lack of benefits
- Inability to engage in self-care
- Difficulty hiring and retaining quality employees
- Lack of quality job-specific training

STEP 3 | CHANGE: Learning from your Workforce

Considerations for MSHN

- See what can be done about adjusting paperwork time v. client time so that the focus of care is on meeting client's needs rather than on the client meeting the agency's needs.
- Understand and address paperwork redundancies and work to consolidate/create efficiencies—reports of unawareness/ambivalence from the different governing and accrediting bodies regarding overlap of paperwork requirements—same issue reported with the auditing process.
- Create opportunities to build trust and improve relationships between MSHN and CMH provider staff.
- Create opportunities for frontline staff at provider agencies to share feedback about changes that impact them directly prior to the changes happening.
- Work with providers to address wage and benefits concerns.

Considerations for Providers

- Create time for self-care initiatives to be included in the work day; burnout was reported to be partially due to an inability to process the difficult and sad client situations that are dealt with.
- Work with MSHN to create opportunities for frontline staff at CMH providers to share feedback about changes that impact them directly prior to the changes happening.
- Shift focus from productivity to client care; ensure supervision conversations prioritize clinical needs over billable hours.
- Better understand the service offerings of other providers in their areas and build relationships with them to be able to provide clients with the best possible care.
- Prioritize time for proper job-specific training.

Considerations regarding Pay and Benefits

- Providers should conduct a study of pay and benefits at comparable local employers to develop appropriate compensation plans; the plans should, at minimum, include wage ranges for staff positions, and policies and procedures for determining and deploying wage increases and/or annual bonuses.
- The compensation plans should be explained clearly to staff, and a feedback loop created for incorporating staff response and ongoing experience with wage and benefit levels.
- While wage increases may not be possible, at minimum, the compensation plan should be shared across the agency; however, most providers would benefit from working on a business plan that would afford targeted pay increases for lower paid positions.
- MSHN should address the additional funding that providers need for more administrative support as their agencies grow.

What's Next?

Thank you for participating in the Occumetrics assessment process. We welcome questions and feedback as MSHN and CMH providers review our actions for consideration. We hope to continue our relationship with MSHN by providing a reassessment in one to two years after potential implementation of any of the actions.

Attachment 4

2019

Mental Health America of Franklin County

OCCUMETRICS

Listen and Learn from Your Workforce

A summary report presented to

MSHN: SUD Providers

SUD PROVIDERS WELLNESS PROFILE: THE SUMMARY

SUD PROVIDERS WELLNESS PROFILE: THE DETAILS

APPENDIX

WELLNESS PROFILE: THE SUMMARY

OVERVIEW

A report prepared for the U.S. National Mental Health Commission and the Mentally Healthy Workplace Alliance says that "workplaces play an important and active role in maintaining the mental health and wellbeing of their workers. A well-designed workplace should support individual mental health and lead to reduced absenteeism, increased employee engagement and improved productivity."

MSHN has taken an invaluable step toward investing in a healthier workplace for its provider network and requested the help of Mental Health America of Franklin County (MHAFC). Through extensive research and field testing, MHAFC has developed a science-based and data-driven assessment method allowing our research team to identify the most impactful predictors in employee retention and job satisfaction within the network of MSHN's SUD providers. We have also developed actions for consideration that are anticipated to decrease turnover intention and increase job satisfaction.

Frequent turnover tends to have a deleterious effect on staff morale and productivity and often places an even heavier workload on already stretched staff. Turnover rates among non-profits have been increasing over the last several years. COMPDATA's Turnover Report 2017[1] found **voluntary** turnover in the Midwest to be 12.5% for Not-For-Profits (15.9% overall including non-voluntary turnover), 16.1% in Healthcare (20.3% overall), and 11.2% in Services (16.2% overall). Non-profits typically report that the hardest positions to retain are in direct service, which usually include some of the lowest-paid positions in an organization. As other scientific studies have concluded, we also find that job satisfaction correlates with turnover. Employees who are satisfied with their jobs tend less frequently to look for other employment.

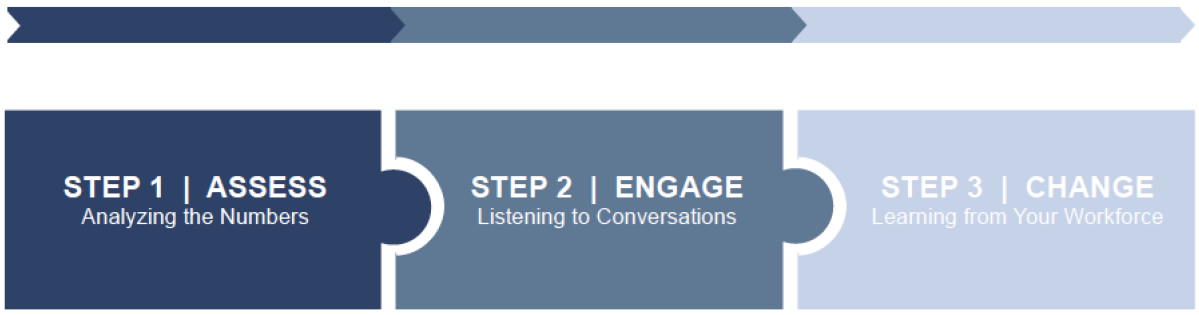
In this report, we identify workplace strengths and challenges, high- and low-scoring dimensions associated with workplace wellbeing, the most critical factors in retaining SUD employees, and actions for consideration for both MSHN and SUD providers designed to improve retention and job satisfaction.

[1] From the *Compensation Data BenchmarkPro* report, which provides cross-industry salary data for more than 560 general staff job titles from nearly 30,000 organizations across the country.

THE OCCUMETRICS PROCESS

First, we surveyed[2] employees of MSHN's SUD provider network along 10 different dimensions of workplace wellbeing described below. These results then informed what areas to explore in seven follow-up focus groups, which included groups of front line and managerial staff, totaling 37 employees. This combination of quantitative and qualitative data using multiple measures provided the information necessary to identify the primary predictors of job satisfaction and turnover intention within MSHN's SUD provider network and develop actions for consideration to improve on any issues.

- **Emotional Exhaustion**—the extent to which employees' mental and emotional reserves are depleted
- **Work Engagement**—the extent to which employees are involved, committed, enthusiastic and focused
- **Supervisor Support** and **Colleague Support**—the extent to which colleagues and managers support and encourage
- **Work Demands**—the extent of requirements on staff concerning hours, deadlines, quantity of work, taking breaks, and time pressures
- **Control/Autonomy**—the extent of independence in how to do the job
- **Interpersonal Relationships**—the nature of workplace relationships, such as friction, harassment, and bullying
- **Job Role**—the extent to which employees understand their duties and responsibilities and fit into the bigger organizational framework
- **Organizational Change**—the extent of employee involvement with organizational change and how they perceive fairness in organizational decision-making
- **Distributive Justice**—the extent to which employees perceive fairness in their pay, praise, etc.



[2] Approximately 19% of staff responded to the survey (283 out of 1500); $^{+/-}$4.1% margin of error

WELLNESS PROFILE: THE SNAPSHOT

DISCOVERIES

The following overall indicators predicted and had the most impact:

- On **turnover intention**: *Work Engagement, Supervisor Support, Job Role,* and *Satisfaction with Pay and Benefits*
- On **overall job satisfaction**: *Work Engagement, Supervisor Support, Job Role, Satisfaction with Pay, Interpersonal relationships,* and *Control/Autonomy.*

Employees reported being motivated by the following factors about their workplace:

- Mission-driven work
- Flexibility
- Supportive coworkers

They reported being most discouraged by these conditions:

- Unmanageable workloads; feeling burnt out and understaffed
- Paperwork taking away from client care
- Low pay and, in some cases, a lack of benefits
- Inability to engage in self-care
- Difficulty hiring and retaining appropriate, quality staff (particularly in rural areas)
- Having to implement the new GAIN process
- Poor communication between treatment providers and MSHN (however, prevention providers report good relationships with MSHN)

ACTIONS FOR CONSIDERATION

MSHN and the SUD providers are anticipated to benefit most from the following actions:

- Looking into paperwork v. client time ratios (for treatment staff; prevention did not report the same paperwork issue)—this was the number one issue brought up by treatment providers.
- Understanding paperwork redundancies and working to consolidate/create efficiencies—reports of different governing and accrediting bodies not realizing what's being asked of providers from each other—same with auditing process
- Creating opportunities for frontline staff at provider agencies to share feedback about changes that impact them directly prior to the changes happening
- Creating shadowing opportunities for MSHN staff to "walk in the shoes" of provider staff
- Creating time for self-care initiatives to be included in the work day; burnout was reported to be partially due to an inability to process the difficult and sad client situations that are dealt with
- Not proceeding with the GAIN assessment instrument
- Understanding and explaining the perception of why licensed clinicians with more credentials (addictions credentials) are paid and reimbursed at a lower rate than licensed clinicians at CMH providers
- Addressing wage and benefits concerns

WELLNESS PROFILE: THE DETAILS

STEP 1 | ASSESS: Analyzing the Numbers

The data analysis, in part, identifies factors most predictive of two outcomes: employee intent to leave and job satisfaction. These factors (or variables) give employers some insight as to what matters most to their employees when it comes to deciding whether to stay and how satisfied they are at work.

These variables were most impactful[3] and predicted 56% of the change in turnover intention (TI) and 68% of the change in job satisfaction (JS), as indicated by TI and/or JS:

Work Engagement

- It happens more and more often that I talk about my work in a negative way. (.31, TI; .20, JS)
  - "It happens more and more often that I talk about my work in a negative way" is best predicted (67.6%) by "I find my work to be a positive challenge" (.28), "I can rely on my immediate supervisor to help me out with a work problem" (.24), "After my work, I feel worn out and weary" (.22), "Over time, I can become disconnected from the type of work I do" (.16), "I find new and interesting aspects in my work" (.16), "Job decisions are applied consistently across all affected employees" (.13), "I have to work very fast" (.11).
- I find my work to be a positive challenge. (.26, JS)
- I feel more and more engaged in my work. (.24, JS; .19, TI)
- My job is the only type of work that I can imagine myself doing. (.09, TI)

Supervisor Support

- I am supported through emotionally demanding work. (.20, JS; .19, TI)

Job Role

- I am clear what is expected of me at work. (.16, TI)
- I am clear what my duties and responsibilities are. (.15, JS)
- I understand how my work fits into the overall aim of the organization. (.14, JS)

Interpersonal Relationships

- I am subject to personal harassment in the form of unkind words or behavior. (.12, JS)

Satisfaction with Pay

- How satisfied are you with your pay? (.11, TI; .10, JS)

Satisfaction with Benefits

- How satisfied are you with your benefits, such as paid time off, medical and dental insurance, retirement plan, and other fringe benefits? (.10, TI)

Control/Autonomy

- My working time can be flexible. (.10, JS)

[3] The coefficient in parenthesis is added in order to provide an idea of relative strength among the variables; the higher the coefficient, the more impactful on TI and/or JS.

Workplace Wellbeing Aggregate Scores

(On a 0-6 scale, the higher the score the better.)

Dimensions of Workplace Wellbeing	N	Mean	Ohio Statewide*
Job Role	258	4.79	4.81
Interpersonal Relationships	258	4.47	4.74
Colleague Support	272	4.26	4.33
Control/Autonomy	260	4.03	3.79
Supervisor Support	268	4.02	3.79
Work Engagement	276	3.78	3.65
Distributive Justice	255	3.60	3.29
Organizational Change	257	3.28	2.97
Work Demands	264	2.93	3.32
Emotional Exhaustion	283	2.87	2.96
Workplace Wellbeing	283	3.76	3.79

Workplace Wellbeing Scale: 0 = Never, 1 = Almost never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Very often, 6 = Always

**Statewide scores represent 5,496 employees in 28 Ohio BH organizations (1.3% margin of error at 99% confidence level)*

	N	Mean	Ohio Statewide
Overall, how satisfied are you with your current job?	254	4.32	4.07
How satisfied are you with your pay?	254	3.32	2.80
How satisfied are you with your benefits, such as paid time off, medical and dental insurance, retirement plan, and other fringe benefits?	253	3.55	3.79

Satisfaction Scale: 0 = Very dissatisfied, 1 = Dissatisfied, 2 = Somewhat dissatisfied, 3 = Neither dissatisfied nor satisfied, 4 = Somewhat satisfied, 5 = Satisfied, 6 = Very satisfied

	N	Mean	Ohio Statewide
I think about quitting my job.	254	3.72	3.65
I am actively looking for another job outside of my organization.	254	4.31	4.20
Turnover Intention	254	4.02	3.91

Turnover Scale: 0 = Always, 1 = Very often, 2 = Often, 3 = Sometimes, 4 = Rarely, 5 = Almost never, 6 = Never

Turnover Intention: Survey respondents indicated their turnover intention as 37% who at least sometimes thought about quitting and actively looked for another job. While this percentage doesn't statistically equate to actual turnover, our experience is that this number is often close to the prior year's actual turnover. 50.8% at least sometimes thought about quitting, and 33.9% at least sometimes actively looked for another job. The overall mean for turnover intention was 4.02 (4=Rarely).

Overall Workplace Wellbeing: "Overall Workplace Wellbeing" combines all ten dimensions of workplace wellbeing. Survey respondents averaged a score of 3.76.

Satisfaction with Pay: The aggregate mean score was 3.32. About 54% of responding staff members were *Somewhat* to *Very satisfied* with their pay. About 37% were at least *Somewhat dissatisfied* with their pay. Satisfaction with pay was a direct factor in turnover intention and job satisfaction.

Satisfaction with Benefits: Satisfaction with benefits had a mean of 3.55. 58% were at least *Somewhat satisfied* and 29% were at least *Somewhat dissatisfied*. Satisfaction with benefits was a factor in turnover intention but not in job satisfaction.

STEP 2 | ENGAGE: Listening to Conversations

Focus group conversations provided fuller personal detail about workplace dynamics. In these groups, staff reported deriving the greatest job satisfaction and work engagement from their clients and the population they serve. As sources of satisfaction, they also cited their flexibility and their relationships with co-workers. They expressed concern about low pay, paperwork taking away from client care, feeling understaffed, poor communication between providers and MSHN and other decision-making bodies, inability to engage in self-care, inability to hire and retain quality employees (particularly in rural areas), and the new GAIN process. More specific information on the focus group discussions can be found in the Appendix.

Summary of focus group discussions:

- **Pay**: generally dissatisfied with pay; reports of being paid lower than CMH employees
- **Benefits:** mostly dissatisfied with benefits (some employees report not being eligible for benefits and would like to be)
- **Organizational Change**: a perception that change happens quickly and is determined by entities who do not know how it impacts the people who have to implement the change at the provider level
- **Colleague Support**: appears to be mostly high
- **Supervisor Support**: varied based on supervisor; perception that supervisors are also stretched thin and burnt out
- **Work Engagement**: employees are mission-focused and find their jobs rewarding but overwhelming
- **Work Demands**: reported difficult workloads, particularly due to paperwork demands; most departments reported being short-staffed

Positive work experiences:

- Mission-driven work
- Flexibility
- Supportive coworkers

Negative work experiences:

- Paperwork taking away from client care
- Unmanageable workloads; feeling short-staffed
- Poor communication between providers and MSHN/other decision-making bodies
- Low pay and lack of benefits
- Inability to engage in self-care
- Inability to hire and retain quality employees (particularly in rural areas)
- Having to implement the new GAIN process

STEP 3 | CHANGE: Learning from your Workforce

Considerations for MSHN

- See what can be done about adjusting paperwork time v. client time so that the focus of care is on meeting clients' needs rather than on the clients meeting the agency's needs.
- Understand and address paperwork redundancies and work to consolidate/create efficiencies—reports of different governing and accrediting bodies not realizing what's being asked of providers from each other—same issue reported with the auditing process.
- Look into reports of negative experiences and interactions between MSHN and treatment provider staff.
- Create opportunities for frontline staff at provider agencies to share feedback about changes that impact them directly prior to the changes happening.
- Create shadowing opportunities for MSHN staff to "walk in the shoes" of treatment provider staff to help build mutual trust and understanding between MSHN and SUD treatment providers.
- Continue to push back against having to implement the GAIN assessment instrument. Providers fear it will cause them to lose potential high-risk clients due to the intrusive, triggering, and overwhelming (in length and content) nature of the assessment.
- Understand and address the competitive versus collaborative nature of relationships among providers; appropriate referrals and chances to help clients more holistically are missed because they are hesitant to collaborate.
- Understand and explain to providers the perception of why licensed clinicians with more credentials (specifically addictions credentials) are paid and reimbursed at a lower rate than licensed clinicians at CMH agencies.
- Work with providers to address wage and benefits concerns.

Considerations for Providers

- Create time for self-care initiatives to be included in the work day; burnout was reported to be partially due to an inability to process the difficult and sad client situations that are dealt with.
- Work with MSHN to create opportunities for frontline staff at their agencies to share feedback about changes that impact them directly prior to the changes happening.
- Better understand the service offerings of other providers in their areas and build relationships with them to be able to provide clients with the best possible care.

Considerations regarding Pay and Benefits

- Providers should conduct a study of pay and benefits at comparable local employers to develop appropriate compensation plans; the plans should, at minimum, include wage ranges for staff positions, and policies and procedures for determining and deploying wage increases and/or annual bonuses.

- The compensation plans should be explained clearly to staff, and a feedback loop created for incorporating staff response and ongoing experience with wage and benefit levels.
- While wage increases may not be possible, at minimum, the compensation plan should be shared across the agency; however, most providers would benefit from working on a business plan that would afford targeted pay increases for lower paid positions.
- MSHN should address the additional funding that providers need for more administrative support as their agencies grow.

What's Next?

Thank you for participating in the Occumetrics assessment process. We welcome questions and feedback as MSHN and SUD providers review our actions for consideration. We hope to continue our relationship with MSHN by providing a reassessment in one to two years after potential implementation of any of the actions.

Introduction

Health Services Advisory Group, Inc. (HSAG), as the external quality review organization (EQRO) for Michigan Department of Health & Human Services (MDHHS), conducted the following external quality review (EQR) activities for the Prepaid Inpatient Health Plans (PIHPs) during state fiscal year (SFY) 2017–2018:

- Compliance monitoring
- Validation of performance measures
- Validation of performance improvement projects (PIPs)

For each EQR activity, HSAG provided PIHP-specific findings and, if indicated, recommendations to the PIHP. On an annual basis, the EQRO is required to report, as part of the technical report that is the State's deliverable to the Centers for Medicare & Medicaid Services (CMS), the PIHP-specific results and the degree to which each PIHP addressed any recommendations made by the EQRO. The SFY 2017–2018 EQR Technical Report that contains those results and recommendations was uploaded to MDHHS' Website at: https://www.michigan.gov/documents/mdhhs/MI2017-18_PIHP_EQR-TR_F1_With_Attachments_651413_7.pdf

This document contains the recommendations and improvement suggestions that were provided for **Mid-State Health Network**, in the SFY 2017–2018 EQR Technical Report.

Directions for Completion

On the following pages, please indicate the activities and/or interventions that were implemented during SFY 2018–2019 in follow-up to the recommendations made in the SFY 2017–2018 EQR Technical Report. Please include a summary of those activities that were either completed or are implemented and still underway, not those that are only in the planning stage, to improve the finding that resulted in the recommendation. Submit the completed documentation via email to HSAG **no later than January 3, 2020.** Please do not include protected health information (PHI) in your submission.

Please contact the following HSAG staff members with any questions:

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LDougherty@hsag.com | 614.477.9735

Ruth Ruby, RN, BSN
RRuby@hsag.com | 602.321.4080

Table 1—Compliance Monitoring—Recommendations and PIHP Response

HSAG Compliance Monitoring Review Recommendation
HSAG recommends that **Mid-State Health Network** develop meaningful plans of action to bring into compliance each of the following deficient standards: • Standard VI—Customer Service (Dan) • Standard VII—Grievance Process (Dan) • Standard IX—Subcontracts and Delegation (Carolyn) • Standard XII—Access and Availability (Sandy/Dan) • Standard XIV—Appeals (Dan) **Mid-State Health Network** should include the following in each of its plans of action, and the plans of action should be provided to MDHHS within 30 days of receipt of required corrective action: • Detailed narrative of the deficiency. • Detailed corrective action steps to resolve each deficiency. • Any resources required to resolve the deficiency. • Due dates for completing each action step. • Assigned party responsible for completing each action step. • Any required deliverables to show that a deficiency has been resolved. • Any dependencies to resolve deficiencies
PIHP Compliance Monitoring Review Response
• **Standard VI—Customer Service** 4. STATUS: Completed The required information identified by HSAG that included information regarding enrollee's right to use any hospital or other setting for emergency care and information on how to report suspected fraud and/or abuse has been added to the MSHN Consumer Handbook for FY2019. MSHN received approval from MDHHS for the FY2019 Handbook, including the addition of the missing elements. MSHN also corrected the timeframe for standard appeal decisions to reflect 30 days as identified by the MDHHS contract. This information was completed at the time MSHN submitted the initial CAP response. 5. STATUS: Completed and Ongoing The twelve CMHSPs under contract with MSHN continue to upload their provider directory file to MSHN's managed care information system (REMI) in accordance with all content required by the contract and 42 CFR 438.10(h) as indicated in the policy (Provider Network Directory – Information Requirements 7/2018) and procedure (Provider Network Directory – Information Requirements 4/2018-). The combined file (of all CMHSPs) is then exported to a CSV file, along with the MSHN SUD network directory and uploaded to the MSHN website for a complete listing of providers, inclusive of independent PCP facilitators, on the MSHN website. The directory template used by CMHSPs to import CMHSP provider directory data includes a field 'Accepting New Enrollees' with an indicator of Yes or No. This information is then displayed on the directory. Additionally, MSHN collects this information at the point when providers apply to the MSHN network and maintains data in the management information system (REMI). Providers are required to submit a monthly waitlist report to MSHN which would indicate they are at capacity and would trigger the system to be updated accordingly. Process improvement that is currently in progress includes the development of data validations to ensure all data is consistent and the elimination/consolidation of duplicate

provider records (i.e. when multiple CMHSPs have a contract with the same provider, the listing will include duplicates).

Standard VII—Grievance Process

3. STATUS: Completed

The MSHN SUD Treatment contracts states that our providers are required to assist beneficiaries with filing grievances and appeals, assessing the local dispute resolution processes, and coordinate, as appropriate, with the Recipient Rights Advisor. MSHN provides oversight and monitoring of this process during the annual site review of the providers by reviewing the provider's grievance policies and procedures, along with reviewing a sample of grievances that have been completed to ensure compliance with all required standards. The grievance site review tool was updated for FY2019 to ensure review of the required elements. MSHN also monitors grievances through quarterly reporting through the Denial, Grievance, Appeals and Second Opinion Report which was updated for FY2019 to require the submission of grievance details for all grievances reported by the provider. All grievances reported directly to MSHN are investigated through to resolution by the Customer Service and Rights Specialist with follow up to the appropriate SUD Provider.

7. STATUS: Completed

MSHN developed a standardized grievance resolution notice template to be utilized by MSHN providers that is compliant with the 42 CFR 438.10. The grievance and appeal tool for the delegated managed care site review has been revised for FY2019 to monitor that letters are written at fourth-grade reading level, when possible, and meets the needs of those with limited English proficiency and limited reading proficiency by answering the question on if the "Resolution notice is easily understood? (length, language, grammar, reading level).

- **Standard IX—Subcontracts and Delegation**

5. STATUS: Completed

As identified in the plan of correction, the following language was added to the FY19 Medicaid Subcontract between MSHN and the CMHSPs, and the SUD Providers (XVIII. E.):

E. The parties hereto agree that the right to audit exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later, in accordance with42 CFR 438.230(c)(3)(iii).

- **Standard XII—Access and Availability**

4. STATUS: Completed and Ongoing

During the review period for the HSAG Compliance Monitoring Site Review, MSHN had the following corrective action plans related to 3c (The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. Developmentally Disabled- Children. Standard = 95%).

FY18Q1 - 1 CMHSP had corrective action. MSHN Performance was 83.05%.

FY18Q2 – 1 CMHSP had corrective action. MSHN performance was 98.08%.

FY18Q3 – 0 CMHSPs. MSHN performance was 97.79%.

FY18Q4 – 2 CMHSPs had corrective action. MSHN performance was 97.56%.

MSHN has demonstrated an increase in performance for those quarters identified below the standard which indicates that corrective action implemented was effective.

MSHN reviews the MMBPIS reports quarterly with the Quality Improvement Council (QIC) which consists of the Quality Improvement representative from each of the 12 CMHSPs and 1 representative from the Substance Use Disorder Program, who is a MSHN staff working with the SUD providers in providing technical assistance and guidance. A Corrective action plan is completed for each indicator that falls below the standard each quarter. The action plan consists of common or special causal factors contributing to the low performing rates. Interventions with an implementation date and the date of full impact/benefit is identified. The plan is reviewed and approved by MSHN staff. The effectiveness of the plan is demonstrated based on the performance of the organization during the upcoming measurement periods.

Additionally, regional activity developed to improve this process includes additional training, development of documents to ensure consistency of reporting, definitions, interpretations (FAQ). The monitoring of the completion of corrective action and validations of data reported is completed during the delegated managed care site reviews.

The status of the process for monitoring the performance is completed, however, is ongoing to ensure that all causes of low performance are continually reviewed and acted upon.

- **Standard XIV—Appeals**

3. STATUS: Completed

The MSHN Appeals and Grievances Policy was revised to include the requirement for providers to be in compliance with 42 CFR 438 Subpart F, which includes the standard of requesting written follow up after the acceptance of an oral request for an appeal. MSHNs appeal and grievance tool for the delegated managed care site review includes the review that if a request for an appeal was submitted orally, then it must be followed up in writing. During the annual review, MSHN reviews the appeal process and a sample of appeals that have been completed to ensure compliance with the standards. The appeal requirements are monitored through the regional Customer Service Committee to ensure the standards are being implemented appropriately and consistently across the region.

8. STATUS: Completed

The MSHN Appeals and Grievances Policy was revised to include the requirement for providers to be in compliance with 42 CFR 438 Subpart F. MSHN monitors the appeals timeframe through a case record review during the delegated managed care site review process. MSHN also monitors appeals through quarterly reporting of the Denial, Grievance, Appeals and Second Opinion Report which was updated for FY2019 to require the submission of appeals details for all appeals reported by the provider. The report details include appeal timeframe data to ensure that each appeal was completed within the required 30 calendar day timeframe. The quarterly report requires that a Corrective Action Plan be submitted by any CMHSP or SUDSP who does not meet the 100% compliance requirement for providing appeals Notices within the 30-day timeframe. 'Currently two of the twelve CMHSP are under corrective action for not meeting the standard of 100%.

11. STATUS: Completed

The grievance and appeal tool for the delegated managed care site review has been revised for FY2019 to monitor that letters are written at a fourth-grade reading level, when possible, and meets the needs of those with limited English proficiency and limited reading proficiency by answering the question on if the

"Resolution notice is easily understood? (length, language, grammar, reading level). MSHN also utilizes standardize appeal notice templates to ensure consistent information is provided throughout the region. The CAP was modified to include the use of the contract attached notice templates for grievance and appeals as required by MDHHS.

12. STATUS: Completed

MSHN revised the standard appeal approval and denial templates for FY2019 to include the date the appeal was completed. The templates also provide a framework to include the required results of the resolution. The appeal tool for the delegated managed care site review had been revised for FY2019. The following was added to the appeal site review tool: "Resolution notice is easily understood? (length, language, grammar, reading level).

Table 2—Performance Measures—Recommendations and PIHP Response

HSAG Performance Measures Recommendation
As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Mid-State Health Network** to members, HSAG recommends that **Mid-State Health Network** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP: **Ratings Below the MPS** • *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional*—DD Children **Performance Declined >2 Percent From Previous Year** • *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional*—MI Children • *#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days* **Mid-State Health Network** should include within its next annual QAPIP review the results of analyses for the performance indicators listed above that answer the following questions: 1. What were the root causes associated with low-performing rates? 2. What unexpected outcomes were found within the data? 3. What disparities were identified in the analyses? 4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)? 5. What intervention(s) is **Mid-State Health Network** considering or has already implemented to improve rates and performance for each identified indicator?

Based on the information presented above, **Mid-State Health Network** should include the following within its quality improvement plan:

- Measurable goals and benchmarks for each indicator.
- Mechanisms to measure performance.
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates.
- Identified opportunities for improvement.
- Ongoing analysis to identify factors that impact adequacy of rates.
- Quality improvement interventions that address the root cause of the deficiency.
- A plan to monitor the quality improvement interventions to detect whether they effect improvement.

Additionally, **Mid-State Health Network** should have defined data entry processes, including documented processes for data quality and data completeness checks.

PIHP Performance Measures Review Response

STATUS: Complete and Ongoing

During this review period MSHN has had the following corrective action plans by different CMHSPs related to 3a, 3c, and 4b completed. Only one CMHSP did not demonstrate improvement or reach the desired performance level after corrective action during the reporting periods below.

FY18Q1 - 5 CMHSPs were required to have a plan of correction
FY18Q2 – 5 CMHSPs were required to have a plan of correction
FY18Q3 – 4 CMHSPs were required to have a plan of correction
FY18Q4 – 2 CMHSPs were required to have a plan of correction

MSHN reviews the MMBPIS reports quarterly with the QIC which consists of the Quality Improvement representative from each of the 12 CMHSPs and 1 representative from, the Substance Use Disorder Program, who is a MSHN staff working with the SUD providers in providing technical assistance and guidance. A Corrective action plan is completed for each indicator that falls below the standard each quarter. The action plan consists of common or special causal factors contributing to the low performing rates. Interventions with an implementation date and the date of full impact/benefit is identified. The plan is reviewed and approved by MSHN staff. The effectiveness of the plan is demonstrated based on the performance of the organization during the upcoming measurement periods.

Additionally, regional activity to improve the process includes additional training, development of documents to ensure consistency of reporting, definitions, interpretations (FAQ). The monitoring of the completion of corrective action and validations of data reported is completed during the delegated managed care site reviews.

The status of the process for monitoring the performance is completed, however, is ongoing to ensure that all causes of low performance are continually reviewed and acted upon.

Table 3—PIP—Recommendations and PIHP Response

HSAG PIP Recommendations
Mid-State Health Network should take proactive steps to ensure a successful PIP. As the PIP progresses, **Mid-State Health Network** should ensure the following: • Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate. • Document the process and steps used to determine barriers to improvement; and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators, and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.
PIHP PIP Response
STATUS: Complete and Ongoing Mid-State Health Network followed the process as indicated in the PIP to determine baseline. After the baseline was obtained a causal analysis was completed by the QIC using a fishbone diagram. Interventions were identified to address each barrier or causal factor. The interventions were prioritized utilizing a prioritization matrix addressing the impact and effect of the interventions. The implementation of the interventions identified are reviewed quarterly by the QIC to determine effectiveness in improving the outcome. Any signals or variations of the data are investigated. If the identified interventions do not address the variations additional action steps are taken to improve or correct the process and ultimately impact the outcome of the study.

Quality Assessment Performance Improvement Program
Quality Improvement Council – Critical Incidents FY19Q4

Summary of Project

The data collected is based on the definition and requirements that have been set forth within the Critical Incident Reporting System (CIRS) attached to the PIHP contract and available on the MDHHS Website.

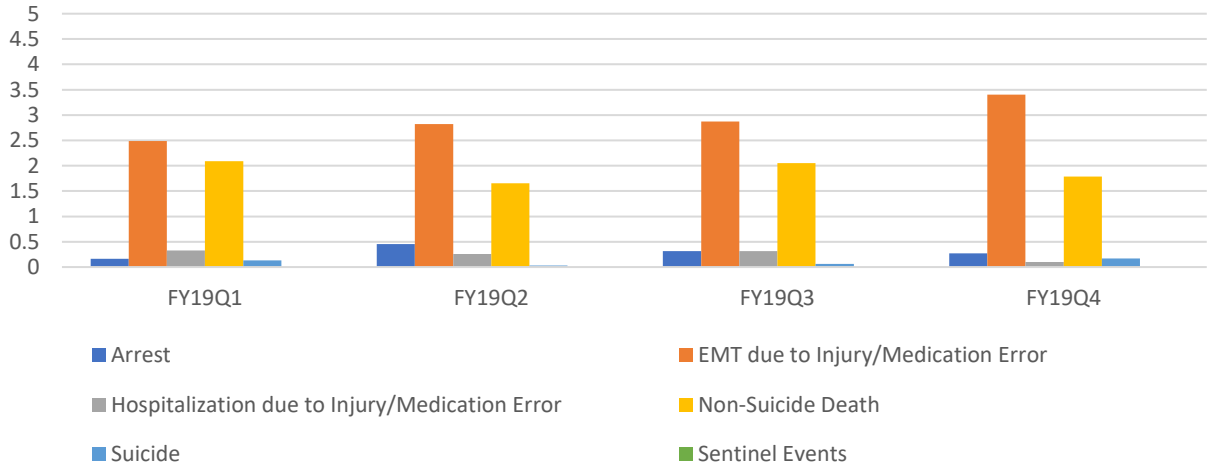
The following incidents are reported by the CMHSP Participants:

- Deaths-Suicide (include those who were seen for an emergency service in previous 30 days) and Non-Suicide for all individuals receiving services. Subsets of deaths include natural cause, accidental, homicidal;
- Emergency Medical Treatment-All Waiver Groups residing in 24 hour specialized residential and/or Child Care Institution
- Hospitalization- All Waiver Groups residing in 24 hour specialized residential and/or Child Care Institution
- Arrests- All Waiver Groups residing in 24 hour specialized residential and/or Child Care Institution
- All Waiver Groups

This data is to be reported and reviewed as part of the CMHSP Quality Assessment and Performance Improvement Program (QAPIP). MSHN will analyze the data on a quarterly basis to address any trends and/or opportunities for quality improvements.

Data Analysis

Figure 1. MSHN Critical Incident Reporting System
Rate per 1000 consumers served (unique)



1. The rate of arrests, per 1000 persons, served will demonstrate a decrease from previous reporting period. MSHN met the standard.

Figure 2. Rate of Arrests per 1000 Served

Organization	Standard	FY19Q1	FY19Q2	FY19Q3	FY19Q4
MSHN	**Trend**	**0.163**	**0.455**	**0.316**	**0.270**
BABH	Trend	0.000	0.275	0.278	0.000
CEI	Trend	0.177	0.000	0.000	0.000
CMHCM	Trend	0.355	0.717	0.351	0.504
GCMH	Trend	0.000	0.000	0.000	0.002
HBH	Trend	1.255	0.000	4.950	0.000
ICCMH	Trend	0.000	0.744	0.000	0.000
LifeWays	Trend	0.000	0.000	0.000	0.000
MCBH	Trend	0.000	1.701	0.778	0.000
NCMH	Trend	0.000	0.000	0.000	0.000
Saginaw	Trend	0.229	1.153	0.454	1.104
Shiawassee	Trend	0.000	0.886	0.000	0.000
TBHS	Trend	0.000	0.000	0.000	0.000

2. The rate, per 1000 persons served, of persons who received emergency medical treatment for an injury or medication error will demonstrate a decrease from previous reporting period. MSHN did not meet this standard. The last four reporting periods demonstrated an increase. This could be a result of an increase in accurate reporting systems being developed within each CMHSP.

Figure 3. Rate of Emergency Medical Treatment for Injury or Medication Error per 1000 served

Organization	Standard	FY19Q1	FY19Q2	FY19Q3	FY19Q4
MSHN	**Trend**	**2.484**	**2.825**	**2.875**	**3.405**
BABH	Trend	0.843	4.132	3.894	3.627
CEI	Trend	1.950	1.073	1.015	0.668
CMHCM	Trend	5.154	5.021	5.966	4.704
GCMH	Trend	0.000	0.000	0.000	0.834
HBH	Trend	0.000	3.846	0.000	0.000
ICCMH	Trend	1.504	1.488	0.000	2.813
LifeWays	Trend	1.178	1.361	0.886	1.540
MCBH	Trend	3.600	5.952	5.443	3.016
NCMH	Trend	0.000	0.000	0.000	0.000
Saginaw	Trend	3.201	3.230	4.538	6.180
Shiawassee	Trend	1.756	4.429	5.089	6.628
TBHS	Trend	6.842	1.104	0.000	2.899

3. The rate, per 1000 persons served, of individuals who were Hospitalized for an injury or medication error will demonstrate a decrease from previous reporting period. MSHN met the standard.

Figure 4. Rate of Hospitalizations for an injury or medication error per 1000 served

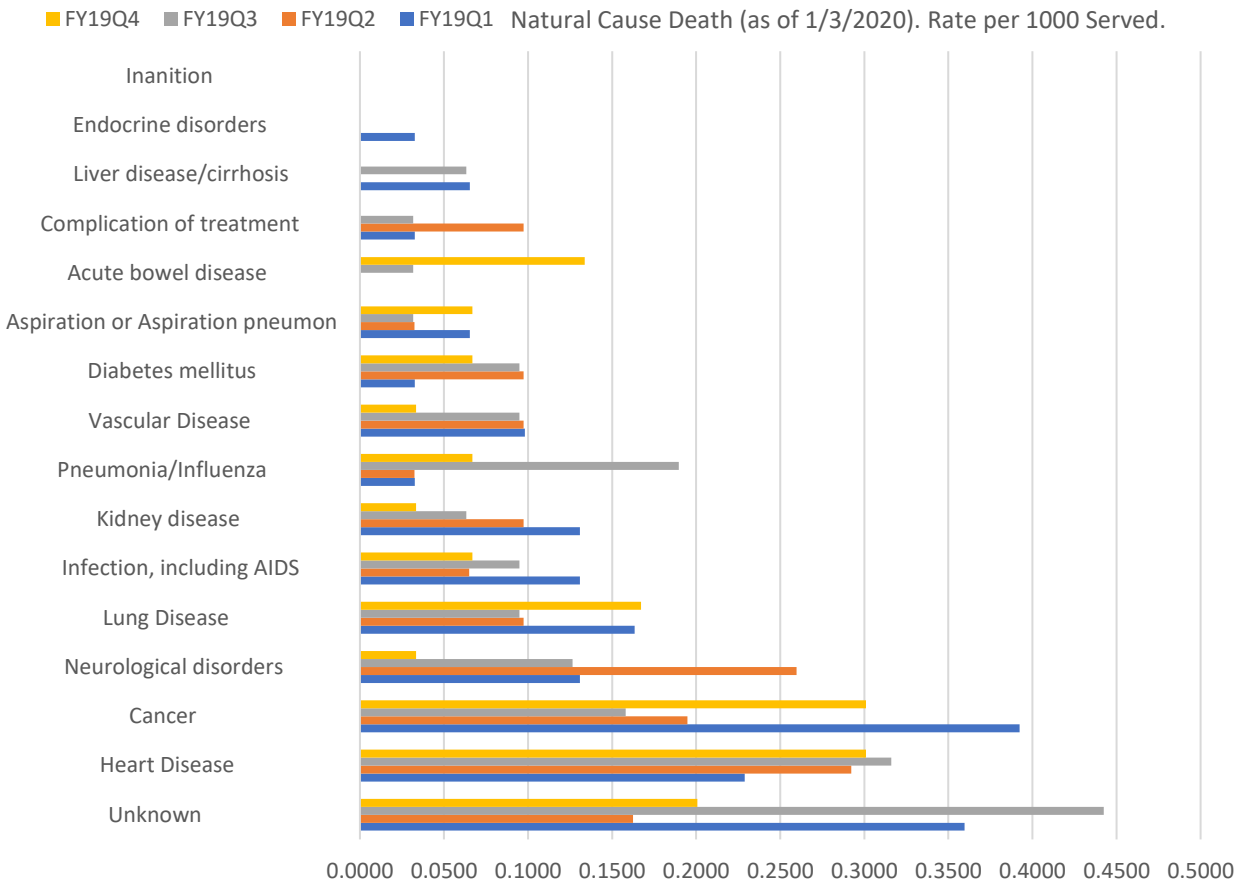
Organization	Standard	FY19Q1	FY19Q2	FY19Q3	FY19Q4
MSHN	**Trend**	**0.327**	**0.260**	**0.316**	**0.101**
BABH	Trend	0.562	0.000	0.000	0.000
CEI	Trend	0.000	0.358	0.000	0.167
CMHCM	Trend	0.178	0.179	0.175	0.168
GCMH	Trend	0.000	0.000	0.000	0.000
HBH	Trend	0.000	2.564	8.663	0.000
ICCMH	Trend	1.504	0.000	0.000	0.703
LifeWays	Trend	0.942	0.680	0.000	0.000
MCBH	Trend	0.000	0.000	0.000	0.000
NCMH	Trend	0.000	0.000	0.000	0.000
Saginaw	Trend	0.000	0.000	0.227	0.221
Shiawassee	Trend	0.878	0.000	0.848	0.000
TBHS	Trend	0.000	0.000	0.000	0.000

4. The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous reporting period. MSHN met the standard. Figure 6 demonstrates the leading cause of death to be heart disease then cancer.

Figure 5. Rate of Non-Suicide Deaths per 1000 served

Organization	Standard	FY19Q1	FY19Q2	FY19Q3	FY19Q4
MSHN	**Trend**	**2.092**	**1.656**	**2.054**	**1.787**
BABH	Trend	3.654	2.755	1.947	1.395
CEI	Trend	1.595	2.324	2.200	2.337
CMHCM	Trend	2.843	2.152	1.404	2.184
GCMH	Trend	0.000	0.000	0.000	0.834
HBH	Trend	3.764	0.000	6.188	1.206
ICCMH	Trend	2.256	0.000	1.451	0.703
LifeWays	Trend	0.942	1.361	2.215	1.980
MCBH	Trend	2.700	0.850	0.000	0.000
NCMH	Trend	0.000	0.000	0.000	0.000
Saginaw	Trend	2.515	1.153	4.084	1.545
Shiawassee	Trend	0.878	0.886	1.696	1.657
TBHS	Trend	1.140	3.311	0.000	0.000

Figure 6. Rate of MSHN Natural Casue Death per 1000 served.



5. The rate, per 1000 persons served, of Suicide Deaths will demonstrate a decrease from previous reporting period. MSHN did not meet the standard.

   MSHN identified an increase in accidental and homicidal deaths for FY19Q4. Accidental deaths include any unexpected death that is not a result of the natural course of an illness. This includes an overdose or other unexpected death that may not have been attributed to a suicide or homicide. Accidental deaths require additional information to be reviewed to identify the cause.

Figure 7. MSHN Rate per 1000 Served

Critical Events	Standard	FY19Q1	FY19Q2	FY19Q3	FY19Q4
Suicide	Trend	0.131	0.032	0.063	0.167
Accidental	Trend	0.196	0.130	0.158	0.468
Homicidal	Trend	0.000	0.000	0.032	0.033

6. The annual rate, per 1000 served, of reportable critical incidents as indicated in Figure 8, demonstrates a decrease in each incident type except arrests.

Figure 8. Annual Rate of Reportable Critical Incidents per 1000 Served

Critical Events	Standard	FY17	FY18	FY19
Arrest	Trend	0.831	0.801	0.812
EMT due to Injury/Medication Error	Trend	8.308	9.704	7.789
Hospitalization due to Injury/Medication Error	Trend	0.572	0.778	0.680
Non-Suicide Death	Trend	5.584	5.996	5.112
Suicide	Trend	0.252	0.481	0.2633

Conclusion: The standard for Critical Incidents is to demonstrate a decrease from the previous quarter. MSHN began to receive the critical incidents through a web service via REMI, MSHNs Managed Care Information System, in FY19Q1. During the past year a review of the process including reconciliation of reported events, has occurred. MSHN did not meet the standard in FY19Q4 for Emergency Medical Treatment. The annual comparisons however, indicate a decrease in Emergency Medical Treatment, Hospitalizations for Injury or Medication Error, Non-Suicide Deaths, and Suicide deaths. The rate of arrest did increase slightly since FY18. The unknown deaths were the leading cause of death for FY19Q1. An increased emphasis was placed on identifying the cause of death to ensure accurate and effective intervention can be applied. The following actions were taken to resolve the "unknown responses": CMHSP Participants updated the data submitted to ensure that accurate data is provided when available and identifying if any of the deaths do not fit into a currently available category for reporting. This was expected to be completed by 1/1/2020 for FY19Q4 final reporting. In FY19Q4 the leading cause of death was heart disease, followed by cancer. The rate of accidental deaths did demonstrate an increase. MSHN assures additional review of the accidental deaths is occurring at each CMHSP through the delegated managed care site review process.

Recommendations: MSHN should review the definition of "accidental deaths" to ensure consistency in reporting, and to identify categories for reporting the "unexpected deaths". Unexpected and accidental deaths should be reviewed to identify specifically the cause of death such as drug related, accidental overdose, or any other cause that may benefit from an intervention.

Each unexpected death should result in additional information being obtained, and each sentinel event should result in a root cause analysis with identified action to prevent from reoccurrence. All sentinel events should be reported to MSHN. Training should occur to ensure providers are able to identify sentinel events and to ensure the reporting process for sentinel events and unexpected deaths to MSHN is occurring.

Prepared by: Sandy Gettel, Quality Manager Date: 1/13/2020

Approved by: MSHN QIC Date:

Attachment 1

Critical Events	Organization	FY19Q1	FY19Q2	FY19Q3	FY19Q4	FY19
Arrest	**MSHN**	5	14	10	8	37
Arrest	BABH	0	1	1	0	2
Arrest	CEI	1	0	0	0	1
Arrest	CMHCM	2	4	2	3	11
Arrest	GCMH	0	0	0	2	2
Arrest	HBH	1	0	4	0	5
Arrest	ICCMH	0	1	0	0	1
Arrest	LifeWays	0	0	0	0	0
Arrest	MCBH	0	2	1	0	3
Arrest	NCMH	0	0	0	0	0
Arrest	Saginaw	1	5	2	5	13
Arrest	Shiawassee	0	1	0	0	1
Arrest	TBHS	0	0	0	0	0
Critical Events	**Organization**	**FY19Q1**	**FY19Q2**	**FY19Q3**	**FY19Q4**	**FY19**
EMT due to Injury/Medication Error	**MSHN**	76	87	91	101	355
EMT due to Injury/Medication Error	BABH	3	15	14	13	45
EMT due to Injury/Medication Error	CEI	11	6	6	4	27
EMT due to Injury/Medication Error	CMHCM	29	28	34	28	119
EMT due to Injury/Medication Error	GCMH	0	0	0	1	1
EMT due to Injury/Medication Error	HBH	0	3	0	0	3
EMT due to Injury/Medication Error	ICCMH	2	2	0	4	8
EMT due to Injury/Medication Error	LifeWays	5	6	4	7	22
EMT due to Injury/Medication Error	MCBH	4	7	7	5	23
EMT due to Injury/Medication Error	NCMH	0	0	0	0	0
EMT due to Injury/Medication Error	Saginaw	14	14	20	28	76
EMT due to Injury/Medication Error	Shiawassee	2	5	6	8	21
EMT due to Injury/Medication Error	TBHS	6	1	0	3	10

Critical Events	Organization	FY19 Q1	FY19 Q2	FY19 Q3	FY19 Q4	FY19
Hospitalization due to Injury/Medication Error	**MSHN**	10	8	10	3	31
Hospitalization due to Injury/Medication Error	BABH	2	0	0	0	2
Hospitalization due to Injury/Medication Error	CEI	0	2	0	1	3
Hospitalization due to Injury/Medication Error	CMHCM	1	1	1	1	4
Hospitalization due to Injury/ Medication Error	GCMH	0	0	0	0	0
Hospitalization due to Injury/Medication Error	HBH	0	2	7	0	9
Hospitalization due to Injury/Medication Error	ICCMH	2	0	0	1	3
Hospitalization due to Injury/Medication Error	LifeWays	4	3	0	0	7
Hospitalization due to Injury/Medication Error	MCBH	0	0	0	0	0
Hospitalization due to Injury/Medication Error	NCMH	0	0	0	0	0
Hospitalization due to Injury/Medication Error	Saginaw	0	0	1	1	2
Hospitalization due to Injury/Medication Error	Shiawassee	1	0	1	0	2
Hospitalization due to Injury/Medication Error	TBHS	0	0	0	0	0
Critical Events	**Organization**	**FY19 Q1**	**FY19 Q2**	**FY19 Q3**	**FY19 Q4**	**FY19**
Non-Suicide Death	**MSHN**	64	51	65	53	233
Non-Suicide Death	BABH	13	10	7	5	35
Non-Suicide Death	CEI	9	13	13	14	49
Non-Suicide Death	CMHCM	16	12	8	13	49
Non-Suicide Death	GCMH	0	0	0	1	1
Non-Suicide Death	HBH	3	0	5	1	9
Non-Suicide Death	ICCMH	3	0	2	1	6
Non-Suicide Death	LifeWays	4	6	10	9	29
Non-Suicide Death	MCBH	3	1	0	0	4
Non-Suicide Death	NCMH	0	0	0	0	0
Non-Suicide Death	Saginaw	11	5	18	7	41
Non-Suicide Death	Shiawassee	1	1	2	2	6
Non-Suicide Death	TBHS	1	3	0	0	4

Critical Events	Organization	FY19Q1	FY19Q2	FY19Q3	FY19Q4	FY19
Natural Cause	**MSHN**	58	47	59	50	214
Natural Cause	BABH	11	8	6	5	30
Natural Cause	CEI	8	12	12	14	46
Natural Cause	CMHCM	16	12	7	12	47
Natural Cause	GCMH	0	0	0	1	1
Natural Cause	HBH	3	0	4	1	8
Natural Cause	ICCMH	3	0	1	1	5
Natural Cause	LifeWays	4	5	10	7	26
Natural Cause	MCBH	3	1	0	0	4
Natural Cause	NCMH	0	0	0	0	0
Natural Cause	Saginaw	8	5	17	7	37
Natural Cause	Shiawassee	1	1	2	2	6
Natural Cause	TBHS	1	3	0	0	4
Critical Events	**Organization**	**FY19Q1**	**FY19Q2**	**FY19Q3**	**FY19Q4**	**FY19**
Accidental	**MSHN**	6	4	5	14	29
Accidental	BABH	2	2	0	4	8
Accidental	CEI	1	1	1	3	6
Accidental	CMHCM	0	0	1	2	3
Accidental	GCMH	0	0	0	0	0
Accidental	HBH	0	0	1	0	1
Accidental	ICCMH	0	0	1	0	1
Accidental	LifeWays	0	1	0	2	3
Accidental	MCBH	0	0	0	0	0
Accidental	NCMH	0	0	0	0	0
Accidental	Saginaw	3	0	1	3	7
Accidental	Shiawassee	0	0	0	0	0
Accidental	TBHS	0	0	0	0	0

Critical Events	Organization	FY19Q1	FY19Q2	FY19Q3	FY19Q4	FY19
Homicidal	**MSHN**	0	0	1	1	2
Homicidal	BABH	0	0	1	1	2
Homicidal	CEI	0	0	0	0	0
Homicidal	CMHCM	0	0	0	0	0
Homicidal	GCMH	0	0	0	0	0
Homicidal	HBH	0	0	0	0	0
Homicidal	ICCMH	0	0	0	0	0
Homicidal	LifeWays	0	0	0	0	0
Homicidal	MCBH	0	0	0	0	0
Homicidal	NCMH	0	0	0	0	0
Homicidal	Saginaw	0	0	0	0	0
Homicidal	Shiawassee	0	0	0	0	0
Homicidal	TBHS	0	0	0	0	0
Critical Events	**Organization**	**FY19Q1**	**FY19Q2**	**FY19Q3**	**FY19Q4**	**FY19**
Suicide	**MSHN**	4	1	2	5	12
Suicide	BABH	1	0	1	1	3
Suicide	CEI	3	1	0	4	8
Suicide	CMHCM	0	0	0	0	0
Suicide	GCMH	0	0	0	0	0
Suicide	HBH	0	0	0	0	0
Suicide	ICCMH	0	0	0	0	0
Suicide	LifeWays	0	0	1	0	1
Suicide	MCBH	0	0	0	0	0
Suicide	NCMH	0	0	0	0	0
Suicide	Saginaw	0	0	0	0	0
Suicide	Shiawassee	0	0	0	0	0
Suicide	TBHS	0	0	0	0	0

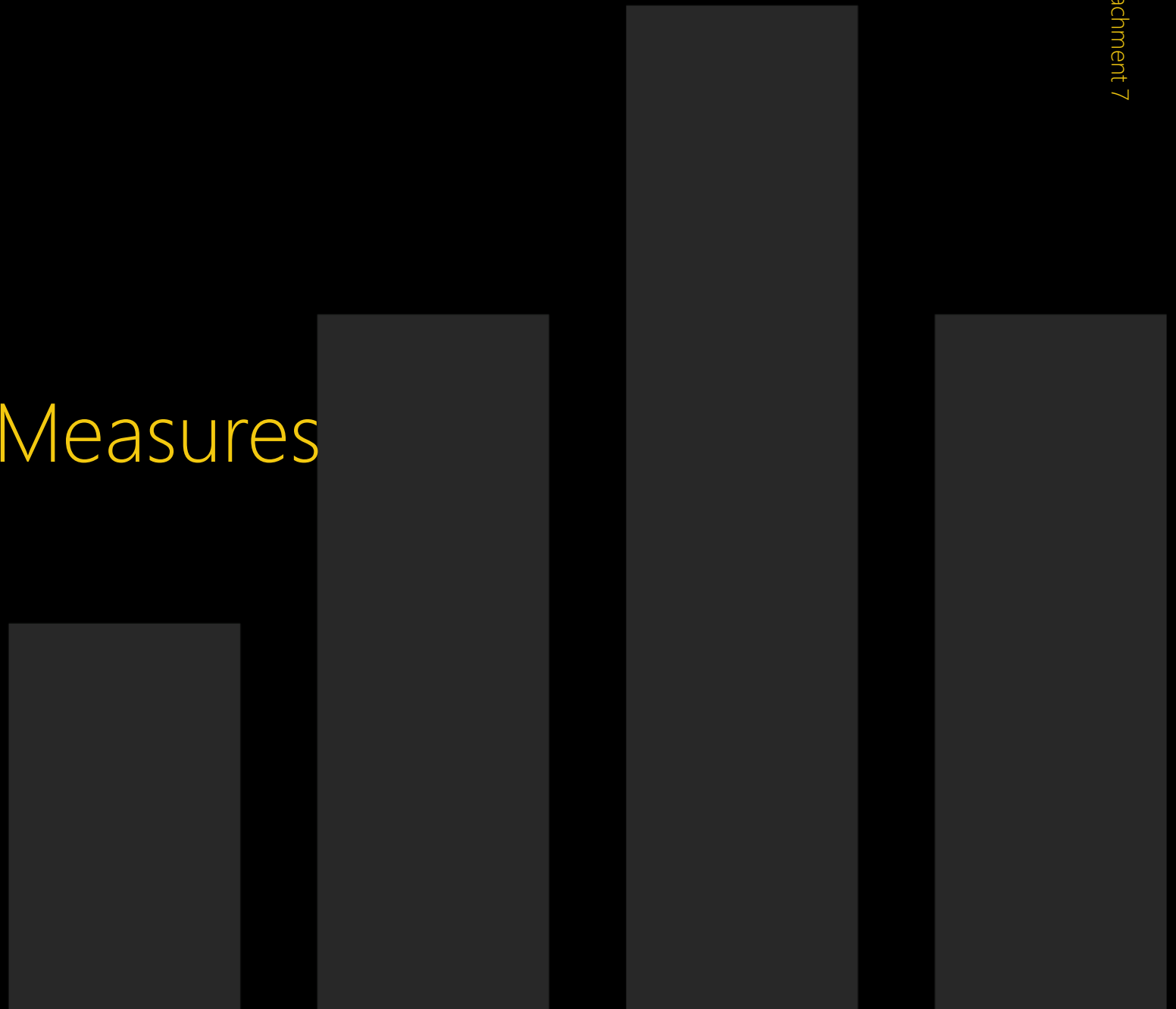
Microsoft | Power BI

Attachment 7

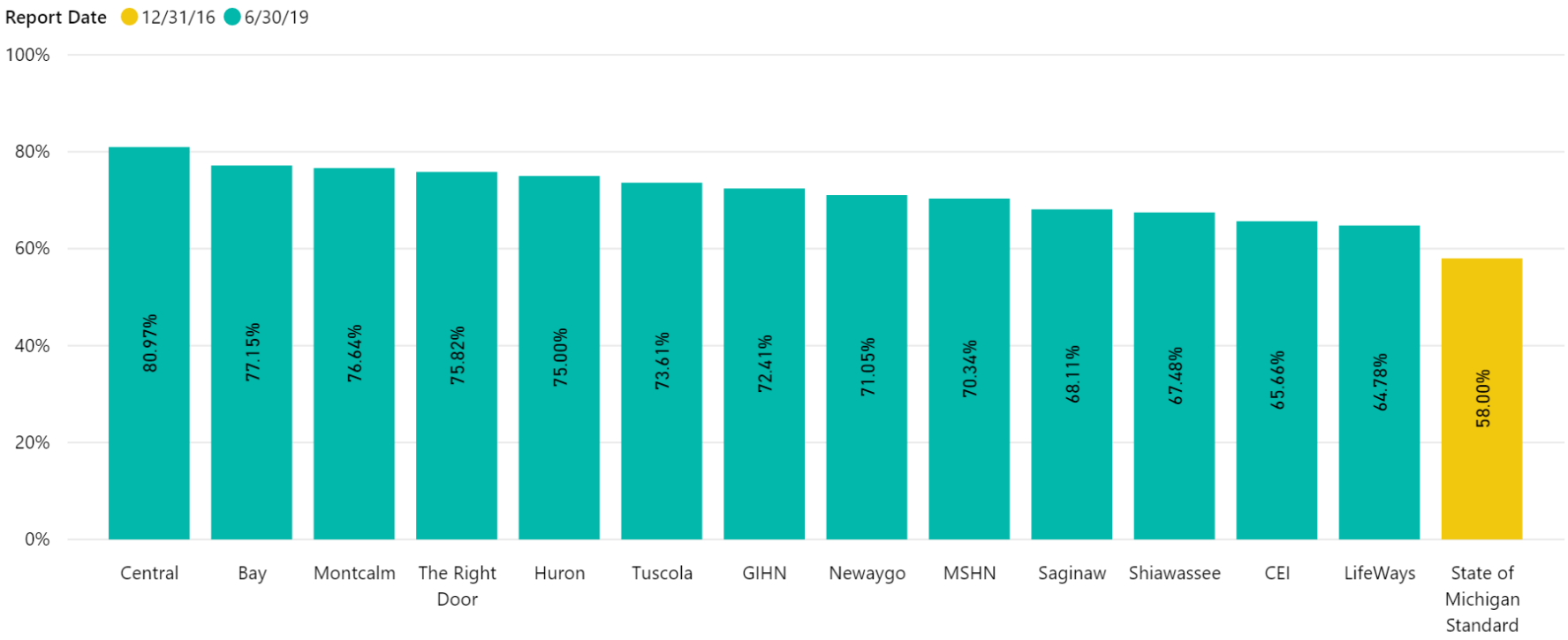
MSHN Priority Measures

View in Power BI

Last data refresh:
1/28/2020 9:43:13 AM Eastern Standard Time
Downloaded at:
1/28/2020 1:23:13 PM Eastern Standard Time

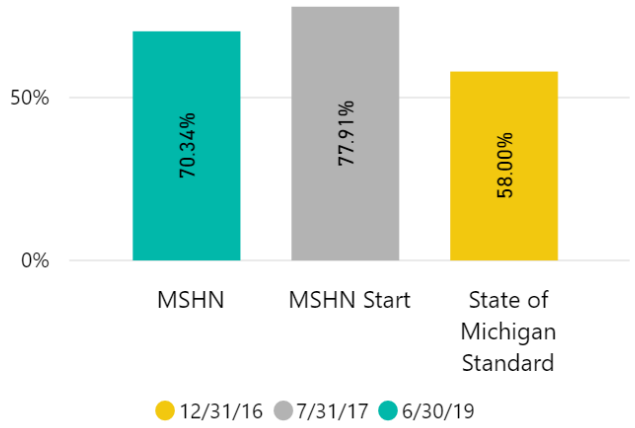


Follow-Up After Hospitalization Adult



Organization	Yes	No	Percentage
Bay	233	69	77.15%
CEI	415	217	65.66%
Central	200	47	80.97%
GIHN	63	24	72.41%
Huron	30	10	75.00%
LifeWays	274	149	64.78%
Montcalm	82	25	76.64%
MSHN	1781	751	70.34%
Newaygo	27	11	71.05%
Saginaw	252	118	68.11%
Shiawassee	83	40	67.48%
State of Michigan Standard			58.00%
The Right Door	69	22	75.82%
Tuscola	53	19	73.61%

FUH Adult -Trend



Measure Description: The percentage of discharges for members with 21 years or older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.

Rates Reported: The percentage of discharges for which the member received follow-up within 30 days of discharge.

Numerator Statement: An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.

Denominator Statement: Members with 21 years or older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.

Exclusions: Exclusions Exclude discharges followed by readmission or direct transfer to a non acute facility within the 30-day follow-up period, regardless of principal diagnosis for the readmission.Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set).These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

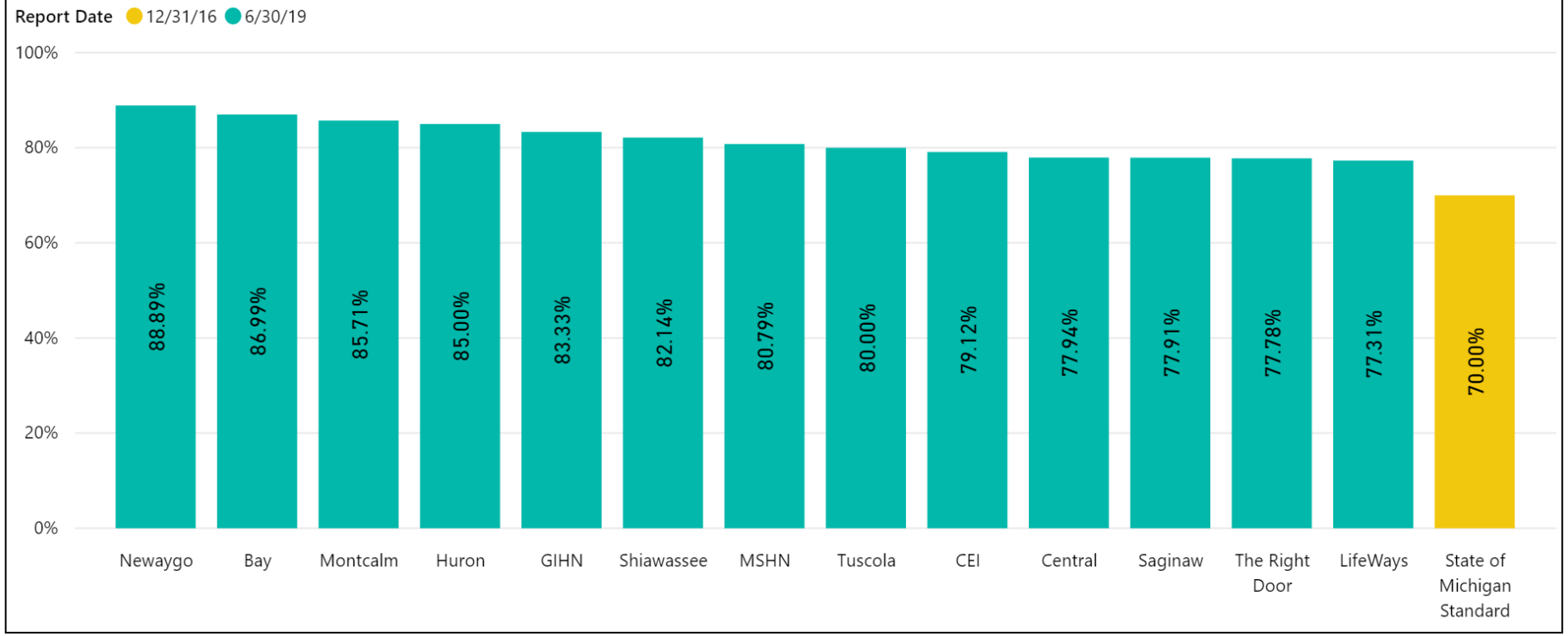
Last updated: 9/20/2019

Steward: Quality Improvement Council

Update frequency: monthly extract of data from ICDP.

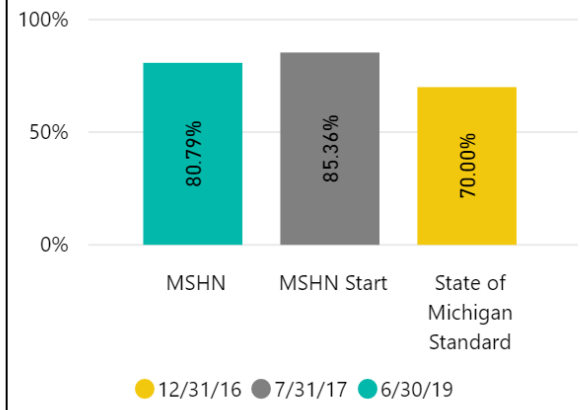
For consumer level detail, access the Interated Care Delivery System (ICDP) by Zenith Technology Solutions

Follow-Up After Hospitalization Child



Organization	Yes	No	Percentage
Bay	107	16	86.99%
CEI	144	38	79.12%
Central	53	15	77.94%
GIHN	35	7	83.33%
Huron	34	6	85.00%
LifeWays	92	27	77.31%
Montcalm	36	6	85.71%
MSHN	740	176	80.79%
Newaygo	16	2	88.89%
Saginaw	127	36	77.91%
Shiawassee	46	10	82.14%
State of Michigan Standard			70.00%
The Right Door	14	4	77.78%
Tuscola	36	9	80.00%

FUH Child-Trend



Measure Description: The percentage of discharges for members with 6 years - 20 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.

Rates Reported: The percentage of discharges for which the member received follow-up within 30 days of discharge.

Numerator Statement: An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.

Denominator Statement: Members with 6 years - 20 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.

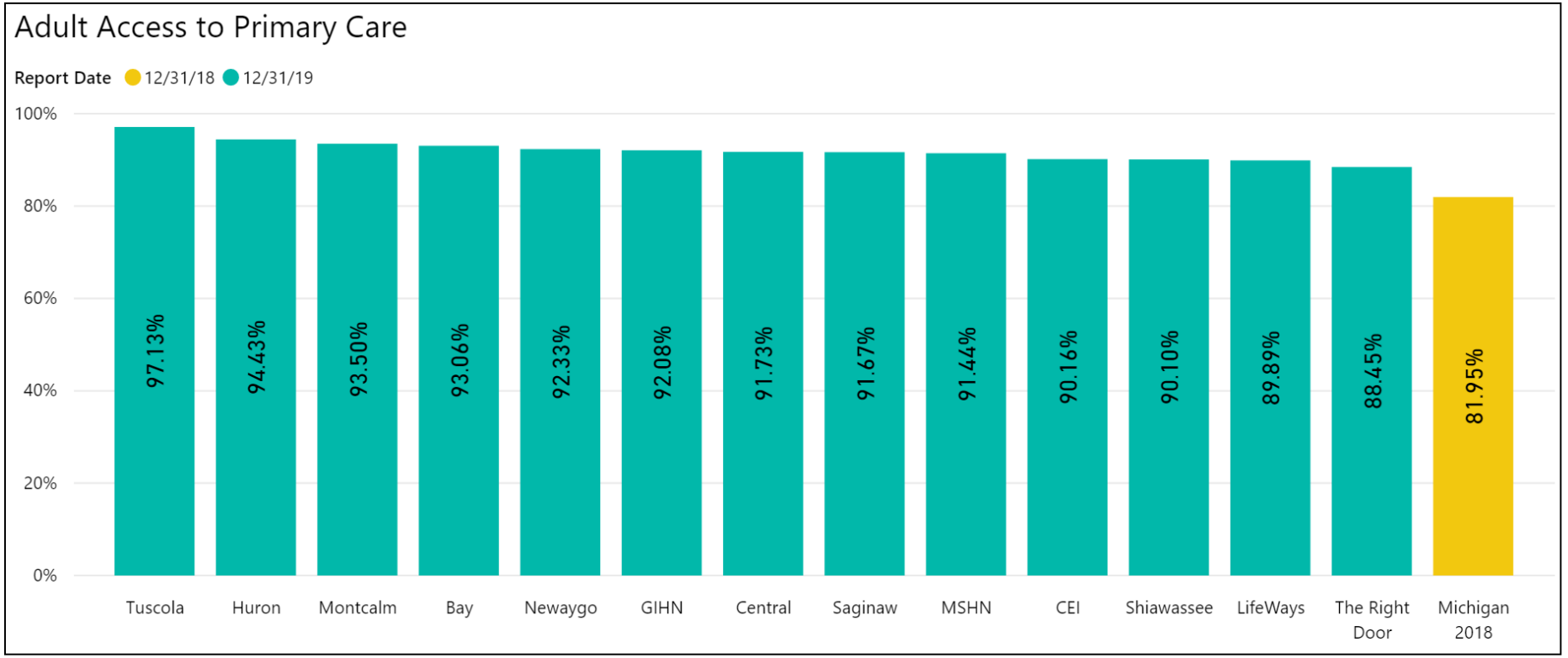
Exclusions: Exclusions Exclude discharges followed by readmission or direct transfer to a non acute facility within the 30-day follow-up period, regardless of principal diagnosis for the readmission.Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set).These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

Last updated: 9/20/2019

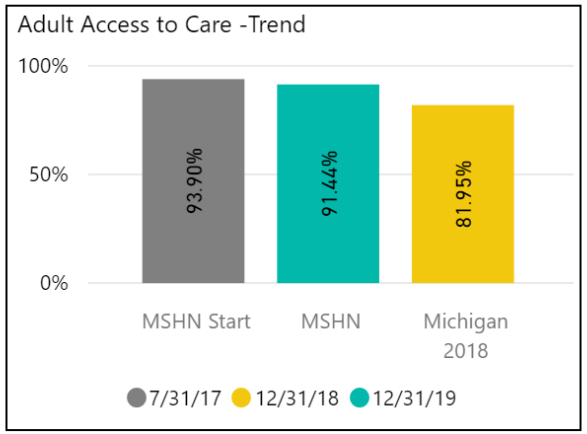
Steward: Quality Improvement Council

Update frequency: monthly extract of data from ICDP.

For consumer level detail, access the Interated Care Delivery System (ICDP) by Zenith Technology Solutions



Organization	Yes	No	Percentage
Bay	147	1970	93.06%
CEI	351	3217	90.16%
Central	297	3295	91.73%
GIHN	48	558	92.08%
Huron	28	475	94.43%
LifeWays	271	2409	89.89%
Michigan 2018			81.95%
Montcalm	42	604	93.50%
MSHN	1629	17401	91.44%
Newaygo	46	554	92.33%
Saginaw	238	2618	91.67%
Shiawassee	71	646	90.10%
The Right Door	76	582	88.45%
Tuscola	14	473	97.13%



Measure Description: The percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.a) Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year.b) Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.

Numerator Statement: One or more ambulatory or preventive care visits during the measurement year or the two years prior to the measurement year.

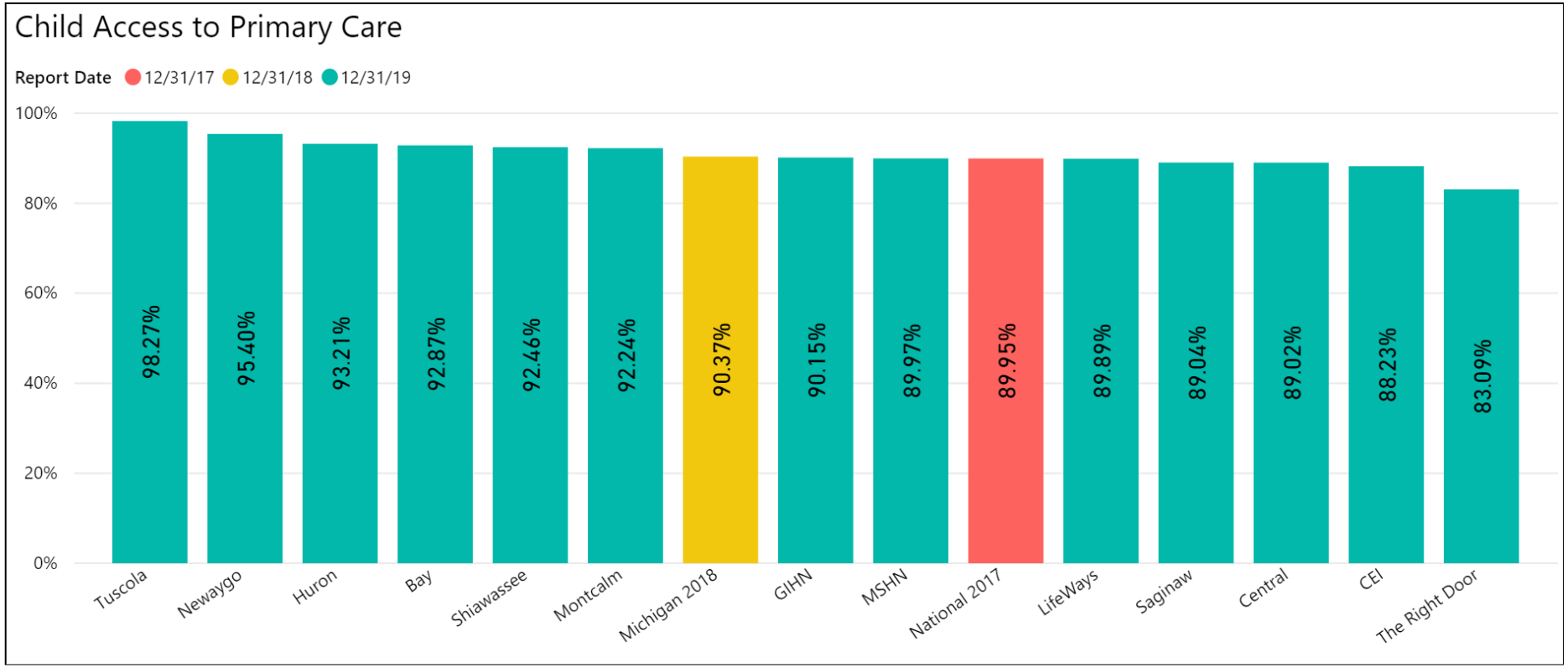
Denominator Statement: Any consumer 20 years of age or older as of the end of the measurement year(e.g., December 31) who have at most one month gap in coverage during each year of continuous enrollment.

Last updated: 9/20/2019

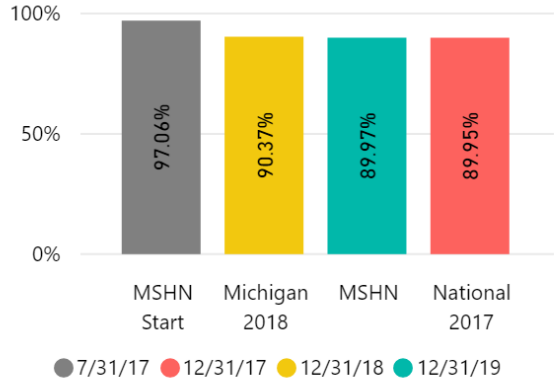
Steward: Utilization Management Committee

Update frequency: monthly extract of data from ICDP.

For consumer level detail, access the Interated Care Delivery System (ICDP) by Zenith Technology Solutions



Organization	Yes	No	Percentage
Bay	100	1302	92.87%
CEI	355	2661	88.23%
Central	294	2383	89.02%
GIHN	51	467	90.15%
Huron	19	261	93.21%
LifeWays	196	1742	89.89%
Michigan 2018			90.37%
Montcalm	61	725	92.24%
MSHN	1525	13674	89.97%
National 2017			89.95%
Newaygo	29	602	95.40%
Saginaw	220	1788	89.04%
Shiawassee	54	662	92.46%
The Right Door	139	683	83.09%
Tuscola	7	398	98.27%



Measure Description: The percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line.a) Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year.b) Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

Numerator Statement: For 12–24 months, 25 months–6 years: One or more visits with a PCP during the measurement year.For 7–11 years, 12–19 years: One or more visits with a PCP during the measurement year or the year prior to the measurement year.

Denominator Statement: Any consumer 12 months to 19 years of age as of the end of the measurement year(e.g., December 31) who have:a) At most one month gap in coverage during the measurement year for ages 12 months to 6 years.b) At most one month gap during the reporting year and the previous year for ages 7 years to 19 years.

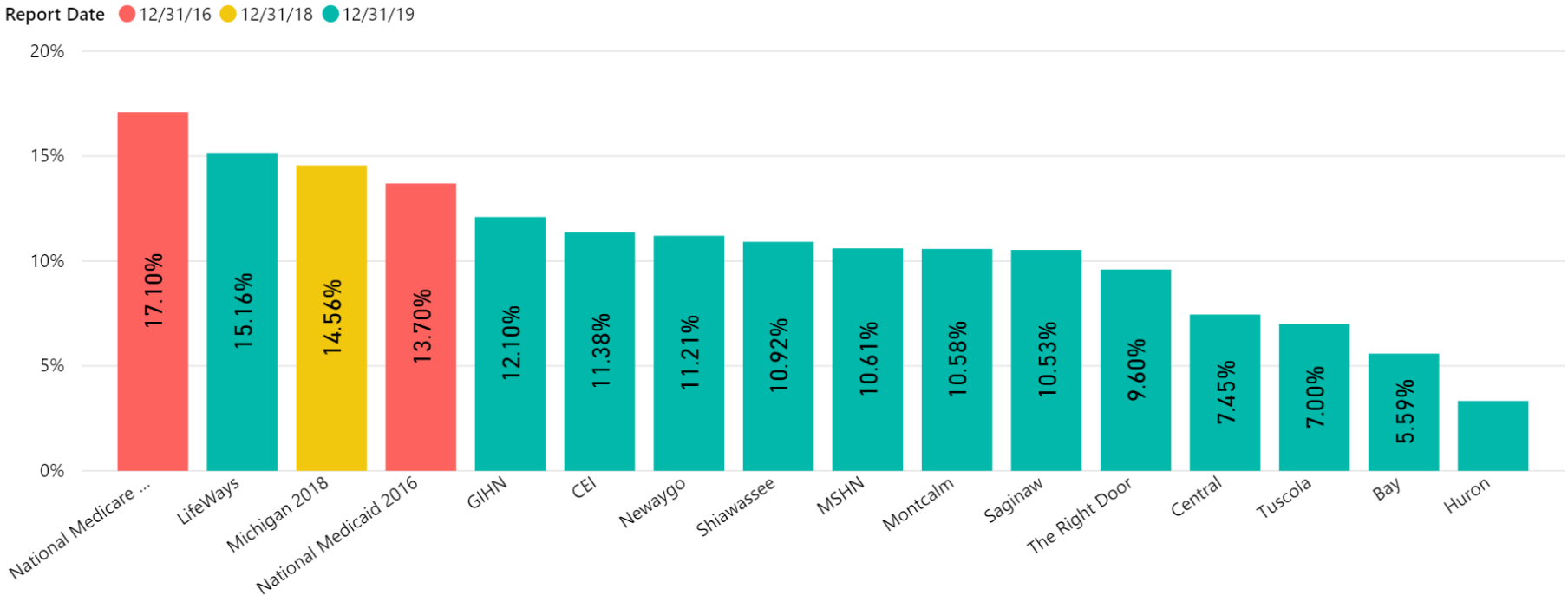
Last updated: 9/20/2019

Steward: Utilization Management Committee

Update frequency: monthly extract of data from ICDP.

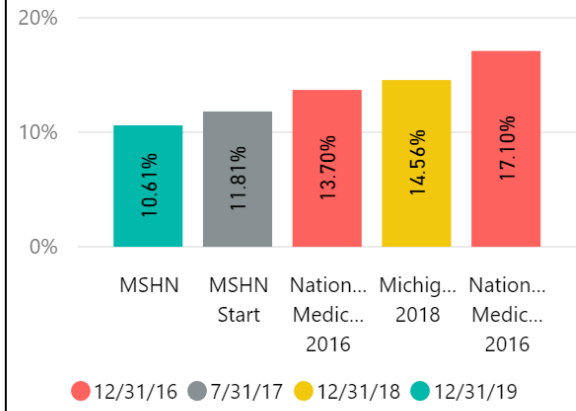
For consumer level detail, access the Interated Care Delivery System (ICDP) by Zenith Technology Solutions

Plan All-Cause Readmission



Organization	Yes	No	Percentage
Bay	19	321	5.59%
CEI	86	670	11.38%
Central	43	534	7.45%
GIHN	19	138	12.10%
Huron	2	58	3.33%
LifeWays	119	666	15.16%
Michigan 2018			14.56%
Montcalm	20	169	10.58%
MSHN	440	3708	10.61%
National Medicaid 2016			13.70%
National Medicare 2016			17.10%
Newaygo	13	103	11.21%
Saginaw	81	688	10.53%
Shiawassee	19	155	10.92%
The Right Door	12	113	9.60%

Plan All-Cause Readmission-Trend



Measure Description: For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

Denominator Statement: An acute inpatient discharge on or between start date and end date of the measurement year.Member must be continuously enrolled.

Numerator Statement: At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

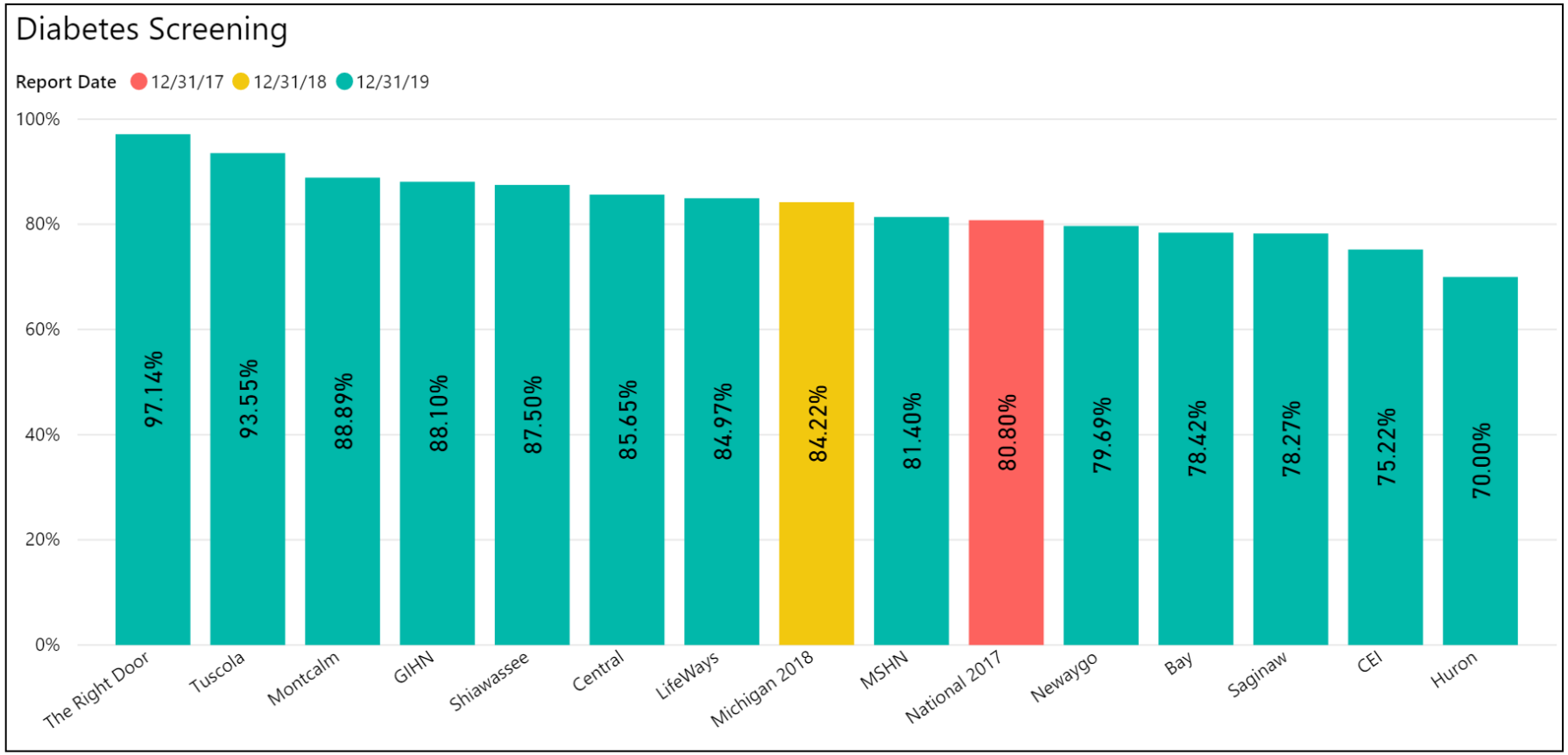
Exclusions: Any acute inpatient hospital discharges with a principal diagnosis of pregnancyInpatient stays with discharges for death.

Last updated: 9/20/2019

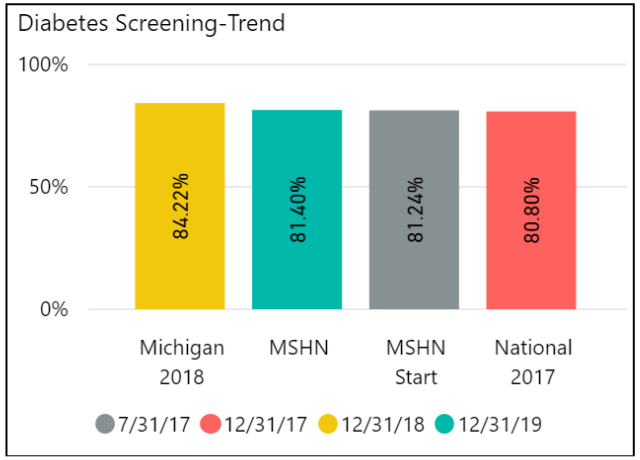
Steward: Utilization Management Committee

Update frequency: monthly extract of data from ICDP.

For consumer level detail, access the Interated Care Delivery System (ICDP) by Zenith Technology Solutions



Organization	Yes	No	Percentage
Bay	149	41	78.42%
CEI	261	86	75.22%
Central	191	32	85.65%
GIHN	37	5	88.10%
Huron	42	18	70.00%
LifeWays	260	46	84.97%
Michigan 2018			84.22%
Montcalm	64	8	88.89%
MSHN	1619	370	81.40%
National 2017			80.80%
Newaygo	51	13	79.69%
Saginaw	389	108	78.27%
Shiawassee	49	7	87.50%
The Right Door	68	2	97.14%
Tuscola	58	4	93.55%



Measure Description: The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder,who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Numerator Statement: One or more glucose or HbA1c tests performed during the measurement year.

Denominator Statement: Patients ages 18 to 64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.

Exclusions: Exclude patients with diabetes during the measurement year or the year prior to the measurement year. Exclude patients who had no antipsychotic medications dispensed during the measurement year.

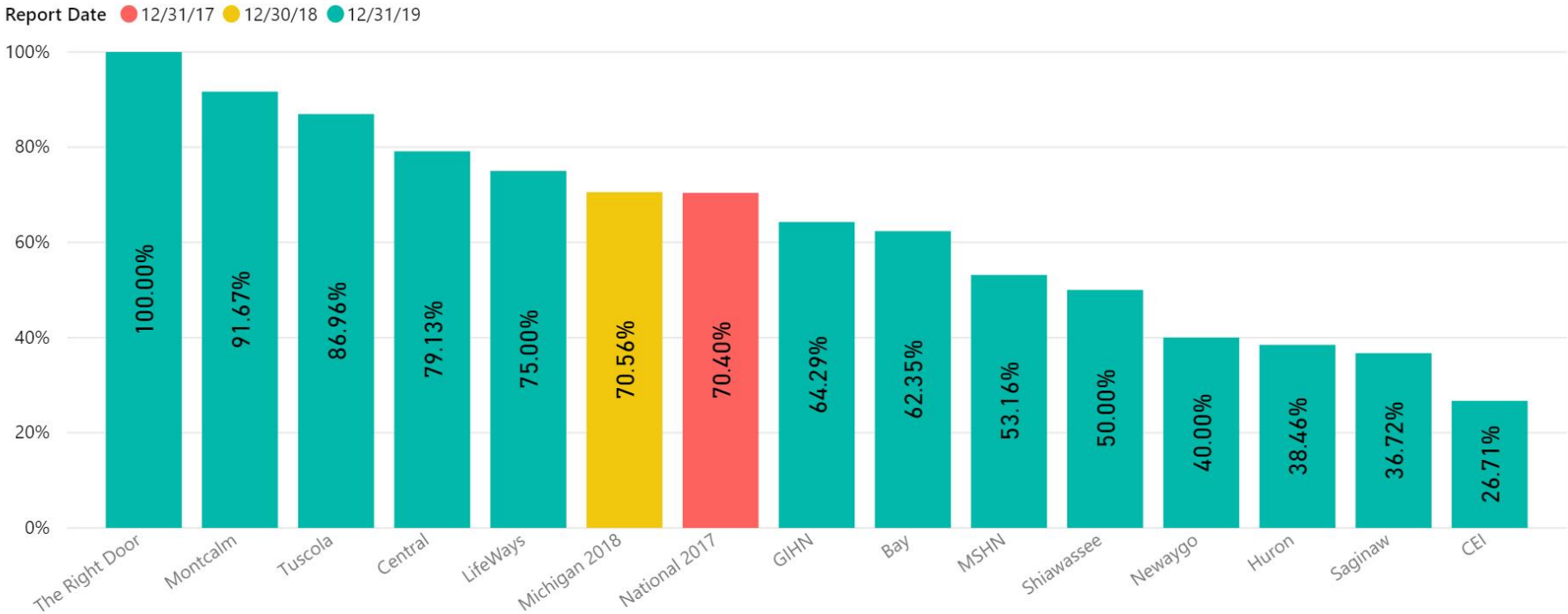
Last updated: 9/20/2019

Steward: Quality Improvement Council

Update frequency: monthly extract of data from ICDP.

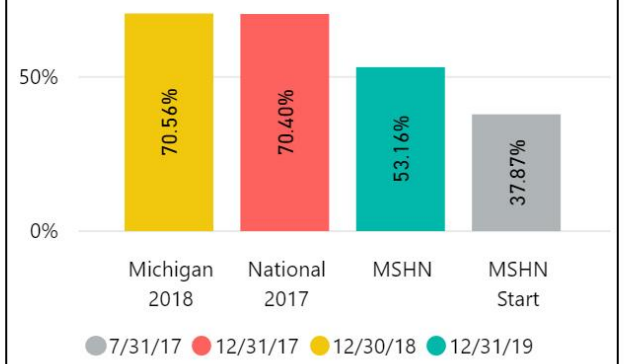
For consumer level detail, access the Interated Care Delivery System (ICDP) by Zenith Technology Solutions

Diabetes Monitoring



Organization	Yes	No	Percentage
Bay	53	32	62.35%
CEI	43	118	26.71%
Central	91	24	79.13%
GIHN	9	5	64.29%
Huron	5	8	38.46%
LifeWays	60	20	75.00%
Michigan 2018			70.56%
Montcalm	22	2	91.67%
MSHN	387	341	53.16%
National 2017			70.40%
Newaygo	6	9	40.00%
Saginaw	65	112	36.72%
Shiawassee	8	8	50.00%
The Right Door	5	0	100.00%
Tuscola	20	3	86.96%

Diabetes Monitoring-Trend



Measure Description: This measure is used to assess the percentage of members 18 to 64 years of age with schizophrenia and diabetes who had both a low-density lipoprotein cholesterol (LDL-C) test and a hemoglobin A1c (HbA1c) test during the measurement year.

Numerator Statement: A hemoglobin A1c (HbA1c) test and a low-density lipoprotein cholesterol (LDL-C) test performed during the measurement year.

Denominator Statement: Medicaid members 18 to 64 years during the measurement year with schizophrenia and diabetes.

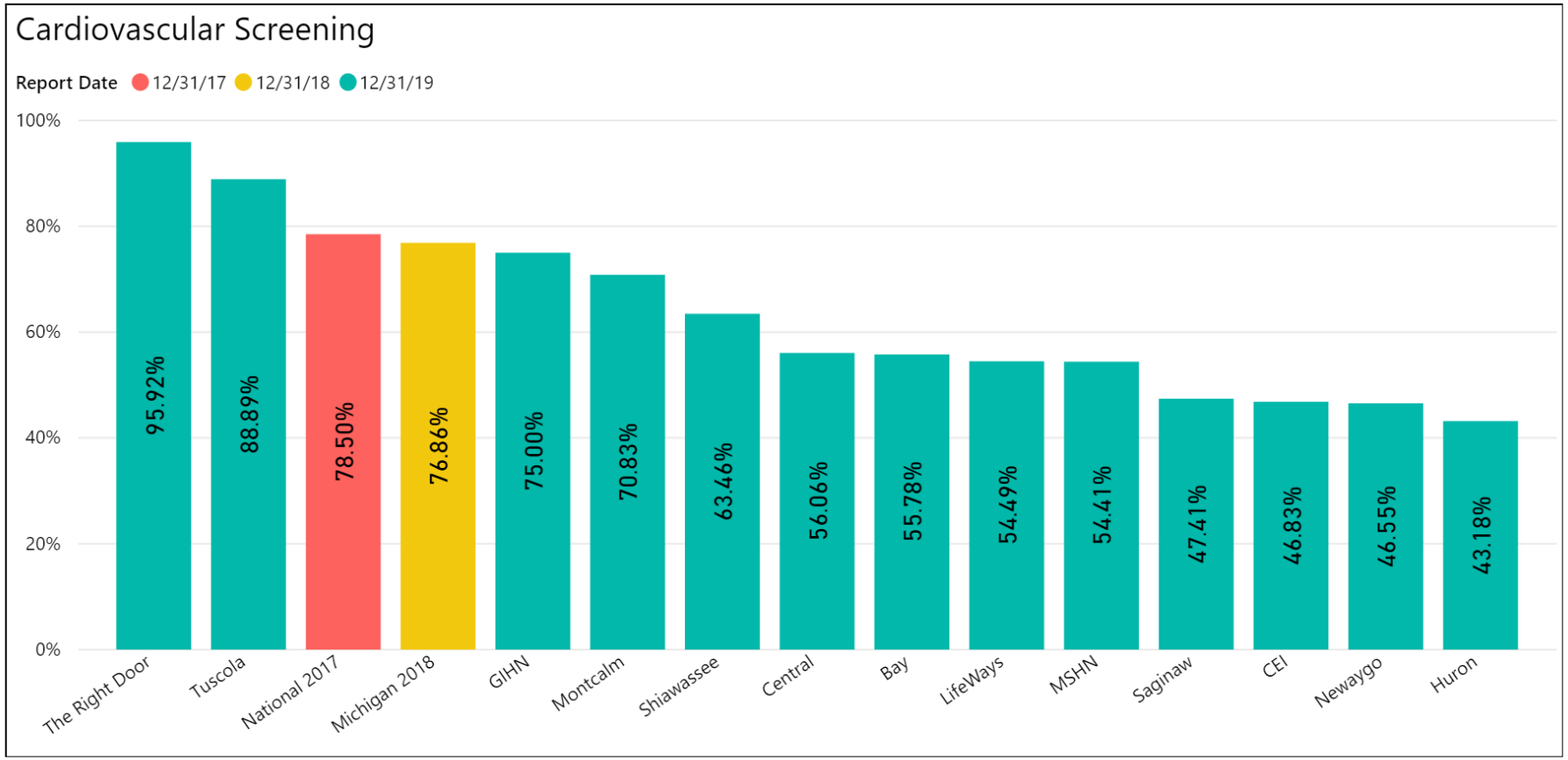
Exclusions: Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

Last updated: 9/20/2019

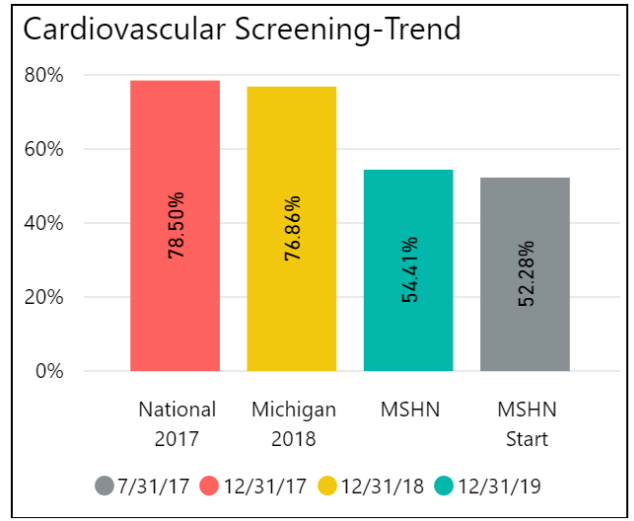
Steward: Quality Improvement Council

Update frequency: monthly extract of data from ICDP.

For consumer level detail, access the Interated Care Delivery System (ICDP) by Zenith Technology Solutions



Organization	Yes	No	Percentage
Bay	111	88	55.78%
CEI	170	193	46.83%
Central	148	116	56.06%
GIHN	24	8	75.00%
Huron	19	25	43.18%
LifeWays	176	147	54.49%
Michigan 2018			76.86%
Montcalm	51	21	70.83%
MSHN	1074	900	54.41%
National 2017			78.50%
Newaygo	27	31	46.55%
Saginaw	220	244	47.41%
Shiawassee	33	19	63.46%
The Right Door	47	2	95.92%



Measure Description: The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year.

Numerator Statement: Individuals who had one or more LDL-C screenings performed during the measurement year.

Denominator Statement: Individuals ages 25 to 64 years of age by the end of the measurement year with a diagnosis of schizophrenia or bipolar disorder who were prescribed any antipsychotic medication during the measurement year.

Exclusions: Individuals are excluded from the denominator if they were discharged alive for a coronary artery bypass graft (CABG) or percutaneous coronary intervention (PCI) (these events may occur in the measurement year or year prior to the measurement year),nor diagnosed with ischemic vascular disease (IVD)(this diagnosis must appear in both the measurement year and the year prior to the measurement year),chronic heart failure,nor had a prior myocardial infarction (identified in the measurement year nor as far back as possible).

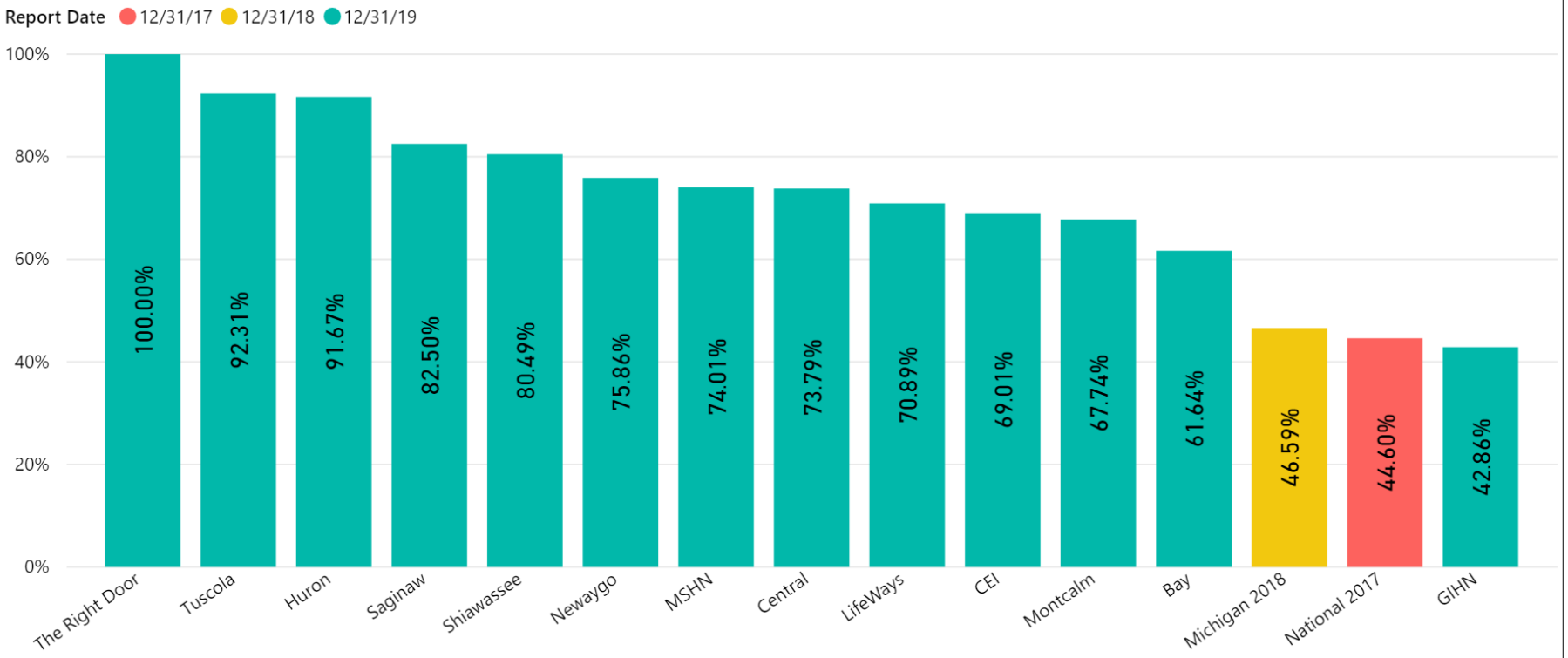
Last updated: 9/20/2019

Steward: Clinical Leadership Committee

Update frequency: monthly extract of data from ICDP.

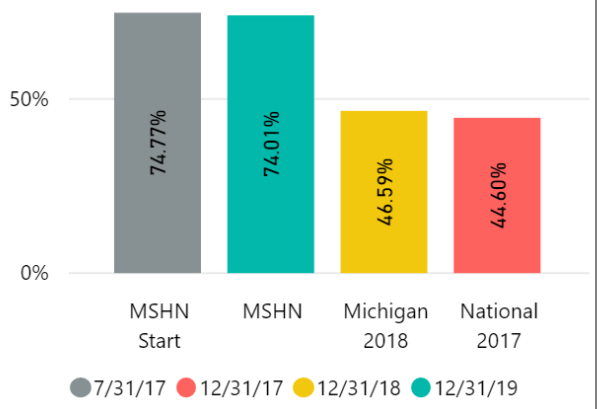
For consumer level detail, access the Interated Care Delivery System (ICDP) by Zenith Technology Solutions

Follow-Up Children ADHD Initiation Phase



Organization	Yes	No	Percentage
Bay	45	28	61.64%
CEI	98	44	69.01%
Central	76	27	73.79%
GIHN	6	8	42.86%
Huron	11	1	91.67%
LifeWays	56	23	70.89%
Michigan 2018			46.59%
Montcalm	21	10	67.74%
MSHN	507	178	74.01%
National 2017			44.60%
Newaygo	22	7	75.86%
Saginaw	99	21	82.50%
Shiawassee	33	8	80.49%
The Right Door	28	0	100.00%
Tuscola	12	1	92.31%

Follow-Up ADHD Initiation-Trend



Measure Description: The percentage of children (6-12 years of age) newly prescribed ADHD medication who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

Denominator Statement: All children in the 6-12 years of age range who were dispensed an ADHD medication during the 12-month Intake Period.Members must be continuously enrolled for 120 days prior to the earliest prescription dispensing date through 30 days after the earliest prescription dispensing date.

Numerator Statement: An outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the earliest prescription dispensing date.

Exclusions: Members who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the earliest prescription dispensing date.

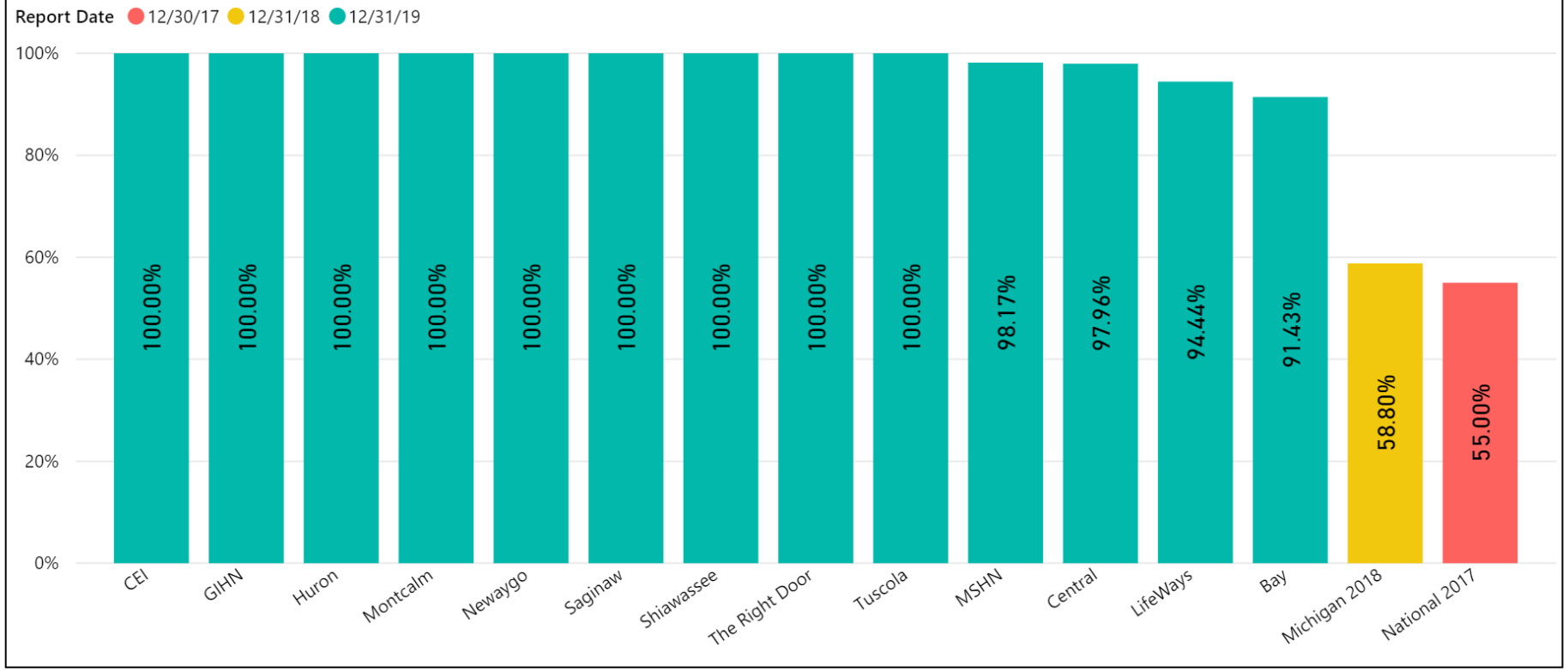
Last updated: 9/20/2019

Steward: Clinical Leadership Committee

Update frequency: monthly extract of data from ICDP.

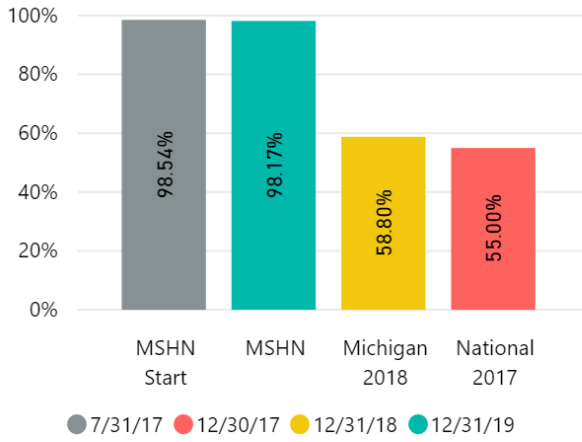
For consumer level detail, access the Interated Care Delivery System (ICDP) by Zenith Technology Solutions

Follow-Up ADHD Children Continuation & Monitoring Phase



Organization	Yes	No	Percentage
Bay	32	3	91.43%
CEI	67	0	100.00%
Central	48	1	97.96%
GIHN	7	0	100.00%
Huron	4	0	100.00%
LifeWays	34	2	94.44%
Michigan 2018			58.80%
Montcalm	19	0	100.00%
MSHN	322	6	98.17%
National 2017			55.00%
Newaygo	15	0	100.00%
Saginaw	55	0	100.00%
Shiawassee	19	0	100.00%
The Right Door	13	0	100.00%
Tuscola	9	0	100.00%

Follow-UP ADHD C&M-Trend



Measure Description: The percentage of members 6–12 years of age with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits within 270 days (9 months) after the Initiation Phase ended.

Denominator Statement: All eligible population of initiation phase.Members must be continuously enrolled for 120 days prior to the earliest prescription dispensing date and 300 days after the earliest prescription dispensing date.Member must fill prescriptions to provide continuous treatment for at least 210 days out of the 300-day period.

Numerator Statement: Numerator Statement compliant for Initiation Phase, and at least two follow-up visits from 31–300 days (9 months)

Exclusions: Members with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through end date of the measurement year.

Last updated: 9/20/2019

Steward: Clinical Leadership Committee

Update frequency: monthly extract of data from ICDP.

For consumer level detail, access the Interated Care Delivery System (ICDP) by Zenith Technology Solutions

MSHN
Mid-State Health Network

Quality Assessment and
Performance Improvement Program

Summary Report

Title of Measure: Behavior Review Data

Committee/Department: Quality Improvement Council

Reporting Period (month/year): FY2019 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 Health and Human Services (MDHHS). 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.

Data Interpretation: (performance against targets and benchmark data)

Study Question 1: Has the proportion of individuals who have a Behavior Treatment Plan with 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:

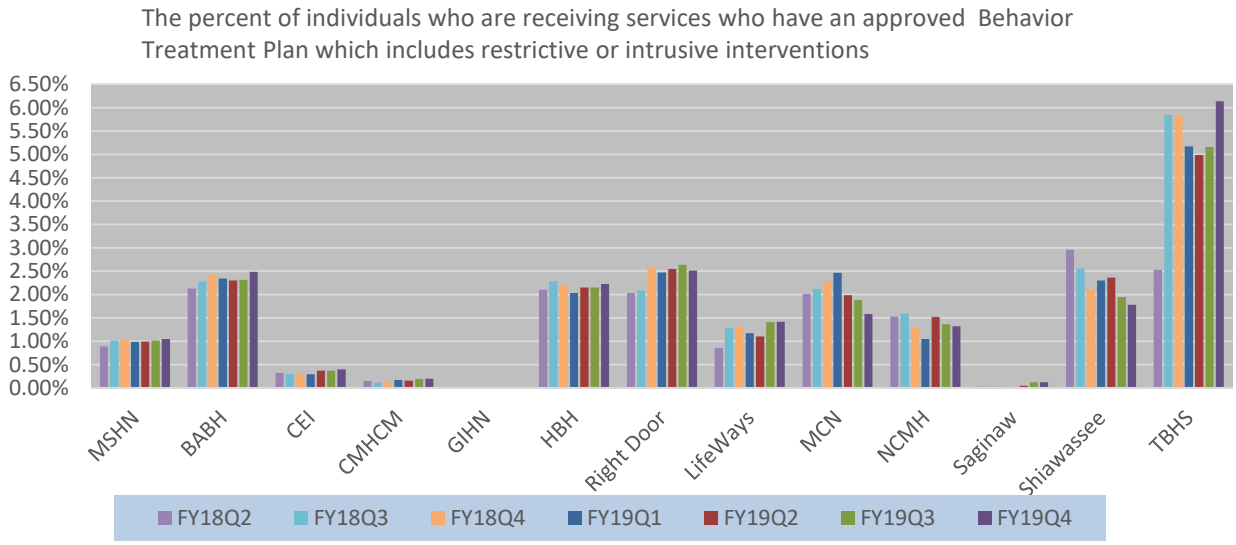
- Discussing the process at Regional BTRC meetings.
- Identifying and defining standard restrictive and intrusive techniques used consistently throughout MSHN. Most commonly used interventions have been defined for regional use.

The variance in the data relates to four main categories which are be addressed in the recommendations and included in ongoing discussion with regional BTPRC.

1. The restrictions that are identified through the Home and Community Based Standards. The exact impact is unknown. There is a need to further define what specific restrictions require behavior treatment review and what restrictions can be addressed in the Individual Plan of Service. MDHHS has not provided any specific guidance related to this area.
2. The incorporation of the individuals receiving the autism benefit. Most of the CMHSPs have begun to review plans that have restrictive or physical interventions for individuals receiving Applied Behavioral Analysis (ABA) services. These interventions have not been discussed with the regional BTPC therefore it is likely that inconsistent definitions are being used causing the increase in reported interventions.
3. Plans that include Medication for behavioral assistance are being incorporated into the review process. Each CMHSP has a process to begin to look at individuals (children and adults) receiving medication for behavioral assistance. However, the capacity to review each child on medication has been identified as a barrier. The MDHHS Standards for Behavior Treatment do not address children specifically as it relates to standards of care and indications for the medication.
4. Psychologist available to evaluate and write behavior treatment plans. The revised Behavioral Treatment Standards indicate "the Committee shall be comprised of at least three individuals one of whom shall be a board certified behavior analyst (BCBA) or licensed behavior analyst (LBA) and/or a licensed psychologist defined in the Medicaid Provider Manual. A committee member who has prepared the behavior treatment plan must recuse themselves from the final decision making of the committee. Therefore if an organization has only one psychologist they have been unable to develop a plan and approve it. The addition of the BCBA or LBA may provide some additional opportunities.

Each CMHSP is at a different level of implementation with the issues identified above. The sudden increase (F18Q3) for TBHS is related to issue number 3 above the rate increase equates to 24 number of individuals.

Figure 1



Study Question 2a: Has the proportion of individuals who have received multiple emergency physical interventions decreased over time?

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.

Study Question 2b: Has the proportion of physical interventions decreased overtime?

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

The increase (FY18Q3) in reported physical interventions is suspected to be related to the number of individuals who are receiving ABA services. The autism clinics that are providing services utilize different programs for physical and non physical intervention. The regional Behavioral Treatment Review Committee has reviewed the NAPPI, CPI, and Safety Care programs. These interventions have been classified into categories agreed upon by the committee to assist with data analyses. There is a need to review the current categories and techniques to ensure that the newly incorporated programs used by the Autism Clinics are included. These interventions include safety measures and additional physical interventions. Any techniques that are related to safety measure would be removed and not categorized as physical interventions. These issues are addressed in the recommendations.

FY19Q4
Figure 2 identifies the percent of emergency physical interventions per 100 served. 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. There is a decrease in the total number of emergency physical interventions and the number of individuals who received an emergency physical intervention. The variance as demonstrated will result in a review of the data to identify why the decrease. Currently the Regional Behavior Treatment Review committee is reviewing the techniques and definitions to ensure consistent application of the terms

Figure 2

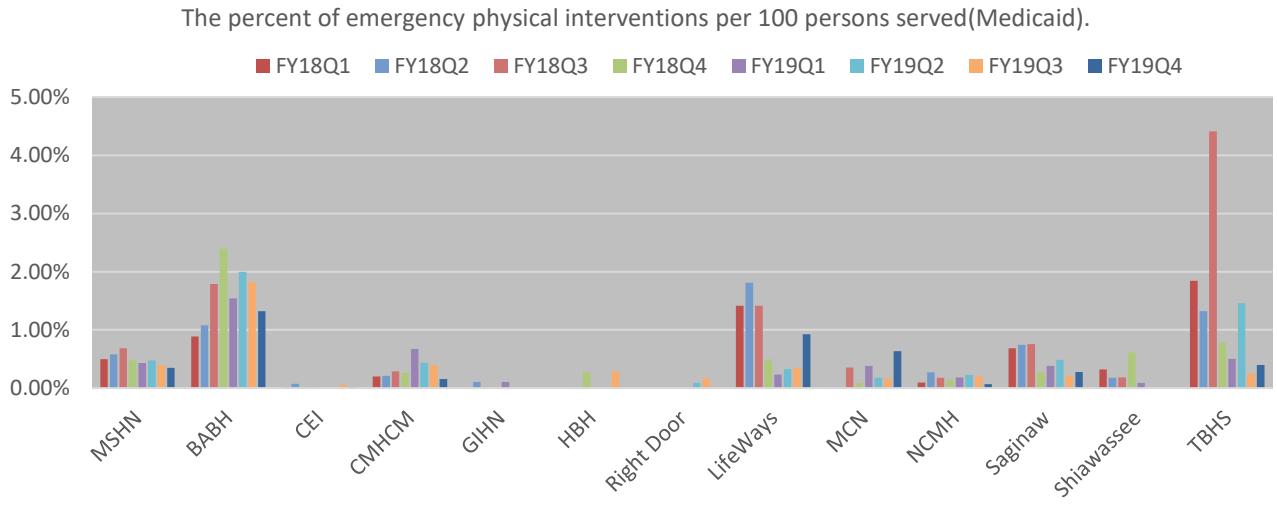


Figure 3

		FY18 Q1	FY18 Q2	FY18 Q3	FY18 Q4	FY19 Q1	FY19 Q2	FY19 Q3	FY19 Q4
MSHN	**# of Individuals who had more than 1 EPI**	**24**	**20**	**24**	**16**	**23**	**24**	**19**	**15**
	# of individuals who had an EPI	**37**	**44**	**52**	**36**	**44**	**39**	**38**	**40**
BABH	**# of Individuals who had more than 1 EPI**	4	5	8	8	9	11	9	7
	# of individuals who had an EPI	6	7	11	8	15	12	13	17
CEI	**# of Individuals who had more than 1 EPI**	0	0	0	0	0	0	2	0
	# of individuals who had an EPI	1	4	1	1	2	3	4	5
CMHCM	**# of Individuals who had more than 1 EPI**	2	3	4	2	5	2	4	2
	# of individuals who had an EPI	4	5	9	9	6	5	4	4
GIHN	**# of Individuals who had more than 1 EPI**	0	0	0	0	0	0	0	0
	# of individuals who had an EPI	0	1	0	0	1	0	0	0
HBH	**# of Individuals who had more than 1 EPI**	0	0	0	1	0	0	0	0
	# of individuals who had an EPI	0	0	0	1	0	0	1	0
Right Door	**# of Individuals who had more than 1 EPI**	0	0	0	0	0	0	0	0
	# of individuals who had an EPI	0	0	0	0	0	0	2	0
LifeWays	**# of Individuals who had more than 1 EPI**	6	5	3	0	2	2	2	4
	# of individuals who had an EPI	7	9	9	4	5	5	5	8
MCN	**# of Individuals who had more than 1 EPI**	0	0	1	0	1	1	0	1
	# of individuals who had an EPI	0	0	2	1	3	1	2	2
NCMH	**# of Individuals who had more than 1 EPI**	0	0	0	1	0	0	0	0
	# of individuals who had an EPI	1	3	2	1	2	3	1	1
Saginaw	**# of Individuals who had more than 1 EPI**	8	4	4	2	5	5	1	1
	# of individuals who had an EPI	10	9	8	7	8	8	7	5
Shiawassee	**# of Individuals who had more than 1 EPI**	0	0	0	1	0	0	0	0
	# of individuals who had an EPI	3	2	2	1	1	0	0	0
TBHS	**# of Individuals who had more than 1 EPI**	4	3	4	1	1	3	1	0
	# of individuals who had an EPI	5	4	8	3	3	5	1	3

EPI=Emergency Physical Intervention

Figure 4 illustrates the percentage of specific types of emergency physical interventions that are used. (FY18Q3) The number of unidentified were 8 which included a "take down to floor" and "body positioning". As it relates to the incorporation of the Autism Benefit and the HCBS the number of interventions have increased. The Autism Clinics are using a different intervention program which is currently being discussed at the regional BTPRC. The names of such interventions have not been fully incorporated into the data collection process. Additionally, interventions that may be considered as "Safety Measures" should be excluded from the count of physical interventions.

Figure 4

Physical Intervention	**FY18Q1**	**FY18Q2**	**FY18Q3**	**FY18Q4**	**FY19Q1**	**FY19Q2**	**FY19Q3**	**FY19Q4**
Supine Hold	(8) 5%	(8) 5%	(6) 3%	(8) 6%	(10) 8%	(11) 8%	(11) 9%	(11) 11%
Wraps/Holds	(68) 48%	(86) 50%	(138) 67%	(104) 74%	(105) 80%	(107) 74%	(84) 69%	(73) 72%
Transport/Escort	(24) 17%	(29) 17%	(29) 14%	(12) 9%	(8) 6%	(7) 5%	(16) 13%	(11) 11%
Hands Down with Resistance/ Hand Wrist Grab	(18) 13%	(17) 10%	(26) 13%	(17) 12%	(7) 5%	(17) 12%	(8) 7%	(4) 4%
Other/Unidentified	(24) 17%	(33) 19%	(8) 4%	(0)	(1)	(3) 2%	(3) 2%	(2) 2%
MSHN Total	(142) 100%	(173) 100%	(207) 100%	(141) 100%	(131) 100%	(145) 100%	(122)100%	101 (100%

The length of time for the interventions was based on each individual intervention. It was agreed by the BTPRC/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, 24 were reported as unknown. Follow up regarding the unreported and reported outside of the window was completed at each CMHSP to ensure a process is in place to collect the length of time for each intervention. Interventions appeared to be effective.

Figure 5

Length of time of intervention	**FY18Q1**	**FY18Q2**	**FY18Q3**	**FY18Q4**	**FY19Q1**	**FY19Q2**	**FY19Q3**	**FY19Q4**
The total number of interventions within this time frame ≤ 5 minutes	79	73	101	93	104	105	82	53
The total number of interventions within this time frame 6-10 minutes	20	23	23	16	14	13	17	8
The total number of interventions within this time frame 11-15 minutes	16	19	24	22	8	14	11	20

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

<u>Numerator</u>: The total number of incidents requiring phone calls made by staff to police for behavioral assistance.
<u>Denominator</u>: The total number of individuals who are actively receiving services during the reporting period.

<u>FY19Q4</u>
As demonstrated in Figure 6, the rate of phone calls for police assistance per 100 consumers served for FY19Q4 was .17% (52/29950). This data includes only those that reside in a 24 hour residential. Figure

7 illustrates the comparison of phone calls requiring police assistance, emergency physical intervention, and the percent who have a Behavior Treatment Plan who have a restrictive and intrusive interventions.

Figure 6

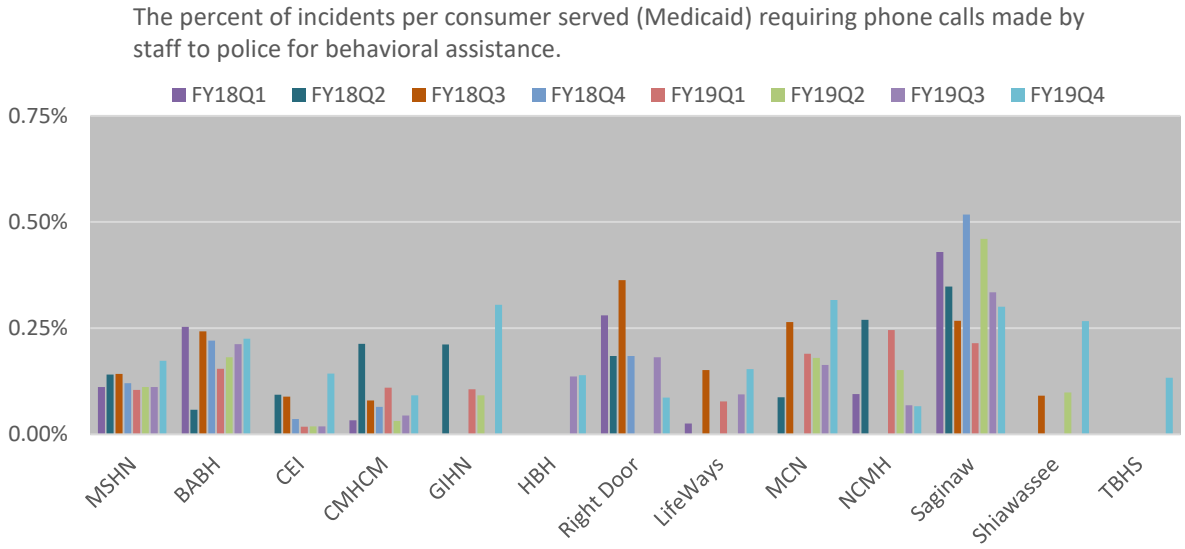
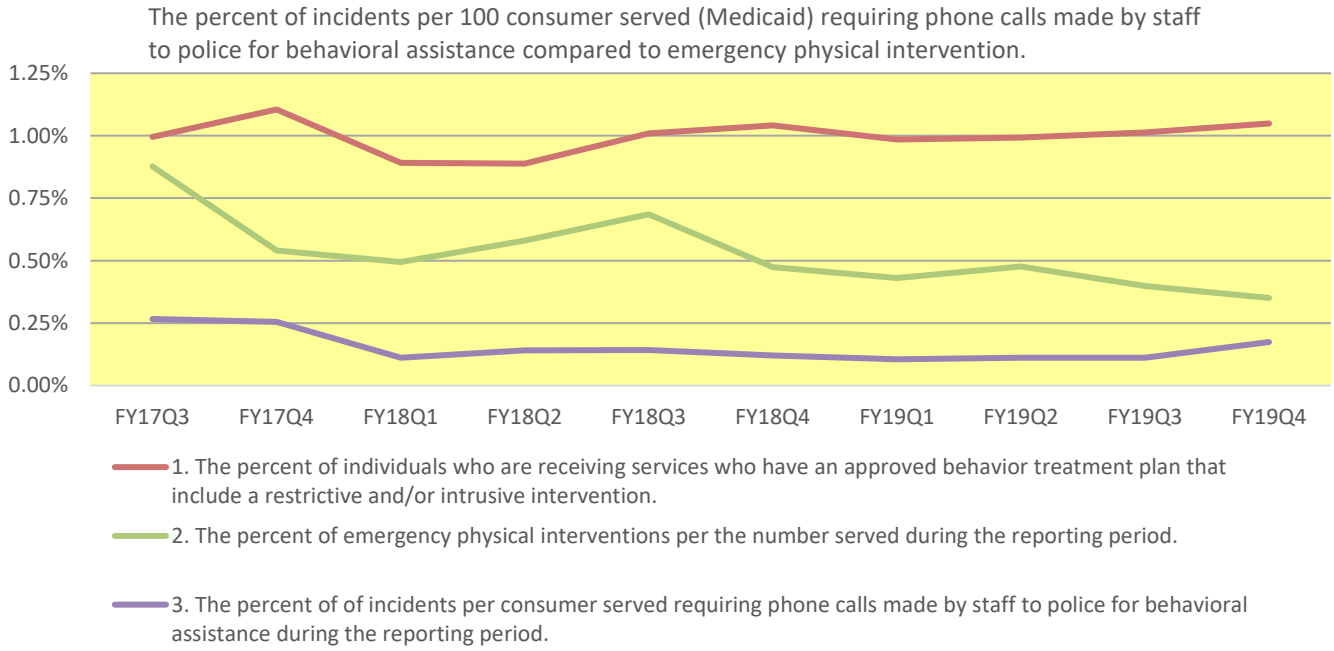


Figure 7



Conclusions:

Study Question 1: Has the proportion of individuals who have a **Behavior Treatment Plan** with a restrictive/intrusive intervention decreased over time? 1.44% (FY14Q2) compared to 1.05%(FY19Q4) of the individuals served have a Behavior Treatment Plan with Intrusive and/or Restrictive Interventions. This indicates that the proportion is lower than first reported in FY14Q2. FY18Q3 demonstrated slight upward trend as the

organizations are developing additional processes to address the following variables: an increased number of individuals receiving Applied Behavioral Analysis Services through Autism Clinics, and plans that identify restrictions as a result of the Home and Community Based Standards. There is an increased amount of individuals who have been incorporating the use of medications for behavioral assistance for children which has also resulted as an increase in the number of plans. Since that time the BTPR commitees have been working with the psychologists and the ABA clinics in coordinating efforts in educating related to the interventions and identifying alternative methods of intervening.

Study Question 2a: Has the proportion of individuals who have received multiple emergency physical interventions decreased over time? In FY14Q2 25% (16/65) of the individuals who had received an emergency physical intervention received multiple physical interventions. In FY19Q4 38%(15/40) have received multiple interventions, however as indicated above the total number of individuals who have received an intervention has decreased over time. This means that fewer individuals are involved in emergency physical interventions. Often an individual new to treatment or experiencing a transition of care may be included in these numbers. It would be expected that this would decrease for such individuals for the next quarter.

Study Question 2b: Has the proportion of physical interventions decreased overtime? .53% (FY14Q2) compared to .35% in FY19Q4 (105/29950) have received an emergency physical intervention. This shows a slight decrease over time. This will continue to be monitored as to address any factors that may be causing a variance.

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 .17% in FY19Q4 (52/29950). During the time this has been monitored, the overall percentage has been trending downward with some quarters fluctuating and showing slight increases. The highest was .37% in FY14Q3 and the lowest was .11% from FY18Q1 to FY19Q3.

Improvement Strategies:

Recommendations as determined by the regional Behavioral Treatment Committee include the following:

The regional BTPRC continues to have discussion related to restrictions, and limitations that require a plan with behavior treatment committee approval. The clinical discussions will begin to transition to the MSHN Clinical Leadership Committee in collaboration with the regional BTPRC.

The BTPRC has requested training to assist in the incorporation of the required elements of the Behavior Treatment Standards. Training information has been received from MDHHS and the Board Association. Further discussion and approval to determine next steps will occur.

Continue to utilize a Frequently Asked Questions Document to identify scenarios that may be interpreted differently and provide guidance as a result of discussion with the BTPRC.

Analysis By: Sandra Gettel, Quality Manager **Date: November 18, 2019**
Approved By: MSHN QIC **Date: November 21, 2019**
Reviewed By: MSHN BTPR Work Group **Date: December 13, 2019**

MSHN
Mid-State Health Network

Quality Assessment and
Performance Improvement Program

Summary Report

Title of Measure: Michigan Mission Based Performance Indicators **MI/DD Adult/Child Data/SUD**
Reporting Period (month/year): FY19Q4

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 as indicated in the MDHHS Codebook).

When an individual served has received services from both a SUD Provider and a CMHSP, the individual served will be counted in the SUD counts and removed from the CMHSP counts.

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 and Autism consumers are excluded from this count.

Indicator 3 indicates that those consumers who are in respite or medication only services are an exception; 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 the original document for any additional or more specific instructions.

Figure 1

	#1 - Pre-Admission Screening		#2 - 1st Request Timeliness					
Affiliate / CMH	Child	Adult	MI / Child	MI / Adult	DD / Child	DD / Adult	SUD	Total
Bay-Arenac	100.00%	98.95%	94.55%	95.15%	100.00%	100.00%		95.29%
CEI	96.22%	96.07%	98.91%	96.63%	100.00%	100.00%		97.77%
Central MI	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%
Gratiot	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%
Huron	100.00%	98.11%	100.00%	97.14%	100.00%	100.00%		98.04%
Ionia	100.00%	100.00%	97.73%	100.00%	100.00%	100.00%		99.24%
LifeWays	96.88%	99.70%	94.12%	96.36%	93.33%	91.67%		95.31%
Montcalm	91.67%	100.00%	98.77%	98.48%	100.00%	100.00%		98.70%
Newaygo	92.86%	97.50%	100.00%	100.00%	100.00%	100.00%		100.00%
Saginaw	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%
Shiawassee	93.33%	100.00%	96.00%	97.83%	100.00%	100.00%		97.59%
Tuscola	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%
MSHN SUD							98.97%	98.97%
Total/PIHP:	**97.86%**	**99.09%**	**98.49%**	**98.61%**	**99.12%**	**98.81%**	**98.97%**	**98.74%**

Indicator 1: Percentage of Children/Adults who received a Prescreen within 3 hours of request (standard is 95% or above) – In Figure 1, MSHN demonstrated a 97.86 (548/560) of the Children who requested a prescreen received one within three (3) hours. MSHN demonstrated a 99.09% compliance (2491/2514) of the Adults who requested a prescreen received one within three (3) hours. Three CMHSPs demonstrated performance Below the standard for Children. All CMHSPs demonstrated performance above the standard for Adults.

Indicator 2: Initial Assessment within 14 Days - Children/Adults (standard is 95% or above) – In Figure 1, MSHN demonstrated a 98.74% (4234/4288) compliance for all population categories within the indicator. Figure 1 exhibits two CMHSPs performed below the standard in one or more population groups.

Figure 2

	#3 - 1st Service Timeliness						#4a - Hospital Discharges F/U		#4b Detox F/U	#10 - Inpatient Recidivism	
Affiliate / CMH	MI / Child	MI / Adult	DD / Child	DD / Adult	SUD	Total	Child	Adult	SUD	Child	Adult
Bay-Arenac	90.00%	91.75%	100%	100%		91.72%	100%	98.08%		16.67%	6.38%
CEI	94.79%	93.13%	100%	100%		94.09%	100%	94.39%		0.00%	10.07%
Central MI	97.40%	98.83%	93.33%	95.00%		98.12%	100%	100%		33.33%	16.05%
Gratiot	100%	100%	100%	100%		100%	100%	95.83%		0.00%	25.00%
Huron	100%	95.45%	100%			96.88%	100%	87.50%		20.00%	8.33%
Ionia	100%	100%	100%	100%		100%	100%	100%		0.00%	7.14%
LifeWays	95.65%	96.89%	100%	91.67%		96.48%	100%	96.67%		9.52%	11.79%
Montcalm	95.92%	94.94%	100%	100%		95.92%	100%	96.55%		16.67%	5.00%
Newaygo	100%	98.65%	100%	100%		99.19%	85.71%	100%		0.00%	0.00%
Saginaw	95.74%	100%	68.18%	100%		95.77%	100%	96.84%		5.26%	15.94%
Shiawassee	88.89%	100%	100%	100%		96.72%	100%	95.24%		0.00%	19.35%
Tuscola	93.75%	96.43%	100%	100%		95.92%	100%	100%		0.00%	0.00%
MSHN SUD					98.05%	98.05%			97.87%		
Total/PIHP:	**96.15%**	**97.36%**	**91.21%**	**97.01%**	**98.05%**	**97.27%**	**98.91%**	**96.69%**	**97.87%**	**8.20%**	**11.83%**

Indicator 3: Start of Service within 14 Days (standard is 95% or above) – In Figure 2, MSHN demonstrated a 97.27% (3421/3517) compliance for all population categories within the indicator. Eight CMHSPs demonstrated performance below the standard.

Indicator 4a: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (standard is 95% or above) – In Figure 2, MSHN demonstrated a 98.91% (91/92) compliance for Children with a diagnosis of mental illness. MSHN demonstrated performance of 96.69% (555/574) compliance for Adults who have a diagnosis of mental illness. Three CMHSPs demonstrated performance below the standard.

Indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (standard is 95% or above) – In Figure 2, MSHN demonstrated a 97.87% (138/141) compliance for individuals who were seen for follow-up care within 7 days of discharge from a detox unit. Performance was above the standard for the Substance Use Disorder (SUD) population.

Indicator 10: Re-admission to Psychiatric Unit within 30 Days (standard is 15% or less) – In Figure 2, MSHN demonstrated a 8.20% (10/122) compliance for Children who were re-admitted within 30 days of being discharged from a psychiatric hospitalization. MSHN demonstrated an 11.83% (102/862) compliance for Adults who have a diagnosis of mental illness. Seven CMHSPs demonstrated performance below the standard.

Figure 3 shows a comparison of the performance indicator percentages starting in FY18 Quarter 2 to current. MSHN will continue to monitor individual CMHSP performance requiring improvement plans as needed to ensure performance improves or remains above the standard across the PIHP.

Figure 3

MMBPIS		FY18Q3	FY18Q4	FY19Q1	FY19Q2	FY19Q3	FY19Q4
Indicator 1a & 1b: Pre-screen within 3 hours of request	Children	99.02%	99.36%	98.42%	98.91%	98.36%	97.86%
	Adults	99.48%	99.45%	98.45%	99.16%	99.42%	99.09%
Indicator 2: % of Persons Receiving an Initial Assessment within 14 calendar days of First Request	MI-Child	99.05%	98.59%	98.16%	98.51%	98.68%	98.49%
	MI-Adult	98.98%	98.84%	98.54%	98.77%	97.17%	98.61%
	DD-Child	99.55%	99.04%	99.01%	98.28%	96.12%	99.12%
	DD-Adult	100.00%	100.00%	100%	96.74%	96.55%	98.81%
	SUD	99.12%	99.08%	98.15%	99.34%	98.22%	98.97%
	Total	98.99%	98.91%	98.34%	98.87%	97.86%	98.74%
Indicator 3: % of Persons Who Started Service within 14 days of Assessment	MI-Child	97.10%	97.35%	96.64%	95.99%	95.50%	96.15%
	MI-Adult	98.25%	98.60%	98.34%	96.85%	97.17%	97.36%
	DD-Child	97.79%	97.56%	90.79%	94.74%	95.74%	91.21%
	DD-Adult	100.00%	98.53%	96.72%	90.00%	98.51%	97.01%
	SUD	97.19%	98.12%	97.92%	98.33%	97.66%	98.05%
	Total	97.48%	98.15%	97.63%	97.13%	97.04%	97.27%
Indicator 4a, and Indicator 4b: Persons seen within 7 days of Inpatient Discharge and Substance Abuse Detox	Children	96.18%	100.00%	98.08%	98.56%	100%	98.91%
	Adults	97.38%	97.50%	94.52%	96.80%	97.36%	96.69%
	SUD	98.78%	97.52%	95.59%	96.88%	97.14%	97.87%
Indicator 10: % of Discharges Readmitted to Inpatient Care within 30 days of Discharge	Children	7.29%	11.80%	9.77%	6.74%	11.24%	8.20%
	Adults	9.59%	11.03%	10.66%	10.07%	13.10%	11.83%

Figures 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. The variance should be resolved to the extent possible.

Figure 4: Indicator 2 - Exception Report

Indicator 2	FY18Q3	FY18Q4	FY19Q1	FY19Q2	FY19Q3	FY19Q4
BABH	14.95%	13.07%	13.67%	11.19%	22.63%	**15.00%**
CMHCM	9.55%	8.65%	9.38%	11.57%	17.31%	**14.04%**
CEI	11.29%	10.10%	13.98%	15.69%	14.88%	**11.51%**
GIHN	7.27%	1.03%	19.35%	12.71%	15.75%	**14.48%**
HBH	15.79%	9.09%	11.84%	5.48%	0.00%	**7.27%**
Lifeways	13.37%	8.45%	13.29%	13.51%	19.39%	**19.94%**
MCN	4.07%	0.58%	4.92%	.95%	0.40%	**1.28%**
Newaygo	21.03%	15.13%	5.39%	9.47%	5.52%	**8.54%**
Saginaw	3.87%	3.30%	3.23%	2.49%	2.18%	**3.07%**
SHW	1.59%	0.00%	2.29%	1.61%	0.00%	**1.19%**
The Right Door/Ionia	12.88%	12.90%	21.01%	19.85%	21.28%	**8.33%**
TBHS	37.63%	13.33%	21.04%	28.71%	20.79%	**13.85%**
SUD		5.67%	3.29%	5.52%	3.38%	**4.13%**
MSHN	**9.07%**	**8.23%**	**8.15%**	**8.95%**	**9.42%**	**8.36%**

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

Figure 5: Indicator 3 - Exception Report

Indicator 3	FY18Q3	FY18Q4	FY19Q1	FY19Q2	FY19Q3	FY19Q4
BABH	23.92%	15.42%	18.92%	20.93%	22.17%	**11.30%**
CMHCM	16.45%	21.81%	17.34%	23.94%	19.31%	**29.88%**
CEI	37.76%	34.20%	31.13%	43.07%	34.44%	**17.42%**
GIHN	13.73%	17.58%	11.30%	17.76%	21.49%	**11.63%**
HBH	18.60%	22.73%	22.86%	33.80%	15.87%	**23.81%**
Lifeways	24.22%	14.92%	18.34%	25.72%	24.35%	**22.66%**
MCN	30.81%	23.49%	18.63%	22.29%	28.76%	**23.83%**
Newaygo	27.33%	16.39%	23.49%	20.69%	18.57%	**12.77%**
Saginaw	28.80%	35.67%	30.24%	25.53%	25.76%	**25.52%**
SHW	14.16%	12.62%	11.11%	20.35%	14.73%	**11.59%**
The Right Door/Ionia	16.98%	10.34%	22.73%	22.81%	21.17%	**13.28%**
TBHS	7.59%	4.30%	1.98%	6.74%	7.14%	**14.04%**
SUD		6.27%	4%	6.15%	6.35	**4.68%**
MSHN	**17.97%**	**22.19%**	**14.84%**	**18.45%**	**16.86%**	**14.07%**

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 Report

Indicator 4a	FY18Q3	FY18Q4	FY19Q1	FY19Q2	FY19Q3	FY19Q4
BABH	32.72%	29.69%	30.82%	26.89%	27.68%	**42.59%**
CMHCM	8%	29.11%	26.09%	32.94%	33.72%	**28.65%**
CEI	41.33%	46.30%	53.58%	54.05%	39.81%	**30.95%**
GIHN	13.79%	13.89%	17.65%	16.67%	20.00%	**28.95%**
HBH	18.18%	27.78%	37.84%	40%	29.03%	**36.36%**
Lifeways	38.74%	44.86%	30.45%	40.66%	36.23%	**39.03%**
MCN	22.22%	24.24%	35.85%	26.32%	26.32%	**23.91%**
Newaygo	28.57%	20.83%	31.58%	18.18%	25.00%	**30.77%**
Saginaw	23.42%	22.42%	31.06%	32.56%	32.24%	**31.01%**
SHW	27.27%	22.00%	37.25%	27.59%	30.91%	**28.57%**
The Right Door/Ionia	14.63%	21.21%	20.00%	25%	23.81%	**31.03%**
TBHS	37.50%	37.50%	36.67%	48.15%	50.00%	**63.16%**
MSHN	**31.33%**	**34.80%**		**39.06%**	**33.64%**	**34.19%**

Figure 6a: 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	FY18Q3	FY18Q4	FY19Q1	FY19Q2	FY19Q3	FY19Q4
MSHN	50.75%	53.74%	60.58%	55.40%	57.96%	53.92%

Figure 6b: 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	FY18Q3	FY18Q4	FY19Q1	FY19Q2	FY19Q3	FY19Q4
BABH	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
CMHCM	0.00%	0.00%	0.00%	0.00%	0.00%	**10.50%**
CEI	3.23%	2.15%	3.02%	3.19%	2.34%	**0.00%**
GIHN	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
HBH	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Lifeways	3.49%	5.53%	2.99%	4.13%	4.53%	**6.72%**
MCN	2.78%	6.06%	0.00%	0.00%	0.00%	**0.00%**
Newaygo	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Saginaw	0.00%	0.00%	0.00%	0.00%	0.00%	**0.63%**
SHW	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
The Right Door/Ionia	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
TBHS	2.86%	0.00%	3.23%	7.41%	2.70%	**0.00%**
MSHN	**1.68%**	**1.85%**		**1.98%**	**1.63%**	**3.72%**

Figure 7: The following are exceptions for Indicator 10: Discharges who choose not to use CMHSP/PIHP Services.

The following table identifies the individual CMHSP's that are required to submit a plan of correction for the current quarter or review a current plan to ensure it addresses the deficiencies in the current quarter report. Regional Best Practice is defined as those that have performance above the standard for three consecutive quarters.

	Current Quarter's Performance Below Standard	Intervention plan in place and being monitored to reach full impact				Regional Best Practice
		FY19Q3	FY19Q2	FY19Q1	FY18Q4	Indicators
BABH	2a, 3a, 3b, 10a	3a, 3b	2c, 3a,	3c,10a	3c, 10a	1,
CMHCM	3c, 10a, 10b	NA	NA	NA	NA	1, 2, 4,
CEI	3a, 3b, 4a2	2b,3a,3b,3c,10a	2b,3a,4a2	3a,3d	NA	1,
GIHN	10b	NA	NA	NA	NA	1, 2, 4
HBH	4a2, 10a	2d, 3c, 10a	NA	NA	3c, 10a	1, 4
Lifeways	2a, 2c, 2d, 3d,	2c, 2d, 3a, 3b, 3c, 3d, 10b	2a, 2c, 2d, 3a, 3c, 3d, 10b	2c,3a,3c,4a1,4a2	2c, 4a2,	1,
MCN	1a, 3b, 10a	2d, 3a, 4a2,10a	3c,3d,4a2	3c,4a2	10a	1,
Newaygo	1a, 4a1,	10a	1b, 3a,3b,3c,3d,4a1	1b,10a	1a, 3d, 10b	2
Saginaw	3c, 10b	NA	NA		NA	1, 2, 3,
SHW	1a, 2a,10b	10b	2d, 10a	3c,10a,10b	10a, 10b	1,4
The Right Door		2a, 3a	2a,2d,3d,	3d	10b	4
TBHS	2a,	NA	NA	3a,	NA	1, 2, 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 up to 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 within 30 days of the presentation of this report to the Quality Improvement Council. The corrective action plan should be completed using the standard template and include a specific date of impact, and clearly identify the indicator in which the action is addressing.

A PowerPoint is currently in development to address the intent and requirements of each performance indicator including the expectation of documenting the allowable exceptions. A focus will be any common areas of deficiency that has been demonstrated in the regions during this past year. The power point training will be available for training of new staff as well as review for all staff. Additional emphasis to develop consistent processes will continue by utilizing the Frequently Asked Questions (FAQ) Document currently available and updated in the REMI Help documents.

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, Quality Manager **Date:** December 30, 2019

MSHN QIC Approved: **Date:**

Appendix A: **Michigan 2018-2019 PIP Validation Tool:**
Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test
for Region 5 - Mid-State Health Network

Demographic Information			
Plan Name:	Region 5 - Mid-State Health Network		
Project Leader Name:	Sandy Gettel	Title:	Quality Manager
Telephone Number:	(517) 220-2422	E-mail Address:	sandy.gettel@midstatehealthnetwork.org
Name of Project:	***Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test***		
Submission Date:	7/8/2019		

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
I.	**Select the Study Topic(s): The study topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve processes and outcomes of healthcare. The topic may also be specified by the State. The study topic:**		
C*	1. Was selected following collection and analysis of data. NA is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The study topic was selected following the collection and analysis of the plan-specific data.
	2. Has the potential to affect consumer health, functional status, or satisfaction. The score for this element will be Met or Not Met.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIP has the potential to affect consumer health, functional status, or satisfaction.

Results for Step I

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
2	2	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
II.	**Define the Study Question(s): Stating the study question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. The study question:**		
C*	1. Was stated in simple terms and in the recommended X/Y format. NA is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The study question was stated in simple terms using the recommended X/Y format.

Results for Step II

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
III.	**Define the Study Population: The study population should be clearly defined to represent the population to which the study question and indicators apply, without excluding consumers with special healthcare needs. The study population:**		
C*	1. Was accurately and completely defined and captured all consumers to whom the study question(s) applied. NA is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP accurately and completely defined the study population.

Results for Step III

Total Evaluation Elements

Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

Critical Elements

Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
IV.	**Select the Study Indicator(s): A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound. The study indicator(s):**		
C*	1. Were well-defined, objective, and measured changes in health or functional status, consumer satisfaction, or valid process alternatives.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The study indicators were based on HEDIS technical specifications. The PIHP cited the measure accurately and provided the year of the HEDIS technical specifications. **General Comment**: The PIHP documented "A 7% increase over the baseline rate (not a 7 percentage point increase);" however, the PIHP should document the Remeasurement 1 percentage goal as 56.3 percent as documented in Step VII.
	2. Included the basis on which the indicator(s) was adopted, if internally developed.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	The study indicator was not internally developed.

Results for Step IV

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
2	1	0	0	1

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
V.	**Use Sound Sampling Techniques: (If sampling is not used, each evaluation element will be scored Not Applicable [NA]). If sampling is used to select consumers in the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. Sampling methods:**		
	1. Included the measurement period for the sampling methods used (e.g., baseline, Remeasurement 1).	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
	2. Included the title of the applicable study indicator(s).	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
	3. Included the population size.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
C*	4. Included the sample size.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
	5. Included the margin of error and confidence level.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
	6. Described in detail the method used to select the sample.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
C*	7. Allowed for the generalization of results to the study population.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.

Results for Step V

Total Evaluation Elements

Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
7	0	0	0	7

Critical Elements

Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
2	0	0	0	2

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
VI.	**Reliably Collect Data: The data collection process must ensure that the data collected on the study indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures include:**		
	1. Clearly defined sources of data and data elements to be collected. NA is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP clearly and accurately defined the data elements and data sources.
C*	2. A clearly defined and systematic process for collecting data that included how baseline and remeasurement data were collected. NA is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP specified a systematic method for collecting baseline and remeasurement data.
C*	3. A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	The PIHP used administrative data collection only.
	4. An estimated degree of administrative data completeness percentage. Met = 80 - 100 percent complete Partially Met = 50 - 79 percent complete Not Met = <50 percent complete or not provided	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The estimated degree of administrative data completeness was between 80 percent and 100 percent, and the PIHP explained how it determined the administrative data completeness.

Results for Step VI

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
4	3	0	0	1

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
2	1	0	0	1

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
VII.	**Analyze Data and Interpret Study Results: Clearly present the results for each study indicator(s). Describe the data analysis performed and the results of the statistical analysis, if applicable, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined. The data analysis and interpretation of the study indicator outcomes:**		
C*	1. Included accurate, clear, consistent, and easily understood information in the data table.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP included accurate, clear, consistent, and easily understood information in the data table. **General Comment**: The PIHP should report the study indicator results to one decimal place with rounding rules applied (i.e., baseline rate of 52.6 percent).The Remeasurement 1 goal of 56.3 percent should be documented in the Remeasurement 1 row.
	2. Include a narrative interpretation that addresses all required components of data analysis and statistical testing.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP provided a narrative interpretation of results that included all required components. **General Comment**: The PIHP should report the study indicator rate to one decimal place with rounding rules applied (i.e., baseline rate of 52.6 percent) in the narrative interpretation of results.
	3. Identified factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP identified that no factors threatened the validity of the reported data.

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements	Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation		

Results for Step VII

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
3	3	0	0	0	1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
VIII.	**Improvement Strategies (interventions for improvement as a result of analysis): Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies are developed from an ongoing quality improvement process that included:**		
C*	1. A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP documented its causal/barrier analysis process, described its quality improvement (QI) team, processes/steps, and tools used.
	2. Barriers that were identified and prioritized based on results of data analysis and/or other quality improvement processes.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	Identified barriers were prioritized based on data analysis and/or appropriate QI processes.
C*	3. Interventions that were logically linked to identified barriers and will directly impact study indicator outcomes.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The interventions were logically linked to identified barriers and have the potential to impact study indicator outcomes.
	4. Intervention that were implemented in a timely manner to allow for impact of study indicator outcomes.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The interventions were implemented in a timely manner to allow for impact of the study indicator outcomes.
C*	5. Evaluation of individual interventions for effectiveness.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	The PIHP has not progressed to the point of evaluating the effectiveness for each intervention.
	6. Interventions that were continued, revised, or discontinued based on evaluation results.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	The PIHP has not progressed to the point of evaluating the effectiveness for each intervention.

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements	Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation		

Results for Step VIII

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
6	4	0	0	2	3	2	0	0	1

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
IX.	**Assess for Real Improvement: Real improvement or meaningful change in performance is evaluated based on study indicator(s) results.**		
	1. The remeasurement methodology was the same as the baseline methodology.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	Not Assessed. The PIP had not progressed to the point of being assessed for real improvement.
	2. The documented improvement meets the State- or plan-specific goal.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	Not Assessed. The PIP had not progressed to the point of being assessed for real improvement.
C*	3. There was statistically significant improvement over the baseline across all study indicators.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	Not Assessed. The PIP had not progressed to the point of being assessed for real improvement.

Results for Step IX

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
3	0	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	0	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Health Care Study Evaluation			
X.	**Assess for Sustained Improvement: Sustained improvement is demonstrated through repeated measurements over comparable time periods.**		
C*	1. Repeated measurements over comparable time periods demonstrated sustained improvement over the baseline.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	Not Assessed. Sustained improvement cannot be assessed until statistically significant improvement over the baseline has been achieved across all study indicators, and a subsequent measurement period has been reported.

Results for Step X

Total Evaluation Elements

Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	0	0	0	0

Critical Elements

Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	0	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Table A-1—2018-2019 PIP Validation Tool Scores:
Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test
for Region 5 - Mid-State Health Network

Review Step		Total Possible Evaluation Elements (Including Critical Elements)	Total Met	Total Partially Met	Total Not Met	Total NA	Total Possible Critical Elements	Total Critical Elements Met	Total Critical Elements Partially Met	Total Critical Elements Not Met	Total Critical Elements NA
I.	Select the Study Topic(s)	2	2	0	0	0	1	1	0	0	0
II.	Define the Study Question(s)	1	1	0	0	0	1	1	0	0	0
III.	Define the Study Population	1	1	0	0	0	1	1	0	0	0
IV.	Select the Study Indicator(s)	2	1	0	0	1	1	1	0	0	0
V.	Use Sound Sampling Techniques	7	0	0	0	7	2	0	0	0	2
VI.	Reliably Collect Data	4	3	0	0	1	2	1	0	0	1
VII.	Analyze Data and Interpret Study Results	3	3	0	0	0	1	1	0	0	0
VIII	Improvement Strategies	6	4	0	0	2	3	2	0	0	1
IX.	Assess for Real Improvement	3		Not Assessed			1	Not Assessed			
X.	Assess for Sustained Improvement	1		Not Assessed			1	Not Assessed			
Totals for All Steps		**30**	**15**	**0**	**0**	**11**	**14**	**8**	**0**	**0**	**4**

Table A-2—2018-2019 PIP Validation Tool Overall Score:
Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test
for Region 5 - Mid-State Health Network

Percentage Score of Evaluation Elements Met*	**100%**
Percentage Score of Critical Elements Met**	**100%**
Validation Status***	***Met***

* The percentage score for all evaluation elements Met is calculated by dividing the total Met by the sum of all evaluation elements Met, Partially Met, and Not Met. The Not Assessed and Not Applicable scores have been removed from the scoring calculations.

** 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.

** Met equals high confidence/confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not credible.

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS
HSAG assessed the validity and reliability of the results based on CMS validation protocols and determined whether the State and key stakeholders can have confidence in the reported PIP findings. Based on the validation of this PIP, HSAG's assessment determined the following:

Met: **High confidence/confidence in reported PIP results. All critical evaluation elements were Met, and 80 to 100 percent of all evaluation elements were Met across all activities.**

Partially Met: **Low confidence in reported PIP results. All critical evaluation elements were Met, and 60 to 79 percent of all evaluation elements were Met across all activities; or one or more critical evaluation elements were Partially Met.**

Not Met: **All critical evaluation elements were Met, and less than 60 percent of all evaluation elements were Met across all activities; or one or more critical evaluation elements were Not Met.**

Summary of Aggregate Validation Findings

[X]	***Met***	[ ]	***Partially Met***	[ ]	***Not Met***

Overview of Mid-State Health Network Recovery Self-Assessment Survey Summary Report FY 2019

Provider Network Measure

Introduction

The following overview of Mid-State Health Network's (MSHN) Recovery Self-Assessment (RSA) Survey was developed to assist MSHN Community Mental Health Service Program (CMHSP) Participants and Substance Abuse Treatment Providers (SATP) develop a better understanding of the strengths and weaknesses in MSHN's recovery-oriented care. This report was developed utilizing voluntary self-reflective surveys completed by administrators and providers representing all CMHSP and SATP that provide services to adults with a Mental Illness and or Substance Abuse diagnosis. Figure 1 illustrates the number of respondents for each RSA-R Version. The survey results were aggregated and scored as outlined in the Yale Program for Recovery and Community Health instructions.

Program	Administrators	Providers
Mid-State Health Network Total	195	435
Bay-Arenac Behavioral Health Authority	24	45
Community Mental Health Authority of CEI	4	40
Community Mental Health for Central Michigan	26	41
Gratiot Integrated Health Network	6	15
Huron Behavioral Health	5	
LifeWays Community Mental Health	2	16
Montcalm Care Center	17	23
Newaygo County Community Mental Health	13	24
Saginaw County Community Mental Health	20	30
Shiawassee County Community Mental Health	7	
The Right Door for Hope Recovery and Wellness	19	28
Tuscola Behavioral Health System	2	6
MSHN SUD Providers	50	167

The distribution period was May 1, 2019 through May 31, 2019 and this marks the fourth year of implementation for the CMHSP Participants for the RSA-R Administrators Version and the first year for the CMHSP Participants and SATP RSA-R Provider Version. The RSA-R Administrator Version is competed by administrators who do not provide direct services to individuals. The RSA-R Provider Version is for providers who, in addition to their administrative functions, provides direct services to individuals.

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 Sandy Gettel, Quality Manager at sandy.gettel@midstatehealthnetwork.org

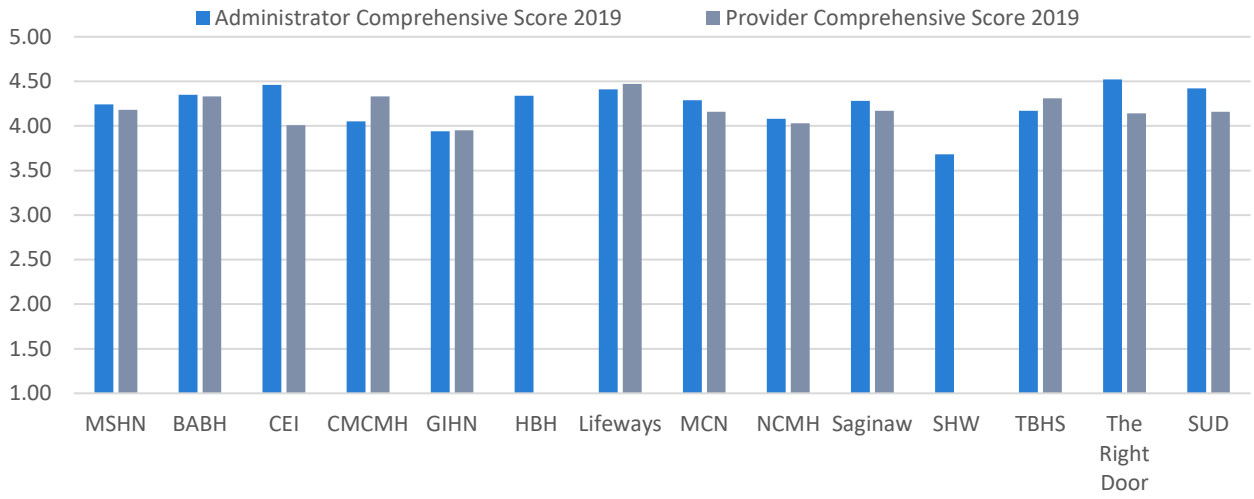
MSHN Summary

The responses from the Recovery Self-Assessment surveys were scored as a comprehensive total, separately as six subcategories, and by individual question. The tool is intended to assess the perceptions of individual recovery and all items are rated using the same 5-point Likert scale that ranges from 1 = “strongly disagree” to 5 = “strongly agree.” The comprehensive score measures how the system is performing, and the subcategories measures the performance of six separate parts. The individual response score for each question in the subcategories is included to assist in determining potential action steps. In addition to analyzing the mean score for each subcategory an analysis was completed utilizing the mean score separated by program type for each provider. The “not applicable” and “do not know” responses were removed from the analysis.

MSHN Comprehensive Summary

MSHN CMHSP Participants have demonstrated an increase in the RSA-R Administrators Version comprehensive score since the onset of the project in FY2015. The CMHSP Participants RSA-R Administrators Version comprehensive score was 3.82 for FY 2015, 4.00 for FY 2016, 4.06 for FY 2017, and 4.14 for FY 2018. MSHN incorporated the Substance Use Provider Network into RSA-R Administrator project and began implementation of the RSA-R Provider Version for the CMHSP Participants and the Substance use Provider Network in 2019. MSHN’s comprehensive score for the administrator’s version was 4.24 for FY2019. MSHN’s comprehensive score for the provider version for FY2019 was 4.18. Figure 2 illustrates the comprehensive score for MSHN and each CMHSP Participants and SA Treatment Providers.

Figure 2 – MSHN Comprehensive Score by CMHSP Participant and Substance Use Provider Network

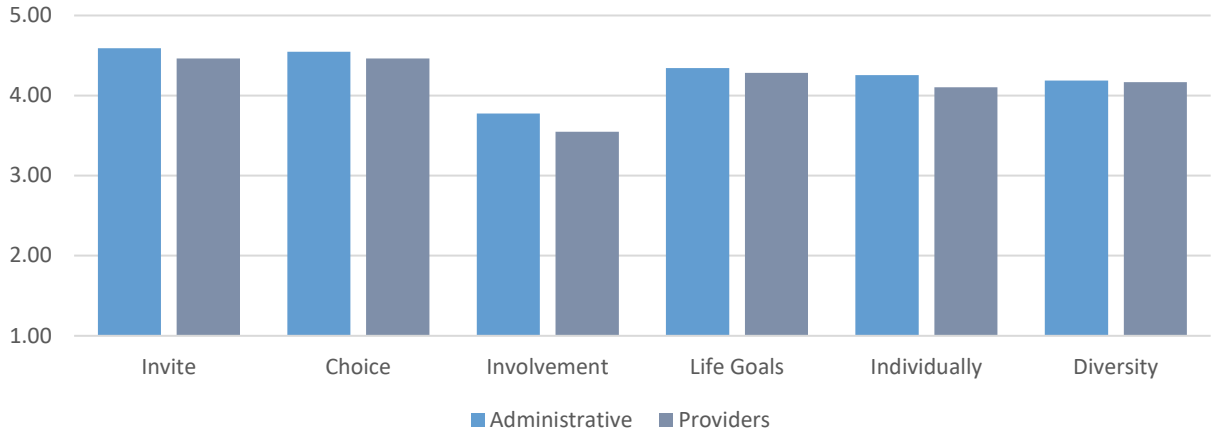


MSHN Subcategory Summary

The MSHN responses from the Recovery Self-Assessment-R Administrator Version and the Recovery Self-Assessment-R Provider Version scores were separated by each subcategory scores.

The MSHN CMHSP Participants RSA-R Administrators Version comprehensive score was 3.82 for FY 2015, 4.00 for FY 2016, 4.06 for FY 2017, 4.14 for FY2018, and the CMHSP Participants and SUD Providers comprehensive score was 4.24 for 2019. Figure 3 illustrates that each CMHSP Participant and the SUD Provider Network scored above 3.50 indicating satisfaction or agreement with the statements included in each subcategory.

Figure 3 MSHN RSA-R Administrator and RSA-R Provider Scores for each Subcategory



Invite Subcategory

The MSHN average was 4.29 for FY 2015, 4.44 for FY 2016, 4.56 for FY 2017, and 4.45 for FY18. Figure 4 illustrates how MSHN and each CMHSP Participant and SUD Provider Network responded to the Invite subcategory for FY2019. The comprehensive score for both the Administrators Version and the Provider Version was above 3.5 indicating agreement or satisfaction with the statements included in the Invite subcategory.

Figure 4 – CMHSP Participants and SUD Provider Network Comparison of Invite Subcategory Score

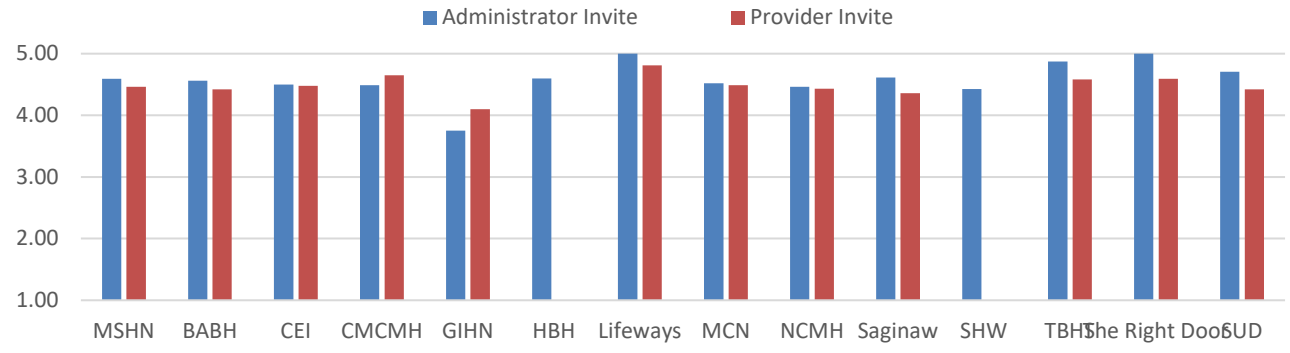


Figure 4a – CMHSP Participants and SUD Provider Network Comparison of Invite Subcategory Score with Questions-Administrator Version

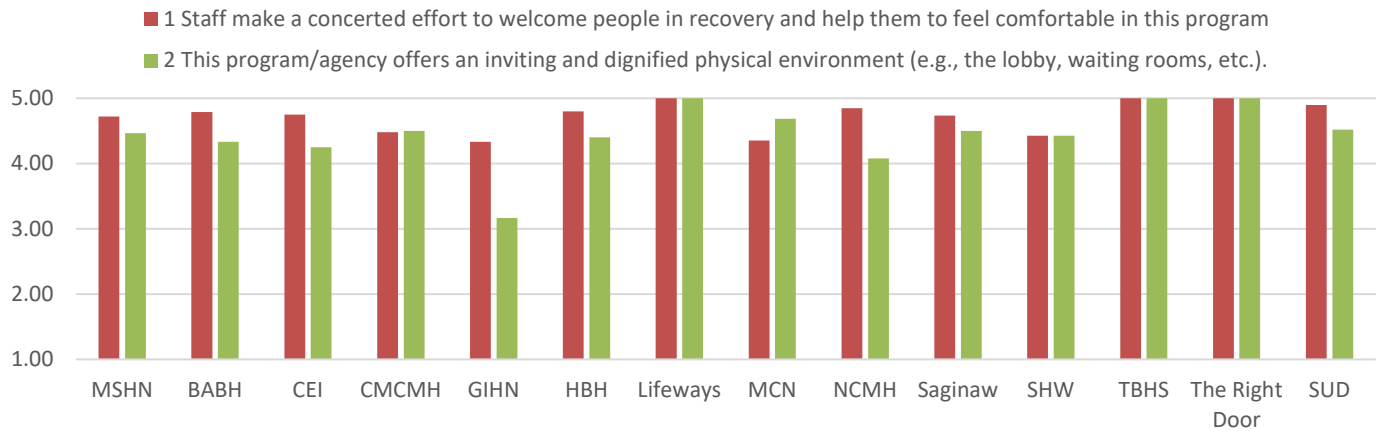


Figure 4b – CMHSP Participants and SUD Provider Network Comparison of Invite Subcategory Score with Questions-Provider Version

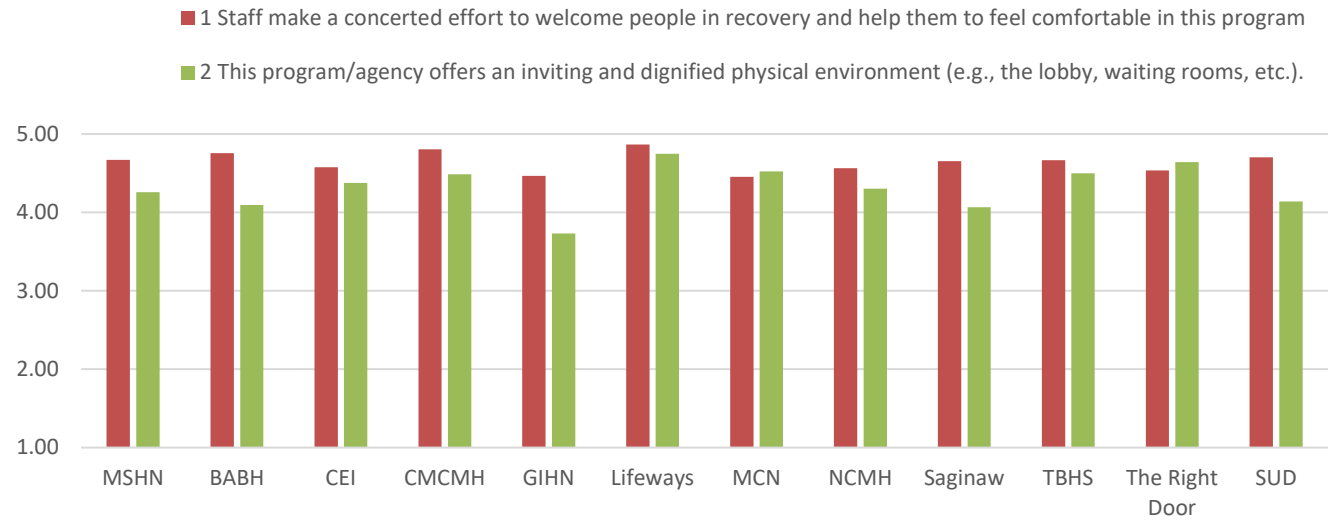
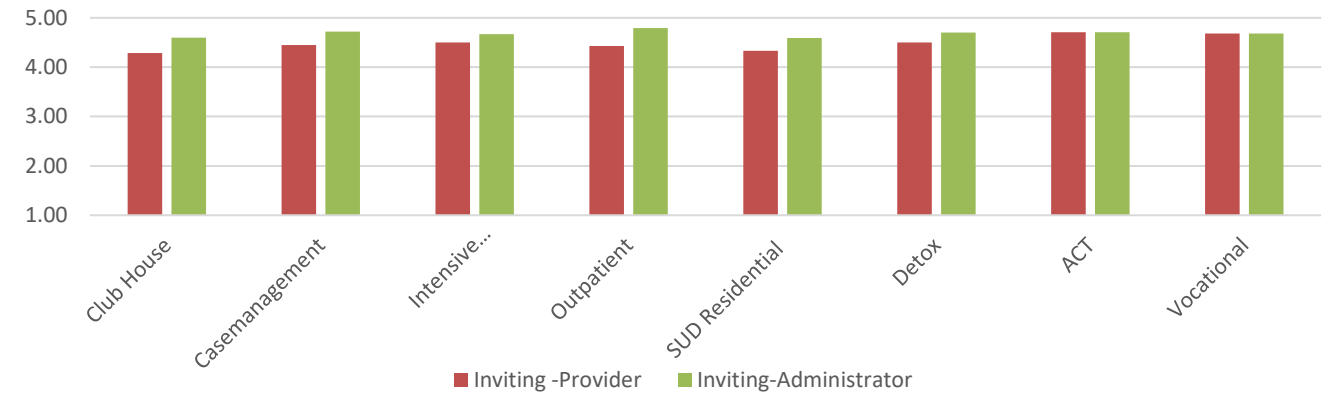


Figure 4c-Comparison of subcategory by service program



Choice Subcategory

The MSHN RSA-R Administrators Version average was 4.21 for FY 2015, 4.38 for FY 2016, 4.36 for FY 2017, and 4.52 for FY18. Figure 5 illustrates how MSHN and each CMHSP Participant and SUD Provider Network responded to the Choice subcategory for FY2019. The comprehensive score for both the Administrators Version and the Provider Version was above 3.5 indicating agreement or satisfaction with the statements included in the Choice subcategory. Figures 5a-5b illustrates how each CMHSP and the SUD Provider Network scored for each question within the subcategory by RSA-R version type. Figure 5c illustrates the comprehensive score of the subcategory by RSA-R Version Type.

Figure 5 – CMHSP Participants and SUD Provider Network Comparison of Choice Subcategory Score

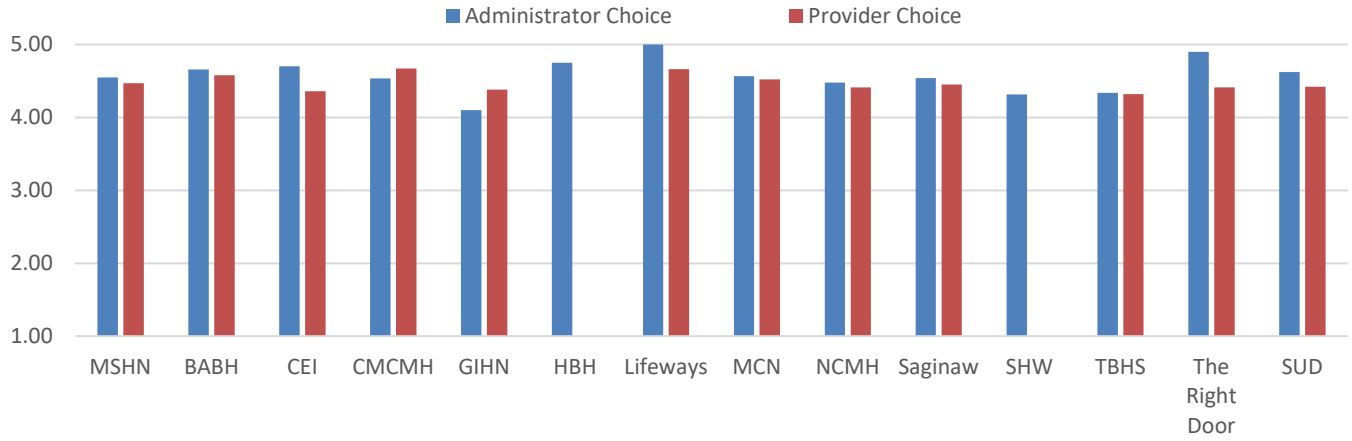


Figure 5a – CMHSP Participants and SUD Provider Network Comparison of Choice Subcategory Score with Questions-Administrator Version

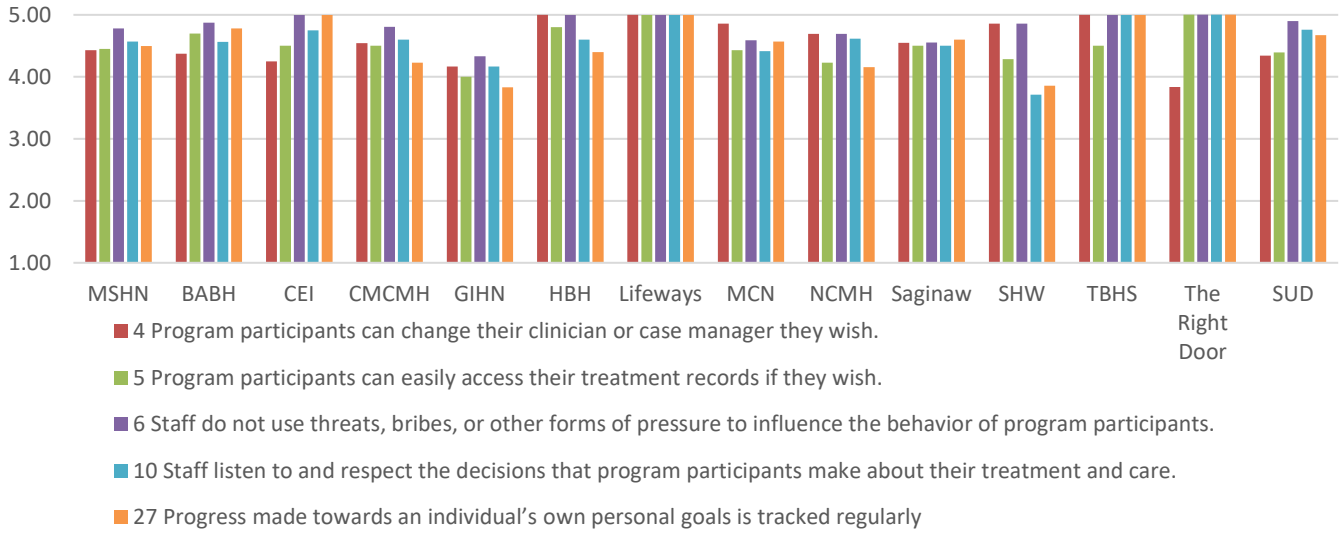


Figure 5b – CMHSP Participants and SUD Provider Network comparison of Choice Subcategory Score with Questions-Provider Version

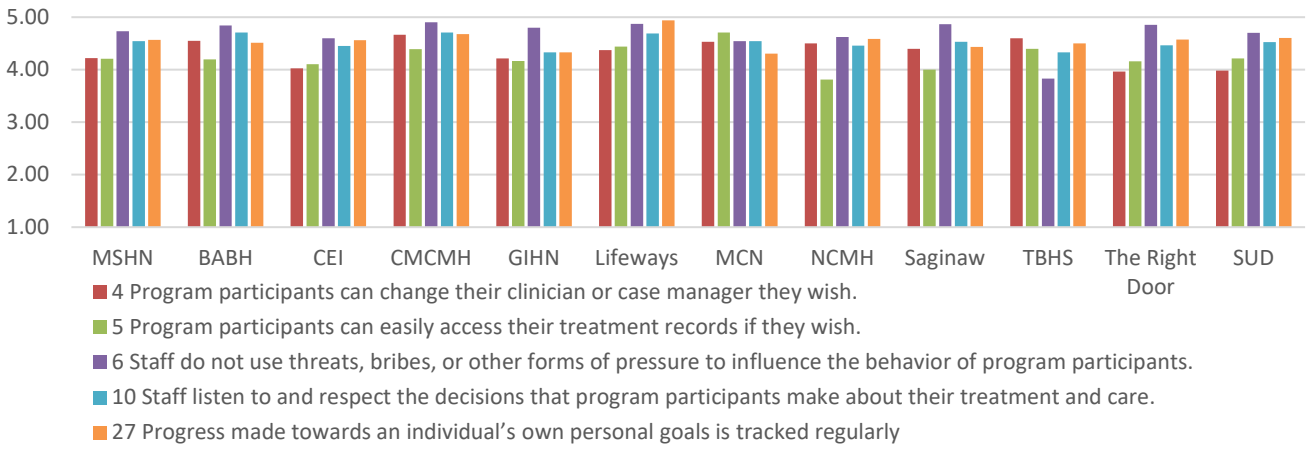
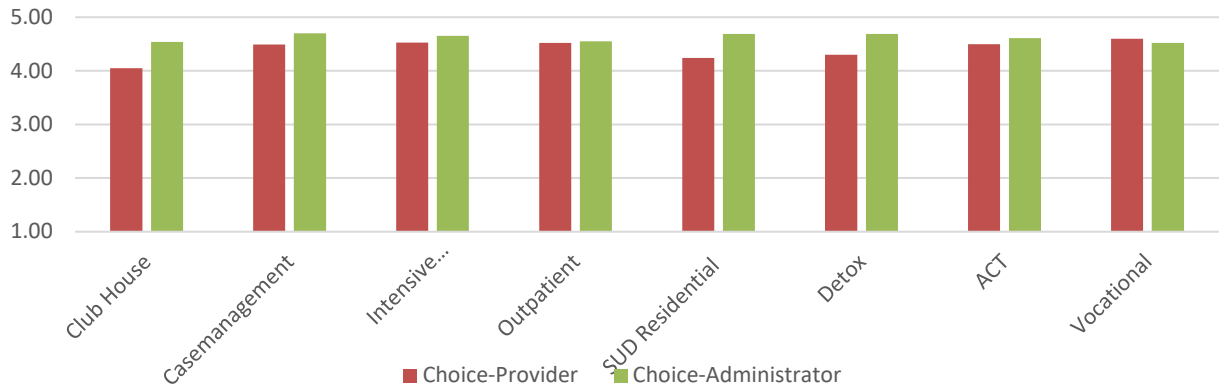


Figure 5c-Comparison subcategory of service programs



Involvement Subcategory

The MSHN average was 3.42 for FY 2015, 3.14 for FY 2016, 3.64 for FY 2017, and 3.73 for FY18. Figure 6 illustrates how MSHN and each CMHSP Participant and SUD Provider Network responded to the Involvement subcategory for FY2019. The comprehensive score for both the Administrators Version and the Provider Version was above 3.5 indicating agreement or satisfaction with the statements included in the Involvement subcategory. Figure 6a illustrates how the CMHSP Participants and the SUD Provider Network responded to the Involvement subcategory administrator version. Figure 6b illustrates how the CMHSP Participants and the SUD Providers Network responded to the Involvement subcategory provider version. The Involvement subcategory for MSHN was above 3.5, however, seven of the CMHSPs demonstrated a score below 3.50 which indicates disagreement with the statements in the Involvement subcategory. Figure 6c illustrates how the CMHSP Participants and the SUD Provider Network scored by RSA-R version type and service program.

Figure 6 – CMHSP Participants and SUD Provider Network Comparison of Involvement Subcategory Score

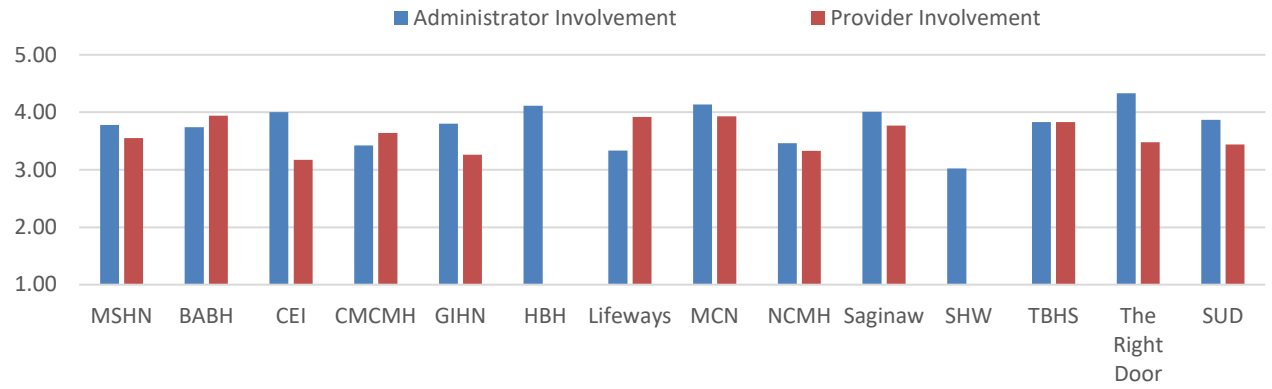


Figure 6a – CMHSP Participants and SUD Provider Network comparison of Involvement Subcategory Score with Questions-Administrator Version

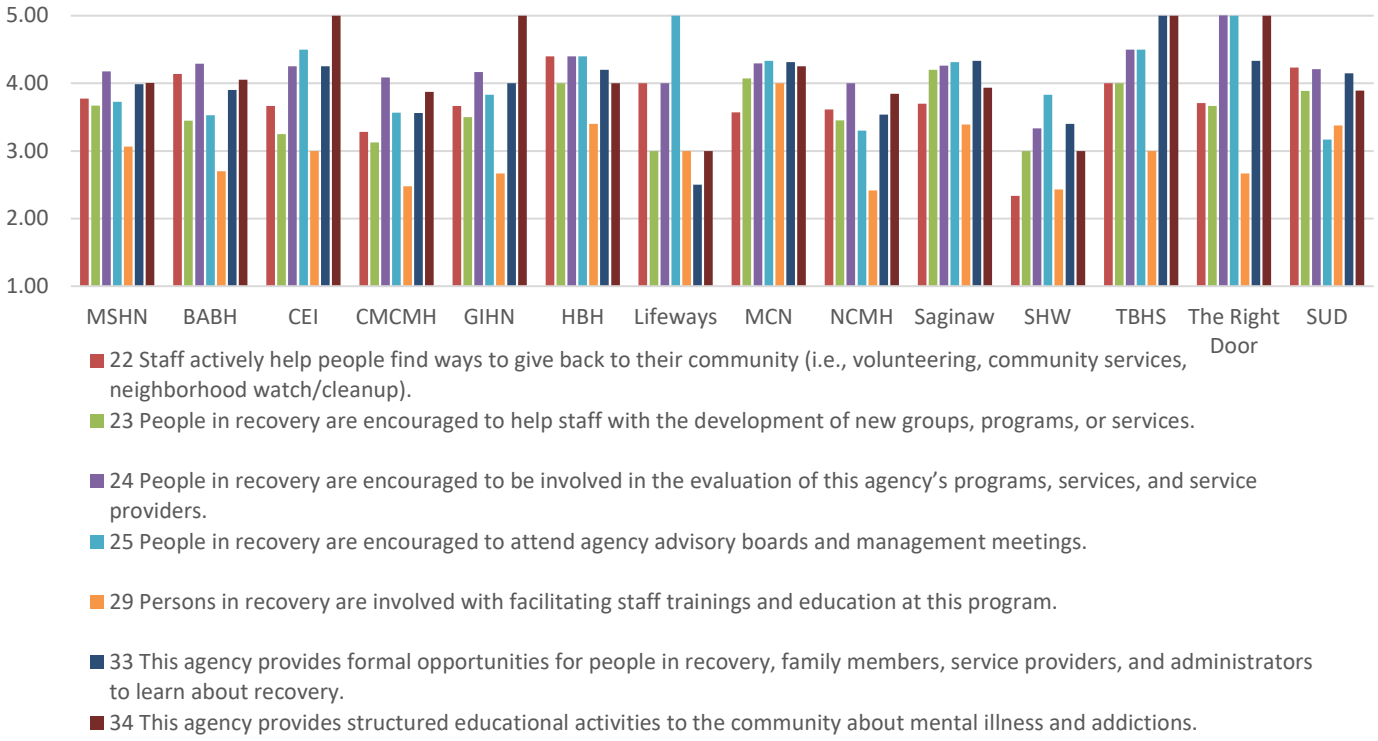
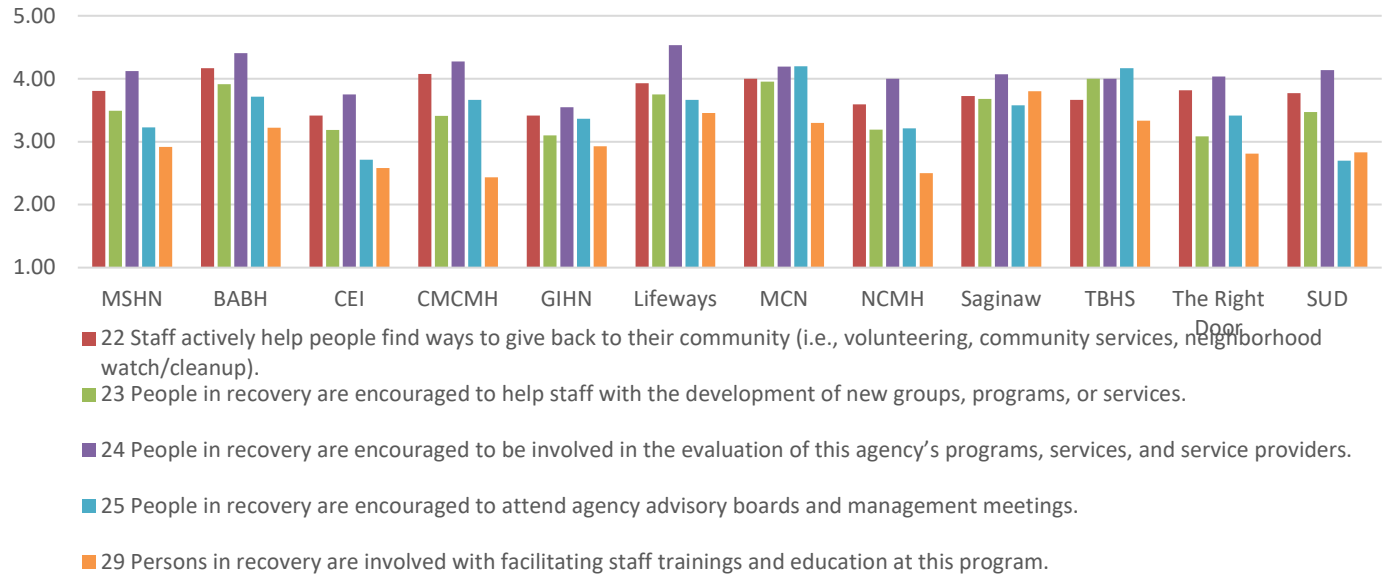
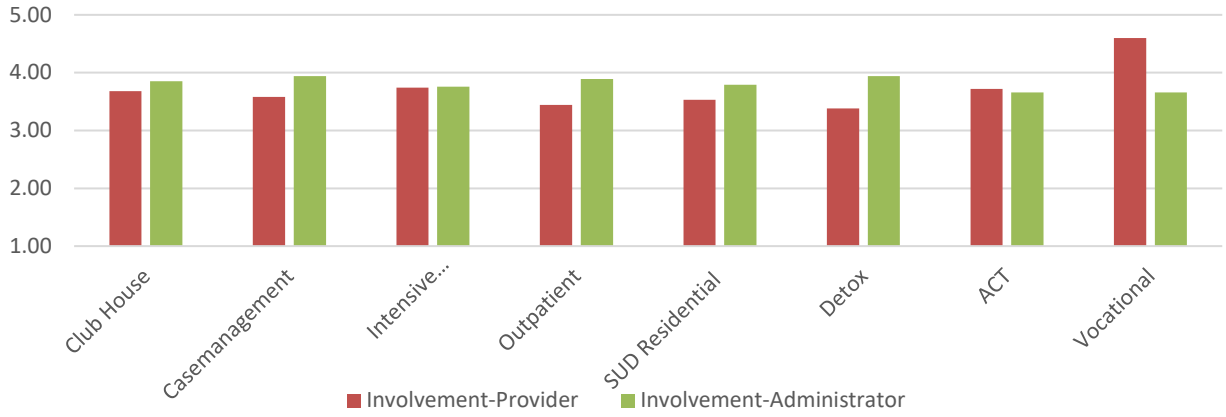


Figure 6b – CMHSP Participants and SUD Provider Network comparison of Involvement Subcategory Score with Questions-Provider Version



6c-Comparison of subcategory by Service Programs



Life Goals Subcategory

The MSHN average was 3.84 for FY 2015, 4.09 for FY 2016, 4.18 for FY 2017, and 4.23 for FY 2018. Figure 7 illustrates how MSHN and each CMHSP Participant and SUD Provider Network responded to the Life Goals subcategory for FY2019. The comprehensive score for both the Administrators Version and the Provider Version was above 3.5 indicating agreement or satisfaction with the statements included in the Life Goals subcategory. Figure 7a-7b illustrates how the CMHSP Participants and the SUD Provider Network responded to the Life Goals subcategory administrator version. Figure 7c-7d illustrates how the CMHSP Participants and the SUD Providers Network responded to the Life Goals provider version. Figure 7e demonstrates how the CMHSP Participant and the SUD Provider Network scored by RSA-R version type and service program.

Figure 7 – CMHSP Participants and SUD Provider Network Comparison of Life Goals Subcategory Score

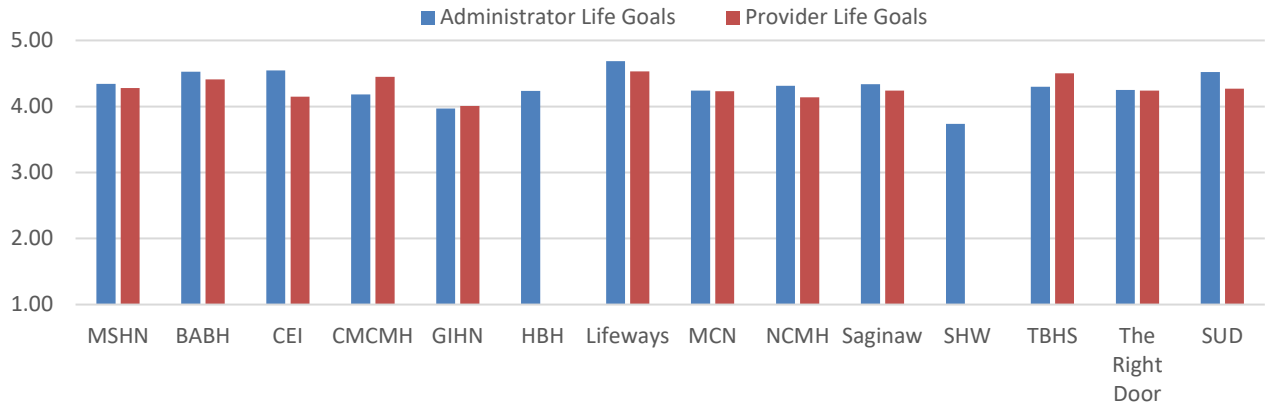


Figure 7a – CMHSP Participants and SUD Provider Network comparison of Life Goals Subcategory Score with Questions-Administrator Version (Questions 3, 7, 8, 9, 12)

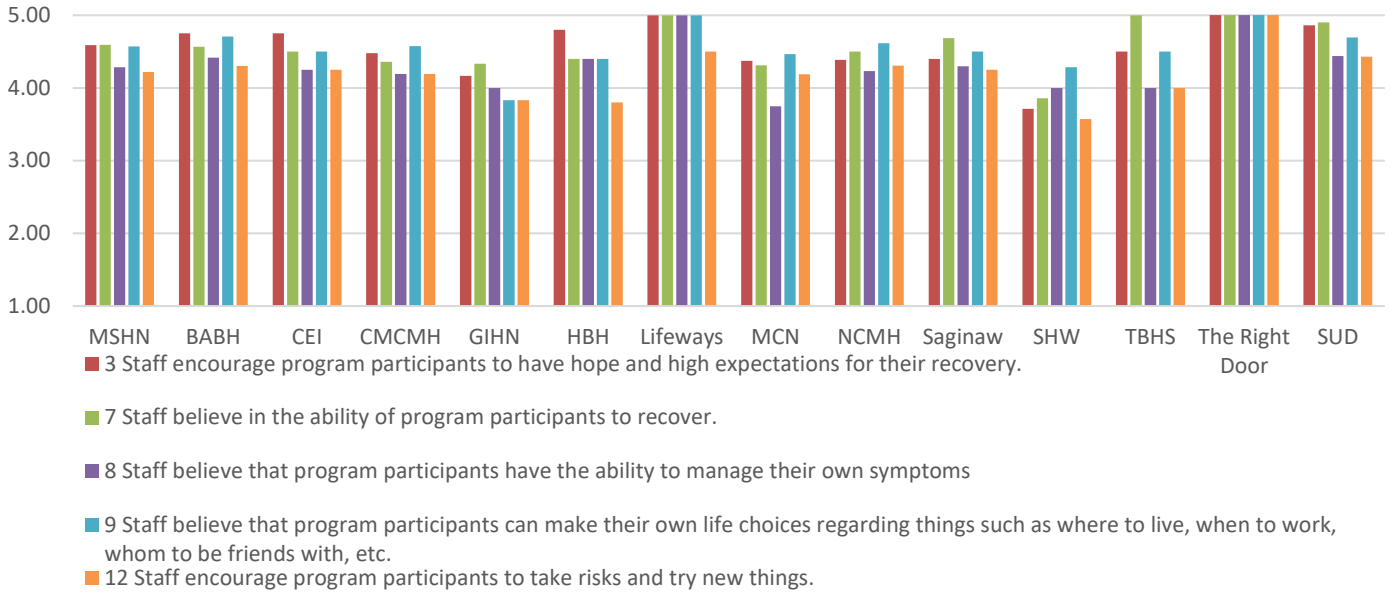


Figure 7b – CMHSP Participants and SUD Provider Network comparison of Life Goals Subcategory Score with Questions-Administrator Version (questions 16, 17, 18, 28, 31, 32)

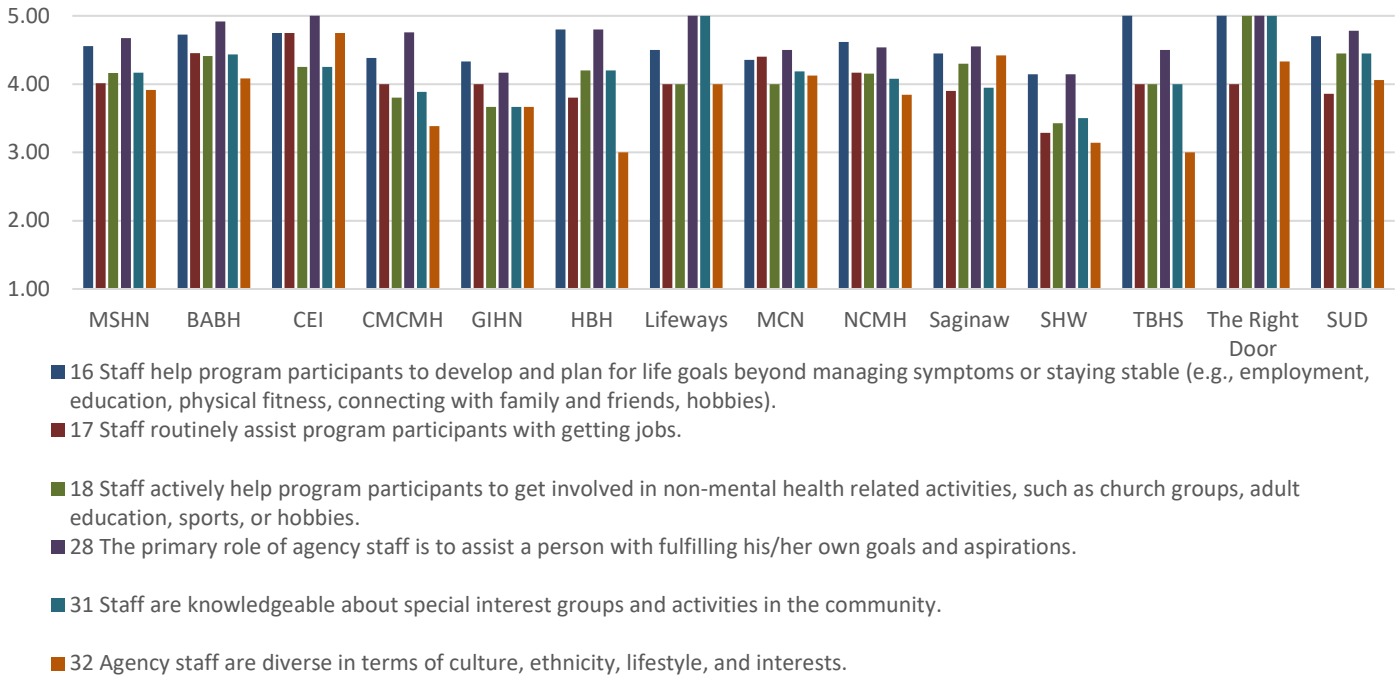


Figure 7c – CMHSP Participants and SUD Provider Network comparison of Life Goals Subcategory Score with Questions-Provider Version (questions 3, 7, 8, 9, 12)

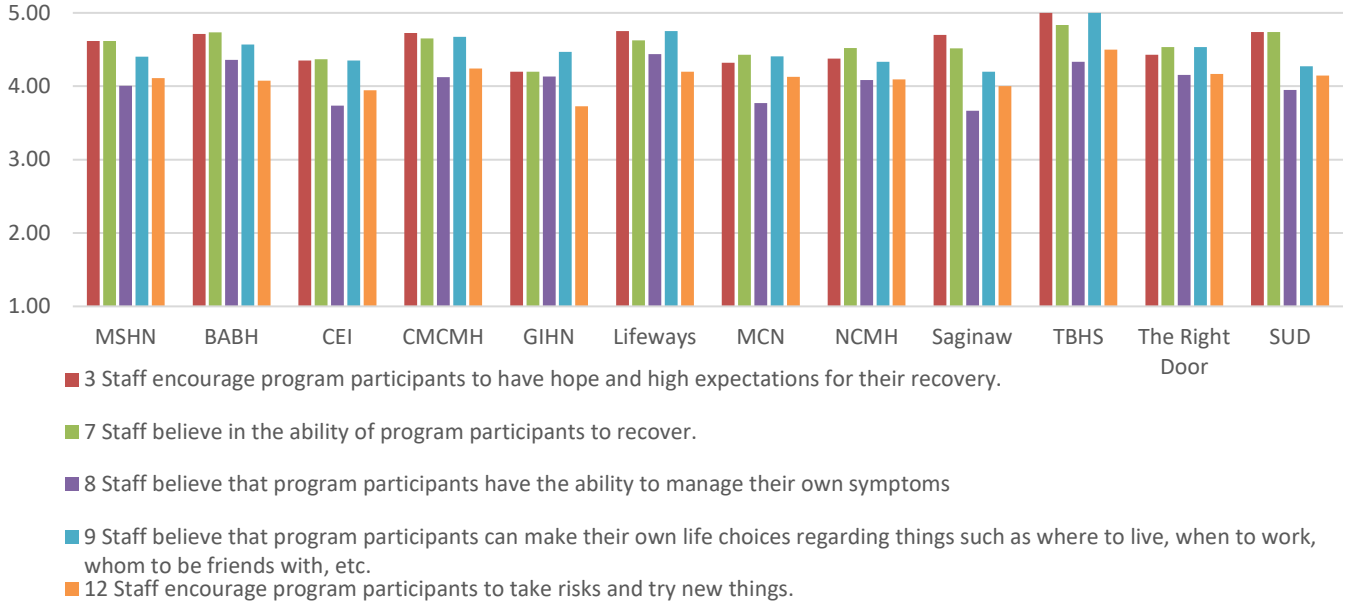


Figure 7d – CMHSP Participants and SUD Provider Network comparison of Life Goals Subcategory Score with Questions-Provider Version (questions 16, 17, 18, 28, 31, 32)

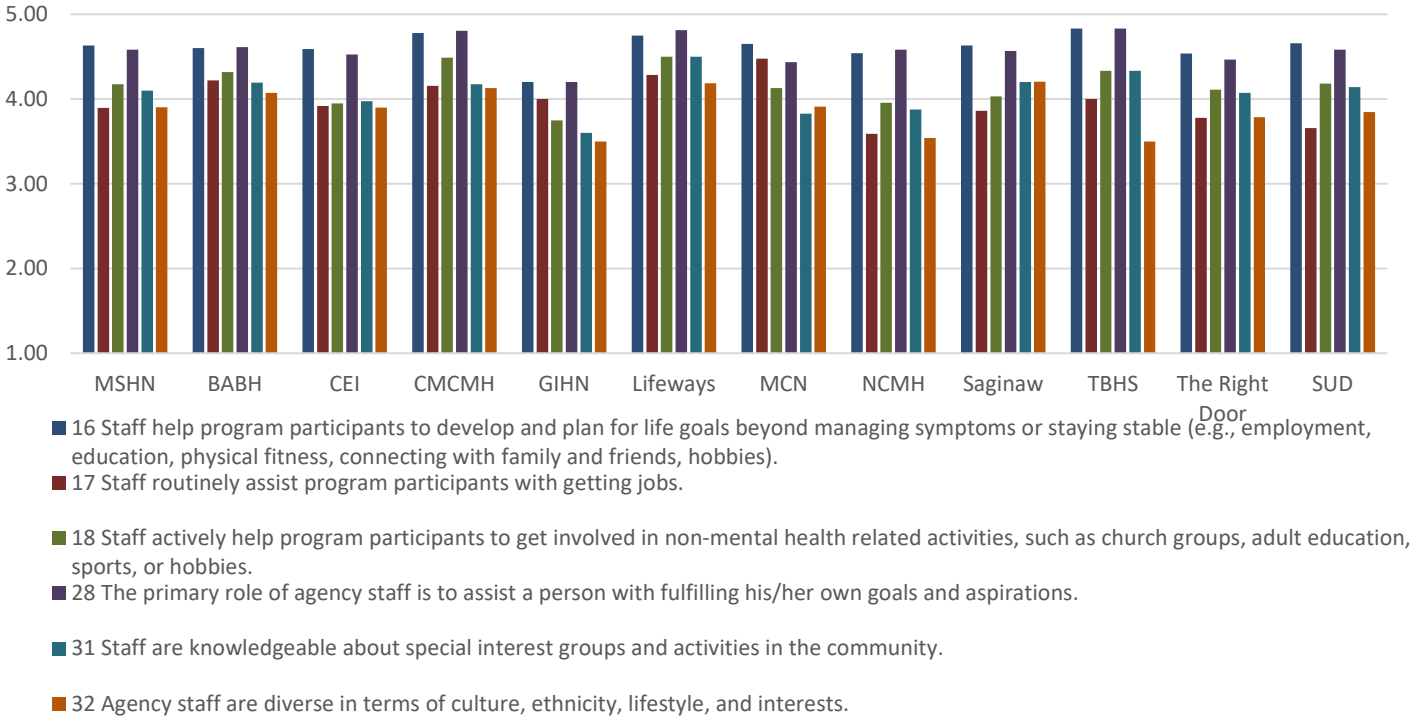
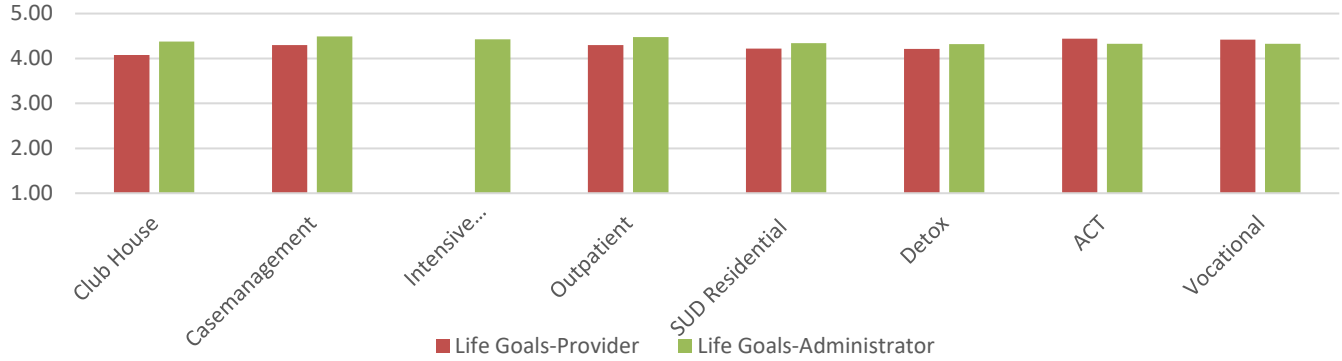


Figure 7e-Comparison of Service Programs



Individually Tailored Services Subcategory

The MSHN average was 3.96 for FY 2015, 4.05 for FY 2016, 4.13 for FY 2017, and 4.16 for FY 2018. Figure 8 illustrates how MSHN and each CMHSP Participant and SUD Provider Network responded to the Individually Tailored Services subcategory for FY2019. The comprehensive score for both the Administrators Version and the Provider Version was above 3.5 indicating agreement or satisfaction with the statements included in the Individually Tailored Services subcategory. Figure 8a illustrates how the CMHSP Participants and the SUD Provider Network responded to the Individually Tailored Services subcategory administrator. Figure 8b illustrates how the CMHSP Participants and the SUD Providers Network responded to the Individually Tailored Services subcategory provider version. Figure 8c demonstrates how the CMHSP Participant and the SUD Provider Network scored by RSA-R version type and service program.

Figure 8 – CMHSP Participants and SUD Provider Network comparison of Individually Tailored Services Subcategory Score

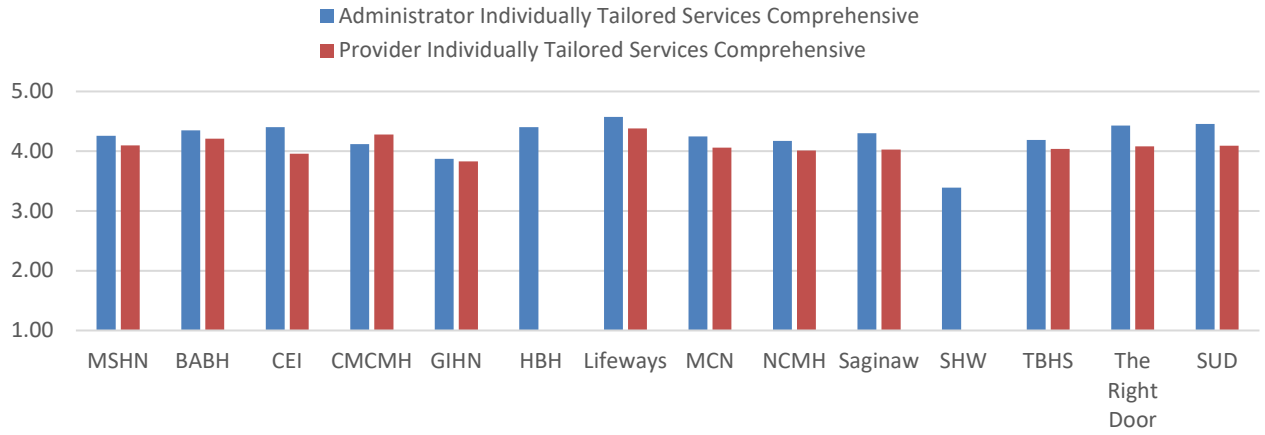


Figure 8a – CMHSP Participants and SUD Provider Network comparison of Individually Tailored Services Subcategory Score with Questions-Administrator Version

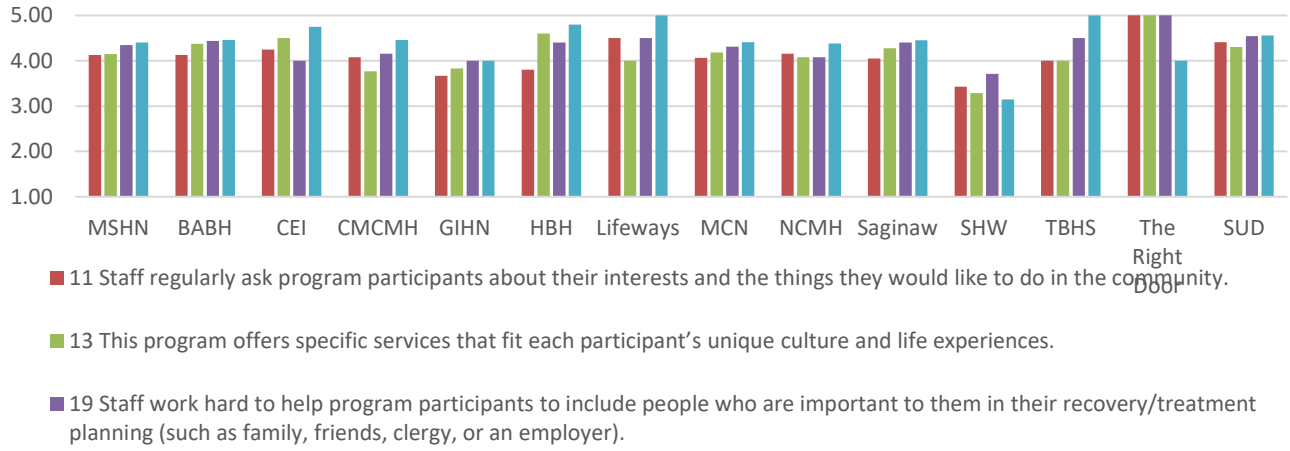


Figure 8b – CMHSP Participants and SUD Provider Network comparison of Individually Tailored Services Subcategory Score with Questions-Provider Version

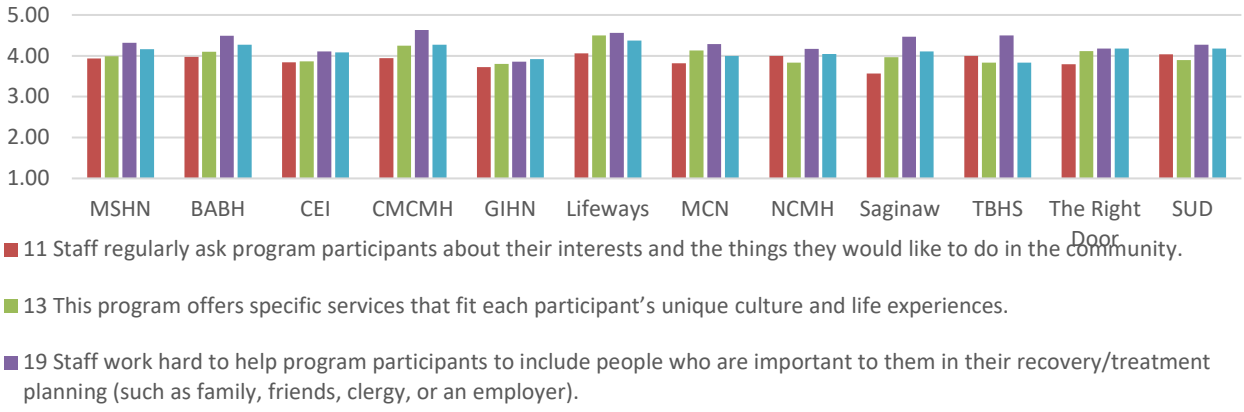
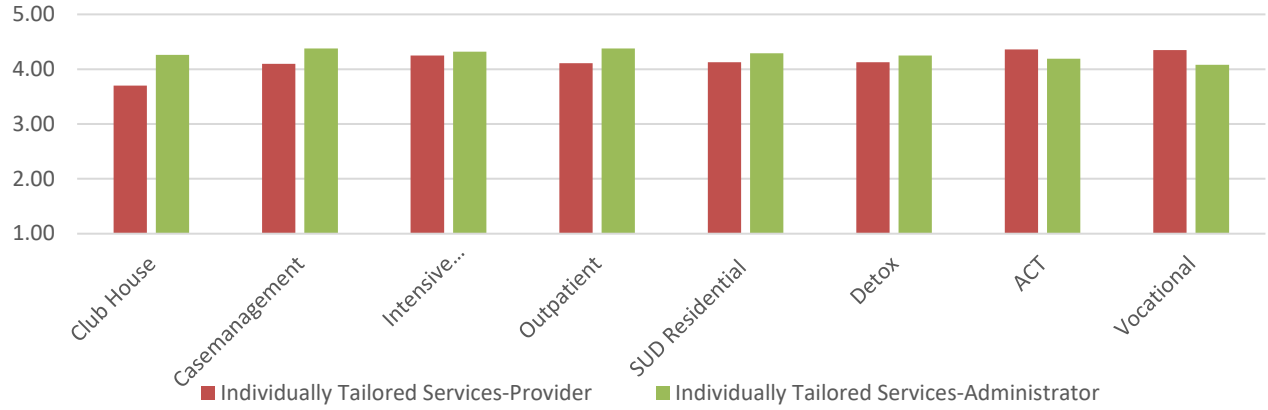


Figure 8c-Comparison of Service Programs



Diversity Subcategory

The MSHN average was 3.72 for FY 2015, 3.84 for FY 2016, 3.90 for FY 2017, and 4.07 for FY18. Figure 9 illustrates how MSHN and each CMHSP Participant and SUD Provider Network responded to the Diversity subcategory for FY2019. The comprehensive score for both the Administrators Version and the Provider Version was above 3.5 indicating agreement or satisfaction with the statements included in the Diversion subcategory. Figure 9a illustrates how the CMHSP Participants and the SUD Provider Network responded to the Diversity subcategory administrator version. Figure 9b illustrates how the CMHSP Participants and the SUD Providers Network responded to the Diversity subcategory provider version. Figure 9c demonstrates how the CMHSP Participant and the SUD Provider Network scored by RSA-R version type and service program.

Figure 9 – CMHSP Participants and SUD Provider Network comparison of Diversity of Treatment Subcategory Score

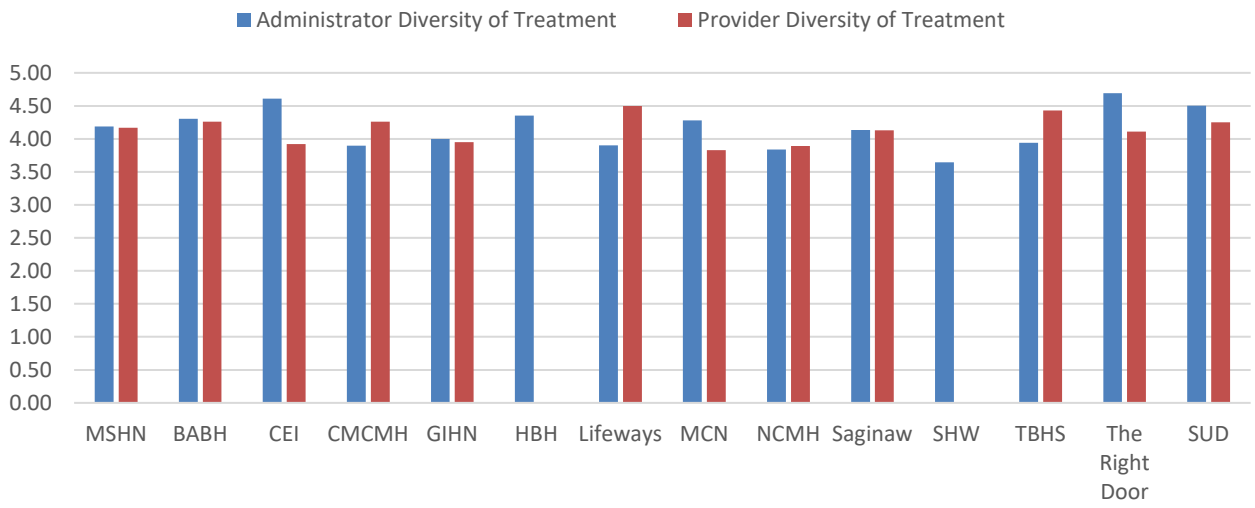


Figure 9a – CMHSP Participants and SUD Provider Network comparison of Diversity of Treatment Subcategory Score with Questions-Administrator Version

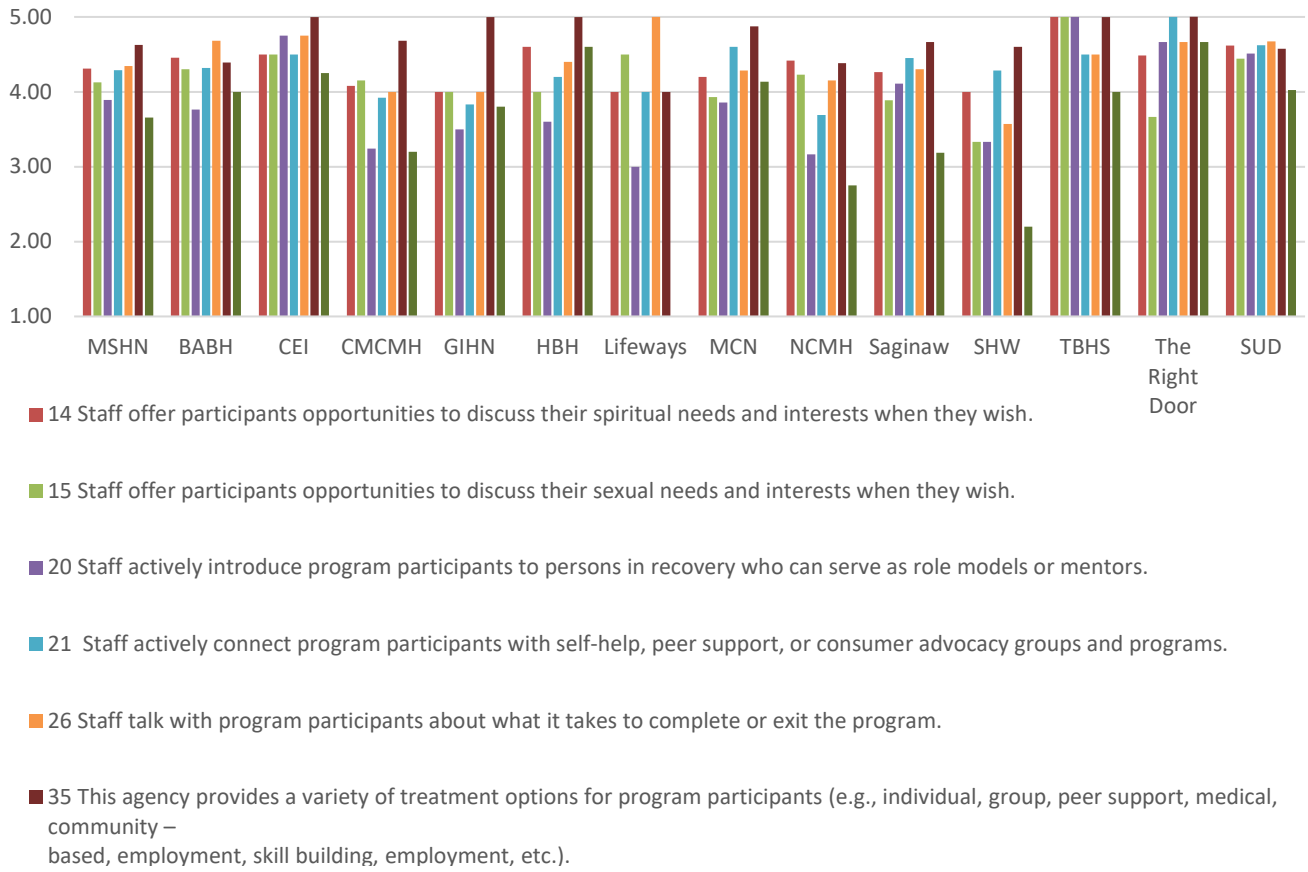


Figure 9b – CMHSP Participants and SUD Provider Network comparison of Diversity of Treatment-Provider Version

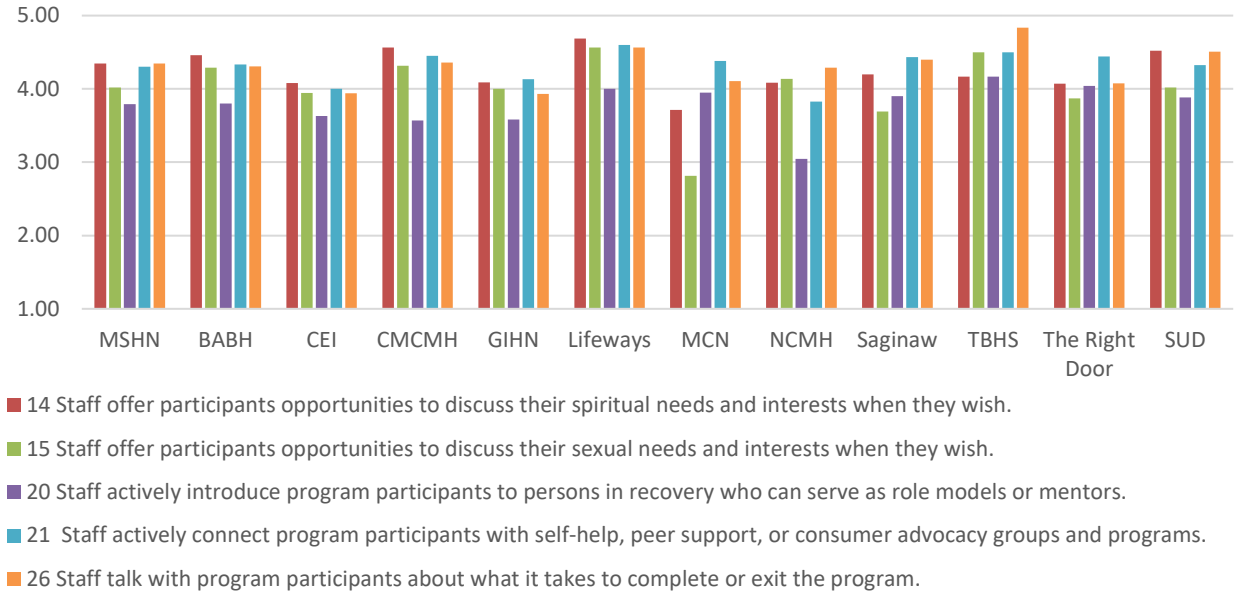


Figure 9c-Comparison of Service Programs

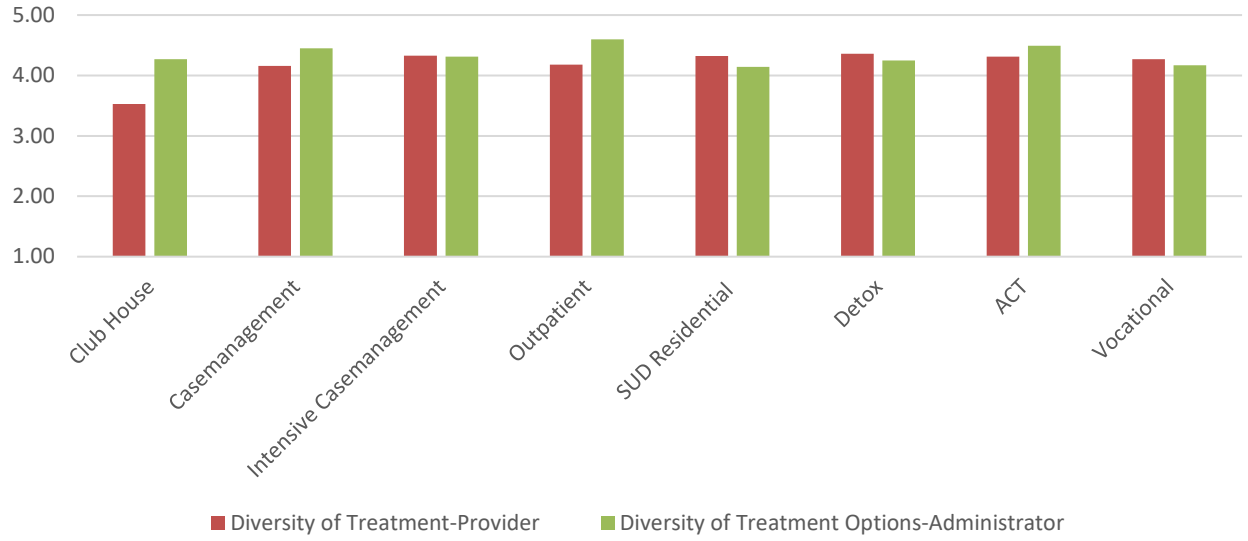


Figure 10 illustrates each comprehensive score for each RSA-R Version, indicating the administrators assessed the recovery environment to be higher than the providers.

Figure 10

FY2019	RSA-R Provider Version	RSA-R Administrator Version
Comprehensive Score	**4.18**	**4.24**
Involvement - Subcategory	3.55	3.78
Individually Tailored Services - Subcategory	4.10	4.26
Diversity of Treatment - Subcategory	4.17	4.19
Life Goals Sub-Category	4.28	4.34
Choice - Subcategory	4.47	4.55
Inviting - Subcategory	4.46	4.59

Summary:

For the FY2019 the RSA-R Administrators version and the RSA-R Provider version was completed for both the CMHSP Participants and the SUD Provider Network. Each version of the assessment was scored separately for comparison purposes. The assessment consisted of six (6) separate subcategories that included Invite, Choice, Involvement, Life Goals, Individually Tailored Services and Diversity of Treatment.

Overall the Administrator version demonstrated a higher score (4.24) for MSHN than the Provider version (4.18) on the assessment. All CMHSP Participants and SUD Provider Network scored above 3.50 indicating generalized agreement with the statements in the assessment. Seven CMHSP Participants and the SUD Provider Network administrators assessed the recovery environment to be higher than the providers assessed the recovery environment.

The subcategories demonstrated a score above 3.5 for each subcategory. Consistent with the comprehensive score for the administrators and the providers, the administrators assessed the recovery environment to be higher than the providers assessed the recovery environment.

The subcategory that scored the lowest was the Involvement subcategory. The comprehensive score for MSHN was above 3.5, however, the analysis of the questions indicated the following questions scored below 3.50:

> Question 29. Persons in recovery are involved with facilitating staff trainings and education at this program. Administrators Version 3.06, Provider Version 2.92.
>
> Question 25. People in recovery are encouraged to attend agency advisory boards and management meetings. Provider Version 3.23.
>
> Question 23. People in recovery are encouraged to help staff with the development of new groups, programs, or services. Provider Version 3.49.

Attachment 1 demonstrates the responses for each question ranked from the highest to lowest average for MSHN Administrators.

Attachment 2 demonstrates the responses for each question ranked from the highest to lowest average for MSHN Providers.

The results will be reviewed further by the MSHN Quality Improvement Council, the SUD Provider Advisory Committee, and the Regional Consumer Advisory Council to determine if there are any trends evident and if any regional improvement efforts would be recommended. Areas of improvement will be targeted toward below average scores (based on the regional average of all scores) and priority areas as identified through said committees and councils. Each CMHSP Participant and SUD Provider should review their local results in all subcategories and identify any of local improvement recommendations.

Report Completed by: Sandy Gettel MSHN Quality Manager **Date:** August 19,2019
MSHN QIC Approved:
Provider Advisory Council Review: September, 9, 2019
Regional Consumer Advisory Council Review:

Comparison by Organization

Key	*Five Lowest Scores **Five Highest Scores
Life Goals	Choice
Involvement	Individually Tailored Services
Diversity of Treatment Options	Inviting Factor

	RSA-R Administrators Version	MSHN	BABH	CEI	CMCMH	GIHN	HBH	Lifeways	MCN	NCMH	Saginaw	SHW	TBHS	The Right Door	SUD
6	Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.	**4.78	**4.88	**5.00	**4.81	**4.33	**5.00	**5.00	**4.59	**4.69	**4.56	**4.86	**5.00	**4.74	**4.90
1	Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in this program	**4.72	**4.79	**4.75	**4.48	**4.33	**4.80	**5.00	4.35	**4.85	**4.74	**4.43	**5.00	**4.89	**4.90
28	The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.	**4.67	**4.92	**5.00	**4.76	4.17	4.80	**5.00	4.50	4.54	4.55	4.14	4.50	4.56	**4.78
35	This agency provides a variety of treatment options for program participants (e.g., individual, group, peer support, medical, community – based, employment, skill building, employment, etc.).	**4.63	4.39	5.00	**4.68	**5.00	**5.00	4.00	**4.88	4.38	**4.67	**4.60	**5.00	4.61	4.57
7	Staff believe in the ability of program participants to recover.	**4.59	4.57	4.50	4.36	4.33	4.40	5.00	4.31	4.50	**4.68	3.86	5.00	**4.68	**4.90
3	Staff encourage program participants to have hope and high expectations for their recovery.	4.59	**4.75	4.75	4.48	4.17	4.80	**5.00	4.38	4.38	4.40	3.71	4.50	**4.67	**4.86
9	Staff believe that program participants can make their own life choices regarding things such as where to live, when to work, whom to be friends with, etc.	4.57	4.71	4.50	**4.58	3.83	4.40	5.00	4.47	**4.62	4.50	4.29	4.50	4.58	4.69
10	Staff listen to and respect the decisions that program participants make about their treatment and care.	4.57	4.57	4.75	**4.60	4.17	4.60	5.00	4.41	**4.62	4.50	3.71	5.00	4.53	4.76

	RSA-R Administrators Version	MSHN	BABH	CEI	CMCMH	GIHN	HBH	Lifeways	MCN	NCMH	Saginaw	SHW	TBHS	The Right Door	SUD
16	Staff help program participants to develop and plan for life goals beyond managing symptoms or staying stable (e.g., employment, education, physical fitness, connecting with family and friends, hobbies).	4.55	4.73	4.75	4.38	**4.33	**4.80	4.50	4.35	4.62	4.45	4.14	5.00	4.53	4.70
27	Progress made towards an individual's own personal goals is tracked regularly	4.50	**4.78	**5.00	4.23	3.83	4.40	5.00	4.57	4.15	**4.60	3.86	5.00	4.38	4.67
2	This program/agency offers an inviting and dignified physical environment (e.g., the lobby, waiting rooms, etc.).	4.46	4.33	4.25	4.50	3.17	4.40	5.00	**4.69	4.08	4.50	**4.43	**5.00	**4.84	4.52
5	Program participants can easily access their treatment records if they wish.	4.45	4.70	4.50	4.50	4.00	4.80	5.00	4.43	4.23	4.50	4.29	4.50	4.37	4.40
4	Program participants can change their clinician or case manager they wish.	4.43	4.38	4.25	4.54	4.17	**5.00	**5.00	**4.86	**4.69	4.55	**4.86	**5.00	*3.68	4.34
30	Staff at this program regularly attend trainings on cultural competency.	4.40	4.46	4.75	4.46	4.00	4.80	5.00	4.41	4.38	4.45	3.14	5.00	4.05	4.56
19	Staff work hard to help program participants to include people who are important to them in their recovery/treatment planning (such as family, friends, clergy, or an employer).	4.35	4.43	*4.00	4.15	4.00	4.40	4.50	4.31	4.08	4.40	3.71	4.50	4.53	4.54
26	Staff talk with program participants about what it takes to complete or exit the program.	4.34	4.68	4.75	4.00	4.00	4.40	5.00	4.29	4.15	4.30	3.57	4.50	4.00	4.67
14	Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.	4.31	4.45	4.50	4.08	4.00	4.60	4.00	4.20	4.42	4.26	4.00	5.00	3.79	4.62

Attachm

	RSA-R Administrators Version	MSHN	BABH	CEI	CMCMH	GIHN	HBH	Lifeways	MCN	NCMH	Saginaw	SHW	TBHS	The Right Door	SUD
21	Staff actively connect program participants with self-help, peer support, or consumer advocacy groups and programs.	4.29	4.32	4.50	3.92	3.83	4.20	4.00	4.60	3.69	4.45	4.29	4.50	4.00	4.62
8	Staff believe that program participants have the ability to manage their own symptoms.	4.28	4.42	4.25	4.19	4.00	4.40	5.00	*3.75	4.23	4.30	4.00	4.00	4.42	4.44
12	Staff encourage program participants to take risks and try new things.	4.22	4.30	4.25	4.19	3.83	*3.80	4.50	4.19	4.31	4.25	3.57	4.00	4.05	4.43
24	People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service providers.	4.18	4.29	4.25	4.09	4.17	4.40	4.00	4.29	4.00	4.26	3.33	4.50	4.17	4.21
31	Staff are knowledgeable about special interest groups and activities in the community.	4.17	4.43	4.25	3.88	3.67	4.20	5.00	4.19	4.08	3.95	3.50	4.00	4.11	4.45
18	Staff actively help program participants to get involved in non-mental health related activities, such as church groups, adult education, sports, or hobbies.	4.16	4.41	4.25	3.80	3.67	4.20	4.00	4.00	4.15	4.30	3.43	4.00	4.05	4.45
13	This program offers specific services that fit each participant's unique culture and life experiences.	4.15	4.38	4.50	3.77	3.83	4.60	4.00	4.19	4.08	4.28	3.29	4.00	4.11	4.31
11	Staff regularly ask program participants about their interests and the things they would like to do in the community.	4.13	4.13	4.25	4.08	3.67	*3.80	4.50	4.06	4.15	4.05	3.43	4.00	4.06	4.41
15	Staff offer participants opportunities to discuss their sexual needs and interests when they wish.	4.12	4.30	4.50	4.15	4.00	4.00	4.50	*3.93	4.23	*3.89	3.33	5.00	*3.58	4.44
17	Staff routinely assist program participants with getting jobs.	4.01	4.45	4.75	4.00	4.00	3.80	4.00	4.40	4.17	*3.90	3.29	4.00	3.72	*3.86

Attachm

	RSA-R Administrators Version	MSHN	BABH	CEI	CMCMH	GIHN	HBH	Lifeways	MCN	NCMH	Saginaw	SHW	TBHS	The Right Door	SUD
34	This agency provides structured educational activities to the community about mental illness and addictions.	4.01	4.05	5.00	3.88	5.00	4.00	3.00	4.25	3.85	3.93	*3.00	5.00	4.17	*3.89
33	This agency provides formal opportunities for people in recovery, family members, service providers, and administrators to learn about recovery.	3.99	*3.90	*4.25	3.56	4.00	4.20	*2.50	4.31	3.54	4.33	3.40	5.00	4.12	4.15
32	Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.	3.92	4.08	4.75	3.38	3.67	*3.00	4.00	4.13	3.85	4.42	3.14	*3.00	3.95	4.06
20	Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.	3.89	*3.76	4.75	*3.24	*3.50	*3.60	*3.00	*3.86	*3.17	4.11	3.33	5.00	3.79	4.51
22	Staff actively help people find ways to give back to their community (i.e., volunteering, community services, neighborhood watch/cleanup).	*3.78	4.14	*3.67	*3.28	*3.67	4.40	4.00	*3.57	3.62	*3.70	*2.33	*4.00	*3.63	4.23
25	People in recovery are encouraged to attend agency advisory boards and management meetings.	*3.73	*3.53	4.50	3.57	3.83	4.40	5.00	4.33	*3.30	4.31	3.83	4.50	3.88	*3.17
23	People in recovery are encouraged to help staff with the development of new groups, programs, or services.	*3.67	*3.45	*3.25	*3.13	*3.50	4.00	*3.00	4.07	*3.45	4.20	*3.00	*4.00	*3.68	*3.89
36	Groups, meetings, and other activities are scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school.	*3.66	4.00	4.25	*3.20	3.80	4.60	*1.00	4.13	*2.75	*3.19	*2.20	*4.00	3.82	4.02
29	Persons in recovery are involved with facilitating staff trainings and education at this program.	*3.06	*2.70	*3.00	*2.48	*2.67	*3.40	*3.00	*4.00	*2.42	*3.39	*2.43	*3.00	*3.18	*3.38

Comparison by Organization

Key	*Five Lowest Scores **Five Highest Scores
Life Goals	Choice
Involvement	Individually Tailored Services
Diversity of Treatment Options	Inviting Factor

#	RSA-R Provider Version	MSHN	BABH	CEI	CMCMH	GIHN	Lifeways	MCN	NCMH	Saginaw	TBHS	The Right Door	SUD
6	Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.	**4.73	**4.84	**4.60	**4.90	**4.80	**4.88	**4.55	**4.63	**4.87	3.83	**4.86	**4.70
1	Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in this program.	**4.67	**4.76	**4.58	**4.80	**4.47	**4.87	4.45	**4.57	**4.66	4.67	4.54	**4.70
16	Staff help program participants to develop and plan for life goals beyond managing symptoms or staying stable (e.g., employment, education, physical fitness, connecting with family and friends, hobbies).	**4.63	4.60	**4.59	**4.78	4.20	4.75	**4.65	**4.54	**4.63	**4.83	**4.54	**4.66
3	Staff encourage program participants to have hope and high expectations for their recovery.	**4.62	**4.71	4.35	**4.73	4.20	4.75	4.32	4.38	**4.70	**5.00	4.43	**4.74
7	Staff believe in the ability of program participants to recover.	**4.62	**4.73	4.37	4.65	4.20	4.63	4.43	4.52	4.52	**4.83	4.54	**4.74
28	The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.	4.58	4.61	**4.53	**4.80	4.20	**4.81	4.43	**4.58	**4.57	**4.83	4.46	4.58
27	Progress made towards an individual's own personal goals is tracked regularly.	4.57	4.51	**4.56	4.68	**4.33	**4.94	4.30	**4.58	4.43	4.50	**4.57	4.60
10	Staff listen to and respect the decisions that program participants make about their treatment and care.	4.55	**4.71	4.45	4.71	**4.33	4.69	**4.55	4.46	4.53	4.33	4.46	4.52
9	Staff believe that program participants can make their own life choices regarding things such as where to live, when to work, whom to be friends with, etc.	4.41	4.57	4.35	4.68	**4.47	**4.75	4.41	4.33	4.20	**5.00	**4.54	4.27

	RSA-R Provider Version	MSHN	BABH	CEI	CMCMH	GIHN	Lifeways	MCN	NCMH	Saginaw	TBHS	The Right Door	SUD
26	Staff talk with program participants about what it takes to complete or exit the program.	4.35	4.31	3.94	4.36	3.93	4.56	4.11	4.29	4.40	4.83	4.08	4.51
14	Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.	4.35	4.46	4.08	4.56	4.09	4.69	*3.71	4.08	4.20	4.17	4.07	4.52
19	Staff work hard to help program participants to include people who are important to them in their recovery/treatment planning (such as family, friends, clergy, or an employer).	4.32	4.49	4.11	4.63	3.86	4.56	4.29	4.17	4.47	4.50	4.18	4.27
21	Staff actively connect program participants with self-help, peer support, or consumer advocacy groups and programs.	4.30	4.33	4.00	4.45	4.13	4.60	4.38	3.83	4.43	4.50	4.44	4.32
2	This program/agency offers an inviting and dignified physical environment (e.g., the lobby, waiting rooms, etc.).	4.26	4.10	4.38	4.49	3.73	4.75	4.52	4.30	4.07	4.50	4.64	4.14
4	Program participants can change their clinician or case manager they wish.	4.22	4.55	4.03	4.67	4.21	4.38	4.53	4.50	4.40	4.60	3.96	3.98
5	Program participants can easily access their treatment records if they wish.	4.21	4.19	4.11	4.39	4.17	4.44	4.71	3.81	4.00	4.40	4.16	4.22
18	Staff actively help program participants to get involved in non-mental health related activities, such as church groups, adult education, sports, or hobbies.	4.17	4.32	3.95	4.49	3.75	4.50	4.13	3.96	4.03	4.33	4.11	4.18
30	Staff at this program regularly attend trainings on cultural competency.	4.16	4.28	4.08	4.27	3.92	4.38	4.00	4.05	4.10	*3.83	4.18	4.18
24	People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service providers.	4.12	4.41	3.75	4.28	3.55	4.53	4.19	4.00	4.07	4.00	4.04	4.14
12	Staff encourage program participants to take risks and try new things.	4.11	4.08	3.95	4.24	3.73	4.20	4.13	4.10	4.00	4.50	4.17	4.15
31	Staff are knowledgeable about special interest groups and activities in the community.	4.10	4.20	3.97	4.18	3.60	4.50	3.83	3.88	4.20	4.33	4.07	4.14

	RSA-R Provider Version	SHN	BABH	CEI	CMCMH	GIHN	Lifeways	MCN	NCMH	Saginaw	TBHS	The Right Door	SUD
15	Staff offer participants opportunities to discuss their sexual needs and interests when they wish.	4.02	4.29	3.94	4.32	4.00	4.56	*2.81	4.14	*3.69	4.50	3.87	4.02
8	Staff believe that program participants have the ability to manage their own symptoms.	4.01	4.36	3.74	4.12	4.13	4.44	*3.77	4.08	*3.67	4.33	4.15	3.95
13	This program offers specific services that fit each participant's unique culture and life experiences.	3.99	4.10	3.86	4.25	3.80	4.50	4.13	3.83	3.97	*3.83	4.12	3.90
11	Staff regularly ask program participants about their interests and the things they would like to do in the community.	3.93	*3.98	3.84	*3.95	3.73	4.06	*3.82	4.00	*3.57	4.00	3.79	4.04
32	Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.	3.90	4.07	3.90	4.13	*3.50	4.19	3.91	*3.54	4.21	*3.50	*3.79	3.85
17	Staff routinely assist program participants with getting jobs.	3.90	4.22	3.92	4.16	4.00	4.29	4.48	3.59	3.86	4.00	*3.78	*3.66
22	Staff actively help people find ways to give back to their community (i.e., volunteering, community services, neighborhood watch/cleanup).	*3.80	4.17	*3.42	4.08	*3.42	*3.93	4.00	3.59	3.72	*3.67	3.81	*3.77
20	Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.	*3.79	*3.80	*3.63	*3.57	3.58	*4.00	3.95	*3.05	3.90	4.17	4.04	3.89
23	People in recovery are encouraged to help staff with the development of new groups, programs, or services.	*3.49	*3.91	*3.19	*3.41	*3.10	*3.75	3.95	*3.19	*3.68	4.00	*3.09	*3.47
25	People in recovery are encouraged to attend agency advisory boards and management meetings.	*3.23	*3.71	*2.71	*3.67	*3.36	*3.67	4.20	*3.21	*3.58	4.17	*3.42	*2.70
29	Persons in recovery are involved with facilitating staff trainings and education at this program.	*2.92	*3.22	*2.58	*2.43	*2.93	*3.45	*3.30	*2.50	3.80	*3.33	*2.81	*2.83

Mid-State Health Network

FY2019 Summary Report
Recovery Self-Assessment-R
Administrator, Provider, Persons in Recovery

Introduction

The following overview of Mid-State Health Network's (MSHN) Recovery Self-Assessment Revised (RSA-R) was developed utilizing voluntary self-reflective assessment scales designed to gauge the degree to which programs implement recovery-oriented practices. The RSA-R is a tool designed to identify strengths and target areas of improvement as agencies and systems strive to offer recovery-oriented care. There are three versions designed specifically for different study populations. The Michigan Department of Health and Human Services (MDHHS) has required the following validated tools be used for continuous quality improvement:

> Recovery Self-Assessment Revised– RSA Administrators Version completed by Chief Executive Officers, and Administrators who oversee programs serving individuals who are adults and experience a mental illness and/or substance use disorder.
>
> Recovery Self-Assessment Revised– RSA-R Provider Version completed by staff who provide direct services to individuals who are adults and experience a mental illness and/or substance use disorder.
>
> Recovery Self-Assessment Revised– RSA-R Persons in Recovery Version completed by individuals who are adults and experience a mental illness and/or substance use disorder and have received a service during the identified implementation period.
> (Davidson, L., Tondora, J., O'Connell, M. J., Lawless, M. S., & Rowe, M.) (2009).

The Community Mental Health Specialty Program (CMHSP)Participants and Substance Use Disorder (SUD) Providers were offered the opportunity to assess their organizations recovery environment by completing one or more of the RSA-R versions offered beginning in May of 2019.

The assessments were to be completed through an electronic survey process by administrators, providers, and persons in recovery. Accommodations were made for those who requested a paper version.

Fourteen hundred and seven respondents (1407) completed the RSA-R during the month of May. The respondents consisted of the Administrators (195), Providers (435), and Persons in Recovery (777) from the SUD Provider Network and the CMHSP Participants. The *MSHN Recovery Self-Assessment Scale FY19: Administrator/Provider Report* and *MSHN Recovery Self-Assessment Scale FY19: Persons in Recovery* provide additional detail of the assessment results. The assessment results were aggregated and scored as outlined in the Yale Program for Recovery and Community Health instructions.

MSHN Summary

The responses from the Recovery Self-Assessment surveys were scored as a comprehensive total and separately as six subcategories. The tool is intended to assess the perceptions of individual recovery and the recovery environment. Items are rated using the same 5-point Likert scale that ranges from 1 = "strongly disagree" to 5 = "strongly agree." The comprehensive score measures how the system is performing, and the subcategories measures the performance of five separate parts. The individual response score for each question in the subcategories is included to assist in determining potential action steps. A score of 3.50 and above indicates satisfaction or agreement with the statement. The "not applicable" and "do not know" responses were removed from the analysis.

MSHN Comprehensive Summary

MSHN's persons in recovery, administrators and providers demonstrated a comprehensive assessment score above 3.50. Figure 1 illustrates the Persons' in Recovery comprehensive score to be assessed higher than the comprehensive score for the Administrators and Providers. Figure 1 also illustrates a score above 3.50 for each of the subcategories as assessed by the Persons in Recovery, the Providers, and the Administrators.

Figure 1 MSHN Comprehensive Summary-Subcategory Summary

FY2019	RSA-R Persons in Recovery	RSA-R Provider Version	RSA-R Administrator Version
Comprehensive Score	**4.28**	**4.18**	**4.24**
Involvement - Subcategory	3.83	3.55	3.78
Individually Tailored Services - Subcategory	4.31	4.10	4.26
Diversity of Treatment - Subcategory	4.17	4.17	4.19
Life Goals Sub-Category	4.36	4.28	4.34
Choice - Subcategory	4.45	4.47	4.55
Inviting - Subcategory	4.52	4.46	4.59

MSHN Subcategory Summary

A comparison of each subcategory by Administrator, Provider, and Persons in Recovery is illustrated in Figures 2 through 7. Questions 33 through 36 are included in the Administrators version only.

33. This agency provides formal opportunities for people in recovery, family members, service providers, and administrators to learn about recovery. (3.99)
34. This agency provides structured educational activities to the community about mental illness and addictions. (4.01)
35. This agency provides a variety of treatment options for program participants. (4.63)
36. Groups, meetings, and other activities are scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school. (3.66)

Figure 2 Comparison of individual questions for Subcategory Involvement

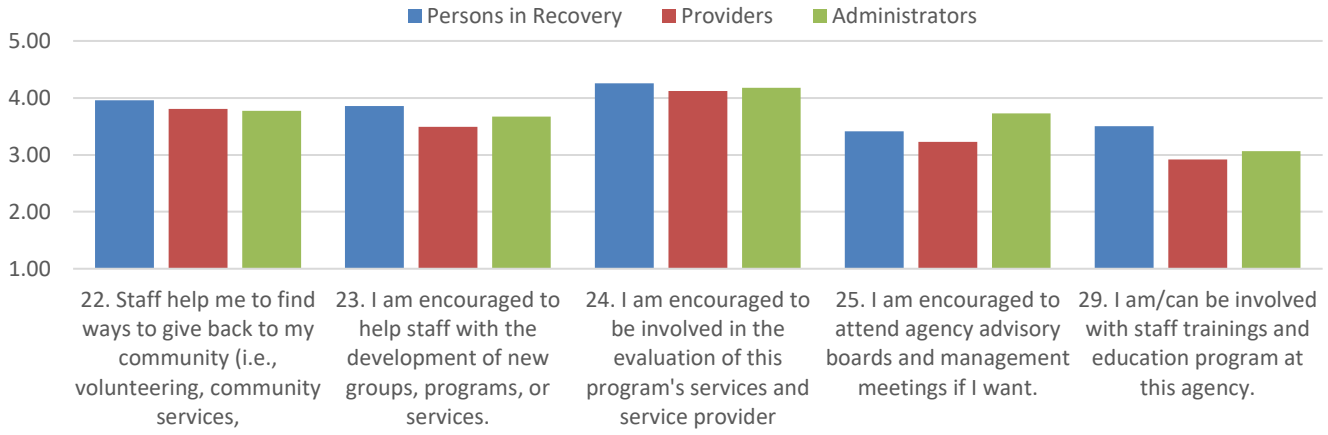


Figure 3 Comparison of individual questions for Subcategory Individually Tailored Service

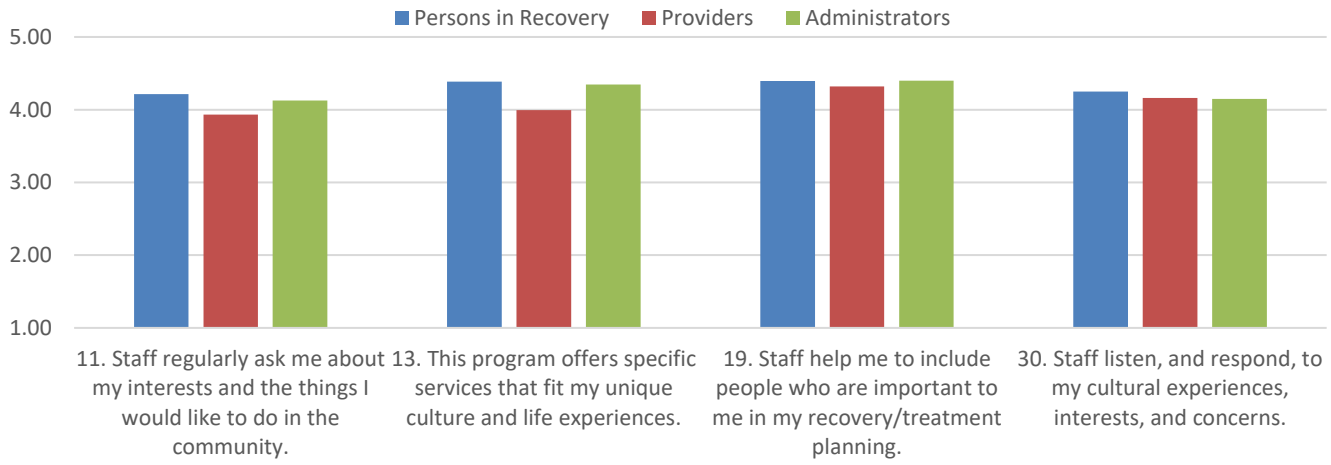


Figure 4 Comparison of individual questions for Subcategory Diversity of Treatment

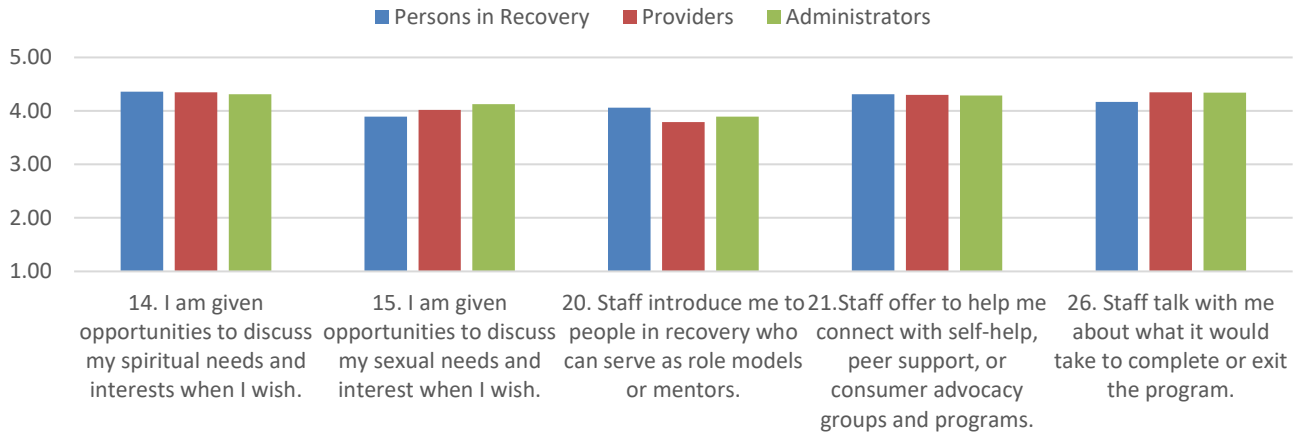


Figure 5 Comparison of Individual questions for Subcategory Choice

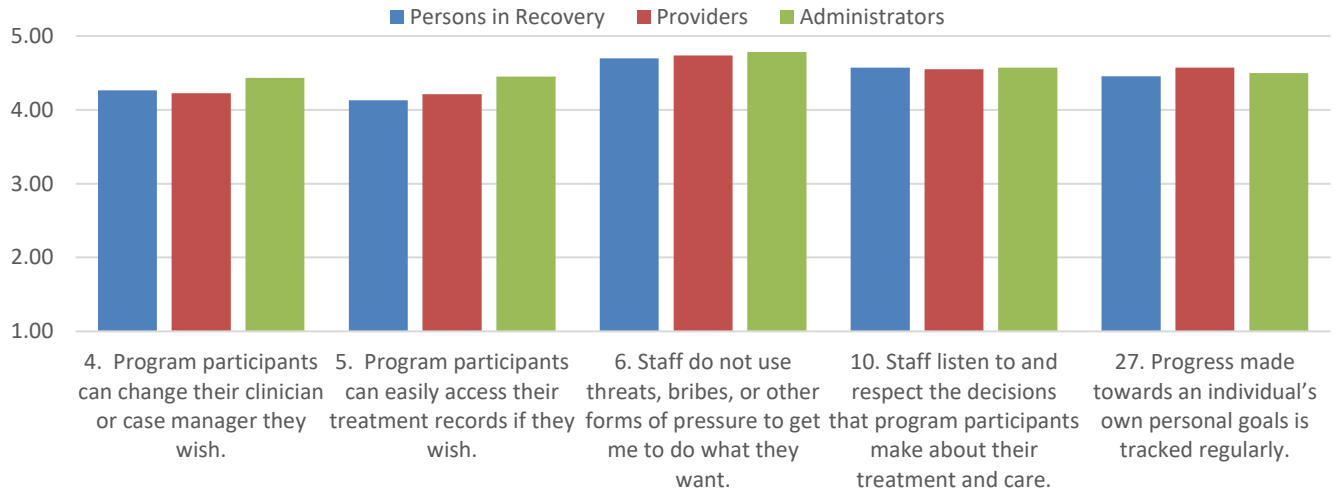


Figure 6 Comparison of individual questions for Subcategory Life Goals (Questions 3, 7 8, 9, 12)

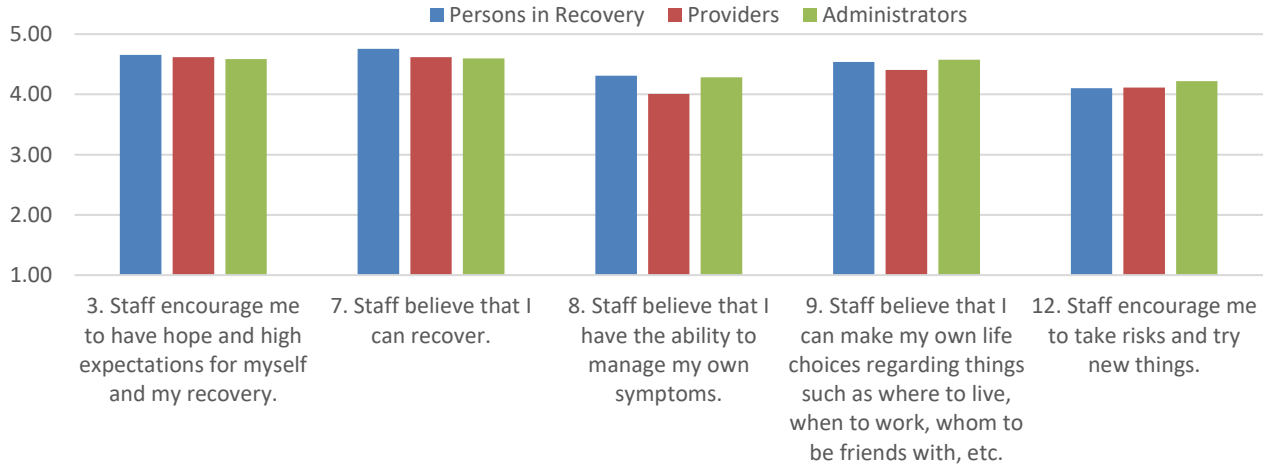


Figure 7 Comparison of individual questions for Subcategory Life Goals (Questions 16,17,18, 28, 31, 32)

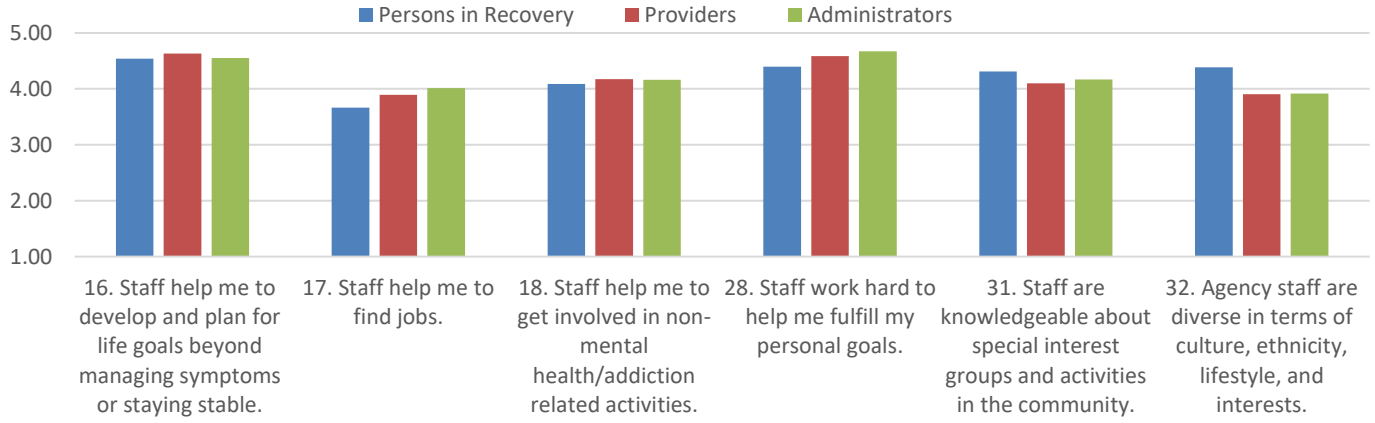
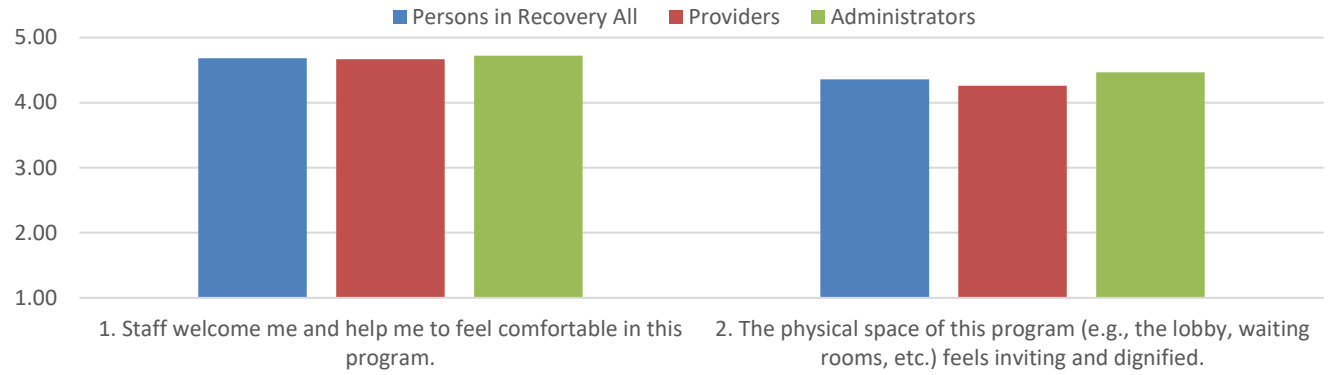


Figure 8 Comparison of individual questions for Subcategory Inviting



Each individual question from the Persons in Recovery assessment scale was ranked from highest to lowest based on the score. Figure 8 demonstrates each individual question color coded by subcategory.

KEY	*Five Lowest Scores **Five Highest Scores
Life Goals	16,17,28,32,18,3,7,8,9,12,31
Involvement	23,25,29,34,24,22,33
Diversity of Treatment Options	20,21,26,14,15,35,36
Choice	5,6,10,4,27
Individually Tailored Services	13,30,11,19
Inviting Factor	1,2

Figure 9 Individual questions ranked

	RSA-R Version Question Comparison	Persons in Recovery	Providers MSHN	Administrators MSHN
7	Staff believe in the ability of program participants to recover.	**4.76	**4.62	**4.59
6	Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.	**4.70	**4.73	**4.78
1	Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in this program	**4.68	**4.67	**4.72
3	Staff encourage program participants to have hope and high expectations for their recovery.	**4.66	**4.62	4.59
10	Staff listen to and respect the decisions that program participants make about their treatment and care.	**4.57	4.55	4.57
9	Staff believe that program participants can make their own life choices regarding things such as where to live, when to work, whom to be friends with, etc.	4.54	4.41	4.57

	RSA-R Version Question Comparison	Persons in Recovery	Providers MSHN	Administrators MSHN
16	Staff help program participants to develop and plan for life goals beyond managing symptoms or staying stable (e.g., employment, education, physical fitness, connecting with family and friends, hobbies).	4.54	**4.63	4.55
27	Progress made towards an individual's own personal goals is tracked regularly	4.45	4.57	4.50
28	The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.	4.40	4.58	**4.67
30	Staff at this program regularly attend trainings on cultural competency.	4.39	4.16	4.40
19	Staff work hard to help program participants to include people who are important to them in their recovery/treatment planning (such as family, friends, clergy, or an employer).	4.39	4.32	4.35
32	Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.	4.38	3.90	3.92
2	This program/agency offers an inviting and dignified physical environment (e.g., the lobby, waiting rooms, etc.).	4.36	4.26	4.46
14	Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.	4.36	4.35	4.31
8	Staff believe that program participants have the ability to manage their own symptoms	4.31	4.01	4.28
31	Staff are knowledgeable about special interest groups and activities in the community.	4.31	4.10	4.17
21	Staff actively connect program participants with self-help, peer support, or consumer advocacy groups and programs.	4.31	4.30	4.29
24	People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service providers.	4.26	4.12	4.18
4	Program participants can change their clinician or case manager they wish.	4.26	4.22	4.43
13	This program offers specific services that fit each participant's unique culture and life experiences.	4.25	3.99	4.15
11	Staff regularly ask program participants about their interests and the things they would like to do in the community.	4.22	3.93	4.13
26	Staff talk with program participants about what it takes to complete or exit the program.	4.17	4.35	4.34
5	Program participants can easily access their treatment records if they wish.	4.13	4.21	4.45
12	Staff encourage program participants to take risks and try new things.	4.10	4.11	4.22
18	Staff actively help program participants to get involved in non-mental health related activities, such as church groups, adult education, sports, or hobbies.	4.09	4.17	4.16
20	Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.	4.06	*3.79	3.89

	RSA-R Version Question Comparison	Persons in Recovery	Providers MSHN	Administrators MSHN
22	Staff actively help people find ways to give back to their community (i.e., volunteering, community services, neighborhood watch/cleanup).	3.96	*3.80	*3.78
15	Staff offer participants opportunities to discuss their sexual needs and interests when they wish.	*3.89	4.02	4.12
23	People in recovery are encouraged to help staff with the development of new groups, programs, or services.	*3.86	*3.49	*3.67
17	Staff routinely assist program participants with getting jobs.	*3.66	3.90	4.01
29	Persons in recovery are involved with facilitating staff trainings and education at this program.	*3.50	*2.92	*3.06
25	People in recovery are encouraged to attend agency advisory boards and management meetings.	*3.42	*3.23	*3.73
36	Groups, meetings, and other activities are scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school. (Administrative Version only)			*3.66
33	This agency provides formal opportunities for people in recovery, family members, service providers, and administrators to learn about recovery. (Administrative Version only)			3.99
34	This agency provides structured educational activities to the community about mental illness and addictions. (Administrative Version only)			4.01
35	This agency provides a variety of treatment options for program participants (e.g., individual, group, peer support, medical, community – based, employment, skill building, employment, etc.). (Administrative Version only)			**4.63

Evaluation of Effectiveness

The aggregated results of the RSA-R will be reviewed by MSHN's Quality Improvement Council, SUD Provider Advisory Council, the Regional Consumer Advisory Council and internal MSHN Committees to determine areas of improvement. Areas of improvement will be targeted toward below average scores (based on regional average of all scores) and priority areas as identified by the regional Quality Improvement Council, the Regional Consumer Advisory Council and the SUD Provider Network. Above average areas will be identified and analyzed for identification of best practice and improvement opportunities for individual providers that fall below the average. Effectiveness of improvement initiatives will be determined as an increase in the regional average for the targeted areas.
Additional detailed information can be found in the full reports found in the links below.

MSHN Recovery Self-Assessment Scale FY19: Administrators/Providers Version
MSHN Recovery Self-Assessment Scale FY19: Persons in Recovery

Prepared By: Sandy Gettel MSHN Quality Manager

Date: 9/02/2019
Revised: 9/27/2019

Attachment 13

MSHN FY19 - Board of Directors and Operations Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2019	Target Value	Performance Level	Target Ranges		
BETTER HEALTH	1. Reduction in Opioid Prescriptions in region	MSHN WILL CONTINUE TO WORK WITH PREVENTION COALITIONS, MEDICAID HEALTH PLANS AND OTHER STAKEHOLDERS TO IMPACT THE REDUCTION OF OPIOID PRESCRIPTIONS IN MSHN'S COUNTIES.	In Development with TBD Solutions. Will be reported on in January 2020					
	Child and adolescent access to primary care.	MSHN Strategic Plan FY19-FY20, MDHHS State Transition Plan; Measurement Portfolio Engaging Primary Care	96%	100%		>=75%	50%-74%	<50%
	Percent of individuals who receive follow up care within 30 days after an emergency department visit for alcohol or drug use.	MSHN Strategic Plan FY19-20; MDHHS/PIHP Contract, Integrated Health Performance Bonus Requirements	23%	100%		>=41%	22%-40%	<21%
	Adult access to primary care.	MSHN Strategic Plan FY19-FY20, MDHHS State Transition Plan; Measurement Portfolio Engaging Primary Care	94%	100%		>=75%	50%-74%	<50%
	Consumers are screened for diabetes.	Measurement Portfolio NQF 1932; NQF 1934; NQF 1927; FY19 PIHP/MDHHS Contract, Attachment P7.9.1 (QAPIP)	84%	Increase over previous quarter		79%	77%	75%
	Consumers are monitored for diabetes.	2018 HEDIS Measure Specifications; FY19 PIHP/MDHHS Contract, Attachment P7.9.1 (QAPIP)	61%	Increase over previous quarter	Collecting Baseline data this year no target range set			
	Implement MCG Healthcare application to support compliance with Parity Rules	MSHN ensures a consistent service array (benefit) across the region and improves access to specialty behavioral health and substance use disorder services in the region	12	12		12	8	6
	6. Increase access and service utilization for Veterans and Military members	MSHN ensures expanded SAPT and CMHSP service access and utilization for veterans and Military Families THROUTH IMPLEMENTATION OF THE REGIONAL AND STATEWIDE VETERAN AND MILITARY MEMBER STRATEGIC PLAN	In Development with TBD Solutions. Expected November 2019.					
	Monitor and ensure compliance with new Provider Network Adequacy Standards	Develop and implement practice strategies for the MSHN provider network to comply with the new standards	Meets Requirments			Meets Reqs		Does not Meet Req's
	Standard for Follow-up After Hospitalization for Adults with Mental Illness is met (FUH)	Measurement Portfolio NQF 0576; FY19 PIHP/MDHHS Contract, Section 8.4.2.1 (2019 Performance Bonus)	79%	58%		>=58%		<58%
	Standard for Follow-up After Hospitalization for Children with Mental Illness is met (FUH)	Measurement Portfolio NQF 0576; FY19 PIHP/MDHHS Contract, Section 8.4.2.1 (2019 Performance Bonus)	90%	70%		>=70%		<70%

MSHN FY19 - Board of Directors and Operations Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2019	Target Value	Performance Level	Target Ranges		
BETTER CARE	Percentage (rate per 100) of Medicaid consumers who are denied overall eligibility were resolved with a written notice letter within 14 calendar days for a standard request of service.	MDHHS PIHP Contract: Grievance and Appeal Technical Requirement	89%	100%		95%	91%-94%	90%
	The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness standards including the written disposition letter (30 calendar days) of a standard request for appeal.	MDHHS PIHP Contract: Grievance and Appeal Technical Requirement	95%	100%		95%	91%-94%	90%
	Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS.	MSHN FY19-20 Strategic Plan	92% (1134/1235)	95%		95-100%	90-94%	<90%
	Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines.	MSHN Strategic Plan FY19-FY20, MSHN UM Plan	95%	100%		97-100%	94-95%	<93%
	Percent of providers who are in compliance with the HCBS Rule.	MSHN Strategic Plan FY19-FY20, MDHHS State Transition Plan	98%	100%		>=76%	46%-75%	<45%
	Complete SIS Assessments for adult persons with IDD	MSHN Strategic Plan FY19-FY20	56%	100%		>=75%	50%-74%	<50%
	The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (Plan All Cause Readmissions)	MSHN Strategic Plan FY19-FY20, MSHN UM Plan; Measurement Porfolio NQF 1768	13%	<=15%		<=15%	16-25%	>25%
BETTER VALUE	MSHN Administrative Budget Performance actual to budget (%)	MSHN's board approved budget	98%	≥ 90%		≥ 90%	> 85% and < 90%	≤ 85% or >100%
	MSHN reserves (ISF)	MSHN WILL WORK WITH ITS CMHSPS AND BOARD OF DIRECTORS TO ESTABLISH A RESERVE'S TARGET SUFFICIENT TO MEET FISCAL RISK RELATED TO DELIVERY OF MEDICALLY NECESSARY SERVICES AND TO COVER ITS MDHHS CONTRACTUAL LIABILITY.	Not available till year end	7.5%		> 6%	≥ 5% and 6%	< 5%
	Develop and implement Provider Incentives (VBP, ER FU, Integration)	MSHN will develop methodologies, within established rules, to incentivize providers to cooperate with the PIHP to improve health or other mutually agreeable outcomes.	1	2		2	1	0
	Continuum of Care - Consumers moving from inpatient psychiatric hospitalization will show in next LOC within 7 days, and 2 additional apts within 30 days of first step-down visit	Aligns with strategic plan goal that MSHN and its CMHSP participants will explore clinical process standardization, especially in the areas of access, emergency services, pre-admission screening, crisis response and inpatient stay management and discharge planning.	In development by TBD (Being developed utilizing REMI data within Power BI) Expected November 2019	Increase over 2017 and 2018		increase over 2017 and 2018	No change from 2017 levels	Below 2017 levels
	Develop and implement consistent regional service benefit for all populations served	MSHN Strategic Plan FY19-FY20, Federal Parity Requirements	65%	100%		>=75%	50%-74%	<50%

MSHN FY19 - Board of Directors and Operations Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2019	Target Value	Performance Level	Target Ranges		
Better Provider Systems	Provider surveys demonstrate satsifaction with REMI enhancements (Audit module)	FULLY IMPLEMENT THE REMI PROVIDER NETWORK MONITORING (AUDIT) MODULE INCLUDING PROVIDER RESPONSE FEATURE TO STREAMLINE PROCESSES AND PROMOTE EFFICIENCIES (INCLUDING SUD AND CMHSP DELEGATED MANAGED CARE AUDITS).	no data available currently	80%		>80%	70-75%	<70%
	Managed Care Information Systems (REMI) Enhancements	Provider portal, Patient Portal, GAIN, Authorization Data, Site Review Module, WSA, Critical Incidents/Grievance and Appeals Module	80%	100%		80%	60%	50%
	FY19 IPHU audits will demonstrate 95% performance standard; those under 95% (FY18 results) will improve performance by an additional 10%	MSHN successfully negotiates regional inpatient contracts resulting in improved rates and performance results.	3	9		9	8-6	<5
	Improve data availability	MSHN FY19-20 Strategic Plan - Staff, Consumers, Providers, and Stakeholders	75%	100%		75%	50%	25%
	Conduct focus groups to inform an action plan that improves workforce	MSHN WILL COORDINATE/FACILITATE FOCUS GROUPS FOR PROVIDER NETWORK TO IDENTIFY PRIMARY WORKFORCE CONCERNS AND ISSUES	100%	100%		100%	71-99%	<70%

MSHN FY19 - Integrated Care - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of 9/30/2019	Target Value	Performance Level	Target Ranges		
BETTER HEALTH	Child and adolescent access to primary care.	MSHN Strategic Plan FY19-FY20, MDHHS State Transition Plan; Measurement Portfolio Engaging Primary Care	96%	100%		>=75%	50%-74%	<50%
	Percent of individuals who receive follow up care within 30 days after an emergency department visit for alcohol or drug use.	MSHN Strategic Plan FY19-20; MDHHS/PIHP Contract, Integrated Health Performance Bonus Requirements	23%	100%		>=41%	22%-40%	<21%
	Adult access to primary care.	MSHN Strategic Plan FY19-FY20, MDHHS State Transition Plan; Measurement Portfolio Engaging Primary Care	94%	100%		>=75%	50%-74%	<50%
BETTER CARE	Percent of care coordination cases that were closed due to successful coordination.	MSHN Strategic Plan FY19-FY20, MDHHS/PIHP Contract, Integrated Health Performance Bonus Requirements	82%	100%		>=50%	25%-49%	<25%
BETTER VALUE	Reduction in number of visits to the emergency room for individuals in care coordination plans between the PIHP and MHP	MSHN Strategic Plan FY19-FY20, MDHHS/PIHP Contract, Integrated Health Performance Bonus Requirements	66.7% (as of 8/31/2019)	100.0%		>=75%	50%-74%	<50%

MSHN FY19 - Clinical SUD - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2019	Target Value	Performance Level	Target Ranges		
BETTER HEALTH	1. Reduction in Opioid Prescriptions in region	MSHN WILL CONTINUE TO WORK WITH PREVENTION COALITIONS, MEDICAID HEALTH PLANS AND OTHER STAKEHOLDERS TO IMPACT THE REDUCTION OF OPIOID PRESCRIPTIONS IN MSHN'S COUNTIES.	In Development with TBD Solutions. Will be reported on in January 2020	Target to be determined based on data generated by TBD	In Development			
	2. Expand SUD stigma related community education	MSHN WILL SUPPORT AND EXPAND SUD-RELATED STIGMA REDUCTION EFFORTS THROUGH COMMUNITY EDUCATION	161 completed as of Sept 30th. Completed.	144 Community Presentations		>=144	<144 and >72	<=72
	3. Increase network capacity for Detox / Withdraw Management	CONTINUE TO ADDRESS NETWORK CAPACITY FOR DETOX SERVICES AND MEDICATION ASSISTED TREATMENT, INCLUDING AVAILABILITY OF METHADONE, VIVOTROL, AND SUBOXONE AT ALL MAT LOCATIONS. -	RFP process took place in Q3. Samaritan Health was chosen to help suport WM/detox and resi in Q4. Clinical team is also evaluating an out of region contract with Salvation Army - Harbour Light to exapnd WM/detox & residential supports for the region.	Increase contracted providers by 5% over FY18 (18 providers)		>=5%	<5% and >2%	<=2%
	4. Increase network capacity for Medication Assisted Treatment	CONTINUE TO ADDRESS NETWORK CAPACITY FOR DETOX SERVICES AND MEDICATION ASSISTED TREATMENT, INCLUDING AVAILABILITY OF METHADONE, VIVOTROL, AND SUBOXONE AT ALL MAT LOCATIONS. -	100% MSHN has 22 MAT sites with at least two more expected in early FY20	Increase contracted providers by 13% over FY18 (22 providers)		>=13%	<13% and >6%	<=6%
BETTER CARE	5. Increase collaboration and coordination with treatment and recovery courts	Define preferred partnerships and implementation approaches	100.0%	100% of all Treatment courts partnered with an SUD Provider		>=100%	<100% and >50%	<=50%
	6. Increase access and service utilization for Veterans and Military members	MSHN ensures expanded SAPT and CMHSP service access and utilization for veterans and Military Families THROUTH IMPLEMENTATION OF THE REGIONAL AND STATEWIDE VETERAN AND MILITARY MEMBER STRATEGIC PLAN	In Development with TBD Solutions. Expected November 2019.	Latest update from TBD on 7/30/19. Target goals pending to be informed by TBD report	In Development			
	7. Increase the percentage of consumers moving from detox or residential that show for one appointment in the next LOC within 7 days, e.g. detox to appropriate lower level of care (per Performance Indicator #4), residential to outpatient, residential to recovery housing, detox to outpatient.		In development with TBD utilizing REMI data - expected November 2019	Increase over 2017 levels Initiation: 34.58% ; Engagement: 45.87%	In Development	Increase over 2017 levels	No change from 2017 levels	Drop below 2017 levels
	8. Engagement of MAT Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of OUD within 30 days of the initiation visit.		Initiation: 88.24% Engagement: 64.89% (9/1/18-8/31/19)	Increase over 2018 levels (I: 76.17%; E: 46.64%)		Increase over 2018 levels	No change from 2018 levels	Drop below 2018 levels
	9. Percent of SUD providers trained and implementing the GAIN	REGIONALLY DEPLOY THE GAIN-I CORE, A STANDARDIZED ASSESSMENT FOR PERSONS WITH PRIMARY SUBSTANCE USE DISORDERS	29 Certified - 75 are in active training - Cohorts of 12 are planned monthly through September 2020. At current training rate, we are on track to meet this goal by go-live date for GAIN of 10/1/20.	125 trained clinicians on GAIN		>=125	<125 and >60	<=60
	10. Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.		Initiation: 63.59% Engagement: 47.45% (9/1/18-8/31/19)	Above National numbers; I: 40.8%; E: 12.5% (2016)		Increase over National levels	No change from National levels	Drop below National levels

MSHN FY19 - Information Technology - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2019	Target Value	Performance Level	Target Ranges		
Better Value	Unique consumers submitted monthly	Contractual Reporting Oversight	98.6%	85%		86.0%	85.0%	84.0%
	Encounters submitted monthly	Contractual Reporting Oversight	98.9%	85%		86.0%	85.0%	84.0%
	BH-TEDS submitted monthly	Contractual Reporting Oversight	96.7%%	85%		86.0%	85.0%	84.0%
	Percentage of encounters with BH-TEDS	Contractual Reporting Oversight	98.9%	95%		95.0%	94.0%	90.0%
Better Care								
	Implement MCG Healthcare application to support compliance with Parity Rules	MSHN ensures a consistent service array (benefit) across the region and improves access to specialty behavioral health and substance use disorder services in the region	12	12		12	8	6
	Integrate standardized assessment tools into REMI	MSHN ensures a consistent service array (benefit) across the region and improves access to specialty behavioral health and substance use disorder services in the region	1	4		3	2	1
Better Health								
	Increase use cases with MiHIN	Health Information Exchange, including expanded number of use cases with MiHIN, occurs with other healthcare providers to assure appropriate integration and coordination of care	3	2		2	1	0
	Increase health information exchange/record sets	MSHN will improve and standardize processes for exchange of data between MSHN and MHPs; CMHSPs and MSHN. Using REMI, ICDP and CC360 as well as PCP, Hospitals, MHPs.	3	5		3	2	1
Better Workforce								
	Managed Care Information Systems (REMI) Enhancements	Provider portal, Patient Portal, GAIN, Authorization Data, Site Review Module, WSA, Critical Incidents/Grievance and Appeals Module	80%	100%		80%	60%	50%
	Improve data use and quality	MSHN FY19-20 Strategic Plan - Staff, Consumers, Providers, and Stakeholders	82%	100%		75%	50%	25%
	Improve data availability	MSHN FY19-20 Strategic Plan - Staff, Consumers, Providers, and Stakeholders	75%	100%		75%	50%	25%

MSHN FY19 - Finance Council - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2019	Target Value	Performance Level	Target Ranges		
BETTER VALUE	MSHN reserves (ISF)	MSHN WILL WORK WITH ITS CMHSPS AND BOARD OF DIRECTORS TO ESTABLISH A RESERVE'S TARGET SUFFICIENT TO MEET FISCAL RISK RELATED TO DELIVERY OF MEDICALLY NECESSARY SERVICES AND TO COVER ITS MDHHS CONTRACTUAL LIABILITY.	Not available till year end	7.5%		> 6%	≥ 5% and 6%	< 5%
	Regional Financial Audits indicate unqualified opinion	MSHN WILL REVIEW CMHSP FINANCIAL AUDITS AND COMPLIANCE EXAMINATIONS TO IDENTIFY SIGNIFICANT DEFICIENCIES THAT IMPACT THE REGION.	Not available till year end	100%		> 92%	< 92% and > 85%	≤ 85%
	No noted significant findings related to regional Compliance Examinations	MSHN WILL REVIEW CMHSP FINANCIAL AUDITS AND COMPLIANCE EXAMINATIONS TO IDENTIFY SIGNIFICANT DEFICIENCIES THAT IMPACT THE REGION.	Not available till year end	100%		> 92%	< 92% and > 85%	≤ 85%
	MSHN Administrative Budget Performance actual to budget (%)	MSHN's board approved budget	98.1%	≥ 90%		≥ 90%	> 85% and < 90%	≤ 85% or >100%
	Medical Loss Ratio is within CMS Guidelines	MSHN WILL MAINTAIN A FISCAL DASHBOARD TO REPORT FINANCE COUNCIL'S AGREED UPON METRICS.	Not Avail Yet	85%		≥ 90%	> 85% and < 90%	≤ 85%
	Regional revenue is sufficient to meet expenditures (Savings estimate report)	MSHN WILL MONITOR TRENDS IN RATE SETTING TO ENSURE ANTICIPATED REVENUE ARE SUFFICIENT TO MEET BUDGETED EXPENDITURES.	103.0%	100%		<100%	> 100% and <105%	>105%
	Develop and implement Provider Incentives (VBP, ER FU, Integration)	MSHN will develop methodologies, within established rules, to incentivize providers to cooperate with the PIHP to improve health or other mutually agreeable outcomes.	1	2		2	1	0

MSHN FY19 - Provider Network Management Committee - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2019	Target Value	Performance Level	Target Ranges		
BETTER CARE	Monitor and ensure compliance with new Provider Network Adequacy Standards	Develop and implement practice strategies for the MSHN provider network to comply with the new standards	Meets Requirments	Meets requirements		Meets Reqs		Does not Meet Req's
	Develop an approved regionally standardized Autism Contract and Peformance Monitoring Protocol	EXPAND REGIONAL AUTISM SERVICE CAPACITY TO ENSURE SUFFICIENT NETWORK CAPACITY TO MEET CONSUMER DEMAND.	100	100% complete		100%	71-99%	<70%
BETTER VALUE	Increase the number of data elements available to the consumers and public	MSHN publishes provider performance data to consumers and the public	0	3		3	2	1
	Regionally organized FI and inpatient monitoring and performance systems demonstrate a reduced adminsitrative cost	Evaluate the effectiveness of regionally organized fiscal intermediary and inpatient provider performance monitoring systems developed in prior years	reduction from FY17	reduction from FY17		reduction from FY17	no change	increase over FY17
	Assess rates; develop an approved strategy to negotiate a regional rate for each hosptial in the MSHN region	MSHN successfully negotiates regional inpatient contracts resulting in improved rates and performance results.	Discontinued	100% complete		100%	71-99%	<70%
Better Provider Systems	Provider surveys demonstrate satsifaction with REMI enhancements (Audit module)	FULLY IMPLEMENT THE REMI PROVIDER NETWORK MONITORING (AUDIT) MODULE INCLUDING PROVIDER RESPONSE FEATURE TO	no data available currently	80%		>80%	70-75%	<70%
	Develop scope of work for provider portal implementation to include provider reporting requirements	FULLY IMPLEMENT THE REMI PROVIDER PORTAL TO FACILITATE PROVIDER SUBMISSION OF REQUIRED REPORTS, PLANS AND OTHER DATA/INFORMATION	75%	100%		100%	71-99%	<70%
	SUD providers satisfaction demonstrates 80% or above with the effectiveness and efficiency of MSHN's processes and communications	Deploy a survey tool to measure participating provider satisfaction and achieve 80% satisfaction with the **effectiveness** and efficiency of MSHN's processes and communications	70%	80%		>80%	70-75%	<70%
	FY19 IPHU audits will demonstrate 95% performance standard; those under 95% (FY18 results) will improve performance by an additional 10%	MSHN successfully negotiates regional inpatient contracts resulting in improved ~~rates and~~ performance results.	3	9		9	8-6	<5
	Conduct focus groups to inform an action plan that improves workforce	MSHN WILL COORDINATE/FACILITATE FOCUS GROUPS FOR PROVIDER NETWORK TO IDENTIFY PRIMARY WORKFORCE CONCERNS AND ISSUES	100%	100%		100%	71-99%	<70%

MSHN FY19 - Quality Improvement/Customer Service - Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with		Actual Value (%) as of September 2019	Target Value	Performance Level	Target Ranges		
Better Care	Percent of all Medicaid Children and Adult beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours	MDHHS PIHP Contract Reporting Requirements		98.9%	100%		95.0%	94.9%	90.0%
	Percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service	MDHHS PIHP Contract Reporting Requirements		97.9%	100%		95.0%	94.9%	90.0%
	Percent of new persons starting any needed on-going services within 14 days of a non-emergent assessment with a professional	MDHHS PIHP Contract Reporting Requirements		97.0%	100%		95.0%	94.9%	90.0%
	Percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days	MDHHS PIHP Contract Reporting Requirements		98.7%	100%		95.0%	94.9%	90.0%
	Percent of discharges from a substance abuse detox unit who are seen for follow up care within seven days	MDHHS PIHP Contract Reporting Requirements		97.1%	100%		95.0%	94.9%	90.0%
	Percent of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge	MDHHS PIHP Contract Reporting Requirements		12.2%	100%		<=15%	>=15.1%	>=16%
	Standard for Follow-up After Hospitalization for Adults with Mental Illness is met (FUH)	Measurement Portfolio NQF 0576; FY19 PIHP/MDHHS Contract, Section 8.4.2.1 (2019 Performance Bonus)		79.1%	58%		>=58%		<58%
	Standard for Follow-up After Hospitalization for Children with Mental Illness is met (FUH)	Measurement Portfolio NQF 0576; FY19 PIHP/MDHHS Contract, Section 8.4.2.1 (2019 Performance Bonus)		89.6%	70%		>=70%		<70%
	Medicaid Event Verification review demonstrates improvement of previous year results with the documentation of the service date and time matching the claim date and time of the service.	MDHHS PIHP Contract: Medicaid Services Verification Technical Requirement		Not Available until Jan. 2020 Not Available until Jan. 2020	Increase over 2018	Not Available until Jan. 2020	95%	90.0%	85%
	Medicaid Event Verification review demonstrates improvement of previous year results with the service being included in the persons individualized plan of service for SUD providers.	MDHHS PIHP Contract: Medicaid Services Verification Technical Requirement		Not Available until Jan. 2020	Increase over 2018	Not Available until Jan. 2020	95%	90.0%	85%
	Percentage (rate per 100) of Medicaid consumers who are denied overall eligibility were resolved with a written notice letter within 14 calendar days for a standard request of service.	MDHHS PIHP Contract: Grievance and Appeal Technical Requirement		89%	100%		95%	91%-94%	90%
	The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness standards including the written disposition letter (30 calendar days) of a standard request for appeal.	MDHHS PIHP Contract: Grievance and Appeal Technical Requirement		95%	100%		95%	91%-94%	90%
	The percentage (rate per 100) of Medicaid second opinion requests regarding inpatient psychiatric hospitalization denials which are resolved in compliance with state and federal timeliness standards, including receiving a written provision of disposition	MDHHS PIHP Contract: Grievance and Appeal Technical Requirement		88%	100%		95%	91%-94%	90%
	The percentage (rate per 100) of Medicaid grievances are resolved with a written disposition sent to the consumer within 90 calendar days of the request for a grievance	MDHHS PIHP Contract: Grievance and Appeal Technical Requirement		98%	100%		95%	91%-94%	90%
Better Health	Consumers are screened for diabetes.	Measurement Portfolio NQF 1932; NQF 1934; NQF 1927; FY19 PIHP/MDHHS Contract, Attachment P7.9.1 (QAPIP)		83.91%	Increase over previous quarter		79.0%	77.0%	75.0%
	Consumers are monitored for diabetes.	2018 HEDIS Measure Specifications; FY19 PIHP/MDHHS Contract, Attachment P7.9.1 (QAPIP)		61.24%	Increase over previous quarter	Collecting Baseline data this year no target range set			

MSHN FY19 - Clinical Leadership Committee - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2019	Target Value	Performance Level	Target Ranges		
BETTER HEALTH	ADHD medication follow up. This HEDIS measure reports the percentage of children newly prescribed ADHD medication who received at least three follow-up visits.	Aligns with strategic plan goal to establish clear criteria and practices that demonstrate improved primary care coordination and with Performance Measure Portfolio (Monthly)	Initiation: 83.33% ; C & M: 94.47% (7/31/19)	Increase over FY 2017 (Initiation 72.86%; C & M 97.25%)		I:74% C&M: 99%	I:70% C&M:95%	I: 65% C&M: 91%
Better Care	MSHN's provider network will demonstrate 95% compliance with trauma-competent standard in the site review chart tool.	Aligns with strategic plan goal that region has a trauma competent culture of care.	87.5% (9/30/19)	increase over 2018 (83.3%)		increase over 2018	No change from 2018 levels	
	Identify schools interested in participating in collaboration for the purpose of addressing mental health and prevention.	MSHN FY19-20 Strategic Plan	4	Increase # schools		Increase over previous timeframe	No change	School withdraws
	Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS.	MSHN FY19-20 Strategic Plan	92% (1134/1235)	95%		95-100%	90-94%	<90%
BETTER VALUE	Continuum of Care - Consumers moving from inpatient psychiatric hospitalization will show in next LOC within 7 days, and 2 additional apts within 30 days of first step-down visit	Aligns with strategic plan goal that MSHN and its CMHSP participants will explore clinical process standardization, especially in the areas of access, emergency services, pre-admission screening, crisis response and inpatient stay management and discharge planning.	In development by TBD (Being developed utilizing REMI data within Power BI) Expected November 2019	Increase over 2017 and 2018		increase over 2017 and 2018	No change from 2017 levels	Below 2017 levels

MSHN FY19 - Utilization Management Committee - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Aligns with	Actual Value (%) as of September 2019	Target Value	Performance Level	Target Ranges		
BETTER CARE								
	Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines.	MSHN Strategic Plan FY19-FY20, MSHN UM Plan	95.00%	100%		97-100%	94-95%	<93%
	Percent of providers who are in compliance with the HCBS Rule.	MSHN Strategic Plan FY19-FY20, MDHHS State Transition Plan	98%	100%		>=76%	46%-75%	<45%
	Complete SIS Assessments for adult persons with IDD	MSHN Strategic Plan FY19-FY20	56%	100%		>=75%	50%-74%	<50%
	Percentage of adults receiving services within the regionally established recommended utilization range for their assessed level of care, including clinical overrides (per LOCUS)	MSHN Strategic Plan FY19-FY20, MDHHS State Transition Plan	82%	100%		100%	90%-99%	<90%
	The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (Plan All Cause Readmissions)	MSHN Strategic Plan FY19-FY20, MSHN UM Plan; Measurement Porfolio NQF 1768	12.61%	<=15%		<=15%	16-25%	>25%
BETTER VALUE								
	Develop and implement consistent regional service benefit for all populations served	MSHN Strategic Plan FY19-FY20, Federal Parity Requirements	65%	100.0%		>=75%	50%-74%	<50%